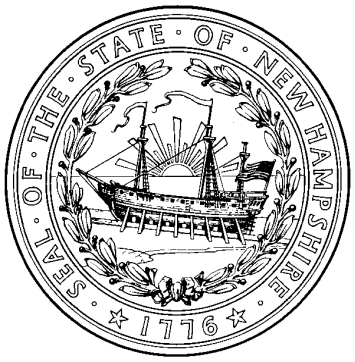
DATA STANDARDS AND DATA DICTIONARY

NEW HAMPSHIRE STATE CANCER INCIDENCE DATA COLLECTION STANDARD MANUAL

New Hampshire Department of Health and Human Services
Division of Public Health Services
Office of Health Statistics and Data Management
New Hampshire State Cancer Registry



NEW HAMPSHIRE STATE CANCER REGISTRY RESEARCH ANALYTIC FORMAT DATA DICTIONARY
MAY, 2011

DATA STANDARDS AND DATA DICTIONARY

New Hampshire Department of Health and Human Services
Division of Public Health Services
Office of Health Statistics and Data Management
New Hampshire State Cancer Registry

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Name	Number	Section	Page Number
CS Site-Specific Factor10	2864	Stage/Prognostic Factors	58
CS Site-Specific Factor11	2865	Stage/Prognostic Factors	58-59
CS Site-Specific Factor12	2866	Stage/Prognostic Factors	59
CS Site-Specific Factor13	2867	Stage/Prognostic Factors	59
CS Site-Specific Factor14	2868	Stage/Prognostic Factors	59-60
CS Site-Specific Factor15	2869	Stage/Prognostic Factors	60
CS Site-Specific Factor16	2870	Stage/Prognostic Factors	60
CS Site-Specific Factor17	2871	Stage/Prognostic Factors	60-61
CS Site-Specific Factor18	2872	Stage/Prognostic Factors	61
CS Site-Specific Factor19	2873	Stage/Prognostic Factors	61
CS Site-Specific Factor20	2874	Stage/Prognostic Factors	61-62
CS Site-Specific Factor21	2875	Stage/Prognostic Factors	62
CS Site-Specific Factor22	2876	Stage/Prognostic Factors	62
CS Site-Specific Factor23	2877	Stage/Prognostic Factors	62-63
CS Site-Specific Factor24	2878	Stage/Prognostic Factors	63
CS Site-Specific Factor25	2879	Stage/Prognostic Factors	63
CS Tumor Size	2800	Stage/Prognostic Factors	63-64
CS Tumor Size/Ext Eval	2820	Stage/Prognostic Factors	64
CS Version Derived	2936	Stage/Prognostic Factors	64-65
CS Version Input Current	2937	Stage/Prognostic Factors	65
CS Version Input Original	2935	Stage/Prognostic Factors	65
Date Case Completed	2090	Edit Overrides/Conversion History/System Admin	65-66
Date Case Completed--CoC	2092	Edit Overrides/Conversion History/System Admin	66
Date Case Initiated	2085	Edit Overrides/Conversion History/System Admin	66
Date Case Last Changed	2100	Edit Overrides/Conversion History/System Admin	66
Date Case Report Exported	2110	Edit Overrides/Conversion History/System Admin	66-67
Date Case Report Loaded	2112	Edit Overrides/Conversion History/System Admin	67
Date Case Report Received	2111	Edit Overrides/Conversion History/System Admin	67
Date Conclusive DX Flag	448	Cancer Identification	67-68
Date of 1st Contact	580	Hospital-Specific	68
Date of 1st Contact Flag	581	Hospital-Specific	68-69
Date of 1st Crs Rx Flag	1271	Treatment-1st Course	69
Date of 1st Crs RX--CoC	1270	Treatment-1st Course	69
Date of 1st Positive BX	1080		70
Date of Birth	240	Demographic	70
Date of Birth Flag	241	Demographic	70
Date of CA Conference	660		70-71
Date of Conclusive DX	443	Cancer Identification	71
Date of Death--Canada	1755	Follow-up/Recurrence/Death	71
Date of Death--CanadaFlag	1756	Follow-up/Recurrence/Death	71-72
Date of Diagnosis	390	Cancer Identification	72
Date of Diagnosis Flag	391	Cancer Identification	72
Date of Initial RX Flag	1261	Treatment-1st Course	72-73
Date of Initial RX--SEER	1260	Treatment-1st Course	73
Date of Inpatient Adm	590	Hospital-Specific	73

Name	Number	Section	Page Number
Path Ordering Fac No 1	7190	Pathology	150
Path Ordering Fac No 2	7191	Pathology	150
Path Ordering Fac No 3	7192	Pathology	151
Path Ordering Fac No 4	7193	Pathology	151
Path Ordering Fac No 5	7194	Pathology	151-152
Path Report Number 1	7090	Pathology	152
Path Report Number 2	7091	Pathology	152
Path Report Number 3	7092	Pathology	152-153
Path Report Number 4	7093	Pathology	153
Path Report Number 5	7094	Pathology	153
Path Report Type 1	7480	Pathology	153-154
Path Report Type 2	7481	Pathology	154-155
Path Report Type 3	7482	Pathology	155
Path Report Type 4	7483	Pathology	155-156
Path Report Type 5	7484	Pathology	156
Path Reporting Fac ID 1	7010	Pathology	156-157
Path Reporting Fac ID 2	7011	Pathology	157
Path Reporting Fac ID 3	7012	Pathology	157
Path Reporting Fac ID 4	7013	Pathology	157-158
Path Reporting Fac ID 5	7014	Pathology	158
Patient ID Number	20	Record ID	158
Patient System ID-Hosp	21	Record ID	158-159
Pediatric Stage	1120	Stage/Prognostic Factors	159
Pediatric Staged By	1140	Stage/Prognostic Factors	159-160
Pediatric Staging System	1130	Stage/Prognostic Factors	160
Physician 3	2490	Other-Confidential	160
Physician 4	2500	Other-Confidential	161
Physician--Follow-Up	2470	Other-Confidential	161
Physician--Managing	2460	Other-Confidential	161
Physician--Primary Surg	2480	Other-Confidential	161-162
Place of Death	1940	Follow-up/Recurrence/Death	162
Presentation at CA Conf	650		162
Primary Payer at DX	630	Hospital-Specific	162-163
Primary Site	400	Cancer Identification	163
Protocol Eligibility Stat	1470		163
Protocol Participation	1480		164
Quality of Survival	1780	Follow-up/Recurrence/Death	164
Race 1	160	Demographic	164-165
Race 2	161	Demographic	165-166
Race 3	162	Demographic	166-167
Race 4	163	Demographic	167-168
Race 5	164	Demographic	168-169
Race Coding Sys--Current	170	Demographic	169
Race Coding Sys--Original	180	Demographic	169-170
Race--NAPIIA(derived API)	193	Demographic	170-171

Name	Number	Section	Page Number
Rad--Boost Dose cGy	3210	Treatment-1st Course	171
Rad--Boost RX Modality	3200	Treatment-1st Course	171-172
Rad--Elapsed RX Days	1530		172
Rad--Intent of Treatment	1560		172-173
Rad--Local Control Status	1590		173
Rad--Location of RX	1550	Treatment-1st Course	173
Rad--No of Treatment Vol	1520	Treatment-1st Course	173
Rad--Regional Dose: CGY	1510	Treatment-1st Course	173-174
Rad--Regional RX Modality	1570	Treatment-1st Course	174-175
Rad--RX Completion Status	1580		175
Rad--Treatment Volume	1540	Treatment-1st Course	175-176
Readm Same Hosp 30 Days	3190	Treatment-1st Course	176
Reason for No Chemo	1440		176-177
Reason for No Hormone	1450		177
Reason for No Radiation	1430	Treatment-1st Course	177
Reason for No Surgery	1340	Treatment-1st Course	177-178
Record Type	10	Record ID	178
Recurrence Date--1st	1860	Follow-up/Recurrence/Death	178
Recurrence Date--1st Flag	1861	Follow-up/Recurrence/Death	178-179
Recurrence Distant Site 1	1871		179
Recurrence Distant Site 2	1872		179
Recurrence Distant Site 3	1873		179
Recurrence Distant Sites	1870		180
Recurrence Type--1st	1880	Follow-up/Recurrence/Death	180-181
Recurrence Type--1st--Oth	1890		181
Referral to Support Serv	1490		181
Regional Nodes Examined	830	Stage/Prognostic Factors	181-182
Regional Nodes Positive	820	Stage/Prognostic Factors	182
Registry ID	40	Record ID	182-183
Registry Type	30	Record ID	183
Religion	260		183
Reporting Facility	540	Hospital-Specific	183-184
Reporting Hospital FAN	538		184
Reserved 00	37	Record ID	184
Reserved 01	370	Record ID	184
Reserved 02	530	Demographic	184
Reserved 03	680	Cancer Identification	184
Reserved 04	750	Hospital-Specific	184-185
Reserved 05	1180	Stage/Prognostic Factors	185
Reserved 06	1190	Treatment-1st Course	185
Reserved 07	1300	Treatment-Subsequent & Other	185
Reserved 08	1650	Edit Overrides/Conversion History/System Admin	185
Reserved 09	1740	Follow-up/Recurrence/Death	185
Reserved 10	1835	Patient-Confidential	185
Reserved 11	1900	Hospital-Confidential	185-186

Name	Number	Section	Page Number
Reserved 12	2510	Other-Confidential	186
Reserved 13	2080	Pathology	186
Reserved 14	2210	Text-Miscellaneous	186
Reserved 16	2400	Hospital-Specific	186
Reserved 17	2450	Hospital-Specific	186
RuralUrban Continuum 1993	3300	Demographic	186-187
RuralUrban Continuum 2003	3310	Demographic	187-188
RX Coding System--Current	1460	Treatment-1st Course	188
RX Date Mst Defn Srg Flag	3171	Treatment-1st Course	188-189
RX Date Rad Ended Flag	3221	Treatment-1st Course	189
RX Date Surg Disch Flag	3181	Treatment-1st Course	189-190
RX Date Systemic Flag	3231	Treatment-1st Course	190
RX Date--BRM	1240	Treatment-1st Course	190-191
RX Date--BRM Flag	1241	Treatment-1st Course	191
RX Date--Chemo	1220	Treatment-1st Course	191
RX Date--Chemo Flag	1221	Treatment-1st Course	191-192
RX Date--DX/Stg Proc	1280	Treatment-1st Course	192
RX Date--Dx/Stg Proc Flag	1281	Treatment-1st Course	192-193
RX Date--Hormone	1230	Treatment-1st Course	193
RX Date--Hormone Flag	1231	Treatment-1st Course	193-194
RX Date--Most Defin Surg	3170	Treatment-1st Course	194
RX Date--Other	1250	Treatment-1st Course	194
RX Date--Other Flag	1251	Treatment-1st Course	194-195
RX Date--Radiation	1210	Treatment-1st Course	195
RX Date--Radiation Ended	3220	Treatment-1st Course	195
RX Date--Radiation Flag	1211	Treatment-1st Course	195-196
RX Date--Surgery	1200	Treatment-1st Course	196
RX Date--Surgery Flag	1201	Treatment-1st Course	196-197
RX Date--Surgical Disch	3180	Treatment-1st Course	197
RX Date--Systemic	3230	Treatment-1st Course	197
RX Hosp--ASA Class	665		197
RX Hosp--BRM	720	Hospital-Specific	197-198
RX Hosp--Chemo	700	Hospital-Specific	198-199
RX Hosp--DX/Stg Proc	740	Hospital-Specific	199-200
RX Hosp--Hormone	710	Hospital-Specific	200
RX Hosp--Other	730	Hospital-Specific	200-201
RX Hosp--Palliative Proc	3280	Hospital-Specific	201-202
RX Hosp--Radiation	690	Hospital-Specific	202
RX Hosp--Reg LN Removed	676	Hospital-Specific	202-203
RX Hosp--Scope Reg 98-02	747	Hospital-Specific	203
RX Hosp--Scope Reg LN Sur	672	Hospital-Specific	203-204
RX Hosp--Screen/BX Proc1	742		204
RX Hosp--Screen/BX Proc2	743		204
RX Hosp--Screen/BX Proc3	744		204-205
RX Hosp--Screen/BX Proc4	745		205

Name	Number	Section	Page Number
RX Hosp--Surg App 2010	668	Hospital-Specific	205
RX Hosp--Surg Oth 98-02	748	Hospital-Specific	205-206
RX Hosp--Surg Oth Reg/Dis	674	Hospital-Specific	206
RX Hosp--Surg Prim Site	670	Hospital-Specific	206-207
RX Hosp--Surg Site 98-02	746	Hospital-Specific	207
RX Hosp--Surg Timing	678		207
RX Summ--BRM	1410	Treatment-1st Course	208
RX Summ--Chemo	1390	Treatment-1st Course	208-209
RX Summ--DX/Stg Proc	1350	Treatment-1st Course	209
RX Summ--Hormone	1400	Treatment-1st Course	209-210
RX Summ--Other	1420	Treatment-1st Course	210
RX Summ--Palliative Proc	3270	Treatment-1st Course	210-211
RX Summ--Rad to CNS	1370	Treatment-1st Course	211
RX Summ--Radiation	1360	Treatment-1st Course	211-212
RX Summ--Reconstruct 1st	1330	Treatment-1st Course	212
RX Summ--Reg LN Examined	1296	Treatment-1st Course	212-213
RX Summ--Scope Reg 98-02	1647	Treatment-1st Course	213
RX Summ--Scope Reg LN Sur	1292	Treatment-1st Course	213-214
RX Summ--Screen/BX Proc1	1642		214
RX Summ--Screen/BX Proc2	1643		214
RX Summ--Screen/BX Proc3	1644		214
RX Summ--Screen/BX Proc4	1645		215
RX Summ--Surg Oth 98-02	1648	Treatment-1st Course	215
RX Summ--Surg Oth Reg/Dis	1294	Treatment-1st Course	215-216
RX Summ--Surg Prim Site	1290	Treatment-1st Course	216
RX Summ--Surg Site 98-02	1646	Treatment-1st Course	216
RX Summ--Surg/Rad Seq	1380	Treatment-1st Course	216-217
RX Summ--Surgery Type	1640	Treatment-1st Course	217
RX Summ--Surgical Approch	1310	Treatment-1st Course	217
RX Summ--Surgical Margins	1320	Treatment-1st Course	217-218
RX Summ--Systemic/Sur Seq	1639	Treatment-1st Course	218
RX Summ--Transplnt/Endocr	3250	Treatment-1st Course	218-219
RX Summ--Treatment Status	1285	Treatment-1st Course	219
RX Text--BRM	2660	Text-Treatment	219-220
RX Text--Chemo	2640	Text-Treatment	220-221
RX Text--Hormone	2650	Text-Treatment	221-222
RX Text--Other	2670	Text-Treatment	222-223
RX Text--Radiation (Beam)	2620	Text-Treatment	223-224
RX Text--Radiation Other	2630	Text-Treatment	224-225
RX Text--Surgery	2610	Text-Treatment	225-226
Screening Date	510		226
Screening Result	520		226
SEER Coding Sys--Current	2120	Edit Overrides/Conversion History/System Admin	226-227
SEER Coding Sys--Original	2130	Edit Overrides/Conversion History/System Admin	227
SEER Record Number	2190	Edit Overrides/Conversion History/System Admin	227

Name	Number	Section	Page Number
SEER Site-Specific Fact 1	3700	Stage/Prognostic Factors	228
SEER Site-Specific Fact 2	3702	Stage/Prognostic Factors	228
SEER Site-Specific Fact 3	3704	Stage/Prognostic Factors	228
SEER Site-Specific Fact 4	3706	Stage/Prognostic Factors	229
SEER Site-Specific Fact 5	3708	Stage/Prognostic Factors	229
SEER Site-Specific Fact 6	3710	Stage/Prognostic Factors	229
SEER Summary Stage 1977	760	Stage/Prognostic Factors	230
SEER Summary Stage 2000	759	Stage/Prognostic Factors	230-231
SEER Type of Follow-Up	2180	Edit Overrides/Conversion History/System Admin	231
Sequence Number--Central	380	Cancer Identification	231-233
Sequence Number--Hospital	560	Hospital-Specific	233-234
Sex	220	Demographic	234
Site (73-91) ICD-O-1	1960	Edit Overrides/Conversion History/System Admin	234
Site Coding Sys--Current	450	Cancer Identification	234-235
Site Coding Sys--Original	460	Cancer Identification	235
Site of Distant Met 1	1090		235
Site of Distant Met 2	1100		235-236
Site of Distant Met 3	1110		236
Social Security Number	2320	Patient-Confidential	236
Spanish/Hispanic Origin	190	Demographic	236-237
State/Requestor Items	2220	Special Use	237
Subsq Report for Primary	2160		237
Subsq RX 2nd Course BRM	1675	Treatment-Subsequent & Other	238
Subsq RX 2nd Course Chemo	1673	Treatment-Subsequent & Other	238
Subsq RX 2nd Course Codes	1670	Treatment-Subsequent & Other	238
Subsq RX 2nd Course Date	1660	Treatment-Subsequent & Other	238-239
Subsq RX 2nd Course Horm	1674	Treatment-Subsequent & Other	239
Subsq RX 2nd Course Oth	1676	Treatment-Subsequent & Other	239
Subsq RX 2nd Course Rad	1672	Treatment-Subsequent & Other	239
Subsq RX 2nd Course Surg	1671	Treatment-Subsequent & Other	239-240
Subsq RX 2ndCrs Date Flag	1661	Treatment-Subsequent & Other	240
Subsq RX 2nd--Reg LN Rem	1679	Treatment-Subsequent & Other	240
Subsq RX 2nd--Scope LN SU	1677	Treatment-Subsequent & Other	240-241
Subsq RX 2nd--Surg Oth	1678	Treatment-Subsequent & Other	241
Subsq RX 3rd Course BRM	1695	Treatment-Subsequent & Other	241
Subsq RX 3rd Course Chemo	1693	Treatment-Subsequent & Other	241
Subsq RX 3rd Course Codes	1690	Treatment-Subsequent & Other	241-242
Subsq RX 3rd Course Date	1680	Treatment-Subsequent & Other	242
Subsq RX 3rd Course Horm	1694	Treatment-Subsequent & Other	242
Subsq RX 3rd Course Oth	1696	Treatment-Subsequent & Other	242-243
Subsq RX 3rd Course Rad	1692	Treatment-Subsequent & Other	243
Subsq RX 3rd Course Surg	1691	Treatment-Subsequent & Other	243
Subsq RX 3rdCrs Date Flag	1681	Treatment-Subsequent & Other	243
Subsq RX 3rd--Reg LN Rem	1699	Treatment-Subsequent & Other	244
Subsq RX 3rd--Scope LN Su	1697	Treatment-Subsequent & Other	244

Name	Number	Section	Page Number
Subsq RX 3rd--Surg Oth	1698	Treatment-Subsequent & Other	244
Subsq RX 4th Course BRM	1715	Treatment-Subsequent & Other	244-245
Subsq RX 4th Course Chemo	1713	Treatment-Subsequent & Other	245
Subsq RX 4th Course Codes	1710	Treatment-Subsequent & Other	245
Subsq RX 4th Course Date	1700	Treatment-Subsequent & Other	245
Subsq RX 4th Course Horm	1714	Treatment-Subsequent & Other	245-246
Subsq RX 4th Course Oth	1716	Treatment-Subsequent & Other	246
Subsq RX 4th Course Rad	1712	Treatment-Subsequent & Other	246
Subsq RX 4th Course Surg	1711	Treatment-Subsequent & Other	246
Subsq RX 4thCrs Date Flag	1701	Treatment-Subsequent & Other	246-247
Subsq RX 4th--Reg LN Rem	1719	Treatment-Subsequent & Other	247
Subsq RX 4th--Scope LN Su	1717	Treatment-Subsequent & Other	247
Subsq RX 4th--Surg Oth	1718	Treatment-Subsequent & Other	247-248
Subsq RX 5th Course BRM	1735		248
Subsq RX 5th Course Chemo	1733		248
Subsq RX 5th Course Codes	1730		248
Subsq RX 5th Course Date	1720		248
Subsq RX 5th Course Horm	1734		248-249
Subsq RX 5th Course Oth	1736		249
Subsq RX 5th Course Rad	1732		249
Subsq RX 5th Course Surg	1731		249
Subsq RX 5th--Reg LN Rem	1739		249
Subsq RX 5th--Scope LN Su	1737		249-250
Subsq RX 5th--Surg Oth	1738		250
Subsq RX--Reconstruct Del	1741	Treatment-Subsequent & Other	250
Telephone	2360	Patient-Confidential	250
Text--DX Proc--Lab Tests	2550	Text-Diagnosis	251
Text--DX Proc--Op	2560	Text-Diagnosis	251-252
Text--DX Proc--Path	2570	Text-Diagnosis	252-253
Text--DX Proc--PE	2520	Text-Diagnosis	254-255
Text--DX Proc--Scopes	2540	Text-Diagnosis	255-256
Text--DX Proc--X-ray/Scan	2530	Text-Diagnosis	256
Text--Histology Title	2590	Text-Diagnosis	257
Text--Place of Diagnosis	2690	Text-Miscellaneous	257-258
Text--Primary Site Title	2580	Text-Diagnosis	258-259
Text--Remarks	2680	Text-Miscellaneous	259
Text--Staging	2600	Text-Diagnosis	259-260
Text--Usual Industry	320	Demographic	260-261
Text--Usual Occupation	310	Demographic	261-262
TNM Clin Descriptor	980	Stage/Prognostic Factors	262
TNM Clin M	960	Stage/Prognostic Factors	262-263
TNM Clin N	950	Stage/Prognostic Factors	263
TNM Clin Stage Group	970	Stage/Prognostic Factors	263
TNM Clin Staged By	990	Stage/Prognostic Factors	263-264
TNM Clin T	940	Stage/Prognostic Factors	264

INTRODUCTION

This manual on the standards for cancer data collection provides information on the different variables collected by New Hampshire State Cancer Registry (NHSCR). This includes clarification of descriptions, rationales and coding instructions of all variables, as well as any new data items, addition of new codes to existing data items etc. This manual is based on the Version 12.1 of the North American Association of Central Cancer Regsitries (NAACCR) (all abbreviations are listed in Appendix B) data exchange record layout, which reflects all the variables that have to be collected and reported on cancers diagnosed from January 1, 2011 onward.

NEW HAMPSHIRE STATE CANCER REGISTRY

This data collection manual provides information on the different variables collected by NHSCR for the purpose of cancer incidence data. Cancer became reportable in New Hampshire in 1985, and since 1986 the NHSCR has been charged with identifying all new cases of cancer occurring among residents of the state. The Centers for Disease Control and Prevention's (CDC) National Program of Cancer Registries (NPCR), through a cooperative agreement, currently provide a grant to New Hampshire's Department of Public Health Services (DPHS) with the principle aim of collecting high quality cancer incidence data. The specific goals of the New Hampshire State Cancer Registry are to:

- assess the cancer burden in the NH population;
- provide high quality data for research to investigate the risk factors for cancer;
- evaluate and plan patient care services; and
- Evaluate early diagnosis and treatment programs.

The New Hampshire DPHS and Office of Health Statistics and Data Management have overall responsibility for the registry, which it funds through a state contract awarded through a competitive bidding process. This contract is held by Dartmouth College and is administered through the Department of Community and Family Medicine at Dartmouth Medical School.

The NHSCR receives reports from hospital registrars operating in all large hospitals, hospital reporters in small hospitals, physician practices, a freestanding radiation oncology center, out-of-state pathology laboratories, and other sources, as required by New Hampshire regulations. New Hampshire also receives reports about cancer incidence among its residents from the central cancer registries of Massachusetts, Vermont, New York and other states, based on inter-state data exchange agreements. Similarly, reports made to NHSCR of cancer cases among residents of these other states are transmitted to the appropriate central cancer registries. These cases form the basis of the NHSCR data file which is used by DPHS to prepare its report and by other users within DPHS; national registry programs who generate cancer incidence and mortality statistics; and by appropriately qualified medical and other scientific researchers.

As part of the cooperative agreement, the NPCR annually assesses the completeness of data reported by state cancer registries and periodically conducts audits of data quality. In addition, the NAACCR provides an assessment of data completeness and quality for central cancer registries. The NHSCR remains in the front rank of population based cancer registries in the United States, in terms of both data quality and completeness, as assessed by independent sources. Since 2001, NHSCR has been awarded nine Gold certifications and two Silver certifications for data quality by NAACCR for years 1998-2008.

Cancer surveillance is the key to a unified scientific and public health approach to fighting cancer. Without a central cancer registry, it would be impossible to determine if reductions in cancer rates occur in New Hampshire and if resources are being directed appropriately. Data collected by the NHSCR provide the basis for identification of cancer trends within the state.

PURPOSE AND USE OF DATA EXCHANGE LAYOUTS

The NAACCR data exchange record layouts were designed to facilitate electronic transmission of cancer registry data among registries for multiple purposes. The layouts can be used to provide standardized data from reporting sources to central registries; to share tumor reports on residents of other states/provinces from one central registry to another; or to report data from diverse facilities or states/provinces contributing to a combined study. The NAACCR data set is comprised of all data items recommended for use by the major cancer registry standard-setting organizations. For some types of data, more than one coding system is provided in the layout. For example, information on stage of the tumor at diagnosis is represented by many items comprising TNM, SEER EOD, Summary Stage, and Collaborative Stage. Any single registry is unlikely to collect all of the items in the layouts. It is hoped that all items collected by an individual registry can be accommodated in the NAACCR layouts and thus shared in a common data format with other registries.

The goal of this manual is to define the NAACCR data standards for cancer registration for use by central registries, hospital-based registries, and other groups in North America to abstract cancer diagnosed on or after January 1, 2011.

Objectives of the standardization effort, and of this manual, are to:

- Provide a comprehensive reference to ensure uniform data collection
- Reduce the need for redundant coding and data recording between agencies
- Facilitate the collection of comparable data among groups
- Provide a resource document to help registries that are establishing or revising their databases

This document can be used by new and existing facility-based and central cancer registries to ensure that their program and standard definitions and codes are consistent with those used by regional and national databases. Other potential users include registry software providers and those using registry data, especially if they are combining data from multiple sources or exchanging data. This manual describes all current data items. Those that are new or have been modified since the preceding manual are listed in the Appendix C.

The manual uses the same structure and philosophy as NAACCR's data exchange standards. Where a standard exists for an item or type of data, the standard is incorporated by reference. Where a variety of standards are in use, alternate coding schemes accommodate them, but the different coding schemes are recorded separately, or another data field is used to indicate which coding standard was used.

CODING STANDARDS

Detailed coding instructions for many data items in the data exchange record are implied by the ―Source of Standard located in NAACCR Standards for Cancer Registries Volume II, *Data Standards and Data Dictionary*. The following list includes the current reference manuals:

- *AJCC Cancer Staging Manual (TNM)*
- *Canadian Cancer Registry Data Dictionary*
- *COC Facility Oncology Registry Data Standards (FORDS)*
- *Collaborative Stage Data Collection System*
- *NAACCR Standards for Cancer Registries Volume I: Data Exchange Standards and Record Description*
- *NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary*
- *SEER Program Code Manual*
- *SEER Summary Stage 2000*
- *WHO ICD-O Third Edition*

Because coding standards have changed over time, it is important to be aware of the coding standards that apply to any given record. The following variables indicate which coding standard was used when the information was originally abstracted, as well as the coding standard that currently applies to the data item. In some instances, there are also variables indicating how the current code in a field was obtained: coded directly from the data source or translated with or without review from codes assigned under another set of coding rules. The sender of the record would specify this information for each record, using the following fields (for definitions see NAACCR Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary)*:

- COC Coding Sys-Current [2140]
- COC Coding Sys-Original [2150]
- Coding System for EOD [870]
- CS Version Derived [2936]
- CS Version Input Current [2937]
- CS Version Original [2953]
- First Course Calc Method [1500]
- ICD-O-2 Conversion Flag [1980]
- ICD-O-3 Conversion Flag [2116]
- Morph Coding Sys-Current [470]
- Morph Coding Sys-Original [480]
- Race Coding Sys-Current [170]
- Race Coding Sys-Original [180]
- RX Coding System-Current [1460]
- SEER Coding Sys-Current [2120]
- SEER Coding Sys-Original [2130]
- Site Coding Sys-Current [450]
- Site Coding Sys-Original [460]
- TNM Edition Number [1060]

SCOPE OF THE MANUAL

The present document is limited to standards regarding data, rather than procedures. More specifically, it focuses on a subset of possible data standards that NAACCR and NHSCR considers important to establish. These include:

1. **Reportability:** Reportability defines the rules for inclusion of specific types of tumors in the registry (Apppendix C**).**
2. **Data Items or Variables to be Included:** Some data items are required or recommended by particular standard setters while others are optional or are retained because they were abstracted in the past. Appendix E specifies the required status for each variable what are transmitted to different organizations. *Example: —Sex is listed as a required standard data element in Appendix E by all standards setters represented.*
3. **Standardized Item Numbers and Item Names:** For ease and consistency of reference, all items are assigned both numbers and names (e.g., the item "Sex" is assigned the item number 220). The item number is intended to be permanent and will not change in NAACCR versions. Assignment of permanent numbers was necessary because standard-setting organizations have changed item names over time or have applied similar names to items with different definitions. Item numbers allow the required precision of reference. When data items are deleted, the item numbers are retired and will never be reused for a different data item. Some data item numbers were intentionally left blank to allow the insertion of related

items in the future. Ranges of available data item numbers, their assigned uses and for more information on these refer to NAACCR Standards Volume II.

4. **Length:** Data item names are limited to 25 characters because that is the maximum length for item names that can be taken up by NAACCR EDITS software system. Standardized abbreviations, punctuation, and spacing are used when necessary (i.e., the word "first" always is entered "1st," "treatment" is "RX," and soon). Thus, item names will be identical in this data standards volume and the NAACCR Metafile of standard edits. These are defined in the definitions of the variables.
5. **Consistency:** Consistency was a goal in formatting names and in using special characters. The character "--" is used to distinguish among item names built on the same stem name. *Example: ―Sequence Number—Hospital and ―Sequence Number--Central are the names of two differently defined sequence numbers.*
6. **Interrelated Items, Fields, and Subfields:** To make the relationship among items more apparent, a constant term was consistently added to the stem of the name. *Example: Names of treatment fields related to radiation therapy begin with ―Rad, so that in a list of item names they will appear together:Rad--No of Treatment Vol, Rad--Elapsed RX Days*
7. **Record Layout/Data Exchange:** Record layout/data exchange identifies the position of the data item in a standard flat file data exchange record. These positions are indicated under definitions of each variable. See NAACCR Standards Volume II for more extensive information on the data exchange and other NAACCR standard layouts. *Example: ―Sex is in character position 192 in the NAACCR Data Exchange Record Layout Version 12.1.*
8. **Codes:** Codes identify allowable values, their meanings, and data entry formats for data items. The NAACCR Standards Volume II - Chapters IX and X specifies either the standard codes for each data item or the source for the codes. *Example for the item ―Sex: Codes- 1 Male, 2 Female, 3 Other (Hermaphrodite), 4 Transsexual, 9 Not stated.* When it is necessary to collect more specific information than that represented by the standard codes, every effort should be made to ensure that the more specific codes will accurately collapse into the pre-existing codes. This approach permits diversity without compromising inter-registry comparability or meta-analyses.
9. **Coding Rules:** Coding rules are the guidelines and interpretations for deciding the correct code for a given tumor and are defined in the documentation of other standard-setting organizations. For each data item, The NAACCR Standards Volume II - Chapters VIII and X list a "Source of Standard," and the documentation from this source should be consulted for coding rule standards. *Hypothetical Example: A coding rule might state what code to assign for sex when the medical record states the patient is female and the death certificate states male.*

DATA DICTIONARY

In this manual, data variables are presented in alphabetical order by variable names. For each variable, name, alternate names, item number, length, source of standard, column, format, allowable values, status, section general description, specific codes and definitions are provided. For many items, the document provides a brief rationale for collecting the data item or for using the codes listed.

ABSTRACTED BY

Alternate Name	Item #	Length	Source of Standard	Column #
	570	3	CoC	742-744

Format: No special characters
Allowable Value: Letters and numbers
Status
NAACCR Record Section: Hospital-Specific

Description

An alphanumeric code assigned by the reporting facility that identifies the individual abstracting the case.

ACCESSION NUMBER--HOSP

Alternate Name	Item #	Length	Source of Standard	Column #
Accession Number (CoC)	550	9	CoC	731-739

Format:
Allowable Values: 9-digit number
NAACCR Record Section: Hospital-Specific
Status

Description

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

The first four numbers specify the year and the last five numbers are the numeric order in which the patient was entered into the registry database. Within a registry, all primaries for an individual must have the same accession number. The first four digits must be greater than or equal to 1944.

Rationale

This data item protects the identity of the patient and allows cases to be identified on a local, state, and national level. If the central registry preserves this number, they can refer to it when communicating with the hospital. It also provides a way to link computerized follow-up reports from hospitals into the central database.

ADDR AT DX--CITY

Alternate Name	Item #	Length	Source of Standard	Column #
City or Town (pre-96 CoC) City/Town at Diagnosis (CoC)	70	50	CoC	95-144

Format: Mixed case letters, special characters only as allowed by USPS, embedded spaces allowed, left justified, blank filled
Allowable Values: City Name or UNKNOWN
NAACCR Record Section: Demographic
Status

Description

Name of the city in which the patient resides at the time the reportable tumor was diagnosed. If the patient resides in a rural area, record the name of the city used in the mailing address. If the patient has multiple primaries, the city of residence may be different for each primary.

Codes

In addition to valid City

UNKNOWN	City at diagnosis unknown

ADDR AT DX--NO & STREET

Alternate Name	Item #	Length	Source of Standard	Column #
Patient Address (Number and Street) at Diagnosis (CoC) Number and Street (pre-96 CoC)	2330	60	CoC	3628-3687

Format: Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled
Allowable Values:
NAACCR Record Section: Patient-Confidential
Status

Description

The number and street address or the rural mailing address of the patient's residence at the time the reportable tumor was diagnosed. If the patient has multiple tumors, address at diagnosis may be different for each tumor. Additional address information such as facility, nursing home, or name of apartment complex should be entered in Addr At DX-Supplemental [2335]. Do not update this item if patient moves after diagnosis.

U.S. addresses should conform to the U.S. Postal Service (USPS), Postal Addressing Standards. These standards are referenced in USPS Publication 28, July 2008, Postal Addressing Standards. The current USPS Pub. 28 may be found and downloaded from the following website: http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf.

Canadian addresses should conform to the Canada Postal Guide, last updated January, 2010. The current Canadian Postal Address standards may be found at the following website: http://www.canadapost.ca/tools/pg/manual/default-e.asp.

Rationale

Addresses that are formatted to conform to USPS Postal Addressing Standards can be more properly geocoded by geographic information systems (GIS) software and vendors to the correct census tract, which is required by NPCR and SEER registries. The USPS Standards also address a number of issues that are problematic in producing precise addresses, including the use of punctuation, abbreviations, and proper placement of address elements, such as street direction, apartment and suite numbers, and unusual addressing situations. Spanish-language addresses also are covered by the USPS Standard.

Coding Instructions (summary of USPS guidelines)

The address should be fully spelled out with standardized use of abbreviations and punctuation per USPS postal addressing standards (USPS Postal Addressing Standards, Pub. 28, July 2008). Upper case recommended. Mixed case allowed.

Abbreviations should be limited to those recognized by USPS standard abbreviations; these include but are not limited to
(A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub. 28):

APT	apartment	N
BLDG	building	NE
FL	floor	NW
STE	suite	S
UNIT	unit	SE
RM	room	SW
DEPT	department	E
		W

Punctuation marks should be avoided, except when punctuation is necessary to convey the meaning. Punctuation normally is limited to periods when the period carries meaning (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 1/2 MAIN ST), and hyphens when the hyphen carries meaning (e.g., 289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (e.g., 425 FLOWER BLVD # 72).

Codes

In addition to valid street address

UNKNOWN	Patient's address is unknown

ADDR AT DX--POSTAL CODE

Alternate Name	Item #	Length	Source of Standard	Column #
Postal Code at Diagnosis (CoC) Zip Code (pre-CoC) Postal Code (CCCR)	100	9	CoC	147-155

Format: Numbers or upper case letters. No special characters or embedded spaces allowed. Left justified, blank filled.
Allowable Values: 5-digit or 9-digit U.S. ZIP codes; 6-character Canadian postal codes; valid postal codes from other countries, 888888888, 999999999, 88888+4 blanks (U.S.), 99999+4 blanks (U.S.), 999999+3 blanks (Canada).
NAACCR Record Section: Demographic
Status

Description

Postal code for the address of the patient's residence at the time the reportable tumor is diagnosed. If the patient has multiple tumors, the postal code may be different for each tumor.

For U.S. residents, use either the 5-digit or the extended 9-digit ZIP code. Blanks follow the 5-digit code if the 4-digit extension is not collected.

For Canadian residents, use the 6-character alphanumeric postal code. Blanks follow the 6-character code.
When available, enter the postal code for other countries.

Codes

In addition to known US and Canadian or other postal codes

888888888	Resident of country other than the United States, U.S. possessions or territories, or Canada and the postal code is unknown
999999999	Resident of the United States (including its possessions, etc.) and the postal code is unknown
999999	Resident of Canada and postal code is unknown

ADDR AT DX--STATE

Alternate Name	Item #	Length	Source of Standard	Column #
State (pre-96 CoC)	80	2	CoC	145-146
State at Diagnosis (CoC)				

Format: Upper case
Allowable Values: Refer to EDITS table STATE.DBF in Appendix B; CD, US, XX, YY, ZZ
NAACCR Record Section: Demographic
Status

Description

USPS abbreviation for the state, territory, commonwealth, U.S. possession, or Canada Post abbreviation for the Canadian province/territory in which the patient resides at the time the reportable tumor is diagnosed. If the patient has multiple primaries, the state of residence may be different for each tumor.

Codes

In addition to USPS abbreviations

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

ADDR AT DX--SUPPLEMENTL

Alternate Name	Item #	Length	Source of Standard	Column #
Patient Address (Number and Street) at Diagnosis--Supplemental	2335	60	CoC	3688-3747

Format: Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled
Allowable Values: Valid address or blank
NAACCR Record Section: Patient-Confidential
Status

Description

This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex. If the patient has multiple tumors, address at diagnosis may be different for each tumor. Do not use this item for information stored in other address items such as Addr At DX- NO&Street [2330].

Rationale

Sometimes the registry receives 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. By having a second street address field to hold address information, the registry can look up and store the street address and not lose the facility name due to a shortage of space. The presence of a second street address field to hold additional address information also aids in follow-up.

ADDR CURRENT--CITY

Alternate Name	Item #	Length	Source of Standard	Column #
City/Town--Current (CoC)	1810	50	CoC	2131-2180

Format: Mixed case letters, no special characters, embedded spaces allowed, left justified, blank filled
Allowable Values: City name or UNKNOWN
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

Name of city of the patient's current usual residence. If the patient has multiple tumors, the current city of residence should be the same for all tumors.

Rationale

"Current address" can be used to measure the regional "cancer burden" (cost, medical care needs), especially in major retirement regions. Sometimes central registries carry out follow-up by contacting the patients by a letter or telephone calls to ascertain their vital status. The most current reported address and telephone number are needed. This information is also useful for conducting interview studies

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ADDR CURRENT--NO & STREET

Alternate Name	Item #	Length	Source of Standard	Column #
Patient Address (Number and Street)-Current (CoC)	2350	60	CoC	3748-3807

Format: Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled
Allowable Values:
NAACCR Record Section: Patient-Confidential
Status

Description

The number and street address or the rural mailing address of the patient's current usual residence. This can be used to generate a follow-up inquiry, and must correspond to other fields in the current address. If the patient has multiple tumors, the current address should be the same. Additional address information such as facility, nursing home, or name of apartment complex should be entered in item Addr Current--Supplemental [2335].

U.S. addresses should conform to the USPS Postal Addressing Standards. These standards are referenced in USPS Pub. 28, July, 2008, Postal Addressing Standards. The current USPS Pub. 28 may be found and downloaded from the following website: http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf.

Canadian addresses should conform to the Canada Postal Guide, last updated January, 2010. The current Canadian Postal Address standards may be found at the following website: http://www.canadapost.ca/personal/tools/pg/default-e.asp

Rationale

"Current address" can be used to measure the regional "cancer burden" (cost, medical care needs), especially in major retirement regions. Sometimes central registries carry out follow-up by contacting the patients via letter or telephone calls to ascertain their vital status. The most current reported address and telephone number are needed. This information also is useful for conducting interview studies.

Addresses that are formatted to conform to USPS Postal Addressing Standards can be more properly geocoded by GIS software and vendors to the correct census tract. The USPS Standards also address a number of issues that are problematic in producing precise addresses, including the use of punctuation, abbreviations, and proper placement of address elements, such as street direction, apartment and suite numbers, and unusual addressing situations. Spanish-language addresses also are covered by the USPS Standard.

Coding Instructions (summary of USPS guidelines)

The address should be fully spelled out with standardized use of abbreviations and punctuation per USPS postal addressing standards (USPS Postal Addressing Standards, Pub. 28, July 2008). Upper case recommended. Mixed case allowed.

Abbreviations should be limited to those recognized by USPS standard abbreviations; these include but are not limited to (a complete list of recognized street abbreviations is provided in Appendix C of USPS Pub. 28.):

APT	apartment	N
BLDG	building	NE
FL	floor	NW
STE	suite	S
UNIT	unit	SE
RM	room	SW
DEPT	department	E
		W

Punctuation marks should be avoided, except when punctuation is necessary to convey the meaning. Punctuation normally is limited to periods when the period carries meaning (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 1/2 MAIN ST), and hyphens when the hyphen carries meaning (e.g., 289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (e.g., 425 FLOWER BLVD # 72).

ADDR CURRENT--POSTAL CODE

Alternate Name	Item #	Length	Source of Standard	Column #
Postal Code--Current (CoC)	1830	9	CoC	2183-2191

Format: Numbers or upper case letters. No special characters or embedded spaces allowed. Left justified, blank filled.
Allowable Values: 5-digit or 9-digit U.S. ZIP codes; 6- character Canadian postal codes; valid postal codes from other countries, 888888888, 999999999, 88888+4 blanks (U.S.), 99999+4 blanks (U.S.), 999999+3 blanks (Canada).
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

Postal code for the address of the patient's current usual residence. If the patient has multiple tumors, the postal codes should be the same. For U.S. residents, use either the 5-digit or the extended 9-digit ZIP code. Blanks follow the 5-digit code. For Canadian residents, use the 6-character alphanumeric postal code. Blanks follow the 6-character code. When available, enter postal code for other countries.

Rationale

"Current address" can be used to measure the regional "cancer burden" (cost, medical care needs), especially in major retirement regions. Sometimes central registries carry out follow-up by contacting the patients by a letter or telephone calls to ascertain their vital status. The most current reported address and telephone number are needed. This information also is useful for conducting interview studies.

Codes

In addition to U.S., Canadian, and Foreign postal codes

888888888	Resident of country other than the United States (including its possessions, etc.) or Canada, and postal code unknown
999999999	Resident of the United States (including its possessions, etc.) and postal code unknown
999999	Resident of Canada and postal code unknown

ADDR CURRENT--STATE

Alternate Name	Item #	Length	Source of Standard	Column #
State--Current (CoC)	1820	2	CoC	2181-2182

Format: Upper case
Allowable Values: See EDITS table STATE.DBF in Appendix B; CD, US, XX, YY, ZZ
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

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

Rationale

"Current address" can be used to measure the regional "cancer burden" (cost, medical care needs), especially in major retirement regions. Sometimes central registries carry out follow-up by contacting the patients via letter or telephone calls to ascertain vital status. The most current reported address and telephone number are needed. This information also is useful for conducting interview studies.

Codes

In addition to the U.S. and Canadian postal service abbreviations

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

ADDR CURRENT--SUPPLEMENTL

Alternate Name	Item #	Length	Source of Standard	Column #
Patient Address (Number and Street) Current--Supplemental (CoC)	2355	60	CoC	3808-3867

Format: Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled
Allowable Values:
NAACCR Record Section: Patient-Confidential
Status

Description

This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex. This can be used to generate a follow-up inquiry, and must correspond to other fields in the current address. If the patient has multiple tumors, the current address should be the same.

Rationale

Sometimes the registry receives 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. By having a second street address field to hold address information, the registry can look up and store the street address and not lose the facility name due to a shortage of space. The presence of a second street address field to hold additional address information also aids in follow-up.

AGE AT DIAGNOSIS

Alternate Name	Item #	Length	Source of Standard	Column #
	230	3	SEER/CoC	193-195

Format: Right justified, zero filled
Allowable Values: 000-120, 999
NAACCR Record Section: Demographic
Status

Description

Age of the patient at diagnosis in complete years. Different tumors for the same patient may have different values.

Codes

000	Less than 1 year old; diagnosed in utero
001	1 year old, but less than 2 years
002	2 years old
…	(Show actual age in completed years)
101	101 years old
…	
120	120 years old
999	Unknown age

ALCOHOL HISTORY

Alternate Name	Item #	Length	Source of Standard	Column #
	350			

Format: No standard
Allowable Values:
NAACCR Record Section: Demographic
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

AMBIGUOUS TERMINOLOGY DX

Alternate Name	Item #	Length	Source of Standard	Column #
Ambiguous Terminology as Basis for Diagnosis	442	1	SEER	566-566

Format:
Allowable Values: 0-2, 9
NAACCR Record Section: Cancer Identification
Status

Description

Identifies all cases, including death certificate only and autopsy only, for which an ambiguous term is the most definitive word or phrase used to establish a cancer diagnosis (i.e., to determine whether or not the case is reportable). Ambiguous terminology may originate from any source document, such as pathology report, radiology report, or from a clinical report. This data item is used only when ambiguous terminology is used to establish diagnosis. It is not used when ambiguous terminology is used to clarify a primary site, specific histology, histologic group, or stage of disease.

Rationale

Cases with a reportable cancer diagnosis that has been established based only on reports that contain ambiguous terminology to describe final diagnostic findings cannot currently be identified. Multiple surveys have identified a lack of consensus in the interpretation and use of ambiguous terms across physician specialties. These cases may or may not have an actual cancer diagnosis based on clinician, radiologist, and pathologist review. Furthermore, the historical interpretation and use of ambiguous terms by cancer registrars and registries has not been consistent or compatible with physician use of these terms.

This data item will identify specific primary sites where the ambiguous terminology is commonly used to describe or establish a cancer diagnosis. Data collected will be used as the basis for modifications to case inclusion and reportable rules following complete analysis and impact assessment. This data item will allow cases to be identified within an analysis file and be excluded from patient contact studies.

Codes

Refer to http://seer.cancer.gov/tools/mphrules/index.html for additional information

0	Conclusive term
1	Ambiguous term only
2	Ambiguous term followed by conclusive term
9	Unknown term

Note: Refer to Table 2, page 23 of http://seer.cancer.gov/tools/mphrules/index.html for a list of ambiguous terms.

ARCHIVE FIN

Alternate Name	Item #	Length	Source of Standard	Column #
	3100	10	CoC	721-730

Format: Right justified, zero filled
Allowable Values: 10-digit number
NAACCR Record Section: Hospital-Specific
Status

Description

This field identifies the CoC Facility Identification Number (FIN) of the facility at the time it originally accessioned the

Rationale

When CoC approved facilities merge or join networks, their unique CoC Facility Identification Number (FIN) [540] may change. Archive FIN preserves the identity of the facility at the time the case was originally accessioned so that records resubmitted subsequent to such reorganization can be recognized as belonging to the same facility.

Codes (Instructions for Coding):
CoC maintains the codes, including those for non-hospital sources of reporting.

For facilities with 7-digit FINs in the range of 6020009-6953290 that were assigned by CoC before January 1, 2001, the coded FIN will consist of three leading zeroes followed by the full 7-digit number.

For facilities with FINs greater than or equal to 10000000 that were assigned by CoC after January 1, 2001, enter FIN codes of this type as two zeroes followed by the full 8-digit code. These sometimes are called CoC FIN 10-digit codes.

AUTOPSY

Alternate Name	Item #	Length	Source of Standard	Column #
	1930	1	NAACCR	2274-2274

Format:
Allowable Values: 0-2,9
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

Code indicating whether or not an autopsy was performed.

Codes

0	Not applicable; patient alive
1	Autopsy performed
2	No autopsy performed
9	Patient expired, unknown if autopsy performed

Note: This data item is no longer supported by CoC (as of January 1, 2003).

BEHAVIOR (73-91) ICD-O-1

Alternate Name	Item #	Length	Source of Standard	Column #
	1972	1	SEER	1917-1917

Format:
Allowable Values: Reference ICD-O-1 for valid entries
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Area for retaining behavior portion (1 digit) of the ICD-O-1 or field trial morphology codes entered before a conversion to ICD-O-2. See grouped data item Morph (73-91) ICD-O-1 [1970] in Appendix E. The item name includes years 73-91. However, some states may have used the codes for cases before 1973. It is a subfield of the morphology code.

Codes

For tumors diagnosed before 1992, contains the ICD-O-1 or field trial 1-digit behavior code as originally coded, if available. Blank for tumors coded directly into a later version of ICD-O.

BEHAVIOR (92-00) ICD-O-2

Alternate Name	Item #	Length	Source of Standard	Column #
ICD-O-2 Behaviour (CCCR)	430	1	SEER/CoC	549-549

Format:
Allowable Values: 0-3, Refer to ICD-0-2
NAACCR Record Section: Cancer Identification
Status: Subfield

Description

Code for the behavior of the tumor being reported using ICD-O-2. NAACCR adopted ICD-O-2 as the standard coding system for tumors diagnosed from January 1, 1992, through December 31, 2000. In addition, NAACCR recommended that cases diagnosed prior to 1992 be converted to ICD-O-2. See Behavior (73-91) ICD-O-1 [1972], for ICD-O-1 and field trial codes.

Codes

Valid codes are 0-3. See ICD-O-2, sup-page 15-22, for behavior codes and definitions.

Clarification

This data item was required by all standard-setting organizations for tumors diagnosed from January 1, 1992, through December 31, 2000, and recommended for tumors diagnosed before 1992.

When the histologic type is coded according to the ICD-O-2, the histology code must be reported in Histology (92-00) ICD-O-2 [420], with behavior coded in Behavior (92-00) ICD-O-2 [430].

For information on required status for related data items for histologic type and behavior when coded according to ICD-O-3, see Histologic Type ICD-O-3 [522] and Behavior Code ICD-O-3 [523].

BEHAVIOR CODE ICD-O-3

Alternate Name	Item #	Length	Source of Standard	Column #
Behavior Code (CoC) ICD-O-3 Behaviour (CCCR)	523	1	SEER/CoC	554-554

Format:

Allowable Values: 0-3, Refer to ICD-O-3
NAACCR Record Section: Cancer Identification
Status: Subfield

Description

Code for the behavior of the tumor being reported using ICD-O-3. NAACCR adopted ICD-O-3 as the standard coding system for tumors diagnosed beginning January 1, 2001, and later recommended that prior cases be converted from ICD-O-2. See Behavior (92-00) ICD-O-2 [430], for ICD-O-2 codes.

Juvenile astrocytoma is coded as borderline in ICD-O-3; North American registries report as 9421/3.

Codes

Valid codes are 0-3. See ICD-O-3, ¹⁴ page 66, for behavior codes and definitions.

Clarification

Behavior is required by all standard-setting organizations for tumors diagnosed on or after January 1, 2001, and recommended (by conversion from ICD-O-2 codes) for tumors diagnosed before 2001.

When the histologic type is coded according to the ICD-O-3, the histology code must be reported in Histologic Type ICD-O-3 [522], with behavior coded in Behavior Code ICD-O-3 [523].

For information on required status for related data items for histologic type and behavior when coded according to ICD-O-2, see Histology (92-00) ICD-O-2 [420] and Behavior (92-00) ICD-O-2 [430].

BIRTHPLACE

Alternate Name	Item #	Length	Source of Standard	Column #
Place of Birth (SEER/CoC)	250	3	SEER/CoC	206-208

Format: Right justified, zero filled
Allowable Values: Reference to EDITS table BPLACE.DBF in Appendix B
NAACCR Record Section: Demographic
Status

Description

Code for place of birth of the patient. If a patient has multiple tumors, all records should contain the same code.

Rationale

Place of Birth is helpful for patient matching and can be used when reviewing race and ethnicity. In addition, adding birthplace data to race and ethnicity allows for a more specific definition of the population being reported. Careful descriptions of ancestry, birthplace, and immigration history of populations studied are needed to make the basis for classification into ethnic groups clear. Birthplace has been associated with variation in genetic, socioeconomic, cultural, and nutritional characteristics that affect patterns of disease. A better understanding of the differences within racial and ethnic categories also can help states develop effective, culturally sensitive public health prevention programs to decrease the prevalence of high-risk behaviors and increase the use of preventive services.

Codes

See Appendix B for numeric and alphabetic lists of places and codes (also see Appendix B of the SEER Program Code Manual at seer.cancer.gov/tools/codingmanuals/index.html).

CANCER STATUS

Alternate Name	Item #	Length	Source of Standard	Column #
	1770	1	CoC	2127-2127

Format:
Allowable Values: 1,2, 9
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

Records the presence or absence of clinical evidence of the patient's malignant or non-malignant tumor as of the Date of Last Contact [1750]. If the patient has multiple primaries, the values may be different for each primary.

Rationale

This item can be used to compute disease-free survival. By maintaining this data item, central registries can assist hospital registries by

sharing this information with other hospital registries that serve the same patients, if the state's privacy laws so permit.

Codes

1	No evidence of this tumor
2	Evidence of this tumor
9	Unknown, indeterminate whether this tumor is present, not stated in patient record

---

CASEFINDING SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
	501	2	NAACCR	564-565

Format:
Allowable Values: 10, 20-30, 40, 50, 60, 70, 75, 80, 85, 90, 95, 99
NAACCR Record Section: Cancer Identification
Status

Description

This variable codes the earliest source of identifying information. For cases identified by a source other than reporting facilities (such as through death clearance or as a result of an audit), this variable codes the type of source through which the tumor was first identified. This data item cannot be used by itself as a data quality indicator. The timing of the case-finding processes (e.g., death linkage) varies from registry to registry, and the coded value of this variable is a function of that timing.

Rationale

This data item will help reporting facilities as well as regional and central registries in prioritizing their case-finding activities. It will identify reportable tumors that were first found through death clearance or sources other than traditional reporting facilities. It provides more detail than "Type of Reporting Source."

Coding Instructions

This variable is intended to code the source that first identified the tumor. Determine where the case was first identified and enter the appropriate code. At the regional or central level, if a hospital and a non-hospital source identified the case independently of each other, enter the code for the non-hospital source (i.e., codes 30-95 have priority over codes 10-29). If the case was first identified at a reporting facility (codes 10-29), code the earliest source (based on patient or specimen contact at the facility) of identifying information.

If a death certificate, independent pathology laboratory report, consultation-only report from a hospital, or other report was used to identify a case that was then abstracted from a different source, enter the code for the source that first identified the case, not the source from which it was subsequently abstracted. If a regional or central registry identifies a case and asks a reporting facility to abstract it, enter the code that corresponds to the initial source, not the code that corresponds to the eventual reporting facility.

Codes

Case first identified at a reporting facility:

10	Reporting Hospital, NOS
20	Pathology Department Review (surgical pathology reports, autopsies, or cytology reports)
21	Daily Discharge Review (daily screening of charts of discharged patients in the medical records department)
22	Disease Index Review (review of disease index in the medical records department)
23	Radiation Therapy Department/Center
24	Laboratory Reports (other than pathology reports, code 20)
25	Outpatient Chemotherapy
26	Diagnostic Imaging/Radiology (other than radiation therapy, codes 23; includes nuclear medicine)
27	Tumor Board
28	Hospital Rehabilitation Service or Clinic
29	Other Hospital Source (including clinic, NOS or outpatient department, NOS)

Case first identified by source other than a reporting facility covered in the codes above:

30	Physician-Initiated Case
40	Consultation-only or Pathology-only Report (not abstracted by reporting hospital)
50	Independent (non-hospital) Pathology-Laboratory Report
60	Nursing Home-Initiated Case
70	Coroner's Office Records Review
75	Managed Care Organization (MCO) or Insurance Records
80	Death Certificate (case identified through death clearance)
85	Out-of-State Case Sharing

90	Other Non-Reporting Hospital Source function of that timing.
95	Quality Control Review (case initially identified through quality control activities such as case-finding audit of a regional or central registry)
99	Unknown

CAUSE OF DEATH

Alternate Name	Item #	Length	Source of Standard	Column #
Underlying Cause of Death (SEER)	1910	4	SEER	2269-2272
Underlying Cause of Death (ICD Code) (pre-96 CoC)				

Format: 4 digits (for ICD-7, 8, 9); for ICD-10 upper case letter followed by 3 digits or upper case followed by 2 digits plus blank
Allowable Values: Valid ICD-7, ICD-8, ICD-9, and ICD-10 codes; also 0000, 7777, 7797
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

Official cause of death as coded from the death certificate in valid ICD-7, ICD-8, ICD-9, and ICD-10 codes.

Rationale

Cause of death is used for calculation of adjusted survival rates by the life table method. The adjustment corrects for deaths other than from the diagnosed cancer.

Codes

Special codes in addition to ICD-7, ICD-8, ICD-9, and ICD-10 (refer to SEER Program Code Manual for additional instructions.)

0000	Patient alive at last contact
7777	State death certificate not available
7797	State death certificate available but underlying cause of death is not coded

Note: This data item is no longer supported by CoC (as of January 1, 2003).

CENSUS BLOCK GROUP 2000

Alternate Name	Item #	Length	Source of Standard	Column #
Census Tract Block Group	362	1	Census	174-174

Format: No standard
Allowable Values: 0-9, Blank
NAACCR Record Section: Demographic
Status

Description

This field is provided for coding the block group of patient's residence at time of diagnosis, as defined by the 2000

Rationale

A block group is a subdivision of a census tract designed to have an average of 1500 people, versus a census tract's average of 4500 people. All land area in the United States is described by a census block group in the 2000 Census. The Census Bureau publishes detailed population and socioeconomic data at this level. Block groups thus offer a high level of specificity for geographical and socioeconomic analyses.

A block group has no meaning in the absence of a census tract. Refer to Census Tr Certainty 2000 [365] to ascertain basis of assignment of Census Block Group 2000.

Codes

0	Census block group assignment was attempted, but the value could not be determined
1-9	Census block group values as defined by the Census Bureau
Blank	Census Block Group 2000 not coded

Clarification

Numerous registries find the distinction between "attempted, could not be determined" (zero) and "not coded" (blank) to be useful for geocoding planning purposes.

Note: The values 1 through 9 are nominal, with no hierarchy of values. This number determines the first digit of all the blocks which comprise

the block group; for instance, census block group 3 would contain blocks numbered 3000 to 3999.

CENSUS BLOCK GROUP 2010

Alternate Name	Item #	Length	Source of Standard	Column #
	363	1	Census	434-434

Format: No standard
Allowable Values: 0-9, Blank
NAACCR Record Section: Demographic
Status: New

Description

This field is provided for coding the block group of patient's residence at time of diagnosis, as defined by the 2010

Rationale

A block group is a subdivision of a census tract designed to have an average of 1500 people, versus a census tract's average of 4500 people. All land area in the United States is described by a census block group in the 2010 Census. The Census Bureau publishes detailed population and socioeconomic data at this level. Block groups thus offer a high level of specificity for geographical and socioeconomic analyses.

A block group has no meaning in the absence of a census tract. Refer to Census Tr Certainty 2010 [367] to ascertain basis of assignment of Census Block Group 2010.

Codes

0	Census block group assignment was attempted, but the value could not be determined
1-9	Census block group values as defined by the Census Bureau
Blank	Census Block Group 2010 not coded

Clarification

Numerous registries find the distinction between "attempted, could not be determined" (zero) and "not coded" (blank) to be useful for geocoding planning purposes.

Note: The values 1 through 9 are nominal, with no hierarchy of values. This number determines the first digit of all the blocks which comprise the block group; for instance, census block group 3 would contain blocks numbered 3000 to 3999.

CENSUS COD SYS 1970/80/90

Alternate Name	Item #	Length	Source of Standard	Column #
Census Coding System (CoC)	120	1	SEER	166-166
Coding System for Census Tract (pre-96 SEER/CoC)				

Format:
Allowable Values: 0-3, blank
NAACCR Record Section: Demographic
Status

Description

Identified the set of Census Bureau census tract definitions (boundaries) that were used to code the census tract in Census Tract 1970/80/90 [110] for a specific record.

Rationale

Allows for changes in census tracts over time. The census tract definition used to code the case must be recorded so that data are correctly grouped and analyzed. If the coding system were not recorded, the census codes would have to be converted or recoded every time the census tracts were changed.

Codes

0	Not tracted
1	1970 Census Tract Definitions
2	1980 Census Tract Definitions
3	1990 Census Tract Definitions
Blank	Census Tract 1970/80/90 not coded

Clarification

NPCR Required Status

Census-1990 data items:	Census-2000 data items:
Census Tract 1970/80/90 [110]	Census Tract 2000 [130]
Census Tr Cert 1970/80/90 [364]	Census Tr Certainty 2000 [365]
Census Tract Cod Sys -- 1970/80/90 [120]	

Note: Information on census tract, census tract certainty, and census tract coding system is required. For tumors diagnosed in or after 2003, Census Tract 2000 [130] and Census Tr Certainty 2000 [365] (Census-2000 data items) are required. For tumors diagnosed in or before 2002, the requirement can be met by collecting either the Census-1990 data items [110, 364, 120] or the Census-2000 data items, although the Census-2000 data items [130 and 365] are recommended for tumors diagnosed in 1998 through 2002.

CENSUS TR CERT 1970/80/90

Alternate Name	Item #	Length	Source of Standard	Column #
Census Tract Certainty	364	1	SEER	167-167

Format:
Allowable Values: 1-6, 9, blank
NAACCR Record Section: Demographic
Status

Description

Code indicating basis of assignment of census tract or block numbering area (BNA) for an individual record. Helpful in identifying cases abstracted from incomplete information or P.O. Box. Most of the time, this information is provided by a geocoding vendor service. Alternatively, a central registry staff manually assigns the code. This item is not coded by the hospital. Codes are hierarchical, with lower numbers having priority.

Codes

1	Census tract/BNA based on complete and valid street address of residence
2	Census tract/BNA based on residence ZIP + 4
3	Census tract/BNA based on residence ZIP + 2
4	Census tract/BNA based on residence ZIP code only
5	Census tract/BNA based on ZIP code of P.O. Box
6	Census tract/BNA based on residence city where city has only one census tract, or based on residence ZIP code where ZIP code has only one census tract
9	Not assigned, geocoding attempted
Blank	Not assigned, geocoding not attempted

Clarification

NPCR Required Status

Census-1990 data item:	Census-2000 data items:
Census Tract 1970/80/90 [110]	Census Tract 2000 [130]
Census Tr Cert 1970/80/90 [364]	Census Tr Certainty 2000 [365]
Census Tract Cod Sys--1970/80/90 [120]	

Note: Codes 1-5 and 9 are usually assigned by a geocoding vendor, while code 6 is usually assigned through a special effort by the central registry. Information on census tract, census tract certainty, and census tract coding system is required. For tumors diagnosed in or after 2003, Census Tract 2000 [130] and Census Tr Certainty 2000 [365] ("Census-2000 data items") are required. For tumors diagnosed in or before 2002, the requirement can be met by collecting either the Census-1990 data items [110, 364, and 120] or the Census-2000 data items, although the Census-2000 data items [130 and 365] are recommended for tumors diagnosed in 1998 through 2002.

CENSUS TR CERTAINTY 2000

Alternate Name	Item #	Length	Source of Standard	Column #
	365	1	NAACCR	175-175

Format:
Allowable Values: 1-6, 9, blank
NAACCR Record Section: Demographic
Status

Description

Code indicating basis of assignment of census tract for an individual record. Helpful in identifying cases abstracted from incomplete

information or P.O. Box. Most of the time, this information is provided by a geocoding vendor service. Alternatively, a central registry staff manually assigns the code. This item is not coded by the hospital. Codes are hierarchical, with lower numbers having priority.

Codes

1	Census tract based on complete and valid street address of residence
2	Census tract based on residence ZIP + 4
3	Census tract based on residence ZIP + 2
4	Census tract based on residence ZIP code only
5	Census tract based on ZIP code of P.O. Box
6	Census tract/BNA based on residence city where city has only one census tract, or based on residence ZIP code where ZIP code has only one census tract
9	Not assigned, geocoding attempted
Blank	Not assigned, geocoding not attempted

Clarification

NPCR Required Status

Census-1990 data items	Census-2000 data items:
Census Tract 1970/80/90 [110]	Census Tract 2000 [130]
Census Tr Cert 1970/80/90 [364]	Census Tr Certainty 2000 [365]
Census Tract Cod Sys -- 1970/80/90 [120]	

Note: Codes 1-5 and 9 are usually assigned by a geocoding vendor, while code 6 is usually assigned through a special effort by the central registry. Information on census tract, census tract certainty, and census tract coding system is required. For tumors diagnosed in or after 2003, Census Tract 2000 [130] and Census Tr Certainty 2000 [365] (Census-2000 data items) are required. For tumors diagnosed in or before 2002, the requirement can be met by collecting either the Census-1990 data items [110, 364, and 120] or the Census-2000 data items, although the Census-2000 data items [130 and 365] are recommended for tumors diagnosed in 1998 through 2002.

CENSUS TR CERTAINTY 2010

Alternate Name	Item #	Length	Source of Standard	Column #
	367	1	NAACCR	435-435

Format:
Allowable Values: 1-6, 9, blank
NAACCR Record Section: Demographic
Status: New

Description

Code indicating basis of assignment of census tract for an individual record. Helpful in identifying cases abstracted from incomplete information or P.O. Box. Most of the time, this information is provided by a geocoding vendor service. Alternatively, a central registry staff manually assigns the code. This item is not coded by the hospital. Codes are hierarchical, with lower numbers having priority.

Codes

1	Census tract based on complete and valid street address of residence
2	Census tract based on residence ZIP + 4
3	Census tract based on residence ZIP + 2
4	Census tract based on residence ZIP code only
5	Census tract based on ZIP code of P.O. Box
6	Census tract/BNA based on residence city where city has only one census tract, or based on residence ZIP code where ZIP code has only one census tract
9	Not assigned, geocoding attempted
Blank	Not assigned, geocoding not attempted

Clarification

NPCR Required Status

Census-1990 data items:	Census-2000 data items:	Census-2010 data items:
Census Tract 1970/80/90 [110]	Census Tract 2000 [130]	Census Tract 2010 [135]
Census Tr Cert 1970/80/90 [364]	Census Tr Certainty 2000 [365]	Census Tr Certainty 2010 [367]
Census Tract Cod Sys--1970/80/90 [120]		

Note: Codes 1-5 and 9 are usually assigned by a geocoding vendor, while code 6 is usually assigned through a special effort by the central registry. Information on census tract and census tract certainty is required. Census Tract and Census Tract Certainty should be recorded in the year-appropriate data item fields in order to reflect demographic information at the time of diagnosis. Until the 2010 Census is completed and data are available for geocoding, tumors diagnosed in 2010 or later, should be coded to the 2000 census definitions and recorded in Census Tract 2000 [130] and Census Tr Certainty 2000 [365]. When the 2010 Census data are available for geocoding, tumors diagnosed in 2010 or later must be coded to the 2010 census tract definitions and recorded in Census Tract 2010 [135] and Census Tract Certainty 2010 [367]. For tumors diagnosed between January 1, 2008, and December 31, 2009, use of Census Tract 2010 [135] and Census Track Certainty 2010.

CENSUS TRACT 1970/80/90

Alternate Name	Item #	Length	Source of Standard	Column #
Census Tract/Block Numbering Area (BNA) (SEER)	110	6	SEER	159-164
Census Tract				

Format: Right justified, zero filled
Allowable Values: Census Tract Codes 000100-949999, BNA Codes 950100-998999, 000000, 999999, blank
NAACCR Record Section: Demographic
Status

Description

Code for the census tract or BNA of the patient's residence at the time of diagnosis. SEER used this field for tumors reported before 1998. If the patient has more than one tumor, the codes may be different for each tumor. Codes are those used by the U.S. Census Bureau. Census Bureau codes for BNA also are entered in this field.

Both census tracts and BNAs have a 4-digit basic number and also may have a 2-digit suffix. Census tract numbers range from 0001.00 to 9499.99. BNA numbers range from 9501.00 to 9989.99. See the Census Bureau's "Area Classifications Supplement 35" for further details.

Rationale

Allows central registries to calculate incidence rates for geographical areas having population estimates. The Census Bureau provides population data for census tracts. Those rates can be used for general surveillance or special geographical and socioeconomic analysis.

Codes

Census Tract Codes	000100-949999
BNA Codes	950100-998999
000000	Area not census-tracted
999999	Area census-tracted, but census tract is not available
Blank	Census Tract 1970/80/90 not coded

Clarification

NPCR Required Status

Census-1990 data items:	Census-2000 data items:
Census Tract 1970/80/90 [110]	Census Tract 2000 [130]
Census Tr Cert 1970/80/90 [364]	Census Tr Certainty 2000 [365]
Census Tract Cod Sys--1970/80/90 [120]	

Note: Information on census tract, census tract certainty, and census tract coding system is required. Tumors diagnosed in 2003 or later, must be coded to the 2000 census definitions and recorded in Census Tract 2000 [130] and Census Tr Certainty 2000 [365]. Tumors diagnosed in 2002, or before must be coded to the 2000 census tract definitions OR to 1990 definitions OR to both the 2000 and 1990 census definitions. Census tract, census tract certainty and census tract coding system should be recorded in the year appropriate data item fields. For tumors diagnosed between January 1, 1998, and December 31, 2002, (inclusive) use of the 2000 census tract definitions is recommended.

CENSUS TRACT 2000

Alternate Name	Item #	Length	Source of Standard	Column #
Census Tract--Alternate (pre-2003)	130	6	NAACCR	168-173

Format: Right justified, zero filled
Allowable Values: Census Tract Codes 000100-999998, 000000, 999999, blank
NAACCR Record Section: Demographic
Status

Description

This field is provided for coding census tract of patient's residence at time of diagnosis. See Census Tract 1970/80/90 [110]. Codes are those used by the U.S. Census Bureau for the Year 2000 Census. Census tract codes have a 4-digit basic number and also may have a 2-digit

suffix. Census tract numbers range from 0001.01 to 9999.98. See the Census Bureau's "Area Classifications" at the following website: http://www.census.gov/prod/cen2000/doc/sf1.pdf for further details.

Rationale

Census tract codes allow central registries to calculate incidence rates for geographical areas having population estimates. This field allows a central registry to add Year 2000 Census tracts to tumors diagnosed in previous years, without losing the codes in data item 110.

The Census Bureau provides population data for census tracts. Those rates can be used for general surveillance or special geographical and socioeconomic analysis.

Because census tracts for particular cases can change between censuses, the central registry may wish to assign an alternate census tract code to its cases. For example, a registry may code its 1985 cases using both the 1980 and 1990 census tract boundaries. The central registry can use this information for different comparisons.

Codes

Census Tract Codes	000100-999998
000000	Area not census tracted
999999	Area census-tracted, but census tract is not available
Blank	Census Tract 2000 not coded

Clarification

NPCR Required Status

Census-1990 data items:	Census-2000 data items:
Census Tract 1970/80/90 [110]	Census Tract 2000 [130]
Census Tr Cert 1970/80/90 [364]	Census Tr Certainty 2000 [365]
Census Tract Cod Sys--1970/80/90 [120]	

Note: Information on census tract, census tract certainty, and census tract coding system is required. Tumors diagnosed in 2003 or later, must be coded to the 2000 census definitions and recorded in Census Tract 2000 [130] and Census Tr Certainty 2000 [365]. Tumors diagnosed in 2002, or before must be coded to the 2000 census tract definitions OR to 1990 definitions OR to both the 2000 and 1990 census tract definitions. Census tract, census tract certainty and census tract coding system should be recorded in the year appropriate data item fields. For tumors diagnosed between January 1, 1998, and December 31, 2002, (inclusive) use of the 2000 cases tract definitions is recommended.

CENSUS TRACT 2010

Alternate Name	Item #	Length	Source of Standard	Column #
	135	6	NAACCR	428-433

Format:
Allowable Values: Census Tract Codes 000100-999998, 000000, 999999, blank
NAACCR Record Section: Demographic
Status: New

Description

This field is provided for coding census tract of patient's residence at time of diagnosis. See Census Tract 1970/80/90 [110]; CENSUS TRACT 2000[130]. Codes are those used by the U.S. Census Bureau for the Year 2010 Census. Census tract codes have a 4-digit basic number and also may have a 2-digit suffix. Census tract numbers range from 0001.01 to 9999.98.

Rationale

Census tract codes allow central registries to calculate incidence rates for geographical areas having population estimates. This field allows a central registry to add Year 2010 Census tracts to tumors diagnosed in previous years, without losing the codes in data items 110 and 130.

The Census Bureau provides population data for census tracts. Those rates can be used for general surveillance or special geographical and socioeconomic analysis.

Because census tracts for particular cases can change between censuses, the central registry may wish to assign an alternate census tract code to its cases. For example, a registry may code its 1985 cases using both the 1980 and 1990 census tract boundaries. The central registry can use this information for different comparisons.

Codes

Census Tract Code	000100-999998
000000	Area not census tracted
999999	Area census tracted, but census tract is not available
Blank	Census Tract 2010 not coded

Clarification

NPCR Required Status

Census-1990 data items:	Census-2000 data items:	Census-2010 data items:
Census Tract 1970/80/90 [110]	Census Tract 2000 [130]	Census Tract 2010 [135]
Census Tr Cert 1970/80/90 [364]	Census Tr Certainty 2000 [365]	Census Tr Certainty 2010 [367]

Note: Information on census tract and census tract certainty is required. Census Tract and Census Tract Certainty should be recorded in the year-appropriate data item fields in order to reflect demographic information at the time of diagnosis. Until the 2010 Census is completed and data are available for geocoding, tumors diagnosed in 2010 or later, should be coded to the 2000 census definitions and recorded in Census Tract 2000 [130] and Census Tr Certainty 2000 [365]. When the 2010 Census data are available for geocoding, tumors diagnosed in 2010 or later must be coded to the 2010 census tract definitions and recorded in Census Tract 2010 [135] and Census Tract Certainty 2010 [367]. For tumors diagnosed between January 1, 2008, and December 31, 2009, use of Census Tract 2010 [135] and Census Track Certainty 2010

CENSUS TRACT COD SYS--ALT

Alternate Name	Item #	Length	Source of Standard	Column #
	140			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

This data item was retired for Version 10 because Census Tract--2000 [130] is expected to contain only Census 2000 codes.

CENSUSBLOCKGROUP 70/80/90

Alternate Name	Item #	Length	Source of Standard	Column #
	368	1	Census	165-165

Format: No standard
Allowable Values: 0-9, Blank
NAACCR Record Section: Demographic
Status

Description

This field is provided for coding the block group of patient's residence at time of diagnosis, as defined by the 1970, 1980, or 1990 Census.

Rationale

A block group is a subdivision of a census tract or block numbering area (BNA). Not all of the United States was described by a census block group or BNA prior to the 2000 Census, but for areas assigned to block groups or BNAs, the Census Bureau published detailed population and socioeconomic data. Block groups thus offer a high level of specificity for geographical and socioeconomic analyses, where available.

A block group has no meaning in the absence of a census tract. Refer to Census Tr Cert 1970/80/90 [364] to ascertain the basis of assignment of Census Block Group 70/80/90. Refer to Census Cod Sys 1970/80/90 [120] to ascertain the decade of reference.

Codes

0	Census block group assignment was attempted, but the value could not be determined
1-9	Census block group values as defined by the Census Bureau
Blank	Census Block Group 70/80/90 not coded

Clarification

Numerous registries find the distinction between "attempted, could not be determined" (zero) and "not coded" (blank) to be useful for geocoding planning purposes.

Note: The values 1 through 9 are nominal, with no hierarchy of values. This number determines the first digit of all the blocks which comprise the block group; for instance, census block group 3 would contain blocks numbered 3000 to 3999.

CHEMOTHERAPY FIELD 1

Alternate Name	Item #	Length	Source of Standard	Column #
	1600			

Format:
Allowable Values:

NAACCR Record Section:
Status: Retired

Description

This field has been listed as in development since 1996. The NAACCR UDSC retired this data item in Version 10.1, as of January 1, 2004.

CHEMOTHERAPY FIELD 2

Alternate Name	Item #	Length	Source of Standard	Column #
	1610			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

This field has been listed as in development since 1996. The NAACCR UDSC retired this data item in Version 10.1, as of January 1, 2004.

CHEMOTHERAPY FIELD 3

Alternate Name	Item #	Length	Source of Standard	Column #
	1620			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

This field has been listed as in development since 1996. The NAACCR UDSC retired this data item in Version 10.1, as of January 1, 2004.

CHEMOTHERAPY FIELD 4

Alternate Name	Item #	Length	Source of Standard	Column #
	1630			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

This field has been listed as in development since 1996. The NAACCR UDSC retired this data item in Version 10.1, as of January 1, 2004.

CLASS OF CASE

Alternate Name	Item #	Length	Source of Standard	Column #
	610	2	CoC	776-777

Format:
Allowable Values: 00, 10-14, 20-22, 30-38, 40-43, 49, 99
NAACCR Record Section: Hospital-Specific
Status

Description

Class of Case divides cases into two groups. Analytic cases (codes 00-22) are those that are required by CoC to be abstracted because of the program's primary responsibility in managing the cancer. Analytic cases are grouped according to the location of diagnosis and treatment. Treatment and outcome reports may be limited to analytic cases. Non analytic cases (codes 30-49 and 99) may be abstracted by the facility to meet central registry requirements or because of a request by the facility's cancer program. Non analytic cases are grouped according to the reason a patient who received care at the facility is non analytic, or the reason a patient who never received care at the facility may have been abstracted.

Class of Case can be used in conjunction with Type of Reporting Source [500]. Type of Reporting Source is designed to document the source of documents used to abstract the cancer being reported.

Rationale

Class of Case reflects the facility's role in managing the cancer, whether the cancer is required to be reported by CoC, and whether the case

was diagnosed after the program's Reference Date.

Codes

Analytic Classes of Case (Required by CoC to be abstracted by accredited cancer programs; refer to the most recent version of FORDS for additional instructions.

INITIAL DIAGNOSIS AT REPORTING FACILITY

00*	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done ELSEWHERE
10*	Initial diagnosis at the reporting facility or in a staff physician's office AND PART OR ALL of first course treatment or a decision not to treat was at the reporting facility, NOS
11	Initial diagnosis in staff physician's office AND PART of first course treatment was done at the reporting facility
12	Initial diagnosis in staff physician's office AND ALL first course treatment or a decision not to treat was done at the reporting facility
13*	Initial diagnosis at the reporting facility AND PART of first course treatment was done at the reporting facility
14*	Initial diagnosis at the reporting facility AND ALL first course treatment or a decision not to treat was done at the reporting facility

INITIAL DIAGNOSIS ELSEWHERE, FACILITY INVOLVED IN FIRST COURSE TREATMENT

20*	Initial diagnosis elsewhere AND PART OR ALL of first course treatment was done at the reporting facility, NOS
21*	Initial diagnosis elsewhere AND PART of treatment was done at the reporting facility
22*	Initial diagnosis elsewhere AND ALL first course treatment was done at the reporting facility

Classes of Case not required by CoC to be abstracted (May be required by Cancer Committee, state or regional registry, or other entity)

PATIENT APPEARS IN PERSON AT REPORTING FACILITY; BOTH INITIAL DIAGNOSIS AND TREATMENT ELSEWHERE

30*	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in DIAGNOSTIC WORKUP (for example, consult only, staging workup after initial diagnosis elsewhere)
31*	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided IN-TRANSIT care
32*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease RECURRENCE OR PERSISTENCE
33*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease HISTORY ONLY
34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility
35	Case diagnosed before program's Reference Date AND initial diagnosis AND PART OR ALL of first course treatment by reporting facility
36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND part of all of first course treatment by reporting facility
37	Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
38*	Initial diagnosis established by AUTOPSY at the reporting facility, cancer not suspected prior to death

PATIENT DOES NOT APPEAR IN PERSON AT REPORTING FACILITY

40	Diagnosis AND all first course treatment given at the same staff physician's office
41	Diagnosis and all first course treatment given in two or more different staff physician offices
42	Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43*	PATHOLOGY or other lab specimens ONLY
49*	DEATH CERTIFICATE ONLY

UNKNOWN RELATIONSHIP TO REPORTING FACILITY

99*	Non analytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases.); UNKNOWN

COC CODING SYS--CURRENT

Alternate Name	Item #	Length	Source of Standard	Column #
Commission on Cancer Coding System-Current (CoC)	2140	2	CoC	1932-1933

Format: Right justified, zero filled

Allowable Values: 00-08, 99
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description
Code the ACoS CoC coding system currently used in the record. CoC codes may be converted from an earlier version.

Codes

00	No CoC coding system used
01	Pre-1988 (Cancer Program Manual Supplement)
02	1988 Data Acquisition Manual
03	1989 Data Acquisition Manual Revisions
04	1990 Data Acquisition Manual Revisions
05	1994 Data Acquisition Manual (Interim/Revised)
06	ROADS (effective with cases diagnosed 1996-1997)
07	ROADS and 1998 Supplement (effective with cases diagnosed 1998-2002)
08	FORDS (effective with cases diagnosed 2003 and forward)
99	Unknown coding system

COC CODING SYS--ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Column #
	2150	2	CoC	1934-1935

Format: Right justified, zero filled
Allowable Values: 00-08, 99
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description
Code for the ACoS CoC coding system originally used to code the record.

Codes

00	No CoC coding system used
01	Pre-1988 (Cancer Program Manual Supplement)
02	1988 Data Acquisition Manual
03	1989 Data Acquisition Manual Revisions
04	1990 Data Acquisition Manual Revisions
05	1994 Data Acquisition Manual (Interim/Revised)
06	ROADS (effective with cases diagnosed 1996-1997)
07	ROADS and 1998 Supplement (effective with cases diagnosed 1998-2002)
08	FORDS (effective with cases diagnosed 2003 and forward)
99	Original CoC coding system is not known

CODING SYSTEM FOR EOD

Alternate Name	Item #	Length	Source of Standard	Column #
Coding System for Extent of Disease (SEER)	870	1	SEER	937-937

Format:
Allowable Values: 0-4, Blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description
Indicates the type of SEER EOD code applied to the tumor. Should be used whenever EOD coding is applied.

Rationale
Used in data editing and analysis.

Codes

0	2-Digit Nonspecific Extent of Disease (1973-82)

1	2-Digit Site-Specific Extent of Disease (1973-82)
2	13-Digit (expanded) Site-Specific Extent of Disease (1973-1982)
3	4-Digit Extent of Disease (1983-87)
4	10-Digit Extent of Disease, 1988 (1988-2003)
Blank	Cases diagnosed 2004+; or the item is not collected

COMORBID/COMPLICATION 1

Alternate Name	Item #	Length	Source of Standard	Column #
Comorbidities and Complications #1 Secondary Diagnoses	3110	5	CoC	1186-1190

Format: Left justified, zero filled
Allowable Values: 00000, 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

Comorbidities may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the

Codes

(Refer to the most recent version of FORDS for additional instructions.) ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049.

00	No secondary diagnoses documented

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMORBID/COMPLICATION 2

Alternate Name	Item #	Length	Source of Standard	Column #
Comorbidities and Complications #2 Secondary Diagnoses	3120	5	CoC	1191-1195

Format: Left justified, zero filled
Allowable Values: 00000, 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

Comorbidities may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care

Codes

(Refer to the most recent version of FORDS for additional instructions.) ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049. Leave blank if no further secondary diagnosis.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the

fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters

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COMORBID/COMPLICATION 3

Alternate Name	Item #	Length	Source of Standard	Column #
Comorbidities and Complications #3	3130	5	CoC	1196-1200
Secondary Diagnoses				

Format: Left justified, zero filled
Allowable Values: 00000, 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

Comorbidities may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care

Codes

(Refer to the most recent version of FORDS for additional instructions.) ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049. Leave blank if no further secondary diagnosis.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters

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COMORBID/COMPLICATION 4

Alternate Name	Item #	Length	Source of Standard	Column #
Comorbidities and Complications #4	3140	5	CoC	1201-1205
Secondary Diagnoses				

Format: Left justified, zero filled
Allowable Values: 00000, 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

Comorbidities may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care

Codes

(Refer to the most recent version of FORDS for additional instructions.) ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049. Leave blank if no further secondary diagnosis.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters

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COMORBID/COMPLICATION 5

Alternate Name	Item #	Length	Source of Standard	Column #
Comorbidities and Complications #5	3150	5	CoC	1206-1210
Secondary Diagnoses				

Format: Left justified, zero filled
Allowable Values: 00000, 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

Comorbidities may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care

Codes

(Refer to the most recent version of FORDS for additional instructions.) ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049. Leave blank if no further secondary diagnosis.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters

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COMORBID/COMPLICATION 6

Alternate Name	Item #	Length	Source of Standard	Column #
Comorbidities and Complications #6	3160	5	CoC	1211-1215
Secondary Diagnoses				

Format: Left justified, zero filled
Allowable Values: 00000, 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

Comorbidities may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care

Codes

(Refer to the most recent version of FORDS for additional instructions.) ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049. Leave blank if no further secondary diagnosis.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMORBID/COMPLICATION 7

Alternate Name	Item #	Length	Source of Standard	Column #
Comorbidities and Complications #7	3161	5	CoC	1216-1220
Secondary Diagnoses				

Format: Left justified, zero filled
Allowable Values: 00000, 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

Comorbidities may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care

Codes

(Refer to the most recent version of FORDS for additional instructions.) ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049. Leave blank if no further secondary diagnosis.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMORBID/COMPLICATION 8

Alternate Name	Item #	Length	Source of Standard	Column #
Comorbidities and Complications #8 Secondary Diagnoses	3162	5	CoC	1221-1225

Format: Left justified, zero filled
Allowable Values: 00000, 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

Comorbidities may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care

Codes

(Refer to the most recent version of FORDS for additional instructions.) ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049. Leave blank if no further secondary diagnosis.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMORBID/COMPLICATION 9

Alternate Name	Item #	Length	Source of Standard	Column #
Comorbidities and Complications #9 Secondary Diagnoses	3163	5	CoC	1226-1230

Format: Left justified, zero filled
Allowable Values: 00000, 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank
NAACCR Record Section: Stage/Prognostic Factors

Status

Description

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

Comorbidities may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care

Codes

(Refer to the most recent version of FORDS for additional instructions.) ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049. Leave blank if no further secondary diagnosis.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMORBID/COMPLICATION 10

Alternate Name	Item #	Length	Source of Standard	Column #
Comorbidities and Complications #10	3164	5	CoC	1231-1235
Secondary Diagnoses				

Format: Left justified, zero filled
Allowable Values: 00000, 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records the patient's pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

Comorbidities may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care

Codes

(Refer to the most recent version of FORDS for additional instructions.) ICD-9-CM Codes 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220- V2310, V2540, V4400-V4589, and V5041-V5049. Leave blank if no further secondary diagnosis.

Note: For comorbid conditions (ICD-9-CM codes 00100-13980 and 24000-99990), there is an assumed decimal point between the third and fourth characters. For complications (ICD-9-CM codes E8700-E8799 and E9300-E9499), there is an assumed decimal point between the fourth and fifth characters. For conditions influencing health status and contact with health services (ICD-9-CM codes V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, and V5041-V5049), there is an assumed decimal point between the third and fourth characters.

COMPUTED ETHNICITY

Alternate Name	Item #	Length	Source of Standard	Column #
	200	1	SEER	190-190

Format:
Allowable Values: 0-7, blank
NAACCR Record Section: Demographic
Status

Description

Code identifying those cases for which ethnicity was determined by matching Name--Last [2230] and Name--Maiden [2390] to a computer list of Spanish/Hispanic names or by a software algorithm. This field was adopted for use for tumors diagnosed 1994 forward. See also Computed Ethnicity Source [210].

Rationale

One method of identifying persons of Hispanic origin is to apply a standard computer list or algorithm to items 2230 and 2390, the patient's surname and/or maiden name. This has advantages across large populations of being reproducible and facilitating comparisons between areas using identical methods. It may sometimes be possible to identify population denominators in which the same method was used to identify Hispanics. Generally, only central registries will have this capability.

This field provides coding to indicate both that such a computerized name-based method was applied and the results of the method. Coding is independent of that in Spanish/Hispanic Origin [190]. The computer-derived ethnicity may be different from the ethnicity reported by registries in Spanish/Hispanic Origin [190] as code 7 (Spanish Surname Only), because that field may include manual review. This field shows the results of computer-derived ethnicity only.

Codes

0	No match was run (for 1994 and later tumors)
1	Non-Hispanic last name and non-Hispanic maiden name
2	Non-Hispanic last name, did not check maiden name or patient was male
3	Non-Hispanic last name, missing maiden name
4	Hispanic last name, non-Hispanic maiden name
5	Hispanic last name, did not check maiden name or patient was male
6	Hispanic last name, missing maiden name
7	Hispanic Maiden name (females only) (regardless of last name)
Blank	1993 and earlier tumors, no match was run

Note: For SEER, blanks are required for all cases diagnosed before 1994 and blanks are not allowed for any case diagnosed 1994 and after. Other registries may have computed this item for earlier years.

NAACCR recognizes that available definitions and abstracting instructions for the data items Name--Last and Name--Maiden may be inadequate for describing names used in some cultures, including Hispanic cultures. Explicit instructions have not been provided for entering compound names, with or without hyphens or "De." Order of names, use of maternal and paternal names, and use of hyphens can vary across cultures. It is likely; too, that abstracting and coding practice for these items varies across registries. Limitations inherent in these definitions should be kept in mind in any use of the data.

COMPUTED ETHNICITY SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
	210	1	SEER	191-191

Format:
Allowable Values: 0-9, blank
NAACCR Record Section: Demographic
Status

Description

Code identifying the method used to determine ethnicity as recorded in Computed Ethnicity [200].

Codes

0	No match was run, for 1994 and later tumors
1	Census Bureau list of Spanish surnames, NOS
2	1980 Census Bureau list of Spanish surnames
3	1990 Census Bureau list of Spanish surnames
4	GUESS Program
5	Combination list including South Florida names
6	Combination of Census and other locally generated list
7	Combination of Census and GUESS, with or without other lists
8	Other type of match
9	Unknown type of match
Blank	1993 and earlier tumors, no match was run

Note: For SEER, blanks are required for all cases diagnosed before 1994 and blanks are not allowed for any case diagnosed 1994 and after. Other registries may have computed this item for earlier years.

COUNTY AT DX

Alternate Name	Item #	Length	Source of Standard	Column #
County (pre-96 SEER/CoC) County at Diagnosis (CoC)	90	3	FIPS/SEER	156-158

Format: Right justified, zero filled
Allowable Values: See Appendix A for county codes for each state. For non-U.S. residents, COC uses Appendix B (BPLACE.DBF). Also 998, 999
NAACCR Record Section: Demographic
Status

Description

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

Detailed standards have not been set for Canadian provinces/territories. Use code 998 for Canadian residents.

Codes

In addition to FIPS and Geocodes

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

Note: See Appendix A for standard FIPS county codes. See EDITS Table BPLACE.DBF in Appendix B for geocodes used by CoC. SEER does not use code 998. CoC uses country geocodes for nonresidents of the United States (see Appendix B) and 998 for residents of other states.

COUNTY--CURRENT

Alternate Name	Item #	Length	Source of Standard	Column #
	1840	3	NAACCR	2192-2194

Format: Right justified, zero filled
Allowable Values: See Appendix A for standard FIPS county codes. See EDITS table BPLACE.DBF in Appendix B for geocodes used by CoC for non-U.S. residents. Also 998, 999.
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

Code for county of patient's current residence. See Volume II NAACCR Data Standards and Dictionary, Chapter V, Unresolved Issues, for further discussion.

Rationale

This item may be used in administrative reports to define a referral area.

Codes (in addition to FIPS and geocodes)

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

Note: This data item is no longer supported by CoC (as of January 1, 2003). This item was used by CoC only. CoC recommended use of FIPS codes (see Appendix A). The ROADS Manual also provided for use of geocodes for countries of residence outside the United States and Canada to be used in the county fields.

CRC CHECKSUM

Alternate Name	Item #	Length	Source of Standard	Column #
	2081	10	NAACCR	1920-1929

Format:
Allowable Values: Calculated or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Cyclic Redundancy Code (CRC) CHECKSUM for the NAACCR record in which it resides. A unique value is calculated for each unique record in a NAACCR file. The value is calculated by applying a CRC algorithm to all data fields of the NAACCR record (excluding the CRC CHECKSUM field). Following a transmission, the CRC CHECKSUM can be recalculated and compared with the transmitted CHECKSUM. Identical values indicate an error-free transmission; differing values indicate an error in transmission.

The algorithm recommended by NAACCR is on the NAACCR website at: http://www.naaccr.org. Users must provide recipients of the data with the algorithm used to create the data transmission file. Otherwise, the item should be left blank.

Rationale

The CHECKSUM can be used to determine if a record-level error occurred during transmission and can also be used to correct any such errors. Record-level CRC CHECKSUMs also allow portions of a NAACCR file to be salvaged in the event of a transmission error.

CS EXTENSION

Alternate Name	Item #	Length	Source of Standard	Column #
	2810	3	AJCC	988-990

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in CS Extension.

Rationale

Tumor extension at diagnosis is a prognostic indicator used by Collaborative Staging to derive some TNM-T codes and some SEER Summary Stage codes.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.)

Note: For cases diagnosed prior to 2010, this was a 2 character field in CS version 1 which was converted to a 3 character field in CS version 2. Most 2 character codes were converted by adding a zero as the third character. For example, code 05 was usually converted to 050, 10 to 100, 11 to 110, etc. Special codes such as 88 and 99 were usually converted to 888 and 999, respectively.

CS LYMPH NODES

Alternate Name	Item #	Length	Source of Standard	Column #
CS Lymph Nodes (SEER EOD)	2830	3	AJCC	992-994

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies the regional lymph nodes involved with cancer at the time of diagnosis.

Rationale

The involvement of specific regional lymph nodes is a prognostic indicator used by Collaborative Staging to derive some TNM-N codes and SEER Summary Stage codes.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

Note: For cases prior to 2010, this was a 2 character field in CS version 1 which was converted to a 3 character field in CS version 2. Most 2 character codes were converted by adding a zero as the third character. For example, code 05 was usually converted to 050, 10 to 100, 11 to 110, etc. Special codes such as 88 and 99 were usually converted to 888 and 999 respectively.

CS LYMPH NODES EVAL

Alternate Name	Item #	Length	Source of Standard	Column #
CS Regional Nodes Evaluation CS Reg Nodes Eval	2840	1	AJCC	995-995

Format:
Allowable Values: 0-9(site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records how the code for CS Lymph Nodes [2830] was determined, based on the diagnostic methods employed.

Rationale

This data item is used by Collaborative Staging to describe whether the staging basis for the TNM-N code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS METS AT DX

Alternate Name	Item #	Length	Source of Standard	Column #
CS Metastasis at Diagnosis	2850	2	AJCC	996-997

Format: Right justified, zero filled
Allowable Values: 00-99 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies the distant site(s) of metastatic involvement at time of diagnosis.

Rationale

The presence of metastatic disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures

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CS METS AT DX-BONE

Alternate Name	Item #	Length	Source of Standard	Column #
	2851	1	AJCC	999-999

Format:
Allowable Values: 0, 1, 8, 9
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies the presence of distant metastatic involvement of bone at time of diagnosis.

Rationale

The presence of metastatic bone disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

Note: This includes only the bone, not the bone marrow.

CS METS AT DX-BRAIN

Alternate Name	Item #	Length	Source of Standard	Column #
	2852	1	AJCC	1000-1000

Format:
Allowable Values: 0, 1, 8, 9
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

The presence of metastatic brain disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

Rationale

The presence of metastatic brain disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures

Note: This includes only the brain, not spinal cord or other parts of the central nervous system.

CS METS AT DX-LIVER

Alternate Name	Item #	Length	Source of Standard	Column #
	2853	1	AJCC	1001-1001

Format:
Allowable Values: 0, 1, 8, 9
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies the presence of distant metastatic involvement of the liver at time of diagnosis.

Rationale

The presence of metastatic liver disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures

Note: This includes only the liver.

CS METS AT DX-LUNG

Alternate Name	Item #	Length	Source of Standard	Column #
	2854	1	AJCC	1002-1002

Format:
Allowable Values: 0, 1, 8, 9
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies the presence of distant metastatic involvement of the lung at time of diagnosis.

Rationale

The presence of metastatic lung disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures

Note: This includes only the lung, not pleura or pleural fluid.

CS METS EVAL

Alternate Name	Item #	Length	Source of Standard	Column #
CS Metastasis Evaluation	2860	1	AJCC	998-998

Format:
Allowable Values: 0-9 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records how the code for CS Mets at Dx [2850] was determined based on the diagnostic methods employed.

Rationale

This data item is used by Collaborative Staging to describe whether the staging basis for the TNM-M code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures

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CS POSTRX EXTENSION

Alternate Name	Item #	Length	Source of Standard	Column #
	2775	3	AJCC	1095-1097

Format:
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. The post-treatment data items measure the amount of tumor remaining after neoadjuvant therapy (systemic therapy or radiation therapy prior to surgery). Effective for cases diagnosed 2012+.

Rationale

The post-treatment data items will be used for analysis of the effectiveness of neoadjuvant therapy.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Supplement 13 for rules and site-specific codes and coding structures

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CS POSTRX LYMPH NODES

Alternate Name	Item #	Length	Source of Standard	Column #
	2780	3	AJCC	1098-1100

Format:
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. The post-treatment data items measure the amount of tumor remaining after neoadjuvant therapy (systemic therapy or radiation therapy prior to surgery). Effective for cases diagnosed 2012+.

Rationale

The post-treatment data items will be used for analysis of the effectiveness of neoadjuvant therapy.

Codes
See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Supplement 13 for rules and site-specific codes and coding structures

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CS POSTRX METS AT DX

Alternate Name	Item #	Length	Source of Standard	Column #
	2785	2	AJCC	1101-1102

Format:
Allowable Values: 00-99 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. The post-treatment data items measure the amount of tumor remaining after neoadjuvant therapy (systemic therapy or radiation therapy prior to surgery). Effective for cases diagnosed 2012+.

Rationale
The post-treatment data items will be used for analysis of the effectiveness of neoadjuvant therapy.

Codes
See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures

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CS POSTRX TUMOR SIZE

Alternate Name	Item #	Length	Source of Standard	Column #
	2770	3	AJCC	1092-1094

Format:
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. The post-treatment data items measure the amount of tumor remaining after neoadjuvant therapy (systemic therapy or radiation therapy prior to surgery). Effective for cases diagnosed 2012+.

Rationale
The post-treatment data items will be used for analysis of the effectiveness of neoadjuvant therapy.

Codes
See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures

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CS PRERX EXTENSION

Alternate Name	Item #	Length	Source of Standard	Column #
	2735	3	AJCC	1081-1083

Format:
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. The CS pre-treatment data items include all information prior to the start of therapy. In rare circumstances where workup could not be completed prior to therapy, these items may be based on testing after limited treatment in the absence of progression or regression of disease, such as delayed planned or usual diagnostic workup. This does not include diagnostic workup for progression of disease or

regression. Effective for cases diagnosed 2012+.

Rationale

The CS pre-treatment data items will record the pre-treatment (clinical) stage. This is used for analysis of appropriate treatment selection. These items are a companion to the AJCC clinical stage information required by CoC, and likely will eventually replace the required AJCC staging. Codes are exactly the same as the regular CS codes. For these data fields, the eval fields also remain the same although the valid options will be limited by edits, in order to use the same tables in CS.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures

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CS PRERX LYMPH NODES

Alternate Name	Item #	Length	Source of Standard	Column #
	2750	3	AJCC	1085-1087

Format:
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. The CS pre-treatment data items include all information prior to the start of therapy. In rare circumstances where workup could not be completed prior to therapy, these items may be based on testing after limited treatment in the absence of progression or regression of disease, such as delayed planned or usual diagnostic workup. This does not include diagnostic workup for progression of disease or regression. Effective for cases diagnosed 2012+.

Rationale

The CS pre-treatment data items will record the pre-treatment (clinical) stage. This is used for analysis of appropriate treatment selection. These items are a companion to the AJCC clinical stage information required by CoC, and likely will eventually replace the required AJCC staging. Codes are exactly the same as the regular CS codes. For these data fields, the eval fields also remain the same although the valid options will be limited by edits, in order to use the same tables in CS.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures

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CS PRERX METS AT DX

Alternate Name	Item #	Length	Source of Standard	Column #
	2760	2	AJCC	1089-1090

Format:
Allowable Values: 00-99 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. The CS pre-treatment data items include all information prior to the start of therapy. In rare circumstances where workup could not be completed prior to therapy, these items may be based on testing after limited treatment in the absence of progression or regression of disease, such as delayed planned or usual diagnostic workup. This does not include diagnostic workup for progression of disease or regression. Effective for cases diagnosed 2012+.

Rationale

The CS pre-treatment data items will record the pre-treatment (clinical) stage. This is used for analysis of appropriate treatment selection. These items are a companion to the AJCC clinical stage information required by CoC, and likely will eventually replace the required AJCC staging. Codes are exactly the same as the regular CS codes. For these data fields, the eval fields also remain the same although the valid options will be limited by edits, in order to use the same tables in CS.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures

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CS PRERX METS EVAL

Alternate Name	Item #	Length	Source of Standard	Column #
	2765	1	AJCC	1091-1091

Format:
Allowable Values: 0-9 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. The CS pre-treatment data items include all information prior to the start of therapy. In rare circumstances where workup could not be completed prior to therapy, these items may be based on testing after limited treatment in the absence of progression or regression of disease, such as delayed planned or usual diagnostic workup. This does not include diagnostic workup for progression of disease or regression. Effective for cases diagnosed 2012+.

Rationale

The CS pre-treatment data items will record the pre-treatment (clinical) stage. This is used for analysis of appropriate treatment selection. These items are a companion to the AJCC clinical stage information required by CoC, and likely will eventually replace the required AJCC staging. Codes are exactly the same as the regular CS codes. For these data fields, the eval fields also remain the same although the valid options will be limited by edits, in order to use the same tables in CS.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures

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CS PRERX REG NODES EVAL

Alternate Name	Item #	Length	Source of Standard	Column #
	2755	1	AJCC	1088-1088

Format:
Allowable Values: 0-9 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

The CS pre-treatment data items include all information prior to the start of therapy. In rare circumstances where workup could not be completed prior to therapy, these items may be based on testing after limited treatment in the absence of progression or regression of disease, such as delayed planned or usual diagnostic workup. This does not include diagnostic workup for progression of disease or regression. Effective for cases diagnosed 2012+.

Rationale

The CS pre-treatment data items will record the pre-treatment (clinical) stage. This is used for analysis of appropriate treatment selection. These items are a companion to the AJCC clinical stage information required by CoC, and likely will eventually replace the required AJCC staging. Codes are exactly the same as the regular CS codes. For these data fields, the eval fields also remain the same although the valid options will be limited by edits, in order to use the same tables in CS.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures

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CS PRERX TUM SZ/EXT EVAL

Alternate Name	Item #	Length	Source of Standard	Column #
	2740	1	AJCC	1084-1084

Format:
Allowable Values: 0-9 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. The CS pre-treatment data items include all information prior to the start of therapy. In rare circumstances where workup could

not be completed prior to therapy, these items may be based on testing after limited treatment in the absence of progression or regression of disease, such as delayed planned or usual diagnostic workup. This does not include diagnostic workup for progression of disease or regression. Effective for cases diagnosed 2012+.

Rationale

The CS pre-treatment data items will record the pre-treatment (clinical) stage. This is used for analysis of appropriate treatment selection. These items are a companion to the AJCC clinical stage information required by CoC, and likely will eventually replace the required AJCC staging. Codes are exactly the same as the regular CS codes. For these data fields, the eval fields also remain the same although the valid options will be limited by edits, in order to use the same tables in CS.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS PRERX TUMOR SIZE

Alternate Name	Item #	Length	Source of Standard	Column #
	2730	3	AJCC	1078-1080

Format:
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. The CS pre-treatment data items include all information prior to the start of therapy. In rare circumstances where workup could not be completed prior to therapy, these items may be based on testing after limited treatment in the absence of progression or regression of disease, such as delayed planned or usual diagnostic workup. This does not include diagnostic workup for progression of disease or regression. Effective for cases diagnosed 2012+.

Rationale

The CS pre-treatment data items will record the pre-treatment (clinical) stage. This is used for analysis of appropriate treatment selection. These items are a companion to the AJCC clinical stage information required by CoC, and likely will eventually replace the required AJCC staging. Codes are exactly the same as the regular CS codes. For these data fields, the eval fields also remain the same although the valid options will be limited by edits, in order to use the same tables in CS.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR 1

Alternate Name	Item #	Length	Source of Standard	Column #
	2880	3	AJCC	1003-1005

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 1 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR 2

Alternate Name	Item #	Length	Source of Standard	Column #

2890	3	AJCC	1006-1008

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 2 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR 3

Alternate Name	Item #	Length	Source of Standard	Column #
	2900	3	AJCC	1009-1011

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 3 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR 4

Alternate Name	Item #	Length	Source of Standard	Column #
	2910	3	AJCC	1012-1014

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 4 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR 5

Alternate Name	Item #	Length	Source of Standard	Column #

2920	3	AJCC	1015-1017

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 5 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR 6

Alternate Name	Item #	Length	Source of Standard	Column #
	2930	3	AJCC	1018-1020

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 6 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR 7

Alternate Name	Item #	Length	Source of Standard	Column #
	2861	3	AJCC	1021-1023

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 7 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR 8

Alternate Name	Item #	Length	Source of Standard	Column #

2862	3	AJCC	1024-1026

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 8 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR 9

Alternate Name	Item #	Length	Source of Standard	Column #
	2863	3	AJCC	1027-1029

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 9 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR10

Alternate Name	Item #	Length	Source of Standard	Column #
	2864	3	AJCC	1030-1032

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 10 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR11

Alternate Name	Item #	Length	Source of Standard	Column #

2865	3	AJCC	1033-1035

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 11 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR12

Alternate Name	Item #	Length	Source of Standard	Column #
	2866	3	AJCC	1036-1038

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 12 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR13

Alternate Name	Item #	Length	Source of Standard	Column #
	2867	3	AJCC	1039-1041

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 13 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR14

Alternate Name	Item #	Length	Source of Standard	Column #

2868	3	AJCC	1042-1044

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 14 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR15

Alternate Name	Item #	Length	Source of Standard	Column #
	2869	3	AJCC	1045-1047

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 15 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR16

Alternate Name	Item #	Length	Source of Standard	Column #
	2870	3	AJCC	1048-1050

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 16 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR17

Alternate Name	Item #	Length	Source of Standard	Column #

2871	3	AJCC	1051-1053

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 17 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR18

Alternate Name	Item #	Length	Source of Standard	Column #
	2872	3	AJCC	1054-1056

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 18 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR19

Alternate Name	Item #	Length	Source of Standard	Column #
	2873	3	AJCC	1057-1059

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 19 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR20

Alternate Name	Item #	Length	Source of Standard	Column #

2874	3	AJCC	1060-1062

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 20 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR21

Alternate Name	Item #	Length	Source of Standard	Column #
	2875	3	AJCC	1063-1065

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 21 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR22

Alternate Name	Item #	Length	Source of Standard	Column #
	2876	3	AJCC	1066-1068

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 22 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR23

Alternate Name	Item #	Length	Source of Standard	Column #
	2877	3	AJCC	1069-1071

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 23 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR24

Alternate Name	Item #	Length	Source of Standard	Column #
	2878	3	AJCC	1072-1074

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 24 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS SITE-SPECIFIC FACTOR25

Alternate Name	Item #	Length	Source of Standard	Column #
	2879	3	AJCC	1075-1077

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Codes

The information recorded in CS Site-Specific Factor 25 differs for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS TUMOR SIZE

Alternate Name	Item #	Length	Source of Standard	Column #
	2800	3	AJCC	985-987

Format: Right justified, zero filled
Allowable Values: 000-999 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records the largest dimension or diameter of the primary tumor in millimeters.

Rationale

Tumor size at diagnosis is an independent prognostic indicator for many tumors and it is used by Collaborative Staging to derive some TNM-T codes.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS TUMOR SIZE/EXT EVAL

Alternate Name	Item #	Length	Source of Standard	Column #
CS Tumor Size/Extension Evaluation CS TS/Ext-Eval	2820	1	AJCC	991-991

Format: Right justified, zero filled
Allowable Values: 0-9 (site specific)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records how the codes for the two items CS Tumor Size [2800] and CS Extension [2810] were determined, based on the diagnostic methods employed.

Rationale

This item is used by Collaborative Staging to describe whether the staging basis for the TNM-T code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS VERSION DERIVED

Alternate Name	Item #	Length	Source of Standard	Column #
CS Version Latest	2936	6	AJCC	1173-1178

Format: 6-digit number
Allowable Values: Any 6-digit number
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item is recorded the first time the CS output fields are derived and should be updated each time the CS Derived items are recomputed. The CS version number is returned as part of the output of the CS algorithm.

Rationale

The CS algorithm may be re-applied to compute the CS Derived items; for example, when the data are to be used for a special study, transmitted, or when an updated CS algorithm is produced. This item identifies the specific algorithm used to obtain the CS Derived values in the data record.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS Version Derived is a 6-digit code (e.g., 010100). The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not

affect coding or derivation results.

This item should not be blank if the CS Derived items contain values. It should be blank if the CS Derived items are empty or the CS algorithm has not been applied.

CS VERSION INPUT CURRENT

Alternate Name	Item #	Length	Source of Standard	Column #
	2937	6	AJCC	1161-1166

Format:
Allowable Values:
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This item indicates the version of CS input fields after they have been updated or recoded. This data item is recorded the first time the CS input fields are entered and should be updated each time the CS input fields are modified. Effective for cases diagnosed 2010+.

Rationale

Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures.

CS Version Input Current is a 6-digit code (e.g., 020100). The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results.

CS VERSION INPUT ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Column #
CS Version 1ST	2935	6	AJCC	1167-1172

Format: 6-digit number
Allowable Values: Any 6-digit number
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This item indicates the number of the version initially used to code Collaborative Staging (CS) fields. The CS version number is returned as part of the output of the CS algorithm.

Rationale

Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), Suppl 13 for rules and site-specific codes and coding structures**.**

CS Version Input Original is a 6-digit code (e.g., 010100). The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results.

DATE CASE COMPLETED

Alternate Name	Item #	Length	Source of Standard	Column #
	2090	8	NAACCR	1959-1966

Format: YYYYMMDD
Allowable Values:
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

The date that: (1) the abstractor decided that the tumor report was complete and (2) the case passed all edits that were applied. Definitions may vary among registries and software providers. This field is locally used by central registries. See Data Standards and Dictionary, Volume II, page 97 for date format. Standard edits check that no dates are later than the current date. These specifications will not necessarily be the same as those used for Date Case Completed--CoC [2092].

DATE CASE COMPLETED--COC

Alternate Name	Item #	Length	Source of Standard	Column #
	2092	8	CoC	1967-1974

Format: YYYYMMDD
Allowable Values:
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Identifies the date that specified items are completed, based on the Class of Case, where those items pass the relevant edits. Follow-up information, including delayed treatment received elsewhere, may be coded after the Date Case Completed--CoC. See the current FORDS for details. This item should be autocoded by the registry software; specifications may be obtained from NCDB. The CoC specifications will not necessarily be the same as those used for Date Case Completed [2090]. See page 97 for date format.

DATE CASE INITIATED

Alternate Name	Item #	Length	Source of Standard	Column #
	2085	8	NAACCR	1951-1958

Format: YYYYMMDD
Allowable Values:
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Date the electronic abstract is initiated in the reporting facility's cancer registry database. See Data Standards and Dictionary, Volume II, page 97 for date format. Standard edits check that no dates are later than the current date or the date completed.

Rationale

This item is used to assess and monitor the timeliness of reporting. Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations and consequently, timeliness standards have been established. Examples of use are as follows:

- This item can be used with the Date of 1st Contact [580] to measure timeliness of abstracting by individual reporting facilities
- This item can be used with Date Case Report Exported [2110] to determine the “residency time” of a case report within a reporting facility’s database prior to data transmission to a central cancer registry
- This item can be used with Date Case Report Received [2111] to monitor central registry timeliness in entering case reports (for case reports abstracted in-house from hardcopy provided by a reporting facility)
- This item can be used with Date Case Completed [2090] to monitor timeliness of case report completion.

DATE CASE LAST CHANGED

Alternate Name	Item #	Length	Source of Standard	Column #
	2100	8	NAACCR	1975-1982

Format: YYYYMMDD
Allowable Values:
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Date the case was last changed or updated. See page 97 for date format. Standard edits check that no dates are later than the current date.

DATE CASE REPORT EXPORTED

Alternate Name	Item #	Length	Source of Standard	Column #
Date Case Transmitted (pre-98 NAACCR)	2110	8	NPCR	1983-1990

Format: YYYYMMDD
Allowable Values:
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Date the reporting facility exports the electronic abstract to a file for transmission to the central registry. See Data Standards and Dictionary, Volume II, page 97 for date format. Standard edits check that no dates are later than the current date. Definitions may vary among registries and software providers.

DATE CASE REPORT LOADED

Alternate Name	Item #	Length	Source of Standard	Column #
	2112	8	NPCR	1999-2006

Format: YYYYMMDD
Allowable Values:
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Date the tumor report is loaded into a central registry computerized processing file for initiation of quality control activities (e.g., visual editing, application of computerized edits, etc.). See Data Standards and Dictionary, Volume II, page 97 for date format.

DATE CASE REPORT RECEIVED

Alternate Name	Item #	Length	Source of Standard	Column #
	2111	8	NPCR	1991-1998

Format: YYYYMMDD
Allowable Values:
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Date the abstract (or source record) is received by the central cancer registry for the respective tumor. If multiple reports are received from two or more sources and if a single date is needed, use the date the first abstract (or source record) was received from any source. See Data Standards and Dictionary, Volume II, page 97 for date format.

Rationale

This item is used to assess and monitor the timeliness of reporting. Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations. This item can be used with the Date of 1st Contact [580] or the Path--Date of Specimen Collection [7320] to measure timeliness of reporting to central cancer registries by individual reporting facilities. This data item also can be used with the Date Tumor Record Availbl [2113] to measure timeliness of processing within the central cancer registry.

DATE CONCLUSIVE DX FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	448	2	NAACCR	575-576

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Cancer Identification
Status

Description

This flag explains why no appropriate value is in the field, Date of Conclusive DX [443]. This data item was first available in Volume II Version 12 (effective January 2010).

Rationale

Before Version 12, date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional (non-date) value. (e.g., unknown if the diagnosis was initially based on ambiguous terminology).
11	No proper value is applicable in this context. (e.g., not applicable, initial diagnosis made by unambiguous terminology (Code 0 in data item Ambiguous Terminology DX [442]).
12	A proper value is applicable but not known (e.g., the initial ambiguous diagnosis was followed by a conclusive term, but the date of the conclusive term is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., accessioned based on ambiguous terminology only (Code 1 in data item Ambiguous Terminology DX [442]).
Blank	A valid date value is provided in item Date of Conclusive DX [443], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF 1ST CONTACT

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Adm/First Contact	580	8	CoC	745-752

Format: YYYYMMDD
Allowable Values: Valid Dates
NAACCR Record Section: Hospital-Specific
Status

Description

Date of first patient contact, as inpatient or outpatient, with the reporting facility for the diagnosis and/or treatment of the tumor. The date may represent the date of an outpatient visit for a biopsy, x-ray, scan, or laboratory test. See page 97 for date format.

When pathology-specimen-only tumors are collected (Class of Case 43, Type of Reporting Source 3), the date of specimen collection from the pathology report should be used as the Date of 1st Contact. If a pathology-specimen-only case is followed by patient contact with a facility for diagnosis and/or treatment of the respective tumor, ACoS coding rules require the hospital registry to change the Date of 1st Contact to reflect the date the patient first registered at that facility. Central registries, however, should retain the earlier date in their consolidated files, as that shows the patient's first recorded contact with the healthcare system for this disease.

When death certificate only (Class of Case 49, Type of Reporting Source 7) tumors are collected, the date of death should be used as the Date of 1st Contact. When Autopsy Only (Class of Case 38, Type of Reporting Source 6) tumors are collected, the date of death should be used as the Date of 1st Contact.

Rationale

Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations. Date of 1st Contact is one of several data items that can be used to measure timeliness of reporting to central cancer registries by individual facilities. For tumors that are not diagnosed at the reporting facility following its Reference Date (Class of Case 20-22, 30-37), the Date of 1st Contact [580] can be used in conjunction with the Date Case Report Received [2111] to measure timeliness of reporting by individual facilities.

Note: To accurately measure the timeliness of data collection and submission of abstracts that are first diagnosed at autopsy (Class of Case 38, Type of Reporting Source 6) the date of death should be used as the Date of 1st Contact since the diagnosis was not determined until the autopsy was performed. Death Certificate Only cases (Class of Case 49, Type of Reporting Source 7) are created only by the central registry. For these cases, Date of 1st Contact should be filled with the date of death, and timeliness for DCO cases should be measured by different criteria.

DATE OF 1ST CONTACT FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
Date of First Contact Flag	581	2	NAACCR	753-754

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Hospital-Specific
Status

Description

This flag explains why no appropriate value is in the field Date of 1st Contact [580]. This data item was first available in Volume II Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

12	A proper value is applicable but not known (e.g., date of 1st contact is unknown)
Blank	A valid date value is provided in item Date of 1st Contact [580], or the date was not expected to have been transmitted

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF 1ST CRS RX FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1271	2	NAACCR	1454-1455

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-1st Course
Status

Description

This flag explains why no appropriate value is in the field, Date of 1st Crs RX [1270]. This data item was first available in Volume II Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown whether treatment was administered)
11	No proper value is applicable in this context (e.g., autopsy only case)
12	A proper value is applicable but not known (e.g., treatment administered but date is unknown)
Blank	A valid date value is provided in item Date of 1st Crs RX [1270], or the date was not expected to have been transmitted

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF 1ST CRS RX--COC

Alternate Name	Item #	Length	Source of Standard	Column #
Date of First Course Treatment (CoC) Date Started (pre 96 CoC)	1270	8	CoC	1446-1453

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Treatment-1st Course
Status

Description

Date of initiation of the first therapy for the cancer being reported, using the CoC definition of first course. The date of first treatment includes the date a decision was made not to treat the patient. See FORDS for details. See Data Standards, Volume II Chapter V, Unresolved Issues for further discussion of the difference between SEER and CoC items. See Data Standards, Volume II, page 97 for date format

Clarification

NPCR Required Status
Central registries funded by NPCR are required to collect either Date of Initial RX--SEER [1260] or Date of 1st Crs RX--CoC [1270].

DATE OF 1ST POSITIVE BX

Alternate Name	Item #	Length	Source of Standard	Column #
	1080			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

DATE OF BIRTH

Alternate Name	Item #	Length	Source of Standard	Column #
Birth Date (SEER/CoC/CCCR)	240	8	SEER/CoC	196-203

Format: YYYYMMDD
Allowable Values: Valid date
NAACCR Record Section: Demographic
Status

Description

Date of birth of the patient. See page 97 for date format. If age at diagnosis and year of diagnosis are known, but year of birth is unknown, then year of birth should be calculated and so coded. Only the year should be entered, left-justified. Estimate date of birth when information is not available. It is better to estimate than to leave birth date unknown.

DATE OF BIRTH FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	241	2	NAACCR	204-205

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Demographic
Status

Description

This flag explains why no appropriate value is in the field, Date of Birth [240]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions. Use code 12 when date of birth is unknown.)

12	A proper value is applicable but not known (i.e., birth date is unknown)
Blank	A valid date value is provided in item Date of Birth [240], or the date was not expected to have been transmitted

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF CA CONFERENCE

Alternate Name	Item #	Length	Source of Standard	Column #
	660			

Format:
Allowable Values:
NAACCR Record Section:

Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

DATE OF CONCLUSIVE DX

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Conclusive Diagnosis	443	8	SEER	567-574

Format: YYYYMMDD
Allowable Values: Valid date
NAACCR Record Section: Cancer Identification
Status

Description

Documents the date when a conclusive cancer diagnosis (definite statement of malignancy) is made following an initial diagnosis that was based only on ambiguous terminology. See Data Standards, Volume II, page 97 for date format.

Rationale

This date will allow analysis of the primary site locations and frequency of cases that were originally diagnosed by ambiguous terminology and later confirmed by other conclusive method.

This date will also allow for analysis of the time interval between cancer diagnosis based on ambiguous terminology and confirmation of the cancer diagnosis by conclusive means.

Codes

Refer to http://seer.cancer.gov/tools/mphrules/index.html for additional information.

DATE OF DEATH--CANADA

Alternate Name	Item #	Length	Source of Standard	Column #
	1755	8	CCCR	2280-2287

Format: YYYYMMDD
Allowable Values: Valid date
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

This field is used by the Canadian provinces/territories to record the patient's date of death. . See Data Standards, Volume II, page 97 for date format.

DATE OF DEATH--CANADAFLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1756	2	NAACCR	2288-2289

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

This flag explains why no appropriate value is in the field, Date of Death--Canada [1755]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., patient is not known to be deceased)

11	No proper value is applicable in this context (e.g. patient is alive)
12	A proper value is applicable but not known (e.g., date of death is unknown)
Blank	A valid date value is provided in item Date of Death--Canada [1755], or the date was not expected to have been transmitted

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF DIAGNOSIS

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Initial Diagnosis (CoC)	390	8	SEER/CoC	530-537

Format: YYYYMMDD
Allowable Values: Valid date
NAACCR Record Section: Cancer Identification
Status

Description

Date of initial diagnosis by a recognized medical practitioner for the tumor being reported whether clinically or microscopically confirmed. See Data Standards, Volume II, page 97 for date format.

For more discussion on determining date of diagnosis, consult the SEER Program Coding and Staging Manual or CoC FORDS manual.

DATE OF DIAGNOSIS FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	391	2	NAACCR	538-539

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Cancer Identification
Status

Description

This flag explains why no appropriate value in the field, Date of Diagnosis [390]. This data item was first available in Volume II Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

12	A proper value is applicable but not known. (e.g., date of diagnosis is unknown)
Blank	A valid date value is provided in item Date of Diagnosis [390], or the date was not expected to have been transmitted

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF INITIAL RX FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1261	2	NAACCR	1444-1445

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-1st Course
Status

Description

This flag explains why no appropriate value is in the field, Date of Initial RX-SEER [1260]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if therapy was administered)
11	No proper value is applicable in this context (e.g., therapy was not administered)
12	A proper value is applicable but not known (e.g., therapy was administered and date is unknown)
Blank	A valid date value is provided in item Date of Initial RX--SEER [1260], or the date was not expected to have been transmitted

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF INITIAL RX--SEER

Alternate Name	Item #	Length	Source of Standard	Column #
Date Therapy Initiated (SEER) Date Started (SEER)	1260	8	SEER	1436-1443

Format: YYYYMMDD
Allowable Values: Valid dates, blank
NAACCR Record Section: Treatment-1st Course
Status

Description

Date of initiation of the first course therapy for the tumor being reported, using the SEER definition of first course. See also Date of 1st Crs RX--CoC [1270]. See Chapter V, Unresolved Issues, for further discussion of the difference between SEER and CoC items. See Data Standards, Volume II, page 97 for date format.

Clarification

NPCR Required Status
Central registries funded by NPCR are required to collect either Date of Initial RX--SEER [1260] or Date of 1st Crs RX--CoC [1270].

DATE OF INPATIENT ADM

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Inpatient Admission (CoC)	590	8	NAACCR	755-762

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Hospital-Specific
Status

Description

Date of the inpatient admission to the reporting facility for the most definitive surgery. In the absence of surgery, use date of inpatient admission for any other therapy. In the absence of therapy, use date of inpatient admission for diagnostic evaluation. See Data Standards, Volume II, page 97 for date format.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

DATE OF INPATIENT DISCH

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Inpatient Discharge (CoC)	600	8	NAACCR	765-772

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Hospital-Specific
Status

Description

Date of the inpatient discharge from the reporting facility after the most definitive surgery. In the absence of surgery, use date of inpatient discharge for other therapy. In the absence of therapy, use date of inpatient discharge for diagnostic evaluation. This discharge date corresponds to the admission date described by Date of Inpatient Adm [590]. See Data Standards, Volume II, page 97 for date format.

Note: This item is not the same as the old NAACCR item, Date of Discharge, which has been deleted from the NAACCR layout. This data item is no longer supported by CoC (as of January 1, 2003).

DATE OF INPT ADM FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	591	2	NAACCR	763-764

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Hospital-Specific
Status

Description

This flag explains why no appropriate value is in the field, Date of Inpatient Adm [590]. This data item was first available in Volume II Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if patient was an inpatient).
11	No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., the patient was an inpatient but the date is unknown).
Blank	A valid date value is provided in item Date of Inpatient Adm [590], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF INPT DISCH FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	601	2	NAACCR	773-774

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Hospital-Specific
Status

Description

This flag explains why no appropriate value is in the field, Date of Inpatient Disch [600]. This data item was first available in Volume II Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if patient was an inpatient).
11	No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility).

12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., the patient was an inpatient but the date is unknown).
Blank	A valid date value is provided in item Date of Inpatient Disch [600], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF LAST CONTACT

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Last Contact or Death (CoC) Date of Last Follow-Up or of Death (SEER)	1750	8	SEER/CoC	2116-2123

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

Date of last contact with the patient, or date of death. If the patient has multiple tumors, Date of Last Contact should be the same for all tumors. See Data Standards, Volume II, page 97 for date format.

Rationale

Used for recording Date of Last Contact from active or passive follow-up. Used to record date of death and to calculate survival.

DATE OF LAST CONTACT FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1751	2	NAACCR	2124-2125

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

This flag explains why no appropriate value is in the field, Date of Last Contact [1750]. This data item first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., date of last contact is unknown).
Blank	A valid date value is provided in item Date of Last Contact [1750], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF MULT TUMORS FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	439	2	NAACCR	587-588

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Cancer Identification
Status

Description

This flag explains why no appropriate value is in the field, Date of Multiple Tumors [445]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

11	No proper value is applicable in this context (e.g., information on multiple tumors not collected/not applicable for this site).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., patient was diagnosed with multiple tumors and the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., single tumor).
Blank	A valid date value is provided in item Date Multiple Tumors [445], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF MULTIPLE TUMORS

Alternate Name	Item #	Length	Source of Standard	Column #
	445	8	SEER	579-586

Format: YYYYMMDD
Allowable Values: Valid date
NAACCR Record Section: Cancer Identification
Status

Description

This data item is used to identify the month, day and year the patient is diagnosed with multiple tumors reported as a single primary using the SEER, IARC, or Canadian Cancer Registry multiple primary rules. See Data Standards, Volume II, page 97 for date format.

Rationale

Patients with multiple tumors may have a worse prognosis or more extensive treatment than patients with a single tumor. This data item will make it possible to identify important information about these cases for data analysis. The Date of Multiple Tumors will allow separation of cases with multiple tumors present at the time of initial diagnosis from cases with subsequent tumors abstracted as the same primary. The date will allow tracking of the time interval between the date of original diagnosis and the first date of subsequent tumor(s) for specific primary sites and tumor histologies.

Codes

Refer to http://seer.cancer.gov/tools/mphrules/index.html for additional information.

DATE TUMOR RECORD AVAILBL

Alternate Name	Item #	Length	Source of Standard	Column #
	2113	8	NPCR	2007-2014

Format: YYYYMMDD
Allowable Values:
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Date the demographic and tumor identification information on a primary/reportable neoplasm, compiled from one or more source records, from one or more facilities, is available in the central cancer registry database to be counted as an incident tumor. Cancer identification information includes, at a minimum, site, histology, laterality, behavior, and date of diagnosis. See Data Standards, Volume II, page 97 for date format.

Rationale

This item is used to assess and monitor the timeliness of reporting. Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations. This data item can be used with the Date Case Report Received [2111] to measure timeliness of processing within the central cancer registry. This item also can be used with the Date of 1st Contact [580] or the Path--Date of Specimen Collection [7320] to

measure overall timeliness.

DC STATE

Alternate Name	Item #	Length	Source of Standard	Column #
	2370			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 6, effective January 1, 1998. See Place of Death [1940].

DC STATE FILE NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	2380	6	State	3878-3883

Format:
Allowable Values: Any characters or blank
NAACCR Record Section: Patient-Confidential
Status

Description

Death certificate identification number as assigned by the vital statistics office in the place recorded in Place of Death.

DERIVED AJCC-6 M

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 6 M Storage Code Derived AJCC M	2980	2	AJCC	1109-1110

Format:
Allowable Values: site-specific (derived from Collaborative Stage fields), blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This is the AJCC “M” component that is derived from CS coded fields, using the CS algorithm, effective with 2004 diagnosis.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED AJCC-6 M DESCRIPT

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 6 M Descriptor Storage Code Derived AJCC M Descriptor	2990	1	AJCC	1111-1111

Format:
Allowable Values: c, p, a, y, N, and blank (derived from Collaborative Stage fields)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for AJCC 6th edition “M Descriptor” and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the “storage” code and its associated label is referred to as the “display” code. Explanations of the “storage” codes and their corresponding “display” codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html).¹³ The display code should be used for display on the screen and in reports.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), supple 13 for rules and site-specific codes and coding structures.

DERIVED AJCC-6 N

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 6 N Descriptor Storage Code Derived AJCC N	2960	2	AJCC	1106-1107

Format:
Allowable Values: Site specific (derived from Collaborative Stage fields), blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for AJCC 6th edition “N” and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the “storage” code and its associated label is referred to as the “display” code. Explanations of the “storage” codes and their corresponding “display” codes can be found in the most current version of the Collaborative Stage Data Collection System(http://cancerstaging.org/cstage/manuals.html)., Suppl 13. The display code should be used for display on the screen and in reports.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.)

DERIVED AJCC-6 N DESCRIPT

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 6 N Descriptor Storage Code Derived AJCC N Descriptor	2970	1	AJCC	1108-1108

Format:
Allowable Values: c, p, a, y, N, and blank (derived from Collaborative Stage fields)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for AJCC 6th edition "N Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html). Suppl 13 The display code should be used for display on the screen and in reports.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED AJCC-6 STAGE GRP

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 6 Stage Group Storage Code	3000	2	AJCC	1112-1113
Derived AJCC Stage Group				

Format:
Allowable Values: Site specific (derived from Collaborative Stage fields)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the AJCC 6th edition "Stage Group" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html).Suppl 13. The display code should be used for display on the screen and in reports.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED AJCC-6 T

Alternate Name	Item #	Length	Source of Standard	Column #
Derived T	2940	2	AJCC	1103-1104
Derived AJCC T				

Format:
Allowable Values: Site specific (derived from Collaborative Stage fields)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the AJCC 6th edition "T" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html) Suppl 13. The display code should be used for display on the screen and in reports.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED AJCC-6 T DESCRIPT

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 6 T Descriptor Storage Code	2950	1	AJCC	1105-1105
Derived AJCC T Descriptor				

Format:
Allowable Values: c, p, a, y, N, and blank (derived from Collaborative Stage fields)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the AJCC 6th edition "T Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html) Suppl 13. The display code should be used for display on the screen and in reports.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED AJCC-7 M

Alternate Name	Item #	Length	Source of Standard	Column #

Derived 7 M Storage Code	3420	3	AJCC	1122-1124

Format:
Allowable Values: 000-999
NAACCR Record Section: Stage/Prognostic Factors
Status

Description
This item is the derived AJCC “T” staging element from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
Derived AJCC-7 T can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Codes
See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED AJCC-7 M DESCRIPT

Alternate Name	Item #	Length	Source of Standard	Column #	Derived 7
M Descript Storage Code	3422	1	AJCC	1125-1125	

Format:
Allowable Values: c, p, a, y, N, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description
This item is the derived AJCC “M Descriptor” from coded fields using the CS algorithm. Effective for cases diagnosed

Rationale
Derived AJCC-7 M Descript can be used in analysis to differentiate the timing of staging with respect to the treatment

Codes
See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED AJCC-7 N

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 7 N Storage Code	3410	3	AJCC	1118-1120

Format:
Allowable Values: 000-999
NAACCR Record Section: Stage/Prognostic Factors
Status

Description
This item is the derived AJCC “N” staging element from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
The CS Derived AJCC-7 N can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Codes
See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED AJCC-7 N DESCRIPT

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 7 N Descript Storage Code	3412	1	AJCC	1121-1121

Format:
Allowable Values: c, p, a, y, N, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This item is the derived AJCC “N Descriptor” from coded fields using the CS algorithm. Effective for cases diagnosed

Rationale

Derived AJCC-7 N Descript can be used in analysis to differentiate the timing of staging with respect to the treatment

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED AJCC-7 STAGE GRP

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 7 Stage Grp Storage Code	3430	3	AJCC	1126-1128

Format:
Allowable Values: 000-999
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This item is the derived AJCC “Stage Group” from coded fields using the CS algorithm. Effective for cases diagnosed

Rationale

The CS Derived AJCC-7 Stage Group can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED AJCC-7 T

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 7 T Storage Code	3400	3	AJCC	1114-1116

Format:
Allowable Values: 000-999
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This item is the derived AJCC “T” staging element from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale

Derived AJCC-7 T can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED AJCC-7 T DESCRIPT

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 7 T Descript Storage Code	3402	1	AJCC	1117-1117

Format:

Allowable Values: c, p, a, y, N, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description
This item is the derived AJCC “T Descriptor” from coded fields using the CS algorithm. Effective for cases diagnosed

Rationale
Derived AJCC-7 T Descript can be used in analysis to differentiate the timing of staging with respect to the treatment

Codes
See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED AJCC--FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
AJCC Conversion Flag	3030	1	AJCC	1158-1158

Format:
Allowable Values: 1, 2, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description
Flag to indicate whether the derived AJCC stage was derived from CS or EOD codes.

Codes

1	AJCC fields derived from Collaborative Stage
2	AJCC fields derived from EOD (prior to 2004)
blank	Not derived

DERIVED NEOADJUV RX FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	3600	1	AJCC	1157-1157

Format:
Allowable Values: 19
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. This field indicates whether the patient received neoadjuvant therapy (systemic therapy or radiation therapy prior to first course surgical treatment) as part of first course of treatment. This data item will record whether neoadjuvant therapy was administered. This will be a derived field based on RX SUMM—SYSTEMIC/SUR SEQ [1639] & RX SUMM—SURG/RAD SEQ [1380].

Rationale
The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes
See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

0	Neoadjuvant therapy was not administered as part of the first course of therapy
1	Neoadjuvant therapy was administered as part of the first course of therapy
9	Unknown

Notes:
1. This data field is used to record that neoadjuvant therapy was administered as part of the first course of treatment
2. This item is derived based on whether systemic therapy and/or radiation therapy was administered prior to surgical treatment
3. If the initial surgical therapy is not performed following the systemic therapy or radiation therapy, then this will be derived as 0, i.e., it is not considered neoadjuvant therapy

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DERIVED POSTRX-7 M

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PostRX 7 M Storage Code	3490	2	AJCC	1150-1151

Format:
Allowable Values: 00-99
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the post-treatment AJCC 7th edition “M” and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the “storage” code and its associated label is referred to as the “display” code. Explanations of the “storage” codes and their corresponding “display” codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html) Suppl13. The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED POSTRX-7 N

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PostRX 7 N Storage Code	3482	3	AJCC	1147-1149

Format:
Allowable Values: 000-999
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the post-treatment AJCC 7th edition “N” and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the “storage” code and its associated label is referred to as the “display” code. Explanations of the “storage” codes and their corresponding “display” codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html) Suppl13. The display code should be used for display on the screen and in reports.. Effective for cases diagnosed 2012+.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC

7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED POSTRX-7 STGE GRP

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PostRX 7 Stge Grp Storage Code	3492	3	AJCC	1152-1154

Format:
Allowable Values: 000-999
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the post-treatment AJCC 7th edition “Stage Group” and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the “storage” code and its associated label is referred to as the “display” code. Explanations of the “storage” codes and their corresponding “display” codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html).¹³ The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED POSTRX-7 T

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PostRX 7 T Storage Code	3480	3	AJCC	1144-1146

Format:
Allowable Values: 000-999
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus the post-treatment AJCC 7th edition “T” and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the “storage” code and its associated label is referred to as the “display” code. Explanations of the “storage” codes and their corresponding “display” codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html) Suppl13. The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the

derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED PRERX-7 M

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PreRX 7 M Storage Code	3460	3	AJCC	1137-1139

Format:
Allowable Values: 000-999
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition “M” and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the “storage” code and its associated label is referred to as the “display” code. Explanations of the “storage” codes and their corresponding “display” codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13. The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED PRERX-7 M DESCRIP

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PreRX 7 M Descrip Storage Code	3462	1	AJCC	1140-1140

Format:
Allowable Values: c, N, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for pre-treatment AJCC 7th edition “M Descriptor” and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the “storage” code and its associated label is referred to as the “display” code. Explanations of the “storage” codes and their corresponding “display” codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl13. The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED PRERX-7 N

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PreRX 7 N Storage Code	3450	3	AJCC	1133-1135

Format:
Allowable Values: 000-999
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition “N” and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the “storage” code and its associated label is referred to as the “display” code. Explanations of the “storage” codes and their corresponding “display” codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13. The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED PRERX-7 N DESCRIP

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PreRX 7 N Descrip Storage Code	3452	1	AJCC	1136-1136

Format:
Allowable Values: c, N, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition “N Descriptor” and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the “storage” code and its associated label is referred to as the “display” code. Explanations of the “storage” codes and their corresponding “display” codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13. The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED PRERX-7 STAGE GRP

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PreRX 7 Stge Grp Storage Code	3470	3	AJCC	1141-1143

Format:
Allowable Values: 000-999
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition “Stage Group” and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the “storage” code and its associated label is referred to as the “display” code. Explanations of the “storage” codes and their corresponding “display” codes can be found in the most current version of the Collaborative Stage Data Collection System> (http://cancerstaging.org/cstage/manuals.html), Suppl 13. The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED PRERX-7 T

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PreRX 7 T Storage Code	3440	3	AJCC	1129-1131

Format:
Allowable Values: 000-999
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition “T” and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the “storage” code and its associated label is referred to as the “display” code. Explanations of the “storage” codes and their corresponding “display” codes can be found in the most current version of the Collaborative Stage Data Collection System

(http://cancerstaging.org/cstage/manuals.html), Suppl 13. The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED PRERX-7 T DESCRIP

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PreRX 7 T Descrip Storage Code	3442	1	AJCC	1132-1132

Format:
Allowable Values: c, N, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition “T Descriptor” and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the “storage” code and its associated label is referred to as the “display” code. Explanations of the “storage” codes and their corresponding “display” codes can be found in the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13. The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED SS1977

Alternate Name	Item #	Length	Source of Standard	Column #
Derived SEER Summary Stage 1977	3010	1	AJCC	1155-1155

Format:
Allowable Values: 0-5, 7, 8, 9 (derived from Collaborative Stage fields)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This item is the derived “SEER Summary Stage 1977” from the CS algorithm (or EOD codes) effective with 2004

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC,

NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED SS1977--FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
SS1977 Conversion Flag	3040	1	AJCC	1159-1159

Format:
Allowable Values: 1, 2, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Flag to indicate whether the derived SEER Summary Stage 1977 was derived from CS or EOD codes.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

Blank	Not derived
1	SS1977 derived from Collaborative Stage
2	SS1977 derived from EOD (prior to 2004)

DERIVED SS2000

Alternate Name	Item #	Length	Source of Standard	Column #
Derived SEER Summary Stage 2000	3020	1	AJCC	1156-1156

Format:
Allowable Values: 0-5, 7, 8, 9 (derived from Collaborative Stage fields)
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This item is the derived “SEER Summary Stage 2000” from the CS algorithm (or EOD codes) effective with 2004

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

DERIVED SS2000--FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
SS2000 Conversion Flag	3050	1	AJCC	1160-1160

Format:
Allowable Values: 1, 2, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Flag to indicate whether the derived SEER Summary Stage 2000 was derived from CS or EOD codes.

Rationale

The Collaborative Stage Data Collection System was designed by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, CCCR, CPAC, and AJCC, to provide a single uniform set of codes and rules for coding extent of disease (EOD) and stage information to meet the needs of all of the participating standard setters. When CS data items are coded, a computer algorithm provides the derivation of T, N, M, and stage-based on AJCC Cancer Staging Manual 6th & 7th Editions, SEER Summary Stage 1977, and SEER Summary Stage 2000. There are separate derived CS fields in the NAACCR record based on AJCC 6th Edition for 2004+ cases and AJCC 7th Edition for 2010+ cases.

Codes

See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org/cstage/manuals.html), Suppl 13 for rules and site-specific codes and coding structures.

Blank	Not derived
1	SS2000 derived from Collaborative Stage
2	SS2000 derived from EOD (prior to 2004)

DIAGNOSTIC CONFIRMATION

Alternate Name	Item #	Length	Source of Standard	Column #
	490	1	SEER/CoC	562-562

Format:
Allowable Values: 1, 2, 4-9
NAACCR Record Section: Cancer Identification
Status

Description

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

Rationale

Diagnostic confirmation is useful to calculate rates based on microscopically confirmed cancers. Full incidence calculations must also include tumors that are only confirmed clinically. The percentage of tumors that not microscopically confirmed is an indication of whether case finding is including sources outside of pathology reports.

Codes

1	Positive histology
2	Positive cytology
3	Positive histology PLUS – positive immunophenotyping AND/OR positive genetic studies (Used only for hematopoietic and lymphoid neoplasms M-9590/3-9992/3)
4	Positive microscopic confirmation, method not specified
5	Positive laboratory test/marker study
6	Direct visualization without microscopic confirmation
7	Radiography and/or other imaging techniques without microscopic confirmation
8	Clinical diagnosis only (other than 5, 6, or 7)
9	Unknown whether or not microscopically confirmed; death certificate only

Note: Code 3 (used only for hematopoietic and lymphoid neoplasms M-9590/3-9992/3) was adopted for use effective with 2010 diagnoses.

DIAGNOSTIC PROC 73-87

Alternate Name	Item #	Length	Source of Standard	Column #
Diagnostic Procedures (1973-87 SEER)	2200	2	SEER	1949-1950

Format:
Allowable Values:
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Data item required by SEER for tumors of certain sites for the years 1973-87. This item is no longer collected. See Appendix D of the SEER Program Code Manual for details.

EOD--EXTENSION

Alternate Name	Item #	Length	Source of Standard	Column #
Extension (pre-96 SEER/CoC) Extension (SEER EOD) (96 CoC)	790	2	SEER	909-910

Format: Right justified, zero filled
Allowable Values: Reference SEER Extent of Disease Manual
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from January 1, 1988, through December 31, 2003.

Codes were revised effective January 1, 1998, to reflect changes in the AJCC Cancer Staging Manual, Fifth Edition.

Rationale

Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See Comparative Staging Guide for Cancer, Supplement 6.

Codes

See SEER Extent of Disease, 1988: Codes and Coding Instructions, Third Edition, Supplement 8 for site-specific codes and coding rules for all EOD fields.

EOD--EXTENSION PROST PATH

Alternate Name	Item #	Length	Source of Standard	Column #
	800	2	SEER	911-912

Format: Right justified, zero filled
Allowable Values: Reference SEER Extent of Disease manual
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from January 1, 1988, through December 31, 2003.

Codes were revised effective January 1, 1998, to reflect changes in the AJCC Cancer Staging Manual, Fifth Edition

Rationale

Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See Comparative Staging Guide for Cancer.

EOD--Extension Prost Path is an additional field for prostate cancer only to reflect information from radical prostatectomy, effective for January

1, 1995, through December 31, 2003, diagnoses. The field is left blank for all other cancers.

Codes

See SEER Extent of Disease, 1988: Codes and Coding Instructions, Third Edition, Supplement 8 for site-specific codes and coding rules for all EOD fields.

EOD--LYMPH NODE INVOLV

Alternate Name	Item #	Length	Source of Standard	Column #
Lymph Nodes (pre 96-SEER/CoC) Lymph Nodes (SEER EOD) (96 CoC)	810	1	SEER	913-913

Format:
Allowable Values: Reference SEER Extent of Disease manual
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from January 1, 1988, through December 31, 2003.

Codes were revised effective January 1, 1998, to reflect changes in the AJCC Cancer Staging Manual, Fifth Edition.

Rationale

Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See Comparative Staging Guide for Cancer.

Codes

See SEER Extent of Disease, 1988: Codes and Coding Instructions, Third Edition, Supplement 8 for site-specific codes and coding rules for all EOD fields.

EOD--OLD 13 DIGIT

Alternate Name	Item #	Length	Source of Standard	Column #
13-Digit (Expanded) Site-Specific Extent of Disease (SEER) SEER EEOD (SEER)	840	13	SEER	918-930

Format: Numeric and special characters
Allowable Values:
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Detailed site-specific codes for EOD used by SEER for selected sites of cancer for tumors diagnosed 1973-1982, except death-certificate-only cases.

Codes

See Extent of Disease: Codes and Coding Instructions (SEER 1977), Supplement 10 for codes.

EOD--OLD 2 DIGIT

Alternate Name	Item #	Length	Source of Standard	Column #
2-Digit Nonspecific and 2-Digit Site-Specific Extent of Disease (1973-1982 SEER)	850	2	SEER	931-932

Format: Numeric plus special characters "&" and "dash" ("-")
Allowable Values:
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Site-specific codes for EOD used by SEER for tumors diagnosed from January 1, 1973, to December 31, 1982, for cancer sites that did not have a 13-digit scheme see EOD--Old 13 Digit [840].

Codes

See Extent of Disease: Codes and Coding Instructions (SEER 1977), Supplement 10 for codes.

EOD--OLD 4 DIGIT

Alternate Name	Item #	Length	Source of Standard	Column #
4-Digit Extent of Disease (1983-1987 SEER)	860	4	SEER	933-936

Format:
Allowable Values:
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Codes for site-specific EOD used by SEER for tumors diagnosed from January 1, 1983, to December 31, 1987, for all cancer sites.

Codes

See SEER Extent of Disease: New 4-Digit Schemes: Codes and Coding Instructions, Supplement 9 for codes.

EOD--TUMOR SIZE

Alternate Name	Item #	Length	Source of Standard	Column #
Size of Primary Tumor (SEER) Size of Tumor (CoC)	780	3	SEER/CoC	906-908

Format: Right justified, zero filled
Allowable Values: See respective source references
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from January 1, 1988, through December 31, 2003. This field was included in the CoC dataset, separate from EOD.

Codes were revised effective January 1, 1998, to reflect changes in the AJCC Cancer Staging Manual, Fifth Edition.

Rationale

Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See Comparative Staging Guide for Cancer.

Codes

See SEER Extent of Disease, 1988: Codes and Coding Instructions, Third Edition, for site-specific codes and coding rules for all EOD fields. The CoC codes for Tumor Size are in the FORDS manual.

Note: See Data Standards and Dictionary Volume II, Chapter V, Unresolved Issues, for a discussion of coding differences between CoC and SEER.

EXTENT OF DISEASE 10-DIG

Alternate Name	Item #	Length	Source of Standard	Column #
	779	12		906-917

Format:

Allowable Values:
NAACCR Record Section: Stage/Prognostic Factors
Status: Group

Description

The name for a group of subfields that contain detailed site-specific codes for the anatomic EOD. SEER uses the subfields for tumors diagnosed from January 1, 1988, through December 31, 2003.
Group names appear only in the data dictionary and in Appendix E.
Subfields:
EOD--Tumor Size [780]
EOD--Extension [790]
EOD--Extension Prost Path [800]
EOD--Lymph Node Involv [810]
Regional Nodes Positive [820]
Regional Nodes Examined [830]

FAMILY HISTORY OF CANCER

Alternate Name	Item #	Length	Source of Standard	Column #
	360			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

FIN CODING SYSTEM

Alternate Name	Item #	Length	Source of Standard	Column #
	35	1	NAACCR	3-3

Format:
Allowable Values: 39815
NAACCR Record Section: Record ID
Status

Description

The FIN Coding System is a generated code that identifies the coding system used by individual facilities (hospital, clinics, or other providers). The CoC defines the date of initial treatment as either the date of first treatment or the date a decision was made not to treat. SEER defines the date of initial treatment as the date of first treatment, only.

This field identifies the coding system used by facilities in the following seven fields of the NAACCR layout:

- Registry ID [40] (when Registry Type [30] = 3)
- Reporting Hospital [540]
- Institution Referred From [2410]
- Institution Referred To [2420]
- Last Follow-Up Hospital [2430] (this data item was retired in Version 11)
- Following Registry [2440]
- Archive FIN [3100]

Within a single NAACCR record, all of these fields listed above must be coded using the same FIN coding system.

Codes

1	CoC 7-digit codes (assigned by CoC until the end of 2000)
2	CoC FIN 10-digit codes (assigned 2001+)
9	Unknown

Note: Code 3, NPI 8-digit code, has been deleted. Code 4, 15-digit codes, has been deleted. This item is no longer supported by CoC (as of January 1, 2003).

FIRST COURSE CALC METHOD

Alternate Name	Item #	Length	Source of Standard	Column #

1500	1	NAACCR	1595-1595

Format:
Allowable Values: 39815
NAACCR Record Section: Treatment-1st Course
Status

Description
Code indicating the source of the standard for defining the first course of therapy.

Codes

1	CoC definitions
2	SEER definitions
9	Other, unknown

FOLLOWING REGISTRY

Alternate Name	Item #	Length	Source of Standard	Column #
	2440	10	CoC	4295-4304

Format: Right justified and zero filled
Allowable Values: 10-digit number
NAACCR Record Section: Hospital-Confidential
Status

Description
Records the FIN of the registry responsible for following the patient.

Rationale
Each FIN is unique. The number is essential to NCDB for monitoring data submissions, ensuring the accuracy of data, and identifying areas for special studies.

Codes
CoC maintains the codes, including those for non-hospital sources of reporting.

For facilities with 7-digit FINs, consisting of a constant “6” followed by 6-digit facility-specific codes in the range of 6020009-6953290 that were assigned by CoC before January 1, 2001: Enter all FIN codes of this type as 3 zeroes, followed by the constant “6” and the 6-digit facility-specific codes.

For facilities with FINs greater than or equal to 10000000 that were assigned by CoC after January 1, 2001: Enter FIN codes of this type as 2 zeroes followed by the full 8-digit code. These sometimes are called CoC FIN 10 digit codes.

In addition to CoC assigned codes

0000000000	Case not reported by a facility
0099999999	Case reported, but facility number is unknown

FOLLOW-UP CONTACT--CITY

Alternate Name	Item #	Length	Source of Standard	Column #
	1842	50	SEER	2208-2257

Format: Mixed case letters, special characters only as allowed by USPS, embedded spaces allowed, left justified, blank filled.
Allowable Values: City name or UNKNOWN
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description
Name of the city of the follow-up contact’s current usual residence. If the patient has multiple tumors, the follow-up contact city of residence should be the same for all tumors.

Rationale
Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

FOLLOW-UP CONTACT--NAME

Alternate Name	Item #	Length	Source of Standard	Column #
	2394	60	SEER	3884-3943

Format:
Allowable Values:
NAACCR Record Section: Patient-Confidential
Status

Description

First and last name, in natural order, of a person, other than the patient or a physician, who can be contacted to obtain follow-up information for the patient. If the patient has multiple tumors, Follow-up Contact-Name should be the same for

Rationale

Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

FOLLOW-UP CONTACT--NO&ST

Alternate Name	Item #	Length	Source of Standard	Column #
	2392	60	SEER	3944-4003

Format: Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled
Allowable Values:
NAACCR Record Section: Patient-Confidential
Status

Description

The number and street address or the rural mailing address of the follow-up contact's current usual residence. This can be used to generate a follow-up inquiry, and must correspond to the other fields in the follow-up contact address. If the patient has multiple tumors, Follow-Up Contact--No&St should be the same for all tumors.

U.S. addresses should conform to the USPS Postal Addressing Standards. These standards are referenced in USPS Pub. 28, November 2000, Postal Addressing Standards. The current USPS Pub. 28 may be found and downloaded from the following website: http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf.

Canadian addresses should conform to the Canada Postal Guide. The current Canadian Postal Address standards may be found at the following website: http://www.canadapost.ca/tools/pg/manual/default-e.asp.

Rationale

Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

Note: Prior to Version 5, Follow-Up Contact fields may have been used for patient current address in the NAACCR record layout.

FOLLOW-UP CONTACT--POSTAL

Alternate Name	Item #	Length	Source of Standard	Column #
	1846	9	SEER	2260-2268

Format: Numbers or upper case letters. No special characters or embedded spaces allowed. Left justified, blank filled.
Allowable Values: 5-digit or 9-digit U.S. ZIP codes; 6- character Canadian postal codes; valid postal codes from other countries, 888888888, 999999999, 88888+4 blanks (U.S.), 99999+4 blanks (U.S.), 999999+3 blanks (Canada).
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

Postal code for the address of the follow-up contact's current usual residence. If the patient has multiple tumors, the Follow-up Contact-Postal

should be the same for all tumors. For U.S. residents, use either the 5-digit or the extended 9-digit ZIP code. Blanks follow the 5-digit code. For Canadian residents, use the 6-character, alphanumeric postal code. Blanks follow the 6-character code. When available, enter postal code for other countries.

Rationale

Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

Codes

(In addition to U.S., Canadian, and foreign postal codes)

888888888	Resident of country other than the United States (including its possessions, etc.) or Canada, and postal code unknown
999999999	Resident of the United States (including its possessions, etc.) or Canada, and postal code unknown

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FOLLOW-UP CONTACT--STATE

Alternate Name	Item #	Length	Source of Standard	Column #
	1844	2	SEER	2258-2259

Format: Upper case
Allowable Values: See EDITS table STATE.DBF in Appendix B
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

USPS abbreviation for the state (including U.S. territories, commonwealths, or possessions), or Canada Post abbreviation for the Canadian province/territory of the follow-up contact's current usual residence. If the patient has multiple tumors, the follow-up contact state should be the same for all tumors.

Rationale

Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

Codes

(In addition to USPS and Canadian Postal Service abbreviations)

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

FOLLOW-UP CONTACT--SUPPL

Alternate Name	Item #	Length	Source of Standard	Column #
	2393	60	SEER	4004-4063

Format: Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled
Allowable Values:
NAACCR Record Section: Patient-Confidential
Status

Description

This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex. It can be used to generate a follow-up inquiry, and must correspond to the other fields in the follow-up contact address. If the patient has multiple tumors, Follow-Up Contact--Suppl should be the same for all tumors.

Rationale

Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

FOLLOW-UP SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
Follow-Up Method (pre-96 CoC)	1790	1	CoC	2129-2129

Format:
Allowable Values: 0-5, 7-9
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

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

Rationale

For registries performing follow-up, this field helps evaluate the success rates of various methods of follow-up. It also can be used to report to institutions the source of follow-up information that is sent to them. When there is a conflict in follow-up information, knowing the source can help resolve the inconsistency.

Codes

0	Reported hospitalization
1	Readmission
2	Physician
3	Patient
4	Department of Motor Vehicles
5	Medicare/Medicaid file
7	Death certificate
8	Other
9	Unknown, not stated in patient record

FOLLOW-UP SOURCE CENTRAL

Alternate Name	Item #	Length	Source of Standard	Column #
	1791	2	NAACCR	2278-2279

Format:
Allowable Values: 00-12, 29-35, 39-43, 48-51, 59-65, 98, 99
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

This field is created by the central registry. It records the source from which the consolidated information was obtained on a patient's vital status and date of last contact. Follow-up Source Central would be updated when new or more reliable information becomes available. However, when the existing date of last contact/vital status is deemed to be more reliable than newly obtained information, then neither the date of last contact/vital status nor the follow-up source central would

Rationale

For central registries performing follow-up, this field could help evaluate the success rates of various methods of follow-up. When new follow-up information conflicts with the existing information, knowing the follow-up source can help resolve any discrepancies.

Codes

00	Follow-up not performed for this patient
(01-29) File Linkages	
01	Medicare/Medicaid File
02	Center for Medicare and Medicaid Services (CMS, formerly HCFA)
03	Department of Motor Vehicle Registration

04	National Death Index (NDI)
05	State Death Tape/Death Certificate File
06	County/Municipality Death Tape/ Death Certificate File
07	Social Security Administration Death Master File
08	Hospital Discharge Data
09	Health Maintenance Organization (HMO) file
10	Social Security Epidemiological Vital Status Data
11	Voter Registration File
12	Research/Study Related Linkage
29	Linkages, NOS
(30-39) Hospitals and Treatment Facilities	
30	Hospital in-patient/outpatient
31	Casefinding
32	Hospital cancer registry
33	Radiation treatment center
34	Oncology clinic
35	Ambulatory surgical center
39	Clinic/facility, NOS
(40-49) Physicians	
40	Attending physician
41	Medical oncologist
42	Radiation oncologist
43	Surgeon
48	Other specialist
49	Physician, NOS
(50-59) Patient	
50	Patient contact
51	Relative contact be changed.
59	Patient, NOS
(60-98) Other	
60	Central or Regional cancer registry
61	Internet sources
62	Hospice
63	Nursing homes
64	Obituary
65	Other research/study related sources
98	Other, NOS
(99) Unknown	
99	Unknown source

FUTURE USE TIMELINESS 1

Alternate Name	Item #	Length	Source of Standard	Column #
	2114			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

Reserved for future use for storing date of a central registry processing milestone. No standards have been adopted for this item. The NAACCR UDSC retired this data item in Version 10.1, as of January 1, 2004.

FUTURE USE TIMELINESS 2

Alternate Name	Item #	Length	Source of Standard	Column #
	2115			

Format:

Allowable Values:
NAACCR Record Section:
Status: Retired

Description

Reserved for future use for storing date of a central registry processing milestone. No standards have been adopted for this item. The NAACCR UDSC retired this data item in Version 10.1, as of January 1, 2004.

GIS COORDINATE QUALITY

Alternate Name	Item #	Length	Source of Standard	Column #
	366	2	NAACCR	422-423

Format:
Allowable Values: 01-12, 98, 99, blank
NAACCR Record Section: Demographic
Status

Description

Code indicating the basis of assignment of latitude and longitude coordinates for an individual record from an address. This data item is helpful in identifying cases that were assigned coordinates based on incomplete information, post office boxes, or rural routes. This item is coded at the central registry, not by the reporting facility. Most of the time, this information is provided by geocoding software. Alternatively, a central registry staff member manually assigns the code. Codes are hierarchical, with lower numbers having priority.

Rationale

Spatial analysis of cancer data often requires identifying data records with a high degree of geographic precision. Researchers can use this code as a basis for selecting records with a degree of precision that is appropriate to the study.

Codes

00	Coordinates derived from local government-maintained address points, which are based on property parcel locations, not interpolation over a street segment's address range
01	Coordinates assigned by Global Positioning System (GPS)
02	Coordinates are match of house number and street, and based on property parcel location
03	Coordinates are match of house number and street, interpolated over the matching street segment's address range
04	Coordinates are street intersections
05	Coordinates are at mid-point of street segment (missing or invalid building number)
06	Coordinates are address ZIP code+4 centroid
07	Coordinates are address ZIP code+2 centroid
08	Coordinates were obtained manually by looking up a location on a paper or electronic map
09	Coordinates are address 5-digit ZIP code centroid
10	Coordinates are point ZIP code of Post Office Box or Rural Route
11	Coordinates are centroid of address city (when address ZIP code is unknown or invalid, and there are multiple ZIP codes for the city)
12	Coordinates are centroid of county
98	Latitude and longitude are assigned, but coordinate quality is unknown
99	Latitude and longitude are not assigned, but geocoding was attempted; unable to assign coordinates based on available information
Blank	GIS Coordinate Quality not coded

Where multiple codes are applicable, use the lower code value.

Note: This data item is similar in function to Census Tract Certainty 1970/80/90 [364] and Census Tract Certainty 2000 [365]. The codes for this data item and the two census tract data items all describe how location information was assigned based on the patient's resident address at the time of diagnosis. This data item must be populated if Latitude [2352] and Longitude [2354] are also populated.

GRADE

Alternate Name	Item #	Length	Source of Standard	Column #
Grade, Differentiation, or Cell Lineage Indicator (SEER/CCCR) Grade/Differentiation (CoC)	440	1	SEER/CoC	555-555

Format:
Allowable Values: 40552
NAACCR Record Section: Cancer Identification
Status

Description

Code for the grade or degree of differentiation of the reportable tumor. For lymphomas and leukemias, field also is used to indicate T-, B-, Null-, or NK-cell origin.

Codes

See the grade tables on page 67 of ICD-O-3.Suppl 16. See also the most current CoC FORDS manual and SEER Program Code Manual, for site specific coding rules and conversions.

1	Grade I
2	Grade II
3	Grade III
4	Grade IV
5	T-cell
6	B-cell
7	Null cell
8	NK (natural killer) cell
9	Grade/differentiation unknown, not stated, or not applicable

Note: Code 8 was adopted for use with lymphoma cases diagnosed in 1995 and later. Use the most recent Hematopoietic and Lymphoid rules for assigning grades 5-8.

GRADE (73-91) ICD-O-1

Alternate Name	Item #	Length	Source of Standard	Column #
	1973	1	SEER	1918-1918

Format:
Allowable Values: Reference ICD-O-1 for valid entries
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Area for retaining the grade portion (1 digit) of the ICD-O-1 or field trial grade code entered before a conversion to ICD-O-2. See grouped data item Morph (73-91) ICD-O-1 [1970] in Appendix E. The item name includes years 1973-91. However, some states may have used the codes for cases before 1973.

Codes

For cases diagnosed before 1992, contains the ICD-O-1 or field trial 1-digit grade code as originally coded, if available Use Supplement 18 and 19.

GRADE PATH SYSTEM

Alternate Name	Item #	Length	Source of Standard	Column #
	449	1	AJCC	557-557

Format:
Allowable Values: 2-4, blank
NAACCR Record Section: Cancer Identification
Status

Description

Indicates whether a two, three or four grade system is used.

Rationale

This item is used to show whether a two, three or four grade system is used. This is the grade system stated in the path report; it is not converted. This item is used in conjunction with Grade Path Value [441] and is abstracted in addition to Grade Differentiation [440].

Codes

Refer to the most recent version of FORDS for additional instructions.

2	Two-Grade System
3	Three-Grade System
4	Four-Grade System
Blank	Not a two, three or four grade system; unknown

GRADE PATH VALUE

Alternate Name	Item #	Length	Source of Standard	Column #
	441	1	AJCC	556-556

Format:
Allowable Values: 1-4, blank
NAACCR Record Section: Cancer Identification
Status

Description

Describes the actual grade according to the grading system in Grade Path System [449].

Rationale

This data item will record grade specified in Grade Path System. This does not replace Grade [440].

Codes

Refer to the most recent version of FORDS for additional instructions.

1	Recorded as Grade I or 1
2	Recorded as Grade II or 2
3	Recorded as Grade III or 3
4	Recorded as Grade IV or 4
Blank	No Two, Three or Four System Grade is available; unknown

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HISTOLOGIC TYPE ICD-O-3

Alternate Name	Item #	Length	Source of Standard	Column #
ICD-O-3 Histology (CCCR)	522	4	SEER/CoC	550-553

Format:
Allowable Values: 8000-9989, Refer to ICD-O-3
NAACCR Record Section: Cancer Identification
Status: Subfield

Description

Codes for the histologic type of the tumor being reported using ICD-O-3. NAACCR adopted ICD-O-3 as the standard coding system for tumors diagnosed in 2001 and later, and recommended that prior tumors be converted from ICD-O-2. Effective with 2010 diagnoses, this item also includes codes for new terms as per the 2008 WHO Hematopoietic/Lymphoid publication, supplement 39.

Codes

See ICD-O-3, Supplement 14, Morphology Section and the SEER Hematopoietic database.

Clarification

Required Status

This data item is required by all standard-setting organizations for tumors diagnosed on or after January 1, 2001, and recommended (by conversion from ICD-O-2 codes when conversion algorithms and tables are available) for tumors diagnosed before 2001.

When the histologic type is coded according to ICD-O-3, the histology code must be reported in Histologic Type ICD-O-3 [522], with behavior coded in Behavior Code ICD-O-3 [523].

For information on required status for related data items for histologic type and behavior when coded according to ICD-O-2, see Histology (92-00) ICD-O-2 [420] and Behavior (92-00) ICD-O-2 [430].

Note: See Histology (92-00) ICD-O-2 [420] for ICD-O-2 codes.

HISTOLOGY (73-91) ICD-O-1

Alternate Name	Item #	Length	Source of Standard	Column #
	1971	4	SEER	1913-1916

Format: Reference ICD-O-1 for valid entries
Allowable Values: 8000-9970
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Area for retaining the histology portion (4 digits) of the ICD-O-1 or field trial morphology codes entered before a conversion to ICD-O-2. See grouped data item Morph (73-91) ICD-O-1 [1970], in Appendix E. The item name includes years 1973-91. However, some states may have used the codes for cases before 1973.

Codes

For cases diagnosed before 1992, contains the ICD-O-1 or field trial 4-digit histology code as originally coded, if available. Blank for tumors coded directly into ICD-O-2 or ICD-O-3 (i.e., 1992 and later cases).

HISTOLOGY (92-00) ICD-O-2

Alternate Name	Item #	Length	Source of Standard	Column #
Histology (CoC)	420	4	SEER/CoC	545-548
ICD-O-2 Histology (CCCR)				

Format:
Allowable Values: 8000-9989, Refer to ICD-0-2
NAACCR Record Section: Cancer Identification
Status: Subfield

Description

Codes for the histologic type of the tumor being reported using ICD-O-2. NAACCR adopted ICD-O-2 as the standard coding system for tumors diagnosed in 1992 and later and recommended that prior cases be converted to ICD-O-2.

Codes

See ICD-O-2, Supplement 15, Morphology Section.

Clarification

Required Status
This data item is required by all standard-setting organizations for tumors diagnosed from January 1, 1992, through December 31, 2000, and recommended for tumors diagnosed before 1992.

When the histologic type is coded according to ICD-O-2, the histology code must be reported in Histology (92-00) ICD-O-2 [420], with behavior coded in Behavior (92-00) ICD-O-2 [430].

For information on required status for related data items for histologic type and behavior when coded according to ICD-O-3, see Histologic Type ICD-O-3 [522] and Behavior Code ICD-O-3 [523].

Note: See Histology (73-91) ICD-O-1 [1971] for ICD-O-1 and field trial codes.

ICD REVISION COMORBID

Alternate Name	Item #	Length	Source of Standard	Column #
ICD Revision Comorbidities	3165	1	CoC	1185-1185

Format:
Allowable Values: 1, 9, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

This item indicates the coding system in which the Comorbidities and Complications (secondary diagnoses) codes are provided.

Rationale

The CoC currently requires the collection and reporting of up to 10 ICD-9-CM codes describing secondary diagnoses for patients hospitalized for cancer treatment. Currently the use of ICD-10-CM is not mandatory in U.S. hospitals, though it may become so in the future. In the event this occurs cancer registries that maintain or collect this information will need to differentiate between ICD-9-CM and ICD-10-CM code use. The code values and definitions for this item would be expanded as necessary. Allowable codes reported in the Comorbidity and Complications items in FORDS would be re-assessed at the same time.

Codes

0	No comorbidities or complications recorded in patient's record
1	ICD-10-CM
9	ICD-9-CM
Blank	Comorbidities and Complications not collected

ICD REVISION NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
ICD Code Revision Used for Cause of Death (SEER)	1920	1	SEER	2273-2273

Format:
Allowable Values: 0, 1, 7, 8, 9
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

Indicator for the coding scheme used to code the cause of death.

Codes

0	Patient alive at last follow-up
1	ICD-10
7	ICD-7
8	ICDA-8
9	ICD-9

ICD-O-2 CONVERSION FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
Review Flag for 1973-91 Cases (SEER)	1980	1	SEER	1919-1919

Format:
Allowable Values: 0-6, blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Code specifying how the conversion of site and morphology codes from ICD-O-1 and the field trial editions to ICD-O-2 was accomplished. The item names include years 1973-91. However, some states may have used the codes for tumors before 1973. The code also covers morphology conversions from ICD-O-3 to ICD-O-2.

Codes

0	Primary site and morphology originally coded in ICD-O-2
1	Primary site and morphology converted without review
2	Primary site converted with review; morphology machine-converted without review
3	Primary site machine-converted without review, morphology converted with review
4	Primary site and morphology converted with review
5	Morphology converted from ICD-O-3 without review
6	Morphology converted from ICD-O-3 with review
Blank	Not converted

ICD-O-3 CONVERSION FLAG

Alternate Name	Item #	Length	Source of Standard	Column #

2116	1	SEER/CoC	2015-2015

Format:
Allowable Values: Blank, 0, 1, 3
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Code specifying how the conversion of site and morphology codes from ICD-O-2 to ICD-O-3 was accomplished.

Codes

0	Morphology (Morph—Type & Behav ICD-O-3 [521]) originally coded in ICD-O-3
1	Morphology (Morph—Type & Behav ICD-O-3 [521]) converted from (Morph—Type & Behav ICD-O-2 [419]) without Review
3	Morphology (Morph—Type & Behav ICD-O-3 [521]) converted from (Morph—Type & Behav ICD-O-2 [419]) with review
Blank	Not converted (clarification for cases diagnosed as of January 1, 2007: cases coded in prior ICD-O version and not converted to ICD-O-3)

IHS LINK

Alternate Name	Item #	Length	Source of Standard	Column #
Indian Health Service Linkage	192	1	NPCR	421-421

Format:
Allowable Values: 0, 1, blank
NAACCR Record Section: Demographic
Status

Description

This variable captures the results of the linkage of the registry database with the Indian Health Service patient registration database.

Rationale

The IHS linkage identifies cancer cases among American Indians who were misclassified as non-Indian in the registry database in order to improve the quality of cancer surveillance data on American Indians in individual registries and in all registries as a whole. The goal is to include cancer incidence data for American Indians in the United States Cancer Statistics by use of this variable as well as the race variable.

Codes

0	Record sent for linkage, no IHS match
1	Record sent for linkage, IHS match
Blank	Record not sent for linkage or linkage result pending

INDUSTRY CODE--CENSUS

Alternate Name	Item #	Length	Source of Standard	Column #
	280	3	Census/NPCR	212-214

Format: Right justified, zero filled
Allowable Values: Reference Industry and Occupation Coding for Death Certificates
NAACCR Record Section: Demographic
Status

Description

Code for the patient’s usual industry, using U.S. Census Bureau codes (2000 Census²⁶ is preferable) according to coding procedures recommended for death certificates.²⁵ This data item applies only to patients who are age 14 years or older at the time of diagnosis.

Rationale

Use of the Census Bureau classification system improves consistency of data collected from multiple sources. The Census Bureau industrial classification system is used for coding industry information from death certificates and from the U.S. Census of Population. The system includes specific coding rules, supplement 22-27.

Codes

For the 1990 Census codes see Instructional Manual Part 19: Industry and Occupation Coding for Death Certificates 1999, Supplement 23 and related materials in the reference list, Chapter VI. A similar instruction manual for the 2000 Census codes has not been developed. Software for automated coding of occupation and industry is available from the Division of Safety Research, National Institute for Occupational Safety and Health, CDC. Contact Suzanne Marsh at (304) 285-6009 or at smm2@cdc.gov. As of press time, NIOSH was updating their automated coding software. The contact person for this software (which probably will not be available until after January 1, 2011) is Sue Nowlin, who can be contacted at sxn1@cdc.gov or (513) 841-4467.

Note: Occupation/industry coding should NOT be performed by reporting facilities. This is a central cancer registry data item. Specially trained and qualified personnel should perform coding. 2000 Census codes for occupation and industry are recommended for tumors diagnosed on or after January 1, 2003, Supplement 26. The 1990 Census codes are recommended for tumors diagnosed before January 1, 2003, Supplement 24. For more information, see the U.S. Census Bureau website at: http://www.census.gov/hhes/www/ioindex/ioindex.html.

INDUSTRY SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
	300	1	NPCR	216-216

Format:
Allowable Values: 0-3, 7-9, blank
NAACCR Record Section: Demographic
Status

Description

Code that best describes the source of industry information provided on this patient. This is a central cancer registry data item (i.e., codes should be applied by a central or regional registry rather than collected from reporting facilities).

Rationale

Industry information may come from a variety of sources. The most valid and reliable source of industry information for patients has not yet been determined.

Codes

0	Unknown industry/no industry available
1	Reporting facility records
2	Death certificate
3	Interview
7	Other source
8	Not applicable, patient less than 14 years of age at diagnosis
9	Unknown source
Blank	Not collected

INPATIENT STATUS

Alternate Name	Item #	Length	Source of Standard	Column #
	605	1	NAACCR	775-775

Format:
Allowable Values: 0, 1, 9, blank
NAACCR Record Section: Hospital-Specific
Status: Revised

Description

This data item records whether there was an inpatient admission for the most definitive therapy, or in the absence of therapy, for diagnostic evaluation. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included information in addition to dates. This data item incorporates the non-date meanings for the Date of Inpatient Adm [590] and Date of Inpatient Disch [600] in order to retain the non-date information with the transition to interoperable dates.

Codes

0	Patient was never an inpatient

1	Patient was inpatient
9	Unknown if patient was an inpatient (only used for consolidated cases)
Blank	Not collected

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

INPATIENT/OUTPT STATUS

Alternate Name	Item #	Length	Source of Standard	Column #
	640			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

INSTITUTION REFERRED FROM

Alternate Name	Item #	Length	Source of Standard	Column #
Facility Referred From	2410	10	CoC	4315-4324

Format: Right justified and zero filled
Allowable Values: 10-digit number
NAACCR Record Section: Hospital-Confidential
Status

Description

Identifies the facility that referred the patient to the reporting facility.

Rationale

Each facility's FIN is unique. This number is used to document and monitor referral patterns.

Codes

CoC maintains the codes, including those for non-hospital sources of reporting. For facilities with 7-digit FINs, consisting of a constant "6" followed by 6-digit facility-specific codes in the range of 6020009-6953290 that were assigned by CoC before January 1, 2001: Enter all FIN codes of this type as 3 zeroes, followed by the constant "6" and the 6-digit facility-specific codes.

For facilities with FINs greater than or equal to 10000000 that were assigned by CoC after January 1, 2001: Enter FIN codes of this type as 2 zeroes followed by the full 8-digit code. These sometimes are called CoC FIN 10-digit codes.
(In addition to CoC assigned codes)

0000000000	Case not referred from a facility
0099999999	Case referred from a facility, but facility number is unknown

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INSTITUTION REFERRED TO

Alternate Name	Item #	Length	Source of Standard	Column #
Facility Referred To	2420	10	CoC	4335-4344

Format: Right justified and zero filled
Allowable Values: 10-digit number
NAACCR Record Section: Hospital-Confidential
Status

Description

Identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

Rationale

Each facility's FIN is unique. This number is used to document and monitor referral patterns.

Codes

CoC maintains the codes, including those for non-hospital sources of reporting. For facilities with 7-digit FINs, consisting of a constant “6” followed by 6-digit facility-specific codes in the range of 6020009-6953290 that were assigned by CoC before January 1, 2001: Enter all FIN codes of this type as 3 zeroes, followed by the constant “6” and the 6-digit facility-specific codes.

For facilities with FINs greater than or equal to 10000000 that were assigned by CoC after January 1, 2001: Enter FIN codes of this type as 2 zeroes followed by the full 8-digit code. These sometimes are called CoC FIN 10-digit codes.
(In addition to CoC assigned codes)

0000000000	Case not referred from a facility
0099999999	Case referred from a facility, but facility number is unknown

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LAST FOLLOW-UP HOSPITAL

Alternate Name	Item #	Length	Source of Standard	Column #
	2430			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

LATERALITY

Alternate Name	Item #	Length	Source of Standard	Column #
Laterality at Diagnosis (SEER)	410	1	SEER/CoC	544-544

Format:
Allowable Values: 36625
NAACCR Record Section: Cancer Identification
Status

Description

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

Codes

0	Not a paired site
1	Right: origin of primary
2	Left: origin of primary
3	Only one side involved, right or left origin unspecified
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms' tumors
5	Paired site: midline tumor
9	Paired site, but no information concerning laterality

LATITUDE

Alternate Name	Item #	Length	Source of Standard	Column #
	2352	10	NAACCR	4064-4073

Format: Right justified
Allowable Values: Numbers, decimal point, negative sign
NAACCR Record Section: Patient-Confidential
Status

Description

Paired with Longitude [2354], this represents the point location of the individual’s residence on the earth’s surface. It is typically determined by matching an address to a reference file or by identifying the residence using satellite imagery. This item is coded at the central registry, not by the reporting facility.

Rationale

Latitude and Longitude comprise the universal standard for designating location on the earth's surface. Geographic Information Systems software can be used to convert these values into projected coordinates for map display.

Codes

Latitude is a 10- digit numeric field, right justified, with up to six decimal places and an explicit decimal point. The format is x12.345678, where "x" is reserved for a negative sign for locations south of the equator. Latitude north of the equator is positive. The datum of the decimal degree data shall be North American Datum of 1983 (NAD 83). Values are in decimal degrees, not degrees/minutes/seconds.

Correct format for Latitude is: 41. 890833. It should not be represented like this: 41 deg 53' 27"

LOC/REG/DISTANT STAGE

Alternate Name	Item #	Length	Source of Standard	Column #
	770			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

LONGITUDE

Alternate Name	Item #	Length	Source of Standard	Column #
	2354	11	NAACCR	4074-4084

Format: Right justified
Allowable Values: Numbers, decimal point, negative sign
NAACCR Record Section: Patient-Confidential
Status

Description

Paired with Latitude [2352], this represents the point location of the individual's residence on the earth's surface. It is typically determined by matching an address to a reference file or by identifying the residence using satellite imagery. This item is coded at the central registry, not by the reporting facility.

Rationale

Latitude and Longitude comprise the universal standard for designating location on the earth's surface. Geographic Information Systems software can be used to convert these values into projected coordinates for map display.

Codes

Latitude is an 11 digit numeric field, right justified, with up to six decimal places and an explicit decimal point. The format is x123.456789, where "x" is reserved for a negative sign for locations west of the Prime Meridian (0 degrees) and east of 180 degrees. The datum of the decimal degree data shall be North American Datum of 1983 (NAD 83).

Values are in decimal degrees, not degrees/minutes/seconds.

Longitude: -123.128943

Longitude: -71 deg 7' 44"

LYMPH-VASCULAR INVASION

Alternate Name	Item #	Length	Source of Standard	Column #
	1182	1	AJCC	984-984

Format:
Allowable Values: 189
NAACCR Record Section: Treatment-1st Course
Status

Description

Indicates whether lymphatic duct or blood vessel (LVI) is identified in the pathology report.

Rationale

This data item will record the information as stated in the record. Presence or absence of cancer cells in the lymphatic ducts or blood vessels is useful for prognosis.

Codes

0	Lymph-vascular Invasion stated as Not Present
1	Lymph-vascular Invasion Present/Identified
8	Not Applicable
9	Unknown/Indeterminate/not mentioned in path report

MARITAL STATUS AT DX

Alternate Name	Item #	Length	Source of Standard	Column #
Marital Status at Diagnosis (SEER/CoC)	150	1	SEER	176-176
Marital Status at Initial Diagnosis (pre-96 CoC)				

Format:
Allowable Values: 39819
NAACCR Record Section: Demographic
Status: Revised

Description

Code for the patient's marital status at the time of diagnosis for the reportable tumor. If the patient has multiple tumors, marital status may be different for each tumor.

Rationale

Incidence and survival with certain cancers vary by marital status. The item also helps in patient identification.

Codes

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

MEDICAL RECORD NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	2300	11	CoC	3606-3616

Format: Leading spaces, right justified
Allowable Values: Alphanumeric
NAACCR Record Section: Patient-Confidential
Status

Description

Records medical record number used by the facility to identify the patient. The CoC FORDS manual instructs registrars to record numbers assigned by the facility's Health Information Management (HIM) Department only, not department-specific numbers.

Rationale

This number identifies the patient in a facility. It can be used by a central registry to point back to the patient record, and it helps identify multiple reports on the same patient.

Codes

(In addition to the medical record number)

UNK	Medical record number unknown
RT	Radiation therapy department patient without HIM number
SU	1-day surgery clinic patient without HIM number

Note: Other standard abbreviations may be used to indicate departments within the facility for patients without HIM numbers assigned.

MILITARY RECORD NO SUFFIX

Alternate Name	Item #	Length	Source of Standard	Column #
Military Medical Record Number Suffix (CoC)	2310	2	CoC	3617-3618

Format: Right justified, zero filled
Allowable Values: 01-20, 30-69, 98, 99, blank
NAACCR Record Section: Patient-Confidential
Status

Description

Patient identifier used by military hospitals to record relationship of the patient to the sponsor.

Codes

01-19	Child
20	Sponsor
30-39	Spouse
40-44	Mother
45-49	Father
50-54	Mother-in-law
55-59	Father-in-law
60-69	Other eligible dependents
98	Civilian emergency (Air Force/Navy)
99	Not classified elsewhere/stillborn
Blank	Not a military facility

MORPH (73-91) ICD-O-1

Alternate Name	Item #	Length	Source of Standard	Column #
	1970	6		1913-1918

Format:
Allowable Values: Reference ICD-O-1 for valid entries
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: Group

Description

The name for a group of subfields describing the type and behavior of the tumor being reported using ICD-O-1 codes. Group names appear only in the data dictionary and Appendix E.

Subfields:
Histology (73-91) ICD-O-1 [1971]
Behavior (73-91) ICD-O-1 [1972]
Grade (73-91) ICD-O-1 [1973]

MORPH CODING SYS--CURRENT

Alternate Name	Item #	Length	Source of Standard	Column #
	470	1	NAACCR	560-560

Format:
Allowable Values: 40552
NAACCR Record Section: Cancer Identification
Status

Description

Code that best describes how morphology is currently coded. If converted, this field shows the system it is converted to.

Codes

1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6	ICD-O, Second Edition, plus FAB codes effective 1/1/98
7	ICD-O, Third Edition
8	ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms effective 1/1/2010
9	Other

MORPH CODING SYS--ORIGINL

Alternate Name	Item #	Length	Source of Standard	Column #
	480	1	NAACCR	561-561

Format:
Allowable Values: 40552
NAACCR Record Section: Cancer Identification
Status

Description

Code that best describes how morphology was originally coded. If later converted, this field shows the original codes used.

Codes

1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6	ICD-O, Second Edition, plus FAB codes effective 1/1/98
7	ICD-O, Third Edition
8	ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms effective 1/1/2010
9	Other

MORPH--TYPE&BEHAV ICD-O-2

Alternate Name	Item #	Length	Source of Standard	Column #
	419	5		545-549

Format:
Allowable Values: Reference to ICD-0-2
NAACCR Record Section: Cancer Identification
Status: Group

Description

The name for a group of subfields describing the type and behavior of the tumor being reported using ICD-O-2 codes.

Group names appear only in the data dictionary and Appendix E.
Subfields
Histology (92-00) ICD-O-2 [420]
Behavior (92-00) ICD-O-2 [430]

MORPH--TYPE&BEHAV ICD-O-3

Alternate Name	Item #	Length	Source of Standard	Column #
	521	5		550-554

Format:
Allowable Values: Reference to ICD-O-3

NAACCR Record Section: Cancer Identification
Status: Group

Description

The name for a group of subfields describing the type and behavior of the tumor being reported using ICD-O-3 codes.

Group names appear only in the data dictionary and Appendix E.

Subfields
Histologic Type ICD-O-3 [522]
Behavior Code ICD-O-3 [523]

MULT TUM RPT AS ONE PRIM

Alternate Name	Item #	Length	Source of Standard	Column #
Multiple Tumors Reported as Single Primary	444	2	SEER	577-578

Format:
Allowable Values: 00, 10-12, 20, 30-32, 40, 80, 88, 99
NAACCR Record Section: Cancer Identification
Status

Description

This data item is used to identify the type of multiple tumors in cases with multiple tumors that are abstracted and reported as a single primary using the SEER, IARC, or Canadian Cancer Registry multiple primary rules. Multiple tumors may individually exhibit in situ, invasive, or a combination of in situ and invasive behaviors. Multiple intracranial and central nervous system tumors may individually exhibit benign, borderline, malignant, or a combination of these behaviors. Multiple tumors found in the same organ or in a single primary site may occur at the time of initial diagnosis or later.

Rationale

Patients with multiple tumors that are currently reported as a single primary may have a worse prognosis or more extensive treatment than patients with a single tumor. This data item will make it possible to identify important information about these cases for data analysis, and to compare individually reported cancer cases with historical data if the rules are changed.

Codes

Refer to http://seer.cancer.gov/tools/mphrules/index.html for additional information

00	Single tumor
10	Multiple benign
11	Multiple borderline
12	Benign and borderline
20	Multiple in situ
30	In situ and invasive
31	Polyp and adenocarcinoma
32	FAP with carcinoma
40	Multiple invasive
80	Unknown in situ or invasive
88	NA
99	Unknown

MULTIPLICITY COUNTER

Alternate Name	Item #	Length	Source of Standard	Column #
	446	2	SEER	589-590

Format:
Allowable Values: 01-88, 99
NAACCR Record Section: Cancer Identification
Status: Revised

Description

This data item is used to count the number of tumors (multiplicity) that are reported as a single primary, when present at the time of diagnosis or occurring later.

Rationale

Patients with multiple tumors reported as a single primary for surveillance purposes may have a worse prognosis or more extensive treatment than patients with a single tumor. This data item will make it possible to identify important information about these cases for data analysis.

Codes

(Refer to http://seer.cancer.gov/tools/mphrules/index.html for additional information)

00	No primary tumor identified
01	One tumor only
02	Two tumors present; bilateral ovaries involved with cystic carcinoma
03	Three tumors present
..	
..	
88	Information on multiple tumors not collected/not applicable for this site
89	Multicentric, multifocal, number unknown
99	Unknown if multiple tumors; not documented
Blank	Information not collected for this diagnosis date (e.g., all cases diagnosed prior to 2007)

Note: Codes 00 and 89 were added effective for 2011.

NAACCR RECORD VERSION

Alternate Name	Item #	Length	Source of Standard	Column #
	50	3	NAACCR	17-19

Format:
Allowable Values: 120, 121
NAACCR Record Section: Record ID
Status: Revised

Description

This item applies only to record types I, C, A, and M. Code the NAACCR record version used to create the record. The correction record (U) has its own record version data item.

Rationale

The NAACCR Layout version is necessary to communicate to the recipient of data in NAACCR form where the various items are found and how they are coded. It should be added to the record when the recorded is created.

Codes

120	2010 Version 12
121	2011 Version 12.1

Historically (before 2010), this was a 1-character field with the following codes in column 19:

1	1992-1994 Version 2 and Version 3
4	1995 Version 4.0
5	1996 and 1997 Version 5.0 or Version 5.1
6	1998 Version 6
7	1999 Version 7
8	2000 Version 8
9	2001 and 2002 Version 9 and 9.1
A	2003, 2004, and 2005 Version 10, 10.1, and 10.2
B	2006, 2007, and 2008 Version 11, 11.1, 11.2, and 11.3
Blank	September 1989 Version

Note: Code 4 was assigned to the 1995 Version to synchronize the document version and the layout version numbers. Layout document Versions 2 and 3 are coded as 1.

NAME--ALIAS

Alternate Name	Item #	Length	Source of Standard	Column #
Alias (CoC)	2280	40	CoC	3466-3505

Format:

Allowable Values:
NAACCR Record Section: Record ID
Status

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].

Note: This data item is no longer supported by CoC (as of January 1, 2003). This data item is not found in FORDS. When CoC changed from ROADS to FORDS, this item was dropped.

NAME--FIRST

Alternate Name	Item #	Length	Source of Standard	Column #
First Name (CoC)	2240	40	CoC	3380-3419

Format:
Allowable Values:
NAACCR Record Section: Patient-Confidential
Status

Description
First name of the patient.

Note: The CoC FORDS manual allows this field to be blank. If facilities with CoC-approved cancer programs submit blanks to the central registry, it is suggested that the central registry devise procedures for completing the last and first name with text, such as UNKNOWN, after verifying with the hospital that the field was left intentionally blank.

NAME--LAST

Alternate Name	Item #	Length	Source of Standard	Column #
Last Name (CoC)	2230	40	CoC	3340-3379

Format:
Allowable Values:
NAACCR Record Section: Patient-Confidential
Status

Description
Last name of the patient.

Note: See the most recent FORDS for CoC allowable values.

NAME--MAIDEN

Alternate Name	Item #	Length	Source of Standard	Column #
Maiden Name (CoC)	2390	40	CoC	3506-3545

Format:
Allowable Values:
NAACCR Record Section: Patient-Confidential
Status

Description
Maiden name of female patients who are or have been married.

Rationale
This is used to link reports on a woman who changed her name between reports. It also is critical when using Spanish surname algorithms to categorize ethnicity.

The field should be left blank if the maiden name is not known or not applicable. Since a value in this field may be used by linkage software or other computer algorithms, only legitimate surnames are allowable, and any variation of "unknown" or "not applicable" is not allowable.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

NAME--MIDDLE

Alternate Name	Item #	Length	Source of Standard	Column #
Middle Name (CoC) Middle Initial (pre-96 CoC)	2250	40	CoC	3420-3459

Format:
Allowable Values:
NAACCR Record Section: Patient-Confidential
Status

Description

Middle name or, if middle name is unavailable, middle initial of the patient.

NAME--PREFIX

Alternate Name	Item #	Length	Source of Standard	Column #
Name Prefix (CoC)	2260	3	CoC	3460-3462

Format:
Allowable Values:
NAACCR Record Section: Patient-Confidential
Status

Description

Abbreviated title that precedes name in a letter (e.g., "Rev," "Ms").

Note: This data item is no longer supported by CoC (as of January 1, 2003).

NAME--SPOUSE/PARENT

Alternate Name	Item #	Length	Source of Standard	Column #
	2290	60	NAACCR	3546-3605

Format:
Allowable Values:
NAACCR Record Section: Patient-Confidential
Status

Description

NAACCR has not adopted standards for this item. Use varies by area.

NAME--SUFFIX

Alternate Name	Item #	Length	Source of Standard	Column #
Name Suffix (CoC)	2270	3	CoC	3463-3465

Format:
Allowable Values:
NAACCR Record Section: Patient-Confidential
Status

Description

Title that follows a patient's last name, such as a generation order or credential status (e.g., "MD," "Jr.").

Note: This data item is no longer supported by CoC (as of January 1, 2003).

NEXT FOLLOW-UP SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
Next Follow-Up Method (pre-96 CoC)	1800	1	CoC	2130-2130

Format:
Allowable Values: 0-5, 8, 9
NAACCR Record Section: Follow-up/Recurrence/Death

Status

Description
Identifies the method planned for the next follow-up.

Codes

0	Chart requisition
1	Physician letter
2	Contact letter
3	Phone call
4	Other hospital contact
5	Other, NOS
8	Foreign residents (not followed)
9	Not followed, other cases for which follow-up is not required

---

NHIA DERIVED HISP ORIGIN

Alternate Name	Item #	Length	Source of Standard	Column #
	191	1	NAACCR	418-418

Format:
Allowable Values: 0-8, blank
NAACCR Record Section: Demographic
Status

Description
The NAACCR Hispanic Identification Algorithm (NHIA) uses a combination of standard variables to directly or indirectly classify cases as Hispanic for analytic purposes. It is possible to separate Hispanic ancestral subgroups (e.g., Mexican) when indirect assignment results from birthplace information but not from surname match. The algorithm uses the following standard variables: Spanish/Hispanic Origin [190], Name--Last [2230], Name--Maiden [2390], Birthplace [250], Race 1 [160], IHS Link [192], and Sex [220].

Code 7 (Spanish surname only) of the Spanish/Hispanic Origin [190] data item became effective with 1994 diagnoses. It is recommended that NHIA should be run on 1995 and later diagnoses. However, a central registry may run it on their data for prior years. For greater detail, please refer to the technical documentation: http://www.naaccr.org/dat#NHIA.

Rationale
Sometimes despite best efforts to obtain complete information directly from the medical record, information is not available and is reported to the cancer registry as a missing data item. With regard to Hispanic ethnicity, some cancer registries have found it necessary to rely on indirect methods to populate this data element. Registries often have significant numbers or proportions of Hispanic populations in their jurisdiction.

Codes

0	Non-Hispanic
1	Mexican, by birthplace or other specific identifier
2	Puerto Rican, by birthplace or other specific identifier
3	Cuban, by birthplace or other specific identifier
4	South or Central American (except Brazil), by birthplace or other specific identifier
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic), by birthplace or other specific identifier
6	Spanish, NOS; Hispanic, NOS; Latino, NOS
7	NHIA surname match only
8	Dominican Republic
Blank	Algorithm has not been run

Note: Code 8 was added in Standards Volume II Version 10.2 effective January 2005.

NPI--ARCHIVE FIN

Alternate Name	Item #	Length	Source of Standard	Column #
	3105	10	CMS	711-720

Format:
Allowable Values: 10-digit NPI code (9-digit NPI integer plus 1 check digit), blank

NAACCR Record Section: Hospital-Specific
Status

Description

This field identifies the NPI number (National Provider Identifier) of the facility at the time it initially accessioned the tumor.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale

The NPI-Archive FIN is the functional equivalent of Archive FIN [3100].

Codes

Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

NPI--FOLLOWING REGISTRY

Alternate Name	Item #	Length	Source of Standard	Column #
	2445	10	CMS	4285-4294

Format:
Allowable Values: 10-digit NPI code (9-digit NPI integer plus 1 check digit), blank
NAACCR Record Section: Hospital-Confidential
Status

Description

The NPI (National Provider Identifier) code that records the registry responsible for following the patient.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale

The NPI equivalent of Following Registry [2440].

Codes

Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

NPI--INST REFERRED FROM

Alternate Name	Item #	Length	Source of Standard	Column #
	2415	10	CMS	4305-4314

Format:
Allowable Values: 10-digit NPI code (9-digit NPI integer plus 1 check digit), blank
NAACCR Record Section: Hospital-Confidential
Status

Description

The NPI (National Provider Identifier) code that identifies the facility that referred the patient to the reporting facility.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale

The NPI equivalent of Institution Referred From [2410].

Codes

Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at:

https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

NPI--INST REFERRED TO

Alternate Name	Item #	Length	Source of Standard	Column #
	2425	10	CMS	4325-4334

Format:
Allowable Values: 10-digit NPI code (9-digit NPI integer plus 1 check digit), blank
NAACCR Record Section: Hospital-Confidential
Status

Description
The NPI (National Provider Identifier) code that identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI equivalent of Institution Referred To [2420].

Codes
Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

NPI--PHYSICIAN 3

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation Oncologist (CoC)	2495	10	CMS	4449-4458

Format:
Allowable Values: 10-digit NPI code (9-digit NPI integer plus 1 check digit), blank
NAACCR Record Section: Other-Confidential
Status

Description
The NPI (National Provider Identifier) code for another physician involved in the care of the patient.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI equivalent of Physician 3 [2490].

Codes
Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

NPI--PHYSICIAN 4

Alternate Name	Item #	Length	Source of Standard	Column #
Medical Oncologist (CoC)	2505	10	CMS	4467-4476

Format:
Allowable Values: 10-digit NPI code (9-digit NPI integer plus 1 check digit), blank
NAACCR Record Section: Other-Confidential
Status

Description
The NPI (National Provider Identifier) code for another physician involved in the care of the patient.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large

practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale

The NPI equivalent of Physician 4 [2500].

Codes

Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

NPI--PHYSICIAN--FOLLOW-UP

Alternate Name	Item #	Length	Source of Standard	Column #
	2475	10	CMS	4413-4422

Format:
Allowable Values: 10-digit NPI code (9-digit NPI integer plus 1 check digit), blank
NAACCR Record Section: Other-Confidential
Status

Description

The NPI (National Provider Identifier) code for the physician currently responsible for the patient's medical care.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale

The NPI equivalent of Physician--Follow-Up [2470].

Codes

Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

NPI--PHYSICIAN--MANAGING

Alternate Name	Item #	Length	Source of Standard	Column #
	2465	10	CMS	4395-4404

Format:
Allowable Values: 10-digit NPI code (9-digit NPI integer plus 1 check digit), blank
NAACCR Record Section: Other-Confidential
Status

Description

The NPI (National Provider Identifier) code that identifies the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale

The NPI equivalent of Physician--Managing [2460].

Codes

Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

NPI--PHYSICIAN--PRIMARY SURG

Alternate Name	Item #	Length	Source of Standard	Column #
	2485	10	CMS	4431-4440

Format:
Allowable Values: 10-digit NPI code (9-digit NPI integer plus 1 check digit), blank
NAACCR Record Section: Other-Confidential
Status

Description

The NPI (National Provider Identifier) code for the physician who performed the most definitive surgical procedure.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale

The NPI equivalent of Physician--Primary Surg [2480].

Codes

Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

NPI--REGISTRY ID

Alternate Name	Item #	Length	Source of Standard	Column #
	45	10	CMS	20-29

Format:
Allowable Values: 10-digit NPI code (9-digit NPI integer plus 1 check digit), blank
NAACCR Record Section: Record ID
Status

Description

The NPI (National Provider Identifier) code that represents the data transmission source. This item stores the NPI of the facility registry that transmits the record.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.
If the transmission source is not a health care provider or a covered entity, this item will be blank and the item Registry ID [40] should be used to identify the transmission source.

Rationale

The NPI equivalent of Registry ID [40].

Codes

Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

NPI--REPORTING FACILITY

Alternate Name	Item #	Length	Source of Standard	Column #
	545	10	CMS	691-700

Format:
Allowable Values: 10-digit NPI code (9-digit NPI integer plus 1 check digit), blank
NAACCR Record Section: Hospital-Specific
Status

Description

The NPI (National Provider Identifier) code for the facility submitting the data in the record.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale

The NPI equivalent of Reporting Facility [540].

Codes
Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

NUMBER OF TUMORS/HIST

Alternate Name	Item #	Length	Source of Standard	Column #
	447		Retired	

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description
The NAACCR UDSC retired this data item in Version 11.2, effective January 1, 2008.

OCCUP/IND CODING SYSTEM

Alternate Name	Item #	Length	Source of Standard	Column #
	330	1	NPCR	417-417

Format:
Allowable Values: 1-4, 7, 9, blank
NAACCR Record Section: Demographic
Status

Description
Code that identifies coding system used for occupation and industry. This is a central cancer registry data item (i.e. codes should be applied by a central or regional registry rather than collected from reporting facilities).

Codes

1	1970 Census
2	1980 Census
3	1990 Census
4	2000 Census
7	Other coding system
9	Unknown coding system
Blank	Not collected

Note: 2000 Census codes for occupation and industry are recommended for tumors diagnosed on or after January 1, 2003. Supplement 26. The 1990 Census codes are recommended for tumors diagnosed before January 1, 2003. Supplement 24. For more information, see the U.S. Bureau of the Census website at: http://www.census.gov/hhes/www/ioindex/ioindex.html.

OCCUPATION CODE--CENSUS

Alternate Name	Item #	Length	Source of Standard	Column #
	270	3	Census/NPCR	209-211

Format: Right justified, zero filled
Allowable Values: Reference Industry and Occupation Coding for Death Certificates
NAACCR Record Section: Demographic
Status

Description
Code for the patient's usual occupation, using U.S. Census Bureau codes (2000 Census Supplement 26 is preferable) according to coding procedures recommended for death certificates, Supplement 25. This data item applies only to patients who are age 14 years or older at the time of diagnosis.

Rationale
Use of the Census Bureau classification system improves consistency of data collected from multiple sources. The Census Bureau occupation classification system is used for coding occupation information from death certificates and from the U.S. Census of Population. The system includes specific coding rules.²²⁻²⁷

Codes

For the 1990 Census codes, see Instructional Manual Part 19: Industry and Occupation Coding for Death Certificates, 1999, Supplement 23 and related materials in the reference list, Chapter VI.A similar instruction manual for the 2000 Census codes has not been developed. Software for automated coding of occupation and industry is available from the Division of Safety Research, National Institute for Occupational Safety and Health, CDC. Contact Suzanne Marsh at (304) 285-6009 or at smm2@cdc.gov.As of press time, NIOSH was updating their automated coding software. The contact person for this software (which probably will not be available until after January 1, 2011) is Sue Nowlin, who can be contacted at sxn1@cdc.gov or (513) 841-4467.

Note: Occupation/industry coding should NOT be performed by reporting facilities. This is a central registry data item. Specially trained and qualified personnel should perform coding.

2000 Census codes for occupation and industry are recommended for cancers diagnosed on or after Januar1, 2003. Supplement 26. The 1990 Census codes are recommended for cancers diagnosed before January 1, 2003, Supplement 24. For more information, see the U.S. Bureau of the Census website at: http://www.census.gov/hhes/www/ioindex/ioindex.html.

OCCUPATION SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
	290	1	NPCR	215-215

Format:
Allowable Values: 0-3, 7-9, blank
NAACCR Record Section: Demographic
Status

Description

Code that best describes the source of occupation information provided on this patient. This is a central cancer registry data item (i.e., codes should be applied by a central or regional registry rather than collected from reporting facilities).

Rationale

Occupation information may come from a variety of sources. The most valid and reliable source of occupation information for patients has not yet been determined.

Codes

0	Unknown occupations/ no occupation available
1	Reporting facility records
2	Death certificate
3	Interview
7	Other source
8	Not applicable, patient less than 14 years of age at diagnosis
9	Unknown source
Blank	Not collected

OTHER STAGING SYSTEM

Alternate Name	Item #	Length	Source of Standard	Column #
	1070			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

OVER-RIDE ACSN/CLASS/SEQ

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Accession/Class of Case/Sequence	1985	1	CoC	1891-1891

Format:
Allowable Values: 1 or blank

NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software: Accession Number, Class of Case, Seq Number (CoC).

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Data Standards and Dictionary Volume II, Chapter IV, Recommended Data Edits and Software Coordination of Standards for more information.

Over-ride Flag as Used in the EDITS Software Package-The edit, Accession Number, Class of Case, Seq Number (CoC), checks the following:

1. If the case is the only case or the first of multiple cases diagnosed at the facility (Sequence Number--Hospital = 00, 01, 60, or 61, and Class of Case = 00, 10-14, or 40), then the first 4 characters of the Accession Number--Hosp must equal the year of the Date of 1st Contact.
2. If the case is first diagnosed at autopsy (Class of Case = 38) and the case is the only case or the first of multiple cases for a patient (Sequence Number--Hospital = 00, 01, 60, or 61), then the first 4 characters of the Accession Number--Hosp must equal the year of the Date of Last Contact AND must equal the year of the Date of 1st Contact.
3. If the case is first diagnosed at autopsy (Class of Case = 38) and the case is not the first case for a patient (Sequence Number--Hospital) greater than 01 or greater than 61), then the year of the Date of 1st Contact must equal the year of Date of Last Contact.

There are some exceptions to the above rules. Over-ride Acsn/Class/Seq may be used to override the edit when the circumstances fit the following situation or one similar to it:

1. The case may be the only or the first of multiple malignant cases for a patient (Sequence Number--Hospital = 00 or 01), but there is an earlier benign case (with an earlier year of the Date of 1st Contact) to which the Accession Number--Hosp applies.

Codes

Instructions for Coding

1. If edit generates an error or warning message, verify that the Accession Number--Hosp, Sequence Number--Hospital and Class of Case are correct.
2. Leave blank if the program does not generate an error message for the edit Accession Number, Class of Case, Seq Number (CoC).
3. Leave blank and correct any errors for the case if an item is discovered to be incorrect.
4. Code 1 if review of accession number, sequence number and class of case verifies that they have been coded correctly and there is an unusual combination of these data items.

1 Reviewed and confirmed as reported

Blank Not reviewed or reviewed and corrected

OVER-RIDE AGE/SITE/MORPH

Alternate Name	Item #	Length	Source of Standard	Column #
Age/Site/Histology Interfield Review (Interfield Edit 15) (SEER #3)	1990	1	SEER	1896-1896

Format:
Allowable Values: 1-3 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Age, Primary Site, Morphology ICDO2 (SEER IF15)
- Age, Primary Site, Morphology ICDO3 (SEER IF15)
- Age, Primary Site, Morph ICDO3--Adult (SEER)
- Age, Primary Site, Morph ICDO3--Pediatric (NPCR)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV,

Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package for some cancers which occur almost exclusively in certain age groups. Edits of the type Age, Primary Site, Morphology require review if a site/morphology combination occurs in an age group for which it is extremely rare. The edit Age, Primary Site, Morph ICDO3--Adult (SEER) edits cases with an Age at Diagnosis of 15 and older. The edit Age, Primary Site, Morph ICDO3--Pediatric (NPCR) edits cases with an Age at Diagnosis of less than 15. The edits Age, Primary Site, Morphology ICDO2 (SEER IF15) and Age, Primary Site, Morphology ICDO3 (SEER IF15) contain logic for all ages.

Codes

Instructions for Coding

1. Leave blank if the program does not generate an error message (and if the case was not diagnosed in utero for the edits of the type Age, Primary Site, Morphology.
2. Correct any errors for the case if an item is discovered to be incorrect.
3. Code 1 or 3 as indicated if review of items in the error or warning message confirms that all are correct.

1	Reviewed and confirmed that age/site/histology combination is correct as reported
2	Reviewed and confirmed that case was diagnosed in utero
3	Reviewed and confirmed that conditions 1 and 2 both apply
Blank	Not reviewed or reviewed and corrected.

OVER-RIDE COC-SITE/TYPE

Alternate Name	Item #	Length	Source of Standard	Column #
	1987	1	CoC	1893-1893

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Primary Site, Morphology-Type ICDO2 (CoC)
- Primary Site, Morphology-Type ICDO3 (CoC)
- Primary Site, Morphology-Type, Behavior ICDO3 (CoC)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package:
Multiple versions of edits of the type Primary Site, Morphology-Type check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus, uses a different over-ride flag. The CoC version of the edit will accept Over-ride CoC Site/Type or Over-ride Site/Type (the SEER edit) as equivalent. The Site/Histology validation list (available on the SEER web site) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not included. These edits require review of all combinations not listed.

Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if primary site is in the range C440-C449 (skin), and ICD-O-2 histology is in the range 8000-8004 (neoplasms, malignant, NOS), 8010-8045 (epithelial carcinomas), 8050-8082 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), or ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No over-ride is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether the combination is biologically plausible or whether cancer registry coding conventions would allow different codes for the diagnosis. Review of these rare combinations often results in a change to either the site or histology.

Codes

Instructions for Coding

1. Leave blank if the program does not generate an error message for the CoC edits of the type Primary Site, Morphology-Type.
2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.
3. Code 1 if review of all items in the error or warning message confirms they are correct and coded in conformance with coding rules.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 1

Alternate Name	Item #	Length	Source of Standard	Column #
	3750	1	AJCC	2016-2016

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 10

Alternate Name	Item #	Length	Source of Standard	Column #
	3759	1	AJCC	2025-2025

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 11

Alternate Name	Item #	Length	Source of Standard	Column #
	3760	1	AJCC	2026-2026

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 12

Alternate Name	Item #	Length	Source of Standard	Column #
	3761	1	AJCC	2027-2027

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 13

Alternate Name	Item #	Length	Source of Standard	Column #
	3762	1	AJCC	2028-2028

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 14

Alternate Name	Item #	Length	Source of Standard	Column #
	3763	1	AJCC	2029-2029

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 15

Alternate Name	Item #	Length	Source of Standard	Column #
	3764	1	AJCC	2030-2030

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 16

Alternate Name	Item #	Length	Source of Standard	Column #
	3765	1	AJCC	2031-2031

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 17

Alternate Name	Item #	Length	Source of Standard	Column #
	3766	1	AJCC	2032-2032

Format:

Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 18

Alternate Name	Item #	Length	Source of Standard	Column #
	3767	1	AJCC	2033-2033

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 19

Alternate Name	Item #	Length	Source of Standard	Column #
	3768	1	AJCC	2034-2034

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 2

Alternate Name	Item #	Length	Source of Standard	Column #
	3751	1	AJCC	2017-2017

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 20

Alternate Name	Item #	Length	Source of Standard	Column #
	3769	1	AJCC	2035-2035

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 3

Alternate Name	Item #	Length	Source of Standard	Column #
	3752	1	AJCC	2018-2018

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 4

Alternate Name	Item #	Length	Source of Standard	Column #
	3753	1	AJCC	2019-2019

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 5

Alternate Name	Item #	Length	Source of Standard	Column #
	3754	1	AJCC	2020-2020

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 6

Alternate Name	Item #	Length	Source of Standard	Column #
	3755	1	AJCC	2021-2021

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 7

Alternate Name	Item #	Length	Source of Standard	Column #
	3756	1	AJCC	2022-2022

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 8

Alternate Name	Item #	Length	Source of Standard	Column #
	3757	1	AJCC	2023-2023

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE CS 9

Alternate Name	Item #	Length	Source of Standard	Column #
	3758	1	AJCC	2024-2024

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: New

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE HISTOLOGY

Alternate Name	Item #	Length	Source of Standard	Column #
Histology/Behavior Interfield Review (Field Item Edit Morph)	2040	1	SEER	1901-1901

Format:
Allowable Values: 1-3 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Diagnostic Confirmation, Behavior ICDO2 (SEER IF31)
- Diagnostic Confirmation, Behavior ICDO3 (SEER IF31)
- Morph (1973-91) ICD-O-1 (SEER MORPH)
- Morphology--Type/Behavior ICDO2 (SEER MORPH)
- Morphology--Type/Behavior ICDO3 (SEER MORPH)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flags as Used in the EDITS Software Package. Edits of the type Diagnostic Confirmation, Behavior differ in the use of ICD-O-2 or ICD-O-3 and check that, for in situ cases (Behavior = 2), Diagnostic Confirmation specifies microscopic confirmation (1, 2, or 4).

The distinction between in situ and invasive is very important to a registry, since prognosis is so different. Since the determination that a neoplasm has not invaded surrounding tissues, i.e., in situ, is made microscopically, cases coded in situ in behavior should have a microscopic confirmation code. However, very rarely, a physician will designate a case noninvasive or in situ without microscopic evidence.

If an edit of the type, Diagnostic Confirmation, Behavior, gives an error message or warning, check that Behavior and Diagnostic Confirmation have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding.

Edits of the type, Morphology--Type/Behavior, perform the following check:

1. Codes listed in ICD-O-2 or ICD-O-3 with behavior codes of only 0 or 1 are considered valid, since the behavior matrix of ICD-O-2 and ICD-O-3 allows for the elevation of the behavior of such histologies when the tumor is in situ or malignant. This edit forces review of these rare cases to verify that they are indeed in situ or malignant.
2. The following histologies are generally not accepted as in situ: ICD-O-2 histologies 8000-8004, 8020, 8021, 8331, 8332, 8800-9054, 9062, 9082, 9083, 9110-9491, 9501-9989, ICD-O-3 histologies 8000-8005, 8020, 8021, 8331, 8332,8800-9055, 9062, 9082, 9083, 9110-9493, 9501-9989. This edit forces review of these cases.
3. If a Morphology-Type/Behavior edit produces an error or warning message and the case is one in which the 4-digit morphology code is one that appears in ICD-O-2 or ICD-O-3 only with behavior codes of 0 or 1, or the case is one in which the 4-digit morphology code is not generally accepted with a behavior code of 2, verify the coding of morphology and that the behavior should be coded malignant or in situ. The registrar may need to consult a pathologist or medical advisor in problem cases.
4. Grade 5-8 with histologies not in the range of 9590-9948 is impossible.
5. Some terms in ICD-O-2 and ICD-O-3 carry an implied statement of grade. These histologies must be reported with the correct grade as stated below. An error of this type cannot be over-ridden.
   ICD-O-2
   - 8020/34 Carcinoma, undifferentiated
   - 8021/34 Carcinoma, anaplastic
   - 8331/31 Follicular adenocarcinoma, well differentiated
   - 8851/31 Liposarcoma, well differentiated

- 9062/34 Seminoma, anaplastic
- 9082/34 Malignant teratoma, undifferentiated
- 9083/32 Malignant teratoma, intermediate type
- 9401/34 Astrocytoma, anaplastic
- 9451/34 Oligodendroglioma, anaplastic
- 9511/31 Retinoblastoma, differentiated
- 9512/34 Retinoblastoma, undifferentiated

ICD-O-3

- 8020/34 Carcinoma, undifferentiated
- 8021/34 Carcinoma, anaplastic
- 8331/31 Follicular adenocarcinoma, well differentiated
- 9082/34 Malignant teratoma, undifferentiated
- 9083/32 Malignant teratoma, intermediate type
- 9401/34 Astrocytoma, anaplastic
- 9451/34 Oligodendroglioma, anaplastic
- 9511/31 Retinoblastoma, differentiated
- 9512/34 Retinoblastoma, undifferentiated

Exceptions:
If year of Date of Diagnosis > 2000, then a behavior code of 1 is valid for the following ICD-O-2 histologies and no over-ride flag is needed: 8931, 9393, 9538, 9950, 9960-9962, 9980-9984, and 9989. Similarly, the following ICD-O-3 histologies are valid with a behavior code of 1: 8442, 8451, 8462, 8472, and 8473.

If year of Date of Diagnosis > 2003, the following ICD-O-3 benign histologies will pass without review: 8146, 8271, 8861,8897, 9121, 9122, 9131, 9161, 9350, 9351, 9352, 9360, 9361, 9383, 9384, 9394, 9412, 9413, 9444, 9492, 9493, 9506, 9531, 9532, 9533, 9534, 9537, 9541, 9550, 9562, and 9570.

Codes
Instructions for Coding: Leave blank if the program does not generate an error message for the edits of the types, Diagnostic Confirmation, Behav Code or Morphology--Type/Behavior.

1	Reviewed and confirmed that the pathologist states the primary to be “in situ” or “malignant” although the behavior code of the histology is designated as “benign” or “uncertain” in ICD-O-2 or ICD-O-3
2	Reviewed and confirmed that the behavior code is “in situ” but the case is not microscopically confirmed
3	Reviewed and confirmed that conditions 1 and 2 both apply
Blank	Not reviewed or reviewed and corrected

OVER-RIDE HOSPSEQ/DXCONF

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Hospital Sequence/Diagnostic Confirmation	1986	1	CoC	1892-1892

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software: Diagnostic Confirm, Seq Num--Hosp (CoC)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package, The edit, Diagnostic Confirm, Seq Num--Hosp (CoC), does the following:

1. If any case is one of multiple primaries and is not microscopically confirmed or lacks a positive lab test/marker study, i.e., Diagnostic Confirmation > 5 and Sequence Number--Hospital > 00 (more than one primary), review is required.
2. If Primary Site specifies an ill-defined or unknown primary (C760-C768, C809), no further checking is done.
3. If Sequence Number--Hospital is in the range of 60-88, this edit is skipped.

It is important to verify that the non-microscopically confirmed case is indeed a separate primary from any others that may have been reported. This edit forces review of multiple primary cancers when one of the primaries is coded to a site other than ill-defined or unknown and is not microscopically confirmed or confirmed by a positive lab test/marker study.

1. If the suspect case is confirmed accurate as coded and if the number of primaries is correct, set the Over-ride HospSeq/ DxConf to 1. Do not set the over-ride flag on the patient's other primary cancers.
2. If it turns out that the non-microscopically confirmed cancer is considered a manifestation of one of the patient's other cancers, delete the non-microscopically confirmed case. Check the sequence numbers of remaining cases, correcting them if necessary. Also check for other data items on the remaining cases that may need to be changed as a result of the corrections, such as stage and treatment.

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Diagnostic Confirm, Seq Num--Hosp (CoC).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE HOSPSEQ/SITE

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Hospital Sequence/Site	1988	1	CoC	1894-1894

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Seq Num--Hosp, Primary Site, Morph ICDO2 (CoC)
- Seq Num--Hosp, Primary Site, Morph ICDO3 (CoC)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: Edits of the type Seq Num--Hosp, Primary Site, Morph differ in use of ICD-O-2 or ICD-O-3 morphology. They force review of multiple primary cancers when one of the primaries is coded to a site/morphology combination that could indicate a metastatic site rather than a primary site.

1. If Sequence Number--Hospital indicates the person has had more than one primary, then any case with one of the following site/histology combinations requires review:
2. C760-C768 (ill-defined sites) or C809 (unknown primary) and ICD-O-2 or ICD-O-3 histology < 9590. Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of “abdominal carcinomatosis” may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry, and should not be entered as a second primary.
3. C770-C779 (lymph nodes) and ICD-O-2 histology not in range 9590-9717 or ICD-O-3 histology not in the range 9590-9729; or C420-C424 and ICD-O-2 histology not in range 9590-9941 or ICD-O-3 histology not in the range 9590-9989. That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.
4. Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741 or ICD-O-3 histology in the range 9740-9758. Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.
5. If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for an edit of the type Seq Num--Hosp, Primary Site, Morph.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that hospital sequence number and site are both correct.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE ILL-DEFINE SITE

Alternate Name	Item #	Length	Source of Standard	Column #
Sequence Number/Ill-defined Site Interfield Review (Interfield Edit 22)	2060	1	SEER	1903-1903

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Seq Num--Central, Prim Site, Morph ICDO2 (SEER IF22)
- Seq Num--Central, Prim Site, Morph ICDO3 (SEER IF22)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: Edits of the type Seq Num--Central, Primary Site, Morph differ in use of ICD-O-2 or ICD-O-3 morphology. They force review of multiple primary cancers when one of the primaries is coded to a site/morphology combination that could indicate a metastatic site rather than a primary site.

1. If Sequence Number-Central indicates the person has had more than one primary, then any case with one of the following site/histology combinations requires review:
2. C760-C768 (ill-defined sites) or C809 (unknown primary) and ICD-O-2 or ICD-O-3 histology < 9590. Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of “abdominal carcinomatosis” may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry, and should not be entered as a second primary.
3. C770-C779 (lymph nodes) and ICD-O-2 histology not in the range 9590-9717 or ICD-O-3 histology not in the range 9590-9729; or C420-C424 and ICD-O-2 histology not in the range 9590-9941 or ICD-O-3 histology not in the range 9590-9989. That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.
4. Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741 or ICD-O-3 histology in the range 9740-9758. Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.
5. If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

Codes

Instructions for Coding

- Code 1 can be used if a second or subsequent primary reporting with an ill-defined primary site has been reviewed and is indeed an independent primary.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

1	Reviewed and confirmed as reported: a second or subsequent primary reported with an ill-defined primary site (C76.0-C76.8, C80.9) has been reviewed and is an independent primary
Blank	Not reviewed or reviewed and corrected

OVER-RIDE LEUK, LYMPHOMA

Alternate Name	Item #	Length	Source of Standard	Column #
Leukemia or Lymphoma/Diagnostic Confirmation Interfield Review (Interfield Edit 48)	2070	1	SEER	1904-1904

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Diagnostic Confirmation, Histology ICDO2 (SEER IF48)
- Diagnostic Confirmation, Histology ICDO3 (SEER IF48)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: Edits of the type Diagnostic Confirmation, Histology differ in use of ICD-O-2 or ICD-O-3 and check the following:

1. Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma that have diagnostic confirmation of direct visualization or clinical, and any leukemia with a diagnostic confirmation of direct visualization.
2. If histology = 9590-9717 for ICD-O-2 or 9590-9729 for ICD-O-3 (lymphoma) then Diagnostic Confirmation cannot be 6 (direct visualization) or 8 (clinical).
3. If histology = 9720-9941 for ICD-O-2 or 9731-9948 for ICD-O-3 (leukemia and other) then Diagnostic Confirmation cannot be 6 (direct visualization).

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for the edits of the type Diagnostic Confirmation, Histology.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- If the edit produces an error or warning message, verify that the ICD-O-2 or ICD-O-3 histology and diagnostic confirmation are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in Diagnostic Confirmation) for leukemia.
- Code 1 indicates that a review has taken place and histologic type and diagnostic confirmation are correctly coded.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE REPORT SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
Type of Reporting Source/Sequence Number Interfield Review (Interfield Edit 04) (Seer #7)	2050	1	SEER	1902-1902

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Type of Rep Srce(DC),Seq Num--Cent, ICDO2 (SEER IF04)
- Type of Rep Srce(DC),Seq Num--Cent, ICDO3 (SEER IF04)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Date Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: Edits of the type 'Type of Rep Srce (DC), Seq Num--Cent' checks that if the case is a death-certificate-only case and the histology is not a lymphoma, leukemia, immunoproliferative or myeloproliferative disease (ICD-O-2 or ICD-O-3 histology is less than 9590), then the tumor sequence number must specify one primary only (sequence '00').

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for the report source edit.
- Code 1 if review of type of reporting source, histologic type and tumor sequence number verified that a second or subsequent primary with a reporting source of death-certificate-only has been reviewed and is indeed an independent primary.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SEQNO/DXCONF

Alternate Name	Item #	Length	Source of Standard	Column #
Sequence Number/Diagnostic Confirmation Interfield Review (Interfield Edit 23)	2000	1	SEER	1897-1897

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software: Diagnostic Confirm, Seq Num--Central (SEER IF23).

Rationale

Some edits check for code combinations that are impossible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: The edit checks if the case is one of multiple primaries and is not microscopically confirmed or has only positive lab test/marker studies (i.e., Diagnostic Confirmation >5) and tumor sequence number >00 (more than one primary). The edit is skipped if the Sequence Number--Central is in the range of 60-99.

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for the Diagnostic Confirmation and Sequence Number Central edit.
- Code 1 if the cases have been reviewed and it is verified that there are multiple primaries of specific sites in which at least one diagnosis has not been microscopically confirmed.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SITE/BEHAVIOR

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Flag for Site/Behavior (IF39)	2071	1	SEER	1905-1905

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Primary Site, Behavior Code ICDO2 (SEER IF39)
- Primary Site, Behavior Code ICDO3 (SEER IF39)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: Edits of the type, Primary Site, Behavior Code, require review of the following primary sites with a behavior of in situ (ICD-O-2 or ICD-O-3 behavior = 2):

1.	C269	Gastrointestinal tract, NOS
2.	C399	Ill-defined sites within respiratory system

3. C559 Uterus, NOS
4. C579 Female genital tract, NOS
5. C639 Male genital organs, NOS
6. C689 Urinary system, NOS
7. C729 Nervous system, NOS
8. C759 Endocrine gland, NOS
9. C760-C768 Ill-defined sites
10. C809 Unknown primary site

Since the designation of in situ is very specific and almost always requires microscopic confirmation, ordinarily specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being in situ is reliable.

If an in situ diagnosis is stated, try to obtain a more specific primary site. A primary site within an organ system can sometimes be identified based on the diagnostic procedure or treatment given or on the histologic type. If no more specific site can be determined, it is usually preferable to code a behavior code of 3. In the exceedingly rare situation in which it is certain that the behavior is in situ and no more specific site code is applicable, set Over-ride Site/Behavior to 1.

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Primary Site, Behavior Code ICDO2 (SEER IF39) and/or the edit Primary Site, Behavior Code ICDO3 (SEER IF39).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of site and behavior verifies that the patient has an in situ cancer of a nonspecific site and no further information about the primary site is available.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

Note: The IF 39 edit does not allow in situ cases of nonspecific sites, such as gastrointestinal tract, NOS; uterus, NOS; female genital tract, NOS; male genital organs, NOS; and others. The over-ride indicates that the conflict has been reviewed.

OVER-RIDE SITE/EOD/DX DT

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Flag for Site/EOD/Diagnosis Date (IF40) (SEER #13)	2072	1	SEER	1906-1906
Over-ride Flag for Site/CS Extension/Diagnosis Date (IF176)				

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Primary Site, EOD, ICDO2 (SEER IF40)
- Primary Site, EOD, ICDO3 (SEER IF40)
- Primary Site, CS Extension (SEER IF 176)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: Edits of this type Primary Site, EOD do not allow “localized” disease with nonspecific sites, such as mouth, NOS; colon, NOS (except ICD-O-2 or ICD-O-3 histology 8210, 8220, 8261, or 8263); bone, NOS; female genital system, NOS; male genital organs, NOS; and others.

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Primary Site, EOD, ICDO2 (SEER IF40) and/or the edit Primary Site, EOD, ICDO3 (SEER IF40).
- Code 1 if the case has been reviewed and it has been verified that the patient had “localized” disease with a nonspecific site and no further information about the primary site is available.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SITE/LAT/EOD

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Flag for Site/Laterality/EOD (IF41)	2073	1	SEER	1907-1907
Over-ride Flag for Site/Laterality/CS Extension (IF177)				

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Primary Site, Laterality, EOD, ICDO2 (SEER IF41)
- Primary Site, Laterality, EOD, ICDO3 (SEER IF41)
- Primary Site, Laterality, CS Extension (SEER IF177)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: Edits of this type Primary Site, Laterality, EOD apply to paired organs and do not allow EOD to be specified as in situ, localized, or regional by direct extension if laterality is coded as “bilateral, site unknown,” or “laterality unknown.”

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Primary Site, Laterality, EOD, ICDO2 (SEER IF41) and/or Primary Site, Laterality, EOD, ICDO3 (SEER IF41).
- Code 1 if the case has been reviewed and it has been verified that the patient had laterality coded nonspecifically and EOD coded specifically.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SITE/LAT/MORPH

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Flag for Site/Laterality/Morphology (IF42)	2074	1	SEER	1908-1908

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Laterality, Primary Site, Morph ICDO2 (SEER IF42)
- Laterality, Primary Site, Morph ICDO3 (SEER IF42)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: Edits of the type Laterality, Primary Site, Morph differ in use of ICD-O-2 or ICD-O-3 morphology and do the following:

1. If the Primary Site is a paired organ and ICD-O-2 or ICD-O-3 behavior is in situ (2), then laterality must be 1, 2, or 3.
2. If diagnosis year less than 1988 and ICD-O-2 or ICD-O-3 histology ≥ 9590, no further editing is performed.
3. If diagnosis year greater than 1987 and ICD-O-2 or ICD-O-3 histology = 9140, 9700, 9701, 9590-9980, no further editing is performed.
4. The intent of this edit is to force review of in situ cases for which laterality is coded 4 (bilateral) or 9 (unknown laterality) as to origin.
5. In rare instances when the tumor is truly midline (9) or the rare combination is otherwise confirmed correct, enter a code 1 for Override Site/Lat/Morph.

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Laterality, Primary site, Morph ICDO2 (SEER IF 42) and/or the edit Laterality, Primary site, Morph ICDO3 (SEER IF42).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of site, laterality and morphology verifies that the case had behavior code of “in situ” and laterality is not stated as “right: origin of primary;” “left: origin of primary;” or “only one side involved, right or left origin not specified”.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SITE/LAT/SEQNO

Alternate Name	Item #	Length	Source of Standard	Column #
Site/Histology/Laterality/Sequence Number Interrecord Review (Interrecord Edit 09)	2010	1	SEER	1898-1898

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following Interrecord Edit from the SEER Program: Verify Same Primary Not Reported Twice for a Person (SEER IR09). Presently, documentation on interrecord edits is not included in the EDITS software.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: Verify Same Primary Not Reported Twice for a Person (SEER IR09) applies to paired organs and does not allow two cases with the same primary site group, laterality and three digit histology code. This edit verifies that the same primary is not reported twice for a person.

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Verify Same Primary Not Reported twice for a Person (SEER IR09).
- Code 1 if the case has been reviewed and it has been verified that the patient had multiple primaries of the same histology (3 digit) in the same primary site group.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SITE/TNM-STGGRP

Alternate Name	Item #	Length	Source of Standard	Column #
	1989	1	CoC	1895-1895

Format:
Allowable Values: 1 or blank

NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software: Primary Site, AJCC Stage Group - Ed 6, ICDO3 (CoC).

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: The edit, Primary Site, AJCC Stage Group - Ed 6, ICDO3 (CoC), checks that the pathologic and clinical AJCC stage group codes are valid for the site and histology group according to the AJCC Cancer Staging Manual Sixth Edition, using the codes described for the items TNM Clin Stage Group [970] and TNM Path Stage Group [910]. Combinations of site and histology not represented in any AJCC schema must be coded 88. Unknown stage groups must be coded 99. Blanks are not permitted.

Since pediatric cancers whose sites and histologies have an AJCC scheme may be coded according to a pediatric scheme instead, Override Site/TNM-Stage Group is used to indicate pediatric cases not coded according to the AJCC manual. Pediatric Stage groups should not be recorded in the TNM Clin Stage Group or TNM Path Stage Group items. When neither clinical nor pathologic AJCC staging is used for pediatric cases, code all AJCC items 88. When any components of either is used to stage a pediatric case, follow the instructions for coding AJCC items and leave Override Site/TNM-Stage Group blank.

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit, Primary Site, AJCC Stage Group - Ed6, ICDO3 (CoC).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case is confirmed to be a pediatric case that was coded using a pediatric coding system.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SITE/TYPE

Alternate Name	Item #	Length	Source of Standard	Column #
Site/Type Interfield Review (Interfield Edit 25)	2030	1	SEER	1900-1900

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Primary Site, Morphology-Type ICDO2 (CoC)
- Primary Site, Morphology-Type ICDO3 (CoC)
- Primary Site, Morphology-Type ICDO2 (SEER IF25)
- Primary Site, Morphology-Type ICDO3 (SEER IF25)
- Primary Site, Morphology-Type, Behavior ICDO3 (SEER IF25)
- Primary Site, Morphology-Type, Behavior ICDO3 (CoC)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: Multiple versions of edits of the type Primary site, Morphology-Type check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different over-ride flag. The CoC version of the edit will accept Over-ride CoC-Site/Type or Over-ride Site/Type as equivalent.

1. The Site/Histology validation list (available on the SEER web site) contains those histologies commonly found in the specified

primary site. Histologies that occur only rarely or never are not included. These edits require review of all combinations not listed.

2. Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if Primary Site is in the range C440-C449 (skin), and ICD-O-2 histology is in the range 8000-8004 (neoplasms, malignant, NOS), 8010-8045 (epithelial carcinomas), 8050-8082 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), or ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No over-ride is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether a) the combination is biologically implausible, or b) there are cancer registry coding conventions that would dictate different codes for the diagnosis. Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for the edits of the type Primary Site, Morphology-Type.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case has been reviewed and both the site and histology are correct.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SS/DISMET1

Alternate Name	Item #	Length	Source of Standard	Column #
	1984			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

OVER-RIDE SS/NODESPOS

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Summary Stage/Nodes Positive	1981	1	NAACCR	1888-1888

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Summary Stage 1977, Regional Nodes Pos (NAACCR)
- Summary Stage 2000, Regional Nodes Pos (NAACCR)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error or warning message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: The edit Summary Stage 1977, Regional Nodes Pos (NAACCR) checks SEER Summary Stage 1977 against Regional Nodes Positive and generates an error or warning if there is an incompatibility between the two data items. The edit Summary Stage 2000, Regional Nodes Pos (NAACCR) checks SEER Summary Stage 2000 against Regional Nodes Positive and generates an error or warning if there is an incompatibility between the two data items.

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Summary Stage 1977, Regional Nodes Pos (NAACCR) or the edit Summary Stage 2000, Regional Nodes Pos (NAACCR).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1 if the case has been reviewed and it has been verified that the case has both SEER Summary Stage 1977 and Nodes Positive coded correctly or SEER Summary Stage 2000 and Nodes Positive coded correctly.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SS/TNM-M

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Summary Stage/TNM-M	1983	1	NAACCR	1890-1890

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
- Summary Stage 1977, TNM-M (NAACCR)
- Summary Stage 2000, TNM-M (NAACCR)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error or warning message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: The edit Summary Stage 1977, TNM-M (NAACCR) checks the SEER Summary Stage 1977 against the TNM-M and generates a warning if the SEER Summary Stage 1977 is ‘distant’ and the TNM-M is ‘0’. (TNM-M is derived from TNM Path M and TNM Clin M, with TNM Path M having precedence.) It also checks if the SEER Summary Stage 1977 is not ‘distant’ and the TNM-M is greater than or equal to ‘1’ and generates an error or a warning. The edit Summary Stage 2000, TNM-M (NAACCR) checks the SEER Summary Stage 2000 against the TNM-M and generates a warning if the SEER Summary Stage 2000 is ‘distant’ and the TNM-M is ‘0’. It also checks if the SEER Summary Stage 2000 is not ‘distant’ and the TNM-M is greater than or equal to ‘1’ and generates an error or a warning.

Codes

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Summary Stage 1977, TNM-M (NAACCR) or the edit Summary Stage 2000, TNM-M (NAACCR).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case has been reviewed and it has been verified that both SEER Summary Stage 1977 and TNM-M have been coded correctly or that SEER Summary Stage 2000 and TNM-M have been coded correctly.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SS/TNM-N

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Summary Stage/TNM-N	1982	1	NAACCR	1889-1889

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
- Summary Stage 1977, TNM-N (NAACCR)
- Summary Stage 2000, TNM-N (NAACCR)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: The edit Summary Stage 1977, TNM-N (NAACCR) checks SEER Summary Stage 1977 against the TNM-N and generates an error if the SEER Summary Stage 1977 indicates regional nodal involvement and the TNM-N does not. (TNM-N is derived from TNM Path N and TNM Clin N, with TNM Path N having precedence.) It also generates an error if the SEER Summary Stage 1977 is 'in situ' or 'localized' and the TNM-N is greater than or equal to '1'. The edit Summary Stage2000, TNM-N (NAACCR) checks SEER Summary Stage 2000 against the TNM-N and generates an error if the SEER Summary Stage 2000 indicates regional nodal involvement and the TNM-N does not. It also generates an error if the SEER Summary Stage 2000 is 'in situ' or 'localized' and the TNM-N is greater than or equal to '1'.

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Summary Stage 1977, TNM-N (NAACCR) or the edit Summary Stage 2000, TNM-N (NAACCR).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case has been reviewed and it has been verified that both SEER Summary Stage 1977 and TNM-N or both SEER Summary Stage 2000 and TNM-N have been coded correctly.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

OVER-RIDE SURG/DXCONF

Alternate Name	Item #	Length	Source of Standard	Column #
Surgery/Diagnostic Confirmation Interfield Review (Interfield Edit 46)	2020	1	SEER	1899-1899

Format:
Allowable Values: 1 or blank
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- RX Summ--Surg Prim Site, Diag Conf (SEER IF76)
- RX Summ--Surg Site 98-02, Diag Conf (SEER IF106)
- RX Summ--Surgery Type, Diag Conf (SEER IF46)

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package: Edits of the type RX Summ--Surg Prim Site, Diag Conf check that cases with a primary site surgical procedure coded 20-90 are histologically confirmed. If the patient had a surgical procedure, most likely there was a microscopic examination of the cancer. Verify the surgery and diagnostic confirmation codes, and correct any errors. Sometimes there are valid reasons why no microscopic confirmation is achieved with the surgery; for example, the tissue removed may be inadequate for evaluation.

Codes

Instructions for Coding

- Leave blank if the program does not generate an error message for edits of the type, RX Summ--Surg Prim Site, Diag Conf.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review confirms that they are correct. The patient had surgery, but the tissue removed was not sufficient for microscopic confirmation.

1	Reviewed and confirmed as reported
Blank	Not reviewed or reviewed and corrected

PAIN ASSESSMENT

Alternate Name	Item #	Length	Source of Standard	Column #
	3260			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

This data item was published in FORDS but later withdrawn by CoC and never implemented. The NAACCR UDSC retired this data item in Version 10.1, as of January 1, 2004.

PATH DATE SPEC COLLECT 1

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-7 Observation Date/Time #00241 (HL7)	7320	14	HL7	4580-4593
Path--Date Spec Collection				

Format:
Allowable Values: YYYYMMDDhhmmss
NAACCR Record Section: Pathology
Status

Description

Records the date and time of the specimen collection for the cancer being reported, not the date read or date the report was typed.

Rationale

Describes the origin of the pathology report contributing to this cancer abstract. The date that the specimen was collected is likely to correspond to the procedure date at the facility where a specimen was obtained.

PATH DATE SPEC COLLECT 2

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-7 Observation Date/Time #00241 (HL7)	7321	14	HL7	4686-4699
Path--Date Spec Collection				

Format:
Allowable Values: YYYYMMDDhhmmss
NAACCR Record Section: Pathology
Status

Description

Records the date and time of the specimen collection for the cancer being reported, not the date read or date the report was typed.

Rationale

Describes the origin of the pathology report contributing to this cancer abstract. The date that the specimen was collected is likely to correspond to the procedure date at the facility where a specimen was obtained.

PATH DATE SPEC COLLECT 3

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-7 Observation Date/Time #00241 (HL7)	7322	14	HL7	4792-4805
Path Date Spec Collect 2				

Format:
Allowable Values: YYYYMMDDhhmmss
NAACCR Record Section: Pathology
Status

Description

Records the date and time of the specimen collection for the cancer being reported, not the date read or date the report was typed.

Rationale

Describes the origin of the pathology report contributing to this cancer abstract. The date that the specimen was collected is likely to correspond to the procedure date at the facility where a specimen was obtained.

PATH DATE SPEC COLLECT 4

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-7 Observation Date/Time #00241 (HL7)	7323	14	HL7	4898-4911
Path--Date Spec Collection				

Format:
Allowable Values: YYYYMMDDhhmmss
NAACCR Record Section: Pathology
Status

Description

Records the date and time of the specimen collection for the cancer being reported, not the date read or date the report was typed.

Rationale

Describes the origin of the pathology report contributing to this cancer abstract. The date that the specimen was collected is likely to correspond to the procedure date at the facility where a specimen was obtained.

PATH DATE SPEC COLLECT 5

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-7 Observation Date/Time #00241 (HL7)	7324	14	HL7	5004-5017
Path Date Spec Collect 4				

Format:
Allowable Values: YYYYMMDDhhmmss
NAACCR Record Section: Pathology
Status

Description

Records the date and time of the specimen collection for the cancer being reported, not the date read or date the report was typed.

Rationale

Describes the origin of the pathology report contributing to this cancer abstract. The date that the specimen was collected is likely to correspond to the procedure date at the facility where a specimen was obtained.

PATH ORDER PHYS LIC NO 1

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-16 Ordering Provider (License Number) #00226	7100	20	HL7	4621-4640
Path Ordering Client/Phys--Lic No.				

Format: Left justified, alphanumeric, no embedded blanks
Allowable Values:
NAACCR Record Section: Pathology
Status

Description

License number of physician submitting specimens for the first path report.

This data item accommodates only one path report. If additional reports were prepared, enter the license number of physician in Path Order Phys Lic No 2 through Path Order Phys Lic No 5 [7101-7104]. Information in this data item should refer to the path report described in data items 7010, 7090, 7190, and 7480.

Rationale

Describes the origin of the pathology first report contributing to this cancer abstract.

PATH ORDER PHYS LIC NO 2

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-16 Ordering Provider (License Number) #00226	7101	20	HL7	4727-4746
Path Ordering Client/Phys--Lic No.				

Format: Left justified, alphanumeric, no embedded blanks
Allowable Values:
NAACCR Record Section: Pathology
Status

Description

License number of physician submitting specimens for the second path report.

This data item accommodates only one path report; if additional path reports were prepared, enter the license number of physician in Path Order Phys Lic No 3 through Path Order Phys Lic No 5 [7102-7104]. Information in this data item should refer to the path report described in data items 7011, 7091, 7191, and 7481.

Rationale

Describes the origin of the second pathology report contributing to this cancer abstract.

PATH ORDER PHYS LIC NO 3

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-16 Ordering Provider (License Number) #00226	7102	20	HL7	4833-4852
Path Ordering Client/Phys--Lic No.				

Format: Left justified, alphanumeric, no embedded blanks
Allowable Values:
NAACCR Record Section: Pathology
Status

Description

License number of physician submitting specimens for the third path report.

This item accommodates only one path report; if additional path reports were prepared, enter the license number of physician in Path Order Phys Lic No 4 through Path Order Phys Lic No 5 [7103-7104]. Information in this data item should refer to the path report described in data items 7012, 7022, 7192, and 7482.

Rationale

Describes the origin of the third pathology report contributing to this cancer abstract.

PATH ORDER PHYS LIC NO 4

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-16 Ordering Provider (License Number) #00226	7103	20	HL7	4939-4958
Path Ordering Client/Phys--Lic No.				

Format: Left justified, alphanumeric, no embedded blanks
Allowable Values:
NAACCR Record Section: Pathology
Status

Description

License number of physician submitting specimens for the fourth path report.

This data item accommodates only one path report; if an additional path report was prepared, enter the license number of physician in Path Order Phys Lic No 5 [7104]. Information in this data item should refer to the path report described in data items 7013, 7023, 7193, and 7483.

Rationale

Describes the origin of the fourth pathology report contributing to this cancer abstract.

PATH ORDER PHYS LIC NO 5

Alternate Name	Item #	Length	Source of Standard	Column #
	7104	20	HL7	5045-5064

Format: Left justified, alphanumeric, no embedded blanks
Allowable Values:
NAACCR Record Section: Pathology
Status

Description

License number of physician submitting specimens for the fifth path report.

Information in this data item should refer to the path report described in data items 7014, 7024, 7194, and 7484.

Rationale

Describes the origin of the fifth pathology report contributing to this cancer abstract.

PATH ORDERING FAC NO 1

Alternate Name	Item #	Length	Source of Standard	Column #
ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)	7190	25	HL7	4596-4620

Format: Left justified, alphanumeric
Allowable Values: Blank
NAACCR Record Section: Pathology

Status

Description

Facility ID number of the facility where the specimen described in the first path report was removed/collected. Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).

This item accommodates only one path report; if additional path reports were prepared, enter the facility ID number(s) in Path Ordering Fac No 2 through Path Ordering Fac No 5 [7191-7194]. Information in this data item should refer to the path report described in data items 7010, 7090, 7100, and 7480.

Rationale

Describes the origin of the first pathology report contributing to this cancer abstract. The facility where the specimen was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

PATH ORDERING FAC NO 2

Alternate Name	Item #	Length	Source of Standard	Column #
ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)	7191	25	HL7	4702-4726

Format: Left justified, alphanumeric
Allowable Values: Blank
NAACCR Record Section: Pathology
Status

Description

Facility ID number of the facility where the specimen described in the second path report was removed/collected.

Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).

This item accommodates only one path report; if additional path reports were prepared, enter the facility ID number(s) in Path Ordering Fac No 3 through Path Ordering Fac No 5 [7192-7194]. Information in this data item should refer to the path report described in data items 7011, 7091, 7101, and 7481.

Rationale

Describes the origin of the second pathology report contributing to this cancer abstract. The facility where the specimen was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

PATH ORDERING FAC NO 3

Alternate Name	Item #	Length	Source of Standard	Column #
ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)	7192	25	HL7	4808-4832

Format: Left justified, alphanumeric
Allowable Values: Blank
NAACCR Record Section: Pathology
Status

Description

Facility ID number of the facility where the specimen described in the third path report was removed/collected.

Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).

This item accommodates only one path report; if additional path reports were prepared, enter the facility ID number(s) in Path Ordering Fac No 4 through Path Ordering Fac No 5 [7193-7194]. Information in this data item should refer to the path report described in data items 7012, 7092, 7102, and 7482.

Rationale

Describes the origin of the third pathology report contributing to this cancer abstract. The facility where the specimen was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

PATH ORDERING FAC NO 4

Alternate Name	Item #	Length	Source of Standard	Column #
ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)	7193	25	HL7	4914-4938

Format: Left justified, alphanumeric
Allowable Values: Blank
NAACCR Record Section: Pathology
Status

Description

Facility ID number of the facility where the specimen described in the fourth path report was removed/collected.

Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).

This item accommodates only one path report; if an additional path report was prepared, enter the facility ID number in Path Ordering Fac No 5 [7194]. Information in this data item should refer to the path report described in data items 7013, 7093, 7103, and 7483.

Rationale

Describes the origin of the fourth pathology report contributing to this cancer abstract. The facility where the specimen was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

PATH ORDERING FAC NO 5

Alternate Name	Item #	Length	Source of Standard	Column #
ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)	7194	25	HL7	5020-5044

Format: Left justified, alphanumeric
Allowable Values: Blank
NAACCR Record Section: Pathology
Status

Description

Facility ID number of the facility where the specimen described in the fifth path report was removed/collected.

Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital

Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).

This item accommodates only one path report. Information in this data item should refer to the path report described in data items 7014, 7094, 7104, and 7484.

Rationale

Describes the origin of the fifth pathology report contributing to this cancer abstract. The facility where the specimen described in the fifth path report was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

PATH REPORT NUMBER 1

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-3 Filler Order Number #00217 (HL7) Path Report Number	7090	20	HL7	4560-4579

Format: Left justified, alphanumeric
Allowable Values:
NAACCR Record Section: Pathology
Status

Description

Unique sequential number assigned by a laboratory to the first report for this case.

This item accommodates only one path report. When information is available for more than one path report, enter the path report number(s) in Path Report No 2 through Path Report No 5 [7091-7094]. Information in this data item should refer to the path report described in data items 7010, 7100, 7190, and 7480.

Rationale

Describes the first pathology report contributing to this cancer abstract. The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow back with the pathology facility.

PATH REPORT NUMBER 2

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-3 Filler Order Number #00217 (HL7) Path Report Number	7091	20	HL7	4666-4685

Format: Left justified, alphanumeric
Allowable Values:
NAACCR Record Section: Pathology
Status

Description

Unique sequential number assigned by a laboratory to the second report for this case.

This item accommodates only one path report. When information is available for more than two path reports, enter the path report number(s) in Path Report No 3 through Path Report No 5 [7092-7094]. Information in this data item should refer to the path report described in data items 7011, 7101, 7191, and 7481.

Rationale

Describes the second pathology report contributing to this cancer abstract. The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow back with the pathology facility.

PATH REPORT NUMBER 3

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-3 Filler Order Number #00217 (HL7) Path Report Number	7092	20	HL7	4772-4791

Format: Left justified, alphanumeric
Allowable Values:
NAACCR Record Section: Pathology

Status

Description
Unique sequential number assigned by a laboratory to the third report for this case.

This item accommodates only one path report. When information is available for more than three path reports, enter the path report number(s) in Path Report No 4 through Path Report No 5 [7093-7094]. Information in this data item should refer to the path report described in data items 7012, 7102, 7192, and 7482.

Rationale
Describes the third pathology report contributing to this cancer abstract. The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow back with the pathology facility.

PATH REPORT NUMBER 4

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-3 Filler Order Number #00217 (HL7) Path Report Number	7093	20	HL7	4878-4897

Format: Left justified, alphanumeric
Allowable Values:
NAACCR Record Section: Pathology
Status

Description
Unique sequential number assigned by a laboratory to the fourth report for this case.

This item accommodates only one path report. When information is available for more than four path reports, enter the path report number in Path Report No 5 [7094]. Information in this data item should refer to the path report described in data items 7013, 7103, 7193, and 7483.

Rationale
Describes the fourth pathology report contributing to this cancer abstract. The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow back with the pathology facility.

PATH REPORT NUMBER 5

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-3 Filler Order Number #00217 (HL7) Path Report Number	7094	20	HL7	4984-5003

Format: Left justified, alphanumeric
Allowable Values:
NAACCR Record Section: Pathology
Status

Description
Unique sequential number assigned by a laboratory to the fifth report for this case.

This item accommodates only one path report. Information in this data item should refer to the path report described in data items 7014, 7104, 7194, and 7484.

Rationale
Describes the fifth pathology report contributing to this cancer abstract. The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow back with the pathology facility.

PATH REPORT TYPE 1

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-4 Universal Service ID #00238 (HL7) Path--Report Type	7480	2	HL7	4594-4595

Format: Right justified, zero filled
Allowable Values: 01-11, 98, 99
NAACCR Record Section: Pathology

Status

Description

This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the path report type(s) in Path Report Type 2 through Path Report Type 5 [7481-7484]. Information in this data item should refer to the path report described in data items 7010, 7100, 7090, and 7190.

Rationale

Describes the origin of the first pathology report contributing to this cancer abstract. This variable is primarily used for administrative purposes at the cancer registry.

Codes

01	Pathology
02	Cytology
03	Gyn Cytology
04	Bone Marrow (biopsy/aspirate)
05	Autopsy
06	Clinical Laboratory Blood Work, NOS
07	Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)
08	Cytogenetics
09	Immunohistochemical Stains
10	Molecular Studies
11	Flow Cytometry, Immunophenotype
98	Other
99	Unknown

PATH REPORT TYPE 2

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-4 Universal Service ID #00238 (HL7) Path--Report Type	7481	2	HL7	4700-4701

Format: Right justified, zero filled
Allowable Values: 01-11, 98, 99
NAACCR Record Section: Pathology
Status

Description

This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the path report type(s) in Path Report Type 3 through Path Report Type 5 [7482-7484]. Information in this data item should refer to the path report described in data items 7011, 7101, 7091, and 7191.

Rationale

Describes the origin of the second pathology report contributing to this cancer abstract. This variable is primarily used for administrative purposes at the cancer registry.

Codes

01	Pathology
02	Cytology
03	Gyn Cytology
04	Bone Marrow (biopsy/aspirate)
05	Autopsy
06	Clinical Laboratory Blood Work, NOS
07	Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)
08	Cytogenetics
09	Immunohistochemical Stains
10	Molecular Studies

11	Flow Cytometry, Immunophenotype
98	Other
99	Unknown

PATH REPORT TYPE 3

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-4 Universal Service ID #00238 (HL7) Path--Report Type	7482	2	HL7	4806-4807

Format: Right justified, zero filled
Allowable Values: 01-11, 98, 99
NAACCR Record Section: Pathology
Status

Description

This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the path report type(s) in Path Report Type 4 through Path Report Type 5 [7433-7484]. Information in this data item should refer to the path report described in data items 7012, 7102, 7092, and 7192.

Rationale

Describes the origin of the third pathology report contributing to this cancer abstract. This variable is primarily used for administrative purposes at the cancer registry.

Codes

01	Pathology
02	Cytology
03	Gyn Cytology
04	Bone Marrow (biopsy/aspirate)
05	Autopsy
06	Clinical Laboratory Blood Work, NOS
07	Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)
08	Cytogenetics
09	Immunohistochemical Stains
10	Molecular Studies
11	Flow Cytometry, Immunophenotype
98	Other
99	Unknown

PATH REPORT TYPE 4

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-4 Universal Service ID #00238 (HL7) Path--Report Type	7483	2	HL7	4912-4913

Format: Right justified, zero filled
Allowable Values: 01-11, 98, 99
NAACCR Record Section: Pathology
Status

Description

This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. If an additional path report was prepared, enter the path report type in Path Report Path Report Type 5 [7484]. Information in this data item should refer to the path report described in data items 7013, 7103, 7093, and 7193.

Rationale

Describes the origin of the fourth pathology report contributing to this cancer abstract. This variable is primarily used for administrative purposes at the cancer registry.

Codes

01	Pathology
02	Cytology
03	Gyn Cytology
04	Bone Marrow (biopsy/aspirate)
05	Autopsy
06	Clinical Laboratory Blood Work, NOS
07	Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)
08	Cytogenetics
09	Immunohistochemical Stains
10	Molecular Studies
11	Flow Cytometry, Immunophenotype
98	Other
99	Unknown

PATH REPORT TYPE 5

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-4 Universal Service ID #00238 (HL7) Path--Report Type	7484	2	HL7	5018-5019

Format: Right justified, zero filled
Allowable Values: 01-11, 98, 99
NAACCR Record Section: Pathology
Status

Description
This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. Information in this data item should refer to the path report described in data items 7014, 7104, 7094, and 7194.

Rationale
Describes the origin of the fifth pathology report contributing to this cancer abstract. This variable is primarily used for administrative purposes at the cancer registry.

Codes

01	Pathology
02	Cytology
03	Gyn Cytology
04	Bone Marrow (biopsy/aspirate)
05	Autopsy
06	Clinical Laboratory Blood Work, NOS
07	Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)
08	Cytogenetics
09	Immunohistochemical Stains
10	Molecular Studies
11	Flow Cytometry, Immunophenotype
98	Other
99	Unknown

PATH REPORTING FAC ID 1

Alternate Name	Item #	Length	Source of Standard	Column #
MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084	7010	25	HL7	4535-4559

Format: Left justified, alphanumeric
Allowable Values:
NAACCR Record Section: Pathology

Status

Description
An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the first report of the case.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the identifying code of pathology facility sending the report in Path Reporting Fac ID 2 through Path Reporting Fac ID 5 [7011-7014]. Information in this data item should refer to the path report described in data items 7100, 7090, 7190, and 7480.

Rationale
Describes the origin of the first pathology report contributing to this cancer abstract. Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.

PATH REPORTING FAC ID 2

Alternate Name	Item #	Length	Source of Standard	Column #
MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084	7011	25	HL7	4641-4665

Format: Left justified, alphanumeric
Allowable Values:
NAACCR Record Section: Pathology
Status

Description
An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the second report of the case.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the identifying code of pathology facility sending the report in Path Reporting Fac ID 3 through Path Reporting Fac ID 5 [7012-7014]. Information in this data item should refer to the path report described in data items 7101, 7091, 7191, and 7480.

Rationale
Describes the origin of the second pathology report contributing to this cancer abstract. Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.

PATH REPORTING FAC ID 3

Alternate Name	Item #	Length	Source of Standard	Column #
MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084	7012	25	HL7	4747-4771

Format: Left justified, alphanumeric
Allowable Values:
NAACCR Record Section: Pathology
Status

Description
An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the third report of the case.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the identifying code of pathology facility sending the report in Path Reporting Fac ID 4 through Path Reporting Fac ID 5 [7013-7014]. Information in this data item should refer to the path report described in data items 7102, 7092, 7192, and 7480.

Rationale
Describes the origin of the third pathology report contributing to this cancer abstract. Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.

PATH REPORTING FAC ID 4

Alternate Name	Item #	Length	Source of Standard	Column #
MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084	7013	25	HL7	4853-4877

Format: Left justified, alphanumeric
Allowable Values:

NAACCR Record Section: Pathology
Status

Description

An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the fourth report of the case.

This data item accommodates information for only one path report. If an additional path report was prepared, enter the identifying code of pathology facility sending the report in Path Reporting Fac ID 5 [7014]. Information in this data item should refer to the path report described in data items 7103, 7093, 7193, and 7483.

Rationale

Describes the origin of the fourth pathology report contributing to this cancer abstract. Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.

PATH REPORTING FAC ID 5

Alternate Name	Item #	Length	Source of Standard	Column #
MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084	7014	25	HL7	4959-4983

Format: Left justified, alphanumeric
Allowable Values:
NAACCR Record Section: Pathology
Status

Description

An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the fifth report of the case.

Information in this data item should refer to the path report described in data items 7104, 7094, 7194, and 7484.

Rationale

Describes the origin of the fifth pathology report contributing to this cancer abstract. Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.

PATIENT ID NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	20	8	Reporting Registry	42-49

Format: Right justified, zero filled
Allowable Values:
NAACCR Record Section: Record ID
Status

Description

Unique number assigned to an individual patient by the central registry. The central registry will assign this same number to all of the patient's subsequent tumors (records).

Patient ID Number will only differ when multiple central registries accession the same patient. Each central registry will assign their unique Patient ID Number.

NAACCR recommends that the registry should not reissue or reuse this number when a patient's record is deleted from the files.

In the transmit file (data exchange) this number will be the Patient ID Number assigned by the sending registry as defined in Registry ID [40].

Rationale

Provides the central registry with a unique identification number that will link all records (multiple tumors) for the same patient. The unique number also allows the central registry to identify the patient when there are multiple reports from different hospitals.

PATIENT SYSTEM ID-HOSP

Alternate Name	Item #	Length	Source of Standard	Column #
	21	8	NAACCR	50-57

Format: Right justified, zero filled

Allowable Values:
NAACCR Record Section: Record ID
Status

Description

The unique, non-repeating number automatically assigned to patients by the hospital tumor registry software system. The same number is used for all the patient's subsequent tumors. This Patient System ID-Hosp number should not be reused when a patient is deleted.

This number is different from Accession Number-Hosp [550]. While Accession Number-Hosp [550] is subject to change, the Patient System ID-Hosp number is created and maintained by the hospital tumor registry's software system, and requires no key entry. Because the Patient System ID-Hosp number is unchanging, it affords an absolute linkage between a hospital patient record and a central registry's patient record.

Rationale

This provides a stable identifier to link back to all reported tumors for a patient. It also serves as a reliable linking identifier; useful when central registries send follow-up information back to hospitals. Other identifiers such as social security number and medical record number, while useful, are subject to change and are thus less useful for this type of

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PEDIATRIC STAGE

Alternate Name	Item #	Length	Source of Standard	Column #
	1120	2	CoC	976-977

Format: Alphanumeric
Allowable Values: Refer to ROADS Manual
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Code for stage of pediatric tumor in an AJCC stage scheme, a pediatric intergroup study scheme, or a pediatric cooperative group scheme.

Rationale

Staging of pediatric tumors requires very different schemes from those used to stage adult tumors.

Codes
See the ROADS Manual for allowable codes for this field.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

PEDIATRIC STAGED BY

Alternate Name	Item #	Length	Source of Standard	Column #
Staged By (Pediatric Stage) (CoC)	1140	1	CoC	980-980

Format:
Allowable Values: 36770
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Code for person who documented the pediatric staging system and stage.

Codes

0	Not staged
1	Managing physician
2	Pathologist
3	Other physician
4	Any combination of 1, 2, or 3
5	Registrar
6	Any combination of 5 with 1, 2, or 3
7	Other
8	Staged, individual not specified
9	Unknown if staged

Note: This data item is no longer supported by CoC (as of January 1, 2003).

PEDIATRIC STAGING SYSTEM

Alternate Name	Item #	Length	Source of Standard	Column #
Type of Staging System (Pediatric) (CoC)	1130	2	CoC	978-979

Format:
Allowable Values: 00-15, 88, 97, 99
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Staging system used to assign the Pediatric Stage.

Rationale

Staging of pediatric tumors requires very different schemes from those used to stage adult tumors.

Codes

00	None
01	AJCC
02	Ann Arbor
03	Children's Cancer Group (CCG)
04	Evans
05	General Summary
06	Intergroup Ewings
07	Intergroup Hepatoblastoma
08	Intergroup Rhabdomyosarcoma
09	International System
10	Murphy
11	NCI (pediatric oncology)
12	National Wilms's Tumor Study
13	Pediatric Oncology Group (POG)
14	Reese-Ellsworth
15	SEER Extent of Disease
88	Not applicable (not pediatric case)
97	Other
99	Unknown

Note: This data item is no longer supported by CoC (as of January 1, 2003).

PHYSICIAN 3

Alternate Name	Item #	Length	Source of Standard	Column #
Physician #3 (CoC) Other Physician (pre-96 CoC)	2490	8	CoC	4459-4466

Format: Left justified
Allowable Values:
NAACCR Record Section: Other-Confidential
Status

Description

Code for another physician involved in the care of the patient. Registry may use physicians' medical license numbers or may create individual numbering systems. See FORDS manual for suggested use of this item and detailed

Codes

(In addition to medical license numbers or facility-generated codes)

00000000	None, no additional physician
99999999	Physician is unknown or an identification number is not assigned

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PHYSICIAN 4

Alternate Name	Item #	Length	Source of Standard	Column #
Physician #4 (CoC) Other Physician (pre-96 CoC)	2500	8	CoC	4477-4484

Format: Left justified
Allowable Values:
NAACCR Record Section: Other-Confidential
Status

Description

Code for another physician involved in the care of the patient. Registry may use physicians' medical license numbers or may create individual numbering systems. See FORDS manual for suggested use of this item and detailed

Codes

(In addition to medical license numbers or facility-generated codes)

00000000	None, no additional physician
99999999	Physician is unknown or an identification number is not assigned

---

PHYSICIAN--FOLLOW-UP

Alternate Name	Item #	Length	Source of Standard	Column #
Following Physician (CoC) Follow-Up Physician (pre-96 CoC)	2470	8	CoC	4423-4430

Format: Left justified
Allowable Values:
NAACCR Record Section: Other-Confidential
Status

Description

Code for the physician currently responsible for the patient's medical care. Registry may use physicians' medical license numbers or may create individual numbering systems.

Codes

(In addition to medical license numbers or facility-generated codes)

99999999	Follow-up physician unknown or ID number not assigned

---

PHYSICIAN--MANAGING

Alternate Name	Item #	Length	Source of Standard	Column #
Managing Physician (CoC) Attending Physician (pre-96 CoC)	2460	8	NAACCR	4405-4412

Format: Left justified
Allowable Values:
NAACCR Record Section: Other-Confidential
Status

Description

Code for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer. Registry may use physicians' medical license numbers or may create individual numbering systems.

Codes

(In addition to medical license numbers or facility-generated codes)

99999999	Follow-up physician unknown or ID number not assigned

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PHYSICIAN--PRIMARY SURG

Alternate Name	Item #	Length	Source of Standard	Column #

Primary Surgeon (CoC)	2480	8	CoC	4441-4448

Format: Left justified
Allowable Values:
NAACCR Record Section: Other-Confidential
Status

Description

Code for physician who performed the most definitive surgical procedure. Registry may use physician's medical license numbers or may create individual numbering systems.

Codes

(in addition to medical license numbers or facility-generated codes)

00000000	Patient had no surgery and no surgical consultation
88888888	Physician who performed a surgical procedure was not a surgeon (i.e., radiation oncologist, diagnostic radiologist, or general practitioner)
99999999	Primary Surgeon unknown or ID number not assigned

PLACE OF DEATH

Alternate Name	Item #	Length	Source of Standard	Column #
	1940	3	NPCR	2275-2277

Format: Right justified, zero filled
Allowable Values: Reference SEER Manual
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

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

Rationale

This field also helps carry out death clearance. When a hospital reports a place of death, the information can help in death certificate matching. It can also signal an out-of-state death for which the death certificate is to be requested.

Codes

(In addition to geocodes)

997	Not applicable, patient alive
999	Place of death unknown

Note: See Appendix B for geocodes.

PRESENTATION AT CA CONF

Alternate Name	Item #	Length	Source of Standard	Column #
	650			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

PRIMARY PAYER AT DX

Alternate Name	Item #	Length	Source of Standard	Column #
Primary Payer at Diagnosis (CoC)	630	2	CoC	778-779

Format: Right justified, zero filled
Allowable Values: 01, 02, 10, 20, 21, 31, 35, 60-68, 99
NAACCR Record Section: Hospital-Specific

Status

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

Rationale
This item is used in financial analysis and as an indicator for quality and outcome analyses. The Joint Commission on Accreditation of Healthcare Organizations requires the patient admission page document the type of insurance or payment structure that will cover the patient while being cared for at the hospital.

Codes

01	Not insured
02	Not insured, self-pay
10	Insurance, NOS
20	Private Insurance: Managed care, HMO, or PPO
21	Private Insurance: Fee-for-Service
31	Medicaid
35	Medicaid - Administered through a Managed Care plan
60	Medicare/Medicare, NOS
61	Medicare with supplement, NOS
62	Medicare - Administered through a Managed Care plan
63	Medicare with private supplement
64	Medicare with Medicaid eligibility
65	TRICARE
66	Military
67	Veterans Affairs
68	Indian/Public Health Service
99	Insurance status unknown

PRIMARY SITE

Alternate Name	Item #	Length	Source of Standard	Column #
IDC-O-2/3 Topography (CCCR)	400	4	SEER/CoC	540-543

Format: C followed by 3 digits, no special characters, no embedded blanks
Allowable Values: Refer to ICD-O-3 (decimals are dropped)
NAACCR Record Section: Cancer Identification
Status

Description
Code for the primary site of the tumor being reported using either ICD-O-2 or ICD-O-3. NAACCR adopted ICD-O-2 as the standard coding system for tumors diagnosed beginning January 1, 1992. In addition, NAACCR recommended that tumors diagnosed prior to 1992 be converted to ICD-O-2. The topography (primary site) codes did not change between ICD-O-2 and ICD-O-3.

Codes
See ICD-O-2, Supplement 14 or ICD-O-3, Supplement 13 of Topography Section, for the codes for primary site.

Note: See data item Site (73-91) ICD-O-1 [1960] for ICD-O-1 cases.

PROTOCOL ELIGIBILITY STAT

Alternate Name	Item #	Length	Source of Standard	Column #
	1470			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

PROTOCOL PARTICIPATION

Alternate Name	Item #	Length	Source of Standard	Column #
	1480			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

QUALITY OF SURVIVAL

Alternate Name	Item #	Length	Source of Standard	Column #
	1780	1	CoC	2128-2128

Format:
Allowable Values: 0-4, 8, 9
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

Records patient's ability to carry on the activities of daily living at the date of last contact.

Codes

0	Normal activity
1	Symptomatic and ambulatory
2	Ambulatory more than 50 percent of the time, occasionally needs assistance
3	Ambulatory less than 50 percent of the time, nursing care needed
4	Bedridden, may require hospitalization
8	Not applicable, dead
9	Unknown or unspecified

Note: This data item is no longer supported by CoC (as of January 1, 2003).

RACE 1

Alternate Name	Item #	Length	Source of Standard	Column #
Race	160	2	SEER/CoC	177-178

Format: Right justified, zero filled
Allowable Values: 01-08, 10-17, 20-22, 25-28, 30-32, 96-99
NAACCR Record Section: Demographic
Status

Description

Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current SEER Program Coding and Staging Manual, Supplement 3.

Rationale

Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Codes

01	White
02	Black
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)
04	Chinese

05	Japanese
06	Filipino
07	Hawaiian
08	Korean
*	
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani
20	Micronesian, NOS
21	Chamorran
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
96	Other Asian, including Asian, NOS and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown

***Code 09 was retired effective with Version 12. See codes 15-17.**

RACE 2

Alternate Name	Item #	Length	Source of Standard	Column #
	161	2	SEER/CoC	179-180

Format: Right justified, zero filled
Allowable Values: 01-08, 10-17, 20-22, 25-28, 30-32, 96-99, blank
NAACCR Record Section: Demographic
Status

Description

Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current SEER Program Coding and Staging Manual, supplement 3.

Rationale

Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Codes

01	White
02	Black
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian

08	Korean
*	
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani
20	Micronesian, NOS
21	Chamorran
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
88	No further race documented
96	Other Asian, including Asian, NOS and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown
Blank	Race 2-5 not coded

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf (Appendix G).
***Code 09 was retired effective with Version 12. See codes 15-17.**

RACE 3

Alternate Name	Item #	Length	Source of Standard	Column #
	162	2	SEER/CoC	181-182

Format: Right justified, zero filled
Allowable Values: 01-08, 10-17, 20-22, 25-28, 30-32, 96-99, blank
NAACCR Record Section: Demographic
Status

Description

Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current SEER Program Coding and Staging Manual, Supplement 3.

Rationale

Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Codes

01	White
02	Black
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean

*

10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani
20	Micronesian, NOS
21	Chamorran
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
88	No further race documented
96	Other Asian, including Asian, NOS and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown
Blank	Race 2-5 not coded

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf (Appendix G).

***Code 09 was retired effective with Version 12. See codes 15-17.**

RACE 4

Alternate Name	Item #	Length	Source of Standard	Column #
	163	2	SEER/CoC	183-184

Format: Right justified, zero filled
Allowable Values: 01-08, 10-17, 20-22, 25-28, 30-32, 96-99, blank
NAACCR Record Section: Demographic
Status

Description

Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current SEER Program Coding and Staging Manual, Supplement 3.

Rationale

Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Codes

01	White
02	Black
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere).
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean

*

10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani
20	Micronesian, NOS
21	Chamorran
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Fiji Islander
31	Fiji Islander
32	New Guinean
88	No further race documented
96	Other Asian, including Asian, NOS and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown
Blank	Race 2-5 not coded

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf (Appendix G).

*** Code 09 was retired effective with Version 12. See codes 15-17.**

RACE 5

Alternate Name	Item #	Length	Source of Standard	Column #
	164	2	SEER/CoC	185-186

Format: Right justified, zero filled
Allowable Values: 01-08, 10-17, 20-22, 25-28, 30-32, 96-99, blank
NAACCR Record Section: Demographic
Status

Description

Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current SEER Program Coding and Staging Manual, Supplement 3.

Rationale

Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Codes

01	White
02	Black
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
*	
10	Vietnamese

11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani
20	Micronesian, NOS
21	Chamorran
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
88	No further race documented
96	Other Asian, including Asian, NOS and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown
Blank	Race 2-5 not coded

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf (Appendix G).

***Code 09 was retired effective with Version 12. See codes 15-17.**

RACE CODING SYS--CURRENT

Alternate Name	Item #	Length	Source of Standard	Column #
	170	1	NAACCR	187-187

Format:
Allowable Values: 39820
NAACCR Record Section: Demographic
Status

Description

Code that best describes how Race [160] currently is coded. If the data have been converted, this field shows the system to which it has been converted.

Rationale

Race 1 - 5 codes [160 - 164] have changed over time. To be able to accurately group and analyze the data, it is necessary to record the system used to record the race codes.

Codes

1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	SEER < 1988 (1-digit)
3	1988-1990 SEER & CoC (2-digit)
4	1991-1993 SEER & CoC (added codes 20-97, additional Asian and Pacific Islander codes)
5	1994-1999 SEER & CoC (added code 14, Thai)
6	2000+ SEER & CoC (added code 88 for Race 2, 3, 4, and 5)
7	2010+ SEER & CoC (added codes 15, 16, and 17; removed 09)
9	Other

RACE CODING SYS--ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Column #
	180	1	NAACCR	188-188

Format:
Allowable Values: 39820

NAACCR Record Section: Demographic
Status

Description

Code that best describes how Race [160] originally was coded. If data have been converted, this field identifies the coding system originally used to code the case.

Rationale

Race 1 - 5 codes [160 - 164] have changed over time. Identifying both original and current coding systems used to code race promotes accurate data grouping and analysis.

Codes

1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	SEER < 1988 (1-digit)
3	1988-1990 SEER & CoC (2-digit)
4	1991-1993 SEER & CoC (added codes 20-97, additional Asian and Pacific Islander codes)
5	1994-1999 SEER & CoC (added code 14, Thai)
6	2000+ SEER & CoC (added code 88 for Race 2, 3, 4, and 5)
7	2010+ SEER & CoC (added codes 15, 16, and 17; removed 09)
9	Other

RACE--NAPIIA(DERIVED API)

Alternate Name	Item #	Length	Source of Standard	Column #
Race--NAPIIA	193	2	NAACCR	419-420

Format: Right justified, zero filled
Allowable Values: 01-08, 10-17, 20-22, 25-28, 30-32, 96-99, blank
NAACCR Record Section: Demographic
Status

Description

NAPIIA is an acronym for NAACCR Asian and Pacific Islander Identification Algorithm. Race--NAPIIA(derived API) recodes some single-race cases with a Race 1 [160] code of 96 to a more specific Asian race category, based on an algorithm that makes use of the birthplace and name fields (first, last, and maiden names). For single-race cases with a Race 1 code other than 96, it returns the Race 1 code. Multiple-race cases (those with information in Race 2 through Race 5, [161-164]) are handled variously; for greater detail please refer to the technical documentation: http://www.naaccr.org/filesystem/pdf/NAPIIA%20v1.1%2007032008.pdf

In Version 1.1 of the algorithm, birthplace can be used to indirectly assign a specific race to one of eight Asian race groups (Chinese, Japanese, Vietnamese, Korean, Asian Indian, Filipino, Thai, and Cambodian), and names can be used to indirectly assign a specific race to one of seven Asian groups (Chinese, Japanese, Vietnamese, Korean, Asian Indian, Filipino, and Hmong). Subsequent versions of NAPIIA may incorporate Pacific Islanders and may potentially incorporate name lists for Thai, Cambodian, and Laotians.

Rationale

The use of more specific Asian and Pacific Islander codes will enhance surveillance and research activities focused on specific API subgroups.

Codes

01	White
02	Black
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western Hemisphere)
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
*	
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai

15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)	
16		Asian Indian
17		Pakistani
20	Micronesian, NOS	
21	Chamorran	
22	Guamanian, NOS	
25	Polynesian, NOS	
26	Tahitian	
27	Samoan	
28	Tongan	
30	Melanesian, NOS	
31	Fiji Islander	
32	New Guinean	
96	Other Asian, including Asian, NOS and Oriental, NOS	
97	Pacific Islander, NOS	
98	Other	
99	Unknown	
Blank	Algorithm was not run	

* Code 09 was retired effective with Version 12. See codes 15-17.

RAD--BOOST DOSE CGY

Alternate Name	Item #	Length	Source of Standard	Column #
Boost Radiation Dose: cGY	3210	5	CoC	1611-1615

Format: Right justified, zero filled
Allowable Values: 00000-99999
NAACCR Record Section: Treatment-1st Course
Status

Description

Records the additional dose delivered to that part of the treatment volume encompassed by the boost fields or devices. The unit of measure is centiGray (cGy).

Rationale

To evaluate patterns of radiation oncology care, it is necessary to describe the boost radiation dose. A boost dose is administered to a volume within the regional volume. As in chemotherapy, outcomes are strongly related to the dose

Codes

(In addition to value dose)

(Fill blanks)	Record the actual boost dose delivered
00000	Boost radiation therapy was not administered
88888	Not applicable, brachytherapy or radioisotopes administered to the patient
99999	Boost radiation therapy administered, boost dose unknown

---

RAD--BOOST RX MODALITY

Alternate Name	Item #	Length	Source of Standard	Column #
Boost Radiation Treatment Modality	3200	2	CoC	1609-1610

Format: Right justified, zero filled
Allowable Values: 00, 20-32, 40-43, 50-55, 60-62, 98, 99
NAACCR Record Section: Treatment-1st Course
Status

Description

Records the dominant modality of radiation therapy used to deliver the most clinically significant boost dose to the primary volume of interest during the first course of treatment. This is accomplished with external beam fields of reduced size (relative to the regional treatment fields), implants, stereotactic radiosurgery, conformal therapy, or intensity-modulated radiation therapy. External beam boosts may consist of two or more successive phases with progressively smaller fields, and they are generally coded as a single entity. This field is used with Rad--Regional RX Modality [1570].

Rationale

Radiation treatment frequently is delivered in two or more phases that can be summarized as regional and boost treatments. A boost dose is administered to a volume within the regional volume. For outcomes analysis, the modalities used for each of these phases can be very important.

Codes

00	No boost treatment
20	External beam, NOS
21	Orthovoltage
22	Cobalt-60, Cesium-137
23	Photons (2-5 MV)
24	Photons (6-10 MV)
25	Photons (11-19 MV)
26	Photons (> 19 MV)
27	Photons (mixed energies)
28	Electrons
29	Photons and electrons mixed
30	Neutrons, with or without photons/electrons
31	IMRT
32	Conformal or 3-D therapy
40	Protons
41	Stereotactic radiosurgery, NOS
42	Linac radiosurgery
43	Gamma Knife
50	Brachytherapy, NOS
51	Brachytherapy, Intracavitary, LDR
52	Brachytherapy, Intracavitary, HDR
53	Brachytherapy, Interstitial, LDR
54	Brachytherapy, Interstitial, HDR
55	Radium
60	Radio-isotopes, NOS
61	Strontium - 89
62	Strontium - 90
98	Other, NOS
99	Unknown

RAD--ELAPSED RX DAYS

Alternate Name	Item #	Length	Source of Standard	Column #
	1530			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

RAD--INTENT OF TREATMENT

Alternate Name	Item #	Length	Source of Standard	Column #
	1560			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

RAD--LOCAL CONTROL STATUS

Alternate Name	Item #	Length	Source of Standard	Column #
	1590			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

RAD--LOCATION OF RX

Alternate Name	Item #	Length	Source of Standard	Column #
Location of Radiation Treatment (CoC)	1550	1	CoC	1606-1606

Format:
Allowable Values: 0-4, 8, 9
NAACCR Record Section: Treatment-1st Course
Status

Description

Identifies the location of the facility where radiation treatment was administered during first course of treatment. See also RX Summ--Radiation [1360].

Codes

0	No radiation treatment
1	All radiation treatment at this facility
2	Regional treatment at this facility, boost elsewhere
3	Boost radiation at this facility, regional elsewhere
4	All radiation treatment elsewhere
8	Other, NOS
9	Unknown

RAD--NO OF TREATMENT VOL

Alternate Name	Item #	Length	Source of Standard	Column #
Number of Treatments to this Volume (CoC)	1520	3	CoC	1601-1603

Format: Right justified, zero filled
Allowable Values: 00-99
NAACCR Record Section: Treatment-1st Course
Status

Description

Records the total number of treatment sessions (fractions) administered during the first course of therapy. See also RX-- Treatment Volume [1540].

Codes

000	None
001-998	Number of treatments
999	Unknown

RAD--REGIONAL DOSE: CGY

Alternate Name	Item #	Length	Source of Standard	Column #
Regional Dose: cGy (CoC)	1510	5	CoC	1596-1600

Format: Right justified, zero filled
Allowable Values: 00000-99999

NAACCR Record Section: Treatment-1st Course
Status

Description

The dominant or most clinically significant total dose of regional radiation therapy delivered to the patient during the first course of treatment. The unit of measure is centiGray (cGy). See also Rad--Regional RX Modality [1570].

Codes

In addition to actual doses

(Fill spaces)	Record the actual regional dose delivered
00000	Radiation therapy was not administered
88888	Not applicable, brachytherapy or radioisotopes administered to the patient
99999	Regional radiation therapy was administered, but the dose is unknown

---

RAD--REGIONAL RX MODALITY

Alternate Name	Item #	Length	Source of Standard	Column #
Regional Treatment Modality (CoC)	1570	2	CoC	1607-1608

Format: Right justified, zero filled
Allowable Values: 00, 20-32, 40-43, 50-55, 60-62, 80, 85, 98, 99
NAACCR Record Section: Treatment-1st Course
Status

Description

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

Rationale

Radiation treatment frequently is delivered in two or more phases that can be summarized as regional and boost treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very

Codes

00	No radiation treatment
20	External beam, NOS
21	Orthovoltage
22	Cobalt-60, Cesium-137
23	Photons (2-5 MV)
24	Photons (6-10 MV)
25	Photons (11-19 MV)
26	Photons (> 19 MV)
27	Photons (mixed energies)
28	Electrons
29	Photons and electrons mixed
30	Neutrons, with or without photons/electrons
31	IMRT
32	Conformal or 3-D therapy
40	Protons
41	Stereotactic radiosurgery, NOS
42	Linac radiosurgery
43	Gamma Knife
50	Brachytherapy, NOS
51	Brachytherapy, Intracavitary, Low Dose Rate (LDR)
52	Brachytherapy, Intracavitary, High Dose Rate (HDR)
53	Brachytherapy, Interstitial, Low Dose Rate (LDR)
54	Brachytherapy, Interstitial, High Dose Rate (HDR)
55	Radium
60	Radio-isotopes, NOS
61	Strontium - 89

62	Strontium - 90
80*	Combination modality, specified
85*	Combination modality, NOS
98	Other, NOS
99	Unknown

RAD--RX COMPLETION STATUS

Alternate Name	Item #	Length	Source of Standard	Column #
	1580			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

RAD--TREATMENT VOLUME

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation Treatment Volume (CoC)	1540	2	CoC	1604-1605

Format: Right justified, zero filled
Allowable Values: 00-41, 50, 60, 98, 99
NAACCR Record Section: Treatment-1st Course
Status

Description

Identifies the volume or anatomic target of the most clinically significant regional radiation therapy delivered to the patient during the first course of therapy. See also Rad--Regional RX Modality [1570].

Codes

00	No radiation therapy, not applicable
01	Eye/orbit
02	Pituitary
03	Brain (NOS)
04	Brain (limited)
05	Head and neck (NOS)
06	Head and neck (limited)
07	Glottis
08	Sinuses
09	Parotid
10	Chest/lung (NOS)
11	Lung (limited)
12	Esophagus
13	Stomach
14	Liver
15	Pancreas
16	Kidney
17	Abdomen (NOS)
18	Breast
19	Breast/lymph nodes
20	Chest wall
21	Chest wall/lymph nodes
22	Mantle, mini-mantle
23	Lower extended field
24	Spine
25	Skull

26	Ribs
27	Hip
28	Pelvic bones
29	Pelvis (NOS)
30	Skin
31	Soft tissue
32	Hemibody
33	Whole body
34	Bladder and pelvis
35	Prostate and pelvis
36	Uterus and Cervix
37	Shoulder
38	Extremities bone, NOS
39	Inverted Y
40	Spinal cord
41	Prostate
50	Thyroid
60	Lymph node region, NOS
98	Other
99	Unknown

READM SAME HOSP 30 DAYS

Alternate Name	Item #	Length	Source of Standard	Column #
Readmission to the Same Hospital Within 30 Days of Surgical Discharge	3190	1	CoC	1619-1619

Format:
Allowable Values: 36594
NAACCR Record Section: Treatment-1st Course
Status

Description

Records a readmission to the same hospital within 30 days of discharge following hospitalization for surgical resection of the primary site for the same illness.

Rationale

This data item provides information related to the quality of care. A patient may have a readmission related to the primary diagnosis on discharge if the length of stay was too short, and then needed to return due to problems or complications. A patient may also need to be readmitted if discharge planning and/or follow-up instructions were ineffective. It is important to distinguish a planned from an unplanned readmission, since a planned readmission is not an indicator of quality of care problems.

Codes

0	No surgical procedure of the primary site was performed. Patient not readmitted to the same hospital within 30 days of discharge.
1	Patient was surgically treated and was then readmitted to the same hospital within 30 days of being discharged. This readmission was unplanned.
2	Patient was surgically treated and was then readmitted to the same hospital within 30 days of being discharged. This readmission was planned (chemotherapy port insertion, revision of colostomy, etc.).
3	Patient was surgically treated and, within 30 days of being discharged, had both a planned and an unplanned readmission to the same hospital.
9	It is unknown whether surgery of the primary site was recommended or performed. It is unknown whether the patient was readmitted to the same hospital within 30 days of discharge. Death certificate only.

REASON FOR NO CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
	1440			

Format:
Allowable Values:
NAACCR Record Section:

Status: Retired

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

REASON FOR NO HORMONE

Alternate Name	Item #	Length	Source of Standard	Column #
	1450			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

REASON FOR NO RADIATION

Alternate Name	Item #	Length	Source of Standard	Column #
Reason for No Regional Radiation Therapy	1430	1	CoC	1592-1592

Format:
Allowable Values: 0-2, 5-9
NAACCR Record Section: Treatment-1st Course
Status

Description
Code the reason the patient did not receive radiation treatment as part of first course of therapy. See also RX--Regional RX Modality [1570].

Codes

0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first-course treatment.
2	Radiation therapy was not administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc).
5	Radiation therapy was not administered because the patient died prior to planned or recommended treatment.
6	Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of the first-course therapy. No reason was noted in the patient's 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 the patient record.
8	Radiation therapy was recommended, but it is unknown if it was administered.
9	It is unknown if radiation therapy was recommended or administered. Death-certificate-only and autopsy-only cases.

REASON FOR NO SURGERY

Alternate Name	Item #	Length	Source of Standard	Column #
Reason for No Cancer-Directed Surgery (SEER) Reason for No CA Dir Surgery (CoC) Reason for No Surgery to Primary Site	1340	1	SEER/CoC	1576-1576

Format:
Allowable Values: 0-2, 5-9
NAACCR Record Section: Treatment-1st Course
Status

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

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

Codes

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

RECORD TYPE

Alternate Name	Item #	Length	Source of Standard	Column #
	10	1	NAACCR	1-1

Format:
Allowable Values: I, C, A, U, M, L
NAACCR Record Section: Record ID
Status

Description

Generated field that identifies which of the seven NAACCR data exchange record types is being used in a file of data exchange records. A file should have records of only one type.

Codes

I	Incidence-only record type (nonconfidential coded data)-Length = 3339
C	Confidential record type (incidence record plus confidential data) Length = 5564
A	Full case Abstract record type (incidence and confidential data plus text summaries; used for reporting to central registries) Length = 22824
U	Correction Update record type (short format record used to submit corrections to data already submitted) Length = 1543
M	Record Modified since previous submission to central registry (identical in format to the "A" record type) Length = 22824
L	Pathology Laboratory

RECURRENCE DATE--1ST

Alternate Name	Item #	Length	Source of Standard	Column #
Date of First Recurrence (CoC)	1860	8	CoC	2196-2203

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

The date of the first recurrence of this tumor. See page 97 for date format.

RECURRENCE DATE--1ST FLAG

Alternate Name	Item #	Length	Source of Standard	Column #

1861	2	NAACCR	2204-2205

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

This flag explains why no appropriate value is in the field, Recurrence Date--1st [1860]. This data item was first available in Volume II Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if the patient had a first recurrence)
11	No proper value is applicable in this context (e.g., patient became disease-free after treatment; never had a recurrence; or patient was never disease-free; autopsy only case)
12	A proper value is applicable but not known (i.e., there was a recurrence, but the date is unknown)
Blank	A valid date value is provided in item Recurrence Date--1st [1860], or the date was not expected to have been Transmitted

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RECURRENCE DISTANT SITE 1

Alternate Name	Item #	Length	Source of Standard	Column #
	1871			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

RECURRENCE DISTANT SITE 2

Alternate Name	Item #	Length	Source of Standard	Column #
	1872			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

RECURRENCE DISTANT SITE 3

Alternate Name	Item #	Length	Source of Standard	Column #
	1873			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

RECURRENCE DISTANT SITES

Alternate Name	Item #	Length	Source of Standard	Column #
	1870			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 9.1, as of January 1, 2002.

RECURRENCE TYPE--1ST

Alternate Name	Item #	Length	Source of Standard	Column #
Type of First Recurrence (CoC)	1880	2	CoC	2206-2207

Format: Right justified, zero filled
Allowable Values: 00, 04, 06, 10, 13-17, 20-22, 25-27, 30, 36, 40, 46, 51-60, 62, 70, 88, 99
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description

Code for the type of first recurrence after a period of documented disease free intermission or remission.

Codes

00	Patient became disease-free after treatment and has not had a recurrence; leukemia in remission.
04	In situ recurrence of an invasive tumor.
06	In situ recurrence of an in situ tumor.
10	Local recurrence and there is insufficient information available to code to 13-17. Recurrence is confined to the remnant of the organ of origin; to the organ of origin; to the anastomosis; or to scar tissue where the organ previously existed.
13	Local recurrence of an invasive tumor.
14	Trocar recurrence of an invasive tumor. Includes recurrence in the trocar path or entrance site following prior surgery.
15	Both local and trocar recurrence of an invasive tumor (both 13 and 14)
16	Local recurrence of an in situ tumor.
17	Both local and trocar recurrence of an in situ tumor.
20	Regional recurrence, and there is insufficient information available to code to 21-27.
21	Recurrence of an invasive tumor in adjacent tissue or organ(s) only.
22	Recurrence of an invasive tumor in regional lymph nodes only.
25	Recurrence of an invasive tumor in adjacent tissue or organ(s) and in regional lymph nodes (both 21 and 22) at the same time.
26	Regional recurrence of an in situ tumor, NOS.
27	Recurrence of an in situ tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time.
30	Both regional recurrence of an invasive tumor in adjacent tissue or organ(s) and/or regional lymph nodes (20-25) and local and/or trocar recurrence (10, 13, 14, or 15).
36	Both regional recurrence of an in situ tumor in adjacent tissue or organ(s) and/or regional lymph nodes (26 or 27) and local and/or trocar recurrence (16 or 17).
40	Distant recurrence and there is insufficient information available to code to 46-62.
46	Distant recurrence of an in situ tumor.
51	Distant recurrence of an invasive tumor in the peritoneum only. Peritoneum includes peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
52	Distant recurrence of an invasive tumor in the lung only. Lung includes the visceral pleura.
53	Distant recurrence of an invasive tumor in the pleura only. Pleura includes the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
54	Distant recurrence of an invasive tumor in the liver only.
55	Distant recurrence of an invasive tumor in bone only. This includes bones other than the primary site.
56	Distant recurrence of an invasive tumor in the CNS only. This includes the brain and spinal cord, but not the external

	eye.
57	Distant recurrence of an invasive tumor in the skin only. This includes skin other than the primary site.
58	Distant recurrence of an invasive tumor in lymph node only. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site.
59	Distant systemic recurrence of an invasive tumor only. This includes leukemia, bone marrow metastasis, carcinomatosis, and generalized disease.
60	Distant recurrence of an invasive tumor in a single distant site (51-58) and local, trocar, and/or regional recurrence (10-15, 20-25, or 30).
62	Distant recurrence of an invasive tumor in multiple sites (recurrences that can be coded to more than one category 51-59).
70	Since diagnosis, patient has never been disease-free. This includes cases with distant metastasis at diagnosis, systemic disease, unknown primary, or minimal disease that is not treated.
88	Disease has recurred, but the type of recurrence is unknown.
99	It is unknown whether the disease has recurred or if the patient was ever disease-free.

RECURRENCE TYPE--1ST--OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1890			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

REFERRAL TO SUPPORT SERV

Alternate Name	Item #	Length	Source of Standard	Column #
	1490			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

REGIONAL NODES EXAMINED

Alternate Name	Item #	Length	Source of Standard	Column #
Number of Regional Lymph Nodes Examined (SEER) Pathologic Review of Regional Lymph Nodes (SEER) Regional Lymph Nodes Examined	830	2	SEER/CoC	916-917

Format: Right justified, zero filled
Allowable Values: 00-90, 95-99
NAACCR Record Section: Stage/Prognostic Factors
Status

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.

Rationale

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

Codes

00	No nodes were examined
01-89	1-89 nodes were examined (code the exact number of regional lymph nodes examined)
90	90 or more nodes were examined

95	No regional nodes were removed, but aspiration of regional nodes was performed
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown
99	It is unknown whether nodes were examined; not applicable or negative; not stated in patient record

---

REGIONAL NODES POSITIVE

Alternate Name	Item #	Length	Source of Standard	Column #
Number of Positive Regional Lymph Nodes (SEER) Pathologic Review of Regional Lymph Nodes (SEER) Regional Lymph Nodes Positive	820	2	SEER/CoC	914-915

Format: Right justified, zero filled
Allowable Values: 00-90, 95, 97-99
NAACCR Record Section: Stage/Prognostic Factors
Status

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. For tumors diagnosed from 1988 through 2003, this item was part of the 10-digit EOD [779], detailed site-specific codes for anatomic EOD.

Rationale

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.

Codes

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

Note: See Chapter V, Unresolved Issues, for a discussion of coding differences between CoC and SEER.

REGISTRY ID

Alternate Name	Item #	Length	Source of Standard	Column #
	40	10	NAACCR	30-39

Format: Right justified, zero filled
Allowable Values: 10-digit number. Reference to EDITS table REGID.DBF in Appendix B
NAACCR Record Section: Record ID
Status

Description

A unique code that represents the data transmission source. This item should be used for central registries and non-US health care providers. Refer to Registry ID table in Appendix B.

For cases diagnosed on or after 2008, this item may be blank if NPI--Registry ID (item 45) is used to represent the data transmission source.

Rationale

Used to track data submission flow and to resolve transmission issues.

Codes

In addition to CoC assigned codes or NAACCR assigned codes

0000000000	Case not reported by a facility
0099999999	Case reported, but facility number is unknown

Note: Prior to 2008, this field may contain data from reporting facilities.

REGISTRY TYPE

Alternate Name	Item #	Length	Source of Standard	Column #
	30	1	NAACCR	2-2

Format:
Allowable Values: 40546
NAACCR Record Section: Record ID
Status

Description

A computer-generated code that best describes the type of registry generating the record; used when cases are pooled from multiple registries (a hospital-based registry reporting to a state should have a “3” in this field).

Rationale

Facilitates tracking of data sources when data from multiple registries are pooled.

Codes

1	Central registry (population-based)
2	Central registry or hospital consortium (not population-based)
3	Single hospital/freestanding center

RELIGION

Alternate Name	Item #	Length	Source of Standard	Column #
	260			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

REPORTING FACILITY

Alternate Name	Item #	Length	Source of Standard	Column #
Institution ID Number (CoC) Facility Identification Number (CoC) Reporting Hospital	540	10	CoC	701-710

Format: Right justified, zero filled
Allowable Values: 10-digit number
NAACCR Record Section: Hospital-Specific
Status

Description

CoC code for the facility whose data are described in the record.

Rationale

The Reporting Facility identification number or FIN is used to identify a reporting facility in the central registry database and is useful for monitoring data submission, ensuring the accuracy of data and identifying areas for special studies.

Codes

In addition to CoC assigned codes

0000000000	Case not reported by a facility
0099999999	Case reported, but facility number is unknown

A listing of valid FINs can be found at http://www.facs.org/cancer/coc/fin.html.

Note: When this special code is being used, the length in 9s should correspond to the length indicated by the code in FIN coding system [35]. The 9s must be right justified in the field, and the remaining spaces should be filled with leading zeroes to a total length of 10.

REPORTING HOSPITAL FAN

Alternate Name	Item #	Length	Source of Standard	Column #
	538			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

RESERVED 00

Alternate Name	Item #	Length	Source of Standard	Column #
	37	13		4-16

Format:
Allowable Values:
NAACCR Record Section: Record ID
Status

RESERVED 01

Alternate Name	Item #	Length	Source of Standard	Column #
	370	37		58-94

Format:
Allowable Values:
NAACCR Record Section: Record ID
Status

RESERVED 02

Alternate Name	Item #	Length	Source of Standard	Column #
	530	92		436-527

Format:
Allowable Values:
NAACCR Record Section: Demographic
Status: Revised

RESERVED 03

Alternate Name	Item #	Length	Source of Standard	Column #
	680	100		591-690

Format:
Allowable Values:
NAACCR Record Section: Cancer Identification
Status

RESERVED 04

Alternate Name	Item #	Length	Source of Standard	Column #
	750	100		804-903

Format:
Allowable Values:
NAACCR Record Section: Hospital-Specific

Status

RESERVED 05

Alternate Name	Item #	Length	Source of Standard	Column #
	1180	200		1236-1435

Format:
Allowable Values:
NAACCR Record Section: Stage/Prognostic Factors
Status

RESERVED 06

Alternate Name	Item #	Length	Source of Standard	Column #
	1190	100		1624-1723

Format:
Allowable Values:
NAACCR Record Section: Treatment-1st Course
Status

RESERVED 07

Alternate Name	Item #	Length	Source of Standard	Column #
	1300	100		1788-1887

Format:
Allowable Values:
NAACCR Record Section: Treatment-Subsequent & Other
Status

RESERVED 08

Alternate Name	Item #	Length	Source of Standard	Column #
	1650	80		2036-2115

Format:
Allowable Values:
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: Revised

RESERVED 09

Alternate Name	Item #	Length	Source of Standard	Column #
	1740	50		2290-2339

Format:
Allowable Values:
NAACCR Record Section: Follow-up/Recurrence/Death
Status

RESERVED 10

Alternate Name	Item #	Length	Source of Standard	Column #
	1835	200		4085-4284

Format:
Allowable Values:
NAACCR Record Section: Patient-Confidential
Status

RESERVED 11

Alternate Name	Item #	Length	Source of Standard	Column #
	1900	50		4345-4394

Format:
Allowable Values:
NAACCR Record Section: Hospital-Confidential
Status

RESERVED 12

Alternate Name	Item #	Length	Source of Standard	Column #
	2510	50		4485-4534

Format:
Allowable Values:
NAACCR Record Section: Other-Confidential
Status

RESERVED 13

Alternate Name	Item #	Length	Source of Standard	Column #
	2080	500		5065-5564

Format:
Allowable Values:
NAACCR Record Section: Pathology
Status

RESERVED 14

Alternate Name	Item #	Length	Source of Standard	Column #
	2210	2000		20825-22824

Format:
Allowable Values:
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

RESERVED 16

Alternate Name	Item #	Length	Source of Standard	Column #
	2400	1		780-780

Format:
Allowable Values:
NAACCR Record Section: Hospital-Specific
Status

RESERVED 17

Alternate Name	Item #	Length	Source of Standard	Column #
	2450			788-788

Format:
Allowable Values:
NAACCR Record Section: Hospital-Specific
Status

RURALURBAN CONTINUUM 1993

Alternate Name	Item #	Length	Source of Standard	Column #
Beale Code	3300	2	NAACCR	424-425

Format: Right justified, zero filled
Allowable Values: 00-09, 98, 99, blank

NAACCR Record Section: Demographic
Status

Description

The RuralUrban Continuum (1993) codes (usually known as the Beale Codes) separate counties into four metropolitan and six non-metropolitan categories, based on the size their populations and form a classification scheme that distinguishes metropolitan counties by size and nonmetropolitan counties by degree of urbanization and proximity to metro areas.

These codes can be derived electronically, using patients' state and county at diagnosis, so registrars do not need to provide them. FIPS state and county code mappings to Beale Codes can be obtained in an Excel file at http://www.ers.usda.gov/Data/RuralUrbanContinuumCodes.

The code is a 10-point continuum, transmitted in standard NAACCR record form with a leading 0, (00-09). Abstractors do not enter these codes.

Areas that are not included in the Rural-Urban Continuum code table, such as Canadian provinces/territories and U.S. territories (other than Puerto Rico) will be coded 98. Records for non-residents of the state of the reporting institution (County at DX = 998) also will be coded 98. If Addr at DX--State is XX, YY or ZZ, or if County at DX = 999, the Rural-Urban Continuum will be coded 99.

Rationale

Categorizing counties by population size helps researchers investigate geographic correlates of the burden of cancer in the area of interest.

Codes

Metropolitan Counties (00-03)

00	Central counties of metropolitan areas of 1 million population or more
01	Fringe counties of metropolitan areas of 1 million population or more
02	Counties in metropolitan areas of 250,000-1,000,000 population

Codes Metropolitan Counties (00-03)

03	Counties in metropolitan areas of less than 250,000 population

Nonmetropolitan Counties (04-09)

04	Urban population of 20,000 or more, adjacent to a metropolitan area
05	Urban population of 20,000 or more, not adjacent to a metropolitan area
06	Urban population of 2,500-19,999, adjacent to a metropolitan area
07	Urban population of 2,500-19,999, not adjacent to a metropolitan area
08	Completely rural (no places with a population of 2,500 or more) adjacent to a metropolitan area
09	Completely rural (no places with a population of 2,500 or more) not adjacent to a metropolitan area
98	Program run, but: (1) area is not included in Rural-Urban Continuum code table, or (2) record is for resident outside of state of reporting institution
99	Unknown
Blank	Program not run; record not coded

RURALURBAN CONTINUUM 2003

Alternate Name	Item #	Length	Source of Standard	Column #
Beale Code RuralUrban Continuum 2000	3310	2	NAACCR	426-427

Format: Right justified, zero filled
Allowable Values: 00-09, 98, 99, blank
NAACCR Record Section: Demographic
Status

Description

The RuralUrban Continuum (2003) codes (usually known as the Beale Codes) separate counties into four metropolitan and six non-metropolitan categories, based on the size their populations and form a classification scheme that distinguishes metropolitan counties by size and nonmetropolitan counties by degree of urbanization and proximity to metro areas.

These codes can be derived electronically, using patients' state and county at diagnosis, so registrars do not need to provide them. FIPS state and county code mappings to Beale Codes can be obtained in an Excel file at http://www.ers.usda.gov/Data/RuralUrbanContinuumCodes.

The code is a 9-point continuum, transmitted in standard NAACCR record form with a leading 0, (01-09). Abstractors do not enter these codes.

Areas that are not included in the Rural-Urban Continuum code table, such as Canadian provinces/territories and U.S. territories (other than Puerto Rico) will be coded 98. Records for non-residents of the state of the reporting institution (County at DX = 998) also will be coded 98. If

Addr at DX--State is XX, YY or ZZ, or if County at DX = 999, the Rural-Urban Continuum will be coded 99.

Rationale

Categorizing counties by population size helps researchers investigate geographic correlates of the burden of cancer in the area of interest.

Codes

Metropolitan Counties (01-03)

01	Counties in metro areas of 1 million population or more
02	Counties in metro areas of 250,000 to 1 million population
03	Counties in metro areas of fewer than 250,000 population

Nonmetropolitan Counties (04-09)

04	Urban population of 20,000 or more, adjacent to a metro area
05	Urban population of 20,000 or more, not adjacent to a metro area
06	Urban population of 2,500 to 19,999, adjacent to a metro area
07	Urban population of 2,500 to 19,999, not adjacent to a metro area
08	Completely rural or less than 2,500 urban population, adjacent to a metro area
09	Completely rural or less than 2,500 urban population, not adjacent to a metro area
98	Program run, but: (1) area is not included in Rural-Urban Continuum code table, or (2) record is for resident outside of state of reporting institution
99	Unknown
Blank	Program not run; record not coded

RX CODING SYSTEM--CURRENT

Alternate Name	Item #	Length	Source of Standard	Column #
	1460	2	NAACCR	1593-1594

Format: Right justified, zero filled
Allowable Values: 00-07, 99
NAACCR Record Section: Treatment-1st Course
Status

Description

Code describing how treatment for this tumor now is coded.

Codes

00	Treatment data not coded/transmitted (i.e., all treatment fields [items 1200-1450 and 1500-1645] blank)
01	Treatment data coded using 1-digit surgery codes (obsolete)
02	Treatment data coded according to 1983-1992 SEER manuals and 1983-1995 CoC manuals
03	Treatment data coded according to 1996 ROADS Manual
04	Treatment data coded according to 1998 ROADS Supplement
05	Treatment data coded according to 1998 SEER Manual
06	Treatment data coded according to FORDS manual
07	Treatment data coded according to 2010 SEER Coding Manual
99	Other coding, including partial or nonstandard coding

RX DATE MST DEFN SRG FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	3171	2	NAACCR	1474-1475

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-1st Course
Status

Description

This flag explains why no appropriate value is in the field, RX Date--Most Defin Surg [3170]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.

10	No information whatsoever can be inferred from this exceptional value. (e.g., unknown if any surgical procedure of the primary site was performed).
11	No proper value is applicable in this context (e.g., no surgical resection of the primary site was performed and for cases diagnosed at autopsy).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., surgical procedure of the primary site was performed but the date is unknown).
Blank	A valid date value is provided in item RX Date--Most Defin Surg [3170], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE RAD ENDED FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	3221	2	NAACCR	1504-1505

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-1st Course
Status

Description

This flag explains why no appropriate value is in the field, RX Date--Radiation Ended [3220]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if radiation therapy administered).
11	No proper value is applicable in this context (e.g., radiation therapy was not administered; diagnosed at autopsy).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., date radiation ended is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., radiation was administered and was ongoing at the time of most recent follow-up).
Blank	A valid date value is provided in item RX Date--Radiation Ended [3220], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE SURG DISCH FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	3181	2	NAACCR	1484-1485

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-1st Course
Status

Description

This flag explains why no appropriate value is in the field, RX Date--Surgical Disch [3180]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown whether surgical treatment was performed).
11	No proper value is applicable in this context (e.g., no surgical treatment of the primary site was performed; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., surgical treatment performed but the date of discharge is unknown).
Blank	A valid date value is provided in item RX Date--Surgical Disch [3180], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE SYSTEMIC FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	3231	2	NAACCR	1514-1515

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-1st Course
Status

Description

This flag explains why no appropriate value is in the field, RX Date--Systemic [3230]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if systemic therapy was administered).
11	No proper value is applicable in this context (e.g., no systemic therapy was administered; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., systemic therapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., systemic therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date--Systemic [3230], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE--BRM

Alternate Name	Item #	Length	Source of Standard	Column #
Date Immunotherapy Started (CoC)	1240	8	CoC	1536-1543

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Treatment-1st Course
Status

Description

Date of initiation for immunotherapy (a.k.a. biological response modifier) that is part of the first course of treatment. See also RX Summ--BRM [1410]. See page 97 for date format.

Rationale

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

Note: CoC discontinued support of this item from 2003 through 2009.

RX DATE--BRM FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1241	2	NAACCR	1544-1545

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-1st Course
Status

Description

This flag explains why no appropriate value is in the field, RX Date--BRM [1240]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if immunotherapy administered).
11	No proper value is applicable in this context (e.g., no immunotherapy administered; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., immunotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., immune therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date BRM [1240], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates

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RX DATE--CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
Date Chemotherapy Started (CoC)	1220	8	CoC	1516-1523

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Treatment-1st Course
Status

Description

Date of initiation of chemotherapy that is part of the first course of treatment. See also RX Summ--Chemo [1390]. See page 97 for date format.

Rationale

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.

Note: CoC discontinued support of this item from 2003 through 2009.

RX DATE--CHEMO FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1221	2	NAACCR	1524-1525

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-1st Course
Status

Description

This flag explains why no appropriate value is in the field, RX Date--Chemo [1220]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if chemotherapy administered).
11	No proper value is applicable in this context (e.g., no chemotherapy administered; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date--Chemo [1220], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates

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RX DATE--DX/STG PROC

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Non Cancer-Directed Surgery (CoC) Date of Diagnostic, Staging or Palliative Procedures (1996-2002) Date of Surgical Diagnostic and Staging Procedure (CoC) RX Date--DX/Stg/Pall Proc	1280	8	CoC	1556-1563

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Treatment-1st Course
Status

Description

Records the date on which the surgical diagnostic and/or staging procedure was performed. See Surgical and Diagnostic Staging Procedure [1350]. See page 97 for date format.

Note: This is a CoC item and for tumors diagnosed from January 1, 1996, through December 31, 2002, this may have been the date on which diagnostic, staging, and palliative procedures were performed. Beginning with tumors diagnosed on or after January 1, 2003, palliative procedures are collected in RX Summ--Palliative Proc [3270] and RX Hosp--Palliative Proc [3280].

RX DATE--DX/STG PROC FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1281	2	NAACCR	1564-1565

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-1st Course
Status

Description

This flag explains why no appropriate value is in the field, RX Date--DX/Stg Proc [1280]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any diagnostic or staging procedure performed).
11	No proper value is applicable in this context (e.g., no diagnostic or staging procedure performed; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., diagnostic or staging procedure performed but date is unknown).
Blank	A valid date value is provided in item RX Date--DX/Stg Proc [1280], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE--HORMONE

Alternate Name	Item #	Length	Source of Standard	Column #
Date Hormone Therapy Started (CoC)	1230	8	CoC	1526-1533

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Treatment-1st Course
Status

Description

Date of initiation for hormone therapy that is part of the first course of treatment. See also RX Summ--Hormone [1400]. See page 97 for date format.

Rationale

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.

Note: CoC discontinued support of this item from 2003 through 2009.

RX DATE--HORMONE FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1231	2	NAACCR	1534-1535

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-1st Course
Status

Description

This flag explains why no appropriate value is in the field, RX Date--Hormone [1230]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any hormone therapy administered).

11	No proper value is applicable in this context (e.g., no hormone therapy administered; autopsy only cases).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., hormone therapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., hormone therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date--Hormone [1230], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE--MOST DEFIN SURG

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Most Definitive Surgical Resection of the Primary Site	3170	8	CoC	1466-1473

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Treatment-1st Course
Status

Description

Date of most definitive surgical resection of the primary site performed as part of the first course of treatment. See page 97 for date format.

Rationale

This item is used to measure lag time between diagnosis and the most definitive surgery of the primary site or survival following the procedure. It also is used in conjunction with Date of Surgical Discharge [3180] to calculate the duration of hospitalization following the most definitive primary site surgical procedure to evaluate treatment efficacy.

RX DATE--OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
Date Other Treatment Started (CoC)	1250	8	CoC	1546-1553

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Treatment-1st Course
Status

Description

Date of initiation for other treatment that is part of the first course of treatment at any facility. See RX Summ--Other [1420]. See page 97 for date format.

Rationale

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.

RX DATE--OTHER FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1251	2	NAACCR	1554-1555

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-1st Course
Status

Description

This flag explains why no appropriate value is in the field, RX Date--Other [1250]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if other therapy administered).
11	No proper value is applicable in this context (e.g., no other treatment administered; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., other therapy administered but the date is unknown).
Blank	A valid date value is provided in item RX Date--Other [1250], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE--RADIATION

Alternate Name	Item #	Length	Source of Standard	Column #
Date Radiation Started (CoC)	1210	8	CoC	1486-1493

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Treatment-1st Course
Status

Description

Records the date on which radiation therapy began at any facility that is part of the first course of treatment. See page 97 for date format.

Rationale

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.

RX DATE--RADIATION ENDED

Alternate Name	Item #	Length	Source of Standard	Column #
Date Radiation Ended	3220	8	CoC	1496-1503

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Treatment-1st Course
Status

Description

The date on which the patient completes or receives the last radiation treatment at any facility. See page 97 for date

Rationale

The length of time over which radiation therapy is administered to a patient is a factor in tumor control and treatment morbidity. It is useful in evaluating the quality-of-care and the success of patient support programs designed to maintain continuity of treatment.

RX DATE--RADIATION FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1211	2	NAACCR	1494-1495

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-1st Course
Status

Description

This flag explains why no appropriate value is in the field, RX Date--Radiation [1210]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown whether any radiation therapy administered).
11	No proper value is applicable in this context (e.g., no radiation therapy administered; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., radiation therapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank	A valid date value is provided in item RX Date--Radiation [1210], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE--SURGERY

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Cancer-Directed Surgery (CoC) Date of Surgery Date of First Surgical Procedure (CoC)	1200	8	CoC	1456-1463

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Treatment-1st Course
Status

Description

Date the first surgery of the type described under Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes was performed. See also RX Summ--Surg PrimSite [1290], RX Summ--Scope Reg LN Sur [1292], and RX Summ--Surg Oth Reg/Dis [1294]. See page 97 for date format.

Rationale

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.

RX DATE--SURGERY FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1201	2	NAACCR	1464-1465

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-1st Course
Status

Description

This flag explains why no appropriate value is in the field, RX Date--Surgery [1200]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any surgical procedure site

	was performed).
11	No proper value is applicable in this context (e.g., no surgical procedure was performed; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., surgery was performed but the date is unknown).
Blank	A valid date value is provided in item RX Date--Surgery [1200], or the date was not expected to have been transmitted.

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

RX DATE--SURGICAL DISCH

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Surgical Discharge	3180	8	CoC	1476-1483

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Treatment-1st Course
Status

Description

Records the date the patient was discharged following primary site surgery. The date corresponds to the event recorded in Date of Most Definitive Surgical Resection [3170]. See page 97 for date format.

Rationale

Length of stay is an important quality-of-care and financial measure among hospital administrations, those who fund public and private health care, and public health users. This date, in conjunction with the data item “Date of Most Definitive Surgical Resection” [3170], will allow for the calculation of a patient’s length of hospitalization associated with primary site surgery.

RX DATE--SYSTEMIC

Alternate Name	Item #	Length	Source of Standard	Column #
Date Systemic Therapy Started	3230	8	CoC	1506-1513

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Treatment-1st Course
Status

Description

Date of initiation of systemic therapy that is part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormone agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy. See page 97 for date format.

Rationale

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.

RX HOSP--ASA CLASS

Alternate Name	Item #	Length	Source of Standard	Column #
	665			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

This new data item was proposed for inclusion in Version 12 but the request was withdrawn prior to implementation of the standard. The data item was retired in Version 12.1, as of January 1, 2011.

RX HOSP--BRM

Alternate Name	Item #	Length	Source of Standard	Column #
Immunotherapy at this Facility (CoC)	720	2	CoC	794-795

Format: Right justified, zero filled
Allowable Values: 00, 01, 82, 85-88, 99
NAACCR Record Section: Hospital-Specific
Status

Description

Records whether immunotherapeutic agents (biologic response modifiers) were administered as first-course treatment at this facility or the reason they were not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Rationale

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

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation

Codes

(Refer to the most recent FORDS and SEER Rx for complete coding)

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

Note: For tumors diagnosed on or after January 1, 2003, information on bone marrow and stem cell transplants is no longer coded under this item. ROADS codes 02-06 should not be used in this field. For diagnosed on or after January 1, 2003, this information should be coded in the new field RX SUMM--Transplnt/Endocr [3250].

RX HOSP--CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
Chemotherapy at this Facility (CoC)	700	2	CoC	790-791

Format: Right justified, zero filled
Allowable Values: 00-03, 82, 85-88, 99
NAACCR Record Section: Hospital-Specific
Status

Description

Records the type of chemotherapy administered at the reporting facility as a part of first course therapy or the reason chemotherapy was not given.

Rationale

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

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation

Codes

(Refer to the most recent FORDS and SEER RX for additional complete coding directions.)

00	None, chemotherapy was not part of the first course of therapy or there was progression of disease prior to administration; Not customary therapy for this cancer. Diagnosed at autopsy.
01	Chemotherapy was administered, but type and number of agents is not documented in patient record.
02	Chemotherapy, single agent.
03	Chemotherapy, multiple agents.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age) or there was progression of disease prior to planned administration.
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy 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	Chemotherapy 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	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether chemotherapy was recommended or administered because it is not stated in patient record. Death certificate-only case

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RX HOSP--DX/STG PROC

Alternate Name	Item #	Length	Source of Standard	Column #
Non Cancer-Directed Surgery at this Facility (CoC) Surgical Diagnostic & Staging Procedure at this Facility (1996-2002) RX Hosp--DX/Stg/Pall Proc	740	2	CoC	797-798

Format: Right justified, zero filled
Allowable Values: 36716
NAACCR Record Section: Hospital-Specific
Status

Description

Identifies the surgical procedure(s) performed in an effort to diagnose and/or stage disease at this facility.

Rationale

This data item is used to track the use of surgical procedure resources that are not considered treatment. If central registries wish to study the procedures performed at particular facilities, the facility-level fields must be used.

The summary fields, conversely, combine information for all facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and diagnostic/staging procedures by type of healthcare setting. Knowing what part of the diagnostic or staging process was performed at a particular facility also helps resolve consolidation issues.

Codes

(Refer to the most recent version of FORDS for additional instructions.)

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 of the primary site or biopsy of a lymph node was done to diagnose or stage lymphoma.
03	A surgical exploration only. The patient was not biopsied or treated during the procedure.
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 about whether a diagnostic or staging procedure was performed.

Note: This item has been used for tumors diagnosed in 1996 and later. For cases diagnosed before 1996, this item may have been converted from the DAM, and cases with surgery would have been converted to 09 in this field. For cases diagnosed between 1996 and 2002, this field may have described palliative care according to coding rules in ROADS. For tumors diagnosed on or after January 1, 2003, palliative care is coded in a new field RX Hosp--Palliative Proc [3280].

RX HOSP--HORMONE

Alternate Name	Item #	Length	Source of Standard	Column #
Hormone Therapy at this Facility (CoC)	710	2	CoC	792-793

Format: Right justified, zero filled
Allowable Values: 00-03, 82, 85-88, 99
NAACCR Record Section: Hospital-Specific
Status

Description

Records whether systemic hormonal agents were administered as first-course treatment at this 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.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of hormonal agents given as part of the first course of therapy. Furthermore, it is useful to know the reason hormone therapy was not administered when evaluating quality of care for certain tumors.

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation

Codes

(Refer to the most recent version of FORDS for additional instructions.)

00	None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Hormone therapy was administered as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age) or there was progression of disease prior to administration.
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 was refused by the patient, or the patient's family member or guardian. The refusal was noted in the patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether hormone therapy was recommended or administered because it is not stated in the patient record; death certificate-only cases.

Note: Codes 02-03 entered under the ROADS rules for tumors diagnosed prior to January 1, 2003, should have been converted to the appropriate code in the new field RX SUMM--Transplnt/Endocr [3250] implemented with FORDS. Endocrine surgery and endocrine radiation therapy are no longer coded as Hormone Therapy for tumors diagnosed on or after January 1, 2003.

RX HOSP--OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
Other Treatment at this Facility (CoC)	730	1	CoC	796-796

Format:
Allowable Values: 0-3, 6-9
NAACCR Record Section: Hospital-Specific

Status

Description

Identifies treatment given at this facility that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment modifies, controls, removes, or destroys proliferating cancer tissue. Supportive care such as phlebotomy, transfusions, or aspirin may be recorded for hematopoietic diseases ONLY.

Rationale

Information on other therapy is used to describe treatment practices and evaluate quality of care. If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes

0	None; all cancer treatment was coded in other treatment fields. Patient received no cancer treatment. Diagnosed at autopsy.
1	Cancer treatment that cannot be assigned to specified treatment data items.
2	Other-Experimental; this code is not defined. It may be used to record participation in institution-based clinical trials.
3	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. Treatment listed in code 1, 2 or 3 was recommended by the patient's physician but was refused by the patient or the patient's family or 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	It is unknown whether other treatment was recommended or administered because it is not stated in the patient record. Death certificate only case.

RX HOSP--PALLIATIVE PROC

Alternate Name	Item #	Length	Source of Standard	Column #
Palliative Procedure at this Facility	3280	1	CoC	799-799
Palliative Care at this Facility				

Format:
Allowable Values: 36716
NAACCR Record Section: Hospital-Specific
Status

Description

Identifies care provided at the reporting facility in an effort to palliate or alleviate symptoms. Palliative procedures may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or pain management.

Rationale

This data item allows reporting facilities to track care that is considered palliative rather than diagnostic or curative in intent. If central registries wish to study types of palliative care given at particular facilities, the facility-level fields must be used. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what palliative procedures and care was performed at a particular facility also helps resolve consolidation issues.

Codes

0	No palliative care provided. Diagnosed at autopsy
1	Surgery (which may involve a bypass procedure) performed to alleviate symptoms, but no attempt to diagnose, stage, or treat the tumor is made.
2	Radiation therapy given to alleviate symptoms, but no attempt to produce cure is made.
3	Chemotherapy, hormone therapy, or other systemic drugs given to alleviate symptoms without curative intent.
4	Patient received or was referred for pain management only.
5	Any combination of codes 1, 2, and/or 3 without code 4.

6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or recommended, but no information on the type of procedure is available in the patient record.
9	Unknown if palliative care was performed or recommended. Not stated in patient record.

RX HOSP--RADIATION

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation at this Facility (CoC)	690	1	SEER	789-789

Format:
Allowable Values: 36655
NAACCR Record Section: Hospital-Specific
Status: Revised

Description

Defines the type of radiation therapy the patient received at the reporting facility as a part of the first course of

Rationale

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation

Codes

0	None
1	Beam radiation
2	Radioactive implants
3	Radioisotopes
4	Combination of 1 with 2 or 3
5	Radiation, NOS—method or source not specified
9	Unknown if radiation therapy administered

Note: CoC no longer requires this item effective January 1, 2002. SEER continues to support it as a historically collected and currently transmitted data item.

RX HOSP--REG LN REMOVED

Alternate Name	Item #	Length	Source of Standard	Column #
Number of Regional Lymph Nodes Examined at This Facility (CoC)	676	2	CoC	786-787
RX Hosp--Reg LN Examined				

Format:
Allowable Values: 00-90, 95-99
NAACCR Record Section: Hospital-Specific
Status

Description

Describes number of regional lymph nodes removed at the reporting facility as part of the first course of treatment.

Rationale

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing the extent of treatment given at a particular facility also helps resolve consolidation issues.

Codes

(Refer to ROADS for additional coding instructions.)

00	No regional lymph nodes removed
01	One regional lymph node removed
02	Two regional lymph nodes removed

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..

90	Ninety or more regional lymph nodes removed
95	No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed
96	Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97	Regional lymph node removal documented as a dissection and number of lymph nodes unknown/not stated
98	Regional lymph nodes surgically removed, but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99	Unknown; not stated; death certificate-only

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

RX HOSP--SCOPE REG 98-02

Alternate Name	Item #	Length	Source of Standard	Column #
Scope of Regional Lymph Node Surgery at this Facility (CoC)	747	1	CoC	802-802

Format:
Allowable Values: 0-9 (site specific), blank
NAACCR Record Section: Hospital-Specific
Status

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 the reporting facility. This field is to be used for ROADS codes after the ROADS to FORDS conversion. It is also to be used to code Scope of Regional Lymph Node Surgery at the reporting facility for all tumors diagnosed before January 1, 2003.

Rationale

In evaluating quality of care and treatment practices it is important to identify 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.

If central registries wish to study the treatment given at particular hospitals, the hospital-level treatment fields must be used. The summary treatment fields, conversely, combine information across all hospitals that provide first course of treatment for the tumor. Hospital-specific fields allow studies of detailed referral patterns and treatment by type of hospital. Knowing the extent of treatment given at a particular hospital also helps resolve coding issues.

Codes

See the CoC ROADS Manual 1998 Supplement and the SEER Program Code Manual for site-specific codes.

RX HOSP--SCOPE REG LN SUR

Alternate Name	Item #	Length	Source of Standard	Column #
Scope of Regional Lymph Node Surgery at this Facility (CoC)	672	1	CoC	784-784

Format:
Allowable Values: 36716
NAACCR Record Section: Hospital-Specific
Status

Description

Describes the removal, biopsy, or aspiration of regional lymph node(s) performed at the reporting facility for diagnosis and/or staging or as a part of the first course of therapy.

Rationale

This item is important for evaluating quality of care and treatment practices relating to initial diagnosis, staging and/or first course of therapy. If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing the extent of treatment given at a particular facility also helps resolve consolidation issues.

If central registries wish to study the treatment given at particular hospitals, the hospital-level treatment fields must be used. The summary

treatment fields, conversely, combine information across all hospitals that provide first course of treatment for the tumor. Hospital-specific fields allow studies of detailed referral patterns and treatment by type of hospital. Knowing the extent of treatment given at a particular hospital also helps resolve coding issues.

Codes

(Refer to the most recent version of FORDS for additional instructions.)

0	No regional lymph nodes removed. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph node, NOS.
2	Sentinel lymph node biopsy.
3	Regional lymph node(s) removed and the number of nodes removed is unknown or not stated; the procedure is not specified as sentinel node biopsy. Regional lymph nodes removed, NOS.
4	1 to 3 regional lymph nodes removed.
5	4 or more regional lymph nodes removed.
6	Sentinel node biopsy and code 3, 4, or 5 at same time or timing not stated.
7	Sentinel node biopsy and code 3, 4, or 5 at different times.
9	Unknown or not applicable. It is unknown whether regional lymph node surgery was performed. Death certificate only case; unknown or ill-defined primary site; hematopoietic, reticuloendothelial, ummunoproliferative or myeloproliferative disease.

Note: One important use of registry data is the tracking of treatment patterns over time. To compare contemporary treatment to previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is very important to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than 4 nodes was not reflected in surgery codes. It is not intended to reflect clinical significance when applied to a particular surgical procedure. It is important to avoid inferring, by data presentation or other method, that one category is preferable to another within the intent of these items.

RX HOSP--SCREEN/BX PROC1

Alternate Name	Item #	Length	Source of Standard	Column #
	742			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

RX HOSP--SCREEN/BX PROC2

Alternate Name	Item #	Length	Source of Standard	Column #
	743			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

RX HOSP--SCREEN/BX PROC3

Alternate Name	Item #	Length	Source of Standard	Column #
	744			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

RX HOSP--SCREEN/BX PROC4

Alternate Name	Item #	Length	Source of Standard	Column #
	745			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

RX HOSP--SURG APP 2010

Alternate Name	Item #	Length	Source of Standard	Column #
	668	1	CoC	781-781

Format:
Allowable Values: 36655
NAACCR Record Section: Hospital-Specific
Status

Description

This item is used to describe the method of surgical approach used for patients undergoing surgery of the primary site at the reporting facility. If the patient has multiple surgeries to the primary site, this item describes the approach used for the most invasive, definitive surgery

Rationale

This item is used to monitor patterns and trends in the adoption and use of minimally-invasive surgical techniques.

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing the extent of treatment given at a particular facility also helps resolve consolidation issues.

Codes

0	No surgical procedure of primary site at this facility. Diagnosed at autopsy.
1	Robotic assisted.
2	Robotic converted to open.
3	Laparoscopic.
4	Laparoscopic converted to open.
5	Open. Approach not specified.
9	Unknown whether surgery was performed; Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

RX HOSP--SURG OTH 98-02

Alternate Name	Item #	Length	Source of Standard	Column #
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) at this Facility (CoC) Surgical Procedure/Other Site at this Facility	748	1	CoC	803-803

Format:
Allowable Values: 0-9 (site specific), blank
NAACCR Record Section: Hospital-Specific
Status

Description

Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site at this facility. This field is to be used for ROADS codes after the ROADS to FORDS conversion. It is also to be used to code Surgery Other Regional/Distant Sites at the reporting facility for all tumors diagnosed before January 1,

Rationale

The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation

Codes
See the CoC ROADS Manual 1998 Supplement and the SEER Program Code Manual for site-specific codes**.**

RX HOSP--SURG OTH REG/DIS

Alternate Name	Item #	Length	Source of Standard	Column #
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) at this Facility (CoC) Surgical Procedure/Other Site at this Facility	674	1	CoC	785-785

Format:
Allowable Values: 36655
NAACCR Record Section: Hospital-Specific
Status

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

Rationale
The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement. If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps

Codes
Refer to the most recent version of FORDS for additional instructions**.**

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

RX HOSP--SURG PRIM SITE

Alternate Name	Item #	Length	Source of Standard	Column #
Cancer-Directed Surgery at This Facility (pre-96 CoC) RX Hosp--CA Dir Surgery (pre-96 NAACCR) Surgical Procedure of Primary Site	670	2	CoC	782-783

Format: Right justified, zero filled
Allowable Values: 00, 10-80, 90, 98, 99 (site specific)
NAACCR Record Section: Hospital-Specific
Status

Description
Describes surgical procedures used to treat the primary site of the reportable tumor. This item records that portion of the first course of treatment given at the reporting facility. See Chapter V, Unresolved Issues, for a discussion of differences in treatment coding among groups and over time.

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

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation

Codes

In addition to the site-specific codes, refer to the most recent version of FORDS for additional instructions.

00	None. No surgical procedure of primary site. Diagnosed at autopsy.
10-19	Site-specific codes. Tumor destruction; no pathologic specimen produced.
20-80	Site-specific codes. Resection. Path specimen produced.
90	Surgery, NOS; surgical treatment of the primary site was done, but no information on the type of procedure is provided.
98	Site specific codes; special.
99	Unknown. Patient record does not state whether surgical treatment of the primary site was performed, and no information is available. Death certificate-only.

RX HOSP--SURG SITE 98-02

Alternate Name	Item #	Length	Source of Standard	Column #
Cancer-Directed Surgery at this Facility (pre-96 CoC) RX Hosp--CA Dir Surgery (pre-96 NAACCR) Surgical Procedure of Primary Site	746	2	CoC	800-801

Format: Right justified, zero filled
Allowable Values: 00, 10-90, 99 (site specific), blank
NAACCR Record Section: Hospital-Specific
Status

Description

Describes surgical procedures used to treat the primary site of the reportable tumor. This item records that portion of the first course of treatment given at the reporting facility. This field is to be used for ROADS codes after the ROADS to FORDS conversion. It is also to be used to code Surgery Primary Site at the reporting facility for all tumors diagnosed before January 1, 2003. See Chapter V, Unresolved Issues, for a discussion of differences in treatment coding among groups and over time.

Rationale

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

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation

Codes

In addition to the site-specific codes

00	No surgery performed
99	Unknown if surgery performed

Note: See the CoC ROADS Manual 1998 Supplement and the SEER Program Code Manual for site-specific codes.

RX HOSP--SURG TIMING

Alternate Name	Item #	Length	Source of Standard	Column #
	678			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

This new data item was proposed for inclusion in Version 12 but the request was withdrawn prior to implementation of the standard. The data item was retired in Version 12.1, as of January 1, 2011.

RX SUMM--BRM

Alternate Name	Item #	Length	Source of Standard	Column #
Immunotherapy (SEER/CoC)	1410	2	SEER/CoC	1589-1590
Biological Response Modifiers (pre-96 SEER)				

Format: Right justified, zero filled
Allowable Values: 00, 01, 82, 85-88, 99
NAACCR Record Section: Treatment-1st Course
Status

Description

Records whether immunotherapeutic (biologic response modifiers) agents were administered as first-course treatment at all facilities or the reason they were not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Rationale

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.

Codes

Refer to the most recent version of FORDS and the SEER Program Code Manual for additional instructions.

00	None, immunotherapy was not part of the planned first course of therapy.
01	Immunotherapy administered as first course therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Immunotherapy 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	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record; death certificate-only cases.

Note: For tumors diagnosed on or after January 1, 2003, information on bone marrow transplants and stem cell transplants should be coded in the new field, RX SUMM--Transplnt/Endocr [3250]. The CoC standards for hospitals do not allow use of codes 02-06 in tumors diagnosed on or after January 1, 2003.

RX SUMM--CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
Chemotherapy (SEER/CoC)	1390	2	SEER/CoC	1585-1586

Format: Right justified, zero filled
Allowable Values: 00-03, 82, 85-88, 99
NAACCR Record Section: Treatment-1st Course
Status

Description

Codes for chemotherapy given as part of the first course of treatment or the reason chemotherapy was not given. Includes treatment given at all facilities as part of the first course.

Codes

Refer to the most recent version of FORDS for additional instructions.

00	None, chemotherapy was not part of the planned first course of therapy.
01	Chemotherapy, NOS.
02	Chemotherapy, single agent.
03	Chemotherapy, multiple agents.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).

85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Chemotherapy 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	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 cases.

RX SUMM--DX/STG PROC

Alternate Name	Item #	Length	Source of Standard	Column #
Non Cancer-Directed Surgery (CoC) Surgical Diagnostic and Staging Procedure (1996-2002) RX Summ--DX/Stg/Pall Proc	1350	2	CoC	1577-1578

Format: Right justified, zero filled
Allowable Values: 36716
NAACCR Record Section: Treatment-1st Course
Status

Description

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

Codes

Refer to the most recent version of FORDS for additional instructions.

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 of the primary site.
03	A surgical exploratory 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 about whether a diagnostic or staging procedure was performed.

Note: CoC recommends this item for tumors diagnosed 1996 and forward. For tumors diagnosed before 1996, this item may have been converted, and tumors with surgery would have been converted to 09 in this field. See also RX Summ--Surg Prim Site [1290] and RX Summ--Reconstruct 1st [1330]. For SEER and pre-1996 CoC, see RX Summ--Surgery Type [1640]. For tumors diagnosed between 1996 and 2002 this field may have described palliative care. For tumors diagnosed on or after January 1, 2003, palliative care is coded in a new field RX Summ--Palliative Proc [3270].

RX SUMM--HORMONE

Alternate Name	Item #	Length	Source of Standard	Column #
Hormone Therapy (SEER/CoC) Endocrine (Hormone/Steroid) Therapy (pre-96 SEER)	1400	2	SEER/CoC	1587-1588

Format: Right justified, zero filled
Allowable Values: 00, 01, 82, 85-88, 99
NAACCR Record Section: Treatment-1st Course
Status

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.

Rationale

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.

Codes

Refer to the most recent version of FORDS and the SEER Program Code Manual for additional instructions.

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.
99	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.

Note: For tumors diagnosed on or after January 1, 2003, information on endocrine surgery and/or endocrine radiation should be coded in the new field, RX Summ--Transplnt/Endocr [3250]. The CoC standards for hospitals do not allow use of codes 02-03 in tumors diagnosed on or after January 1, 2003.

RX SUMM--OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
Other Treatment (CoC)	1420	1	SEER/CoC	1591-1591
Other Cancer-Directed Therapy (SEER/pre-96 CoC)				

Format:
Allowable Values: 0-3, 6-9
NAACCR Record Section: Treatment-1st Course
Status

Description

Identifies other treatment given at all facilities that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment modifies, controls, removes, or destroys proliferating cancer tissue. Such treatments include phlebotomy, transfusions, and aspirin.

Rationale

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

Codes

Refer to the most recent version of FORDS for additional coding

0	None
1	Other
2	Other Experimental
3	Other-Double Blind
6	Other-Unproven
7	Refusal
8	Recommended
9	Unknown; unknown if administered

RX SUMM--PALLIATIVE PROC

Alternate Name	Item #	Length	Source of Standard	Column #
Palliative Procedure	3270	1	CoC	1579-1579
Palliative Care				

Format:
Allowable Values: 36716
NAACCR Record Section: Treatment-1st Course
Status

Description

Identifies any care provided in an effort to palliate or alleviate symptoms. Palliative care is performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or pain management therapy.

Rationale

This data item allows reporting facilities to track care that is considered palliative rather than diagnostic or curative intent.

Codes

0	No palliative care provided; diagnosed at autopsy
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made
4	Patient received or was referred for pain management therapy with no other palliative care
5	Any combination of codes 1, 2, and/or 3 without code 4
6	Any combination of codes 1, 2, and/or 3 with code 4
7	Palliative care was performed or referred, but no information on the type of procedure is available in the patient record
9	Unknown if palliative care was performed or referred; not stated in patient record

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RX SUMM--RAD TO CNS

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation Therapy to CNS (CoC)	1370	1	SEER/CoC	1581-1581
Radiation to the Brain and/or Central Nervous System (SEER)				

Format:
Allowable Values: 0, 1, 7-9
NAACCR Record Section: Treatment-1st Course
Status

Description

For lung and leukemia cases only, codes for radiation given to the brain or central nervous system. Includes treatment given at all facilities as part of the first course. See Chapter V, Unresolved Issues, for more information.

Codes

For Lung and Leukemia Cases only:

0	No radiation to the brain and/or central nervous system
1	Radiation
7	Patient or patient's guardian refused
8	Radiation recommended, unknown if administered
9	Unknown

For all other cases (primaries other than lung or leukemia):

9	Not applicable

Note: SEER does not collect this data item beginning with 1998 cases. They retain the codes for older cases in this field, and they have also recoded radiation coded here as radiation in RX Summ--Radiation [1360]. CoC does not collect this data item beginning with 1996 cases.

RX SUMM--RADIATION

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation (SEER/CoC)	1360	1	SEER	1580-1580
Radiation Therapy (pre-96 CoC)				

Format:

Allowable Values: 36770
NAACCR Record Section: Treatment-1st Course
Status

Description
Codes for the type of radiation therapy performed as part of the first course of treatment.

Codes

0	None
1	Beam radiation
2	Radioactive implants
3	Radioisotopes
4	Combination of 1 with 2 or 3
5	Radiation, NOS—method or source not specified
6	Currently allowable for historic cases only; see note below
7	Patient or patient's guardian refused*
8	Radiation recommended, unknown if administered*
9	Unknown if radiation administered

Note: Radiation to brain and central nervous system for leukemia and lung cases is coded as radiation in this field.

CoC discontinued collection of this item in 2003 when FORDS was implemented. For CoC, codes 7 and 8 were used for tumors diagnosed before 1996, but should have been converted to 0 in this field and to the appropriate code in the new field Reason for No Radiation [1430]. SEER continues to use codes 7 and 8 for all years. See Chapter V, Unresolved Issues, for further discussion.

In the SEER program, a code 2 for other radiation was used between 1973 and 1987. When the radiation codes were expanded to add codes '2' radioactive implants and '3' radioisotopes, all cases with a code '2' and diagnosed in 1973-1987 were converted to a code '6' radiation other than beam radiation.

RX SUMM--RECONSTRUCT 1ST

Alternate Name	Item #	Length	Source of Standard	Column #
Reconstruction--First Course (SEER) Reconstruction/Restoration-First Course (CoC)	1330	1	SEER	1575-1575

Format:
Allowable Values: 0-9 (site-specific)
NAACCR Record Section: Treatment-1st Course
Status

Description
Codes for surgical procedures done to reconstruct, restore, or improve the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or therapies. Reconstructive/restorative procedures are coded here when started during the first course of therapy.

CoC introduced site-specific codes for this item in the CoC ROADS Manual 1998 Supplement. RX Coding System--Current [1460] identifies which coding system applies.

SEER collects reconstructive procedures for breast cancer tumors only. For reconstructive/restorative procedures performed later, see Subseq RX--Reconstruct Del [1741]. See also RX Summ--Surgery Type [1640].

Note: This data item is no longer supported by CoC (as of January 1, 2003).

RX SUMM--REG LN EXAMINED

Alternate Name	Item #	Length	Source of Standard	Column #
Number of Regional Lymph Nodes Examined (SEER/CoC) Number of Regional Lymph Nodes Removed (CoC)	1296	2	SEER/CoC	1571-1572

Format: Right justified, zero filled
Allowable Values: 00-90, 95-99
NAACCR Record Section: Treatment-1st Course
Status

Description

Codes for the number of regional lymph nodes examined in conjunction with surgery performed as part of the first-course treatment. This includes treatment given at all facilities as part of the first course of treatment. See also RX Summ--Scope Reg LN Sur [1292].

Codes

00	No regional lymph nodes examined
01	One regional lymph node examined
02	Two regional lymph nodes examined
..	
..	
90	90 or more regional lymph nodes examined
..	
95	No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed
96	Regional lymph node removal documented as sampling, and number of lymph nodes unknown/not stated
97	Regional lymph node removal documented as a dissection, and number of lymph nodes unknown/not stated
98	Regional lymph nodes surgically removed, but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99	Unknown; not stated; death certificate-only

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

RX SUMM--SCOPE REG 98-02

Alternate Name	Item #	Length	Source of Standard	Column #
Scope of Regional Lymph Node Surgery (SEER/CoC)	1647	1	SEER/CoC	1622-1622

Format:
Allowable Values: 0-9 (site specific)
NAACCR Record Section: Treatment-1st Course
Status

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. This field is to be used for ROADS codes after the ROADS to FORDS conversion. It is also to be used to code Scope of Regional Lymph Node Surgery at all facilities for all tumors diagnosed before January 1, 2003.

Rationale

In evaluating quality of care and treatment practices it is important to identify 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.

Codes

See the CoC ROADS Manual 1998 Supplement and the SEER Program Code Manual for site-specific codes.

RX SUMM--SCOPE REG LN SUR

Alternate Name	Item #	Length	Source of Standard	Column #
Scope of Regional Lymph Node Surgery (SEER/CoC)	1292	1	SEER/CoC	1569-1569

Format:
Allowable Values: 36716
NAACCR Record Section: Treatment-1st Course
Status

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.

Rationale

In evaluating quality-of-care and treatment practices it is important to identify 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.

Codes

(Refer to the most recent version of FORDS and SEER Program Code Manual for additional instructions.)

0	None
1	Biopsy or aspiration of regional lymph node, NOS
2	Sentinel lymph node biopsy
3	Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS
4	1 to 3 regional lymph nodes removed
5	4 or more regional lymph nodes removed
6	Sentinel node biopsy and code 3, 4, or 5 at same time or timing not noted
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

Note: One important use of registry data is the tracking of treatment patterns over time. To compare contemporary treatment to previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is very important to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than 4 nodes was not reflected in surgery codes. It is not intended to reflect clinical significance when applied to a particular surgical procedure. It is important to avoid inferring, by data presentation or other methods, that one category are preferable to another within the intent of these items.

RX SUMM--SCREEN/BX PROC1

Alternate Name	Item #	Length	Source of Standard	Column #
	1642			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

RX SUMM--SCREEN/BX PROC2

Alternate Name	Item #	Length	Source of Standard	Column #
	1643			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

RX SUMM--SCREEN/BX PROC3

Alternate Name	Item #	Length	Source of Standard	Column #
	1644			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

RX SUMM--SCREEN/BX PROC4

Alternate Name	Item #	Length	Source of Standard	Column #
	1645			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

RX SUMM--SURG OTH 98-02

Alternate Name	Item #	Length	Source of Standard	Column #
Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes (SEER/CoC) Surgical Procedure/Other Site	1648	1	SEER/CoC	1623-1623

Format: Right justified, zero filled
Allowable Values: 0-9 (site specific), blank
NAACCR Record Section: Treatment-1st Course
Status

Description

Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site given at all facilities as part of the first course of treatment. This field is to be used for ROADS codes after the ROADS to FORDS conversion. It is also to be used to code Surgery Regional/Distant Sites at all facilities for all tumors diagnosed before January 1, 2003.

Rationale

The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Codes

See the CoC ROADS Manual 1998 Supplement and the SEER Program Code Manual for site-specific codes.

RX SUMM--SURG OTH REG/DIS

Alternate Name	Item #	Length	Source of Standard	Column #
Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes (SEER/CoC) Surgical Procedure/Other Site	1294	1	SEER/CoC	1570-1570

Format:
Allowable Values: 36655
NAACCR Record Section: Treatment-1st Course
Status

Description

Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

Rationale

The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Codes

Refer to the most recent version of FORDS and SEER Program Code Manual for additional instructions.

0	None; diagnosed at autopsy
1	Non-primary surgical procedure performed
2	Non-primary surgical procedure to other regional sites
3	Non-primary surgical procedure to distant lymph node(s)
4	Non-primary surgical procedure to distant site
5	Any combination of codes 2, 3, or 4

9	Unknown; death certificate only

RX SUMM--SURG PRIM SITE

Alternate Name	Item #	Length	Source of Standard	Column #
Cancer-Directed Surgery (pre-96 CoC) Surgery of Primary Site (SEER/CoC)	1290	2	SEER/CoC	1567-1568

Format: Right justified, zero filled
Allowable Values: 00, 10-80, 90, 98, 99 (site specific)
NAACCR Record Section: Treatment-1st Course
Status

Description

Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment. This includes treatment given at all facilities as part of the first course of treatment.

Codes

In addition to the site-specific codes; Refer to the most recent version of FORDS and SEER Program Code manual for additional instructions.

00	None
10-19	Site-specific code; tumor destruction
20-80	Site-specific codes; resection
90	Surgery, NOS
98	Site specific codes; special
99	Unknown

RX SUMM--SURG SITE 98-02

Alternate Name	Item #	Length	Source of Standard	Column #
Cancer-Directed Surgery (pre-96 CoC) Surgery of Primary Site (SEER/CoC)	1646	2	SEER/CoC	1620-1621

Format: Right justified, zero filled
Allowable Values: 00, 10-90, 99 (site specific), blank
NAACCR Record Section: Treatment-1st Course
Status

Description

Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment. This includes treatment given at all facilities as part of the first course of treatment. This field is to be used for ROADS codes after the ROADS to FORDS conversion. It is also to be used to code Surgery Primary Site at all facilities for all tumors diagnosed before January 1, 2003.

Rationale

If central registries wish to study the treatment given at particular hospitals, the hospital-level treatment fields must be

Codes

In addition to the site-specific codes

00	No primary site surgery performed
99	Unknown if primary site surgery performed

Note: See the CoC ROADS Manual, 1998 Supplement, CoC Coding System [2140] code 7, and the SEER Program Code Manual, RX Coding System [1460] code 5, 1998 for site-specific codes.

RX SUMM--SURG/RAD SEQ

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation Sequence with Surgery (pre-96 SEER/CoC) Radiation/Surgery Sequence (CoC)	1380	1	SEER/CoC	1582-1582

Description

Codes for the sequencing of radiation and surgery given as part of the first course of treatment. See also RX Summ--Surg Prim Site [1290], RX Summ--Scope LN Surg [1292], RX Summ--Surg Oth Reg/Dis [1294], and RX Summ--Radiation

Codes

0	No radiation and/or no surgery; unknown if surgery and/or radiation given
2	Radiation before surgery
3	Radiation after surgery
4	Radiation both before and after surgery
5	Intraoperative radiation
6	Intraoperative radiation with other radiation given before or after surgery
9	Sequence unknown, but both surgery and radiation were given

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RX SUMM--SURGERY TYPE

Alternate Name	Item #	Length	Source of Standard	Column #
Site--Specific Surgery (pre-98 SEER)	1640	2	SEER	1617-1618

Format: Right justified, zero filled
Allowable Values: 00-99 (site-specific)
NAACCR Record Section: Treatment-1st Course
Status

Description

Field for pre-1996 surgery codes for CoC and pre-1998 surgery codes for SEER. Surgery codes used 1998 and later can be backward converted into the older codes and the converted value can be stored in this field. See Chapter V, Unresolved Issues, for discussion of CoC/SEER differences in coding treatment.

RX SUMM--SURGICAL APPROCH

Alternate Name	Item #	Length	Source of Standard	Column #
Surgical Approach (CoC)	1310	1	CoC	1573-1573

Format:
Allowable Values: 0-9 (site-specific)
NAACCR Record Section: Treatment-1st Course
Status

Description

Codes for method used to approach the surgical field for the primary site.

Codes

See the CoC ROADS Manual, 1998 Supplement, for site-specific codes.

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained. This former item should not be confused with NAACCR item [668] RX HOSP--SURG APP 2010.

RX SUMM--SURGICAL MARGINS

Alternate Name	Item #	Length	Source of Standard	Column #
Surgical Margins (CoC)	1320	1	CoC	1574-1574
Residual Primary Tumor Following Cancer-Directed Surgery (pre-96 CoC)				

Format:
Allowable Values: 0-3, 7-9
NAACCR Record Section: Treatment-1st Course
Status

Description

Codes describe the final status of surgical margins after resection of the primary tumor. See also RX Summ--Surg Prim Site [1290].

Rationale

This item serves as a quality measure for pathology reports, is used for staging, and may be a prognostic factor in recurrence. This item is not limited to cases that have been staged. It applies to all cases that have a surgical procedure of the primary site.

Codes

Refer to the most recent version of FORDS for additional instructions.

0	No residual tumor
1	Residual tumor, NOS
2	Microscopic residual tumor
3	Macroscopic residual tumor
7	Margins not evaluable
8	No primary site surgery
9	Unknown or not applicable

Note: Codes were site specific (1998-2002), and have been changed to be generic across all disease sites.

RX SUMM--SYSTEMIC/SUR SEQ

Alternate Name	Item #	Length	Source of Standard	Column #
Systemic/Surgery Sequence	1639	1	CoC	1616-1616

Format:
Allowable Values: 0, 2-6, 9
NAACCR Record Section: Treatment-1st Course
Status

Description

Records the sequencing of systemic therapy (RX Summ-Chemo [1390], RX Summ-Hormone [1400], RX Summ-BRM [1410], and RX Summ-Transplnt/Endocr [3250]) and surgical procedures given as part of the first course of treatment. See also RX Summ--Surg Prim Site [1290], RX Summ--Scope LN Surg [1292], and RX Summ--Surg Oth Reg/Dis [1294].

Rationale

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 time of delivery of treatment to the patient.

Codes

0	No systemic therapy and/or surgical procedures; unknown if surgery and/or systemic therapy given
2	Systemic therapy before surgery
3	Systemic therapy after surgery
4	Systemic therapy both before and after surgery
5	Intraoperative systemic therapy
6	Intraoperative systemic therapy with other therapy administered before or after surgery
9	Sequence unknown, but both surgery and systemic therapy given

---

RX SUMM--TRANSPLNT/ENDOCR

Alternate Name	Item #	Length	Source of Standard	Column #
Hematologic Transplant and Endocrine Procedures	3250	2	CoC	1583-1584

Format: Right justified, zero filled
Allowable Values: 00, 10-12, 20, 30, 40, 82, 85-88, 99
NAACCR Record Section: Treatment-1st Course
Status

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.

Rationale

This data item 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.

Codes

Refer to the most recent version of FORDS for additional instructions.

00	No transplant procedure or endocrine therapy was administered as part of first course therapy; diagnosed at autopsy
10	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
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).
85	Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Hematologic transplant and/or endocrine surgery/radiation was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian; refusal 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 cases.

RX SUMM--TREATMENT STATUS

Alternate Name	Item #	Length	Source of Standard	Column #
	1285	1	SEER/CoC	1566-1566

Format:
Allowable Values: 36565
NAACCR Record Section: Treatment-1st Course
Status

Description

This data item is a summary of the status for all treatment modalities. It is used in conjunction with Date of Initial RX-SEER [1260] and/or Date of 1st Crs RX--CoC [1270] and each modality of treatment with their respective date field to document whether treatment was given or not given, whether it is unknown if treatment was given, or whether treatment was given on an unknown date. Also indicates active surveillance (watchful waiting). This data item is effective for January 2010+ diagnoses.

Rationale

This field will document active surveillance (watchful waiting) and eliminate searching each treatment modality to determine whether treatment was given.

Codes

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

RX TEXT--BRM

Alternate Name	Item #	Length	Source of Standard	Column #
	2660	1000	NPCR	17765-18764

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed

NAACCR Record Section: Text-Treatment
Status

Description

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

Rationale

Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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.
Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

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

Codes:
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 in the following fields:

Item name	Item number
Date of Initial RX--SEER	1260
Date of 1st Crs RX--CoC	1270
RX Hosp--BRM	720
RX Date Systemic	3230
RX Summ--Tranplnt/Endocr	3250
RX Summ--BRM	1410
RX Date--BRM	1240
RX Summ--Systemic/Sur Seq	1639

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

RX TEXT--CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
	2640	1000	NPCR	15765-16764

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Treatment
Status

Description

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

Rationale

Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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 <b>and should not be generated electronically from coded values.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

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.

Codes:
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 in the following fields:

Item name	Item number
Date of Initial RX--SEER	1260
Date of 1st Crs RX--CoC	1270
RX Summ--Chemo	1390
RX Hosp--Chemo	700
RX Date--Systemic	3230
RX Date--Chemo	1220
RX Summ--Systemic/Sur Seq	1639

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

RX TEXT--HORMONE

Alternate Name	Item #	Length	Source of Standard	Column #
	2650	1000	NPCR	16765-17764

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Treatment
Status

Description
Text area for information about hormonal treatment.

Rationale
Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.

- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

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.

Codes:
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 in the following fields:

Item name	Item number
Date of Initial RX--SEER	1260
Date of 1st Crs RX--CoC	1270
RX Summ--Hormone	1400
RX Hosp--Hormone	710
RX Date--Systemic	3230
RX Date--Hormone	1230
RX Summ--Systemic/Sur Seq	1639

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

RX TEXT--OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
	2670	1000	NPCR	18765-19764

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Treatment
Status

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.

Rationale

Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

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.

Codes:
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 in the following fields:

Item name	Item number
Date of Initial RX--SEER	1260
Date of 1st Crs RX--CoC	1270
RX Summ--Other	1420
RX Date--Other	1250
RX Hosp--Other	730

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

RX TEXT--RADIATION (BEAM)

Alternate Name	Item #	Length	Source of Standard	Column #
	2620	1000	NPCR	13765-14764

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Treatment
Status

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

Rationale
Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

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.

Code:
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 in the following fields:

Item name	Item number
Date of Initial RX--SEER	1260
Date of 1st Crs RX--CoC	1270

RX Summ--Radiation	1360
RX Summ--Surg/Rad Seq	1380
Reason For No Radiation	1430
RX Date--Radiation	1210
Rad Regional RX Modality	1570
RX Hosp--Radiation	690
RX Date Radiation Ended	3220
RX Summ--Rad to CNS	1370
Rad--No of Treatment Vol	1520
Rad--Regional Dose cGy	1510
Rad Treatment Volume	1540
Rad Location of RX	1550
Rad Boost RX Modality	3200
Rad Boost Dose cGy	3210

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

RX TEXT--RADIATION OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
	2630	1000	NPCR	14765-15764

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Treatment
Status

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.

Rationale

Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

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

Codes:

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 in the following fields:

Item name	Item number
Date of Initial RX--SEER	1260

Date of 1st Crs RX--CoC	1270
RX Summ--Radiation	1360
RX Summ--Surg/Rad Seq	1380
Reason For No Radiation	1430
RX Date--Radiation	1210
Rad Regional RX Modality	1570
RX Hosp--Radiation	690
RX Date Radiation Ended	3220
RX Summ--Rad to CNS	1370
Rad--No of Treatment Vol	1520
Rad--Regional Dose cGy	1510
Rad Treatment Volume	1540
Rad Location of RX	1550
Rad Boost RX Modality	3200
Rad Boost Dose cGy	3210

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

RX TEXT--SURGERY

Alternate Name	Item #	Length	Source of Standard	Column #
	2610	1000	NPCR	12765-13764

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Treatment
Status

Description
Text area for information describing all surgical procedures performed as part of treatment.

Rationale
Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

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.

Codes:
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 in the following fields:

Item name	Item number
Date of Initial RX--SEER	1260
Date of 1st Crs RX--CoC	1270
RX Date Surgery	1200
RX Summ--Surg Prim Site	1290
RX Hosp--Surg Prim Site	670
RX Summ--Scope Reg LN Sur	1292
RX Hosp--Scope Reg LN Sur	672
RX Summ--Surg Oth Reg/Dis	1294
RX Hosp--Surg Oth Reg/Dis	674
Reason for No Surgery	1340
RX Summ--Surgical Margins	1320
RX Hosp--Palliative Proc	3280
RX Summ--Palliative Proc	3270
Text--Place of Diagnosis	2690
RX Summ--Surg/Rad Seq	1380
RX Summ--Systemic/Sur Seq	1639

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

SCREENING DATE

Alternate Name	Item #	Length	Source of Standard	Column #
	510			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

SCREENING RESULT

Alternate Name	Item #	Length	Source of Standard	Column #
	520			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

SEER CODING SYS--CURRENT

Alternate Name	Item #	Length	Source of Standard	Column #
	2120	1	NAACCR	1930-1930

Format:
Allowable Values: Alphanumeric
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: Revised

Description

This shows the SEER coding system best describing the majority of SEER items as they are in the record (after

Rationale

Change the allowable values to alpha-numeric in order to accommodate SEER Program Manual editions.

Codes

0	No SEER coding
1	Pre-1988 SEER Coding Manuals
2	1988 SEER Coding Manual
3	1989 SEER Coding Manual
4	1992 SEER Coding Manual
5	1998 SEER Coding Manual
6	2003 SEER Coding Manual
7	2004 SEER Coding Manual
8	2007 SEER Coding Manual
A	January 2010 SEER Coding Manual
9	January 2008 SEER Coding Manual

SEER CODING SYS--ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Column #
	2130	1	NAACCR	1931-1931

Format:
Allowable Values: Alphanumeric
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status: Revised

Description

This shows the SEER coding system best describing the way the majority of SEER items in the record were originally

Rationale

Change the allowable values to alpha-numeric in order to accommodate SEER Program Manual editions.

Codes

0	No SEER coding
1	Pre-1988 SEER Coding Manuals
2	1988 SEER Coding Manual
3	1989 SEER Coding Manual
4	1992 SEER Coding Manual
5	1998 SEER Coding Manual
6	2003 SEER Coding Manual
7	2004 SEER Coding Manual
8	2007 SEER Coding Manual
A	January 2010 SEER Coding Manual
9	January 2008 SEER Coding Manual

SEER RECORD NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
Record Number (SEER)	2190	2	SEER	1947-1948

Format: Right justified, zero filled
Allowable Values: 36161
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

A unique sequential number assigned by the SEER participant to each record for the person for each submission. The number may change from submission to submission. See also Tumor Record Number [60].

Codes

01	One or first of more than one record for person
02	Second record for person
..	
..	
nn	Last of nn records for person

SEER SITE-SPECIFIC FACT 1

Alternate Name	Item #	Length	Source of Standard	Column #
	3700	1	SEER	1179-1179

Format:
Allowable Values: 0-9, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale

This field is a place holder when site-specific information is needed for SEER.

Codes

To be determined for each site where needed. Refer to the most current version of the SEER Program Coding and Staging Manual, Supplement 3 for details.

Blank Field not coded

SEER SITE-SPECIFIC FACT 2

Alternate Name	Item #	Length	Source of Standard	Column #
	3702	1	SEER	1180-1180

Format:
Allowable Values: 0-9, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale

This field is a place holder when site-specific information is needed for SEER.

Codes

To be determined for each site where needed. Refer to the most current version of the SEER Program Coding and Staging Manual, Supplement 3 for details.

Blank Field not coded

SEER SITE-SPECIFIC FACT 3

Alternate Name	Item #	Length	Source of Standard	Column #
	3704	1	SEER	1181-1181

Format:
Allowable Values: 0-9, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale

This field is a place holder when site-specific information is needed for SEER.

Codes

To be determined for each site where needed. Refer to the most current version of the SEER Program Coding and Staging Manual, Supplement 3 for details.

Blank Field not coded

SEER SITE-SPECIFIC FACT 4

Alternate Name	Item #	Length	Source of Standard	Column #
	3706	1	SEER	1182-1182

Format:
Allowable Values: 0-9, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale

This field is a place holder when site-specific information is needed for SEER.

Codes

To be determined for each site where needed. Refer to the most current version of the SEER Program Coding and Staging Manual, Supplement 3 for details.

Blank	Field not coded

SEER SITE-SPECIFIC FACT 5

Alternate Name	Item #	Length	Source of Standard	Column #
	3708	1	SEER	1183-1183

Format:
Allowable Values: 0-9, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale

This field is a place holder when site-specific information is needed for SEER.

Codes

To be determined for each site where needed. Refer to the most current version of the SEER Program Coding and Staging Manual, Supplement 3 for details.

Blank	Field not coded

SEER SITE-SPECIFIC FACT 6

Alternate Name	Item #	Length	Source of Standard	Column #
	3710	1	SEER	1184-1184

Format:
Allowable Values: 0-9, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale

This field is a place holder when site-specific information is needed for SEER.

Codes

To be determined for each site where needed. Refer to the most current version of the SEER Program Coding and Staging Manual, Supplement 3 for details.

Blank	Field not coded

SEER SUMMARY STAGE 1977

Alternate Name	Item #	Length	Source of Standard	Column #
General Summary Stage (SEER/CoC)	760	1	SEER	905-905

Format:
Allowable Values: 0-5, 7, 8, 9
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Code for summary stage at the initial diagnosis or treatment of the reportable tumor. This has traditionally been used by central registries to monitor time trends. For hospital registries, CoC requires its use in the absence of a defined AJCC classification. For site-specific definitions of categories, see the SEER Summary Staging Guide.

SEER Summary Stage 1977 is limited to information available within 2 months of the date of diagnosis. NAACCR approved extension of this time period to 4 months for prostate tumors diagnosed beginning January 1, 1995.

Rationale

Stage information is important when evaluating the effects of cancer control programs. It is crucial for understanding whether changes over time in incidence rates or outcomes are due to earlier detection of the cancers. In addition, cancer treatment cannot be studied without knowing the stage at diagnosis.

To study historical trends in stage, the coding system must be relatively unchanged (stable) over time. AJCC's TNM system is updated periodically to maintain clinical relevance with changes in diagnosis and treatment. The surveillance registries often rely on the Summary Stage, which they consider to be more "stable." Summary Stage has been in widespread use, either as the primary staging scheme or a secondary scheme, in most central and hospital registries since 1977.

Codes

0	In situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant
8	Not applicable
9	Unstaged

Clarification

Code 8 has been added in Version 10.1 to be used when there is not an applicable code to reflect stage (e.g., benign brain, borderline ovarian).

See also the item Derived SS1977 [3010] for the value of SEER Summary Stage 1977 as generated by the Collaborative Staging algorithm.

Clarification of NAACCR and NPCR Required Status
Summary stage is required. The correct data item to use (and corresponding code manual) is determined by the year in which the cancer was diagnosed. Tumors diagnosed on or after January 1, 2004, should be assigned a summary stage based upon the Collaborative Stage data item algorithms and retained in Derived SS2000 [3020]. Tumors diagnosed on or after January 1, 2001, should be assigned a summary stage according to the SEER Summary Staging Manual 2000, and the code should be reported in SEER Summary Stage 2000 [759]. Tumors diagnosed before January 1, 2001, should be assigned a summary stage according to SEER Summary Stage Guide 1977, and the code should be reported in SEER Summary Stage 1977 [760].

SEER SUMMARY STAGE 2000

Alternate Name	Item #	Length	Source of Standard	Column #
	759	1	SEER	904-904

Format:
Allowable Values: 0-5, 7, 8, 9
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Code for summary stage at the initial diagnosis or treatment of the reportable tumor. For hospital registries, CoC requires its use in the absence of a defined AJCC classification. For site-specific definitions of categories, see SEER Summary Staging Manual 2000.

Summary stage should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Rationale

Stage information is important when evaluating the effects of cancer control programs. It is crucial in understanding whether changes over time in incidence rates or outcomes are due to earlier detection of the cancers. In addition, cancer treatment cannot be studied without knowing the stage at diagnosis.

Codes

0	In situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant
8	Not applicable
9	Unstaged

Clarification

Code 8 has been added in Version 10.1 to be used when there is not an applicable code to reflect stage (e.g., benign brain, borderline ovarian).

See also the item Derived SS2000 [3020] for the value of SEER Summary Stage 2000 as generated by the collaborative Staging algorithm.

Clarification of NAACCR and NPCR Required Status
Summary stage is required. The correct data item to use (and corresponding code manual) is determined by the year in which the cancer was diagnosed. Tumors diagnosed on or after January 1, 2004, should be assigned a summary stage based upon the Collaborative Stage data item algorithms and retained in Derived SS2000 [3020]. Tumors diagnosed on or after January 1, 2001, should be assigned a summary stage according to the SEER Summary Staging Manual 2000, and the code should be reported in SEER Summary Stage 2000 [759]. Tumors diagnosed before January 1, 2001, should be assigned a summary stage according to SEER Summary Stage Guide 1977, and the code should be reported in SEER Summary Stage 1977 [760].

SEER TYPE OF FOLLOW-UP

Alternate Name	Item #	Length	Source of Standard	Column #
Type of Follow-Up (SEER)	2180	1	SEER	1946-1946

Format:
Allowable Values: 40547
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Codes for the type of follow-up expected for a SEER case.

Codes

1	“Autopsy-Only” or “Death Certificate-Only” case
2	Active follow-up case
3	In situ cancer of the cervix uteri only
4	Case not originally in active follow-up, but in active follow-up now (San Francisco-Oakland only)

SEQUENCE NUMBER--CENTRAL

Alternate Name	Item #	Length	Source of Standard	Column #
Sequence Number (pre-96 SEER)	380	2	SEER	528-529

Format: Right justified, zero filled
Allowable Values: 00-35, 60-87, 88, 98, 99
NAACCR Record Section: Cancer Identification
Status

Description

Code indicates the sequence of all reportable neoplasms over the lifetime of the person. This data item differs from Sequence Number-Hospital [560], because the definitions of reportable neoplasms often vary between a hospital and a central registry. Each neoplasm is assigned a different number. Sequence Number 00 indicates that the person has had only one in situ or one malignant neoplasm as defined by the Federal reportable list (regardless of central registry reference date). Sequence Number 01 indicates the first of two or more reportable neoplasms, but 02 indicates the second of two or more reportable neoplasms, and so on. Because the time period of Sequence Number is a person's lifetime, reportable neoplasms not included in the central registry (those that occur outside the registry catchment area or before the reference date) also are 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 preceded the central registry's reference date.

Reporting Requirements:

Federally Required and State/Province Defined
The Federal or SEER/NPCR standard defining the reportable neoplasms is described in Chapter III, Standards For Tumor Inclusion and Reportability. It is assumed that this shared standard is the "minimum" definition of reportability. Individual central cancer registries may define additional neoplasms as reportable.

Numeric codes in the 00-59 range indicate the sequence of neoplasms of in situ or malignant behavior (2 or 3) at the time of diagnosis, which SEER/NPCR standards require to be reported. Codes 60 to 87 indicate the sequence of non-malignant tumors (as defined in Chapter III) and any other neoplasms that the central registry has defined as reportable. Neoplasms required by SEER/NPCR with an in situ or malignant behavior at the time of diagnosis are sequenced completely independently of this higher-numbered category. Sequence Number-Hospital does not affect Sequence Number-Central. The two notational systems are independent but central registries should take Sequence Number-Hospital [560] into account when coding Sequence Number Central.

Rationale

The purpose of sequencing based on the patient's lifetime is to truly identify the 00s, the people who only had one malignant primary in their lifetimes for survival analysis. If a central registry sequences by just what is reported to them, then it will be unclear whether 00 means the person only had one malignant primary in his lifetime or the person had one malignant primary since the central registry started collecting data. The Federally required reportable list has changed throughout the years, so the registry must use the appropriate reportable list for the year of diagnosis. The central registry reference date will not affect Sequence Number-Central.

Codes

In Situ /Malignant as Federally Required based on Diagnosis Year:

00	One primary in the patient's lifetime
01	First of two or more primaries
02	Second of two or more primaries
..	
..	
59	Fifty-ninth or higher of fifty-nine or more primaries
99	Unspecified or unknown sequence number of Federally required in situ or malignant tumors. Sequence number 99 can be used if there is a malignant tumor and its sequence number is unknown. If there is known to be more than one malignant tumor, then the tumors must be sequenced.)

Non-malignant Tumor as Federally Required based on Diagnosis Year or State/Province Defined:

60	One non-malignant tumor or central registry-defined neoplasm
61	First of two or more non-malignant tumor or central registry-defined neoplasms
62	Second of two or more non-malignant tumor or central registry-defined neoplasms
..	..
88	Unspecified or unknown sequence number for non-malignant tumor or central registry-defined neoplasms. (Sequence number 88 can be used if there is a non-malignant tumor and its sequence number is unknown. If there is known to be more than one non-malignant tumor, then the tumors must be sequenced.)
98	Cervix carcinoma in situ (CIS)/CIN III, Diagnosis Years 1996-2002.

The table that follows shows which sequence number series to use by type of neoplasm.

Code Number	Code Description
In Situ/Malignant as Federally Required based on Diagnosis Year	
In Situ (behavior code = 2) (Cervix CIS/CIN III, Diagnosis Year before 1996) (includes VIN III, VAIN III, AIN III)	00 - 59
Malignant (behavior code = 3)	00 - 59
Juvenile Astrocytoma, Diagnosis Year 2001+ (*)	00 - 59
Invasive following *In Situ*--New primary as defined by CoC	00 - 59
Invasive following *In Situ*--New primary as defined by SEER	00 - 59
Unspecified Federally Required Sequence Number or Unknown	99

Non-malignant Tumor as Federally Required based on Diagnosis Year or State/Province Registry-Defined
Examples:

Non-malignant Tumor/Benign Brain	60 - 87
Borderline Ovarian, Diagnosis Year 2001+	60 - 87
Other Borderline/Benign	60 - 87
Skin SCC/BCC	60 - 87
PIN III	60 - 87
Cervix CIS/CIN III, Diagnosis Year 2003+	60 - 87
Unspecified Non-malignant Tumor or Central Registry-Defined Sequence Number	88
Cervix CIS/CIN III, Diagnosis Year 1996-2002	98

*Juvenile astrocytomas should be reported as 9421/3.

SEQUENCE NUMBER--HOSPITAL

Alternate Name	Item #	Length	Source of Standard	Column #
Sequence Number (CoC)	560	2	CoC	740-741

Format: Right justified, zero filled
Allowable Values: 00-35, 60-87, 88, 99
NAACCR Record Section: Hospital-Specific
Status

Description

Item indicates the sequence of all malignant and non-malignant neoplasms over the lifetime of the patient. The code may differ from the Sequence Number--Central [380] because the definitions of reportable neoplasms often vary between a hospital and a central registry. The two items also handle some types of tumors differently. Each neoplasm is assigned a different number. Sequence Number 00 indicates that the person has only one malignant neoplasm in his lifetime (regardless of hospital registry reference date). 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.

Sequence numbers should be reassigned if the facility subsequently learns of an unaccessioned tumor that affects sequencing. Sequence Number-Central [380] does not affect Sequence Number-Hospital. The two notational systems are independent.

Timing Rule
If two or more malignant tumors are diagnosed at the same time, the lowest sequence number will be assigned to the diagnosis with the worst prognosis. Likewise, if two or more non-malignant tumors are diagnosed at the same time, the lowest sequence number is assigned to the diagnosis with the worse prognosis. If no difference in prognosis is evident, the decision is arbitrary.

Codes
In situ and Malignant Tumors:

00	One malignant primary only in the patient's lifetime
01	First of two or more malignant primaries
02	Second of two or more malignant primaries
..	
..	(Actual number of this malignant primary)
..	
59	Fifty-ninth or higher of fifty-nine or more malignant primaries
99	Unspecified sequence number of a primary malignant tumor or unknown (When a patient has multiple tumors with Unspecified / unknown sequence numbers code 99 should only be used once.)

Nonmalignant Tumors

60	Only one non-malignant tumor in the patient's lifetime
61	First of two or more non-malignant tumors
62	Second of two or more non-malignant tumors
..	
88	Unspecified number of non-malignant tumors (When a patient has multiple unspecified neoplasms in this category code 88 should only be used once.)

The table that follows shows which sequence number series to use by type of neoplasm

Neoplasm	**SeqNum--Hospital**
***In situ* and Malignant**	**(code range)**
One *in situ* (behavior code = 2) or malignant (behavior code =3) primary tumor only in the patient's lifetime	00

First of multiple *in situ* or malignant primary tumors in the patient's lifetime	01
Actual sequence of two or more *in situ* or malignant primary tumors	02 - 59
Unspecified malignant sequence number or unknown	99
Non-Malignant	
One benign (behavior code = 0) or borderline (behavior code = 1) primary tumor only in the patient's lifetime	60
First of two or more benign or borderline primary tumors in the patient's lifetime	61
Actual sequence of two or more non-malignant primary tumors	62 - 87
Unspecified non-malignant sequence number or unknown	88
*Juvenile astrocytomas should be reported as 9421/3.	

Note: See the section on Sequence Number in CoC FORDS manual.

SEX

Alternate Name	Item #	Length	Source of Standard	Column #
	220	1	SEER/CoC	192-192

Format:
Allowable Values: 39817
NAACCR Record Section: Demographic
Status

Description

Code for the sex of the patient.

Codes

1	Male
2	Female
3	Other (hermaphrodite)
4	Transsexual
9	Not stated/Unknown

SITE (73-91) ICD-O-1

Alternate Name	Item #	Length	Source of Standard	Column #
Primary Site (1973-91) (SEER)	1960	4	SEER	1909-1912

Format: Four digits, first digit equals 1. Reference ICD-O-1 for valid entries
Allowable Values: 1400-1999
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description

Area for retaining the ICD-O-1 primary site code entered before conversion to ICD-0-2. The item name includes years 1973-91. However, some states may have used the codes for cases before 1973.

Codes

For tumors diagnosed before 1992, contains the ICD-O-1 site code as originally coded, if available. Blank for tumors coded directly into ICD-O-2 (i.e., 1992 and later tumors).

SITE CODING SYS--CURRENT

Alternate Name	Item #	Length	Source of Standard	Column #
	450	1	NAACCR	558-558

Format:
Allowable Values: 39819
NAACCR Record Section: Cancer Identification
Status

Description
Code that best describes how the primary site currently is coded. If converted, this field shows the system to which it is converted.

Codes

1	ICD-8 and MOTNAC
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

SITE CODING SYS--ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Column #
	460	1	NAACCR	559-559

Format:
Allowable Values: 39819
NAACCR Record Section: Cancer Identification
Status

Description
Code that best describes how primary site was originally coded. If converted, this field shows the original coding system

Codes

1	ICD-8 and MOTNAC
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

SITE OF DISTANT MET 1

Alternate Name	Item #	Length	Source of Standard	Column #
	1090			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description
The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

SITE OF DISTANT MET 2

Alternate Name	Item #	Length	Source of Standard	Column #
	1100			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description
The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

SITE OF DISTANT MET 3

Alternate Name	Item #	Length	Source of Standard	Column #
	1110			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description
The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

SOCIAL SECURITY NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	2320	9	CoC	3619-3627

Format: 9 digits, no dashes
Allowable Values: Any 9-digit number except 000000000
NAACCR Record Section: Patient-Confidential
Status

Description
Records patient's social security number. The number is entered without dashes and without any letter suffix. This is not always identical to the Medicare claim number.

Codes
In addition to social security number
999999999 Unknown

SPANISH/HISPANIC ORIGIN

Alternate Name	Item #	Length	Source of Standard	Column #
Spanish Origin--All Sources (96 CoC) Spanish Surname or Origin (SEER)	190	1	SEER/CoC	189-189

Format:
Allowable Values: 36747
NAACCR Record Section: Demographic
Status

Description
Code identifying persons of Spanish or Hispanic origin. This code is used by hospital and central registries to show the "best guess" as to whether or not the person should be classified as Hispanic for purposes of calculating cancer rates. If the patient has multiple tumors, all records should have the same code.

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf

All information resources should be used to determine the correct code, including:
- Stated ethnicity in the medical record
- Stated Hispanic origin on the death certificate
- Birthplace
- Information about life history and/or language spoken found during the abstracting process
- Patient's last name [2230] or maiden name [2390] found on a list of Hispanic names

Some registries code the information from the medical record, others code ethnicity based on Spanish names, and others use a combination of methods.

Persons of Spanish or Hispanic origin may be of any race, but these categories generally are not used for Native Americans, Filipinos, etc., who may have Spanish names. If a patient has an Hispanic name, but there is reason to believe they are not Hispanic (e.g., the patient is Filipino, or the patient is a woman known to be non-Hispanic who has a Hispanic married name), the code in this field should be 0 (non-

Spanish, non-Hispanic). The code in item Computed Ethnicity [200], however, would reflect the Hispanic name.

Assign code 7 if Hispanic ethnicity is based strictly on a computer list or algorithm (unless contrary evidence is available) and also code in Computed Ethnicity [200].

See also Computed Ethnicity [200].

Rationale

See the rationales for the Race 1-5 [160-164] and Computed Ethnicity [200]. Ethnic origin has a significant association with cancer rates and outcomes. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the “white” category of Race [160].

Codes

0	Non-Spanish; non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS
6	Hispanic, NOS
6	Latino, NOS.There is evidence, other than surname or maiden name, that the person is Hispanic, but he/she cannot be assigned to any of the categories 1-5
7	Spanish surname only (Code 7 is ordinarily for central registry use only, hospital registrars may use code 7 if using a list of Hispanic surnames provided by their central registry; otherwise, code 9 'unknown whether Spanish or not' should be used.) The only evidence of the person’s Hispanic origin is the surname or maiden name and there is no contrary evidence that the patient is not Hispanic
8	Dominican Republic
9	Unknown whether Spanish or not

Note: NAACCR recognizes that available definitions and abstracting instructions for Name--Last [2230] and Name--Maiden [2390] may be inadequate for describing names used in some cultures, including Hispanic cultures. Explicit instructions have not been provided for entering compound names, with or without hyphens or “De.” Order of names, use of maternal and paternal names, and use of hyphens can vary across cultures. It is likely that abstracting and coding practice for these items varies across registries. Limitations inherent in these definitions should be kept in mind when using the data.

STATE/REQUESTOR ITEMS

Alternate Name	Item #	Length	Source of Standard	Column #
	2220	1000	Varies	2340-3339

Format:
Allowable Values:
NAACCR Record Section: Special Use
Status

Description

Reserved for use by individual states or central registries, or for use by special studies.

SUBSQ REPORT FOR PRIMARY

Alternate Name	Item #	Length	Source of Standard	Column #
	2160			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 6, effective January 1, 1998.

SUBSQ RX 2ND COURSE BRM

Alternate Name	Item #	Length	Source of Standard	Column #
	1675	1	CoC	1743-1743

Format:
Allowable Values: 36770
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of biological response modifier therapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Immunotherapy, 1998 ROADS Manual, p. 243. See also First Course Calc Method [1500].

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 2ND COURSE CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
	1673	1	CoC	1741-1741

Format:
Allowable Values: 36594
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of chemotherapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Chemotherapy, 1998 ROADS Manual, p. 228. See also First Course Calc Method [1500].

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 2ND COURSE CODES

Alternate Name	Item #	Length	Source of Standard	Column #
	1670	11		1734-1744

Format:
Allowable Values:
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

The name for a group of subfields that describe the second course or set of subsequent therapy. As of January 1, 2003, CoC no longer supports Subsequent Therapy data items.

Group names appear only in the data dictionary and Appendix E.
Subfields

- Subsq RX 2nd Course Surg [1671]
- Subsq RX 2nd Course Rad [1672]
- Subsq RX 2nd Course Chemo [1673]
- Subsq RX 2nd Course Horm [1674]
- Subsq RX 2nd Course BRM [1675]
- Subsq RX 2nd Course Oth [1676]

SUBSQ RX 2ND COURSE DATE

Alternate Name	Item #	Length	Source of Standard	Column #
Second Course of Therapy-Date Started (pre-96 CoC)	1660	8	CoC	1724-1731

Format: YYYYMMDD
Allowable Values: Valid Dates
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description
Date of initiation of second-course treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. See page 97 for date format.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 2ND COURSE HORM

Alternate Name	Item #	Length	Source of Standard	Column #
	1674	1	CoC	1742-1742

Format:
Allowable Values: 36594
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description
Codes for the type of hormonal therapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Hormone Therapy, 1998 ROADS Manual, p. 238. See also First Course Calc Method [1500].

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 2ND COURSE OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1676	1	CoC	1744-1744

Format:
Allowable Values: 0-3, 6-9
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description
Codes for the type of other treatment given as part of the second course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Other Treatment, 1998 ROADS Manual, p. 246. See also First Course Calc Method [1500].

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 2ND COURSE RAD

Alternate Name	Item #	Length	Source of Standard	Column #
	1672	1	CoC	1740-1740

Format:
Allowable Values: 36655
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description
Codes for the type of radiation given as part of the second course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Radiation, 1998 ROADS Manual, p. 199. See also First Course Calc Method [1500].

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 2ND COURSE SURG

Alternate Name	Item #	Length	Source of Standard	Column #
	1671	2	CoC	1734-1735

Format: Right justified, zero filled

Allowable Values: 00, 10-90, 99
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of primary site surgery given as part of the second course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Surgery of Primary Site, 1998 ROADS Manual, p. 187. See also First Course Calc Method [1500].

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 2NDCRS DATE FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1661	2	NAACCR	1732-1733

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

This flag explains why no appropriate value is in the field, Subsq RX 2nd Course Date [1660]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

See Appendix H for the Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any subsequent therapy)
11	No proper value is applicable in this context (e.g., no subsequent therapy)
Blank	A valid date value is provided in item Subsq RX 2nd Course Date [1660], or the date was not expected to have been Transmitted

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

SUBSQ RX 2ND--REG LN REM

Alternate Name	Item #	Length	Source of Standard	Column #
	1679	2	CoC	1738-1739

Format: Right justified, zero filled
Allowable Values: 00-90, 95-99
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the number of regional lymph nodes removed as part of the second course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Number of Regional Lymph Nodes Removed, 1998 ROADS Manual, p. 193. See also First Course Calc Method [1500].

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 2ND--SCOPE LN SU

Alternate Name	Item #	Length	Source of Standard	Column #
	1677	1	CoC	1736-1736

Format:
Allowable Values: 36770
NAACCR Record Section: Treatment-Subsequent & Other

Status

Description

Codes for the type of surgery performed to remove regional lymph nodes as part of the second course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Scope of Regional Lymph Node Surgery, 1998 ROADS Manual, p. 192. See also First Course Calc Method [1500].

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 2ND--SURG OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1678	1	CoC	1737-1737

Format:
Allowable Values: 36770
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of surgery performed on tissue or organs other than the primary site and regional lymph nodes as part of the second course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s), 1998 ROADS Manual, p. 194. See also First Course Calc Method [1500].

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 3RD COURSE BRM

Alternate Name	Item #	Length	Source of Standard	Column #
	1695	1	CoC	1764-1764

Format:
Allowable Values: 36770
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of biological response modifier therapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Immunotherapy, 1998 ROADS Manual, p. 243

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 3RD COURSE CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
	1693	1	CoC	1762-1762

Format:
Allowable Values: 36594
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of chemotherapy given as part of the third course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Chemotherapy, 1998 ROADS Manual, p. 228.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 3RD COURSE CODES

Alternate Name	Item #	Length	Source of Standard	Column #

1690	11		1755-1765

Format:
Allowable Values:
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

The name for a group of subfields that describe the third course or set of subsequent therapy. As of January 1, 2003, CoC no longer supports Subsequent Therapy data items.

Group names appear only in the data dictionary and Appendix E.

Subfields

- Subsq RX 3rd Course Surg [1691]
- Subsq RX 3rd Course Rad [1692]
- Subsq RX 3rd Course Chemo [1693]
- Subsq RX 3rd Course Horm [1694]
- Subsq RX 3rd Course BRM [1695]
- Subsq RX 3rd Course Oth [1696]

SUBSQ RX 3RD COURSE DATE

Alternate Name	Item #	Length	Source of Standard	Column #
	1680	8	CoC	1745-1752

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Date of initiation of third course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. See page 97 for date format.

SUBSQ RX 3RD COURSE HORM

Alternate Name	Item #	Length	Source of Standard	Column #
	1694	1	CoC	1763-1763

Format:
Allowable Values: 36594
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of hormonal therapy given as part of the third course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Hormone Therapy, 1998 ROADS Manual, p. 238.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 3RD COURSE OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1696	1	CoC	1765-1765

Format:
Allowable Values: 0-3, 6-9
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of other treatment given as part of the third course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Other Treatment, 1998 ROADS Manual, p. 246.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 3RD COURSE RAD

Alternate Name	Item #	Length	Source of Standard	Column #
	1692	1	CoC	1761-1761

Format:
Allowable Values: 36655
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of radiation given as part of the third course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Radiation, 1998 ROADS Manual, p. 199.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 3RD COURSE SURG

Alternate Name	Item #	Length	Source of Standard	Column #
	1691	2	CoC	1755-1756

Format: Right justified, zero filled
Allowable Values: 00, 10-90, 99
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of primary site surgery given as part of the third course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Surgery of Primary Site, 1998 ROADS Manual, p. 187.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 3RDCRS DATE FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1681	2	NAACCR	1753-1754

Format:
Allowable Values: 10-20, blank
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

This flag explains why no appropriate value is in the field, Subsq RX 3rd Course Date [1680]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

(See Appendix H for the Flavors of Null table in its entirety which includes the NAACCR codes, HL7 codes and definitions.)

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any subsequent therapy)
11	No proper value is applicable in this context (e.g., no subsequent therapy)
Blank	A valid date value is provided in item Subsq RX 3rd Course Date [1680], or the date was not expected to have been Transmitted

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

SUBSQ RX 3RD--REG LN REM

Alternate Name	Item #	Length	Source of Standard	Column #
	1699	2	CoC	1759-1760

Format: Right justified, zero filled
Allowable Values: 00-90, 95-99
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the number of regional lymph nodes removed as part of the third course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Number of Regional Lymph Nodes Removed, 1998 ROADS Manual, p. 193.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 3RD--SCOPE LN SU

Alternate Name	Item #	Length	Source of Standard	Column #
	1697	1	CoC	1757-1757

Format:
Allowable Values: 36770
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of surgery performed to remove regional lymph nodes as part of the third course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Scope of Regional Lymph Node Surgery, 1998 ROADS Manual, p. 192.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 3RD--SURG OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1698	1	CoC	1758-1758

Format:
Allowable Values: 36770
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of surgery performed on tissue or organs other than the primary site and regional lymph nodes as part of the third course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s), 1998 ROADS Manual, p. 194.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 4TH COURSE BRM

Alternate Name	Item #	Length	Source of Standard	Column #
	1715	1	CoC	1785-1785

Format:
Allowable Values: 36770
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of biological response modifier therapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Immunotherapy, 1998 ROADS Manual, p. 243

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 4TH COURSE CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
	1713	1	CoC	1783-1783

Format:
Allowable Values: 36594
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of chemotherapy given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Chemotherapy, 1998 ROADS Manual, p. 228.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 4TH COURSE CODES

Alternate Name	Item #	Length	Source of Standard	Column #
	1710	11		1776-1786

Format:
Allowable Values:
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

The name for a group of subfields that describe the fourth course or set of subsequent therapy. As of January 1, 2003, CoC no longer support Subsequent Therapy data items.

Group names appear only in the data dictionary and Appendix E.
Subfields

- Subsq RX 4th Course Surg [1711]
- Subsq RX 4th Course Rad [1712]
- Subsq RX 4th Course Chemo [1713]
- Subsq RX 4th Course Horm [1714]
- Subsq RX 4th Course BRM [1715]
- Subsq RX 4th Course Oth [1716]

SUBSQ RX 4TH COURSE DATE

Alternate Name	Item #	Length	Source of Standard	Column #
	1700	8	CoC	1766-1773

Format: YYYYMMDD
Allowable Values: Valid dates
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Date of initiation of the fourth course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. See page 97 for date format.

SUBSQ RX 4TH COURSE HORM

Alternate Name	Item #	Length	Source of Standard	Column #
	1714	1	CoC	1784-1784

Format:
Allowable Values: 36594
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of hormonal therapy given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Hormone Therapy, 1998 ROADS Manual, p. 238.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 4TH COURSE OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1716	1	CoC	1786-1786

Format:
Allowable Values: 0-3, 6-9
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of other treatment given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Other Treatment, 1998 ROADS Manual, p. 246.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 4TH COURSE RAD

Alternate Name	Item #	Length	Source of Standard	Column #
	1712	1	CoC	1782-1782

Format:
Allowable Values: 36655
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of radiation given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Radiation, 1998 ROADS Manual, p. 199.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 4TH COURSE SURG

Alternate Name	Item #	Length	Source of Standard	Column #
	1711	2	CoC	1776-1777

Format: Right justified, zero filled
Allowable Values: 00, 10-90, 99
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of primary site surgery given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Surgery of Primary Site, 1998 ROADS Manual, p. 187.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 4THCRS DATE FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1701	2	NAACCR	1774-1775

Format:
Allowable Values: 10-20, blank

NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

This flag explains why no appropriate value is in the field, Subsq RX 4th Course Date [1700]. This data item was first available in Volume II, Version 12 (effective January 2010).

Rationale

Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes

See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any subsequent therapy)
11	No proper value is applicable in this context (e.g., no subsequent therapy)
Blank	A valid date value is provided in item Subsq RX 4th Course Date [1700], or the date was not expected to have been Transmitted

Note: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

SUBSQ RX 4TH--REG LN REM

Alternate Name	Item #	Length	Source of Standard	Column #
	1719	2	CoC	1780-1781

Format: Right justified, zero filled
Allowable Values: 00-90, 95-99
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the number of regional lymph nodes removed as part of the fourth course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Number of Regional Lymph Nodes Removed, 1998 ROADS Manual, p. 193.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 4TH--SCOPE LN SU

Alternate Name	Item #	Length	Source of Standard	Column #
	1717	1	CoC	1778-1778

Format:
Allowable Values: 36770
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of surgery performed to remove regional lymph nodes as part of the fourth course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Scope of Regional Lymph Node Surgery, 1998 ROADS Manual, p. 192.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 4TH--SURG OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1718	1	CoC	1779-1779

Format:
Allowable Values: 36770
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Codes for the type of surgery performed on tissue or organs other than the primary site and regional lymph nodes as part of the fourth course of treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. The codes are the same as those for Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s), 1998 ROADS Manual, p. 194.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

SUBSQ RX 5TH COURSE BRM

Alternate Name	Item #	Length	Source of Standard	Column #
	1735			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

SUBSQ RX 5TH COURSE CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
	1733			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

SUBSQ RX 5TH COURSE CODES

Alternate Name	Item #	Length	Source of Standard	Column #
	1730			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

SUBSQ RX 5TH COURSE DATE

Alternate Name	Item #	Length	Source of Standard	Column #
	1720			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

SUBSQ RX 5TH COURSE HORM

Alternate Name	Item #	Length	Source of Standard	Column #
	1734			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

SUBSQ RX 5TH COURSE OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1736			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

SUBSQ RX 5TH COURSE RAD

Alternate Name	Item #	Length	Source of Standard	Column #
	1732			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

SUBSQ RX 5TH COURSE SURG

Alternate Name	Item #	Length	Source of Standard	Column #
	1731			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

SUBSQ RX 5TH--REG LN REM

Alternate Name	Item #	Length	Source of Standard	Column #
	1739			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

SUBSQ RX 5TH--SCOPE LN SU

Alternate Name	Item #	Length	Source of Standard	Column #

1737

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

SUBSQ RX 5TH--SURG OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1738			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

SUBSQ RX--RECONSTRUCT DEL

Alternate Name	Item #	Length	Source of Standard	Column #
Reconstruction/Restoration--Delayed (CoC)	1741	1	CoC	1787-1787

Format:
Allowable Values: Site-specific
NAACCR Record Section: Treatment-Subsequent & Other
Status

Description

Code for surgical procedure done to reconstruct, restore, or improve shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or therapies. Reconstructive/restorative procedures are coded here when started after the first course of therapy. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. For reconstructive/restorative procedures started during the first course of therapy, see RX Summ--Reconstruct 1st [1330]. See also RX Summ--Surgery Type [1640].

Codes

See the CoC ROADS Manual, 1998 Supplement, for site-specific codes.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

TELEPHONE

Alternate Name	Item #	Length	Source of Standard	Column #
	2360	10	CoC	3868-3877

Format: 10-digit number
Allowable Values: Any 10-digit number
NAACCR Record Section: Patient-Confidential
Status

Description

Current telephone number with area code for the patient. Number is entered without dashes.

Codes

In addition to valid telephone number

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

Note: Prior to Version 5, Follow-Up Contact fields may have been used for patient current telephone in the NAACCR record layout.

TEXT--DX PROC--LAB TESTS

Alternate Name	Item #	Length	Source of Standard	Column #
	2550	1000	NPCR	8565-9564

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Diagnosis
Status

Description

Text area for manual documentation of information from laboratory examinations other than cytology or histopathology.

Rationale

Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

Suggestions for text:

- Type of lab test/tissue specimen(s)
- Record both positive and negative findings. Record positive test results first.
- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Date(s) of lab test(s)
- Tumor markers included, but are not limited to:
  - Breast Cancer – Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu.
  - Prostate Cancer – Prostatic Specific Antigen (PSA)
  - Testicular Cancer – Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH)

Codes

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 in the following fields:

Item name	Item number
Primary Site	400
Grade	440
Diagnostic Confirmation	490
Collaborative Stage variables	2800-2930
Date of Diagnosis	390

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

TEXT--DX PROC--OP

Alternate Name	Item #	Length	Source of Standard	Column #
	2560	1000	NPCR	9565-10564

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed

NAACCR Record Section: Text-Diagnosis
Status

Description
Text area for manual documentation of all surgical procedures that provide information for staging.

Rationale
Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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.

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

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

Codes
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 in the following fields:

Item name	Item number
Date of Diagnosis	390
RX Summ--Dx/Stg Proc	1350
Diagnostic Confirmation	490
Primary Site	400
RX Hosp--Dx/Stg Proc	740
RX Summ--Surg Prim Site	1290
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759
Reason for No Surgery	1340

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

TEXT--DX PROC--PATH

Alternate Name	Item #	Length	Source of Standard	Column #
	2570	1000	NPCR	10565-11564

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Diagnosis
Status

Description
Text area for manual documentation of information from cytology and histopathology reports.

Rationale

Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

Suggestions for text:

- Date(s) of procedure(s)
- Anatomic source of specimen
- Type of tissue specimen(s)
- Tumor type and grade (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.)
- Gross tumor size
- Extent of tumor spread
- Involvement of resection margins
- Number of lymph nodes involved and examined
- Record both positive and negative findings. Record positive test results first.
- Note if pathology report is a slide review or a second opinion from an outside source, i.e., AFIP, Mayo, etc.
- Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored

Codes

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 in the following fields:

Item name	Item number
Date of Diagnosis	390
Primary Site	400
Laterality	410
Histologic Type ICD-O-3	522
Grade	440
Collaborative Stage variables	2800-2930
Diagnostic confirmation	490
RX Hosp--Surg Prim Site	670
RX Hosp--Scope Reg LN Sur	672
RX Hosp--Surg Oth Reg/Dis	674
RX Summ--Surg Prim Site	1290
RX Summ--Scope Reg LN Sur	1292
RX Summ--Surg Oth Reg/Dis	1294
SEER Summary Stage 2000	759
SEER Summary Stage 1977	760
Regional Nodes Positive	820
Regional Nodes Examined	830
RX Date--Surgery	1200
Reason for No Surgery	1340
RX Summ--Surg/Rad Seq	1380
RX Summ-Systemic/Sur Seq	1639

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

TEXT--DX PROC--PE

Alternate Name	Item #	Length	Source of Standard	Column #
	2520	1000	NPCR	5565-6564

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Diagnosis
Status

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.

Rationale

Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

Suggestions for text:

- Date of physical exam
- Age, sex, race/ethnicity
- History that relates to cancer diagnosis
- Primary site
- Histology (if diagnosis prior to this admission)
- Tumor location
- Tumor size
- Palpable lymph nodes
- Record positive and negative clinical findings. Record positive results first
- impression (when stated and pertains to cancer diagnosis)
- treatment plan

Codes

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 in the following fields:

Item name	Item number
Date of 1st Contact	580
Date of Diagnosis	390
Age at Diagnosis	230
Race 1 - 5	160-164
Spanish Hispanic Origin	190
Sex	220
Primary Site	400
Laterality	410
Histology ICD-O-3	522
Sequence Number--Hospital	560
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759

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

TEXT--DX PROC--SCOPES

Alternate Name	Item #	Length	Source of Standard	Column #
	2540	1000	NPCR	7565-8564

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Diagnosis
Status

Description

Text area for manual documentation from endoscopic examinations that provide information for staging and treatment.

Rationale

Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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 <b>and should not be generated electronically from coded values.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

Suggestions for text:

- Date(s) of endoscopic exam(s)
- Primary site
- Histology (if given)
- Tumor location
- Tumor size
- Record site and type of endoscopic biopsy
- Record positive and negative clinical findings.
- Record positive results first

Codes

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 in the following fields:

Item name	Item number
Date of Diagnosis	390
RX Summ--Dx/Stg Proc	1350
Diagnostic Confirmation	490
Primary Site	400
Laterality	410
Histology (92-00) ICD-O-2	420
Histology ICD-O-3	522
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759
RX Hosp--Surg Prim Site	670
RX Date—Surgery	1200

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

TEXT--DX PROC--X-RAY/SCAN

Alternate Name	Item #	Length	Source of Standard	Column #
	2530	1000	NPCR	6565-7564

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Diagnosis
Status

Description

Text area for manual documentation from all X-rays, scan, and/or other imaging examinations that provide information about staging.

Rationale

Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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 <b>and should not be generated electronically from coded values.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

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

Codes

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 in the following fields:

Item name	Item number
Date of Diagnosis	390
RxSumm--Dx/Stg Proc	1350
Primary Site	400
Laterality	410
Histology (92-00) ICD-O-2	420
Histology ICD-O-3	522
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759

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

TEXT--HISTOLOGY TITLE

Alternate Name	Item #	Length	Source of Standard	Column #
	2590	100	NPCR	11665-11764

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Diagnosis
Status

Description

Text area for manual documentation of information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.

Rationale

Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

Suggestions for text:

- Information on histologic type and behavior
- Information on differentiation from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc.

Codes

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 in the following fields:

Item name	Item number
Histology (92-00) ICD-O-2	420
Behavior (92-00) ICD-O-2	430
Histologic Type ICD-O-3	522
Behavior Code ICD-O-3	523
Grade	440

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

TEXT--PLACE OF DIAGNOSIS

Alternate Name	Item #	Length	Source of Standard	Column #
Place of Diagnosis	2690	60	NPCR	20765-20824

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Miscellaneous
Status

Description

Text area for manual documentation of the facility, physician office, city, state, or county where the diagnosis was

Rationale

Text documentation is an essential component of a complete electronic abstract 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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

Suggestions for text:

- The complete name of the hospital or the physician office where diagnosis occurred. The initials of a hospital are not adequate.
- For out-of-state residents and facilities, include the city and the state where the medical facility is located.

Codes

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 in the following fields:

Item name	Item Number
Reporting Hospital	540
RX Hosp--DX/Stg Proc	740
RX Hosp--Surg Prim Site	670
Type of Reporting Source	500
Class of Case	610
Institution Referred From	2410
Institution Referred To	2420

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

TEXT--PRIMARY SITE TITLE

Alternate Name	Item #	Length	Source of Standard	Column #
	2580	100	NPCR	11565-11664

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Diagnosis
Status

Description

Text area for manual documentation of information regarding the primary site and laterality of the tumor being reported.

Rationale

Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

Suggestions for text:
- State the specific location of the primary site, including subsite.
- Include available information on tumor laterality

Codes
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 in the following fields:

Item name	Item number
Primary site	400
Laterality	410

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

TEXT--REMARKS

Alternate Name	Item #	Length	Source of Standard	Column #
	2680	1000	NPCR	19765-20764

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Miscellaneous
Status

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.

Rationale
Text documentation is an essential component of a complete electronic abstract 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.

Instructions
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments from other text fields can be continued in the Remarks field. 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.

Suggestions for text:
- Smoking history
- Family and personal history of cancer
- Comorbidities
- Information on sequence numbers if a person was diagnosed with another primary out-of-state or before the registry's reference date
- Place of birth
- Justification of over-ride flags
- Information clarifying anything unusual such as reason for reporting a case seemingly not reportable for that facility or reason for coding numerous fields as "unknown."

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

TEXT--STAGING

Alternate Name	Item #	Length	Source of Standard	Column #
	2600	1000	NPCR	11765-12764

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Text-Diagnosis
Status

Description

Additional text area for staging information not already entered in other Text fields.

Rationale

Text documentation is an essential component of a complete electronic abstract 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 abstractor independently from the code(s). If cancer abstraction 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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- 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.

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

Codes

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 in the following fields:

Item name	Item number
RX Date--DX/Stg Proc	1280
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759
Regional Nodes Positive	820
Regional Nodes Examined	830
RX Hosp--Surg Prim Site	670
RX Summ--Surg Prim Site	1290
RX Hosp--Scope Reg LN Sur	672
RX Summ--Scope Reg LN Sur	1292
RX Hosp--Surg Oth Reg/Dis	674
RX Summ--Surg Oth Reg/Dis	1294
Mult Tum Rpt as One Prim	444
Laterality	410

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

TEXT--USUAL INDUSTRY

Alternate Name	Item #	Length	Source of Standard	Column #
	320	100	NPCR	317-416

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Demographic

Status

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

Rationale
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.

The data item "usual industry" is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death, Supplement 25. See related materials in reference list, Chapter VII.

Abstracting Instructions
Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that performs more than one of these components.

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 name and city/town to determine the type of activity conducted at that location.

As noted in the Text--Usual Occupation [310] section, in those situations where the usual occupation is not available or is unknown, the patient's current or most recent occupation is recorded, if available. The information for industry should be based upon the information in occupation. Therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient's current or most recent business/industry.

If later documentation in the patient's record provides an industry that is more likely to be the usual industry than what was originally recorded, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with industry information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

There should be an entry for Text--Usual Industry if any occupation is recorded. If no information is available regarding the industry in which the reported occupation was carried out, record "unknown." If the patient was not a student or homemaker and had never worked, record "never worked" as the usual industry. This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

TEXT--USUAL OCCUPATION

Alternate Name	Item #	Length	Source of Standard	Column #
	310	100	NPCR	217-316

Format: Free text
Allowable Values: Neither carriage return nor line feed characters allowed
NAACCR Record Section: Demographic
Status

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

Rationale
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.

The data item "usual occupation" is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death, supplement 25. See related materials in reference list, Chapter VII.

Abstracting Instructions
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). 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 later documentation in the patient's record provides an occupation that is more likely to be the usual occupation than what was originally recorded, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with occupation information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

If the patient was a homemaker and also worked outside the home during most of his/her adult life, record the usual occupation outside the

home; if the patient was a homemaker and did not work outside the home for most of his/her adult life, record “homemaker.” If the patient was not a student or homemaker and had never worked, record “never worked” as the usual occupation.

If no information is available, record “unknown.”

This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

TNM CLIN DESCRIPTOR

Alternate Name	Item #	Length	Source of Standard	Column #
Clinical Stage (Prefix/Suffix) Descriptor (CoC)	980	1	CoC	974-974

Format:
Allowable Values: 0-3, 5, 9
NAACCR Record Section: Stage/Prognostic Factors
Status: Revised

Description

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

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout. CoC defines a descriptor and “Staged By” item for each of these three areas.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes

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

TNM CLIN M

Alternate Name	Item #	Length	Source of Standard	Column #
Clinical M (CoC)	960	4	AJCC	966-969

Format: Upper case, alphanumeric, left justified, blank filled
Allowable Values: See AJCC Cancer Staging Manual and FORDS Manual; also 88, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Detailed site-specific codes for the clinical metastases (M) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes

In addition to those published in the AJCC Cancer Staging Manual

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.

This field is left blank if no information at all is available to code this item.

Note: See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. See the

FORDS manual for specifications for codes and data entry rules.

TNM CLIN N

Alternate Name	Item #	Length	Source of Standard	Column #
Clinical N (CoC)	950	4	AJCC	962-965

Format: Upper case, alphanumeric, left justified, blank filled
Allowable Values: See AJCC Cancer Staging Manual and FORDS Manual; also 88, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Detailed site-specific codes for the clinical nodes (N) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes

In addition to those published in the AJCC Cancer Staging Manual

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.

This field is left blank if no information at all is available to code this item.

Note: See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TNM CLIN STAGE GROUP

Alternate Name	Item #	Length	Source of Standard	Column #
Clinical Stage Group (CoC)	970	4	AJCC	970-973

Format: Upper case, alphanumeric. Convert AJCC Roman numerals to Arabic numerals. Left justified, blank filled
Allowable Values: See AJCC Cancer Staging Manual and FORDS Manual; also 88, 99, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Detailed site-specific codes for the clinical stage group as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes

In addition to those published in the AJCC Cancer Staging Manual

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
99	Unknown, not staged

Note: See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TNM CLIN STAGED BY

Alternate Name	Item #	Length	Source of Standard	Column #
Staged By (Clinical Stage) (CoC)	990	1	CoC	975-975

Format:
Allowable Values: 36770
NAACCR Record Section: Stage/Prognostic Factors
Status

Description
Identifies the person who recorded the clinical AJCC staging elements and the stage group in the patient's medical record.

Rationale
Data captured in this field can be used to evaluate the source of clinical staging and form the basis for quality management and improvement studies. This item can be used to monitor application of the CoC Staging Standard.

Codes
Refer to the most recent version of FORDS for additional coding

0	Not staged
1	Managing physician
2	Pathologist
3	Pathologist and managing physician
4	Cancer Committee chair, cancer liaison physician, or registry physician advisor
5	Cancer registrar
6	Cancer registrar and physician
7	Staging assigned at another facility
8	Case is not eligible for staging
9	Unknown; not stated in patient record

TNM CLIN T

Alternate Name	Item #	Length	Source of Standard	Column #
Clinical T (CoC)	940	4	AJCC	958-961

Format: Upper case, alphanumeric, left justified, blank filled
Allowable Values: See AJCC Cancer Staging Manual and FORDS Manual; also 88, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description
Detailed site-specific codes for the clinical tumor (T) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale
CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes
In addition to those published in the AJCC Cancer Staging Manual

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.

This field is left blank if no information at all is available to code this item.

Note: See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TNM EDITION NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	1060	2	CoC	938-939

Format: Right justified, zero filled
Allowable Values: 00-07, 88, 99
NAACCR Record Section: Stage/Prognostic Factors

Status

Description
A code that indicates the edition of the AJCC manual used to stage the case. This applies to the manually coded AJCC fields. It does not apply to the Derived AJCC T, N, M and AJCC Stage Group fields [2940, 2960, 2980, and 3000].

Rationale
TNM codes have changed over time and conversion is not always simple. Therefore, a case-specific indicator is needed to allow grouping of cases for comparison.

Codes

00	Not staged (cases that have AJCC staging scheme and staging was not done)
01	First Edition
02	Second Edition (published 1983)
03	Third Edition (published 1988)
04	Fourth Edition (published 1992), recommended for use for cases diagnosed 1993-1997
05	Fifth Edition (published 1997), recommended for use for cases diagnosed 1998-2002
06	Sixth Edition (published 2002), recommended for use for cases diagnosed 2003-2009
07	Seventh Edition (published 2009), recommended for use with cases diagnosed 2010+
88	Not applicable (cases that do not have an AJCC staging scheme)
99	Edition Unknown

TNM OTHER DESCRIPTOR

Alternate Name	Item #	Length	Source of Standard	Column #
	1050			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

TNM OTHER M

Alternate Name	Item #	Length	Source of Standard	Column #
	1020			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

TNM OTHER N

Alternate Name	Item #	Length	Source of Standard	Column #
	1010			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

TNM OTHER STAGE GROUP

Alternate Name	Item #	Length	Source of Standard	Column #
	1030			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

TNM OTHER STAGED BY

Alternate Name	Item #	Length	Source of Standard	Column #
	1040			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

TNM OTHER T

Alternate Name	Item #	Length	Source of Standard	Column #
	1000			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

TNM PATH DESCRIPTOR

Alternate Name	Item #	Length	Source of Standard	Column #
Pathologic Stage (Prefix/Suffix) Descriptor (CoC)	920	1	CoC	956-956

Format:
Allowable Values: 36686
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

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

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout. CoC defines a descriptor and “Staged By” item for each of these three areas.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes

0	None
1	E (Extranodal, lymphomas only)
2	S (Spleen, lymphomas only)
3	M (Multiple primary tumors in a single site)
4	Y (Classification during or after initial multimodality therapy)—pathologic staging only

5	E & S (Extranodal and spleen, lymphomas only)
6	M & Y (Multiple primary tumors and initial multimodality therapy)
9	Unknown, not stated in patient record

TNM PATH M

Alternate Name	Item #	Length	Source of Standard	Column #
Pathologic M (CoC)	900	4	AJCC	948-951

Format: Upper case, alphanumeric, left justified, blank filled
Allowable Values: See AJCC Cancer Staging Manual and FORDS Manual; also 88, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Detailed site-specific codes for the pathologic metastases (M) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes

In addition to those published in the AJCC Cancer Staging Manual

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.

This field is left blank if no information at all is available to code this item.

Note: See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TNM PATH N

Alternate Name	Item #	Length	Source of Standard	Column #
Pathologic N (CoC)	890	4	AJCC	944-947

Format: Upper case, alphanumeric, left justified, blank filled
Allowable Values: See AJCC Cancer Staging Manual and FORDS Manual; also 88, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Detailed site-specific codes for the pathologic nodes (N) as defined by AJCC and recorded by physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes

In addition to those published in the AJCC Cancer Staging Manual

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.

This field is left blank if no information at all is available to code this item.

Note: See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TNM PATH STAGE GROUP

Alternate Name	Item #	Length	Source of Standard	Column #
Pathologic Stage Group (CoC)	910	4	AJCC	952-955

Format: Upper case, alphanumeric. Convert AJCC Roman numerals to Arabic numerals. Left justified, blank filled
Allowable Values: See AJCC Cancer Staging Manual and FORDS Manual; also 88, 99
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Detailed site-specific codes for the pathologic stage group as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes

In addition to those published in the AJCC Cancer Staging Manual

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.
99	Unknown, unstaged

Note: See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TNM PATH STAGED BY

Alternate Name	Item #	Length	Source of Standard	Column #
Staged By (Pathologic Stage) (CoC)	930	1	CoC	957-957

Format:
Allowable Values: 36770
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Identifies the person who recorded the pathologic AJCC staging elements and the stage group in the patient's medical

Rationale

Data captured in this field can be used to evaluate the source of pathologic staging and form the basis for quality management and improvement studies.

Codes

Refer to the most recent version of FORDS for additional coding

0	Not staged
1	Managing physician
2	Pathologist
3	Pathologist and managing physician
4	Cancer Committee chair, cancer liaison physician, or registry physician advisor
5	Cancer registrar
6	Cancer registrar and physician
7	Staging assigned at another facility
8	Case is not eligible for staging
9	Unknown; not stated in patient record

TNM PATH T

Alternate Name	Item #	Length	Source of Standard	Column #
Pathologic T (CoC)	880	4	AJCC	940-943

Format: Upper case, alphanumeric. Left justified, blank filled

Allowable Values: See AJCC Cancer Staging Manual and FORDS Manual; also 88, blank
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Detailed site-specific codes for the pathologic tumor (T) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale

CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes

In addition to those published in the AJCC Cancer Staging Manual

88	Not applicable, no code assigned for this case in the current AJCC Staging Manual.

This field is left blank if no information at all is available to code this item.

Note: See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TOBACCO HISTORY

Alternate Name	Item #	Length	Source of Standard	Column #
	340			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

TUMOR MARKER 1

Alternate Name	Item #	Length	Source of Standard	Column #
Tumor Marker One (CoC)	1150	1	SEER	981-981

Format:
Allowable Values: 0-6, 8, 9
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records prognostic indicators for specific sites or histologies. CoC offered these items for optional use for cases diagnosed 1996 and forward. See the CoC ROADS Manual, 1998 Supplement, for a list of specific sites and histologies.

For SEER requirements for the specific sites, histologies, and diagnosis years for which this item is coded, see the 1998 SEER Program Code Manual.

Codes

0	None done (SX)
1	Positive/elevated
2	Negative/normal; within normal limits (S0)
3	Borderline; undetermined whether positive/elevated or negative/normal
Three-tiered system:	
4	Range 1 (S1)
5	Range 2 (S2)
6	Range 3 (S3)
8	Ordered, but results not in chart
9	Unknown or no information

For sites for which Tumor Marker 1 is not collected:

9	Not applicable

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

TUMOR MARKER 2

Alternate Name	Item #	Length	Source of Standard	Column #
Tumor Marker Two (CoC)	1160	1	SEER	982-982

Format:
Allowable Values: 0-6, 8, 9
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records prognostic indicators for specific sites or histologies. CoC offered these items for optional use for cases diagnosed 1996 and forward. See the CoC ROADS Manual, 1998 Supplement, for a list of specific sites and histologies.

For SEER requirements for the specific sites, histologies, and diagnosis years for which this item is coded, see the 1998 SEER Program Code Manual.

Codes

0	None done (SX)
1	Positive/elevated
2	Negative/normal; within normal limits (S0)
3	Borderline; undetermined whether positive/elevated or negative/normal
Three-tiered system:	
4	Range 1 (S1)
5	Range 2 (S2)
6	Range 3 (S3)
8	Ordered, but results not in chart
9	Unknown or no information
For sites for which Tumor Marker 2 is not collected:	
9	Not applicable

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

TUMOR MARKER 3

Alternate Name	Item #	Length	Source of Standard	Column #
Tumor Marker Three (CoC)	1170	1	SEER	983-983

Format:
Allowable Values: 0-6, 8, 9
NAACCR Record Section: Stage/Prognostic Factors
Status

Description

Records prognostic indicators for specific sites or histologies. CoC offered these items for optional use for cases diagnosed 1996 and forward. See the CoC ROADS Manual, 1998 Supplement, for a list of specific sites and histologies.

For SEER requirements for the specific sites, histologies, and diagnosis years for which this item is coded, see the 1998 SEER Program Code Manual.

Codes

0	None done (SX)
1	Positive/elevated
2	Negative/normal; within normal limits (S0)
3	Borderline; undetermined whether positive/elevated or negative/normal
Three-tiered system:	
4	Range 1 (S1)
5	Range 2 (S2)
6	Range 3 (S3)

8	Ordered, but results not in chart
9	Unknown or no information

For sites for which Tumor Marker 2 is not collected:

9	Not applicable

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

TUMOR RECORD NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	60	2	NAACCR	40-41

Format: Right justified, zero filled
Allowable Values: 36161
NAACCR Record Section: Record ID
Status

Description

A system-generated number assigned to each tumor. The number should never change even if the tumor sequence is changed or a record (tumor) is deleted.

Rationale

This is a unique number that identifies a specific tumor so data can be linked. “Sequence Number” cannot be used as a link because the number is changed if a report identifies an earlier tumor or if a tumor record is deleted.

TYPE OF REPORTING SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
	500	1	SEER	563-563

Format:
Allowable Values: 40551
NAACCR Record Section: Cancer Identification
Status

Description

This variable codes the source documents used to abstract the majority of information on the tumor being reported. This may not be the source of original case finding (for example, if a case is identified through a pathology laboratory report review and all source documents used to abstract the case are from the physician’s office, code this item 4).

Rationale

The code in this field can be used to explain why information may be incomplete on a tumor. For example, death certificate only cases have unknown values for many data items, so one may want to exclude them from some analyses. The field also is used to monitor the success of non-hospital case reporting and follow-back mechanisms. All population-based registries should have some death certificate-only cases where no hospital admission was involved, but too high a percentage can imply both shortcomings in case-finding and that follow-back to uncover missed hospital reports was not complete.

Coding Instructions
Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. This is a change to reflect the addition of codes 2 and 8 and to prioritize laboratory reports over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.

This data item is intended to indicate the completeness of information available to the abstractor. Reports from health plans (e.g., Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally and is available to the abstractor are expected to be at least as complete as reports for hospital inpatients, which is why these sources are grouped with inpatients and given the code with the highest priority.

Sources coded with '2' usually have complete information on the cancer diagnosis, staging, and treatment.

Sources coded with '8' would include, but would not be limited to, outpatient surgery and nuclear medicine services. A physician's office that calls itself a surgery center should be coded as a physician's office. Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. If a physician's office calls itself a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

Codes

1	Hospital inpatient; Managed health plans with comprehensive, unified medical records
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
3	Laboratory only (hospital-affiliated or independent)
4	Physician's office/private medical practitioner (LMD)
5	Nursing/convalescent home/hospice
6	Autopsy only
7	Death certificate only
8	Other hospital outpatient units/surgery centers

UNUSUAL FOLLOW-UP METHOD

Alternate Name	Item #	Length	Source of Standard	Column #
	1850	1	CoC	2195-2195

Format:
Allowable Values: 36770
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description
User-defined numeric codes used to flag cases that need unusual follow-up methods.

Codes
User-defined

Note: This data item is no longer supported by CoC (as of January 1, 2003).

VENDOR NAME

Alternate Name	Item #	Length	Source of Standard	Column #
	2170	10	NAACCR	1936-1945

Format:
Allowable Values:
NAACCR Record Section: Edit Overrides/Conversion History/System Admin
Status

Description
System-generated. Name of the computer services vendor who programmed the system submitting the data. Abbreviate as necessary and keep a consistent name throughout all submissions. Include software version number where available. Code is self-assigned by vendor.

Rationale
This is used to track which vendor and which software version submitted the case. It helps define the source and extent of a problem discovered in data submitted by a software provider.

VITAL STATUS

Alternate Name	Item #	Length	Source of Standard	Column #
	1760	1	SEER/CoC	2126-2126

Format:
Allowable Values: 36529
NAACCR Record Section: Follow-up/Recurrence/Death
Status

Description
Vital status of the patient as of the date entered in Date of Last Contact [1750]. If the patient has multiple tumors, vital status should be the same for all tumors.

Codes

0	Dead (CoC)
1	Alive

4	Dead (SEER)

YEAR FIRST SEEN THIS CA

Alternate Name	Item #	Length	Source of Standard	Column #
	620			

Format:
Allowable Values:
NAACCR Record Section:
Status: Retired

Description

The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

APPENDICES

APPENDIX A

STANDARD-SETTING ORGANIZATIONS AND OTHER STANDARDS DOCUMENTS

Several organizations have played a major role in the development of cancer registry standards. They are listed in alphabetical order.

American Cancer Society
ACS historically has supported the development of standardized cancer classification systems, publishing the first code manual for the morphology of neoplasms in 1951. ACS has long supported the standard-setting programs of ACoS, including the Fundamental Tumor Registry Operations Education Program, the Registry Operations and Data Standards, and the American Joint Committee on Cancer (AJCC).

American College of Surgeons
Since the 1950s, ACoS has taken a leading role in establishing standards for hospital-based cancer programs and the cancer registries that are a part of such programs. Through its Approvals Program, CoC implements its requirements for case management, registry operation and case inclusion, and data set specifications as published in:

- *Cancer Program Standards*, which presents standards for the full range of cancer program activities, including the registry.
- *Facility Oncology Registry Data Standards (FORDS): Revised for 2010,* which specifies standards for cases to be included in the registry, data items to be collected, and the codes and coding rules for those items.

CoC requires approved cancer programs to use the codes and coding instructions published by CoC. Through NCDB, CoC provides data quality feedback to approved cancer programs, software providers, and the general cancer registry community. Hospitals in the Accreditation Program are required to submit nonconfidential registry data to NCDB, and CoC monitors the quality of data submissions in accordance with existing published standards for approved programs. *FORDS*, the Cancer Program Standards, and the NCDB Call for Data announcements, instructions, and technical specifications are available to download at no charge at http://www.facs.org. CoC maintains an interactive Inquiry and Response Database to answer questions about all cancer-related requirements at the same site.

American Joint Committee on Cancer
AJCC formulates and publishes systems of classification of tumors by their anatomic site and histology through use of the Tumor, Node, Metastasis (TNM) staging system. The TNM staging system is the U.S standard used by the medical profession to select the most effective treatments and determine prognosis to facilitate the management of cancer care. AJCC is dedicated to the ideal that all cancer cases should be staged, and it publishes the *Cancer Staging Manual*, now in its Seventh Edition as well as the *Collaborative Stage Data Collection System,* now in its Second Edition.

National Cancer Registrars Association
An organization of cancer data professionals founded as the National Tumor Registrars Association in 1974, the National Cancer Registrars Association (NCRA) has been instrumental in the training and certification of cancer registrars. NCRA has produced a variety of educational materials, including guidelines for a college curriculum in cancer registry management, a planning manual for registry staffing, training materials for staging of cancer, and a publication on using cancer data to promote the services of the cancer registry. Their publications also include a college-level cancer registry methods textbook (*Cancer Registry Management: Principles and Practice*, 2nd Edition, 2004). Since 1983, NCRA has promoted the certification of cancer registrars through a semi-annual

examination. More than 4,000 Certified Tumor Registrars (CTRs) have successfully completed the exam, which evaluates technical knowledge of methods of cancer data collection, management, and quality control, as well as *International Classification of Diseases for Oncology* (ICD-O) topography and morphology coding and AJCC, Collaborative Staging and Surveillance, Epidemiology and End Results (SEER) Program staging systems. To maintain their credentials, CTRs are required to complete 20 hours of continuing education every 2 years, which can be obtained by participating in conferences and teleconferences that NCRA has recertified, and by obtaining a passing score on quizzes in NCRA's *Journal of Registry Management*. Membership in NCRA is open to anyone interested in cancer data collection. For further information, contact NCRA on the Web at: http://www.ncra-usa.org.

National Coordinating Council for Cancer Surveillance

Founded in 1995, the National Coordinating Council for Cancer Surveillance (NCCCS) meets semi-annually to coordinate surveillance activities within the United States through communication and collaboration among major national cancer organizations, ensuring that the needs of cancer patients and the communities in which they live are fully served; that scarce resources are maximally used; and that the burden of cancer in the United States is adequately measured and ultimately reduced. NCCCS includes representatives from the Armed Forces Institute of Pathology, ACoS, ACS, AJCC, CDC-NPCR, CDC-NCHS, NCI-SEER, NCI-Applied Research Program, NCRA, and NAACCR. Current priorities for NCCCS include building coordination among cancer incidence surveillance and other cancer surveillance systems; electronic medical records and real-time reporting; improving source information to measure disparity (race, ethnicity, and socioeconomic status); non-hospital reporting; and defining a decision process for incidence surveillance expansion, both in the addition of data elements and modification of surveillance systems.

National Program of Cancer Registries

CDC has worked to improve registry data nationwide since 1992, when Congress authorized the establishment of the National Program of Cancer Registries (NPCR) through the Cancer Registries Amendment Act (Public Law 102-515). CDC provides funds to 46 states, 3 territories, and the District of Columbia to assist in planning or enhancing cancer registries, developing model legislation and regulations for programs to increase the viability of registry operations, setting standards for data, providing training for registry personnel, and helping establish computerized reporting and data processing systems.

CDC has contributed substantially to the development of data standards through its financial support of NAACCR, as well as by funding and developing EDITS, a software system that facilitates the coordination of data standards (see Chapter IV). In administering NPCR, CDC requires participating central registries to collect data items that conform to NAACCR's standards. NPCR staff also continues to maintain Registry PLUS™, a suite of publicly accessible free software programs made available by CDC to facilitate the implementation of NPCR.

To maximize the benefits of state-based cancer registries, CDC uses the NPCR-Cancer Surveillance System (CSS) for receiving, assessing, enhancing, aggregating, and disseminating data from NPCR-funded registries. This system of cancer surveillance provides valuable feedback to improve the quality and usefulness of registry data and monitor the impact of cancer prevention and control programs. In 2002 the CDC published the first edition of the United States Cancer Statistics (USCS) in collaboration with NCI and with contributions from NAACCR. This report contained 1999 incidence data from 37 states and metropolitan areas. In 2007 the sixth edition of this joint publication was released. This edition contained 2004 incidence data from 49 states (40 NPCR-, 4 NPCR/SEER-, and 5 SEER-funded registries), 6 SEER metropolitan areas and the District of Columbia (NPCR). In total, the cancer registries whose data are included in this report cover 98% of the U.S. population. For additional information on NPCR, visit the CDC/NPCR website at: http://www.cdc.gov/cancer/npcr/.

North American Association of Central Cancer Registries

The American Association of Central Cancer Registries (AACCR) was established in 1987, and with the addition in 1995 of Canadian registries as members, the name was changed to the North American Association of Central

Cancer Registries (NAACCR). Members are population-based cancer registries in the United States and Canada, national cancer and vital statistics organizations in both countries, and other organizations and individuals interested in cancer registration and surveillance. NAACCR is a professional organization that develops and promotes uniform data standards for cancer registration; provides education and training; certifies population-based registries for high-quality data; evaluates, aggregates, and publishes data from central cancer registries; and promotes the use of cancer surveillance data and systems for cancer control and epidemiologic research, public health programs, and patient care to reduce the burden of cancer in North America. NAACCR welcomes membership from cancer registries and other organizations or individuals that are interested in the collection, analysis, and publication of data on cancer incidence.

Surveillance Epidemiology and End Results Program

NCI's SEER Program has collected standardized data to measure progress in cancer prevention and control for more than 30 years. Established by a Federal mandate--the National Cancer Act of 1971--the SEER Program is a sequel to two earlier NCI programs: the End Results Group (1956-72) and the Third National Cancer Survey (1969-71). Seven population-based registries have provided data continuously since the SEER Program began in 1973: the States of Connecticut, Iowa, New Mexico, Utah, and Hawaii; and the Metropolitan Areas of Detroit and San Francisco-Oakland. In 1974-75, the regions of Seattle-Puget Sound and Metropolitan Atlanta were added. These areas, plus the rural Georgia region added in 1978, cover about 9.5 percent of the U.S. population. In 1992, the SEER Program added two additional regions in California--Los Angeles and San Jose-Monterey-- bringing coverage of the U.S. population to 14 percent. In order to increase coverage of the American Indian/Alaska Native populations, SEER has included data from the Alaska Native Tumor Registry since 1984. These regions were selected for their epidemiologically significant population subgroups and, in fact, over-sample minority populations in the United States. In 2001, four states were added--Kentucky, Louisiana, New Jersey, and the remainder of California--resulting in coverage of about 26 percent of the U.S. population. The purpose of the SEER Program, as stated in the National Cancer Act legislation, is to collect, analyze, and disseminate data useful in the prevention, diagnosis, and treatment of cancer. The goals of the Program are to:

1. Monitor annual cancer incidence trends to identify patterns of cancer occurring in population subgroups
2. Provide continuing information on changes over time in the extent of disease (EOD) at diagnosis, trends in therapy, and associated changes in patient survival
3. Promote studies to identify factors that can be studied and applied to achieve cancer prevention and control

These goals illustrate that the aim of the SEER Program is providing cancer surveillance over time. As a result, changes in standards are carefully considered for their impact both on future data and compatibility with previous data. Participating registries are required to submit data in a standard format using standardized definitions and codes (currently the *SEER Program Coding and Staging Manual 2007*, and the *Collaborative Staging Standards for Cancer Registries, Manual and Coding Instructions*. However, the individual SEER registries have not used identical data collection methods or identical data management methods, and they differ in the extent to which they impose data requirements on the reporting facilities in their areas. Standardized edits, developed by SEER and shared with participating registries, are applied to data submissions, and the results are returned to the participating registries.

SEER Program publications relating to data standards (http://www.seer.cancer.gov) include:

- A series of eight self-instructional manuals for cancer registrars[35] covering abstracting, coding, terminology, anatomy, treatment, statistics, and other aspects of cancer registry operations. Book 8 in the series is a comprehensive list of drugs used in treating cancer and, before January of 2005, was the standard reference for drug-treatment coding rules. For cancer diagnoses beginning in January of 2005, book 8 was replaced by SEER*Rx, an interactive antineoplastic drug database that is updated on a regular basis (http://www.seer.cancer.gov/tools/seerrx/). Additional instructional resources are available on the SEER website (http://seer.cancer.gov/registrars/).

- *SEER Extent of Disease-1998: Codes and Coding Instructions*, Third Edition.[8] This document includes site-specific codes and coding guidelines to describe spread of tumor in anatomic terms. EOD is a 10-digit code that includes 3 digits for size of tumor, 2 digits for tumor extension, 1 digit for lymph node involvement, 2 digits for the number of regional lymph nodes examined, and 2 digits for the number of positive regional lymph nodes. SEER always has collected EOD information and collapses this information into different staging schemes.
- The *SEER Program Coding and Staging 2007 Manual*. This manual includes comprehensive codes and coding guidelines for the data elements required by SEER.
- *Comparative Staging Guide for Cancer*.[6] This guide illustrates the relationships among EOD codes, the summary staging system, and the Third Edition of the TNM Staging System. A revision updating the comparative staging to the Fifth Edition of the TNM Staging System is in development.
- *Summary Staging Guide for the Cancer Surveillance, Epidemiology and End Results Reporting Program*. Originally published in April 1977, and most recently reprinted in July 1986, this is the standard for localized-regional-distant staging for tumors diagnosed between 1977 and 2000.
- *SEER Summary Staging Manual 2000*. Published in 2001, is the standard for summary stage for cases diagnosed January 1, 2001, and after. There is no charge for single copies of SEER Program publications. To place an order or to obtain further information, go to the SEER Program Website at: http://seer.cancer.gov/publications.

World Health Organization

The World Health Organization (WHO), an agency of the United Nations, is responsible for publishing and maintaining the international standard for diagnosis coding systems. Selected publications include:

- *International Classification of Diseases* (ICD-9, the Ninth Revision), as modified by the Health Care Financing Administration.
- *International Statistical Classification of Diseases and Related Health Problems* (ICD-10, the 10th Revision)
- *International Classification of Diseases for Oncology*.

These publications are world-standard diagnosis coding systems. ICD-9 was adapted for use in the United States as the Clinical Modification of ICD-9 (ICD-9-CM), and is the current standard for coding medical record diagnoses in health information management departments in U.S. health care facilities. ICD-10 was implemented for coding causes of death on death certificates in the United States effective January 1, 1999. The Second Edition of ICD-O became the standard for coding cancer diagnoses in the United States in 1992. An extensive revision of the morphology codes, especially the Lymphoma and Leukemia Section, was field tested for the 1999 and 2000 diagnosis years, and the Third Edition of ICD-O[16] was implemented for 2001 diagnoses.

WHO publications are sold through the following two agencies in the United States:
Q Corporation
49 Sheridan Avenue
Albany, NY 12210
(518) 436-9686

College of American Pathologists
325 Waukegan Road
Northfield, IL 60076
(800) 323-4040
http://www.cap.org/index.cfm

In the United States, the contact for further information on ICD-O is the Expert on Nomenclature and Coding at SEER (http://seer.cancer.gov).

APPENDIX B

ABBREVIATIONS AND SYMBOLS USED

AACCR American Association of Central Cancer Registries
ACoS American College of Surgeons
ACS American Cancer Society
AJCC American Joint Committee on Cancer
BNA Block Numbering Area
CCCR Canadian Council of Cancer Registries
CDC Centers for Disease Control and Prevention
CIN Cervical intraepithelial neoplasia
CIS Carcinoma *in situ*
CLIA Clinical Laboratory Improvement Act
CMS Centers for Medicare & Medicaid Services
CoC Commission on Cancer (of ACoS)
CPT Current Procedural Terminology (codes)
CRC Cyclic redundancy code
CS Collaborative Staging
CTR Certified Tumor Registrar
DAM *Data Acquisition Manual* (manual of ACoS)
DCO Death Certificate Only
EOD Extent of Disease
FIPS Federal Information Processing Standards
FORDS *Facility Oncology Registry Data Standards* (manual of ACoS)
FTRO *Fundamental Tumor Registry Operations Program* (of ACoS)
GenEDITS Generic EDITS Driver Program
GIS Geographic Information System
HCFA Health Care Finance Administration
HIM Health Information Management
HL7 Health Level 7
IACR International Association of Cancer Registries
IARC International Agency for Research on Cancer
ICD International Classification of Diseases
ICD-O *International Classification of Diseases for Oncology*
ICD-O-1 *International Classification of Diseases for Oncology*, First Edition
ICD-O-2 *International Classification of Diseases for Oncology*, Second Edition
ICD-O-3 *International Classification of Diseases for Oncology*, Third Edition
N.d. No date (bibliographic term: no ascertainable place of publication)
N.p. No place (bibliographic term: no ascertainable place of publication)
NAACCR North American Association of Central Cancer Registries
NAPIIA NAACCR Asian/Pacific Islander Identification Algorithm
NCCCS National Coordinating Council for Cancer Surveillance
NCDB National Cancer Data Base
NCI National Cancer Institute
NCRA National Cancer Registrars Association
NHIA NAACCR Hispanic Identification Algorithm
NOS Not Otherwise Specified
NPCR National Program of Cancer Registries
NPI National Provider Identifier
PIN Prostatic intraepithelial neoplasia

ROADS *Registry Operations and Data Standards* (manual of ACoS)
SEER Surveillance, Epidemiology, and End Results Program of NCI
SIL Squamous intraepithelial lesion
SS Summary Stage
TNM Tumor, Nodes and Metastasis: staging system of AJCC and UICC
UDSC Uniform Data Standards Committee of NAACCR
UICC Union Internationale Contre le Cancer (in English, International Union Against Cancer)
USPS United States Postal Service
WHO World Health Organization

APPENDIX C

New Hampshire State Cancer Regsitry—Casefinding List Effective January 1, 2004

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
042	AIDS (review cases for AIDS-related malignancies)
140.0-208.9	Malignant neoplasms
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
225.0	Benign neoplasm of brain
225.1	Benign neoplasm of cranial nerves
225.2	Benign neoplasm of cerebral meninges; cerebral meningioma
225.3	Benign neoplasm of spinal cord, cauda equina
225.4	Benign neoplasm of spinal meninges; spinal meningioma
225.8	Benign neoplasm of other specified sites of nervous system
225.9	Benign neoplasm of nervous system, part unspecified
227.3	Benign neoplasm of pituitary, craniopharyngeal duct, craniobuccal pouch, hypophysis, Rathke's pouch, sella turcica
227.4	Benign neoplasm of pineal gland, pineal body
230.0 – 234.9	Carcinoma in situ
237.0	Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct
237.1	Neoplasm of uncertain behavior of pineal gland
237.5	Neoplasm of uncertain behavior of brain and spinal cord
237.6	Neoplasm of uncertain behavior of meninges: NOS, cerebral, spinal
237.70	Neurofibromatosis, Unspecified von Recklinghausen's Disease
237.71	Neurofibromatosis, Type One von Recklinghausen's Disease
237.72	Neurofibromatosis, Type Two von Recklinghausen's Disease
237.9	Neoplasm of uncertain behavior of other and unspecified parts of nervous system; cranial nerves
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)
238.6	Extramedullary plasmacytoma (9734/3)
238.7	Chronic myeloproliferative disease (9960/3)
238.7	Myelosclerosis with myeloid metaplasia (9961/3)
238.7	Essential thrombocythemia (9962/3)
238.7	Refractory cytopenia with multilineage dysplasia (9985/3)
238.7	Myelodysplastic syndrome with 5q-syndrome (9986/3)
238.7	Therapy –related myelodysplastic syndrome (9987/3)
273.2	Gamma heavy chain disease; Franklin's disease
273.3	Waldenstrom's macroglobulinemia
284.9	Refractory anemia (9980/3)
285.0	Refractory anemia with ringed sideroblasts (9982/3)
285.0	Refractory anemia with excess blasts (9983/3)
285.0	Refractory anemia with excess blasts in transformation (9984/3)
288.3	Hypereosinophilic syndrome (9964/3)
289.8	Acute myelofibrosis (9932/3)
V07.3	Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
V07.8	Other specified prophylactic measure
V10.0-V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries, and/or subsequent treatment)
V58.0	Admission for radiotherapy

V58.1	Admission for chemotherapy
V71.1	Observation for suspected malignant neoplasm
V76.0-V76.9	Special screening for malignant neoplasm

APPENDIX D

RECORD LAYOUT TABLE (COLUMN # ORDER)

The following table presents Version 12.1 of the NAACCR record layout. The table has item umber, item name, section, and status. Please note that "Retired" items are not represented in any section in this table.

Item Number	Item Name	Section	Status
10	Record Type	Record ID	
20	Patient ID Number	Record ID	
21	Patient System ID-Hosp	Record ID	
30	Registry Type	Record ID	
35	FIN Coding System	Record ID	
37	Reserved 00	Record ID	
40	Registry ID	Record ID	
45	NPI--Registry ID	Record ID	
50	NAACCR Record Version	Record ID	Revised
60	Tumor Record Number	Record ID	
70	Addr at DX--City	Demographic	
80	Addr at DX--State	Demographic	
90	County at DX	Demographic	
100	Addr at DX--Postal Code	Demographic	
110	Census Tract 1970/80/90	Demographic	
120	Census Cod Sys 1970/80/90	Demographic	
130	Census Tract 2000	Demographic	
135	Census Tract 2010	Demographic	New
140	Census Tract Cod Sys--Alt		Retired
150	Marital Status at DX	Demographic	Revised
160	Race 1	Demographic	
161	Race 2	Demographic	
162	Race 3	Demographic	
163	Race 4	Demographic	
164	Race 5	Demographic	
170	Race Coding Sys--Current	Demographic	
180	Race Coding Sys--Original	Demographic	
190	Spanish/Hispanic Origin	Demographic	
191	NHIA Derived Hisp Origin	Demographic	
192	IHS Link	Demographic	
193	Race--NAPIIA(derived API)	Demographic	
200	Computed Ethnicity	Demographic	
210	Computed Ethnicity Source	Demographic	
220	Sex	Demographic	
230	Age at Diagnosis	Demographic	
240	Date of Birth	Demographic	
241	Date of Birth Flag	Demographic	
250	Birthplace	Demographic	

Item Number	Item Name	Section	Status
260	Religion		Retired
270	Occupation Code--Census	Demographic	
280	Industry Code--Census	Demographic	
290	Occupation Source	Demographic	
300	Industry Source	Demographic	
310	Text--Usual Occupation	Demographic	
320	Text--Usual Industry	Demographic	
330	Occup/Ind Coding System	Demographic	
340	Tobacco History		Retired
350	Alcohol History		Retired
360	Family History of Cancer		Retired
362	Census Block Group 2000	Demographic	
363	Census Block Group 2010	Demographic	New
364	Census Tr Cert 1970/80/90	Demographic	
365	Census Tr Certainty 2000	Demographic	
366	GIS Coordinate Quality	Demographic	
367	Census Tr Certainty 2010	Demographic	New
368	CensusBlockGroup 70/80/90	Demographic	
370	Reserved 01	Record ID	
380	Sequence Number--Central	Cancer Identification	
390	Date of Diagnosis	Cancer Identification	
391	Date of Diagnosis Flag	Cancer Identification	
400	Primary Site	Cancer Identification	
410	Laterality	Cancer Identification	
419	Morph--Type&Behav ICD-O-2	Cancer Identification	
420	Histology (92-00) ICD-O-2	Cancer Identification	
430	Behavior (92-00) ICD-O-2	Cancer Identification	
439	Date of Mult Tumors Flag	Cancer Identification	
440	Grade	Cancer Identification	
441	Grade Path Value	Cancer Identification	
442	Ambiguous Terminology DX	Cancer Identification	
443	Date of Conclusive DX	Cancer Identification	
444	Mult Tum Rpt as One Prim	Cancer Identification	
445	Date of Multiple Tumors	Cancer Identification	
446	Multiplicity Counter	Cancer Identification	Revised
447	Number of Tumors/Hist		Retired
448	Date Conclusive DX Flag	Cancer Identification	
449	Grade Path System	Cancer Identification	
450	Site Coding Sys--Current	Cancer Identification	
460	Site Coding Sys--Original	Cancer Identification	
470	Morph Coding Sys--Current	Cancer Identification	
480	Morph Coding Sys--Originl	Cancer Identification	
490	Diagnostic Confirmation	Cancer Identification	
500	Type of Reporting Source	Cancer Identification	

Item Number	Item Name	Section	Status
501	Casefinding Source	Cancer Identification	
510	Screening Date		Retired
520	Screening Result		Retired
521	Morph--Type&Behav ICD-O-3	Cancer Identification	
522	Histologic Type ICD-O-3	Cancer Identification	
523	Behavior Code ICD-O-3	Cancer Identification	
530	Reserved 02	Demographic	Revised
538	Reporting Hospital FAN		Retired
540	Reporting Facility	Hospital-Specific	
545	NPI--Reporting Facility	Hospital-Specific	
550	Accession Number--Hosp	Hospital-Specific	
560	Sequence Number--Hospital	Hospital-Specific	
570	Abstracted By	Hospital-Specific	
580	Date of 1st Contact	Hospital-Specific	
581	Date of 1st Contact Flag	Hospital-Specific	
590	Date of Inpatient Adm	Hospital-Specific	
591	Date of Inpt Adm Flag	Hospital-Specific	
600	Date of Inpatient Disch	Hospital-Specific	
601	Date of Inpt Disch Flag	Hospital-Specific	
605	Inpatient Status	Hospital-Specific	Revised
610	Class of Case	Hospital-Specific	
620	Year First Seen This CA		Retired
630	Primary Payer at DX	Hospital-Specific	
640	Inpatient/Outpt Status		Retired
650	Presentation at CA Conf		Retired
660	Date of CA Conference		Retired
665	RX Hosp--ASA Class		Retired
668	RX Hosp--Surg App 2010	Hospital-Specific	
670	RX Hosp--Surg Prim Site	Hospital-Specific	
672	RX Hosp--Scope Reg LN Sur	Hospital-Specific	
674	RX Hosp--Surg Oth Reg/Dis	Hospital-Specific	
676	RX Hosp--Reg LN Removed	Hospital-Specific	
678	RX Hosp--Surg Timing		Retired
680	Reserved 03	Cancer Identification	
690	RX Hosp--Radiation	Hospital-Specific	Revised
700	RX Hosp--Chemo	Hospital-Specific	
710	RX Hosp--Hormone	Hospital-Specific	
720	RX Hosp--BRM	Hospital-Specific	
730	RX Hosp--Other	Hospital-Specific	
740	RX Hosp--DX/Stg Proc	Hospital-Specific	
742	RX Hosp--Screen/BX Proc1		Retired
743	RX Hosp--Screen/BX Proc2		Retired
744	RX Hosp--Screen/BX Proc3		Retired
745	RX Hosp--Screen/BX Proc4		Retired

Item Number	Item Name	Section	Status
746	RX Hosp--Surg Site 98-02	Hospital-Specific	
747	RX Hosp--Scope Reg 98-02	Hospital-Specific	
748	RX Hosp--Surg Oth 98-02	Hospital-Specific	
750	Reserved 04	Hospital-Specific	
759	SEER Summary Stage 2000	Stage/Prognostic Factors	
760	SEER Summary Stage 1977	Stage/Prognostic Factors	
770	Loc/Reg/Distant Stage		Retired
779	Extent of Disease 10-Dig	Stage/Prognostic Factors	
780	EOD--Tumor Size	Stage/Prognostic Factors	
790	EOD--Extension	Stage/Prognostic Factors	
800	EOD--Extension Prost Path	Stage/Prognostic Factors	
810	EOD--Lymph Node Involv	Stage/Prognostic Factors	
820	Regional Nodes Positive	Stage/Prognostic Factors	
830	Regional Nodes Examined	Stage/Prognostic Factors	
840	EOD--Old 13 Digit	Stage/Prognostic Factors	
850	EOD--Old 2 Digit	Stage/Prognostic Factors	
860	EOD--Old 4 Digit	Stage/Prognostic Factors	
870	Coding System for EOD	Stage/Prognostic Factors	
880	TNM Path T	Stage/Prognostic Factors	
890	TNM Path N	Stage/Prognostic Factors	
900	TNM Path M	Stage/Prognostic Factors	
910	TNM Path Stage Group	Stage/Prognostic Factors	
920	TNM Path Descriptor	Stage/Prognostic Factors	
930	TNM Path Staged By	Stage/Prognostic Factors	
940	TNM Clin T	Stage/Prognostic Factors	
950	TNM Clin N	Stage/Prognostic Factors	
960	TNM Clin M	Stage/Prognostic Factors	
970	TNM Clin Stage Group	Stage/Prognostic Factors	
980	TNM Clin Descriptor	Stage/Prognostic Factors	Revised
990	TNM Clin Staged By	Stage/Prognostic Factors	
1000	TNM Other T		Retired
1010	TNM Other N		Retired
1020	TNM Other M		Retired
1030	TNM Other Stage Group		Retired
1040	TNM Other Staged By		Retired
1050	TNM Other Descriptor		Retired
1060	TNM Edition Number	Stage/Prognostic Factors	
1070	Other Staging System		Retired
1080	Date of 1st Positive BX		Retired
1090	Site of Distant Met 1		Retired
1100	Site of Distant Met 2		Retired
1110	Site of Distant Met 3		Retired
1120	Pediatric Stage	Stage/Prognostic Factors	
1130	Pediatric Staging System	Stage/Prognostic Factors	

Item Number	Item Name	Section	Status
1140	Pediatric Staged By	Stage/Prognostic Factors	
1150	Tumor Marker 1	Stage/Prognostic Factors	
1160	Tumor Marker 2	Stage/Prognostic Factors	
1170	Tumor Marker 3	Stage/Prognostic Factors	
1180	Reserved 05	Stage/Prognostic Factors	
1182	Lymph-vascular Invasion	Stage/Prognostic Factors	
1190	Reserved 06	Treatment-1st Course	
1200	RX Date--Surgery	Treatment-1st Course	
1201	RX Date--Surgery Flag	Treatment-1st Course	
1210	RX Date--Radiation	Treatment-1st Course	
1211	RX Date--Radiation Flag	Treatment-1st Course	
1220	RX Date--Chemo	Treatment-1st Course	
1221	RX Date--Chemo Flag	Treatment-1st Course	
1230	RX Date--Hormone	Treatment-1st Course	
1231	RX Date--Hormone Flag	Treatment-1st Course	
1240	RX Date--BRM	Treatment-1st Course	
1241	RX Date--BRM Flag	Treatment-1st Course	
1250	RX Date--Other	Treatment-1st Course	
1251	RX Date--Other Flag	Treatment-1st Course	
1260	Date of Initial RX--SEER	Treatment-1st Course	
1261	Date of Initial RX Flag	Treatment-1st Course	
1270	Date of 1st Crs RX--CoC	Treatment-1st Course	
1271	Date of 1st Crs Rx Flag	Treatment-1st Course	
1280	RX Date--DX/Stg Proc	Treatment-1st Course	
1281	RX Date--Dx/Stg Proc Flag	Treatment-1st Course	
1285	RX Summ--Treatment Status	Treatment-1st Course	
1290	RX Summ--Surg Prim Site	Treatment-1st Course	
1292	RX Summ--Scope Reg LN Sur	Treatment-1st Course	
1294	RX Summ--Surg Oth Reg/Dis	Treatment-1st Course	
1296	RX Summ--Reg LN Examined	Treatment-1st Course	
1300	Reserved 07	Treatment-Subsequent & Other	
1310	RX Summ--Surgical Approch	Treatment-1st Course	
1320	RX Summ--Surgical Margins	Treatment-1st Course	
1330	RX Summ--Reconstruct 1st	Treatment-1st Course	
1340	Reason for No Surgery	Treatment-1st Course	
1350	RX Summ--DX/Stg Proc	Treatment-1st Course	
1360	RX Summ--Radiation	Treatment-1st Course	
1370	RX Summ--Rad to CNS	Treatment-1st Course	
1380	RX Summ--Surg/Rad Seq	Treatment-1st Course	
1390	RX Summ--Chemo	Treatment-1st Course	
1400	RX Summ--Hormone	Treatment-1st Course	
1410	RX Summ--BRM	Treatment-1st Course	
1420	RX Summ--Other	Treatment-1st Course	
1430	Reason for No Radiation	Treatment-1st Course	

Item Number	Item Name	Section	Status
1440	Reason for No Chemo		Retired
1450	Reason for No Hormone		Retired
1460	RX Coding System--Current	Treatment-1st Course	
1470	Protocol Eligibility Stat		Retired
1480	Protocol Participation		Retired
1490	Referral to Support Serv		Retired
1500	First Course Calc Method	Treatment-1st Course	
1510	Rad--Regional Dose: CGY	Treatment-1st Course	
1520	Rad--No of Treatment Vol	Treatment-1st Course	
1530	Rad--Elapsed RX Days		Retired
1540	Rad--Treatment Volume	Treatment-1st Course	
1550	Rad--Location of RX	Treatment-1st Course	
1560	Rad--Intent of Treatment		Retired
1570	Rad--Regional RX Modality	Treatment-1st Course	
1580	Rad--RX Completion Status		Retired
1590	Rad--Local Control Status		Retired
1600	Chemotherapy Field 1		Retired
1610	Chemotherapy Field 2		Retired
1620	Chemotherapy Field 3		Retired
1630	Chemotherapy Field 4		Retired
1639	RX Summ--Systemic/Sur Seq	Treatment-1st Course	
1640	RX Summ--Surgery Type	Treatment-1st Course	
1642	RX Summ--Screen/BX Proc1		Retired
1643	RX Summ--Screen/BX Proc2		Retired
1644	RX Summ--Screen/BX Proc3		Retired
1645	RX Summ--Screen/BX Proc4		Retired
1646	RX Summ--Surg Site 98-02	Treatment-1st Course	
1647	RX Summ--Scope Reg 98-02	Treatment-1st Course	
1648	RX Summ--Surg Oth 98-02	Treatment-1st Course	
1650	Reserved 08	Edit Overrides/Conversion History/System Admin	Revised
1660	Subsq RX 2nd Course Date	Treatment-Subsequent & Other	
1661	Subsq RX 2ndCrs Date Flag	Treatment-Subsequent & Other	
1670	Subsq RX 2nd Course Codes	Treatment-Subsequent & Other	
1671	Subsq RX 2nd Course Surg	Treatment-Subsequent & Other	
1672	Subsq RX 2nd Course Rad	Treatment-Subsequent & Other	
1673	Subsq RX 2nd Course Chemo	Treatment-Subsequent & Other	
1674	Subsq RX 2nd Course Horm	Treatment-Subsequent & Other	
1675	Subsq RX 2nd Course BRM	Treatment-Subsequent & Other	
1676	Subsq RX 2nd Course Oth	Treatment-Subsequent & Other	
1677	Subsq RX 2nd--Scope LN SU	Treatment-Subsequent & Other	
1678	Subsq RX 2nd--Surg Oth	Treatment-Subsequent & Other	
1679	Subsq RX 2nd--Reg LN Rem	Treatment-Subsequent & Other	
1680	Subsq RX 3rd Course Date	Treatment-Subsequent & Other	
1681	Subsq RX 3rdCrs Date Flag	Treatment-Subsequent & Other	

Item Number	Item Name	Section	Status
1690	Subsq RX 3rd Course Codes	Treatment-Subsequent & Other	
1691	Subsq RX 3rd Course Surg	Treatment-Subsequent & Other	
1692	Subsq RX 3rd Course Rad	Treatment-Subsequent & Other	
1693	Subsq RX 3rd Course Chemo	Treatment-Subsequent & Other	
1694	Subsq RX 3rd Course Horm	Treatment-Subsequent & Other	
1695	Subsq RX 3rd Course BRM	Treatment-Subsequent & Other	
1696	Subsq RX 3rd Course Oth	Treatment-Subsequent & Other	
1697	Subsq RX 3rd--Scope LN Su	Treatment-Subsequent & Other	
1698	Subsq RX 3rd--Surg Oth	Treatment-Subsequent & Other	
1699	Subsq RX 3rd--Reg LN Rem	Treatment-Subsequent & Other	
1700	Subsq RX 4th Course Date	Treatment-Subsequent & Other	
1701	Subsq RX 4thCrs Date Flag	Treatment-Subsequent & Other	
1710	Subsq RX 4th Course Codes	Treatment-Subsequent & Other	
1711	Subsq RX 4th Course Surg	Treatment-Subsequent & Other	
1712	Subsq RX 4th Course Rad	Treatment-Subsequent & Other	
1713	Subsq RX 4th Course Chemo	Treatment-Subsequent & Other	
1714	Subsq RX 4th Course Horm	Treatment-Subsequent & Other	
1715	Subsq RX 4th Course BRM	Treatment-Subsequent & Other	
1716	Subsq RX 4th Course Oth	Treatment-Subsequent & Other	
1717	Subsq RX 4th--Scope LN Su	Treatment-Subsequent & Other	
1718	Subsq RX 4th--Surg Oth	Treatment-Subsequent & Other	
1719	Subsq RX 4th--Reg LN Rem	Treatment-Subsequent & Other	
1720	Subsq RX 5th Course Date		Retired
1730	Subsq RX 5th Course Codes		Retired
1731	Subsq RX 5th Course Surg		Retired
1732	Subsq RX 5th Course Rad		Retired
1733	Subsq RX 5th Course Chemo		Retired
1734	Subsq RX 5th Course Horm		Retired
1735	Subsq RX 5th Course BRM		Retired
1736	Subsq RX 5th Course Oth		Retired
1737	Subsq RX 5th--Scope LN Su		Retired
1738	Subsq RX 5th--Surg Oth		Retired
1739	Subsq RX 5th--Reg LN Rem		Retired
1740	Reserved 09	Follow-up/Recurrence/Death	
1741	Subsq RX--Reconstruct Del	Treatment-Subsequent & Other	
1750	Date of Last Contact	Follow-up/Recurrence/Death	
1751	Date of Last Contact Flag	Follow-up/Recurrence/Death	
1755	Date of Death--Canada	Follow-up/Recurrence/Death	
1756	Date of Death--CanadaFlag	Follow-up/Recurrence/Death	
1760	Vital Status	Follow-up/Recurrence/Death	
1770	Cancer Status	Follow-up/Recurrence/Death	
1780	Quality of Survival	Follow-up/Recurrence/Death	
1790	Follow-Up Source	Follow-up/Recurrence/Death	
1791	Follow-up Source Central	Follow-up/Recurrence/Death	

Item Number	Item Name	Section	Status
1800	Next Follow-Up Source	Follow-up/Recurrence/Death	
1810	Addr Current--City	Follow-up/Recurrence/Death	
1820	Addr Current--State	Follow-up/Recurrence/Death	
1830	Addr Current--Postal Code	Follow-up/Recurrence/Death	
1835	Reserved 10	Patient-Confidential	
1840	County--Current	Follow-up/Recurrence/Death	
1842	Follow-Up Contact--City	Follow-up/Recurrence/Death	
1844	Follow-Up Contact--State	Follow-up/Recurrence/Death	
1846	Follow-Up Contact--Postal	Follow-up/Recurrence/Death	
1850	Unusual Follow-Up Method	Follow-up/Recurrence/Death	
1860	Recurrence Date--1st	Follow-up/Recurrence/Death	
1861	Recurrence Date--1st Flag	Follow-up/Recurrence/Death	
1870	Recurrence Distant Sites		Retired
1871	Recurrence Distant Site 1		Retired
1872	Recurrence Distant Site 2		Retired
1873	Recurrence Distant Site 3		Retired
1880	Recurrence Type--1st	Follow-up/Recurrence/Death	
1890	Recurrence Type--1st--Oth		Retired
1900	Reserved 11	Hospital-Confidential	
1910	Cause of Death	Follow-up/Recurrence/Death	
1920	ICD Revision Number	Follow-up/Recurrence/Death	
1930	Autopsy	Follow-up/Recurrence/Death	
1940	Place of Death	Follow-up/Recurrence/Death	
1960	Site (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	
1970	Morph (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	
1971	Histology (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	
1972	Behavior (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	
1973	Grade (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	
1980	ICD-O-2 Conversion Flag	Edit Overrides/Conversion History/System Admin	
1981	Over-ride SS/NodesPos	Edit Overrides/Conversion History/System Admin	
1982	Over-ride SS/TNM-N	Edit Overrides/Conversion History/System Admin	
1983	Over-ride SS/TNM-M	Edit Overrides/Conversion History/System Admin	
1984	Over-ride SS/DisMet1		Retired
1985	Over-ride Acsn/Class/Seq	Edit Overrides/Conversion History/System Admin	
1986	Over-ride HospSeq/DxConf	Edit Overrides/Conversion History/System Admin	
1987	Over-ride CoC-Site/Type	Edit Overrides/Conversion History/System Admin	
1988	Over-ride HospSeq/Site	Edit Overrides/Conversion History/System Admin	
1989	Over-ride Site/TNM-StgGrp	Edit Overrides/Conversion History/System Admin	
1990	Over-ride Age/Site/Morph	Edit Overrides/Conversion History/System Admin	
2000	Over-ride SeqNo/DxConf	Edit Overrides/Conversion History/System Admin	
2010	Over-ride Site/Lat/SeqNo	Edit Overrides/Conversion History/System Admin	
2020	Over-ride Surg/DxConf	Edit Overrides/Conversion History/System Admin	
2030	Over-ride Site/Type	Edit Overrides/Conversion History/System Admin	
2040	Over-ride Histology	Edit Overrides/Conversion History/System Admin	

Item Number	Item Name	Section	Status
2050	Over-ride Report Source	Edit Overrides/Conversion History/System Admin	
2060	Over-ride Ill-define Site	Edit Overrides/Conversion History/System Admin	
2070	Over-ride Leuk, Lymphoma	Edit Overrides/Conversion History/System Admin	
2071	Over-ride Site/Behavior	Edit Overrides/Conversion History/System Admin	
2072	Over-ride Site/EOD/DX Dt	Edit Overrides/Conversion History/System Admin	
2073	Over-ride Site/Lat/EOD	Edit Overrides/Conversion History/System Admin	
2074	Over-ride Site/Lat/Morph	Edit Overrides/Conversion History/System Admin	
2080	Reserved 13	Pathology	
2081	CRC CHECKSUM	Edit Overrides/Conversion History/System Admin	
2085	Date Case Initiated	Edit Overrides/Conversion History/System Admin	
2090	Date Case Completed	Edit Overrides/Conversion History/System Admin	
2092	Date Case Completed--CoC	Edit Overrides/Conversion History/System Admin	
2100	Date Case Last Changed	Edit Overrides/Conversion History/System Admin	
2110	Date Case Report Exported	Edit Overrides/Conversion History/System Admin	
2111	Date Case Report Received	Edit Overrides/Conversion History/System Admin	
2112	Date Case Report Loaded	Edit Overrides/Conversion History/System Admin	
2113	Date Tumor Record Availbl	Edit Overrides/Conversion History/System Admin	
2114	Future Use Timeliness 1		Retired
2115	Future Use Timeliness 2		Retired
2116	ICD-O-3 Conversion Flag	Edit Overrides/Conversion History/System Admin	
2120	SEER Coding Sys--Current	Edit Overrides/Conversion History/System Admin	Revised
2130	SEER Coding Sys--Original	Edit Overrides/Conversion History/System Admin	Revised
2140	CoC Coding Sys--Current	Edit Overrides/Conversion History/System Admin	
2150	CoC Coding Sys--Original	Edit Overrides/Conversion History/System Admin	
2160	Subsq Report for Primary		Retired
2170	Vendor Name	Edit Overrides/Conversion History/System Admin	
2180	SEER Type of Follow-Up	Edit Overrides/Conversion History/System Admin	
2190	SEER Record Number	Edit Overrides/Conversion History/System Admin	
2200	Diagnostic Proc 73-87	Edit Overrides/Conversion History/System Admin	
2210	Reserved 14	Text-Miscellaneous	
2220	State/Requestor Items	Special Use	
2230	Name--Last	Patient-Confidential	
2240	Name--First	Patient-Confidential	
2250	Name--Middle	Patient-Confidential	
2260	Name--Prefix	Patient-Confidential	
2270	Name--Suffix	Patient-Confidential	
2280	Name--Alias	Patient-Confidential	
2290	Name--Spouse/Parent	Patient-Confidential	
2300	Medical Record Number	Patient-Confidential	
2310	Military Record No Suffix	Patient-Confidential	
2320	Social Security Number	Patient-Confidential	
2330	Addr at DX--No & Street	Patient-Confidential	
2335	Addr at DX--Supplementl	Patient-Confidential	
2350	Addr Current--No & Street	Patient-Confidential	

Item Number	Item Name	Section	Status
2352	Latitude	Patient-Confidential	
2354	Longitude	Patient-Confidential	
2355	Addr Current--Supplementl	Patient-Confidential	
2360	Telephone	Patient-Confidential	
2370	DC State		Retired
2380	DC State File Number	Patient-Confidential	
2390	Name--Maiden	Patient-Confidential	
2392	Follow-Up Contact--No&St	Patient-Confidential	
2393	Follow-Up Contact--Suppl	Patient-Confidential	
2394	Follow-Up Contact--Name	Patient-Confidential	
2400	Reserved 16	Hospital-Specific	
2410	Institution Referred From	Hospital-Confidential	
2415	NPI--Inst Referred From	Hospital-Confidential	
2420	Institution Referred To	Hospital-Confidential	
2425	NPI--Inst Referred To	Hospital-Confidential	
2430	Last Follow-Up Hospital		Retired
2440	Following Registry	Hospital-Confidential	
2445	NPI--Following Registry	Hospital-Confidential	
2450	Reserved 17	Hospital-Specific	
2460	Physician--Managing	Other-Confidential	
2465	NPI--Physician--Managing	Other-Confidential	
2470	Physician--Follow-Up	Other-Confidential	
2475	NPI--Physician--Follow-Up	Other-Confidential	
2480	Physician--Primary Surg	Other-Confidential	
2485	NPI--Physician--Primary Surg	Other-Confidential	
2490	Physician 3	Other-Confidential	
2495	NPI--Physician 3	Other-Confidential	
2500	Physician 4	Other-Confidential	
2505	NPI--Physician 4	Other-Confidential	
2510	Reserved 12	Other-Confidential	
2520	Text--DX Proc--PE	Text-Diagnosis	
2530	Text--DX Proc--X-ray/Scan	Text-Diagnosis	
2540	Text--DX Proc--Scopes	Text-Diagnosis	
2550	Text--DX Proc--Lab Tests	Text-Diagnosis	
2560	Text--DX Proc--Op	Text-Diagnosis	
2570	Text--DX Proc--Path	Text-Diagnosis	
2580	Text--Primary Site Title	Text-Diagnosis	
2590	Text--Histology Title	Text-Diagnosis	
2600	Text--Staging	Text-Diagnosis	
2610	RX Text--Surgery	Text-Treatment	
2620	RX Text--Radiation (Beam)	Text-Treatment	
2630	RX Text--Radiation Other	Text-Treatment	
2640	RX Text--Chemo	Text-Treatment	
2650	RX Text--Hormone	Text-Treatment	

Item Number	Item Name	Section	Status
2660	RX Text--BRM	Text-Treatment	
2670	RX Text--Other	Text-Treatment	
2680	Text--Remarks	Text-Miscellaneous	
2690	Text--Place of Diagnosis	Text-Miscellaneous	
2730	CS PreRx Tumor Size	Stage/Prognostic Factors	
2735	CS PreRx Extension	Stage/Prognostic Factors	
2740	CS PreRx Tum Sz/Ext Eval	Stage/Prognostic Factors	
2750	CS PreRx Lymph Nodes	Stage/Prognostic Factors	
2755	CS PreRx Reg Nodes Eval	Stage/Prognostic Factors	
2760	CS PreRx Mets at DX	Stage/Prognostic Factors	
2765	CS PreRx Mets Eval	Stage/Prognostic Factors	
2770	CS PostRx Tumor Size	Stage/Prognostic Factors	
2775	CS PostRx Extension	Stage/Prognostic Factors	
2780	CS PostRx Lymph Nodes	Stage/Prognostic Factors	
2785	CS PostRx Mets at DX	Stage/Prognostic Factors	
2800	CS Tumor Size	Stage/Prognostic Factors	
2810	CS Extension	Stage/Prognostic Factors	
2820	CS Tumor Size/Ext Eval	Stage/Prognostic Factors	
2830	CS Lymph Nodes	Stage/Prognostic Factors	
2840	CS Lymph Nodes Eval	Stage/Prognostic Factors	
2850	CS Mets at DX	Stage/Prognostic Factors	
2851	CS Mets at Dx-Bone	Stage/Prognostic Factors	
2852	CS Mets at Dx-Brain	Stage/Prognostic Factors	
2853	CS Mets at Dx-Liver	Stage/Prognostic Factors	
2854	CS Mets at Dx-Lung	Stage/Prognostic Factors	
2860	CS Mets Eval	Stage/Prognostic Factors	
2861	CS Site-Specific Factor 7	Stage/Prognostic Factors	
2862	CS Site-Specific Factor 8	Stage/Prognostic Factors	
2863	CS Site-Specific Factor 9	Stage/Prognostic Factors	
2864	CS Site-Specific Factor10	Stage/Prognostic Factors	
2865	CS Site-Specific Factor11	Stage/Prognostic Factors	
2866	CS Site-Specific Factor12	Stage/Prognostic Factors	
2867	CS Site-Specific Factor13	Stage/Prognostic Factors	
2868	CS Site-Specific Factor14	Stage/Prognostic Factors	
2869	CS Site-Specific Factor15	Stage/Prognostic Factors	
2870	CS Site-Specific Factor16	Stage/Prognostic Factors	
2871	CS Site-Specific Factor17	Stage/Prognostic Factors	
2872	CS Site-Specific Factor18	Stage/Prognostic Factors	
2873	CS Site-Specific Factor19	Stage/Prognostic Factors	
2874	CS Site-Specific Factor20	Stage/Prognostic Factors	
2875	CS Site-Specific Factor21	Stage/Prognostic Factors	
2876	CS Site-Specific Factor22	Stage/Prognostic Factors	
2877	CS Site-Specific Factor23	Stage/Prognostic Factors	
2878	CS Site-Specific Factor24	Stage/Prognostic Factors	

Item Number	Item Name	Section	Status
2879	CS Site-Specific Factor25	Stage/Prognostic Factors	
2880	CS Site-Specific Factor 1	Stage/Prognostic Factors	
2890	CS Site-Specific Factor 2	Stage/Prognostic Factors	
2900	CS Site-Specific Factor 3	Stage/Prognostic Factors	
2910	CS Site-Specific Factor 4	Stage/Prognostic Factors	
2920	CS Site-Specific Factor 5	Stage/Prognostic Factors	
2930	CS Site-Specific Factor 6	Stage/Prognostic Factors	
2935	CS Version Input Original	Stage/Prognostic Factors	
2936	CS Version Derived	Stage/Prognostic Factors	
2937	CS Version Input Current	Stage/Prognostic Factors	
2940	Derived AJCC-6 T	Stage/Prognostic Factors	
2950	Derived AJCC-6 T Descript	Stage/Prognostic Factors	
2960	Derived AJCC-6 N	Stage/Prognostic Factors	
2970	Derived AJCC-6 N Descript	Stage/Prognostic Factors	
2980	Derived AJCC-6 M	Stage/Prognostic Factors	
2990	Derived AJCC-6 M Descript	Stage/Prognostic Factors	
3000	Derived AJCC-6 Stage Grp	Stage/Prognostic Factors	
3010	Derived SS1977	Stage/Prognostic Factors	
3020	Derived SS2000	Stage/Prognostic Factors	
3030	Derived AJCC--Flag	Stage/Prognostic Factors	
3040	Derived SS1977--Flag	Stage/Prognostic Factors	
3050	Derived SS2000--Flag	Stage/Prognostic Factors	
3100	Archive FIN	Hospital-Specific	
3105	NPI--Archive FIN	Hospital-Specific	
3110	Comorbid/Complication 1	Stage/Prognostic Factors	
3120	Comorbid/Complication 2	Stage/Prognostic Factors	
3130	Comorbid/Complication 3	Stage/Prognostic Factors	
3140	Comorbid/Complication 4	Stage/Prognostic Factors	
3150	Comorbid/Complication 5	Stage/Prognostic Factors	
3160	Comorbid/Complication 6	Stage/Prognostic Factors	
3161	Comorbid/Complication 7	Stage/Prognostic Factors	
3162	Comorbid/Complication 8	Stage/Prognostic Factors	
3163	Comorbid/Complication 9	Stage/Prognostic Factors	
3164	Comorbid/Complication 10	Stage/Prognostic Factors	
3165	ICD Revision Comorbid	Stage/Prognostic Factors	
3170	RX Date--Most Defin Surg	Treatment-1st Course	
3171	RX Date Mst Defn Srg Flag	Treatment-1st Course	
3180	RX Date--Surgical Disch	Treatment-1st Course	
3181	RX Date Surg Disch Flag	Treatment-1st Course	
3190	Readm Same Hosp 30 Days	Treatment-1st Course	
3200	Rad--Boost RX Modality	Treatment-1st Course	
3210	Rad--Boost Dose cGy	Treatment-1st Course	
3220	RX Date--Radiation Ended	Treatment-1st Course	
3221	RX Date Rad Ended Flag	Treatment-1st Course	

Item Number	Item Name	Section	Status
3230	RX Date--Systemic	Treatment-1st Course	
3231	RX Date Systemic Flag	Treatment-1st Course	
3250	RX Summ--Transplnt/Endocr	Treatment-1st Course	
3260	Pain Assessment		Retired
3270	RX Summ--Palliative Proc	Treatment-1st Course	
3280	RX Hosp--Palliative Proc	Hospital-Specific	
3300	RuralUrban Continuum 1993	Demographic	
3310	RuralUrban Continuum 2003	Demographic	
3400	Derived AJCC-7 T	Stage/Prognostic Factors	
3402	Derived AJCC-7 T Descript	Stage/Prognostic Factors	
3410	Derived AJCC-7 N	Stage/Prognostic Factors	
3412	Derived AJCC-7 N Descript	Stage/Prognostic Factors	
3420	Derived AJCC-7 M	Stage/Prognostic Factors	
3422	Derived AJCC-7 M Descript	Stage/Prognostic Factors	
3430	Derived AJCC-7 Stage Grp	Stage/Prognostic Factors	
3440	Derived PreRx-7 T	Stage/Prognostic Factors	
3442	Derived PreRx-7 T Descrip	Stage/Prognostic Factors	
3450	Derived PreRx-7 N	Stage/Prognostic Factors	
3452	Derived PreRx-7 N Descrip	Stage/Prognostic Factors	
3460	Derived PreRx-7 M	Stage/Prognostic Factors	
3462	Derived PreRx-7 M Descrip	Stage/Prognostic Factors	
3470	Derived PreRx-7 Stage Grp	Stage/Prognostic Factors	
3480	Derived PostRx-7 T	Stage/Prognostic Factors	
3482	Derived PostRx-7 N	Stage/Prognostic Factors	
3490	Derived PostRx-7 M	Stage/Prognostic Factors	
3492	Derived PostRx-7 Stge Grp	Stage/Prognostic Factors	
3600	Derived Neoadjuv Rx Flag	Stage/Prognostic Factors	
3700	SEER Site-Specific Fact 1	Stage/Prognostic Factors	
3702	SEER Site-Specific Fact 2	Stage/Prognostic Factors	
3704	SEER Site-Specific Fact 3	Stage/Prognostic Factors	
3706	SEER Site-Specific Fact 4	Stage/Prognostic Factors	
3708	SEER Site-Specific Fact 5	Stage/Prognostic Factors	
3710	SEER Site-Specific Fact 6	Stage/Prognostic Factors	
3750	Over-ride CS 1	Edit Overrides/Conversion History/System Admin	New
3751	Over-ride CS 2	Edit Overrides/Conversion History/System Admin	New
3752	Over-ride CS 3	Edit Overrides/Conversion History/System Admin	New
3753	Over-ride CS 4	Edit Overrides/Conversion History/System Admin	New
3754	Over-ride CS 5	Edit Overrides/Conversion History/System Admin	New
3755	Over-ride CS 6	Edit Overrides/Conversion History/System Admin	New
3756	Over-ride CS 7	Edit Overrides/Conversion History/System Admin	New
3757	Over-ride CS 8	Edit Overrides/Conversion History/System Admin	New
3758	Over-ride CS 9	Edit Overrides/Conversion History/System Admin	New
3759	Over-ride CS 10	Edit Overrides/Conversion History/System Admin	New
3760	Over-ride CS 11	Edit Overrides/Conversion History/System Admin	New

Item Number	Item Name	Section	Status
3761	Over-ride CS 12	Edit Overrides/Conversion History/System Admin	New
3762	Over-ride CS 13	Edit Overrides/Conversion History/System Admin	New
3763	Over-ride CS 14	Edit Overrides/Conversion History/System Admin	New
3764	Over-ride CS 15	Edit Overrides/Conversion History/System Admin	New
3765	Over-ride CS 16	Edit Overrides/Conversion History/System Admin	New
3766	Over-ride CS 17	Edit Overrides/Conversion History/System Admin	New
3767	Over-ride CS 18	Edit Overrides/Conversion History/System Admin	New
3768	Over-ride CS 19	Edit Overrides/Conversion History/System Admin	New
3769	Over-ride CS 20	Edit Overrides/Conversion History/System Admin	New
7010	Path Reporting Fac ID 1	Pathology	
7011	Path Reporting Fac ID 2	Pathology	
7012	Path Reporting Fac ID 3	Pathology	
7013	Path Reporting Fac ID 4	Pathology	
7014	Path Reporting Fac ID 5	Pathology	
7090	Path Report Number 1	Pathology	
7091	Path Report Number 2	Pathology	
7092	Path Report Number 3	Pathology	
7093	Path Report Number 4	Pathology	
7094	Path Report Number 5	Pathology	
7100	Path Order Phys Lic No 1	Pathology	
7101	Path Order Phys Lic No 2	Pathology	
7102	Path Order Phys Lic No 3	Pathology	
7103	Path Order Phys Lic No 4	Pathology	
7104	Path Order Phys Lic No 5	Pathology	
7190	Path Ordering Fac No 1	Pathology	
7191	Path Ordering Fac No 2	Pathology	
7192	Path Ordering Fac No 3	Pathology	
7193	Path Ordering Fac No 4	Pathology	
7194	Path Ordering Fac No 5	Pathology	
7320	Path Date Spec Collect 1	Pathology	
7321	Path Date Spec Collect 2	Pathology	
7322	Path Date Spec Collect 3	Pathology	
7323	Path Date Spec Collect 4	Pathology	
7324	Path Date Spec Collect 5	Pathology	
7480	Path Report Type 1	Pathology	
7481	Path Report Type 2	Pathology	
7482	Path Report Type 3	Pathology	
7483	Path Report Type 4	Pathology	
7484	Path Report Type 5	Pathology	

APPENDIX E

REQUIRED STATUS TABLE (ITEM # ORDER)

The following table presents Version 12.1 of the NAACCR required status summarizing the requirements and recommendations for collection of each item by standard-setting groups.

NPCR - Refers to requirements and recommendations of the NPCR regarding data items that should be collected or computed by NPCR state registries. The NPCR transmit column in the Required Status Table has been removed with Version 11.2. Transmit instructions will be provided by NPCR. ***Note: Patient identifying data items collected but are not transmitted to CDC.***

CoC - Refers to requirements of CoC. CoC-approved cancer program registries are required to collect the indicated items in the "Collect" column and are required to report items indicated in the "Transmit" column to the NCDB. Facilities should refer to the CoC *FORDS* manual for further clarification of required fields. Note: Patient identifying data items collected are not transmitted to the NCDB.

SEER - Refers to requirements of NCI's SEER Program. Central registries are required to collect the indicated items in the "Collect" column and are required to report the items indicated in the "Transmit" column to NCI-SEER. Facilities and central registries should refer to the *SEER Program Code Manual* for further clarification of required fields.

Exchange Elements for Hospital to Central and Central to Central

The target audience for this set of requirements is comprised of the various designers of registry software, at the hospital, central registry, and national levels. In the Exchange Elements columns, data items marked are either required by key national organizations for cancer reporting or are of special importance in the unambiguous communication of reports and the proper linking of records. A clear distinction is made between items required for facilities reporting to central registries (labeled Hosp → Central), and those items that central registries should use when sending cases to other central registries (labeled Central → Central). Some central registries have additional required data fields. For these, vendors should contact the central registry directly.

Code Description

# = Central registries may code available data using either SEER or CoC data items and associated rules
RC =Collected by SEER from CoC approved hospitals
T = Data is vital to complete exchange record
D = Derived
RH = Historically collected and currently transmitted
RH* = Historically collected and currently transmitted when available
. =No recommendations
TH = only certain historical cases may require these fields
R =Required
RS =Required, site specific
R^ = Required, these text requirements may be met with one or several text block fields
R* =Required, when available
R$ =Requirements differ by year
S =Supplementary/recommended
T* =transmit data if available for any case in exchange record

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
10	Record Type	T	T	NAACCR	R	R	.	R	.
20	Patient ID Number	.	T	Reporting Registry	R	.	.	R	R
21	Patient System ID-Hosp	T	.	NAACCR	.	.	.	.	.
30	Registry Type	.	T	NAACCR	.	.	.	.	.
35	FIN Coding System	.	.	NAACCR	.	.	.	.	.
37	Reserved 00								
40	Registry ID	T	T	NAACCR	R	.	.	R	R
45	NPI--Registry ID	.	.	CMS	.	.	.	.	R*
50	NAACCR Record Version	T	T	NAACCR	R	R	.	.	.
60	Tumor Record Number	T	T	NAACCR	.	.	.	S	S
70	Addr at DX--City	T	T	CoC	R	R	R	.	R
80	Addr at DX--State	T	T	CoC	R	R	R	.	R
90	County at DX	T	T	FIPS/SEER	R	R	R	R	R
100	Addr at DX--Postal Code	T	T	CoC	R	R	R	.	R
110	Census Tract 1970/80/90	.	T*	SEER	RH*	.	.	RH	RH
120	Census Cod Sys 1970/80/90	.	T*	SEER	RH*	.	.	RH	RH
130	Census Tract 2000	.	T*	NAACCR	R	.	.	R	R
135	Census Tract 2010	.	.	NAACCR	R*	.	.	.	.
140	Census Tract Cod Sys--Alt								
150	Marital Status at DX	.	.	SEER	.	.	.	R	R
160	Race 1	T	T	SEER/CoC	R	R	R	R	R
161	Race 2	T	T	SEER/CoC	R	R	R	R	R
162	Race 3	T	T	SEER/CoC	R	R	R	R	R
163	Race 4	T	T	SEER/CoC	R	R	R	R	R
164	Race 5	T	T	SEER/CoC	R	R	R	R	R
170	Race Coding Sys--Current	T	T	NAACCR	.	R	R	.	.
180	Race Coding Sys--Original	T	T	NAACCR	.	R	R	.	.
190	Spanish/Hispanic Origin	T	T	SEER/CoC	R	R	R	R	R
191	NHIA Derived Hisp Origin	.	.	NAACCR	D	.	.	R	D
192	IHS Link	.	.	NPCR	R*	.	.	R	.
193	Race--NAPIIA(derived API)	.	.	NAACCR	R	.	.	R	D
200	Computed Ethnicity	.	.	SEER	R	.	.	R	D

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
210	Computed Ethnicity Source	.	.	SEER	R	.	.	R	R
220	Sex	T	T	SEER/CoC	R	R	R	R	R
230	Age at Diagnosis	.	.	SEER/CoC	R	R	R	R	R
240	Date of Birth	T	T	SEER/CoC	R	R	R	R	R
241	Date of Birth Flag	T	T	NAACCR	R	R	R	R	R
250	Birthplace	T*	T	SEER/CoC	R*	R	R	R	R
260	Religion								
270	Occupation Code--Census	.	.	Census/NPCR	R*	.	.	.	.
280	Industry Code--Census	.	.	Census/NPCR	R*	.	.	.	.
290	Occupation Source	.	.	NPCR	R*	.	.	.	.
300	Industry Source	.	.	NPCR	R*	.	.	.	.
310	Text--Usual Occupation	T*	T*	NPCR	R*	.	.	.	.
320	Text--Usual Industry	T*	T*	NPCR	R*	.	.	.	.
330	Occup/Ind Coding System	.	.	NPCR	R*	.	.	.	.
340	Tobacco History								
350	Alcohol History								
360	Family History of Cancer								
362	Census Block Group 2000	.	.	Census	.	.	.	.	S
363	Census Block Group 2010	.	.	Census	.	.	.	.	.
364	Census Tr Cert 1970/80/90	.	.	SEER	RH*	.	.	RH	RH
365	Census Tr Certainty 2000	.	.	NAACCR	R	.	.	R	R
366	GIS Coordinate Quality	.	.	NAACCR	R*	.	.	.	S
367	Census Tr Certainty 2010	.	.	NAACCR	R*	.	.	.	.
368	CensusBlockGroup 70/80/90	.	.	Census	.	.	.	.	S
370	Reserved 01								
380	Sequence Number--Central	.	T	SEER	R	.	.	R	R
390	Date of Diagnosis	T	T	SEER/CoC	R	R	R	R	R
391	Date of Diagnosis Flag	T	T	NAACCR	R	.	.	R	R
400	Primary Site	T	T	SEER/CoC	R	R	R	R	R
410	Laterality	T	T	SEER/CoC	R	R	R	R	R
419	Morph--Type&Behav ICD-O-2	.	.		.	.	.	.	.
420	Histology (92-00) ICD-O-2	TH	TH	SEER/CoC	RH	RH	RH	RH	RH
430	Behavior (92-00) ICD-O-2	TH	TH	SEER/CoC	RH	RH	RH	RH	RH
439	Date of Mult Tumors Flag	.	.	NAACCR	.	R	R	R	R

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
440	Grade	T	T	SEER/CoC	R	R	R	R	R
441	Grade Path Value	T*	T*	AJCC	R*	R	R	R	R
442	Ambiguous Terminology DX	.	.	SEER	.	R	R	R	R
443	Date of Conclusive DX	.	.	SEER	.	R	R	R	R
444	Mult Tum Rpt as One Prim	.	.	SEER	.	R	R	R	R
445	Date of Multiple Tumors	.	.	SEER	.	R	R	R	R
446	Multiplicity Counter	.	.	SEER	.	R	R	R	R
447	Number of Tumors/Hist			Retired					
448	Date Conclusive DX Flag	.	.	NAACCR	.	R	R	R	R
449	Grade Path System	T*	T*	AJCC	R*	R	R	R	R
450	Site Coding Sys--Current	T	T	NAACCR	R	R	R	.	.
460	Site Coding Sys--Original	T	T	NAACCR	.	R	R	.	.
470	Morph Coding Sys--Current	T	T	NAACCR	R	R	R	.	.
480	Morph Coding Sys--Originl	T	T	NAACCR	.	R	R	.	.
490	Diagnostic Confirmation	T	T	SEER/CoC	R	R	R	R	R
500	Type of Reporting Source	T	T	SEER	R	.	.	R	R
501	Casefinding Source	T*	T*	NAACCR	.	.	.	.	.
510	Screening Date								
520	Screening Result								
521	Morph--Type&Behav ICD-O-3				.	.	.	.	.
522	Histologic Type ICD-O-3	T	T	SEER/CoC	R	R	R	R	R
523	Behavior Code ICD-O-3	T	T	SEER/CoC	R	R	R	R	R
530	Reserved 02								
538	Reporting Hospital FAN								
540	Reporting Facility	T	.	CoC	R	R	R	.	R
545	NPI--Reporting Facility	.	.	CMS	R*	R	R	.	R*
550	Accession Number--Hosp	T*	.	CoC	.	R	R	.	R
560	Sequence Number--Hospital	T	.	CoC	.	R	R	.	R
570	Abstracted By	.	.	CoC	.	R	R	.	R
580	Date of 1st Contact	T	.	CoC	R	R	R	.	.
581	Date of 1st Contact Flag	T	.	NAACCR	R	R	R	.	.
590	Date of Inpatient Adm	.	.	NAACCR	.	.	.	.	.
591	Date of Inpt Adm Flag	.	.	NAACCR	.	.	.	.	.
600	Date of Inpatient Disch	.	.	NAACCR	.	.	.	.	.

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
601	Date of Inpt Disch Flag	.	.	NAACCR	.	.	.	.	.
605	Inpatient Status	.	.	NAACCR	.	.	.	.	.
610	Class of Case	T	.	CoC	R	R	R	.	RC
620	Year First Seen This CA								
630	Primary Payer at DX	.	.	CoC	R*	R	R	R	R
640	Inpatient/Outpt Status								
650	Presentation at CA Conf								
660	Date of CA Conference								
665	RX Hosp--ASA Class	.	.		.	.	.	.	.
668	RX Hosp--Surg App 2010	T*	.	CoC	.	R	R	.	.
670	RX Hosp--Surg Prim Site	T*	.	CoC	.	R	R	.	R
672	RX Hosp--Scope Reg LN Sur	T*	.	CoC	.	R	R	.	R
674	RX Hosp--Surg Oth Reg/Dis	T*	.	CoC	.	R	R	.	R
676	RX Hosp--Reg LN Removed	T*	.	CoC	.	RH	RH	.	.
678	RX Hosp--Surg Timing	.	.		.	.	.	.	.
680	Reserved 03								
690	RX Hosp--Radiation	TH*	.	SEER	.	.	.	.	RH
700	RX Hosp--Chemo	T*	.	CoC	.	R	R	.	R
710	RX Hosp--Hormone	T*	.	CoC	.	R	R	.	R
720	RX Hosp--BRM	T*	.	CoC	.	R	R	.	R
730	RX Hosp--Other	T*	.	CoC	.	R	R	.	R
740	RX Hosp--DX/Stg Proc	.	.	CoC	.	R	R	.	.
742	RX Hosp--Screen/BX Proc1								
743	RX Hosp--Screen/BX Proc2								
744	RX Hosp--Screen/BX Proc3								
745	RX Hosp--Screen/BX Proc4								
746	RX Hosp--Surg Site 98-02	TH*	.	CoC	.	RH	RH	.	RH
747	RX Hosp--Scope Reg 98-02	TH*	.	CoC	.	RH	RH	.	RH
748	RX Hosp--Surg Oth 98-02	TH*	.	CoC	.	RH	RH	.	RH
750	Reserved 04								
759	SEER Summary Stage 2000	TH*	TH*	SEER	RH	RH	RH	S	.
760	SEER Summary Stage 1977	TH*	TH*	SEER	RH	RH	RH	S	.
770	Loc/Reg/Distant Stage								
779	Extent of Disease 10-Dig				.	.	.	.	.

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
780	EOD--Tumor Size	TH*	TH*	SEER/CoC	.	RH	RH	RH	RH
790	EOD--Extension	TH*	TH*	SEER	.	.	.	RH	RH
800	EOD--Extension Prost Path	TH*	TH*	SEER	.	.	.	RH	RH
810	EOD--Lymph Node Involv	TH*	TH*	SEER	.	.	.	RH	RH
820	Regional Nodes Positive	T*	T*	SEER/CoC	R*	R	R	R	R
830	Regional Nodes Examined	T*	T*	SEER/CoC	R*	R	R	R	R
840	EOD--Old 13 Digit	.	.	SEER	.	.	.	RH	RH
850	EOD--Old 2 Digit	.	.	SEER	.	.	.	RH	RH
860	EOD--Old 4 Digit	.	.	SEER	.	.	.	RH	RH
870	Coding System for EOD	.	TH*	SEER	.	.	.	RH	RH
880	TNM Path T	T*	T*	AJCC	.	R*	R*	.	.
890	TNM Path N	T*	T*	AJCC	.	R*	R*	.	.
900	TNM Path M	T*	T*	AJCC	.	R*	R*	.	.
910	TNM Path Stage Group	T*	T*	AJCC	.	R*	R*	.	.
920	TNM Path Descriptor	T*	T*	CoC	.	R*	R*	.	.
930	TNM Path Staged By	T*	T*	CoC	.	R*	R*	.	.
940	TNM Clin T	T*	T*	AJCC	.	R	R	.	.
950	TNM Clin N	T*	T*	AJCC	.	R	R	.	.
960	TNM Clin M	T*	T*	AJCC	.	R	R	.	.
970	TNM Clin Stage Group	T*	T*	AJCC	.	R	R	.	.
980	TNM Clin Descriptor	T*	T*	CoC	.	R	R	.	.
990	TNM Clin Staged By	T*	T*	CoC	.	R	R	.	.
1000	TNM Other T								
1010	TNM Other N								
1020	TNM Other M								
1030	TNM Other Stage Group								
1040	TNM Other Staged By								
1050	TNM Other Descriptor								
1060	TNM Edition Number	T*	T*	CoC	.	R	R	.	.
1070	Other Staging System								
1080	Date of 1st Positive BX								
1090	Site of Distant Met 1								
1100	Site of Distant Met 2								
1110	Site of Distant Met 3								

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
1120	Pediatric Stage	.	.	CoC	.	.	.	.	.
1130	Pediatric Staging System	.	.	CoC	.	.	.	.	.
1140	Pediatric Staged By	.	.	CoC	.	.	.	.	.
1150	Tumor Marker 1	TH*	TH*	SEER	.	RH	RH	RH	RH
1160	Tumor Marker 2	TH*	TH*	SEER	.	RH	RH	RH	RH
1170	Tumor Marker 3	TH*	TH*	SEER	.	RH	RH	RH	RH
1180	Reserved 05								
1182	Lymph-vascular Invasion	T*	T*	AJCC	.	R	R	RS	RS
1190	Reserved 06								
1200	RX Date--Surgery	T*	T*	CoC	R	R	R	.	S
1201	RX Date--Surgery Flag	T*	T*	NAACCR	R	R	R	.	S
1210	RX Date--Radiation	T*	T*	CoC	R	R	R	.	S
1211	RX Date--Radiation Flag	T*	T*	NAACCR	R	R	R	.	S
1220	RX Date--Chemo	T*	T*	CoC	R	R	R	.	.
1221	RX Date--Chemo Flag	T*	T*	NAACCR	R	R	R	.	.
1230	RX Date--Hormone	T*	T*	CoC	R	R	R	.	.
1231	RX Date--Hormone Flag	T*	T*	NAACCR	R	R	R	.	.
1240	RX Date--BRM	T*	T*	CoC	R	R	R	.	S
1241	RX Date--BRM Flag	T*	T*	NAACCR	R	R	R	.	S
1250	RX Date--Other	T*	T*	CoC	R	R	R	.	S
1251	RX Date--Other Flag	T*	T*	NAACCR	R	R	R	.	S
1260	Date of Initial RX--SEER	T*	T*	SEER	R#	.	.	R	R
1261	Date of Initial RX Flag	T*	T*	NAACCR	R#	.	.	R	R
1270	Date of 1st Crs RX--CoC	T*	T*	CoC	R#	R	R	.	.
1271	Date of 1st Crs Rx Flag	T*	T*	NAACCR	R#	R	R	.	.
1280	RX Date--DX/Stg Proc	.	.	CoC	.	R	R	.	.
1281	RX Date--Dx/Stg Proc Flag	.	.	NAACCR	.	R	R	.	.
1285	RX Summ--Treatment Status	T*	T*	SEER/CoC	R#	R	R	R	R
1290	RX Summ--Surg Prim Site	T	T*	SEER/CoC	R	R	R	R	R
1292	RX Summ--Scope Reg LN Sur	T	T*	SEER/CoC	R	R	R	R	R
1294	RX Summ--Surg Oth Reg/Dis	T	T*	SEER/CoC	R	R	R	R	R
1296	RX Summ--Reg LN Examined	TH*	TH*	SEER/CoC	.	RH	RH	RH	RH
1300	Reserved 07								
1310	RX Summ--Surgical Approch	.	.	CoC	.	RH	RH	.	.

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
1320	RX Summ--Surgical Margins	.	.	CoC	.	R	R	.	.
1330	RX Summ--Reconstruct 1st	.	.	SEER	.	RH	RH	RH	RH
1340	Reason for No Surgery	T	T*	SEER/CoC	R	R	R	R	R
1350	RX Summ--DX/Stg Proc	.	.	CoC	.	R	R	.	.
1360	RX Summ--Radiation	TH*	TH*	SEER	D	.	.	R	R
1370	RX Summ--Rad to CNS	.	.	SEER/CoC	.	.	.	R	R
1380	RX Summ--Surg/Rad Seq	T	T*	SEER/CoC	R	R	R	R	R
1390	RX Summ--Chemo	T*	T*	SEER/CoC	R	R	R	R	R
1400	RX Summ--Hormone	T*	T*	SEER/CoC	R	R	R	R	R
1410	RX Summ--BRM	T*	T*	SEER/CoC	R	R	R	R	R
1420	RX Summ--Other	T*	T*	SEER/CoC	R	R	R	R	R
1430	Reason for No Radiation	.	.	CoC	R	R	R	.	.
1440	Reason for No Chemo								
1450	Reason for No Hormone								
1460	RX Coding System--Current	T*	T*	NAACCR	R	R	R	RH	.
1470	Protocol Eligibility Stat								
1480	Protocol Participation								
1490	Referral to Support Serv								
1500	First Course Calc Method	.	.	NAACCR	R	.	.	.	.
1510	Rad--Regional Dose: CGY	T	.	CoC	.	R	R	.	.
1520	Rad--No of Treatment Vol	T	.	CoC	.	R	R	.	.
1530	Rad--Elapsed RX Days								
1540	Rad--Treatment Volume	T	.	CoC	.	R	R	.	.
1550	Rad--Location of RX	T	.	CoC	.	R	R	.	.
1560	Rad--Intent of Treatment								
1570	Rad--Regional RX Modality	T	T*	CoC	R	R	R	.	RC
1580	Rad--RX Completion Status								
1590	Rad--Local Control Status								
1600	Chemotherapy Field 1								
1610	Chemotherapy Field 2								
1620	Chemotherapy Field 3								
1630	Chemotherapy Field 4								
1639	RX Summ--Systemic/Sur Seq	T	T	CoC	R	R	R	R	R
1640	RX Summ--Surgery Type	TH*	TH*	SEER	.	.	.	RH	RH

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
1642	RX Summ--Screen/BX Proc1								
1643	RX Summ--Screen/BX Proc2								
1644	RX Summ--Screen/BX Proc3								
1645	RX Summ--Screen/BX Proc4								
1646	RX Summ--Surg Site 98-02	TH*	TH*	SEER/CoC	.	RH	RH	RH	RH
1647	RX Summ--Scope Reg 98-02	TH*	TH*	SEER/CoC	.	RH	RH	RH	RH
1648	RX Summ--Surg Oth 98-02	TH*	TH*	SEER/CoC	.	RH	RH	RH	RH
1650	Reserved 08								
1660	Subsq RX 2nd Course Date	.	.	CoC	.	.	.	.	.
1661	Subsq RX 2ndCrs Date Flag	.	.	NAACCR	.	.	.	.	.
1670	Subsq RX 2nd Course Codes				.	.	.	.	.
1671	Subsq RX 2nd Course Surg	.	.	CoC	.	.	.	.	.
1672	Subsq RX 2nd Course Rad	.	.	CoC	.	.	.	.	.
1673	Subsq RX 2nd Course Chemo	.	.	CoC	.	.	.	.	.
1674	Subsq RX 2nd Course Horm	.	.	CoC	.	.	.	.	.
1675	Subsq RX 2nd Course BRM	.	.	CoC	.	.	.	.	.
1676	Subsq RX 2nd Course Oth	.	.	CoC	.	.	.	.	.
1677	Subsq RX 2nd--Scope LN SU	.	.	CoC	.	.	.	.	.
1678	Subsq RX 2nd--Surg Oth	.	.	CoC	.	.	.	.	.
1679	Subsq RX 2nd--Reg LN Rem	.	.	CoC	.	.	.	.	.
1680	Subsq RX 3rd Course Date	.	.	CoC	.	.	.	.	.
1681	Subsq RX 3rdCrs Date Flag	.	.	NAACCR	.	.	.	.	.
1690	Subsq RX 3rd Course Codes	.	.		.	.	.	.	.
1691	Subsq RX 3rd Course Surg	.	.	CoC	.	.	.	.	.
1692	Subsq RX 3rd Course Rad	.	.	CoC	.	.	.	.	.
1693	Subsq RX 3rd Course Chemo	.	.	CoC	.	.	.	.	.
1694	Subsq RX 3rd Course Horm	.	.	CoC	.	.	.	.	.
1695	Subsq RX 3rd Course BRM	.	.	CoC	.	.	.	.	.
1696	Subsq RX 3rd Course Oth	.	.	CoC	.	.	.	.	.
1697	Subsq RX 3rd--Scope LN Su	.	.	CoC	.	.	.	.	.
1698	Subsq RX 3rd--Surg Oth	.	.	CoC	.	.	.	.	.
1699	Subsq RX 3rd--Reg LN Rem	.	.	CoC	.	.	.	.	.
1700	Subsq RX 4th Course Date	.	.	CoC	.	.	.	.	.
1701	Subsq RX 4thCrs Date Flag	.	.	NAACCR	.	.	.	.	.

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
1710	Subsq RX 4th Course Codes	.	.		.	.	.	.	.
1711	Subsq RX 4th Course Surg	.	.	CoC	.	.	.	.	.
1712	Subsq RX 4th Course Rad	.	.	CoC	.	.	.	.	.
1713	Subsq RX 4th Course Chemo	.	.	CoC	.	.	.	.	.
1714	Subsq RX 4th Course Horm	.	.	CoC	.	.	.	.	.
1715	Subsq RX 4th Course BRM	.	.	CoC	.	.	.	.	.
1716	Subsq RX 4th Course Oth	.	.	CoC	.	.	.	.	.
1717	Subsq RX 4th--Scope LN Su	.	.	CoC	.	.	.	.	.
1718	Subsq RX 4th--Surg Oth	.	.	CoC	.	.	.	.	.
1719	Subsq RX 4th--Reg LN Rem	.	.	CoC	.	.	.	.	.
1720	Subsq RX 5th Course Date								
1730	Subsq RX 5th Course Codes								
1731	Subsq RX 5th Course Surg								
1732	Subsq RX 5th Course Rad								
1733	Subsq RX 5th Course Chemo								
1734	Subsq RX 5th Course Horm								
1735	Subsq RX 5th Course BRM								
1736	Subsq RX 5th Course Oth								
1737	Subsq RX 5th--Scope LN Su								
1738	Subsq RX 5th--Surg Oth								
1739	Subsq RX 5th--Reg LN Rem								
1740	Reserved 09								
1741	Subsq RX--Reconstruct Del	.	.	CoC	.	.	.	.	.
1750	Date of Last Contact	T	T	SEER/CoC	R	R	R	R	R
1751	Date of Last Contact Flag	T	T	NAACCR	R	R	R	R	R
1755	Date of Death--Canada	.	.	CCCR	.	.	.	.	.
1756	Date of Death--CanadaFlag	.	.	NAACCR	.	.	.	.	.
1760	Vital Status	T	T	SEER/CoC	R	R	R	R	R
1770	Cancer Status	.	.	CoC	.	R	R	.	.
1780	Quality of Survival	.	.	CoC	.	.	.	.	.
1790	Follow-Up Source	T*	.	CoC	R*	.	R	.	.
1791	Follow-up Source Central	.	T*	NAACCR	R	.	.	.	.
1800	Next Follow-Up Source	.	.	CoC	.	.	R	.	.
1810	Addr Current--City	T*	.	CoC	.	.	R	.	R

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
1820	Addr Current--State	T*	.	CoC	.	.	R	.	R
1830	Addr Current--Postal Code	T*	.	CoC	.	.	R	.	R
1835	Reserved 10								
1840	County--Current	.	.	NAACCR	.	.	.	.	.
1842	Follow-Up Contact--City	T*	.	SEER	.	.	.	.	R
1844	Follow-Up Contact--State	T*	.	SEER	.	.	.	.	R
1846	Follow-Up Contact--Postal	T*	.	SEER	.	.	.	.	R
1850	Unusual Follow-Up Method	.	.	CoC	.	.	.	.	.
1860	Recurrence Date--1st	T*	.	CoC	.	R	R	.	RC
1861	Recurrence Date--1st Flag	T*	.	NAACCR	.	R	R	.	RC
1870	Recurrence Distant Sites								
1871	Recurrence Distant Site 1								
1872	Recurrence Distant Site 2								
1873	Recurrence Distant Site 3								
1880	Recurrence Type--1st	T*	.	CoC	.	R	R	.	RC
1890	Recurrence Type--1st--Oth								
1900	Reserved 11								
1910	Cause of Death	.	T	SEER	R	.	.	R	R
1920	ICD Revision Number	.	T	SEER	R	.	.	R	R
1930	Autopsy	.	.	NAACCR	.	.	.	.	.
1940	Place of Death	T*	T*	NPCR	R	.	.	.	.
1960	Site (73-91) ICD-O-1	.	.	SEER	.	.	.	RH	RH
1970	Morph (73-91) ICD-O-1								
1971	Histology (73-91) ICD-O-1	.	.	SEER	.	.	.	RH	RH
1972	Behavior (73-91) ICD-O-1	.	.	SEER	.	.	.	RH	RH
1973	Grade (73-91) ICD-O-1	.	.	SEER	.	.	.	RH	RH
1980	ICD-O-2 Conversion Flag	T*	T*	SEER	.	RH	RH	R	R
1981	Over-ride SS/NodesPos	T*	T*	NAACCR	.	.	.	.	.
1982	Over-ride SS/TNM-N	T*	T*	NAACCR	.	.	.	.	.
1983	Over-ride SS/TNM-M	T*	T*	NAACCR	.	.	.	.	.
1984	Over-ride SS/DisMet1								
1985	Over-ride Acsn/Class/Seq	T*	T*	CoC	.	R	R	.	.
1986	Over-ride HospSeq/DxConf	T*	T*	CoC	.	R	R	.	.
1987	Over-ride CoC-Site/Type	T*	T*	CoC	.	R	R	.	.

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
1988	Over-ride HospSeq/Site	T*	T*	CoC	.	R	R	.	.
1989	Over-ride Site/TNM-StgGrp	T*	T*	CoC	.	R	R	.	.
1990	Over-ride Age/Site/Morph	T*	T*	SEER	R	R	R	R	R
2000	Over-ride SeqNo/DxConf	T*	T*	SEER	R	.	.	R	R
2010	Over-ride Site/Lat/SeqNo	T*	T*	SEER	R	.	.	R	R
2020	Over-ride Surg/DxConf	T*	T*	SEER	R	R	R	R	R
2030	Over-ride Site/Type	T*	T*	SEER	R	R	R	R	R
2040	Over-ride Histology	T*	T*	SEER	R	R	R	R	R
2050	Over-ride Report Source	T*	T*	SEER	R	.	.	R	R
2060	Over-ride Ill-define Site	T*	T*	SEER	R	.	.	R	R
2070	Over-ride Leuk, Lymphoma	T*	T*	SEER	R	R	R	R	R
2071	Over-ride Site/Behavior	T*	T*	SEER	R	R	R	R	R
2072	Over-ride Site/EOD/DX Dt	T*	T*	SEER	.	.	.	R	R
2073	Over-ride Site/Lat/EOD	T*	T*	SEER	.	.	.	R	R
2074	Over-ride Site/Lat/Morph	T*	T*	SEER	R	R	R	R	R
2080	Reserved 13								
2081	CRC CHECKSUM	.	.	NAACCR	.	.	.	S	S
2085	Date Case Initiated	.	.	NAACCR	.	.	.	.	.
2090	Date Case Completed	.	.	NAACCR	.	.	.	.	.
2092	Date Case Completed--CoC	.	.	CoC	.	R	R	.	.
2100	Date Case Last Changed	.	.	NAACCR	.	R	D	.	.
2110	Date Case Report Exported	T	.	NPCR	R	.	.	.	.
2111	Date Case Report Received	.	.	NPCR	R	.	.	.	.
2112	Date Case Report Loaded	.	.	NPCR	R	.	.	.	.
2113	Date Tumor Record Availbl	.	.	NPCR	R	.	.	.	.
2114	Future Use Timeliness 1								
2115	Future Use Timeliness 2								
2116	ICD-O-3 Conversion Flag	T	T	SEER/CoC	R	.	.	R	R
2120	SEER Coding Sys--Current	T*	T*	NAACCR	.	.	.	R	.
2130	SEER Coding Sys--Original	T*	T*	NAACCR	.	.	.	R	.
2140	CoC Coding Sys--Current	T*	T*	CoC	.	R	R	.	.
2150	CoC Coding Sys--Original	T*	T*	CoC	.	R	R	.	.
2160	Subsq Report for Primary								
2170	Vendor Name	T	T	NAACCR	.	R	R	.	.

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
2180	SEER Type of Follow-Up	.	.	SEER	.	.	.	R	R
2190	SEER Record Number	.	.	SEER	.	.	.	R	.
2200	Diagnostic Proc 73-87	.	.	SEER	.	.	.	RH	RH
2210	Reserved 14								
2220	State/Requestor Items	.	.	Varies	.	.	.	.	.
2230	Name--Last	T	T	CoC	R	.	R	.	R
2240	Name--First	T	T	CoC	R	.	R	.	R
2250	Name--Middle	T*	T*	CoC	R	.	R	.	R
2260	Name--Prefix	.	.	CoC	.	.	.	.	.
2270	Name--Suffix	T*	T*	CoC	.	.	.	.	R
2280	Name--Alias	T*	T*	CoC	R	.	.	.	R
2290	Name--Spouse/Parent	.	.	NAACCR	.	.	.	.	.
2300	Medical Record Number	T	.	CoC	R	.	R	.	R
2310	Military Record No Suffix	.	.	CoC	.	.	.	.	.
2320	Social Security Number	T	T	CoC	R	.	R	.	R
2330	Addr at DX--No & Street	T	T	CoC	R	.	R	.	R
2335	Addr at DX--Supplementl	T*	T*	CoC	R	.	R*	.	R
2350	Addr Current--No & Street	T*	T*	CoC	.	.	R	.	R
2352	Latitude	.	.	NAACCR	R*	.	.	.	S
2354	Longitude	.	.	NAACCR	R*	.	.	.	S
2355	Addr Current--Supplementl	T*	.	CoC	.	.	R*	.	R
2360	Telephone	T*	T*	CoC	.	.	R	.	R
2370	DC State								
2380	DC State File Number	.	T*	State	R	.	.	.	R*
2390	Name--Maiden	T*	T*	CoC	R	.	.	.	R
2392	Follow-Up Contact--No&St	.	.	SEER	.	.	.	.	R
2393	Follow-Up Contact--Suppl	.	.	SEER	.	.	.	.	R
2394	Follow-Up Contact--Name	.	.	SEER	.	.	.	.	R
2400	Reserved 16								
2410	Institution Referred From	T*	.	CoC	.	.	.	.	.
2415	NPI--Inst Referred From	.	.	CMS	.	.	R	.	.
2420	Institution Referred To	T*	.	CoC	.	.	.	.	.
2425	NPI--Inst Referred To	.	.	CMS	.	.	R	.	.
2430	Last Follow-Up Hospital								

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
2440	Following Registry	.	.	CoC	.	.	.	.	R
2445	NPI--Following Registry	.	.	CMS	.	.	.	.	R*
2450	Reserved 17								
2460	Physician--Managing	.	.	NAACCR	.	.	.	.	.
2465	NPI--Physician--Managing	.	.	CMS	.	.	R	.	.
2470	Physician--Follow-Up	T*	T*	CoC	.	.	.	.	R
2475	NPI--Physician--Follow-Up	.	.	CMS	.	.	R	.	R*
2480	Physician--Primary Surg	.	.	CoC	.	.	.	.	.
2485	NPI--Physician--Primary Surg	.	.	CMS	.	R	R	.	.
2490	Physician 3	.	.	CoC	.	.	.	.	.
2495	NPI--Physician 3	.	.	CMS	.	R	R	.	.
2500	Physician 4	.	.	CoC	.	.	.	.	.
2505	NPI--Physician 4	.	.	CMS	.	R	R	.	.
2510	Reserved 12								
2520	Text--DX Proc--PE	T*	T*	NPCR	R^	.	.	.	R
2530	Text--DX Proc--X-ray/Scan	T*	T*	NPCR	R^	.	.	.	R
2540	Text--DX Proc--Scopes	T*	T*	NPCR	R^	.	.	.	R
2550	Text--DX Proc--Lab Tests	T*	T*	NPCR	R^	.	.	.	R
2560	Text--DX Proc--Op	T*	T*	NPCR	R^	.	.	.	R
2570	Text--DX Proc--Path	T*	T*	NPCR	R^	.	.	.	R
2580	Text--Primary Site Title	T*	T*	NPCR	R^	.	.	.	R
2590	Text--Histology Title	T*	T*	NPCR	R^	.	.	.	R
2600	Text--Staging	T*	T*	NPCR	R^	.	.	.	R
2610	RX Text--Surgery	T*	T*	NPCR	R^	.	.	.	R
2620	RX Text--Radiation (Beam)	T*	T*	NPCR	R^	.	.	.	R
2630	RX Text--Radiation Other	T*	T*	NPCR	R^	.	.	.	R
2640	RX Text--Chemo	T*	T*	NPCR	R^	.	.	.	R
2650	RX Text--Hormone	T*	T*	NPCR	R^	.	.	.	R
2660	RX Text--BRM	T*	T*	NPCR	R^	.	.	.	R
2670	RX Text--Other	T*	T*	NPCR	R^	.	.	.	R
2680	Text--Remarks	T*	T*	NPCR	.	.	.	.	R
2690	Text--Place of Diagnosis	.	.	NPCR	.	.	.	.	.
2730	CS PreRx Tumor Size	.	.	AJCC	.	.	.	.	.
2735	CS PreRx Extension	.	.	AJCC	.	.	.	.	.

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
2740	CS PreRx Tum Sz/Ext Eval	.	.	AJCC	.	.	.	.	.
2750	CS PreRx Lymph Nodes	.	.	AJCC	.	.	.	.	.
2755	CS PreRx Reg Nodes Eval	.	.	AJCC	.	.	.	.	.
2760	CS PreRx Mets at DX	.	.	AJCC	.	.	.	.	.
2765	CS PreRx Mets Eval	.	.	AJCC	.	.	.	.	.
2770	CS PostRx Tumor Size	.	.	AJCC	.	.	.	.	.
2775	CS PostRx Extension	.	.	AJCC	.	.	.	.	.
2780	CS PostRx Lymph Nodes	.	.	AJCC	.	.	.	.	.
2785	CS PostRx Mets at DX	.	.	AJCC	.	.	.	.	.
2800	CS Tumor Size	T	T	AJCC	R	R	R	R	R
2810	CS Extension	T	T	AJCC	R	R	R	R	R
2820	CS Tumor Size/Ext Eval	T*	T*	AJCC	R	R	R	R	R
2830	CS Lymph Nodes	T	T	AJCC	R	R	R	R	R
2840	CS Lymph Nodes Eval	T*	T*	AJCC	R*	R	R	R	R
2850	CS Mets at DX	T	T	AJCC	R	R	R	R	R
2851	CS Mets at Dx-Bone	T*	T*	AJCC	.	R	R	R	R
2852	CS Mets at Dx-Brain	T*	T*	AJCC	.	R	R	R	R
2853	CS Mets at Dx-Liver	T*	T*	AJCC	.	R	R	R	R
2854	CS Mets at Dx-Lung	T*	T*	AJCC	.	R	R	R	R
2860	CS Mets Eval	T*	T*	AJCC	R*	R	R	R	R
2861	CS Site-Specific Factor 7	T*	T*	AJCC	RS*	RS	RS	RS	RS
2862	CS Site-Specific Factor 8	T*	T*	AJCC	RS	RS	RS	RS	RS
2863	CS Site-Specific Factor 9	T*	T*	AJCC	RS	RS	RS	RS	RS
2864	CS Site-Specific Factor10	T*	T*	AJCC	RS	RS	RS	RS	RS
2865	CS Site-Specific Factor11	T*	T*	AJCC	RS	RS	RS	RS	RS
2866	CS Site-Specific Factor12	T*	T*	AJCC	RS	RS	RS	RS	RS
2867	CS Site-Specific Factor13	T*	T*	AJCC	RS	RS	RS	RS	RS
2868	CS Site-Specific Factor14	T*	T*	AJCC	RS	RS	RS	RS	RS
2869	CS Site-Specific Factor15	T*	T*	AJCC	RS	RS	RS	RS	RS
2870	CS Site-Specific Factor16	T*	T*	AJCC	RS	RS	RS	RS	RS
2871	CS Site-Specific Factor17	T*	T*	AJCC	RS*	RS	RS	RS	RS
2872	CS Site-Specific Factor18	T*	T*	AJCC	RS*	RS	RS	RS	RS
2873	CS Site-Specific Factor19	T*	T*	AJCC	RS*	RS	RS	RS	RS
2874	CS Site-Specific Factor20	T*	T*	AJCC	RS*	RS	RS	RS	RS

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
2875	CS Site-Specific Factor21	T*	T*	AJCC	RS*	RS	RS	RS	RS
2876	CS Site-Specific Factor22	T*	T*	AJCC	RS*	RS	RS	RS	RS
2877	CS Site-Specific Factor23	T*	T*	AJCC	RS*	RS	RS	RS	RS
2878	CS Site-Specific Factor24	T*	T*	AJCC	RS*	RS	RS	RS	RS
2879	CS Site-Specific Factor25	T*	T*	AJCC	RS	RS	RS	RS	RS
2880	CS Site-Specific Factor 1	T*	T*	AJCC	RS	RS	RS	R	R
2890	CS Site-Specific Factor 2	T*	T*	AJCC	RS	RS	RS	R	R
2900	CS Site-Specific Factor 3	T*	T*	AJCC	RS	RS	RS	R	R
2910	CS Site-Specific Factor 4	T*	T*	AJCC	RS*	RS	RS	R	R
2920	CS Site-Specific Factor 5	T*	T*	AJCC	RS*	RS	RS	R	R
2930	CS Site-Specific Factor 6	T*	T*	AJCC	RS*	RS	RS	R	R
2935	CS Version Input Original	.	.	AJCC	R	R	R	R	D
2936	CS Version Derived	.	.	AJCC	R	R	R	R	D
2937	CS Version Input Current	T*	T*	AJCC	R	R	R	R	D
2940	Derived AJCC-6 T	T*	T*	AJCC	.	R	D	R	D
2950	Derived AJCC-6 T Descript	T*	T*	AJCC	.	R	D	R	D
2960	Derived AJCC-6 N	T*	T*	AJCC	.	R	D	R	D
2970	Derived AJCC-6 N Descript	T*	T*	AJCC	.	R	D	R	D
2980	Derived AJCC-6 M	T*	T*	AJCC	.	R	D	R	D
2990	Derived AJCC-6 M Descript	T*	T*	AJCC	.	R	D	R	D
3000	Derived AJCC-6 Stage Grp	T*	T*	AJCC	.	R	D	R	D
3010	Derived SS1977	T*	T*	AJCC	.	R	D	R	D
3020	Derived SS2000	T*	T*	AJCC	D	R	D	R	D
3030	Derived AJCC--Flag	T*	T*	AJCC	.	R	D	R	D
3040	Derived SS1977--Flag	T*	T*	AJCC	.	R	D	R	D
3050	Derived SS2000--Flag	T*	T*	AJCC	D	R	D	R	D
3100	Archive FIN	.	.	CoC	.	R	R	.	.
3105	NPI--Archive FIN	.	.	CMS	.	R	R	.	.
3110	Comorbid/Complication 1	T*	.	CoC	.	R	R	.	.
3120	Comorbid/Complication 2	T*	.	CoC	.	R	R	.	.
3130	Comorbid/Complication 3	T*	.	CoC	.	R	R	.	.
3140	Comorbid/Complication 4	T*	.	CoC	.	R	R	.	.
3150	Comorbid/Complication 5	T*	.	CoC	.	R	R	.	.
3160	Comorbid/Complication 6	T*	.	CoC	.	R	R	.	.

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
3161	Comorbid/Complication 7	T*	.	CoC	.	R	R	.	.
3162	Comorbid/Complication 8	T*	.	CoC	.	R	R	.	.
3163	Comorbid/Complication 9	T*	.	CoC	.	R	R	.	.
3164	Comorbid/Complication 10	T*	.	CoC	.	R	R	.	.
3165	ICD Revision Comorbid	T*	.	CoC	.	R	R	.	.
3170	RX Date--Most Defin Surg	T*	.	CoC	.	R	R	.	.
3171	RX Date Mst Defn Srg Flag	T*	.	NAACCR	.	R	R	.	.
3180	RX Date--Surgical Disch	.	.	CoC	.	R	R	.	.
3181	RX Date Surg Disch Flag	.	.	NAACCR	.	R	R	.	.
3190	Readm Same Hosp 30 Days	.	.	CoC	.	R	R	.	.
3200	Rad--Boost RX Modality	T*	T*	CoC	.	R	R	.	RC
3210	Rad--Boost Dose cGy	.	.	CoC	.	R	R	.	.
3220	RX Date--Radiation Ended	.	.	CoC	.	R	R	.	.
3221	RX Date Rad Ended Flag	.	.	NAACCR	.	R	R	.	.
3230	RX Date--Systemic	T*	T*	CoC	.	R	R	.	S
3231	RX Date Systemic Flag	T*	T*	NAACCR	.	R	R	.	S
3250	RX Summ--Transplnt/Endocr	T*	T*	CoC	R	R	R	R	R
3260	Pain Assessment								
3270	RX Summ--Palliative Proc	T*	.	CoC	.	R	R	.	.
3280	RX Hosp--Palliative Proc	T*	.	CoC	.	R	R	.	.
3300	RuralUrban Continuum 1993	.	.	NAACCR	D	.	.	.	.
3310	RuralUrban Continuum 2003	.	.	NAACCR	D	.	.	.	.
3400	Derived AJCC-7 T	T*	T*	AJCC	D*	R	D	R	D
3402	Derived AJCC-7 T Descript	T*	T*	AJCC	D*	R	D	R	D
3410	Derived AJCC-7 N	T*	T*	AJCC	D*	R	D	R	D
3412	Derived AJCC-7 N Descript	T*	T*	AJCC	D*	R	D	R	D
3420	Derived AJCC-7 M	T*	T*	AJCC	D*	R	D	R	D
3422	Derived AJCC-7 M Descript	T*	T*	AJCC	D*	R	D	R	D
3430	Derived AJCC-7 Stage Grp	T*	T*	AJCC	D*	R	D	R	D
3440	Derived PreRx-7 T	.	.	AJCC	.	.	.	.	.
3442	Derived PreRx-7 T Descrip	.	.	AJCC	.	.	.	.	.
3450	Derived PreRx-7 N	.	.	AJCC	.	.	.	.	.
3452	Derived PreRx-7 N Descrip	.	.	AJCC	.	.	.	.	.
3460	Derived PreRx-7 M	.	.	AJCC	.	.	.	.	.

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
3462	Derived PreRx-7 M Descrip	.	.	AJCC	.	.	.	.	.
3470	Derived PreRx-7 Stage Grp	.	.	AJCC	.	.	.	.	.
3480	Derived PostRx-7 T	.	.	AJCC	.	.	.	.	.
3482	Derived PostRx-7 N	.	.	AJCC	.	.	.	.	.
3490	Derived PostRx-7 M	.	.	AJCC	.	.	.	.	.
3492	Derived PostRx-7 Stge Grp	.	.	AJCC	.	.	.	.	.
3600	Derived Neoadjuv Rx Flag	T*	T*	AJCC	.	.	.	.	.
3700	SEER Site-Specific Fact 1	.	.	SEER	.	.	.	.	.
3702	SEER Site-Specific Fact 2	.	.	SEER	.	.	.	.	.
3704	SEER Site-Specific Fact 3	.	.	SEER	.	.	.	.	.
3706	SEER Site-Specific Fact 4	.	.	SEER	.	.	.	.	.
3708	SEER Site-Specific Fact 5	.	.	SEER	.	.	.	.	.
3710	SEER Site-Specific Fact 6	.	.	SEER	.	.	.	.	.
3750	Over-ride CS 1	.	.	AJCC	.	.	.	.	.
3751	Over-ride CS 2	.	.	AJCC	.	.	.	.	.
3752	Over-ride CS 3	.	.	AJCC	.	.	.	.	.
3753	Over-ride CS 4	.	.	AJCC	.	.	.	.	.
3754	Over-ride CS 5	.	.	AJCC	.	.	.	.	.
3755	Over-ride CS 6	.	.	AJCC	.	.	.	.	.
3756	Over-ride CS 7	.	.	AJCC	.	.	.	.	.
3757	Over-ride CS 8	.	.	AJCC	.	.	.	.	.
3758	Over-ride CS 9	.	.	AJCC	.	.	.	.	.
3759	Over-ride CS 10	.	.	AJCC	.	.	.	.	.
3760	Over-ride CS 11	.	.	AJCC	.	.	.	.	.
3761	Over-ride CS 12	.	.	AJCC	.	.	.	.	.
3762	Over-ride CS 13	.	.	AJCC	.	.	.	.	.
3763	Over-ride CS 14	.	.	AJCC	.	.	.	.	.
3764	Over-ride CS 15	.	.	AJCC	.	.	.	.	.
3765	Over-ride CS 16	.	.	AJCC	.	.	.	.	.
3766	Over-ride CS 17	.	.	AJCC	.	.	.	.	.
3767	Over-ride CS 18	.	.	AJCC	.	.	.	.	.
3768	Over-ride CS 19	.	.	AJCC	.	.	.	.	.
3769	Over-ride CS 20	.	.	AJCC	.	.	.	.	.
7010	Path Reporting Fac ID 1	.	.	HL7	.	.	.	.	.

Item Number	Item Name	Hosp → Central	Central → Central	Source Standard	NPCR Collect	COC Transmit	COC Collect	SEER Transmit	SEER Collect
7011	Path Reporting Fac ID 2	.	.	HL7	.	.	.	.	.
7012	Path Reporting Fac ID 3	.	.	HL7	.	.	.	.	.
7013	Path Reporting Fac ID 4	.	.	HL7	.	.	.	.	.
7014	Path Reporting Fac ID 5	.	.	HL7	.	.	.	.	.
7090	Path Report Number 1	.	.	HL7	.	.	.	.	.
7091	Path Report Number 2	.	.	HL7	.	.	.	.	.
7092	Path Report Number 3	.	.	HL7	.	.	.	.	.
7093	Path Report Number 4	.	.	HL7	.	.	.	.	.
7094	Path Report Number 5	.	.	HL7	.	.	.	.	.
7100	Path Order Phys Lic No 1	.	.	HL7	.	.	.	.	.
7101	Path Order Phys Lic No 2	.	.	HL7	.	.	.	.	.
7102	Path Order Phys Lic No 3	.	.	HL7	.	.	.	.	.
7103	Path Order Phys Lic No 4	.	.	HL7	.	.	.	.	.
7104	Path Order Phys Lic No 5	.	.	HL7	.	.	.	.	.
7190	Path Ordering Fac No 1	.	.	HL7	.	.	.	.	.
7191	Path Ordering Fac No 2	.	.	HL7	.	.	.	.	.
7192	Path Ordering Fac No 3	.	.	HL7	.	.	.	.	.
7193	Path Ordering Fac No 4	.	.	HL7	.	.	.	.	.
7194	Path Ordering Fac No 5	.	.	HL7	.	.	.	.	.
7320	Path Date Spec Collect 1	.	.	HL7	.	.	.	.	.
7321	Path Date Spec Collect 2	.	.	HL7	.	.	.	.	.
7322	Path Date Spec Collect 3	.	.	HL7	.	.	.	.	.
7323	Path Date Spec Collect 4	.	.	HL7	.	.	.	.	.
7324	Path Date Spec Collect 5	.	.	HL7	.	.	.	.	.
7480	Path Report Type 1	.	.	HL7	.	.	.	.	.
7481	Path Report Type 2	.	.	HL7	.	.	.	.	.
7482	Path Report Type 3	.	.	HL7	.	.	.	.	.
7483	Path Report Type 4	.	.	HL7	.	.	.	.	.
7484	Path Report Type 5	.	.	HL7	.	.	.	.	.