VCR 2016 User Manual

2016 USER MANUAL

COMMONWEALTH OF VIRGINIA

The Honorable Terry McAuliffe,
Governor

Marissa J Levine, MD, MPH, FAAFP,
State Health Commissioner

VIRGINIA CANCER REGISTRY MANUAL
2016

Commonwealth of Virginia Department of Health

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Table of Contents

Table of Contents

PREFACE

The rate of new cancer cases in Virginia is a public health concern. More than 33,000 Virginia residents are diagnosed with cancer each year (Virginia Department of Health, 2012). Without information on these new cases of cancer, it is difficult to plan prevention, education, screening, early detection, treatment, and rehabilitation programs. The Virginia Cancer Registry (VCR) records the incidence of cancer for the Commonwealth of Virginia and provides data to help public health authorities, physicians, researchers, and other health professionals plan and evaluate cancer programs. The registry also directly serves the citizens of the Commonwealth by providing and interpreting statistical information on cancer in the state.

In 1970, hospitals began voluntarily contributing cancer reports to the Virginia Tumor Registry. In 1990, the Virginia General Assembly mandated that the Virginia Cancer Registry be established in the Virginia Department of Health (see Appendix A). The legislation prescribed the purpose of the statewide cancer registry to include:

- Determining means of improving the diagnosis and treatment of cancer patients.
- Determining the need for and means of providing better long-term, follow-up care of cancer patients.
- Conducting epidemiological analyses of the incidence, prevalence, survival, and risk factors associated with the occurrence of cancer in Virginia.
- Collecting data to evaluate the possible carcinogenic effects of environmental hazards including exposure to dioxin and the defoliant, Agent Orange.
- Improving rehabilitative programs for cancer patients. Assisting in the training of hospital personnel.
- Determining other needs of cancer patients and health personnel.

As a population-based cancer incidence registry, the VCR collects demographic, diagnostic, and first course treatment information on all Virginia residents diagnosed with cancer. A population based incidence registry collects all reports for an entire population; for VCR, the relevant population is the population of the state. All information collected and maintained in the VCR database is strictly confidential. Only summary statistical information is published for general distribution and public knowledge. The Virginia Department of Health may permit use of in-depth information for research, subject to careful screening, strict supervision, and only to accomplish approved program objectives.

To fulfill some of the goals the state legislature set for the registry, VCR is an active partner with Virginia Department of Health programs that promote cancer prevention and control. These programs include the Virginia Comprehensive Cancer Control Program and the Virginia Breast and Cervical Cancer Early Detection Program. VCR data are used for cancer research and surveillance activities, and for epidemiologic and other special studies. Virginia incidence and mortality data are published annually in the national summary *United States Cancer Statistics* (USCS, https://nccd.cdc.gov/uscs/). USCS is a joint publication that CDC and the National Cancer Institute (NCI) produce. It includes the most recent five years of data. A large variety of cancer incidence data broken out by site and demographic variables is available on the VCR website at http://www.vdh.virginia.gov/virginia-cancer-registry/ . Virginia data are also published in

Cancer in North America (CINA), which is an annual report the North American Association of Central Cancer Registries (NAACCR) publishes. CINA is available at the NAACCR web site, http://www.naaccr.org/.

VCR is recognized as a high quality reporting system and a valuable resource for cancer data. VCR uses current technology and national data collection standards to enhance the completeness, accuracy, and timeliness of cancer data. As the volume of VCR incidence data increases over time, the utility of these data for program planning, evaluation, and epidemiologic studies increases as well. VCR depends on all cancer reporters for support, cooperation, and accurate reporting for the ongoing operation of the statewide cancer registry. As VCR staff work together with staff of reporting facilities statewide, complete and reliable cancer incidence data will continue to be available to provide answers to our questions, to reduce the burden of cancer in Virginia, and to improve the lives of both present and future patients.

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VIRGINIA CANCER REGISTRY
USER MANUAL 2016

Part One:

GENERAL INFORMATION REPORTING REQUIREMENTS

VCR MANUAL, 2016 EDITION

This manual shall be used to submit reportable cases with a date of diagnosis on or after January 1, 2016 except where noted.

WHAT IS THE VCR

The Virginia Cancer Registry (VCR) is a population-based cancer incidence registry responsible for the collection of demographic, diagnostic, and treatment information on all cancer patients diagnosed and treated at hospitals, laboratories, and other health care facilities in Virginia with reportable cancer. Population-based cancer registries collect information on cancers among the entire population for which they are responsible.

The VCR is also defined as an incidence only cancer registry rather than a multi-purpose registry. Incidence only registries gather only the information necessary to determine the incidence of cancer by geographic areas, by demographic characteristics, and by stage at diagnosis for each type of cancer. Treatment information has also been added to the information collected.

The term *central cancer registry* is also used in referring to the VCR. Although a central registry does not have to be population-based, this term is frequently used to mean a statewide cancer registry. A central registry is designed to aggregate data from various sources. The contributing sources required to report to the VCR provide statewide coverage of the population.

WHY REPORT TO THE VCR

The mission of the VCR is to collect and provide complete, accurate, and timely statewide incidence data for determination of cancer rates and trends in the population. To fulfill this mission, the VCR depends on complete ascertainment of cases and use of the data.

The Law and Regulations

Statewide collection and dissemination of data on cancer by the Virginia Department of Health is mandated in the *Code of Virginia* and Virginia Department of Health disease reporting regulations. The state laws include Chapter 2 (§32.1-70 *et seq.)* of Title 32.1*(VCR Manual Appendix A)* According to these statutes, each hospital, clinic, and independent pathology laboratory in the Commonwealth is required to report all cases of cancer, which are diagnosed or treated at the hospital, clinic or laboratory. Physicians are required to report when they know the case has not been reported by a hospital, clinic or in-state laboratory. These cases are to be submitted in the format prescribed by the Virginia Cancer Registry. Regulations mandating reporting cancer cases by hospitals, clinics, laboratories, other health care facilities and health care practitioners appear Part VIII of the State Board of Health publication *Regulations for Disease Reporting and Control*. *(VCR Manual Appendix B)*

1. Cancer Control

   The ultimate value of the registry lies not in collection of the data but in the degree to which the data are used for cancer control. The basis for any successful cancer control program is a comprehensive registry system. Registry data provide answers to questions, the means to target limited cancer control resources, and the mechanism to evaluate cancer control activities.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPAA)

HIPAA allows for the reporting of identifiable cancer data to public health entities. Because the VCR falls under the definition of a public health entity, HIPAA allows you to report data to the VCR in compliance with Virginia state laws and regulations. Written informed consent from each cancer patient reported to public health entities is not required under HIPAA.

The VCR depends on reporting facilities to submit quality data. Through the dedicated efforts of these facilities, the VCR is able to provide accurate information used to establish and enhance cancer control programs, and thus improve the lives of present and future patients with cancer.

VCR REFERENCE DATE

Reference date refers to the start date after which all eligible records must be included in the registry. The VCR reference date is January 1, 1995. This means complete statewide cancer incidence data are available from the VCR for 1995 to the present.

Note: In order to assure complete case ascertainment, reference date is not used to determine what cases are reportable to the VCR. See *VCR Manual Part One, Date of Diagnosis Reportability*.

VCR REPORTING SOURCES

The *Code of Virginia* mandates each hospital, clinic, physician and laboratory in the Commonwealth shall report all cases of cancer which are diagnosed and/or treated at the above-designated facility. In addition, VCR has agreements with other states to exchange data.

Hospitals

The term *registry hospital* refers to hospitals with cancer registries functioning as an integral component of the hospital cancer program. They may or may not be accredited by the American College of Surgeons Commission on Cancer. Generally, the cancer registrar or cancer program manager at a registry hospital is delegated the responsibility of reporting to the VCR.

The term *non-registry hospital* refers to hospitals that do not have a cancer registry functioning as an integral component of a hospital cancer program. Generally, personnel in the Health Information Management (HIM) Dept are delegated the responsibility of reporting to the VCR.

Non-Hospital Sources

The Board of Health Regulations concerning the Regulations for Disease Reporting was revised in January 2002 to expand cancer reporting requirements to include additional non-hospital sources.

Part VIII, 12 VAC 5-90-170 requires hospitals, clinical laboratories, or other health care facilities providing screening, diagnostic or therapeutic services for cancer patients to report cases of cancer. Reporting by "other health care facilities" will be phased in as follows: 1) Radiation Centers; 2) Medical Oncology Centers/Clinics; 3) Hematology/Oncology Practices; and, 4) Ambulatory Surgery Centers.

Laboratories

The addition of these cases provides the VCR data on cases never seen in the hospital setting, thereby increasing the overall completeness of VCR data.

Required reporting of cases by hospital laboratories is performed by cancer registry or HIM personnel as described above.

Reporting of cases by designated free-standing laboratories is required.

Data Exchange

The VCR has written agreements to exchange data with other cancer registries including all contiguous states. This insures a resident of Virginia who was diagnosed and/or treated out-of-state will be included in the VCR database

REPORTING METHODS

All reporting facilities *shall* submit all their cases electronically. Electronic reporting is the submission of reportable cases to the VCR via secure email or FTP site using commercial, hospital-developed or AbstractPlus software.

Registry hospitals are required to electronically report cases included in the hospital cancer registry using commercial or hospital-developed software. CTR's must abstract cases from Commission on Cancer accredited facilities. It is highly recommended that other hospitals consider hiring a CTR or utilize a contracting company to abstract cases.

Use of Web Plus software for non-registry facilities will begin implementation late in 2016 through early 2017. VCR has is phasing in all facilities currently reporting via paper. If you are not utilizing this at your facility or office, please contact the VCR.

REPORTABLE CONDITIONS

VCR List of Reportable Conditions

The Virginia Board of Health defines cancer and the reportable cancers in its Regulation for Disease Reporting and Control. VCR follows this standard as noted in the *VCR List of Reportable Conditions.* A casefinding list is found in the *VCR Manual Appendix D*. This section identifies diagnoses that must be reported to the VCR and can be used to develop a report called the Disease Index from your HIM data system IT department. Conditions are to be reported if the diagnosis includes the words *malignant, cancer, carcinoma,* and *lymphoma.* Most *leukemias* and *sarcomas* are reportable except when noted as exclusions on the listing. In addition, there are other conditions which do not include these particular terms but are reportable such as *Wilms tumor, blastoma, anemia* and *carcinoid*. It is therefore very important to refer to the *VCR List of Reportable Conditions* to make sure all reportable conditions are identified.

All primary intracranial and central nervous system (CNS) tumors are reportable. This includes benign, malignant and borderline tumors for the following sites:

- Meninges (C70.0 - C70.9)
- Brain (C71.0 - C71.9)
- Spinal Cord (C72.0)
- Cauda equina (C72.1)
- Cranial nerves (C72.2 - C72.5)
- Other CNS (C72.8, C72.9)
- Pituitary gland (C75.1)
- Craniopharyngeal duct (C75.2)
- Pineal gland (C75.3)

Ambiguous Terminology

A patient has a reportable condition if a *recognized medical practitioner* says so. In most cases, the patient's record clearly presents the diagnosis by use of specific terms, which are synonymous with the diagnosis. However, the physician may not always be certain or the recorded language definitive. VCR rules concerning the usage of ambiguous terminology are as follows:

1. Terms That Constitute a Diagnosis **-** Interpret the following terms as a reportable diagnosis:

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

2. Terms That Do Not Constitute a Diagnosis - Do not interpret the following terms as a diagnosis. Do not report patients who have a final diagnosis consisting only of these terms without additional information to support reportability:

cannot be ruled out	*potentially malignant*	*suggests*
equivocal	*questionable*	*worrisome*
possible	*rule(d) out*	

3. **How to Use Ambiguous Terminology for Case Ascertainment** The first and foremost resource for the registrar for questionable cases is the physician who diagnosed and/or staged the tumor. The ideal way to approach abstracting situations when the medical record is not clear is to *follow up with the physician*. If the physician is not available, the medical record, and any other pertinent reports (e.g., pathology, etc.) should be read closely for the required information. The purpose of the Ambiguous Terminology lists is so that in the case *where wording in the patient record is ambiguous* with respect to reportability or tumor spread and *no further information* is available ***from any resource***, registrars will make consistent decisions. When there is a clear statement of malignancy or tumor spread (i.e., the registrar can determine malignancy or tumor spread from the resources available), they should not refer to the Ambiguous Terminology lists. Registrars should only rely on these lists when the situation is not clear and the case cannot be discussed with the appropriate physician/pathologist.

   VCR recognizes that not every registrar has access to the physician who diagnosed and/or staged the tumor, as a result, the Ambiguous Terminology lists continue to be used in CoC-accredited programs and maintained by CoC as "references of last resort".

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

      i) If any of the reportable **ambiguous terms precede** a word that is **synonymous** with an in situ or invasive tumor (e.g., cancer, carcinoma, malignant neoplasm, etc.), the case is reportable.

         Example 1: The pathology report says: Prostate biopsy with markedly abnormal cells that are typical of adenocarcinoma. Report the case.

         Example 2: The final diagnosis on the outpatient report reads: Rule out leukemia. Do not report the case.

ii) Discrepancies: If one section of the medical record(s) uses a reportable term such as "apparently" and another section of the medical record(s) uses a non-reportable term such as "cannot be ruled out", accept the reportable term and report the case.

Exception: Do not report a case based ***only*** on suspicious cytology. The case is reported only if proven by positive cytology or other diagnostic methods including a physician's clinical diagnosis.

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

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

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

Benign and borderline primary intracranial and CNS tumors

a. Use the "Ambiguous Terms that are Reportable" list to identify benign and borderline primary intracranial and CNS tumors that are reportable.

b. If any of the reportable ambiguous terms precede either the word "**tumor"** or the word "**neoplasm**," the case is reportable. Report the case.

Example: The mass on the CT scan is consistent with pituitary tumor. Report the case.

Discrepancies: If one section of the medical record(s) uses a reportable term such as "apparently" and another section of the medical record(s) uses a non-reportable term such as "cannot be ruled out", accept the reportable term and accession the case.

Exception: Do not report a case based only on suspicious cytology. The case is reported only if proven by positive cytology or other diagnostic methods including a physician's clinical diagnosis.

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

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

c. Confirmation of an Ambiguous Diagnosis - Subsequent admissions for patients whose initial diagnosis contained ambiguous terminology must be reviewed. It is established practice to accept the information at the time of the latest admission, or the most complete or detailed information.

DO NOT USE AMBIGUOUS TO STAGE THE TUMOR.

AJCC Cancer Staging does not recognize the use of ambiguous terminology to determine stage.

Emergency Room admissions

If a patient comes to your emergency room and expires, and the death certificate has cancer listed in any of the first three causes of death, the case MUST be abstracted and submitted.

Reportable Diagnosis

A diagnosis is reportable to the VCR if it is included on the *VCR List of Reportable Conditions* (See *VCR Manual Appendix D, Reportable Conditions*). The following guidelines provide further clarification for the specified conditions:

Basal and Squamous Cell Carcinomas

Basal and squamous cell carcinomas are reportable except when primary to the skin, C44.0-C44.9 (see *VCR Manual Part One, Exclusions*). Carcinomas originating in mucoepidermoid sites are reportable. These sites include: lip (C00.0-C00.9), anus (C21.0), vulva (C51.0-C51.9), vagina (C52.9), penis (C60.0- C60.9), and scrotum (C63.2). Basal and squamous cell carcinomas originating in the nasal cavity (C30.0) and middle ear (C30.1) are also reportable.

Class IV and Class V Cytologies

Cytology results of Class IV or Class V are reportable to the VCR.

Exception: If the terminology on the cytology report further defines the Class IV and Class V as *suspicious* then the record is not reportable. Report this record only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Note: See VCR Manual Part Three, Data Item Instructions, Diagnostic Confirmation for clarification of histology and cytology using cell block and smear preparation of specimens.

a. Low Malignant Potential/Borderline Malignancy of Ovary or Peritoneum

Cystadenomas or tumors primary to the ovary or peritoneum qualified by the phrases *borderline malignancy* or *low malignant potential* are reportable only if diagnosed prior to January 1, 2001

b. Intraepithelial Neoplasia

Patients with the following diagnoses of intraepithelial neoplasia **are** reportable:

Vaginal intraepithelial neoplasia 3 (VAIN III)
Vulvar intraepithelial neoplasia 3 (VIN III)
Anal intraepithelial neoplasia 3 (AIN III)
All other intraepithelial neoplasia or squamous intraepithelial tumors ARE reportable to the VCR.

See also *VCR Manual Appendix D, Reportable Conditions* and *VCR Manual Part One, Exclusions, Intraepithelial Neoplasia.*

Reportable Situations

A case is reportable to the VCR if it is a condition included on the *VCR List of Reportable Conditions* (See *VCR Manual Appendix D, Reportable Conditions*) and meets the following criteria:

1. *Patients diagnosed or treated in your inpatient or outpatient departments, emergency room, ambulatory care center, or other units included under your hospital license.*

a. The reportable diagnosis has been made at your hospital. This diagnosis can be made on the basis of histology (including autopsy), hematology, cytology, endoscopy or other direct visualization, diagnostic radiology or clinical findings.

b. A "clinical diagnosis only" is a diagnosis based solely on clinical judgment; diagnostic procedures were not performed or did not confirm the diagnosis. Patients diagnosed clinically are reportable to the VCR.

c. The VCR requires patients receiving treatment, cancer-directed or non- cancer-directed, to be reported provided they have not been previously reported by your hospital.

The VCR recognizes the following definitions of treatment:

i) Cancer-Directed Treatment – Cancer-directed treatment is tumor directed, and its purpose is to modify, control, remove or destroy primary or metastatic cancer tissue. Physicians administer the therapy (ies) to remove or minimize the size of tumor or to delay the spread of disease.

ii) Patients Diagnosed at Autopsy – Final autopsy reports containing reportable diagnoses or incidental findings of reportable conditions must be reported to the VCR.

2. *Patients Diagnosed Elsewhere*

Patients diagnosed elsewhere and newly admitted to your hospital for further diagnostic workup or treatment, cancer-directed or non-cancer-directed are to be reported. Although this may result in multiple records on one patient, it enables the VCR to assure complete statewide casefinding and to have the most comprehensive information on each patient. Because the VCR is a population-based registry, every attempt must be made to receive all cases diagnosed within Virginia to provide accurate statistical reports.

a. Recurrence - Recurrence refers to the same cancer arising in or from the same primary site where it appeared earlier. A recurrent diagnosis is reportable as instructed in the *Multiple Primary and Histology Coding Rules, January 01, 2007.*

b. Residual Tumor – The VCR requires all records in which the pathology report states "no residual tumor" to be reported. The re-excision is considered cancer-directed treatment.

Example: Outside the hospital setting, a patient has a biopsy and is diagnosed with a malignant melanoma. The patient is seen at your hospital for a wide excision. The tissue report from the excision states no residual tumor. This record is reportable to the VCR. Even though the cancer was diagnosed elsewhere, the patient's hospital visit was for cancer related treatment.

3. *Private Outpatient Specimens (POP) (Path Only)*

Private outpatient specimens (POP) are specimens submitted from a physician's office to be read by the hospital pathologist as part of the Pathology Department's regular course of business. The patient is not registered as an inpatient or outpatient at the hospital. POPs are reportable to the VCR as a Class of Case 43 and a Reporting Source code of 3.

Example: A physician performs a biopsy in the office and sends the specimen to your Pathology Department where a reportable diagnosis is made.

a. POP reports should be held for two to three months because many of these patients may return for treatment and more information can be obtained from these records.

b. If the patient does not return as an inpatient or hospital outpatient, abstract the record using all available information. Every effort must be made to obtain accurate information. This information can be found through hospital billing systems, clinical history, or if needed by contacting physician offices.

c. Data items should be completed as *unknown* only after further investigation does not provide more specific information.

4. Ambiguous Situations

When the distinction between a hospital department and a freestanding facility cannot readily be made, such as a radiation therapy group practice versus a hospital unit, the ownership of the medical record is used to determine whether or not a record must be reported by the owner of the record. If the medical record is the property of the institution, the record must be reported. If the hospital is part of a corporation, ownership of the record refers to the facility, not the corporation.

Non-Reportable Diagnosis

The following diagnoses are not reportable to the VCR:

Skin Cancers

a. The following site/histology combinations for skin cancers are not reportable:

8000-8005	Neoplasms malignant, NOS of the skin (C44.0 – C44.9
8010-8046	Epithelial carcinomas of the skin (C44.0-C44.9)
8050-8084	Papillary and squamous cell carcinomas of the skin (C44.0-C44.9)
8090-8110	Basal cell carcinomas of the skin (C44.0-C44.9)

i. ICD-O codes C44.0-C44.9 include skin of the lip, eyelid, external ear, face, nose, scalp, neck, trunk, perineum, (peri) anus, umbilicus, upper and lower limbs, shoulders, hips, and skin around ostomy sites.

Note: The above lesions are reportable when the primary tumor originates in a mucoepidermoid site (See *VCR Manual Part One, Reportable Records*).

ii. Basal and squamous cell carcinomas originating in the external nose (C44.3) are not reportable; however, those primary to the nasal cavity (C30.0) such as nostril, nasal septum, and nares are reportable.

iii. If the primary site is not reportable but the cancer has metastasized to other sites, the record is still not reportable.

Carcinoma-In-Situ of the Cervix (CIS)

The diagnosis carcinoma in situ of the cervix (CIS) is not reportable. Terms indicating in situ include: *noninvasive, preinvasive, intraepithelial,* and *FIGO Stage 0.* A diagnosis of carcinoma in situ with endocervical gland involvement is still considered in situ and is not reportable.

Note: Diagnoses of invasive carcinoma of the cervix are reportable. A diagnosis of

carcinoma in situ of the cervix with microinvasion is considered invasive and is, therefore, reportable.

Intraepithelial Neoplasia

Patients with the following diagnoses of intraepithelial neoplasia are not reportable:

- Cervical intraepithelial neoplasia (CIN)
- Prostatic intraepithelial neoplasia (PIN)

Non-Reportable Situations

A case is ***not*** reportable to the VCR if it meets any of the following criteria:

1. Patients seen in consultation to provide a second opinion to confirm an established diagnosis or treatment plan are not reportable. Also, if the reporting institution provides services not available at the diagnosing or treatment facility, such as Computerized Tomography (CT) scans or Magnetic Resonance Imaging (MRI) scans, the case is not reportable.

2. Records in which slides are sent to your hospital's pathologist for a second opinion are encouraged to be reported, but are not required. Since the slide was already read by another pathologist, the facility requesting the slide review is required to report the final diagnosis as determined after the slide review.

3. Patients with a history of a reportable condition who are clinically free of disease are not reportable. If, however, the patient has actually received treatment during this admission the record must be reported. For example: if a patient is admitted for an unrelated condition, has a history of breast cancer and the hospital administers Tamoxifen during their admission, the case is reportable.

   Exception: If a patient expires at your facility with a history of cancer, even though the patient was clinically disease free, the case **is** reportable

4. Patients receiving transient care at the reporting institution to prevent interruption of the first course of treatment are not reportable. This only applies to patients vacationing or visiting in the area, or equipment failure at the primary treating institution which requires the patient to temporarily receive treatment elsewhere.

   ***Exception*:** Cancer patients evacuated to other states due to natural disasters may receive diagnostic/treatment services in facilities in that state. If this occurs at your facility, consider these cases reportable to the Virginia Cancer Registry (VCR). They should not be excluded as transient care or consult only cases.

   When abstracting these cases, please record the patient's usual residence when the tumor was diagnosed in the Address at Diagnosis fields. Do not enter the patient's current address if the patient was diagnosed prior to relocating permanently or temporarily to Virginia or other nearby state.

5. Recurrence is defined as the same cancer arising in or from the same primary site where it appeared earlier and is not considered a new primary cancer by the physician. Do not report a recurrent diagnosis when you have previously reported it.

   ***Exception*:** If an in situ tumor is followed by an invasive cancer in the same site more than two months apart, report as two primaries even if stated to be a recurrence. The invasive primary should be reported with the date of the *invasive* diagnosis. See also *VCR Manual Part One, Reportable Cases, Recurrence*.

6. If a patient is readmitted and new or additional metastatic sites are diagnosed or

documented, the record is not reportable provided it has already been reported for the original primary site. Records of readmitted patients must be reviewed to determine if a new primary site has been diagnosed. Each new primary must be reported separately.

7. Metastatic Sites – Do not report the metastatic or secondary sites of a malignant neoplasm; however, check to make sure the primary site was previously reported. A diagnosis of metastatic cancer with an unknown primary site not previously reported should be submitted with the primary site documented or coded as unknown.
8. Special Units – Patients admitted to a skilled nursing unit or other separately licensed units are encouraged to be reported but are not required. These patients are either discharged from an acute care hospital unit and readmitted to a separately licensed unit or are admitted directly to the separately licensed unit.

CASE ELIGIBILITY

The VCR requires all reporting entities to accession, abstract and submit to VCR for required tumors diagnosed and/or treated at your facility. The tumors must meet the criteria for submission and all patients must be submitted.

Tumors required by the VCR to be accessioned, abstracted and submitted to VCR:

Malignancies with an ICD-O-3 behavior code of 2 or 3 area required for all sites.

i. **Exception 1**: Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, *is required* and should be recorded as 9421/3 in the registry.
ii. **Exception 2**: Effective in 2015, code 8240/1 for carcinoid tumor, NOS, of appendix (C18.1) becomes obsolete. Carcinoid tumors of the appendix must be coded to **8240/3.** Effective with 2015. This is required and must be coded with a behavior 3. Prior appendix primaries coded to 8240/1 are converted to 8240/3 by the implementation conversions for 2015.
iii. **Exception 3**: Malignant primary skin cancers (C44.*x*) with histology codes 8000 – 8110 *are not required* to be reported to the VCR. Skin primaries with those histologies diagnosed prior to January 1, 2003 were required to be abstracted if the AJCC stage group at diagnosis was II, III or IV. These cases should remain in the registry.
iv. **Exception 4:** Carcinoma in situ of the cervix (CIS), intraepithelial neoplasia grade III (8077/2) of the cervix **(CIN III)** and prostate **(PIN III) are** *not required by VCR*. Intraepithelial neoplasia of the vulva **(VIN III)**, vagina **(VAIN III),** anus **(AIN III)**, LARYNX **(LIN III),** and SQUAMOUS INTRAEPITHELIAL NEOPLASIA GRADE III **(SIN III),** excluding those listed above, ***ARE reportable to the VCR***.

If a pathologist verifies a /0 (benign) or /1 (uncertain whether benign or malignant) behavior code tern in ICD-O as /2 (in situ) or /3 (malignant), these records are reportable.

DATE OF DIAGNOSIS

All reportable cases included in the VCR List of Reportable Conditions (See *VCR Manual, Appendix D, Reportable Conditions*) diagnosed and/**OR** treated at your facility are required to be reported to the VCR regardless of the Date of First Contact. This includes patients with an unknown date of initial diagnosis.

Exception: Conditions only reportable if diagnosed on January 1, 2001 and after (the conditions with** in *VCR Manual, Appendix D*) are not reportable if the date of diagnosis is unknown.

Example 1: If a patient is admitted on January 3, 2016 and receives palliative care for bone metastasis from a breast primary diagnosed in 1990, the case is reportable

Example 2: If a patient is admitted on January 3, 2016 and receives palliative care for bone metastasis from a breast primary for which a diagnosis date is not stated in the medical record, the case is required to be reported with a ***BLANK*** date of diagnosis and the appropriate *Date of Diagnosis Flag* is recorded.

Example 3: If a patient is admitted on January 3, 2004 and receives a blood transfusion for polycythemia vera, originally diagnosed in November 1999, the case is not reportable per the VCR List of Reportable Conditions and Exception above.

MULTIPLE PRIMARY DETERMINATION

More Than One Cancer

If more than one primary is diagnosed, a separate record must be submitted on each primary.

Multiple Primary Cancers

The VCR, like most registries in the United States, follows the rules of the Surveillance, Epidemiology and End Results (SEER) Program for determination of multiple primary cancers. Beginning with cases diagnosed on January 1, 2007 the SEER rules for determining solid tumor multiple primary cancers are documented in the most current SEER *Multiple Primary and Histology Coding Rules.* For hematopoietic and lymphoid neoplasms diagnosed January 1, 2010, the most current *SEER Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the *Hematopoietic Database* must be used. For cases diagnosed prior to 2007, the SEER rules for determining multiple primary cancers are documented in the *VCR Manual Appendix E, Multiple Primary Determination.*

CONFLICTING STANDARDS

When standards of regulatory agencies differ, all reporters ***must*** implement procedures to comply with the Board of Health standards as designated in this document.

VCR REQUIRED DATA ITEMS

The VCR requires specific data items to be completed for each reportable case. These data items include demographic, cancer identification, treatment, hospital-specific and text information. A listing of the VCR Required Data Set is included in *VCR Manual Appendix K.* Instructions on completing each data item are provided in *VCR Manual Part Three, Data Item Instructions.*

All data items required for participation in the National Program of Cancer Registries (NPCR) are included in the VCR data set. VCR-required codes and definitions comply with national standards established by the North American Association of Central Cancer Registries (NAACCR) and American College of Surgeons Commission on Cancer (ACOS COC).

There are six (6) fields that are required to be collected and transmitted to the VCR by all reporting entities. These are fields that are specifically designated in the code of Virginia. See VCR Manual, Appendix K for the fields and the instructions on how to code these fields.

CHANGING INFORMATION

A change includes updating or correcting previously submitted information.

Importance of Change/Deletion Procedure

The change procedure insures the most accurate information is available to users of VCR data by enabling reporting facilities to provide updated or corrected information after a record has been accessioned by the VCR.

Example 1: At the time a record was reported to the VCR, the primary site was unknown. On a subsequent admission, the primary site was documented as upper lobe of left lung. A change must be submitted to update the primary site, laterality, and stage (as was known during first course of treatment). Send an encrypted email with the patient's name and social security number with a reason for change. The VCR will update this information on the patient's record on the VCR data file.

Example 2: At the time a record was reported to the VCR, the patient's initial diagnosis was *probable carcinoma*. After further review, it was determined the patient does not have cancer. Such cases must be deleted. Send an encrypted email with the patient's name and social security number with a reason for deletion.

What to Change

1. Change any required data item when incorrect or unknown information was initially reported and more specific/correct information is later available.
2. Change SEER Summary Stage 2000 only if additional information is available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression whichever is longer for cases diagnosed on or after January 1, 2001. Change SEER Summary Stage 1977 only if additional information is available within two months of diagnosis (four months for prostate primaries) for cases diagnosed prior to January 1, 2001.
3. Submit a change for name when incorrectly spelled on a record and when name is changed due to marital status or other reason. Clearly indicate previous and current name.

4. Do not submit changes to update address changes or admission/discharge dates when the patient is readmitted.

When to Submit Changes

Changes should be sent under a separate cover. Include *only* the changes that must be made, along with the patient identifier

How to Change Information

As corrections are made to records previously accessioned by the VCR, document the changes in your encrypted email with the submission. If you have more than five (5) changes, submit the changes in an excel spreadsheet, encrypt it and sent to the VCR.

Document number of changes in your email documentation.

Note: Corrections ***may NOT*** be transmitted as a *case* electronically. Email shall be the medium of transmission for any changes noted above.

VCR SUBMISSIONS

How to Report

Records containing all required data items must be submitted to the VCR electronically. Detailed instructions for completing the required data items can be found in the *VCR Manual, Part Three: Data Item Instructions.* An electronic file must be created and submitted to the appropriate VCR staff.

It is suggested you keep a copy of your submission until your accession list has been cleared for the year.

Actual submission forms will no longer be required. However, an email must be sent that includes the following:

- Facility name and Facility Identification Number (FIN). (Please contact VCR if you do not know your assigned FIN)
- Date of the transmission
- Number of records included in the transmission *by year*
- Denote if this is the last transmission of a submission year

DO NOT submit changes/corrections in this email. They MUST be sent in a separate email. An email must be sent every month, even if you have no records to submit. The email must designate there are not records to report for the given month.

Submissions must be received by the 5th of *every* month. Any submission submitted after the 5th of the month will be held until the next month and your facility will be denoted as having missed a submission. Any submission returned for correction must be returned within three (3) business days. If the file is not returned in the designated time frame, your facility will be denoted as having missed a submission.

When to Report

1. The ***VCR requires 90% of abstracts submitted by reporting facilities to be received within 180 days from Date of Diagnosis***.
2. ***The first working day in July is the deadline for submitting all reportable cases from the previous year.*** The months of May and June should be used to perform quality assurance procedures to ensure all cases have been identified and reported. These cases may fall into the 10% over 180 days. This is expected and acceptable. The timeliness requirement was established at 90% to provide a cushion of 10% to encourage late reporting of missed cases to assure reporting completeness.
3. When patients are hospitalized for a period of six (6) months or longer, records should be submitted 180 days from Date of Admission/1st Contact. Enter the current date in the Date of Discharge field. Date of Discharge may not be left blank and the exact Date of Discharge should be submitted later as a change. See *VCR Manual Part One, Changing Information*

Where to Report

Be sure all files are encrypted and password protected. Passwords should be sent in a different file from the transmission email. Include in one of the emails the number of cases and changes included in the file.

Document Retention

There is no statute governing how long copies of the monthly submission files should be saved. It is strongly suggested, however, that submission files be retained until you have cleared the yearly accession list reconciliation.

VCR PHONE NUMBERS

If you have any questions regarding the VCR, contact us at the central number; 804-864-7866 or:

Tina Hall, CTR.....	804-864-7187
John LaDouceur, MHA.....	804-864-7857
Chioke Murray, BA.....	804-864-7196
Mike Peyton, CTR.....	804-864-7885
Danielle Quinn, CTR.....	804-864-7856
Sally Siddon, CTR.....	804-864-7859
Cheryl Walker-Smith, Data Manager.....	804-864-7866
Laurel Gray, CTR, Quality Assurance Coordinator.....	804-864-7860
Jayne Holubowsky, CTR, Director, Virginia Cancer Registry.....	804-864-7873

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PART TWO:
CASEFINDING

CASEFINDING

Casefinding Procedures

Casefinding is a system for identifying patients with a reportable diagnosis. Because cancer incidence can be most accurately reflected only when every reportable diagnosis is identified and submitted to the central registry, effective casefinding procedures are essential.

Although casefinding procedures will vary among reporting facilities, the key to effective casefinding is the identification of reportable conditions in all areas where patients are diagnosed or treated in a routine and systematic manner. The following concepts should be considered when developing procedures to insure complete identification of cases reportable to Virginia Cancer Registry (VCR).

Reportable Conditions

The first step in establishing effective casefinding procedures is to know what conditions are reportable. These conditions are defined in the following references:

List of Reportable Conditions - *VCR Manual Appendix D* provides documentation of all conditions reportable to the VCR. It is structured alphabetically by the main histologic term.

ICD-10-CM Codes – *VCR Manual, Appendix N,* provides a list of ICD-10-CM codes used to identify reportable diagnoses. The appendix also includes a list you can provide to your Information Technology department to program a disease index you need to review for possible cases.

Casefinding Sources

The second step in establishing effective casefinding procedures is to identify all areas in the facility where these reportable conditions are either diagnosed or treated and the sources for casefinding in each area. The Health Information Management (HIM) Department and Pathology Department must be included as casefinding sources by all facilities; the remaining sources listed below should be included as applicable. Copies of reports forwarded for review to the person responsible for reporting to the VCR serve as a pending or tickler file to cross-reference with medical records flagged in the HIM Department.

The term "records" as used in the descriptions below refers to all patient records, i.e., inpatient, outpatient, Emergency Room, ambulatory care, short stay procedures, radiation therapy, chemotherapy. For each source, review all of the following reports and records.

Health Information Management Department (HIM)

1. All records with a diagnosis included in *VCR Manual Appendix D* or *ICD-10-CM Codes* listed in *VCR Manual Part One, Reportable* should be flagged for the person responsible for VCR reporting.
2. Records assigned an ICD-10-CM code included on the list provided in *VCR Manual Part One; Reportable Codes* should be reviewed to identify reportable cases. In addition to casefinding, the disease index should also be used as a quality control measure to make sure all reportable diagnoses have been submitted. See also *VCR Manual Part Four, Quality Control: Reporting Facilities.*

a. All discharge summaries with a reportable condition in the final diagnosis and operative reports bearing a post-operative reportable diagnosis should be copied and forwarded to the person responsible for reporting to VCR.

Pathology Department/Laboratory Medicine

Casefinding from Pathology Department/Laboratory Medicine must include identification of reportable diagnoses made on inpatient, outpatient, and private outpatient (POP) specimens.

1. Surgical pathology reports should be reviewed for a reportable diagnosis. If your Pathology Department screens the reports and forwards copies of those reports to the person responsible for VCR reporting, they must be provided with a copy of *VCR Manual Appendix D.* Surgical pathology reports showing "no residual malignancy (or tumor)" and reports resulting from orchiectomy or oophorectomy performed for prostate or breast malignancies or wide re-excisions for melanomas should be included in what is copied and forwarded to the person responsible for VCR reporting.
2. All cytology reports should be reviewed for a malignant diagnosis and, when identified, a copy forwarded to the person responsible for VCR reporting. An alternative would be to review a log of positive or abnormal cytologies.
3. Peripheral blood reports should be reviewed for a diagnosis of malignancy and, when identified, a copy forwarded to the person responsible for VCR reporting. Bone Marrow All bone marrow reports should be reviewed for a diagnosis of malignancy and, when identified, a copy forwarded to the person responsible for VCR reporting.
4. All final autopsy reports should be reviewed for reportable diagnoses including incidental findings and, when identified, a copy forwarded to the person responsible for VCR reporting. Reportable diagnoses on autopsy reports from coroner's cases should also be identified. See *VCR Manual Part One, Patients Diagnosed at Autopsy.*

Outpatient Departments

1. Short Procedure/Same Day Surgery/Ambulatory Care Unit - A system must be implemented to routinely review all outpatient records maintained within or separate from the HIM Department for diagnoses. If reporting criteria are met, cases must be submitted to the VCR.
2. Emergency Room (ER) - Pathology and cytology reports from procedures performed in the ER should be screened and reported if a reportable diagnosis is made or if the patient expires with a history of a reportable disease.

Oncology Services

1. Radiation therapy records, appointment logs, or patient rosters must be reviewed. If reporting criteria are met, cases must be submitted to the VCR. Patients diagnosed elsewhere but treated at your facility must be reported.
2. Chemotherapy records, appointment logs, or patient rosters must be reviewed. If reporting criteria are met, cases must be submitted to the VCR. Patients diagnosed elsewhere but treated at your facility must be reported.

Other Areas

Records from other areas of the hospital where reportable conditions are either diagnosed or treated must be reviewed and submitted if a reportable diagnosis is made.

COMPLETENESS OF CASEFINDING

After all reportable diagnoses have been identified through routine casefinding procedures, the final step to effective casefinding is quality control. Procedures should be in place to verify all cases were identified and reported to the VCR. *VCR Manual Part Four, Quality Control* describes various quality control strategies to assure complete casefinding and reporting.

Most Effective Casefinding Procedure

The most effective approach to identifying all reportable diagnoses for reporting to the VCR should include the following:

1. Flag all inpatient and outpatient medical records with an ICD-10-CM diagnosis code as listed in *VCR Manual Part One, Reportable Codes.*
2. Review reports from all inpatient, outpatient, and private outpatient (POP) pathology, cytology, bone marrow, hematology, and autopsy specimens analyzed at your facility.
3. Review records, appointment logs, or rosters of patients seen in the chemotherapy, radiation therapy, and any other area where reportable conditions are diagnosed or treated.
4. Review the ICD-10-CM disease index monthly to identify reportable diagnoses.
5. Perform quality control procedures to assure all reportable cases were identified and reported to the VCR.

Part Three:
Data Item Instructions

GENERAL INFORMATION

Data Item Completion

Each case reported to the VCR must include all data items identified in *VCR Manual Appendix K, Required Data Set for Reporting Facilities.* These data items must be completed according to codes, definitions, and instructions specified for each item in this section. The codes and definitions for each required data item conform to national cancer registration standards as defined by NAACCR (North American Association of Central Cancer Registries), NPCR (National Program of Cancer Registries), and ACOS COC (American College of Surgeons Commission on Cancer).

Every effort ***must*** be made to obtain specific, complete, and accurate information for each required data item. Inpatient and outpatient health records, clinical history on pathology reports, hospital billing records, and contact with physician offices should be used as sources of information in completing data items.

Recording Unknown or Not Applicable Information

Data items should be recorded as *unknown* only after *all* efforts to obtain specific information prove unsuccessful.

Unknown, Text - When specific information is not available for any data item requiring an alphabetic entry, record the word *unknown* in the field as specified in the data item instructions in this section.

Unknown, Code 9 - When specific information is not available for any data item requiring a numeric entry, record the code for unknown, *9,* in the field as specified in the data item instructions in this section.

Unknown/Not Applicable, Blank Since information for the following required data items may be unknown or not applicable; they are the only data items that may be left blank as specified in the data item instructions in this section:

Name - Suffix
Name - Middle
Name - Maiden
Name - Alias
Text - Usual Occupation for age < 14 (should be recorded as "child")
Text - Usual Industry for age < 14 (should be recorded as "child")
Place of Diagnosis when patient is diagnosed at reporting facility
Accession Number for Non-registry hospitals

Coding Dates

Beginning in 2010, the way dates are transmitted between facility registries and central registries was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date.

Interoperable dates are displayed in CCYYMMDD form, *with the unknown portions of the date*

filled with blank spaces. If a *date is entirely blank, an associated date flag is used* to explain the missing date. The following table illustrates the relationship among these items for Date of Most Definitive Surgical Resection of the Primary Site, where each lower case 'b' represents a blank space. Flags are not used for software-generated dates.

Description	**Traditional Date of Most Definitive Surgical Resection of the Primary Site** *Date entered in MMDDCCY sequence; unknown portions represented by 99 or 9999*	**Interoperable Date of Most Definitive Surgical Resection of the Primary Site** *Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable*	**Rx Date Mst Defn Srg Flag**
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb))	bb
Unknown if any surgery	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No surgery	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown,	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

Allowable Values

Month		**Day**	**Year**
01 January	08 August	01	Use four-digit year
02 February	09 September	02	
03 March	10 October	03	
04 April	11 November	…	
05 May	12 December	…	
06 June		31	
07 July			

Unknown (blank) is not valid for certain date fields; see "*Unknown Dates, Exceptions,"* below.

Cancer Identification

The following instructions apply to *Primary Site* (NAACCR Item #400), *Laterality* (NAACCR Item #410), *Histology* (NAACCR Item #522), *Behavior Code* (NAACCR Item #523), and *Grade/Differentiation* (NAACCR Item #440).

Hematopoietic and Lymphoid Cancers

Beginning with cases diagnosed in 2010, the **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** is to be used for coding primary site, histology, and grade of hematopoietic and lymphoid tumors (M9590 – 9992) and to determine whether multiple conditions represent one or more tumors to be abstracted. *See Part One: General Instructions and Reporting Requirements, pg 15.* For tumors diagnosed prior to January 1, 2010, use the rules applicable when the cancer was diagnosed.

Kaposi Sarcoma

Code Kaposi sarcoma to the site in which it arises.
Code to Skin, NOS (C44.9) if Kaposi sarcoma arises simultaneously in the skin and another site or the primary site is not identified.

Melanoma

Code to Skin, NOS (C44.9) if a patient is diagnosed with metastatic melanoma and the primary site is not identified.

Specific Tissues with Ill-Defined Sites

If any of the following histologies appears with only an ill-defined site description (ego, "abdominal" or "arm"), code it to the tissue in which such tumors arise rather than the ill-defined region (C76.*x*) of the body, which contains multiple tissues. Use the alphabetic index in **ICD-O-3** to assign the most specific site if only a general location is specified in the record.

HISTOLOGY	DESCRIPTION	CODE TO THIS SITE
8720–8790	Melanoma	C44._, Skin
8800–8811, 8813–8830, 8840–8921,	Sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	C49._, Connective, Subcutaneous and Other Soft Tissues
8990–8991	Mesenchymoma	C49._, Connective, Subcutaneous and Other Soft Tissues
9120–9170	Blood vessel tumors, lymphatic vessel tumors	C49._, Connective, Subcutaneous and Other Soft Tissues
9580–9582	Granular cell tumor and alveolar soft part sarcoma	C49._, Connective, Subcutaneous and Other Soft Tissues
9240–9252	Mesenchymal chondrosarcoma and giant cell tumors	C40._, C41._ for Bone and Cartilage C49._, Connective, Subq & Oth Soft Ti
8940–8941	Mixed tumor, salivary gland type	C07._ for Parotid Gland C08._ for Oth & Unspec Major Salivary Gland

Laterality NAACCR Item #410

*Laterality (*NAACCR Item #410) must be recorded for the following paired organs as 1 – 5 or 9. Organs that are not paired are coded to 0. Midline origins are coded 5. "Midline" in this context refers to the point where the "right" or "left" sides of paired organs come into direct contact and a tumor forms at that point. Most paired sites cannot develop midline tumors. For example, skin of the trunk can have a midline tumor, but the breasts cannot.

Paired Organ Sites

ICD-O-3	Site
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C31.1 – C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bones of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum)
C41.4	Pelvic bones (excluding sacrum, coccyx and symphysis pubis)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves & autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous, & other soft tissue of upper limb & shoulder
C49.2	Connective, subcutaneous & other soft tissues of lower limb and hip
C50.0 – C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0 – C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis

Paired Organ Sites

ICD-O-3	Site
C66.9	Ureter
C69.0 – C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges, NOS (excluding benign diagnoses prior to 1995)
C71.0	Cerebrum (excluding benign diagnoses prior to 1995)
C71.1	Frontal lobe (excluding benign diagnoses prior to 1995)
C71.2	Temporal lobe (excluding benign diagnoses prior to 1995)
C71.3	Parietal lobe (excluding benign diagnoses prior to 1995)
C71.4	Occipital lobe (excluding benign diagnoses prior to 1995)
C72.2	Olfactory nerve (excluding benign diagnoses prior to 1995)
C72.3	Optic nerve (excluding benign diagnoses prior to 1995)
C72.4	Acoustic never (excluding benign diagnoses prior to 1995)
C72.5	Cranial nerve, NOS (excluding benign diagnoses prior to 1995)
C74.0 – C74.9	Adrenal gland
C75.4	Carotid body

Morphology: Grade

The word "grade" is used to indicate several distinct continual of cellular variability in cancer. Cancer registries have collected *Grade/Differentiation* (NAACCR Item #440) form many years, and in recent years, registrars have become familiar with other grade systems**. These are coding instructions for cases diagnosed 01/01/2014 and forward.** For diagnoses prior to that date, consult the applicable VCR User Manual based on the date of diagnosis of the cancer.

Hematopoietic & Lymphoid Neoplasms: Cell Indicator (Codes 5, 6, 7, 8, 9)

Cell indicator describes the lineage or phenotype of the cell. Codes 5, 6, 7, and 8 are used only for hematopoietic and lymphoid neoplasms. Code 9 indicates the cell type is not determined, not stated, or not applicable.

1. Determine the histology based on the current Hematopoietic and Lymphoid Neoplasm Manual
2. Determine the cell indicator by applying the "Grade of Tumor Rules" within the current Hematopoietic and Lymphoid Neoplasm Manual to code the grade.

Grade codes for hematopoietic and lymphoid neoplasms

Terminology	Grade Code
T-cell; T-precursor	5
B-Cell; Pre-B; B-precursor	6
Null cell; Non T-non B	7
NK cell (natural killer)	8
Grade unknown, not stated, or not applicable	9

Solid Tumors (Grade, Differentiation: Codes 1, 2, 3, 4, 9)

Pathologic examination determines the grade, or degree of differentiation, of the tumor. For these cancers, the grade is a measurement of how closely the tumor cells resemble the parent tissue (organ of origin). Well-differentiated tumor cells closely resemble the tissue from the organ of origin. Poorly differentiated and undifferentiated tumor cells are disorganized and abnormal looking; they bear little (poorly differentiated) or no (undifferentiated) resemblance to the tissue from the organ of origin. These similarities/differences may be based on pattern (architecture), cytology, nuclear (or nucleolar) features, or a combination of these elements, depending upon the grading

system that is used. Some grading systems use only pattern, for example, Gleason grading in prostate. Others use only a nuclear grade (usually size, amount of chromatin, degree of irregularity and mitotic activity). Fuhrman's grade for kidney is based only on nuclear features. Most systems use a combination of pattern and cytologic and nuclear features; for example, Nottingham's for breast combines numbers for pattern nuclear size and shape, and mitotic activity. The information from this data item is useful for determining prognosis and treatment.

Pathologists describe the tumor grade using three systems or formats:

1. Two levels of similarity; also called a two-grade system
2. Three levels of similarity; also called a three-grade system(code according to "coding for solid tumors."
   a. Grade I, well
   b. Grade II, moderately
   c. Grade III, poorly (undifferentiated carcinoma is usually separated from this system, since "poorly" bears some, albeit little, similarity to the host tissue, while "undifferentiated" has none, e.g., Undifferentiated carcinoma).
3. Four levels of similarity; also called a four grade system. The four-grade system describes the tumor as:
   a. Grade I; also called well-differentiated
   b. Grade II; also called moderately differentiated
   c. Grade III; also called poorly differentiated
   d. Grade IV; also called undifferentiated or anaplastic

Breast and prostate grade my convert differently than other sites. These exceptions are noted in "Coding Solid Tumors, "# 7 and 8 below.

Coding for Solid Tumors

1. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code grade based on information prior to neoadjuvant therapy even if grade is unknown.

2. Code the grade from the primary tumor only.
   a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary sit is not available, code grade from the contiguous site.
   b. If primary site is unknown, code grade to 9.

3. Code the grade shown below (6th digit) for specific histologic terms that imply a grade:
   Carcinoma, undifferentiated (8010/3<u>4</u>)
   Carcinoma, anaplastic (8021/3<u>4</u>)
   Follicular adenocarcinoma, well differentiated (8331/3<u>1</u>)
   Thymic carcinoma, well differentiated (8585/3<u>1</u>)
   Sertoli-Leydig cell tumor, poorly differentiated (8631/3<u>1</u>)
   Sertoli-Leydig cell tumor, poorly differentiated with heterologous elements (8634/3<u>3</u>)
   Undifferentiated sarcoma (8805/3<u>4</u>)
   Liposarcoma, well differentiated (8881/3<u>1</u>)
   Seminoma, anaplastic 9062/3<u>4</u>)
   Malignant teratoma, undifferentiated (9082/3<u>4</u>)
   Malignant teratoma, intermediate type (9083/3<u>2</u>)
   Intraosseous osteosarcoma, well differentiated (9787/3<u>1</u>)

Astrocytoma, anaplastic (9041/34)
Oligodendroglioma, anaplastic (9481/34)
Retinoblastoma, differentiated (9511/31)
Retinoblastoma, undifferentiated (9512/34)

4. In situ and/or combined in situ/invasive components
   a. If a grade is given for an in situ tumor, code it. Do NOT code grade for dysplasia such as high grade dysplasia.
   b. If there are both in situ and invasive components, code only the grade for the invasive portion even if its grade is unknown.
5. If there is more than one grade, code the highest grade within the applicable system. Code the highest grade even if it is only a focus. Code grade in the following priority order using the first applicable system:
   a. Special grade systems for the sites listed in Coding for Solid Tumors #6
   b. Differentiation: use Coding for Solid Tumors#7: 2-, 3-, or 4-grade system
   c. Nuclear grade: use Coding for Solid Tumors #7: 2-, 3-, or 4-grade system
   d. If it is not clear whether it is a differentiation or a nuclear grade and a 2-, 3-, or 4-grade system was used, code it
   e. Terminology (use Coding for Solid Tumors #8
6. Use the information from the special grade systems first. If not special grade can be coded, continue with Coding for Solid Tumors #7 - 9

Special grade for solid tumors

Grade information based on CS Site-Specific factors for **breast, prostate, heart, mediastinum, peritoneum, retroperitoneum, soft tissue, and kidney parenchyma** is used to code grade. See *Special Grade System Rules* below for details on how to use this information to code grade.

CS Schema	Special grade system
Breast	Nottingham or Bloom-Richardson (BR) Score/Grade (SSF7)
Prostate	Gleason's score on core biopsy or TURP (SSF 8)
Prostate	Gleason's score on Prostatectomy/Autopsy (SSF 10)
Heart, Mediastinum	Grade for Sarcomas (SSF 1)
Peritoneum	Grade for Sarcomas (SSF 1)
Retroperitoneum	Grade for Sarcomas (SSF 1)
Soft Tissue	Grade for Sarcomas (SSF 1)
Kidney Parenchyma	Fuhrman Nuclear Grade (SSF 6)

Do not use this table to code grade for any other groups including WHO (CNS Tumors), WHO/ISUP (bladder, renal pelvis) or FIGO (female gynecologic sites)

1. Use the Two-, Three- or Four-grade system information
   a. Two-grade system

Term	Description	Grade code	Exception for Breast and Prostate Grade code
1/2; I/II	Low grade	2	1
2/2; II/II	High grade	4	3

In transitional cell carcinoma for bladder, the terminology high grade TCC and low grade TCC are coded in the two-grade system.

b. Three-grade system

Term	Description	Grade code	Exception for Breast and Prostate Grade code
1/3	Low grade	2	1
2/3	Intermediate grade	3	2
3/3	High grade`	4	3

c. Four-grade system; Any four-grade system, including Edmondson & Steiner grade for liver.

Term	Description	Grade code
1/4	Grade I; Well differentiated	1
2/4	Grade II; Moderately differentiated	2
3/4	Grade III; Poorly differentiated	3
4/4	Grade IV; Undifferentiated	4

2. Terminology: Use the "Description" column or the "Grade" column to code grade. Breast and Prostate use the same grade code with a few noted exceptions.

Description	Grade	Assign grade code	Exception for Breast and Prostate Grade code
Differentiated, NOS	I	1	
Well differentiated	I	1	
Only stated as 'Grade I'	I	1	
Fairly well differentiated	II	2	
Intermediate differentiation	II	2	
Low grade	I – II	2	1
Mid differentiation	II	2	
Moderately differentiated	II	2	
Moderately well differentiated	II	2	
Partially differentiated	II	2	
Partially well differentiated	I – II	2	1
Relatively or generally well differentiated	II	2	
Only stated as 'Grade II'	II	2	
Medium grade, intermediate grade	II – III	3	2
Moderately poorly differentiated	III	3	
Moderately undifferentiated	III	3	
Poorly differentiated	III	3	
Relatively poorly differentiated	III	3	
Relatively undifferentiated	III	3	
Slightly differentiated	III	3	
Dedifferentiated	III	3	
Only stated as 'Grade III'	III	3	
High grade	III – IV	4	3
Undifferentiated, anaplastic, not differentiated	IV	4	
Only stated as 'Grade IV'	IV	3	
Non-high grade		9	

3. If no description fits or grade is unknown prior to neoadjuvant therapy, code as 9 (unknown).

Special Grade System Rules

Breast (site: breast, excluding lymphomas; CS schema: breast)

Use Bloom Richardson (BR) or Nottingham score/grade based on CSv2 SSF7 as stated below (VCR does NOT require coding SSF 7 for breast).

BR could be referred to as: Bloom-Richardson, modified Bloom-Richardson, BR, BR grading, Scarff-Bloom-Richardson, SBR grading, Elston-Ellis modification of Bloom-Richardson score, Nottingham modification of Bloom-Richardson score, Nottingham modification of Scarff-Bloom-Richardson, Nottingham-Tenovus grade, or Nottingham grade.

Code the tumor grade using the following priority order:

1. BR scores 3-9
2. BR grade (low, intermediate, high)

If only a grade of 1 through 4 is given with no information on the score and it is unclear if it is a Nottingham or BR Grade, do not use the table below. Continue with the next priority according to "coding for Solid Tumors" #7 above.

Code the highest score if multiple scores are reported (exclude scores from tests after neoadjuvant therapy began). Examples: different scores may be reported on multiple pathology reports for the same primary cancer; different scores may be reported for multiple tumors assigned to the same primary cancer.

CS Site Specific Factor 7		
Nottingham or Bloom-Richardson (BR) Score/Grade		
Description	CS Code	Grade Code
Score of 3	030	1
Score of 4	040	1
Score of 5	050	1
Score of 6	060	2
Score of 7	070	2
Score of 8	080	3
Score of 9	090	3
Low Grade; BR grade 1, score not given	110	1
Medium (Intermediate grade); BR grade 2, score not given	120	2
High Grade; BR grade 3; score not given	130	3

Kidney Parenchyma (Site: kidney parenchyma excluding lymphomas; CS Schema: KidneyParenchyma) : Fuhrman Nuclear Grade

The Fuhrman Nuclear Grade should be used to code grade for kidney parenchyma only based on CSv2 SSF6 (NOT required by VCR) as stated below. Do NOT use for kidney renal pelvis. Fuhrman nuclear grade is a four-grade system based on nuclear diameter and shape, the prominence of nucleoli, and the presence of chromatin clumping in the highest grade.

Description	CS Code	Grade Code
Grade 1	010	1
Grade 2	020	2
Grade 3	030	3
Grade 4	040	4

Soft Tissue (sites excluding lymphoma: soft tissue, heart mediastinum, peritoneum, and retroperitoneum; for CS users: SoftTissue, HeartMediastinum, Peritoneum, and Retroperitoneum schemas): Grade for Sarcomas

The Grade for Sarcomas should be used to code grade based on CSv2 SSF 1 (NOT require by VCR) as stated below. If your registry does not collect this SSF, use the description in the table to determine the grade. The grading system of the French Federation of Cancer Centers Sarcoma Group (FNCLCC) is the preferred system.

Record the grade from any three-grade sarcoma grading system the pathologist uses. For such terms such as "well differentiated" or "poorly differentiated," go to Coding for Solid Tumors #8. In some cases, especially for needle biopsies, grade may be specified only as "low grade" or "high grade." The numeric grade take precedence over "low grade" or "high grade."

Description	CS Code	Grade Code
Specified as Grade 1 [of 3]	010	2
Specified as Grade 2 [of 3]	020	3
Specified as Grade 3 [of 3]	030	4
Grade stated as low grade, NOS	100	2
Grade stated as high grade, NOS	200	4

Prostate (site: prostate, excluding lymphomas; CS Schema: prostate).

Use the highest Gleason score from the biopsy/TURP or prostatectomy/autopsy. Use a known value over an unknown value. Exclude results from tests performed after neoadjuvant therapy began.

This information is collected in CSv2 SSF 8 (NOT required by VCR) (Gleason score from biopsy/TURP) and SSF 10 (Gleason score from prostatectomy/autopsy) as stated below.

Use the table below to determine grade even if your registry does not collect these SSF's. Usually prostate cancers are graded using Gleason score or pattern. Gleason grading for prostate primaries is based on a 5-component system (5 histologic patterns) Prostatic cancer generally shows two main histologic patterns. The primary pattern, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason grade, and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10. If there

are two numbers, assume that they refer to two pattern (the first number being the primary pattern and the second number the secondary pattern), and sum them to obtain the score. If only one number is given on a particular test and it is less than or equal to 5 and not specified as a score, do not use the information because it could refer to either a score or grade. If only one number is given and it is greater than 5, assume that it is a score and use it. If the pathology report specifies a specific number out of a total of 10, the first number given is the score.

Example: The pathology report says Gleason 3/10. The Gleason score would be 3.

Historic Perspective

Gleason Score	Description					
	CS Code	Grade Code	AJCC 7th ed	SEER 2003-2013	AJCC 6th ed	SEER prior to 2003
2	002	1	G1	G1	G1	G1
3	003	1	G1	G1	G1	G1
4	004	1	G1	G1	G1	G1
5	005	1	G1	G1	G2	G2
6	006	1	G1	G2	G2	G2
7	007	2	G2	G2	G3	G2
8	008	3	G3	G3	G3	G3
9	009	3	G3	G3	G3	G3
10	101	3	G3	G3	G3	G3

Historical perspective on long term trends in prostate grade: The relationship of Gleason score to grade changed for 1/1/2014+ diagnoses in order to have the grade field in sync with the AJCC 7th edition. Analysis of prostate grade before 2014 based solely on the grade field is not recommended. In Collaborative Stage (CS), Gleason score was originally coded in CSv1 in one filed (SSF 6) and then it was split into two fields in CSv2 based on the tissue used for the test – needle biopsy/TURP in SSF 8 and prostatectomy/autopsy in SSF10. For trends using data back to 2004, if one collected the various CS Gleason scores, one could design a recode to have the same criteria as the data collected 2014+. The original grade field would NOT be changed, but for this analyses this recode could be based on the CS SSF's and the original grade code.

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DATA ITEM INSTRUCTIONS

Patient Identification

Sequence Number – Hospital NAACCR Item #560

Record the sequence number representing the order of this primary. Sequence number counts the occurrence of *independent, malignant and non-malignant neoplasms* except basal and squamous cell cancer of the skin during the patient's lifetime. Each neoplasm is assigned a different number. This number may change over the lifetime of the patient.

Codes 00-35 and 99 indicate neoplasms of in situ or malignant behavior (2 or 3). Codes 60-88 indicate neoplasms of non-malignant behavior (0, benign or 1, borderline).

Sequence Numbers for Malignant or In Situ Primaries

00 One malignant or in situ primary only in the patient's lifetime
01 First of two or more independent malignant or in situ primaries
02 Second of two or more independent malignant or in situ primaries
... (Actual sequence of this malignant or in situ primary)
35 Thirty-fifth of thirty-five independent malignant or in-situ primaries.
99 Unspecified malignant or in situ sequence number or unknown

Sequence Numbers for Non-Malignant Tumors

60 Only one non-malignant primary in the patient's lifetime
61 First of two or more independent non-malignant primaries
62 Second of two or more independent non-malignant primaries
... (Actual number of this primary)
87 Twenty-seventh of twenty-seven independent non-malignant primaries
88 Unspecified number of neoplasms in this category

Recording Sequence Number

1. Code 00 only if the patient has a single malignant primary.
2. If the patient develops a subsequent malignant primary or in situ primary tumor, change the sequence number for the first tumor from 00 to 01, and number subsequent tumors sequentially.

   Example: In January 2001, the registry assigns sequence number 00 to a patient with malignant melanoma. The patient develops a second primary cancer of the lung in July 2002. Assign sequence number 02 to the second cancer (lung). Change the sequence number of the first cancer (malignant melanoma) to 01.

   Note: Reporting institutions are not required to forward a change sheet to the VCR when changing sequence number from 00 to 01.
3. Code 60 only if the patient has a single non-malignant primary.
4. If the patient develops a subsequent non-malignant primary, change the sequence number of the first tumor from 60 to 61, and number subsequent non-malignant tumors sequentially.

   Note: Reporting institutions are not required to forward a change sheet to the VCR when changing sequence number from 60 to 61.

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

   Example 1: A patient enters the reporting institution with simultaneous carcinoma in situ of the breast and invasive adenocarcinoma of the colon. Assign sequence number 01 to the colon primary and sequence number 02 to the breast primary.

   Example 2: A patient has simultaneous adenocarcinoma in situ in a colon polyp and squamous cell carcinoma in situ in a vocal cord polyp. Assign sequence numbers in any order, since both primaries have similar prognoses.

6. If two or more non-malignant neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.

7. If an in situ tumor is followed by an invasive cancer in the same site more than two months apart, report as two primaries even if stated to be a recurrence. The invasive primary should be reported with the date of the invasive diagnosis. Assign sequence numbers to both primaries with the in situ cancer being the first of the two. Refer to the *Multiple Primary and Histology Coding Rules* for more specific information by site.

8. The sequence number counts the patient's independent, primary tumors regardless of the location(s) or institution(s) where those primaries were diagnosed and treated or the date of diagnosis.

   Example: The reporting institution diagnosed colon cancer. The patient has a history of kidney cancer diagnosed in 1980. The colon cancer is the second of this patient's primary cancers. Assign a sequence number 02 to colon cancer.

9. If the patient has a condition that was diagnosed prior to the condition being reportable do not count that condition when assigning sequence number.

   Example: A patient was diagnosed with refractory anemia on June 25, 1999 (not reportable until 2001) and then was later diagnosed with acute myelogenous leukemia on March 21, 2003 at your facility. Abstract only the acute myelogenous leukemia and assign a Sequence Number of 00.

10. Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence.

11. The following sites/histologies are single primaries. Any reappearance of the original disease is documented as a recurrence. Assign a sequence number to the first disease occurrence. Do not assign another sequence number to any subsequent occurrences.

    Examples: Invasive transitional and papillary transitional cell carcinomas (8120-8130) of the bladder

    Invasive adenocarcinoma (8140) of the prostate

    Kaposi sarcoma (9140/3) regardless of primary site

    Non-malignant brain & CNS tumors of the same histology, same site, and same laterality.

12. Use the sequence number 99 when it is impossible to estimate whether the patient has been diagnosed with an earlier malignancy (primary). If more information becomes available, change the sequence number(s).

    Example: A patient is diagnosed in the reporting facility with cancer of the colon. The medical record contains the statement "The patient recently had a salivary gland tumor removed. The patient does not know if the lesion was malignant." Assign a 99 sequence number to the colon primary. The patient returns to the reporting facility a year later for treatment of prostate cancer. The medical record says "The patient has a history of a malignant salivary gland tumor." Change the sequence number of the colon cancer from 99 to 02. Assign the sequence number 03 to the prostate cancer.

13. Do not enter fictitious sequence numbers. Fictitious sequence numbers harm the scientific integrity of the data.

Name – Last NAACCR Item #2230

Record the patient's full last name. Do not leave blank.

Recording Name – Last

1. Truncate name if more than 40 letters long. Blank spaces, hyphens, and apostrophes are allowed. Do NOT use other punctuation
2. Change To Name This data item should be updated on the hospital abstract if the last name changes and the change must be submitted to the VCR. See *VCR Manual Part One, Changing Information*.

   Example: Janet White marries and becomes Janet Black. Change the last name to Black and record White in the maiden name field; forward the change to the VCR.
3. Suffixes and Prefixes Name suffixes when available must be entered in the field *Name - Suffix* and not included in the *Name - Last* field. Do not include name prefixes (e.g., Sister, Reverend, Brother, Dr) as part of the patient last name. Name prefixes are not collected by the VCR and must not be included in any of the required name fields.

Name – First NAACCR Item #2240

Recording Name-First

1. Truncate name if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed. Do NOT use other punctuation

   Example: Mary Jane is entered as Mary Jane.

2. First Initial Only If the patient uses the initial of their first name and their full middle name, enter the patient's first initial in the *Name - First* field. Record the middle name in the *Name - Middle* field.

   Example: Patient's name is M. Jane
   (*Name - First)* = M
   (*Name - Middle)* =
   Jane

3. Prefixes Do not include name prefixes (e.g., Sister, Reverend, Brother, Dr) as part of the patient first name. Name prefixes are not collected by the VCR and must not be included in any of the required name fields.

Name – Middle NAACCR Item #2250

Record the patient's middle name.

Recording Name-Middle

1. Truncate name if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed. Do NOT use other punctuation
2. Leave this item blank if the patient does not have a middle name or initial, or if the middle name or initial is unknown. Do not record *not applicable*, *N/A* or *unknown*.
3. Do not use *any* punctuation.

Name – Maiden NAACCR Item #2390

Record the maiden name of female patients who are or have been married. This item is useful for matching multiple records on the same patient.

Recording Name-Maiden

1. Truncate name if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed. Do NOT use other punctuation

2. Hyphens are allowed
   Example: The last name is Green-Moss. Record as Green-Moss.

3. Leave this data item blank if the patient does not have a maiden name, information is not available, or it is not applicable to the patient as in the case of a male. Do not record *not applicable*, *n/a* or *unknown*.

Name – Alias NAACCR Item #2280

Record any alternate name or "AKA" (also known as) used by the patient, if known. This item is useful for matching multiple records on the same patient.

Recording Name-Alias

1. Truncate name if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed. Do NOT use other punctuation

2. Leave this data item blank if the patient does not have an alias or if the information is not available. Do not record *not applicable*, *n/a* or *unknown*.

3. Do not record maiden name in this field. It should be recorded in the *Name-Maiden* field.

Guidelines for Recording Patient Address

The address is the home or residence named by the patient at the time he/she was diagnosed. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to, or comparable with, the rules of the United States Census Bureau whenever possible. Resolve residency questions by using the Census Bureau's definition "the place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home." Vital Statistic rules may differ from census rules. Do not record residence from the death certificate. Review each record carefully to determine correct residence. If address at diagnosis is unavailable, use current address.

Rules for Persons Without Apparent Residences:

Persons with More Than One Residence

(Summer and winter homes): Use the address the patient specifies if a usual residence is not apparent.

Persons with No Usual Residence

(Transients, homeless): Use the address of the place they were staying when the cancer was diagnosed. This could be a shelter or the diagnosing institution.

Persons Away at School

College students are residents of the school area. Boarding school children below college level are residents of their parents' home.

Persons in Institutions

The Census Bureau states "Persons under formally authorized, supervised care or custody" are residents of the institution. This includes the following:

1. Incarcerated persons
2. Persons in nursing, convalescent, and rest homes
3. Persons in homes, schools, hospitals, or wards for the physically disabled, mentally retarded, or mentally ill
4. Long-term residents of other hospitals, such as Veterans Administration (VA) hospitals

Persons in the Armed Forces and on Maritime Ships:

Members of the armed forces are residents of the installation area. Use the stated address for military personnel and their family. Military personnel may use the installation address or the surrounding community's address. The Census Bureau has detailed residency rules for Naval personnel, Coast Guard, and maritime ships. Refer to the Census Bureau publications for these detailed rules.

Address at Diagnosis – No & Street NAACCR Item #2330

Record the number and street address of the patient's usual residence at the time the tumor was initially diagnosed. Patient address is used to provide census tract and other geocodes for incidence statistics and epidemiologic research. The VCR uses geocoding software for automated assignment of geocodes. To increase the rate of automated geocoding, improve the quality of residence data, and enhance the specificity of residence information available for research, addresses must conform to the following format rules.

Recording Addr At Dx - No & Street

1. Leave a blank between numbers and words if space permits.
2. *The use of capital letters is* **preferred**.
   Example: 103 First Avenue should be recorded as 103 1st AVE
3. If the patient has multiple tumors, the address may be different for each primary.
4. If no information is available on address at diagnosis, assume the current address was also address at time of original diagnosis.
5. If the patient's current address is not known, record UNKNOWN only after all efforts to obtain this information prove unsuccessful.
6. Do Not Update this data item if the patient's address changes over time. See *VCR Manual Part Three, Guidelines for Recording Patient Address* for detailed residency rules.
7. Punctuation marks should be avoided, except when punctuation is necessary to convey the meaning.
   a. Punctuation normally is limited to periods when the period carries meaning (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 ½ MAIN ST) and hyphens when the hyphen carries meaning (e.g., 289-01 MONTGOMERY AVE).
   b. Pound signs- The use of pound signs (#) to designate address units should be avoided whenever possible. The preferred notation is as follows:

      Example:
      Address: 1234 Main St., Apartment
      Record as: 1234 MAIN ST APT 12

      If a pound sign is used, there must be a space between the pound sign and secondary number (e.g., 425 FLOWER BLVD # 72).
   c. Do not use commas, semicolons, colons, dashes, question marks, exclamation points, apostrophes, parentheses, brackets, braces, quotation marks or asterisks (*) when recording address.
8. Abbreviations: Enter complete street names without abbreviation. Abbreviate only directional prefixes, directional suffixes and street type suffixes as included on the following VCR list, *Standardized Abbreviations for Street Address.* Use of abbreviations for these terms will enable the entire street address to be recorded.

   Examples: 101 W PINE ST RICHMOND 23234 is in Chesterfield County 101 W PINE WAY RICHMOND 23234 is in Richmond City
9. PO Box: Avoid using PO Box numbers in place of street address. Use of street address is necessary for more accurate geocoding.

   Example: Address: P.O. Box 20, 221 Springfield Rd
   Record as: 221 SPRINGFIELD RD

10. Postal Route Numbers: Avoid using postal route numbers in place of street address. Confirm the house number is not part of the postal route. Use of street address is necessary for more accurate geocoding.

    Example: Address: RD2 35 Sycamore St
    Record as: 35 SYCAMORE ST when it is known that 35 is the street number

11. Apartment Numbers or Letters: Enter apartment numbers or letters in *Address at DX-Supplemental* field.

    Example: Address: Apartment F at 321 Knollwood Dr.
    Record *Addr at DX-No and Street* as: 321 KNOLLWOOD DR
    Record *Address at DX- Supplemental* as: APT F

12. Intersections: Use one of the following formats when an intersection is used in place of a street number:

    Example: SMITH AND JONES ST (not Sts or Streets)
    SMITH ST AND JONES ST
    SMITH AT JONES

13. Nursing Home or Other Institution: If residence is a nursing home or other institution, enter the street address given in this field. The name of the institution should be entered in the *Address at DX Supplemental* field.

    Example: Address: Oak Nursing Home, 1530 Elm Ave
    Record *Addr at DX-No and Street* as: 1530 ELM AVE
    Record *Address at DX- Supplemental* as: OAK NURSING HOME

VCR Standard Abbreviations for Street Address

Directional Prefix or Suffix Abbreviations

Prefix/Suffix	Abb	Prefix/Suffix	Abb	Prefix/Suffix	Abb	Prefix/Suffix	Abb
North	N	East	E	Northeast	NE	Southeast	SE
South	S	West	W	Northwest	NW	Southwest	SW

Street Prefix Abbreviations

Prefix	Abb	Prefix	Abb	Prefix	Abb	Prefix	Abb
Avenue	AV,AVE	Camino	CMN	Paseo	PAS	Via	VIA
Boulevard	BLVD	Circulo	CIR	Place/Placita	PL	Vista	VISTA
Calle	CLL	Corte	CT	Plaza	PLZ		
Caminito	CMT	Drive	DR	Rue	RUE		

Street Suffix Abbreviations

Suffix	Abb	Suffix	Abb	Suffix	Abb	Suffix	Abb
Alley	AL	Crossing	G	Overpass	OVPS	Square	SQ
Alley	ALY	Drive	DR	Park	PARK	Street	ST

Arcade	ARC	Expressway	I XWY	Parkway	PKWY	Terrace	TER
Avenue	AV,AVE	Expressway	I XY	Parkway	PKY	Trafficway	FWY
Boulevard	BLVD	Freeway	FRWY	Pass	PASS	Throughway	THWY
Bypass	BYP	Freeway	FWY	Path	PATH	Trail	TRL
Calle	CLL	Gardens	GDNS	Pike	PKE	Turnpike	TPKE
Causeway	CSWY	Highway	HWY	Place	PL	Underpass	UNP
Center	CTR	Lane	LA	Plaza	PLZ	Walk	WALK
Circle	CIR	Loop	LOOP	Road	RD	Way	WY
Concourse	CONC	Mews	MEWS	Row	ROW		
Court	CT	Motorway	MTWY	Rue	RUE		
Crescent	CRES	Oval	OVAL	Skyway	SKWY		

Addr at DX – Supplemental NAACCR Item #2335

Record additional address information such as the name of a place or facility (e.g., a nursing home or name of an apartment complex) at the time of diagnosis.

Recording Addr at Dx – Supplemental

1. If additional address space is not needed, leave blank.

2. Do Not Update this data item if the patient's address changes over time. See *VCR Manual Part Three, Guidelines for Recording Patient Address* for detailed residency rules.

Addr at DX – City/Town NAACCR Item #70

Record the city or town of the patient's usual residence when the tumor was initially diagnosed. The address is a part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies.

Recording Addr at DX-City

1. *Do Not Update* this data item if the patient's address changes over time. Changing this data item would destroy its usefulness. See *VCR Manual Part Three, Guidelines For Recording Patient Address* for detailed residency rules.
2. Rural area - If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.
3. Punctuation - Do not use punctuation, special characters, or abbreviations.
4. Capital Letters- The use of capital letters is preferred.
5. Multiple Tumors- If the patient has multiple tumors, the address may be different for each primary.
6. Unknown- If the city is not known, record UNKNOWN only after all efforts to obtain this information prove unsuccessful.
7. No Information- If no information is available on address at time of diagnosis, use current address.

Addr at Dx – State NAACCR Item #80

Record the US postal service abbreviation for the state or Canadian province of the patient's usual residence when the tumor was diagnosed.

The address is part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies. Do not update this data item if the patient's address changes over time – changing this data item would destroy its usefulness. See *VCR Manual Part Three, Guidelines for Recording Patient Address* for detailed residency rules.

Recording Addr at DX-State

1. Multiple Tumors- If the patient has multiple tumors, the address may be different for each primary.
2. *Do Not Update* this data item if the patient's address changes over time. Changing this data item would destroy its usefulness. See *VCR Manual Part Three, Guidelines for Recording Patient Address* for detailed residency rules.
3. Abbreviations- Only abbreviations on the following three tables are acceptable.

Abbreviations - US States

US State		US State		US State	
Alabama	AL	Kentucky	KY	North Dakota	ND
Alaska	AK	Louisiana	LA	Ohio	OH
Arizona	AZ	Maine	ME	Oklahoma	OK
Arkansas	AR	Maryland	MD	Oregon	OR
California	CA	Massachusetts	MA	Pennsylvania	PA
Colorado	CO	Michigan	MI	Rhode Island	RI
Connecticut	CT	Minnesota	MN	South Carolina	SC
Delaware	DE	Mississippi	MS	South Dakota	SD
District of Columbia	DC	Missouri	MO	Tennessee	TN
Florida	FL	Montana	MT	Texas	TX
Georgia	GA	Nebraska	NE	Utah	UT
Hawaii	HI	Nevada	NV	Vermont	VT
Idaho	ID	New Hampshire	NH	Virginia	VA
Illinois	IL	New Jersey	NJ	Washington	WA
Indiana	IN	New Mexico	MN	West Virginia	WV
Iowa	IA	New York	NY	Wisconsin	WI
Kansas	KS	North Carolina	NC	Wyoming	WY

Abbreviations – Other US Possessions

US Possession		US Possession	
American Samoa	AS	Marshall Islands	MH
Guam	GU	Outlying Islands	UM
Puerto Rico	PR	APO/FPO Armed Services America	AA
Virgin Islands	VI	APO/FPO Armed Services Europe	AE
Palau	PW	APO/FPO Armed Services Pacific	AP
Micronesia	FM		

Abbreviations – Canadian Provinces

Province		Province	
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland/Labrador	NL	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS		

Abbreviations – Other

Other Country or Unknown	
Resident of a country other than the US (including its territories, commonwealths, or possessions) or Canada and the country is known	XX
Resident of a country other than the US (including its territories, commonwealths, or possessions) or Canada and the country is unknown	YY
Resident of US, NOS (including its territories, commonwealths, or possessions); Canada, NOS; residence unknown	ZZ

Addr at Dx – Postal Code NAACCR Item #100

For US residents, record the patient's nine-digit extended postal (ZIP) code when the tumor was diagnosed. The address is a part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies.

Example: The extended postal code 60611-2797 is recorded as 606112797.

Recording Addr At DX- Postal Code

1. Only Five-Digits Available – When the nine-digit extended code is unavailable, record the five-digit postal code.

   Example: When only five digits, 60611, are available, record 60611_ _ _ _.

2. Canadian Residents – For Canadian residents, record the six-character postal code as noted below.

3. Hyphens – Do *not* record hyphens.

4. *Do Not Update* this data item if patient's address changes over time. Changing this data item would destroy its usefulness. See *VCR Manual Part Three, Guidelines for Recording Patient Address* for detailed residency rules.

5. Multiple Tumors – If the patient has multiple tumors, the postal code may be different for each primary.

6. Other countries – When available, record the postal code for other countries.

7. Unknown Postal Code – If the street address, city and state are known, but the postal code is unknown, the following US Postal Service's Web site may be used to determine the correct postal code:
   http://www.usps.com/

8. Unknown Address – If street address, city, state and postal code are unknown and the information cannot be obtained from any other sources, use codes noted below.

Codes and Definitions

Code	Definition
23219_ _ _ _	When the nine-digit extended US Zip code is not available, record the five-digit postal code, left justified, followed by four blanks
M6G2S8	The patient's six-character Canadian postal code left justified, followed by three blanks
888888888	Permanent address in a country other than Canada, United States or US possessions **and** postal code is unknown
999999999	Permanent address in Canada, United States, or US possession **and** postal code is unknown. Permanent address (street, city and state) is totally unknown

County at Diagnosis NAACCR Item #90

Record the county of the patient's usual residence when the tumor was diagnosed. Do not update this data item if the patient's county of residence changes.

Recording County at Dx

1. If the patient has multiple tumors, the county may be different for each primary.
2. This data item must contain the specific county at diagnosis. If the city and state are known, but the county is unknown, the following web site may be used to determine the correct county: http://www.melissadata.com/Lookups/addressverify.asp.
3. If the patient is a Virginia resident, the specific county *must* be recorded.
   Record the county at diagnosis using county codes issued by the Bureau of Standards in the Federal Information Processing Standards (FIPS). The FIPS codes for Virginia counties are listed in *VCR Manual Appendix F, Federal Information Processing Standards (FIPS)* and are generally incorporated into abstracting software.
4. If the patient resides in a state other than Virginia, in Canada, or in a US possession, the specific county is not required and should be coded to 998.
5. Record 999 when the patient is a non-US resident.

Medical Record Number NAACCR Item #2300

Record the patient's medical record number. The medical record number is a patient identification number usually assigned by the reporting facility.

Recording Medical Record Number

1. This item is used to locate the medical record. It may also be used to link records and should be recorded exactly as it is recorded on your Disease Index.
2. If the medical record number is fewer than 11 characters, right justify the characters and allow leading blanks.

   Example: Medical record number 811234 would be recorded

					8	1	1	2	3	4

3. Record standard abbreviations for departments that do not use medical record numbers.

   Examples: Radiation Therapy

									R	T

   One-day surgery clinic

									S	U

4. If the medical record number is unknown, record

								U	N	K

Social Security Number NAACCR Item #2320

Record the patient's Social Security Number (SSN) without dashes.

Recording Social Security Number

1. Providing a social security is mandated by the Code of Virginia. See Appendix ### for the Code.
2. When a patient does not have a Social Security Number, or the information is not available, record 999999999. DO NOT make up a social security number to denote unknown.
3. It is important to enter the correct Social Security Number since this data item is used for record linkage to match patients at the VCR as well as to match VCR information with the Social Security Number on the hospital's Disease Index. Verify entries for missing values and transpositions. Do not record Social Security Numbers that end with B or D. These are the spouse's Social Security Number.
4. According to how a Social Security Number is assigned by the Social Security Administration, the following are invalid entries:
   a. First three digits cannot = 000 or 666
   b. Fourth and Fifth digits cannot = 00
   c. Last four digits cannot = 0000
   d. First digit cannot = 8 or 9 unless entire SSN is unknown (999999999)
5. ***If a correction is made to the Social Security Number, a change sheet must be submitted to the VCR***. See *VCR Manual Part One, Changing Information*.

Birthplace – State NAACCR Item #252

Record the patient's place of birth. This data item is used to evaluate medical care delivery to special populations and to identify populations at special risk for certain cancers. It corresponds to Birthplace – Country.

Recording Birth Place

1. State of Birth – If the patient was born in the United States, record the state of birth.
2. SEER Geo-codes – Record the patient's place of birth using the *VCR Manual Appendix G, SEER Geo-Codes*. These codes include states of the United States as well as foreign countries.
   a. Use the most specific code possible.
   b. These codes are generally incorporated in abstracting software.
   c. At the time SEER assigned geo-codes in the 1970's, the United States owned or controlled islands in the Pacific. Many of these islands are now independent. Some are controlled by countries other than the United States. The original codes are used for these islands to preserve historic information. The names have been annotated to show the new political designation. The alphabetic list displays the correct code.

   Examples:

Code	Definition
VA	If the state in which the patient was born is Virginia, then use the USPS code for the state of Virginia
XX	Born in a country other than the US (including its territories, commonwealths, or possessions) or Canada and the *country is known*
YY	Born in a country other than the US (including its territories, commonwealths, or possessions) or Canada and the *country is unknown*
US	Born in a country other than the US (including its territories, commonwealths, or possessions) and the state is *unknown*
CD	Born in Canada and the province is *unknown*
ZZ	Place of birth is unknown, not mentioned in the patient record

Birthplace – Country NAACCR Item #254

Record the country where the patient was born. The codes are based on International Organization for Standardization (ISO) -1 aplha-3country codes, with some custom codes.

1. This item corresponds to Birthplace – State.
2. Use the most specific code

   Examples:

Code	Country
USA	United States
CAN	Canada
ZZU	Place of birth is unknown, not mentioned in patient record

Date of Birth NAACCR Item #240

Record the patient's date of birth

Recording Birth Date

1. Date Format – Record date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces and the day in the last two spaces. A zero must precede single- digit months and days. See *VCR Manual, Part Three, General Instructions* for allowable values.

   Example: Record June 30, 1906 as 19060630.

2. Date Unavailable, but Age Known – When age is known, estimate year of birth when further information is not available. It is better to estimate than to record as an unknown year.

   Example 1: The patient is 60 years old when diagnosed on June 15, 1996. The medical record does not have a birth date. Record unknown month (blank) and day (blank). Estimate the year as 1936 (----1936).

   Example 2: Record the patient's date of birth as ----1927 when the medical record contains only the year of birth (1927).

3. Unknown Month, Day and/or Year – If date is not known, leave the field blank. If only part of the date is known, record what is known and enter approximations for month and/or year if descriptions are available or blank for what is unknown. No approximation of day is acceptable. *Fictitious dates or default values are not acceptable to be entered for month, day, or year*.

   a. If the data of birth cannot be determined at all, record the reason *in Date of Birth Flag.*

4. Beginning in 2010, the way dates are transmitted between facility registries and central registries was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. Interoperable dates are displayed in CCYYMMDD form, *with the unknown portions of the date filled with blank spaces*. If a *date is entirely blank, an associated date flag is used* to explain the missing date. Flags are not used for software-generated dates.

   a. For more information regarding dates, please see *Virginia Cancer Registry Manual, Part Three: Data Item Instructions, General Information, Coding Dates*

Date of Birth Flag NAACCR Item #241

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

Recording Date of Birth Flag

1. Leave this item blank if *Date of Birth* has a full or partial date recorded.
2. Code 12 if the *Date of Birth* cannot be determined at all.
3. Registrars should enter this data item directly (when appropriate) even if the traditional form of data entry is used in the software.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Birth Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space.***

Description	**Traditional Date of Birth**	**Interoperable Date of Birth**	**Date of Birth Flag**
	Date entered in MMDDCCY sequence; unknown portions represented by 99 or 9999	*Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.*	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb))	bb
Date is unknown	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

Sex NAACCR Item #220

Record the patient's sex.

Codes and Definitions

Code	Definition
1	Male
2	Female
3	Other (Hermaphrodite)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not stated/Unknown

Special Instructions

1. Sex **must** be documented in the PE Text field
2. Codes of 3 through 6 ***requires*** documentation in the PE Text field
3. These codes may be used in cases prior to 2015
4. Transsexual, NOS may be used for new cases if natal sex is unknown

Spanish/Hispanic Origin NAACCR Item #190

Record the Spanish/Hispanic origin. This item identifies persons of Spanish or Hispanic ethnicity. This code is used by VCR to identify whether or not the person should be classified as "Hispanic" for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the White category (01) of *Race 1* through *Race 5*.

Codes and Definitions

Code	Definition
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)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS; (There is evidence other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1 – 5)
7	Spanish surname only (the only evidence of the person's Hispanic origin is surname or maiden name and there is no contrary evidence that the person is not Hispanic
8	Dominican Republic
9	Unknown whether Spanish or not

Recording Spanish/Hispanic Origin

1. A person of Spanish/Hispanic origin may be any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.
2. Code 0 (Non-Spanish; non-Hispanic) for Portuguese and Brazilian persons.
3. If a patient has multiple tumors, all records should have the same code.
4. If this information is not available, reference ***"A Toolkit for Collecting Race, Ethnicity, and Primary Language Information From Patients"*** which was developed by the Health Research Educational Trust providing guidance on how to collect this information during patient registration. This resource is available at the following link and should be shared with personnel responsible for patient registration throughout your facilities:

   www.hretdisparities.org/hretdisparities/index.jsp.

Race NAACCR Item #160,161,162,163,164

Race 1, Race 2, Race 3, Race 4, Race 5

Record the appropriate codes for the patient's race(s) in Race 1, Race 2, Race 3, Race 4, and Race 5. Race is coded separately from Spanish/Hispanic Origin.
Codes 08 – 13 became effective with diagnoses January 1, 1988 and after. Code 14 became effective with diagnoses January 1, 1994 and later. In 2010, code 09 w3as converted to the new code 15, and codes 16 and 17 were added. Codes 20 – 97 became effective with diagnoses on or after January 1, 1991.

Codes and Definitions

Code	Definition	Code	Definition
01	White	17	Pakistani
02	Black	20	Micronesian
03	American Indian, Aleutian, or Eskimo (*includes all indigenous populations of the Western hemisphere*)	21	Chamorro/Chamoru
04	Chinese	22	Guamanian, NOS
05	Japanese	25	Polynesian, NOS
06	Filipino	26	Tahitian
07	Hawaiian	27	Samoan
08	Korean	28	Tongan
09	Retired – **DO NOT USE**	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	88	No further race documented (*Do **Not** use in Race 1)*
13	Kampuchean, includes Khmer & Cambodian	96	Other Asian, includes Asian NOS, & Oriental NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (*formerly code 09)*	98	Other
16	Asian Indian	99	Unknown

Recording Race

Race 1 is the field used to compare with race data on cases diagnosed prior to January 1, 2000. "Race" is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. All tumors for the same patient should have the same race code(s).

Single Race

1. If only one race is reported for the patient, in Race 1 enter the race code and in Race 2 through Race 5, enter 88.
2. A specific race code (other than 88 or 99) must not occur more than once.

   Example 1: If the patient's race is listed as white, in Race 1 enter 01 and in Race 2 through Race 5 enter 88. Do not code 01 in Race 1 signifying one parent and 01 again in Race 2 for other parent.

Example 2: A patient was born in Mexico of Mexican parentage. Code Race 1 as 01 and Race 2 through Race 5 as 88.

Multiple Races

1. Code primary race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5. The five race fields allow for the coding of multiple races consistent with the Census 2000. Rules 2-6 further specify how to code Race 1 through Race 5.
2. If less than five specific race codes apply for a patient, code 88 in the remaining race fields.

   Example: A patient has a Hawaiian father, black mother, Japanese grandfather, and Korean grandmother. Code Race 1 as 07 Hawaiian, Race 2 as 02 Black, Race 3 as 05 Japanese, Race 4 as 08 Korean, and Race 5 as 88.
3. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white in the next race field.
4. If a person's race is a combination of Hawaiian and any other race(s), code Race 1 as 07 Hawaiian and code the other races in Race 2, Race 3, Race 4, and Race 5 as appropriate.

   Example: Patient is described as Japanese and Hawaiian. Code Race 1 as 07, Hawaiian, Race 2 as 05 Japanese, and Race 3 through Race 5 as 88.
5. If the person is not Hawaiian, code Race 1 to the first stated non-white race (02-98).

   Example: Patient is stated to be Vietnamese and Black. Code Race 1 as 10 Vietnamese, Race 2 as 02 Black, and Race 3 through Race 5 as 88.
6. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to list the non-white race(s) first.

   Example: The patient is described as Asian-American with Korean parents. Code race as 08 Korean because it is more specific than 96 Asian, NOS. Code Race 2 through 5 as 88.

No Race Stated

1. If no race is stated in the medical record, or if the stated race cannot be coded, review the documentation for a statement of race category.

   Example 1: Patient described as a black female in the physical exam, consultation or nursing notes, Code Race 1 as 02 Black and Race 2 through Race 5 as 88.

   Example 2: Patient describes herself as multi-racial (nothing more specific) and nursing notes say 'African-American.' Code Race 1 as 02 Black and Race 2 through Race 5 as 88.

   Example 3: Patient states she has a Polynesian mother and Tahitian father. Code Race 1 as 25 Polynesian, Race 2 as 26 Tahitian and Race 3 through Race 5 as 88.

2. If race is unknown, not stated in the medical record, or not stated specifically, refer to the race-specific guidelines below. If none apply, code Race 1 through Race 5 as unknown (99). Do not use patient name in determining race.

Race-Specific Guidelines

1. White (01) includes Mexican, Puerto Rican, Cuban, and all other Caucasians.
2. Black (02) includes the designations Negro or African-American.
3. Native American (03) should be used for any person stated to be Native American or [western hemisphere] Indian, whether from North, Central, South, or Latin America.
4. Race is based on birthplace information when place of birth is given as China, Japan, or the Philippines and race is reported only as Asian, Oriental, or Mongolian.

   Example: If the patient's race is recorded as Asian and the place of birth is recorded as Japan, code Race 1 as 05 Japanese and Race 2 through Race 5 as 88.
5. Do not code Asian in a subsequent race field if a specific Asian race has already been coded.

Use of Code 88 (No further race documented)

1. Code 88 is valid for Race 2 through Race 5; it is not valid for Race 1.
2. If Race 2 is coded to 88, then Race 3 through Race 5 must be coded to 88.

Use of Code 99 (Unknown)

1. If the patient's race is unknown, enter 99 in Race 1 through Race 5.
2. If any race equals 99 then all race codes (Race 1, 2, 3, 4, and 5) must equal 99.

Special Instructions

Race must be recorded in the PE Text field. If race is unknown, it should be recorded as such in the text field.

Reference

"***A Toolkit for Collecting Race, Ethnicity, and Primary Language Information from Patients***" is a reference developed by the Health Research Educational Trust providing guidance on how to collect this information during patient registration. This resource is available at the following link and should be shared with personnel responsible for patient registration throughout your facilities:

http://www.hretdisparities.org/

Primary Payer at Diagnosis NAACCR Item #630

Record the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

This item is used in financial analysis and as an indicator for quality and outcome analyses. Joint Commission on Accreditation of Healthcare Organizations (*JCAHO) requires* the patient admission page to document the type of insurance or payment structure that will cover the patient while being cared for at the facility.

Recording Primary Payer at Diagnosis

1. If the patient is diagnosed at the reporting facility, record the payer at the time of diagnosis
2. If the patient is diagnosed elsewhere or the payer at the time of diagnosis is not known, record the payer when the patient is initially admitted for treatment
3. Record the type of insurance reported on the patient's admission page
4. Codes 21 and 65 – 68 are to be used for patients diagnosed on or after January 1, 2006
5. If more than one payer or insurance carrier is listed on the patient's admission page, record the first
6. If the patient's payer or insurance carrier changes, do not change the initially recorded code.

Code	Definition
01	*Not Insured*- Patient has no insurance and is declared a charity write-off.
02	*Not Insured, Self-Pay*- Patient has no insurance and is declared responsible for charges.
10	*Insurance, NOS*- Type of insurance is unknown or other than types listed in codes 20, 21, 31, 35, 60-68.
20	*Private Insurance: Managed Care, HMO, or PPO*- An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network, or a staff model. "Gatekeeper- model" is another term for describing this type of insurance.
21	*Private Insurance: Fee-for-Service*- An insurance plan that does not have a negotiated fee structure with the participating facility. Type of insurance plan not coded as 20
31	*Medicaid*- State government administered ins for persons who are uninsured, below poverty level, or covered under entitlement programs. Medicaid other than described in code 35.
35	*Medicaid-Administered through a Managed Care plan*- Patient is enrolled in Medicaid through a Managed Care program (e.g. HMO or PPO). The managed care plan pays for incurred costs.
60	*Medicare without supplement, Medicare, NOS*- Federal government funded insurance for persons who are 62 years of age and older, or are chronically disabled (SOCIAL SECURITY insurance eligible). Not described in codes 61, 62, or 63.
61	*Medicare with supplement, NOS* – Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare.
62	*Medicare-Administered through a Managed Care Plan*- Patient is enrolled in Medicare through a Managed Care plan (e.g. HMO or PPO). The Managed Care plan pays for all incurred costs.

Code	Definition
63	*Medicare with private supplement*- Patient has Medicare and private insurance to pay costs not covered by Medicare.
64	*Medicare with Medicaid eligibility*- Federal government Medicare with State Medicaid administered supplement.
65	*TRICARE*- Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents Formerly CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)
66	*Military*- Military personnel or their dependents who are treated at a military facility.
67	*Veterans Affairs*- Veterans who are treated in Veterans Affairs facilities.
68	*Indian/Public Health Service*- Patient who receives care at an Indian Health Service facility or another facility, and the costs are reimbursed by the Indian Health Service. Patient receives care at a Public Health Service facility or at another facility, and medical costs are reimbursed by the Public Health Service.
99	*Insurance Status Unknown*- It is unknown from the patient's medical record whether or not the patient is insured.

Text – Usual Occupation NAACCR Item #310

Record the patient's usual occupation, the kind of work performed during most of the patient's working life before diagnosis of this tumor.

This data item is used to identify new work-related health hazards, serves as an additional measure of socioeconomic status, and identifies occupational groups in which cancer screening or prevention activities may be beneficial.

Usual occupation is defined identically as on death certificates and conforms to the 1989 revision of the US Standard Certificate of Death.

Recording Text-Usual Occupation

1. **Do not record retired.**
2. If *usual* occupation is not available or is unknown, record the patient's current or most recent occupation or any known occupation.
3. Update this data item if better information is obtained as to the usual occupation of the patient. However, it is not the responsibility of facility abstractors to update abstracts with information provided on death certificates. Comparison with death certificate information is the function of the VCR.
4. If the patient was a housewife/househusband and also worked outside the home most of her/his adult life, record the usual occupation outside the home. If the patient was a housewife/ househusband and did not work outside the home for most of her/his adult life, record *housewife* or *househusband*.
5. If the patient is not a student or housewife and never worked, record *never worked* as the usual occupation.
6. If no information is available, record *unknown*.
7. This data item cannot be blank unless the patient is under 14 years old. It applies only to patients who are 14 years or older at the time of diagnosis. For patients under the age of 14, leave blank.
8. The patient's occupation may be found on the face sheet, nursing assessment, history and physical or consult reports in the medical record.

Text – Usual Industry NAACCR Item #320

Record the primary type of activity carried on by the business/industry where the patient was employed for the most number of years before diagnosis of this tumor.

Both occupation and business/industry are required to accurately describe an individual's occupation. These data items are used to identify new work-related health hazards, serve as an additional measure of socioeconomic status, and identify occupational groups in which cancer screening or prevention activities may be beneficial.

Usual industry (also known as "kind of business/industry") is defined identically as on death certificates and conforms to the 1989 revision of the US Standard Certificate of Death.

Recording Text-Usual Industry

1. Be sure to distinguish among *manufacturing*, *wholesale*, *retail*, and *service* components of an industry that performs more than one of these components.
2. If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient to record the name of the company (with city or town) for which the patient performed his/her usual occupation. In these situations, if resources permit, the VCR may be able to use the employer name and city/town to determine the type of activity conducted at that location.
3. If current or most recent occupation, rather than usual occupation was recorded, record the patient's current or most recent business/industry.
4. Update this data item if better information is obtained as to the usual industry of the patient. However, it is not the responsibility of facility abstractors to update abstracts with industry information provided on death certificates. Comparison with death certificate information is the function of the VCR.
5. There must be an entry for usual industry when any occupation is reported. If no information is available regarding the industry in which the reported occupation was carried out or the occupation is unknown, record *unknown*.
6. This data item cannot be blank unless the patient is under 14 years old. It applies only to patients who are 14 years or older at the time of diagnosis. For patients under the age of 14, leave blank.

Cancer Identification

Class of Case NAACCR Item #610

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 first course of treatment. Nonanalytic cases (codes 30 – 49 and 99) must be abstracted for submission to the VCR. Nonanalytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic. Use January 1, 1990 as the reference date. (See *VCR Manual Part One, Reference Date*)

Recording Class of Case

1. Code the Class of Case that most precisely describes the patient's relationship to the facility.
2. Code 00 applies only when it is known the patient went elsewhere for treatment. If it is not known that the patient actually went somewhere else, code Class of Case to 10.
3. It is possible that information for coding Class of Case will change during the patient's first course of care. If that occurs, change the code accordingly.
4. Use class of case 34 or 36 to report benign CNS tumors prior to 1995 and to report SIL's.
5. "In-transit" care is given to a patient who is temporarily away from the patient's usual practitioner for continuity of care. These cases do NOT have to be reported to the VCR.
6. If a patient presents to your ER and expires and the physician writes a diagnosis of cancer as the principle or secondary cause of death, code as active disease. This MUST be sent to the VCR.

CODES AND DEFINITIONS	
Analytic Classes of Case	
	Initial Diagnosis at Reporting Facility
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10	Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of 1st course treatment or a decision not to treat was at the reporting facility, NOS
11	Initial diagnosis in an office of a physician with admitting privileges AND part of 1st course treatment was done at the reporting facility
12	Initial diagnosis in an office of a physician AND part of the 1st course treatment or a decision not to treat was done at the reporting facility
13	Initial diagnosis at the reporting facility AND part of 1st course treatment was done at the reporting facility; part of 1st course treatment was done elsewhere
14	Initial diagnosis at the reporting facility AND all 1st course treatment or a decision not to treat was done at the reporting facility
	Initial Diagnosis Elsewhere
20	Initial diagnosis elsewhere AND all or part 1st course treatment was done at reporting facility, NOS
21	Initial diagnosis elsewhere AND part of 1st course treatment was done at the reporting facility; part of 1st course treatment was done elsewhere
22	Initial diagnosis elsewhere AND all 1st course treatment or decision not to treat was done at the reporting facility

Classes of Case **REQUIRED TO BE REPORTED BY VCR**	
	Patient appears in person at the reporting facility
30	Initial diagnosis and all 1st course treatment elsewhere AND reporting facility participated in diagnostic workup (for example: consult only, treatment plan only, staging workup after initial diagnosis elsewhere)
31	NOT reportable
32	Diagnosis AND all 1st course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease)
33	Diagnosis AND all 1st course treatment provided elsewhere AND patient presents at reporting facility with disease history only
34	Type of case required by VCR to be accessioned (for example: squamous intraepithelial lesions – SIL) AND initial diagnosis AND part or all of 1st course treatment by reporting facility
35	Case diagnosed before program's reference date but after VCR reference date of January 1, 1995 AND all or part of 1st course treatment by reporting facility
36	Type of case required by VCR to be accessioned (for example: high grade intraepithelial neoplasia) AND initial diagnosis elsewhere AND all or part of 1st course treatment at reporting facility
37	Case diagnosed before program's reference date but after VCR reference date of January 1, 1995 AND all or part of 1st course treatment by facility
38	Initial diagnosis established at autopsy at the reporting facility, cancer NOT suspected prior to death
	Patient does not appear in person at reporting facility
40	Diagnosis AND all 1st course treatment given at the same staff physician's office
41	Diagnosis and all 1st course treatment given in 2 or more different offices of physicians with admitting privileges
42	Non-staff physician or non-CoC accredited clinic or facility, not part of reporting facility, accession by reporting facility for diagnosis and/or treatment by that entity (for example: hospital abstracts cases from an independent radiation facility)
43	Pathology or other lab specimens only
49	Death certificate only
99	Nonanalytic case of unknown relationship to facility

Examples: Patients from an unaffiliated, free-standing clinic across the street that hospital voluntarily abstracts with its cases because many physicians work at the clinic and the hospital, code to 42.

After treatment failure, patient was admitted to your facility for supportive care, code to 32.

Patient is diagnosed with a high grade dysplasia of the colon in your facility; code to 34.

Casefinding Source NAACCR Item #501

Record 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 by which the tumor was first identified. This data item cannot be used by itself as a data quality indicator. The timing of the casefinding processes (e.g., death linkage) varies from registry to registry, and the coded value of this variable is a function of that timing.

This data item will help facilities in prioritizing their casefinding activities. It provides more detail than "Type of Reporting Source."

Case 1st identified at reporting facility:	
CODE	DEFINITION
10	Reporting hospital, NOS
20	Pathology department review (surgical pathology reports, autopsies, or cytology reports)
21	Daily discharge review
22	Disease index review (review of report from 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, code 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 1st identified by source other than a reporting facility covered in codes 10 – 29	
30	Physician-initiated case
50	Independent (non-hospital) pathology/laboratory report
60	Nursing home initiated case
75	Managed care or insurance records
85	Out of state case sharing
90	Other non-reporting hospital source
95	Quality Control review (case initially identified by QC activities such as casefinding, audit of central registry. NOTE: this includes cases reported as a result of reconciliation and quality assessment audits
99	Unknown

Recording Casefinding Source

1. Record the source where the tumor was first identified during routine casefinding procedures using the codes under 'Case first identified at a reporting facility'. Code the earliest source (based on patient or specimen contact at the facility) of identifying information.

   Example: A reportable case is identified while reviewing path reports during routine casefinding. Code *Casefinding Source* to 20 Pathology Department Review.

2. If the tumor was first identified by a source other than the reporting facility, select the most appropriate code to identify the source from the list of codes under 'Case 1st identified by source other than a reporting facility covered' in the Codes above. One specific use of these codes will be to indicate previous unreported tumors identified as a result of QC procedures by the VCR (e.g. reconciliation, audit, death clearance).

   Example: During VCR reconciliation, a tumor on the list of cases to be reconciled is determined to be reportable. The facility abstracts the case & enters code 95.

Type of Reporting Source NAACCR Item #500

This data item is intended to indicate the source of documents available to the abstractor. Record the code identifying the source documents used to abstract the majority of information on the condition being reported. This may be different than the source used for the original casefinding.

Code	Definition
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
5	Nursing/convalescent home/hospice
6	Autopsy
7	Death certificate only **(VCR use only)**
8	Other hospital outpatient units/surgery centers (independent)

Recording Type of Reporting Source

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 to 2 usually have complete information on the cancer diagnosis, staging, and treatment.

Sources coded to 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.

Example: The patient was first found through your pathology department as a private outpatient specimen (Code 3). The patient was admitted as an inpatient to your hospital a month later for surgery. The inpatient record is used for abstracting (Code 1). Code this data item to ***1***.

Date of First Contact NAACCR Item #580

Record the 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.

When pathology-specimen-only tumors are collected (Class of Case 43, Type of Reporting Source 3), the date of specimen collection form 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, the hospital should change the Date of 1st Contact to reflect the date the patient first registered at the facility. VCR will retain the earliest date in the consolidated file.

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.

Beginning in 2010, the way dates are transmitted between facility registries and central registries was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. Interoperable dates are displayed in CCYYMMDD form, *with the unknown portions of the date filled with blank spaces*. If a *date is entirely blank, an associated date flag is used* to explain the missing date. Flags are not used for software-generated dates.
For more information regarding dates, please see *Virginia Cancer Registry Manual, Part Three: Data Item Instructions, General Information, Coding Dates*

Date of First Contact Flag NAACCR Item #581

This flag explains why there is no appropriate value in the field *Date of First Contact*. As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes and Definitions

Code	Description
12	A proper value is applicable but is not known. (*Date of 1st Contact* is not known)
(blank)	A valid date value is provided in the item *Date of First Contact*

Recording Date of First Contact Flag

1. Leave this item blank if *Date of 1st Contact* has a full or partial date recorded.
2. Code 12 if *Date of 1st Contact* cannot be determined at all.

Date of Initial Diagnosis NAACCR Item #390

Record the date a physician diagnosed the tumor being reported. Beginning in 2010, the way dates are transmitted between facility registries and central registries was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. Interoperable dates are displayed in CCYYMMDD form, *with the unknown portions of the date filled with blank spaces*. If a *date is entirely blank, an associated date flag is used* to explain the missing date. Flags are not used for software-generated dates.

For more information regarding dates, please see *Virginia Cancer Registry Manual, Part Three: Data Item Instructions, General Information, Coding Dates*

Recording Date of 1st Contact

1. Use the first date of diagnosis whether clinically or histologically established.

   Example 1: The patient was diagnosed with cystic pancreatic endocrine neoplasm (CPEN) August 24, 2016. The patient presents to the reporting institution for treatment of the CPEN on November 5, 2001. This case would be reportable with a Date of Diagnosis of 20160824.

   Example 2: The patient has a history of breast cancer diagnosed September 10, 2014. The patient now presents to the reporting institution with metastasis from the breast. This case would be reportable with a Date of Diagnosis of 20140910.

   Example 3: A March 12, 2016 mammogram reveals a mass in the upper-outer quadrant of a patient's right breast compatible with carcinoma. On March 20, 2016, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma. Date of Diagnosis is 20160312.

   Example 4: A physician notes a prostate nodule possible for cancer during a May 12, 2016 physical exam. On June 15, 2016 a needle biopsy of the prostate histologically confirms adenocarcinoma. Date of Diagnosis is 20160615 because "possible for cancer" does not constitute a reportable diagnosis.

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

   Example 1: A patient has a total abdominal hysterectomy for endometriosis in January 2014. The patient is admitted to the hospital with abdominal pain in November 2016. An omental biopsy shows metastatic cystadenocarcinoma. Pathologists review the 2010 histology specimen. They identify and area of cystadenocarcinoma in the left ovary. Date of diagnosis is 201401--.

3. Refer to the list of "Ambiguous Terms" Part One: General Information and Reporting Requirements for language that represents a diagnosis of cancer

4. Use the date treatment was started as the date of diagnosis if the patient receives a first course of treatment before a diagnosis is documented.

5. Use the actual date of diagnosis for and *in utero* diagnosis for cases diagnosed on January 1, 2009 or later.

6. If the year of diagnosis cannot be identified, it must be approximated. Record what is known and enter approximation for month and/or year if descriptions are available or blank for what is unknown. Approximation of day is acceptable. Refer to *VCR Manual, Part Three: Data Item Instructions, General Information, Dates* for instructions regarding Approximating Dates and Unknown Dates. Fictitious dates or default values are not acceptable to be entered for month, day, or year.

   Note for hospitals: When a patient is diagnosed elsewhere prior to entering the reporting facility and the Date of Diagnosis is unknown, the cases must be reported to the VCR with an unknown Date of Diagnosis (blank).

   Example 1: The patient has a history of breast cancer. The patient presents to the reporting facility July 5, 2016 and receives Tamoxifen for breast cancer. The original Date of Diagnosis is unknown. The correct Date of Diagnosis is blank.

   Example 2: Patient receives palliative treatment for breast cancer diagnosed in June 2016. The correct Date of Diagnosis is 201606-- (where "-" equals a blank space). Do not record 20070615 where 15 is a default value for day.

   Example 3: Documentation in the patient's record from a June 2016 admission indicates the patient was diagnosed 'last year'. The correct Date of Diagnosis is 2015bbbb. Do not record 20150101 where 0101 are default values for month and day.

   Example 4: Patient is admitted on January 15, 2016 with severe flank pain with history of lung cancer diagnosed five years ago. The correct Date of Diagnosis is 2011bbbb. Do not record unknown when descriptive information can be used to approximate the year.

7. If a patient is diagnosed with a non-reportable condition that later transforms into a reportable condition, record the date the patient was diagnosed with the reportable condition.

   Example: The patient was diagnosed with myelodysplastic syndrome on May 1, 2000 (not reportable until 2001) and it transforms into acute myelogenous leukemia on June 15, 2012. Abstract as acute myelogenous leukemia with a Date of Diagnosis of 20120615.

8. The date of death is the Date of Diagnosis for a case diagnosed at autopsy.

Date of Diagnosis Flag NAACCR Item #391

This flag explains why there is no appropriate value in the field *Date of Diagnosis*. As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes and Definitions

Code	Description
12	A proper value is applicable but is not known. (for example, diagnosis was confirmed in a note, but the actual date is unknown).
(blank)	A valid date value is provided in the item *Date of Diagnosis*

Recording Date of Diagnosis Flag

3. Leave this item blank if *Date of Diagnosis* has a full or partial date recorded.

4. Code 12 if *Date of Diagnosis* cannot be determined, but the patient does have a diagnosis of cancer

Primary Site NAACCR Item #400

This data item records the topography code for the primary site of the cancer/tumor condition being reported using ICD-O-3 or ICD-O-2 (*International Classification of Diseases for Oncology, Third or Second Edition* published by the World Health Organization).

1. Cases Diagnosed on or after January 1, 2001 - Code according to ICD-O-3.
2. Cases Diagnosed prior to January 1, 2001 - Code according to ICD-O-2.
3. Cases with Unknown *Date of Diagnosis*- If the *Date of Diagnosis* is unknown and cannot be estimated, the *Date of 1st Contact* should be used to determine the correct coding manual to use. Code according to ICD-O- 3 when the *Date of 1st Contact* is on or after January 1, 2001. Code according to ICD-O-2 when the *Date of 1st Contact* is prior to January 1, 2001. Newly reportable conditions for 2001 and 2004 are not reportable when Date of Diagnosis is unknown.

Recording Primary Site

1. Record the IDC-O-3 topography for the site of origin.
2. Consult the physician to identify the primary site or the most definitive site code if the medical record does not contain that information.
3. Topography codes are indicated by a "C" preceding the three-digit code number. Do not record the decimal point.
4. Follow the instruction in *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic and Lymphoid Neoplasms Database (Hematopoietic DB) for assigning site for lymphomas, leukemias and other hematopoietic neoplasms.
5. Lymphomas may arise in lymph nodes, lymphatic tissue such as tonsils, spleen, Waldeyers ring, or thymus, or in extranodal sites. Distinguishing between nodal and extranodal origin is important because extranodal lymphomas have a better prognosis. Do NOT record the biopsy site as the primary site unless it has been confirmed as the primary site. Do not record a metastatic site as the primary site.
    a. The primary site for a lymphoma involving multiple lymph node regions should list the nodal regions involved in the *Text-Primary Site Title* field and coded to C77.8
6. Use subcategory 8 for single tumors that overlap the boundaries of two or more sub-sites and the point of origin is unknown.

    Example 1: Overlapping lesion of oropharynx. Code overlapping lesion when a large tumor involves both the lateral wall of the oropharynx (C10.2) and the posterior wall of the oropharynx (C10.3) and the point of origin is not stated.

    Example 2: Overlapping lesion of the bladder. Code overlapping lesion of the bladder when a single lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated
7. Use subcategory 9 for multiple tumors that originate in different subsites of one organ.

    Example 1: Colon, NOS. Code familial polyposis with carcinoma throughout the transverse colon (C18.4) and descending colon (C18.6) would be one primary and coded to colon, NOS (C18.9)

8. If the patient is diagnosed with metastatic melanoma and the primary site is not identified, the primary site is *skin, NOS* (C44.9).
9. The primary site for Kaposi Sarcoma is the site in which it arises. The primary site is *skin, NOS* (C44.9) if the Kaposi Sarcoma arises simultaneously in the skin and another site and the primary site is not identified.
10. The primary site for Waldenstrom Macroglobulinemia is *blood* (C42.0).
11. If the primary site is not known, use the following guidelines and the guidelines listed above to assign a primary site. Do NOT record a metastatic site as the primary.
    a. Osteosarcoma is recorded as *bone, NOS* (C41.9)
    b. Sarcoma is recorded as *soft tissue, NOS* (C49.9)

Text

Text to support this data item must be recorded in the specific text field. See *VCR Manual Part Three, Data Item Instructions, Text-Primary Site Title.* This text field is used by the VCR to validate ICD-O topography and laterality codes reported.

Laterality NAACCR Item #410

This identifies the side of a paired organ or the side of the body on which the reportable tumor originated. This applies to the primary site only. Laterality supplements staging and extent of disease information and defines the number of primaries involved.

NOTE: *Although FORDS allows you to code laterality for a non-paired organ ("Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites 0"), the VCR will **NOT** accept non-paired organ laterality.*

Code	Definition
0	Not a paired organ
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 lateral origin unknown; midline tumor

Recording Laterality

1. Code laterality for all paired sites (see *Part Three: Data Item Instructions; General Instructions – Laterality)*
2. Do not code metastatic sites as bilateral involvement
3. If both lungs have nodules or tumors and the lung of origin is not known, assign code 4.
4. Where the right and left sides of paired site are contiguous (come into contact) and the lesion is at the point of contact of the right and left sides, use code 5, midline. Note that "midline of the right breast is coded 1, right; midline in this usage indicates the primary site is C50.8 (overlapping sites).]
5. Code non-paired site 0

Text

Text to support this data item must be recorded in the specific text field. See *VCR Manual Part Three, Data Item Instructions, Text-Primary Site Title.*

Histology NAACCR Item #522

This data item records the code for histologic type of the cancer/tumor being reported using ICD-O-3 or ICD-O-2 (*International Classification of Diseases for Oncology, Third* or *Second Edition* published by the World Health Organization). Histology is a basis for staging and the determination of treatment options. It also affects the prognosis and course of the disease.

1. Cases Diagnosed on or after January 1, 2001- Code according to ICD-O-3.
2. Cases Diagnosed prior to January 1, 2001- Code according to ICD-O-2.
3. If the *Date of Diagnosis* is unknown and cannot be estimated, the *Date of 1st Contact* should be used to determine the correct coding manual to use.

Coding Histology

1. ICD-O-3 identifies the morphology codes with an "M" preceding the code number. Do not record the "M"
2. Record histology using the ICD-O-3 codes in the numeric Lists/Morphology section (ICD-O-3, pp 69 – 104) and in the Alphabetic Index (ICD-O-3, pp 105 – 218)
3. Follow the coding rules outlined on pages 20 through 40 of ICD-O-3
4. Use the current *Multiple Primary and Histology Coding Rules* when coding the histology for all reportable solid tumors. These rules are effective for cases diagnosed January 1, 2007 and later. Do not use these rules to abstract cases diagnosed prior to January 1, 2007

   Example 1: Final pathologic diagnosis is non-small cell carcinoma, most likely adenocarcinoma. The phrase *most likely adenocarcinoma* is an important component of the complete histologic diagnosis and impacts the proper ICD-O code assignment. This should be coded to adenocarcinoma (8140)

   Example 2: Final pathologic diagnosis is adenocarcinoma of the lung vs. mesothelioma. The diagnosis on the discharge summary was mesothelioma. The complete histologic diagnosis is *mesothelioma,* code 9050
5. Review all pathology reports
6. Code the **final** pathologic diagnosis for solid tumors
   a. At times, the final diagnosis is *Not Otherwise Specified* (carcinoma, NOS; melanoma, NOS; sarcoma, NOS; lymphoma, NOS; or malignant tumor, NOS). Use the histology form the addenda or comment if it identifies a more specific histologic type such as adenocarcinoma, amelanotic melanoma or spindle cell sarcoma.

      Example: Final pathologic diagnosis is *ductal carcinoma, NOS* of the breast. Comment states the histology is *ductal carcinoma, mucinous type*; code as 8523.
7. For lymphomas, leukemias and other hematopoietic tumors, follow the instructions in *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic and Lymphoid Neoplasms Database (hematopoietic DB)
8. The codes for cancer, NOS (8000) and carcinoma, NOS (8010) are **NOT** interchangeable. If the physician says that the patient has carcinoma, then code it as carcinoma, NOS (8010)

9. In the absence of pathologic confirmation, use a physician statement to assign a histology code. Cancer, NOS and carcinoma, NOS are not interchangeable. If the physician states the patient has carcinoma, code to 8010/3, Carcinoma, NOS. If the statement is that the patient has cancer, record the histology as 8000/3, Cancer, NOS.

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-DX Proc-Path* and *Text-Histology Title.* These text fields are used by the VCR to validate ICD-O histology codes reported.

Behavior Code NAACCR Item #523

This data item records the behavior of the tumor being reported. The fifth digit of the morphology code is the behavior code. This is used by pathologists to describe whether the tissue samples are benign (0), borderline (1), in situ (2), or invasive (3).

The ICD-O-3 behavior code for juvenile astrocytoma (9421/1) is coded as 3 by agreement of North American registry standard-setters. Gastrointestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, they must be abstracted and assigned a behavior code of 3 if they are noted to have multiple foci, metastasis or positive lymph nodes.

Coding Behavior

1. The VCR requires the reporting of /2 (in situ) and /3 (malignant) tumors.
2. If the only specimen is from a metastatic site, the behavior is malignant.
3. Primary intracranial and central nervous system tumors with a behavior code of **/**0 or /1 (benign and borderline or "non-malignant") are reportable regardless of histologic type for the sites listed below:
   - Meninges (C70.0 - C70.9)
   - Brain (C71.0 - C71.9)
   - Spinal Cord (C72.0)
   - Cauda equina (C72.1)
   - Cranial nerves (C72.2 - C72.5)
   - Other CNS (C72.8, C72.9)
   - Pituitary gland (C75.1)
   - Craniopharyngeal duct (C75.2)
   - Pineal gland (C75.3)
4. The following terms are synonymous with in situ (behavior code 2):
   - Adenocarcinoma in an adenomatous polyp with no invasion of stalk
   - Bowen's disease
   - Clark's level 1 for melanoma (limited to epithelium)
   - Comedocarcinoma, noninfiltrating
   - Confined to epithelium
   - Hutchinson's melanotic freckle, NOS
   - Intracystic, noninfiltrating
   - Intraductal
   - Intraepidermal, NOS
   - Intraepithelial, NOS
   - Involvement up to but not including the basement membrane
   - Lentigo maligna
   - Lobular neoplasia, grade III (LN3)
   - Lobular, noninfiltrating
   - Noninfiltrating
   - Noninvasive
   - No stromal involvement
   - Papillary, noninfiltrating or intraductal
   - Precancerous melanosis
   - Pre-invasive
   - Queyrat's erythroplasia
   - Stage 0
   - Vaginal epithelial neoplasia, grade 3 (VAIN III)
   - Vulvar epithelial neoplasia, grade 3 (VIN III)
5. Record behavior as /3 (malignant) if any invasion is present, no matter how limited.

   Example: The pathology report reads *intraductal carcinoma* (8500/2) *with focal areas of invasion.* The phrase *with focal areas of invasion* is an important component in determining behavior and impacts the proper ICD-O code assignment. The histologic type must include the invasive component, *intraductal carcinoma with focal areas of invasion* (8500/3).

6. If your facility considers the terminology of severe dysplasia or high grade dysplasia of the colon as synonymous with carcinoma in-situ, use the following guidelines for reporting colon cases to the VCR:

    a. Obtain a statement from your pathologists that outlines the terminology policy of their department.

    b. Submit the statement to the appropriate medical staff committee for approval. Registry hospitals would normally submit the statement to the Cancer Committee.

    c. Document a policy that states colon sites diagnosed with severe dysplasia and/or high grade dysplasia will be abstracted as carcinoma in-situ.

    d. Add the policy to your Policy and Procedure Manual attaching the approved statement from your pathologists.

    e. Forward a copy of the policy and statement to the VCR to keep on permanent file.

    f. Abstract all colon cases diagnosed with severe dysplasia and/or high grade dysplasia as carcinoma in-situ. In the text for each case, document the final pathologic diagnosis along with the statement "in-situ per pathologist".

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-DX Proc-Path* and *Text-Histology Title.* For registry hospitals, these text fields are used by the VCR to validate ICD-O behavior codes reported.

Grade/Differentiation NAACCR Item #440

This data item describes the tumor's resemblance to normal tissue. Well differentiated (Grade 1) is the most like normal tissue, and undifferentiated (Grade 4) is the least like normal tissue. Grades 5 – 8 define particular cell lines for lymphoma and leukemias. It is useful in prognosis.

Grade/differentiation records the code for grade or differentiation of the cancer/tumor being reported using ICD-O-3 or ICD-O-2 (*International Classification of Diseases for Oncology, Third* or *Second Edition* published by the World Health Organization).

Codes and Definitions

Code	Definition
1	*Grade I* - Well differentiated, differentiated NOS
2	*Grade II* - Moderately differentiated, moderately well differentiated, Intermediate differentiation
3	*Grade III* - Poorly differentiated, dedifferentiated
4	*Grade IV* - Undifferentiated, anaplastic
5	*T Cell* - For lymphomas and leukemias only, T cell, T precursor
6	*B Cell* - For lymphomas and leukemias only, B cell, Pre B, B precursor
7	*Null Cell* - For lymphomas and leukemias only, null cell, non T, non B
8	*N K Cell* - For lymphomas and leukemias only, Natural killer cell
9	*Grade Unknown* - Grade/cell type not determined, not stated, not applicable

Assigning Grade/Differentiation

See Virginia Cancer Registry Manual, *Part Three: Data Item Instructions, General Instructions – Morphology: Grade, pg 33*

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-DX Proc-Path* and *Text-Histology Title.* These text fields are used by the VCR to validate ICD-O grade codes reported; for non-registry hospitals, these text fields are used to assign the ICD-O grade codes.

Lymph-Vascular Invasion NAACCR Item #1182

This data item indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist. Lymph-vascular invasion is an indicator of prognosis.

Lymph-vascular invasion is defined as the presence of tumor cells found inside small blood vessels or lymphatic channels within the tumor and surrounding tissues in the primary site. The tumor cells have broken free of the primary tumor and now have the capability to float throughout the body. Other names for lymph-vascular invasion are LVI, lymphovascular invasion, vascular invasion, blood vessel invasion, and lymphatic invasion. Vascular invasion is not the same as direct tumor extension from the primary tumor into adjacent blood vessels; LVI cells are not attached to or growing into the wall of the blood vessel. Lymphatic invasion is not the same as involvement of regional lymph nodes. Lymph-vascular invasion does not include perineural invasion.

Codes and Descriptions

Code	Description
0	Lymph-vascular invasion not present (absent)/Not identified
1	Lymph-vascular invasion present/Identified
8	Not applicable
9	Unknown if lymph-vascular

Recording Lymph-Vascular Invasion

1. Code the absence or presence of lymph-vascular invasion as described in the pathology report.
    a. The primary sources of information about lymph-vascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from the pathology report or a physician's statement, in that order.
    b. Do not code perineural invasion in this field.
    c. Information to code this field can be taken from any specimen from the primary tumor.
    d. If lymph-vascular invasion is identified anywhere in the resected specimen, it should be coded as present/identified.
    e. For cases with benign or borderline behavior, code the lymph-vascular invasion documented (negative or positive) and, if not documented, code unknown.
    f. For cases treated with neoadjuvant therapy refer to table below in order to code this field. However, if documentation in the medical record indicated information that conflicts with this table, code lymph-vascular invasion with the documentation in the medical record.
2. Use code 0 when the pathology report indicates that there is no lymph-vascular invasion.
3. Use code 1 when the pathology report or a physician's statement indicates that lymph-vascular invasion (or one of its synonyms) is present in the specimen.

4. Use code 8 for cases that have no microscopic examination of a primary specimen and for the following primary sites:
   a. Hodgkin and Non-Hodgkin lymphoma
   b. Leukemias
   c. Hematopoietic and reticuloendothelial disorders
   d. Myelodysplastic syndromes including refractory anemias and refractory cytopenias
   e. Myeloproliferative disorders
5. Use code 9 when it is not possible to determine whether lymph-vascular invasion is present

Diagnostic Confirmation NAACCR Item #490

Record the diagnostic confirmation that specifies whether a diagnosis was confirmed microscopically at any time during the disease course.

Codes and Definitions - solid tumors

Code	Label	Definition
1	*Positive histology*	Histologic confirmation (tissue microscopically examined)
2	*Positive cytology*	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined)
4	*Positive microscopic confirmation, method not specified*	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology
5	*Positive laboratory test/marker study.*	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. Examples include alpha-fetoprotein for liver primaries. Elevated PSA is not diagnostic of cancer; however, if the physician uses the PSA as a basis for diagnosis prostate cancer with no other workup, record as 5
6	*Direct visualization without microscopic confirmation*.	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination
7	*Radiography and other imaging techniques without microscopic confirmation*.	The malignancy was reported by the physician form an imaging technique report only
8	*Clinical diagnosis only, other than 5, 6, or 7*	The malignancy was reported by the physician in the medical record
9	*Unknown whether or not microscopically confirmed*	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed

Recording Diagnostic Confirmation – Solid Tumors

1. This is an hierarchical coding scheme with code 1 taking precedence. A lower number take priority over all higher numbers
2. This data item is dynamic and must be changed to the lower code if a more definitive method confirms the diagnosis at any time during the course of the disease. See *VCR Manual Part One, Changing Information* on how to submit a change

   Example: A patient is admitted on 11/28/2014. A chest x-ray dated 12/1/2014 diagnoses a probable lung cancer. The patient refuses a diagnostic workup. The registry codes the diagnostic confirmation to radiography (7). The patient consents to a lymph node biopsy on 2/3/2015. The biopsy confirms small cell carcinoma. Change the diagnostic confirmation code to positive histology (1). Send change to VCR.

3. Assign **code 1** when the microscopic diagnosis is based on:

a. Tissue specimens from biopsy, frozen section, surgery, autopsy or D&C

b. Bone marrow specimens (aspiration and biopsy)

c. For leukemia only, positive hematologic findings including peripheral blood smears, CBCs and WBCs

4. Assign **code 2** when the microscopic diagnosis is based on:

   a. Examination of cells (rather than tissue) including but not limited to: sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears.

   b. Paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid

5. Assign **code 4** when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.

6. Assign **code 5** when the diagnosis of cancer is based on laboratory tests or marker studies that are clinically diagnostic for that specific cancer.

   Example 1: The presence of alpha-fetoprotein for liver cancer

   Example 2: An abnormal electrophoretic spike for multiple myeloma or Waldenstrom macroglobulinemia.

   Example 3: If the workup for a prostate cancer patient is limited to a highly elevated PSA and the physician diagnoses and/or treats the patient based only on that PSA, code the diagnostic confirmation to 5.

7. Assign **code 6** when the diagnosis is based only on:

   a. The surgeon's operative report from a surgical exploration or endoscopy such as colonoscopy, mediastinoscopy, or peritoneoscopy and no tissue was examined.

   b. Gross autopsy findings (no tissue or cytologic confirmation).

8. Assign **code 7** when the only confirmation of malignancy was diagnostic imaging such as computerized axial tomography (CT scans), magnetic resonance imaging (MRI scans), or ultrasounds/ sonography.

9. Assign **code 8** when the case was diagnosed by any clinical method not mentioned in preceding codes. The diagnostic confirmation is coded 8 when the only confirmation of disease is a physician's clinical diagnosis.

10. Assign **code 9** if it is unknown if the diagnosis was confirmed microscopically and for Death certificate only cases.

Codes and Definitions – Hematopoietic and Lymphoid Neoplasms

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined)
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined)
3	Positive histology PLUS Positive immunophenotyping AND/OR Positive genetic studies	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results. For example, bone marrow examination is positive for acute myeloid leukemia (9861/3). Genetic testing shows AML with inv(16)(p13.1q22) (9871/3)
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory test/marker studies which are clinically diagnostic for cancer
6	Direct visualization without microscopic confirmation	The tumor was visualiz3ed during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only
8	Clinical diagnosis only, other than 5, 6, or 7	The malignancy was reported by the physician in the medical record
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed

Recording Diagnostic Confirmation – Hematopoietic and Lymphoid Neoplasms

1. There is not priority hierarchy for coding *Diagnostic Confirmation* for hematopoietic an lymphoid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing. See the *Hematopoietic Database (DB)* for information of the definitive diagnostic confirmation for specific types of tumors.
2. Assign Code **1** when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, or autopsy or bone marrow specimens from aspiration or biopsy.
    a. *For leukemia only*, code **1** when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear. Do not use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow, or blood.
3. Assign code **2** when the microscopic diagnosis is based on cytologic examination of *cells* (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.
4. Assign code **3** when there is a histology positive for cancer AND positive immunophenotyping and/or positive genetic testing results. Do not use code 3 for neoplasms diagnosed prior to January 1, 2010.
5. Assign code **5** when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer, but no positive histologic confirmation.

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

7. Assign code **8** when the case was diagnosed by any clinical method that cannot be coded as 6 or 7. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-DX Proc-Path.* For registry hospitals, these text fields are used by the VCR to validate ICD-O grade codes reported; for non-registry hospitals, these text fields are used to assign the ICD-O grade codes.

Regional Nodes Positive NAACCR Item #820

Record the exact number of regional lymph nodes examined by the pathologist and found to contain metastasis. 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 for the patient.

Codes and Definitions – Regional Nodes Positive

Code	Description
00	All nodes examined negative
01 - 89	1 to 89 nodes positive (code exact number of nodes positive)
90	90 or more nodes positive
95	Positive aspiration or core biopsy of lymph node(s). *See Rule 8.*
97	Positive nodes - number unspecified. *See Rule 9*.
98	No nodes examined. *See Rule 10.*
99	Unknown whether nodes are positive; not applicable; not documented in patient record.

Recording Regional Nodes Positive

1. **Regional lymph nodes only.** Record information about only regional lymph nodes in this field.

2. This field is based on *pathologic* information only. This field is to be recorded regardless of whether the patient received preoperative treatment.

3. True in situ cases cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined). Codes 01-97 and 99 are not allowed.

4. **Cumulative nodes positive.** Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.

   a. The number of regional lymph nodes positive is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.

   b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection. In other words, if there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also Use of Code 95 below.

      ***Example*:** Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. *Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.*

      ***Example*:** Positive right cervical lymph node aspiration followed by right cervical lymph node dissection showing 1 of 6 nodes positive. *Code Regional Nodes Positive as 01 and Regional Nodes Examined as 06.*

   c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Positive.

***Example*:** Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. *Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.*

d. If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Positive.

***Example*:** Patient record states that core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. *Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.*

5. **Priority of lymph node counts.** If there is a discrepancy regarding the number of positive lymph nodes, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.

6. **Positive Nodes in Multiple Primaries in Same Organ**. If there are multiple primary cancers with different histologic types in the same organ and the pathology report just states the number of nodes positive, the registrar should first try to determine the histology of the metastases in the nodes and code the nodes as positive for the primary with that histology. If no further information is available, code the nodes as positive for all primaries.

Example: A breast cancer has two separate primaries as determined by the SEER multiple primary rules. the pathology report states "3 of 11 lymph nodes positive for metastasis" with no further information available. *Code Regional Nodes Positive as 03 and Regional Nodes Examined as 11 for both primaries.*

7. **Isolated tumor cells (ITCs) in lymph nodes.** For all primary sites except cutaneous melanoma and Merkel cell carcinoma of skin, count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size). Do not include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs). If the path report indicates that nodes are positive but the size of metastasis is not stated, assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive.

a. **For cutaneous melanoma and Merkel cell carcinoma,** count nodes with ITCs as positive lymph nodes.

8. **Use of Code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

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

***Example*:** Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. *Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.*

b. Use code 95 when a positive lymph node is aspirated and surgically resected lymph nodes are negative.

***Example*:** Lung cancer patient has aspiration of suspicious hilar mass, which shows metastatic squamous carcinoma in lymph node tissue. Patient undergoes preoperative radiation therapy followed by lobectomy showing 6 negative hilar lymph nodes. *Code Regional Nodes Positive as 95 and Regional Nodes Examined as the 06 nodes surgically resected. (Code Lymph Nodes Eval as 5.)*

9. **Definition of Code 97.** Use code 97 for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.

***Example*:** Patient with carcinoma of the pyriform sinus has a mass in the mid neck. Fine needle aspiration (FNA) of one node is positive. The patient has neoadjuvant chemotherapy, then resection of the primary tumor and a radical neck dissection. In the radical neck dissection "several" of 10 nodes are positive; the remainder of the nodes show chemotherapy effect. *Code Regional Nodes Positive as 97 because the total number of positive nodes biopsied and removed is unknown, and code Regional Nodes Examined as 10.*

Note: For primary sites where the number of involved nodes must be known in order to map to N1, N2, etc., code 97 maps to N1 and therefore should be avoided.

Note: If the aspirated node is the only one that is microscopically positive, use code 95.

Note: Avoid using Regional Nodes Positive code 97 if possible, even if this means slightly undercounting the number of nodes positive.

10. **Use of Code 98.** Code 98 may be used in several situations.

a. When the assessment of lymph nodes is clinical only.

b. When no lymph nodes are removed and examined.

c. When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.

d. If Regional Nodes Positive is coded as 98, Regional Nodes Examined is usually coded 00.

11. **Use of code 99**. Use code 99 if it is unknown whether regional lymph nodes are positive.

12. **Primary sites always coded 99**. For the following primary sites and histologies, the Regional Nodes Positive field is always coded as 99:

    Placenta
    Brain and Cerebral Meninges
    Other Parts of Central Nervous System
    Intracranial Gland
    Hodgkin and non-Hodgkin Lymphoma
    Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
    Myeloma and PlasmaCell Disorders
    Other and Ill-Defined Primary Sites
    Unknown Primary Site

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-Path.*

Regional Nodes Examined NAACCR Item #830

This field records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with cases diagnosed on or after January 1, 2004, this item became a component of the Collaborative Staging System (CS). In 2016, use of CS was discontinued; however, this data item continued to be required.

Codes and Description – Regional Nodes Examined

Code	Description
00	No nodes examined
01 - 89	1 to 89 nodes examined (code exact number of nodes examined)
90	90 or more nodes positive
95	No regional nodes removed, but aspiration or core biopsy of regional nodes performed *See Rule 8.*
96	Regional lymph node removal documented as a sampling, and the number of nodes unknown/not stated. *See Rule 7 and Rule 8.*
97	Regional lymph node removal documented as dissection, and the number of nodes unknown/not stated. *See Rule 9 and Rule 10.*
98	Regional lymph nodes surgically removed, but number of lymph nodes unknown/not stated and not documented as sampling or dissection; nodes examined, but the number unknown. *See Rule 4e.*
99	Unknown whether nodes were examined; not applicable; not documented in patient record.

Recording Regional Nodes Examined

1. Record information about only regional lymph nodes in this field.
2. This field is **based on pathologic information only**. This field is to be recorded regardless of whether the patient received preoperative treatment.
3. Code 00 may be used in several situations, as noted below:
   a. When the assessment of lymph nodes is clinical.
   b. When no lymph nodes are removed and examined.
   c. When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
   d. If Regional Nodes Examined is coded 00, Regional Nodes Positive is coded as 98.
4. Record the total number of regional lymph nodes removed and examined by the pathologist.
   a. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment with the exception of aspiration or core biopsies coded to 95.
   b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Examined.

      ***Example*:** Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. *Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.*

c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Examined.

***Example*:** Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. *Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.*

d. If the location of the lymph node that is aspirated or core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Examined.

***Example*:** Patient record states that core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. *Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.*

e. When neither the type of lymph node removal procedure nor the number of lymph nodes examined is known, use code 98.

5. **Priority of lymph node counts.** If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.

6. **Use of code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. *Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.*

7. **Lymph node biopsy.** If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, use code 96.

8. **Definition of "sampling" (code 96).** A lymph node "sampling" is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.

9. **Definition of "dissection" (code 97).** A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed and the number is unknown.

10. **Multiple lymph node procedures.** If both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown, use code 97.

11. **Use of Code 99.** If it is unknown whether nodes were removed or examined, code as 99.

12. **Primary sites always coded 99.** For the following schemas, the Regional Nodes Examined field is always coded as 99:
    - Placenta
    - Brain and Cerebral Meninges
    - Other Parts of Central Nervous System
    - Intracranial Gland
    - Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
    - Hodgkin and non-Hodgkin Lymphoma
    - Myeloma and Plasma Cell Disorders
    - Other and Ill-Defined Primary Sites
    - Unknown Primary Site

Stage of Disease at Diagnosis

Tumor Size Summary NAACCR Item #756

This data item records the most accurate measurement of a solid primary tumor, usually measured in the surgical resection specimen. Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Codes and Descriptions

Code	Description
000	No mass/tumor found
001	1mm or described as less than 1mm
002 – 988	Exact size in millimeters (2mm to 988mm)
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
998	SITE-SPECIFIC CODES: Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: Rectosigmoid and rectum (C19.9 and C20.9) If no size is documented: Circumferential: Esophagus (C15.0 – C15.5, C15.8 – C15.9) Diffuse; widespread: ¾ or more; linitis plastica: Stomach and Esophagus GE Junction (C16.0 – C16.6, C16.8 – C16.9) Diffuse, entire lung, or NOS: Lung and mainstem bronchus (C34.0 – C34.3, C34.8 – C34.9) Diffuse: Breast (C50.0 – C50.6, C50.8 – C50.9)
999	Unknown; size not stated Not documented in patient record Size of tumor cannot be assessed Not applicable (see section 13 below)

Recording Tumor Size Summary

All measurements are in millimeters (mm).

Record size in specified order:

1. Size measured on the surgical specimen, when surgery is administered as the first definitive treatment; i.e., no pre-surgical treatment administered.
   a. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (also known as CAP protocol or pathology report checklist). If only a test report is available, use the following in the prescribed order:
      i. Final diagnosis
      ii. Microscopic
      iii. Gross examination

      Example 1: Chest x-ray shows 3.5cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8cm. Record the size as 028 (28mm).

Example 2: Pathology report states lung carcinoma is 2.1 x 3.2 x1.4cm. Record tumor size as 032 (32mm).

2. If neoadjuvant therapy follow by surgery, do not record the size of the pathologic specimen. Code the largest siz3e of tumor prior to neoadjuvant treatment; if unknown, code size as 999.

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

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

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

Coding Rules

1. Tumor size is the **diameter** of the tumor, ***not* the depth or thickness** of the tumor.

2. Recording **less than/greater than Tumor Size:**

   a. If tumor size is reported as less than *x* mm or less than *x* cm, the reported size should be 1mm less; for example, if size is <10mm, code size as 009. Often, these are given in cm such as < 1cm which is coded to 009, <2cm is coded as 019, <3cm is coded as 029, etc. If stated as less than 1mm, use code 001.

   b. If tumor size is reported as more than *x* mm or more than *x* cm, code size as 1mm more; for example, if size is >10mm, size should be coded as 011. Often, these are given in cm such as >1cm, which is coded to 011, >2cm is coded as 021, etc. If stated as anything greater than 989mm (98.9cm), code to 989.

   c. If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two: i.e., add the two sizes together, then divide by two (between 2 and 3cm would be coded as 025).

3. **Rounding**

   Round the tumor size only if it is described in fractions of millimeters. If the largest dimension of a tumor is less than 1 millimeter (between 01. And 0.9mm), record the size as 001 (do not round down to 000). If tumor size is greater than 1 millimeter, round tents of millimeters in the 1 – 4 range down to the nearest whole millimeter, and round tents of millimeters in the 5 – 9 range up to the nearest whole millimeter. Do not round tumor size expressed in centimeters to the nearest centimeter (rather, move the decimal point one space to the right, converting the measurement to millimeters).

   Example 1: Breast cancer described as 6.5mm in size. Round up *Tumor Size* to 007.

   Example 2: Cancer in a polyp described as 2.3mm in size. Round down *Tumor Size* to 002.

   Example 3: Focus of cancer described as 1.4mm in size. Round down *Tumor Size to 001.*

   Example 4: There is a 5.2mm breast cancer described in the pathology report. Round down to 5mm and code as 005.

4. **Priority of imaging/radiographic techniques**

   Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but it should be taken as low priority, over a physical exam.

5. **Tumor size discrepancies among imaging and radiographic reports**

   If there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies which imaging is most accurate, record the largest size in the record, regardless os which imaging technique reports it.

6. **Always code the size of the primary tumor**

   Do not code the size of the polyp, ulcer, cyst or distant metastasis. However, if the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

7. **Record the size of the invasive component, if given.**

   a. If both in situ and invasive components are present and the invasive component is measured, record the size of the invasive component, even if it is smaller.

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

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

      Example 1: A breast tumor with infiltrating duct carcinoma with extensive in situ component; total size 2.3cm. Record tumor size as 023.

      Example 2: Duct carcinoma in situ measuring 1.9cm with an area of invasive ductal carcinoma. Record size as 019.

8. **Record the largest dimension or diameter of tumor**, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

   Example: Tumor is described as 2.4 x 5.1 x 1.8cm in size. Record tumor size as 051.

9. **Record the size as stated for purely in situ lesions.**

10. **Disregard microscopic residual or positive surgical margins when coding tumor size.** Microscopic residual tumor does not affect overall tumor size.

11. **Do not add the size of pieces or chips together to create a whole tumor**; they may not be from the same location or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size). Record that size. If the only measurement describes pieces or chips, record tumor size as 999.

12. **Multifocal/multicentric tumors**

    If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor or if all of the tumors are in situ, code the size of the largest in situ tumor.

13. **Tumor size code 999 is used when the size is unknown or not applicable.**
    Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms (histology codes 9590 – 9992)
    Kaposi Sarcoma
    Melanoma Choroid
    Melanoma Iris

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text-Path, Text-DX Proc-X-ray/Scans, Text-DX Proc-OP, and Text-DX Proc-Scopes*.

Clinical T NAACCR Item #940

This field evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor prior to the start of therapy.

Beginning in 2016, new T, N, and M categories were implemented for the AJCC T, N, and M data items. These new categories have been generated by adding the prefixes of "c" and "p" to existing valid clinical and pathological T, N, and M categories respectively, and modifying, adding and deleting specific categories. The new categories enable registrars to comply with AJCC clinical and pathological staging/classification timeframe rules while abstracting. The new categories will be used for cases of all diagnosis years abstracted using NAACCR version 16-compliant (and later) software.

Coding Instructions

1. The clinical T staging data item must be recorded for all cases.
2. Code clinical T as documented by the first treating physician or the managing physician in the medical record.
3. If the managing physician has not recorded clinical T, registrars ***will*** code this item based on the best available information, without necessarily requiring additional contact with the physician.
4. If a site/histology combination is not defined in the AJCC Manual, code 88 for clinical and pathologic T, N, and M as well as stage group
5. For in situ tumors that are not staged according to the AJCC manual, code 88 for clinical and pathological T, N, and M as well as stage group
6. For lung, occult carcinoma is coded to cTx
7. Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text – Staging*

Clinical N NAACCR Item #950

This field identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis.

Beginning in 2016, new T, N, and M categories were implemented for the AJCC T, N, and M data items. These new categories have been generated by adding the prefixes of "c" and "p" to existing valid clinical and pathological T, N, and M categories respectively, and modifying, adding and deleting specific categories. The new categories enable registrars to comply with AJCC clinical and pathological staging/classification timeframe rules while abstracting. The new categories will be used for cases of all diagnosis years abstracted using NAACCR version 16-compliant (and later) software.

Coding Instructions

1. The clinical N must be recorded for all cases.
2. Record clinical N as documented by the first treating physician or the managing physician in the medical record
3. If the managing physician has not recorded clinical N, registrars ***will*** code this item based on the best clinical information, without necessarily requiring additional contact with the physician
4. If a site/histology combination is not defined in the AJCC Manual, code 88 for clinical and pathologic T, N, and M as well as stage group
5. For in situ tumors that are not staged according to the AJCC manual, code 88 for clinical and pathological T, N, and M as well as stage group
6. For lung, occult carcinoma is coded to cTx
7. Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text – Staging*

Clinical M NAACCR Item #960

This data item identifies the presence or absence of distant metastasis (M) of the tumor known prior to the start of any therapy.

Beginning in 2016, new T, N, and M categories were implemented for the AJCC T, N, and M data items. These new categories have been generated by adding the prefixes of "c" and "p" to existing valid clinical and pathological T, N, and M categories respectively, and modifying, adding and deleting specific categories. The new categories enable registrars to comply with AJCC clinical and pathological staging/classification timeframe rules while abstracting. The new categories will be used for cases of all diagnosis years abstracted using NAACCR version 16-compliant (and later) software.

Coding Instructions

1. The clinical M must be recorded for all cases.
2. Record clinical M as documented by the first treating physician or the managing physician in the medical record
3. If the managing physician has not recorded clinical M, registrars ***will*** code this item based on the best clinical information, without necessarily requiring additional contact with the physician
4. If a site/histology combination is not defined in the AJCC Manual, code 88 for clinical and pathologic T, N, and M as well as stage group
5. For in situ tumors that are not staged according to the AJCC manual, code 88 for clinical and pathological T, N, and M as well as stage group
6. For lung, occult carcinoma is coded to cTx
7. Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text – Staging*

Clinical Stage Group NAACCR Item #970

This field identifies the anatomic extent of disease based on the T, N, and M data items known prior to the start of any therapy.

The VCR requires that AJCC TNM staging be assigned on all cases. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Record the clinical stage group as documented by the first treating physician in the medical record
2. If the managing physician has not recorded the clinical stage, registrars ***will*** code this data item based on the best available information, without necessarily requiring additional contact with the physician
3. If a site/histology combination is not defined in the AJCC manual, code 88 for clinical and pathological T, N, M as well as stage group
4. For in situ tumors that are not staged according to the AJCC manual, code 88 for clinical and pathological T, N, and M as well as stage group
5. To assign stage group when some, but not all T, N, and/or M components can be determined, interpret missing components as "x"
6. Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
7. Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text – Staging*

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

This identified the AJCC clinical stage descriptors of the tumor prior to the start of any therapy. Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group.

The VCR requires that AJCC TNM staging be assigned on all cases. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Codes and Definitions

Code	Label	Description
0	None	There are no prefix or suffix descriptors that would be used for this case
1	E-Extranodal, lymphomas only	A lymphoma case involving an extranodal site
2	S-Spleen, lymphomas only	A lymphoma case involving the spleen
3	M-Multiple primary tumors in a single site	This is one primary with multiple tumors in the primary site at the time of diagnosis
5	E and S - Extranodal & spleen, lymphomas only	A lymphoma case with involvement of both an extranodal site and the spleen
9	Unknown, not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct

Coding Instructions

1. Record the clinical stage descriptor as documented by the first treating physician or the managing physician in the medical record.
2. If the managing physician has not recorded the descriptor, registrars ***will*** code tis item based on the best available information, without necessarily requiring additional contact with the physician.
3. If the tumor is not staged according to the AJCC manual, leave this item blank
4. If the tumor is not staged according to the AJCC manual, leave this data item blank
5. Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text – Staging*

Staged By (Clinical Stage) NAACCR Item #990

This data item identifies the person who assigned the clinical AJCC staging data items and the Stage Group.

The VCR requires that AJCC clinical TNM staging be recorded in the abstract beginning in 2015. Data captured in this data item can be used to evaluate the accuracy and completeness of staging recorded in the registry and form the basis for quality management and improvement studies.

In 2016, this data item was expanded to two (2) characters and additional categories were added to document additional, more detailed sources of staging assignment and help in targeting training. The implementation of the new codes included data conversion and redefinition of "unknown" from "unknown stage" to unknown who assigned the stage ("9-Unknown; not stated in patient record" was converted to "99 – Staged but unknown who assigned stage").

Codes and Definitions

Code	Label	Definition
00	Not staged	Clinical staging was not assigned; no information was found in the medical record to assign clinical stage
10	Physician, NOS, or physician type not specified in codes 11 – 15	Clinical staging assigned by a physician not described under codes 11 – 15)i.e.: cancer committee chair, cancer liaison physician or registry physician advisor)
11	Surgeon	Clinical staging assigned by the surgeon only
12	Radiation Oncologist	Clinical staging assigned by the radiation oncologist only
13	Medical Oncologist	Clinical staging assigned by the medical oncologist only
14	Pathologist	Clinical staging by the pathologist only
15	Multiple Physicians; Tumor Board, etc	Clinical staging assigned by multiple physicians such as during a tumor board meeting
20	Cancer Registrar	Clinical staging assigned by the Cancer Registrar only
30	Cancer Registrar and physician	Clinical staging assigned by the Cancer Registrar and any of the physicians specified in codes 10 – 15. This would include the Cancer Registrar assigning the stage and a physician approving it
40	Nurse, physician assistant, or other non-physician medical staff	Clinical staging assigned by medical non-physician staff such as a nurse or a physician assistant (PA)
50	Staging assigned at another facility	Clinical staging assigned at another facility, person's role is unknown
60	Staging by Central Registry including consolidation of multiple sources	Clinical staging assigned by Central Registry personnel based on information from one facility or multiple facilities
88	Case is not eligible for staging	The site/histology combination is not defined in the AJCC Manual
99	Staged but unknown who assigned stage	A stage was found in the medical record but it is unknown who assigned it

Coding Instructions

1. Record the role of the person who documented the clinical AJCC staging data items and the Stage Group
2. If code 10 – 20 is used, then all of the staging elements (T, N, and M) and Stage Group must be assigned by the same person

3. If the tumor was not staged, or stage is unknown, use code 00
4. If the physician who assigned the stage cannot be identified as a surgeon, radiation oncologist, or medical oncologist use code 10. Other physicians can include, but are not limited to dentist, gynecologist or urologist.
5. If it is clear from the treatment provided that the physician providing the stage information is a surgeon, use code 11.

   Example: Urologist provides stage information for surgical resection of tumor; code as surgeon – 11
6. If a pathologist assigns T and/or N, and the registrar determines M and determines the stage group from other portions of the record, use code 30
7. If staging was obtained from outside the facility, code the role of the person who staged it if known (codes 10 – 40); otherwise, use code 50
8. If applicable, the Staging Elements (T, N, M) and the Stage Group must be recorded.
   Exception: lymphoma does not have TNM elements, only assigning Stage Group is applicable.
9. The staging source may be different for clinical vs. pathological stage

   Example 1: Initial staging is assigned by the Primary Care General Practitioner – Code as 10

   Example 2: During tumor conference, after discussion among pathologist, radiologist and surgeon, the facilitator announces the final TNM and Stage Group – Code as 15

   Example3: The only information on staging in the medical record states, 'T1, nodes negative', registrar enters the listed T, N0 and add the M and stage group in the abstract – Code as 30

   Example 4: Nurse practitioner documents all staging elements – code as 40

   Example 5: Staging is entered into the medical record by a physician assistant (PA) – Code as 40

   Example 6: Patient transfers to your facility, there is a completed staging form in the chart copies received from the transferring facility, but the staging form is not signed – Code as 50

   Example 7: Uploaded data to central registry from two facilities; there is no documentation listing staging; just a comment saying the patient has a late stage cancer. The central registry enters the TNM and Stage Group based on the consolidated record from the two facilities – Code as 60

   Example 8: A child is diagnosed with a Neuroblastoma – code as 88

Pathological T NAACCR Item #880

This field evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor following the completion of surgical treatment.

Beginning in 2016, new T, N, and M categories were implemented for the AJCC T, N, and M data items. These new categories have been generated by adding the prefixes of "c" and "p" to existing valid clinical and pathological T, N, and M categories respectively, and modifying, adding and deleting specific categories. The new categories enable registrars to comply with AJCC clinical and pathological staging/classification timeframe rules while abstracting. The new categories will be used for cases of all diagnosis years abstracted using NAACCR version 16-compliant (and later) software.

Coding Instructions

1. The pathological T staging data item must be recorded for all cases.
2. Code pathological T as documented by the treating physician or the managing physician in the medical record.
3. If the managing physician has not recorded clinical T, registrars ***will*** code this item based on the best available information, without necessarily requiring additional contact with the physician.
4. If a site/histology combination is not defined in the AJCC Manual, code 88 for clinical and pathologic T, N, and M as well as stage group
5. For in situ tumors that are not staged according to the AJCC manual, code 88 for clinical and pathological T, N, and M as well as stage group
6. Truncate the least significant subdivision of the category from the right as needed
7. For lung, occult carcinoma is coded Tx
8. Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text – Staging*

Pathological N NAACCR Item #890

This field identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis.

Beginning in 2016, new T, N, and M categories were implemented for the AJCC T, N, and M data items. These new categories have been generated by adding the prefixes of "c" and "p" to existing valid clinical and pathological T, N, and M categories respectively, and modifying, adding and deleting specific categories. The new categories enable registrars to comply with AJCC clinical and pathological staging/classification timeframe rules while abstracting. The new categories will be used for cases of all diagnosis years abstracted using NAACCR version 16-compliant (and later) software.

Coding Instructions

1. The pathological N must be recorded for all cases.
2. Record pathological N as documented by the first treating physician(s) or the managing physician in the medical record
3. If the managing physician has not recorded pathological N, registrars ***will*** code this item based on the best information, without necessarily requiring additional contact with the physician
4. If a site/histology combination is not defined in the AJCC Manual, code 88 for clinical and pathologic T, N, and M as well as stage group
5. For in situ tumors that are considered as "impossible diagnoses" in the AJCC Manual, code 88 for clinical and pathological T, N, and M as well as stage group
6. Use of the new category of cN0 for tis data item is limited only to in situ tumors beginning in 2016
7. Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text – Staging*

Pathological M NAACCR Item #900

This data item identifies the presence or absence of distant metastasis (M) of the tumor known following the completion of surgical treatment.

Beginning in 2016, new T, N, and M categories were implemented for the AJCC T, N, and M data items. These new categories have been generated by adding the prefixes of "c" and "p" to existing valid clinical and pathological T, N, and M categories respectively, and modifying, adding and deleting specific categories. The new categories enable registrars to comply with AJCC clinical and pathological staging/classification timeframe rules while abstracting. The new categories will be used for cases of all diagnosis years abstracted using NAACCR version 16-compliant (and later) software.

Coding Instructions

1. The pathological M must be recorded for all cases.
2. Record clinical M as documented by the treating physician(s) or the managing physician in the medical record
3. If the managing physician has not recorded pathological M, registrars ***will*** code this item based on the best clinical information, without necessarily requiring additional contact with the physician
4. If a site/histology combination is not defined in the AJCC Manual, code 88 for clinical and pathologic T, N, and M as well as stage group
5. For in situ tumors that are considered as "impossible diagnoses" in the AJCC Manual, code 88 for clinical and pathological T, N, and M as well as stage group
6. Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text – Staging*

Pathological Stage Group NAACCR Item #910

This field identifies the anatomic extent of disease based on the T, N, and M data items known following the completion of surgical treatment.

The VCR requires that AJCC TNM staging be assigned on all cases. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

1. Record the pathological stage group as documented by the treating physician(s) or the managing physician in the medical record
2. If the managing physician has not recorded the pathological stage, registrars ***will*** code this data item based on the best available information, without necessarily requiring additional contact with the physician
3. If a site/histology combination is not defined in the AJCC manual, code 88 for clinical and pathological T, N, M as well as stage group
4. For in situ tumors that are not staged according to the AJCC manual, code 88 for clinical and pathological T, N, and M as well as stage group
5. To assign stage group when some, but not all T, N, and/or M components can be determined, interpret missing components as "x"
6. If pathological M is coded as blank and clinical M is coded as 0, 1, 1A, 1B, or 1C, then the combination of staging items pT, pN and cM may be sued to complete the pathological stage group
7. If the value does not fill all four (4) characters, then record the value to the left and leave the remaining spaces blank
8. Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
9. Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text – Staging*

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

This identified the AJCC clinical stage descriptors known following the completion of surgical treatment. Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group.

The VCR requires that AJCC TNM staging be assigned on all cases. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Codes and Definitions

Code	Label	Description
0	None	There are no prefix or suffix descriptors that would be used for this case
1	E-Extranodal, lymphomas only	A lymphoma case involving an extranodal site
2	S-Spleen, lymphomas only	A lymphoma case involving the spleen
3	M-Multiple primary tumors in a single site	This is one primary with multiple tumors in the primary site at the time of diagnosis
5	E and S - Extranodal & spleen, lymphomas only	A lymphoma case with involvement of both an extranodal site and the spleen
9	Unknown, not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct

Coding Instructions

1. Record the pathological stage descriptor as documented by the treating physician(s) or the managing physician in the medical record.
2. If the managing physician has not recorded the descriptor, registrars ***will*** code tis item based on the best available information, without necessarily requiring additional contact with the physician.
3. If the tumor is not staged according to the AJCC manual, leave this item blank
4. Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Text

Text to support this data item must be recorded in the specific text fields. See *VCR Manual Part Three, Data Item Instructions, Text – Staging*

Staged By (Pathological Stage) NAACCR Item #930

This data item identifies the person who assigned the clinical AJCC staging data items and the Stage Group.

The VCR requires that AJCC clinical TNM staging be recorded in the abstract beginning in 2015. Data captured in this data item can be used to evaluate the accuracy and completeness of staging recorded in the registry and form the basis for quality management and improvement studies.

In 2016, this data item was expanded to two (2) characters and additional categories were added to document additional, more detailed sources of staging assignment and help in targeting training. The implementation of the new codes included data conversion and redefinition of "unknown" from "unknown stage" to unknown who assigned the stage ("9-Unknown; not stated in patient record" was converted to "99 – Staged but unknown who assigned stage").

Codes and Definitions

Code	Label	Definition
00	Not staged	Clinical staging was not assigned; no information was found in the medical record to assign clinical stage
10	Physician, NOS, or physician type not specified in codes 11 – 15	Clinical staging assigned by a physician not described under codes 11 – 15)i.e.: cancer committee chair, cancer liaison physician or registry physician advisor)
11	Surgeon	Clinical staging assigned by the surgeon only
12	Radiation Oncologist	Clinical staging assigned by the radiation oncologist only
13	Medical Oncologist	Clinical staging assigned by the medical oncologist only
14	Pathologist	Clinical staging by the pathologist only
15	Multiple Physicians; Tumor Board, etc	Clinical staging assigned by multiple physicians such as during a tumor board meeting
20	Cancer Registrar	Clinical staging assigned by the Cancer Registrar only
30	Cancer Registrar and physician	Clinical staging assigned by the Cancer Registrar and any of the physicians specified in codes 10 – 15. This would include the Cancer Registrar assigning the stage and a physician approving it
40	Nurse, physician assistant, or other non-physician medical staff	Clinical staging assigned by medical non-physician staff such as a nurse or a physician assistant (PA)
50	Staging assigned at another facility	Clinical staging assigned at another facility, person's role is unknown
60	Staging by Central Registry including consolidation of multiple sources	Clinical staging assigned by Central Registry personnel based on information from one facility or multiple facilities
88	Case is not eligible for staging	The site/histology combination is not defined in the AJCC Manual
99	Staged but unknown who assigned stage	A stage was found in the medical record but it is unknown who assigned it

Coding Instructions

1. Record the role of the person who documented the pathological AJCC staging data items and the Stage Group
2. If the case does not meet the criteria for pathologic staging, the tumor was not staged, or stage is unknown, use code 00.

3. If code 10 – 20 is used, then all of the staging elements (T, N, and M) and Stage Group must be assigned by the same person
4. If the physician who assigned the stage cannot be identified as a surgeon, radiation oncologist, or medical oncologist use code 10. Other physicians can include, but are not limited to dentist, gynecologist or urologist.
5. If it is clear from the treatment provided that the physician providing the stage information is a surgeon, use code 11.

   Example: Urologist provides stage information for surgical resection of tumor; code as surgeon – 11
6. If a pathologist assigns T and/or N, and the registrar determines M and determines the stage group from other portions of the record, use code 30
7. If staging was obtained from outside the facility, code the role of the person who staged it if known (codes 10 – 40); otherwise, use code 50
8. If applicable, the Staging Elements (T, N, M) and the Stage Group must be recorded.
   Exception: lymphoma does not have TNM elements, only assigning Stage Group is applicable.
9. The staging source may be different for clinical vs. pathological stage

   Example 1: Initial staging is assigned by the Primary Care General Practitioner – Code as 10

   Example 2: During tumor conference, after discussion among pathologist, radiologist and surgeon, the facilitator announces the final TNM and Stage Group – Code as 15

   Example3: The only information on staging in the medical record states, 'T1, nodes negative', registrar enters the listed T, N0 and add the M and stage group in the abstract – Code as 30

   Example 4: Nurse practitioner documents all staging elements – code as 40

   Example 5: Staging is entered into the medical record by a physician assistant (PA) – Code as 40

   Example 6: Patient transfers to your facility, there is a completed staging form in the chart copies received from the transferring facility, but the staging form is not signed – Code as 50

   Example 7: Uploaded data to central registry from two facilities; there is no documentation listing staging; just a comment saying the patient has a late stage cancer. The central registry enters the TNM and Stage Group based on the consolidated record from the two facilities – Code as 60

   Example 8: A child is diagnosed with a Neuroblastoma – code as 88

SEER Summary Stage 2000 NAACCR Item #759

This field if for summary stage at the initial diagnosis or treatment of the reportable tumor. Summary stage should include all information available through completion of surgery(ies) in the first course of treatment or within four (4) months of diagnosis in the absence of disease progression, whichever is longer.

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.

Summary staging is the most basic way of categorizing how far a cancer has spread from its point of origin. Summary staging uses all information available in the medical record; in other words, it is a combination of the most precise clinical and pathological documentation of the extent of disease.

Codes and Definitions

Code	Definition
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

Coding Instructions

1. Use code 8 for benign and borderline brain/CNS cases
2. In situ (Code 0) diagnosis can only be made microscopically, because a pathologist must identify the basement membrane and determine that it has not been penetrated.
    a. Other ways of describing in situ: non-invasive, pre-invasive, non-infiltrating, intra-epithelial, Stage 0, intraductal, Intracystic, no stromal invasion, no penetration below the basement membrane
3. Localized (Code 1) cancer has spread no farther than the organ in which it started; there is infiltration past the basement membrane into the functional part of the organ, but there is no spread beyond the boundaries of the organ.
    a. It is important to know and recognize the names of different structures within the organ – lamina propria , myometrium, muscularis, for example – so that a description of invasion or involvement of these structures will not be interpreted as regional spread
    b. Be sure to read pathology and operative reports as Summary Stage is based on both clinical and pathological information
4. Regional stage (Codes 2 – 5) when the cancer has spread beyond the limits of the organ of origin
    a. Regional by direct extension (Code 2) is invasion through entire wall of origin into surrounding and/or adjacent tissues

b. Invasion to regional lymph nodes (Code 3) means the tumor has invaded the walls of lymphatics where cells can travel through lymphatic vessels to nearby lymph nodes where they are "filtered" our and begin to grow in the nodes

c. Code 4 is a combination of positive regional lymph nodes and direct extension of the tumor

d. Regional, NOS (code 5) is used when it is unclear whether the tissue are involved by direct extension or when the other categories are not applicable

   i. Staging for non-Hodgkin or Hodgkin lymphomas would use this code when there are more than one lymph node chain is involved.

e. Code only regional nodes – not distant nodes – in this category. Check the *SEER Summary Staging Manual 2000* for lists of regional nodes. Do NOT use AJCC TNM listing of regional nodes to code this field

5. Distant metastasis (Code 7) is when tumor cells have broken away from the main tumor and travelled to other parts of the body and have begun to grow at the new location.

   a. May also be called remote, diffuse, disseminated, metastatic or secondary disease

   b. Cancer cells travel from the primary in four (4) ways:

      i. Extension from primary organ beyond adjacent tissue into next organ

         1) Lung through the pleura into bone

      ii. Travel in lymph channels beyond the first (regional) drainage area

      iii. Hematogenous or blood-borne metastasis due to invasion of blood vessels within the primary tumor (veins are more susceptible to invasion than thicker-walled arteries) allows escape of tumor cells or tumor emboli which are transported through the blood stream to another part of the body

      iv. Spread through fluids in a body cavity

         1) Malignant cells rupture the surface of the primary tumor and are released into the thoracic or peritoneal cavity

         2) This spread is also called implantation or seeding metastasis

         3) Some tumors form large quantity of fluid called ascites

   c. The most common sites of distant spread are liver, lung, brain and bone

Collaborative Stage Site-Specific Factors

See *CS Data Collection System Coding Instructions, Part I, Section 2, Version 02.05* for values and specific coding instructions, located at:
https://cancerstaging.org/cstage/schema/Pages/version0205.aspx

Site Specific Factor 1 — NAACCR Item #2880

VCR Required for Mycosis Fungoides, Placenta, Prostate, Brain/CNSOther/IntracranialGland and Breast

Mycosis Fungoides – Peripheral Blood Involvement

Placenta – Prognostic Scoring Index

Prostate – PSA Value

Brain/CNSOther/IntracranialGland – WHO (World Health Organization) Grade Classification

Breast – Estrogen Receptor (ER) Assay

Site Specific Factor 2 — NAACCR Item #2890

VCR Required for Breast

Breast – Progesterone Receptor (PR) Assay

Site Specific Factor 5 — NAACCR Item #2920

VCR Required for GISTPeritoneum

GISTPeritoneum – Mitotic Count

Site Specific Factor 6 — NAACCR Item #2930

VCR Required for GISTEsophagus, GISTSmallIntestine, GISTStomach

GISTEsophagus – Mitotic Count

GISTSmallIntestine – Mitotic Count

GISTStomach – Mitotic Count

Site Specific Factor 8 — NAACCR Item #2862

VCR Required for Prostate and Breast

Prostate – Gleason's Primary Pattern & Secondary Pattern Values on Needle Core Biopsy/Transurethral Resection of Prostate

Breast – HER2: Immunohistochemistry (IHC) Lab Value

Site Specific Factor 9 — NAACCR Item #2863

VCR Required for Breast

Breast – HER2: Immunohistochemistry (IHC) Test Interpretation

Site Specific Factor 10 NAACCR Item #2864

VCR Required for GISTPeritoneum and Prostate

GISTPeritoneum – Location of Primary Tumor

Prostate – Gleason's Score on Prostatectomy/Autopsy

Site Specific Factor 11 NAACCR Item #2865

VCR Required for Breast

Breast – HER2: Fluorescence In Situ Hybridization (FISH) Test Interpretation

Site Specific Factor 13 NAACCR Item #2867

VCR Required for Testis and Breast

Testis – Post Orchiectomy Alpha Fetoprotein (AFP) Range

Breast – HER2: Chromogenic In Situ Hybridization (CISH) Test Interpretation

Site Specific Factor 14 NAACCR Item #2868

VCR Required for Breast

Breast – HER2: Result of Other or Unknown Test

Site Specific Factor 15 NAACCR Item #2869

VCR Required for Testis and Breast

Testis – Post Orchiectomy Human Chorionic Gonadotropin (hCG) Range

Breast – HER2: Summary Result of Testing

Site Specific Factor 16 NAACCR Item #2870

VCR Required for Testis and Breast

Testis – Post Orchiectomy Lactate Dehydrogenase (LDH) Range

Breast – Combination of ER, PR, and HER2 Results

Site Specific Factor 25 NAACCR Item #2879

VCR Required for BileDuctsDistal, BileDuctsPerihilar, CysticDuct, EsophagusGEJunction, LacrimalGland, LacrimalSac, MelanomaCiliaryBody, MelanomaIris, Nasopharynx, PharyngealTonsil, Stomach

BileDuctsDistal – Schema Discriminator: BileDuctsDistal/BileDuctsPerihilar/Cystic Duct

BileDuctsPerihilar – Schema Discriminator: BileDuctsDistal/BileDuctsPerihilar/Cystic Duct

CysticDuct - Schema Discriminator: BileDuctsDistal/BileDuctsPerihilar/Cystic Duct

EsophagusGEJunction – Schema Discriminator: EsophagusGEJunction (EGJ)/Stomach

LacrimalGland – Schema Discriminator: LacrimalGland/LacrimalSac

LacrimalSac – Schema Discriminator: LacrimalGland/LacrimalSac

MelanomaCiliaryBody – Schema Discriminator: MelanomaCiliaryBody/MelanomaIris

MelanomaIris – Schema Discriminator: MelanomaCiliaryBody/MelanomaIris

Nasopharynx – Schema Discriminator: Nasopharynx/PharyngealTonsil

PharyngealTonsil – Schema Discriminator: Nasopharynx/PharyngealTonsil

Stomach – Schema Discriminator: EsophagusGEJunction (EGJ)/Stomach

First Course of Treatment

Guidelines for Recording First Course of Treatment

First course of treatment includes all methods of cancer-directed therapy recorded in the treatment plan and administered to the patient before disease progression or recurrence. Never code treatment unless you know it has actually been administered at your facility or any other facility; record as none, 00 or 0.

No therapy is a treatment option (the patient refused therapy, the family/guardian refused therapy, the patient expired before therapy started, the physician recommended no therapy, or the patient is on active surveillance/watchful waiting). Therefore, first course of treatment may be no treatment. Use the date the decision was made not to treat as *Date of 1st Course Rx*.

All modalities of treatment are included regardless of sequence or degree of completion of any component method.

Treatment Plan

A treatment plan describes the cancer-directed treatment intended to modify, control, remove or destroy proliferating cancer cells. The documentation confirming a treatment plan may be fragmented. It is frequently found in several different sources, e.g., medical or clinic records, consultation reports, and outpatient records. All cancer-directed therapies specified in the physician(s) treatment plan are a part of the first course of treatment. When a treatment plan is not available or unclear, consult a physician.

A discharge plan may contain part or all of the treatment plan.

A treatment plan may specify one or more modalities of therapy (surgery, radiation, chemotherapy, hormone therapy, immunotherapy, or other therapy). A treatment "regimen" may include combinations of concurrent or adjuvant therapies.

Example: A patient had a transurethral resection diagnostic of bladder cancer. Resection was followed by Cobalt-60 radiation, ileal loop diversion, and a complete cystectomy with node dissection. Code as follows:

Data Item	Treatment Code
Cancer-directed surgery	50 - Complete cystectomy
Radiation Regional RX Modality	22- Cobalt-60 radiation
Chemotherapy	00 - None
Hormone Therapy	00 - None
Immunotherapy	00 - None
Other treatment	0 - No other cancer-directed therapy

Guidelines for Determining *First Course of Treatment*

First course of treatment includes all cancer-directed therapy planned and administered by the physician(s) during or after the first diagnosis of cancer. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more.

Time Period Rules for First Course of Treatment for Malignancies except Leukemias (in order of precedence).

1. If there is a documented, planned first course of treatment, first course ends at the completion of this treatment plan, regardless of the duration of the treatment plan.
2. If the patient is treated according to a facility's standards of practice (established protocol), first course ends at the completion of the treatment.
3. If there is no documented treatment plan, established protocol, or management guidelines, and consultation with a physician is not possible, use the principle: "initial treatment must begin within four months of the date of initial diagnosis."
4. If the patient refuses all treatment modalities, then changes his/her mind and the treatment is initiated, consult a physician to determine if this is part of first course of treatment.

Special Rules for Leukemias

The first course of definitive treatment is related to the first *remission* as follows:

1. If a remission, complete or partial, is achieved during the first course of therapy for the leukemic process, include:
    1. All definitive therapy considered as *remission-inducing* for the first remission.
    2. All definitive therapy considered as *remission-maintaining* for the first remission (maintenance chemotherapy or irradiation to the central nervous system).
    3. Disregard all treatment administered to the patient after the relapse of the first remission.
2. If no remission is attained during the first course of therapy, record all treatment attempted to induce the remission. Disregard all treatment administered to the patient as a subsequent attempt to induce remission.

Watchful Waiting

If a treatment plan is given for symptoms/disease progression after period of *watchful waiting*, this treatment is not considered part of first course. For example, if physician and patient choose a *wait and watch* approach to prostate cancer and the patient becomes symptomatic, consider the symptoms to be an indication the disease has progressed and any further treatment is not part of first course.

Treatment Failure

Treatment failure or disease progression may prompt the physician to stop therapy before the full course has been completed. Any therapy administered after the discontinuation of first course must be considered as secondary or subsequent treatment.

Treatment for Recurrence or Progression

Treatment for recurrence or progression of disease includes all cancer-directed therapies administered after the first course of treatment is complete.

If the patient does not respond or if the disease progresses, a physician may stop the first course of treatment before it is complete. Therapy administered after the first course ends is not recorded as first course of treatment.

Non Cancer-Directed Treatment

Non cancer-directed treatments prolong the patient's life, alleviate pain, make the patient comfortable, or prepare the patient for cancer-directed therapy. They are not meant to destroy or control the tumor or delay the spread of disease. Non cancer-directed procedures include diagnostic tests and supportive care (treatments designed to relieve symptoms and minimize the effects of the cancer). Surgical procedures performed to diagnose/stage disease (exploratory) or for relief of symptoms (palliative) are non-cancer directed surgery. **Non-cancer directed therapies should not be coded as treatment.**

Examples of non-cancer directed therapies include:

1. Diagnostic procedures:
   a. Incisional biopsies
   b. Exploratory procedures/surgery with or without biopsies, such as celiotomy, laparotomy, cystotomy, nephrotomy, gastrotomy, thoracotomy
   c. Brushings, washings, aspiration of cells, and hematologic findings (peripheral blood smears) are not surgical procedures.
2. Palliative procedures:
   a. Colostomy
   b. Nephrostomy
   c. Esophagostomy
   d. Tracheostomy
   e. Gastrostomy
3. Supportive care/relieving symptoms:
   a. Pain medication
   b. Oxygen
   c. Antibiotics administered for an associated infection
   d. Intravenous therapy to maintain fluid or nutritional balance
   e. Laser therapy directed at relieving symptoms

Exception: Treatment for 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". See *VCR Manual, Part Three, RX Summ-Other).*

Cancer-Directed Treatment

Cancer-directed treatment is tumor directed, and its purpose is to modify, control, remove, or destroy primary or metastatic cancer tissue. Physicians administer the therapy(ies) to remove or minimize the size of tumor or to delay the spread of disease. Record all cancer-directed therapy administered to the patient. For complete treatment information, record therapies given in other institutions and failed treatments (the patient did not respond).

Example 1: A patient is diagnosed with stage IV small cell carcinoma of the lung. The treatment plan recommends radiation to shrink the metastatic tumor and alleviate the pain caused by rib metastases. The reporting institution delivers beam radiation. The data item *Rad--Reg RX Modality* is coded 22, beam radiation, NOS.

Example 2: A patient with breast cancer enters the reporting institution for a lumpectomy. The physician's treatment plan specifies radiation therapy to the breast following surgery. It is unknown if the patient had radiation. Code the data item *RX Summ - Surg Prim Site* to a partial or less than total mastectomy (22). Record the data item *Rad--Regional RX Modality* as (00), none. If additional follow-up information reveals the patient did receive radiation, change to the appropriate radiation code.

Date of First Course of Treatment NAACCR Item #1270

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

Beginning in 2010, the way dates are transmitted between facility registries and central registries was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. Interoperable dates are displayed in CCYYMMDD form, with the unknown portions of the date filled with blank spaces. If a date is entirely blank, an associated date flag is used to explain the missing date. Flags are not used for software-generated dates.

For more information regarding dates, please see *Virginia Cancer Registry Manual, Part Three: Data Item Instructions, General Information, Coding Dates*

Recording Date 1st Course of Treatment

1. Record the earliest of the following dates: *Date of First Surgical Procedure*, *Date Radiation Started*, *Date Systemic Therapy Started*, or *Date Other Treatment Started*.
2. If active surveillance or watchful waiting is selected as the first course of treatment (*RX Summ–Treatment Status* = 2) record the date this decision is made.
3. In cases of no treatment (*RX Summ–Treatment Status* = 0), in which a physician decides not to treat a patient or a patient's family or guardian declines all treatment, the date of first course of treatment is the date this decision was made.
4. Leave this item blank if the cancer was diagnosed at autopsy and not suspected prior to that.
5. Unknown Month, Day, and/or Year - If only part of the date is known record what is known and leave blank what is unknown. Approximation is acceptable; refer to *VCR Manual, Part Three: Data Item Instructions, General Information, Dates* for instructions regarding approximating dates and unknown dates. Fictitious dates or default dates are not acceptable.

Date 1st Course Rx Flag NAACCR Item #1271

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

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes and Definitions

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any treatment was given).
11	No proper value is applicable in this context. (for example, autopsy only).
12	A proper value is applicable but is not known. This event occurred but the date is unknown (for example, treatment was given but the date is unknown).
(blank)	A valid date value is provided in the item *Date of 1st Course of Treatment.*

Recording Date 1st Course Rx Flag

1. Leave this item blank if *Date of 1st Course of Treatment* has a full or partial date recorded.
2. Code 12 if *Date of 1st Course of Treatment* cannot be determined, but the patient did receive first course treatment.
3. Code 12 if a decision not to treat was made, but the date is totally unknown
4. Code 10 if it is unknown whether any treatment was administered.
5. Code 11 if no proper value is applicable in this context (e.g., autopsy only case)

RX Summ – Treatment Status NAACCR Item #1285

This item documents active surveillance (watchful waiting) and eliminates searching each treatment modality to determine whether treatment was given. It is used in conjunction with *Date of First Course of Treatment* to document whether treatment was or was not given, it is unknown if treatment was given, or treatment was given on an unknown date.

Codes and Descriptions

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

Instructions for Coding

1. This item may be left blank for cases diagnosed prior to 2010.
2. Treatment given after a period of active surveillance is considered subsequent treatment and it not coded in this item.
3. Use code 0 when treatment is refused or the physician decides not to treat for any reason such as the presence of comorbidities

Example 1: Patient is expected to have radiation, but it has not occurred yet: code as 0

Example 2: Treatment plan for a lymphoma patient is active surveillance: code as 2

Example 3: Patient and physician opt for watchful waiting for the patient's prostate cancer: code as 2

Date of First Surgical Procedure NAACCR Item #1200

Record the earliest date on which the patient had cancer-directed surgery for this primary or metastatic site. This includes *RX Summ-Surg Prim Site, RX Summ-Scope Reg LN Surg, and RX Summ-Surg Oth Reg/Dis*. This item is used to measure the lag time between diagnosis and the most definitive surgery of the primary site. Formerly called "Date of Cancer-Directed Surgery."

Beginning in 2010, the way dates are transmitted between facility registries and central registries was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. Interoperable dates are displayed in CCYYMMDD form, with the unknown portions of the date filled with blank spaces. If a date is entirely blank, an associated date flag is used to explain the missing date. Flags are not used for software-generated dates.

For more information regarding dates, please see *Virginia Cancer Registry Manual, Part Three: Data Item Instructions, General Information, Coding Dates*

Recording RX Date-Surgery

1. Record the date of cancer-directed surgery in month, day, year format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, and the day in the last two spaces. A zero must precede single-digit months and days. See *VCR Manual Part Three, General Instructions* for allowable values.
2. This data item may contain a date even when surgery to the primary site equals 00 (none).

   Example: Patient has excision of a brain lesion on January 15, 2003; final pathology diagnosis is metastatic lung carcinoma. Patient refuses further work-up.

   RX Summ - Surg Prim Site code = 00
   RX Date - Surgery = 01152003
   RX Summ - Surg Oth Reg/Dis = 4

3. Collecting the dates for each treatment modality allows sequencing of multiple treatments and aids evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence). The date in this data item may be the same as that in *Date of Most Definitive Surgical Resection of the Primary Site.*
4. Unknown dates:
   a. Blank spaces are used for unknown trailing portions of the date or where a date is not applicable.
   b. If the exact date of cancer-directed surgery is not available, record an approximate date. Refer to *VCR Manual Part Three, General Information*.

Special Instructions

If you can record multiple surgery dates, make sure the data item transmitted to the VCR *as RX Date-Surgery* reflects the earliest date of cancer-directed surgery.

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery.*

RX Date – Surgery Flag NAACCR Item #1201

This flag explains why there is no appropriate value in the corresponding date field, *RX Summ-Surg Prim Site.*

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes and Definitions

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery was performed).
11	No proper value is applicable in this context. (for example, no surgery performed).
12	A proper value is applicable but is not known. This event occurred but the date is unknown (for example, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in the item *RX Summ-Surg Prim Site.*

Recording Date 1st Course Rx Flag

1. Leave this item blank if *RX Summ-Surg Prim Site* has a full or partial date recorded.
2. Code 12 if *RX Summ-Surg Prim Site* cannot be determined, but the patient did receive first course surgery.
3. Code 10 if it is unknown whether any surgery was performed
4. Code 11 if no surgical procedure was performed.

RX Summ – Surgical Procedure of Primary Site NAACCR Item #3170

Record the most invasive, definitive cancer-directed procedure performed to the primary site as part of the first course of treatment. Cancer-directed surgery modifies, controls, removes, or destroys proliferating cancer tissue. This item can be used to sequence multiple treatment modalities and to evaluate the time intervals between treatment.

Recording Surgery to Primary Site

1. An excisional biopsy is cancer-directed surgery.

   Example: The surgeon states the procedure is an excisional biopsy, but the pathology report shows microscopic involvement of the margins. Record the code for an excisional biopsy as *Rx Summ - Surg Prim Site*.

   Note: Biopsies that remove all gross tumor or leave only microscopic margins should be coded to surgery of the primary site.

2. If no cancer-directed surgery was performed, code to 00.
3. If it is unknown if cancer-directed surgery was performed, code to 99.
4. Use the best information in the operative/pathology reports to determine the operative procedure. Do not depend on the name of the procedure since it may be incomplete. If the operative report is unclear as to what was excised or if there is a discrepancy between the operative and pathology reports, use the pathology report, unless there is reason to doubt its accuracy.
5. Site-Specific Surgery Codes- Refer to *VCR Manual Appendix I* for surgical codes.

a. Hierarchy – For codes 00 through 79, the descriptions of the surgical procedures are hierarchical. Last- listed responses take precedence over earlier-listed responses. (regardless of code or numeric value). Code 98 takes precedence over all other codes values.

i. Codes 10 through 18 are site-specific descriptions of tumor-destruction procedures that do not produce a pathologic specimen.

ii. Codes 20 through 80 are site-specific descriptions of resection procedures.

b. Numeric Code Sequence – To the extent possible, codes and their definitions are the same as those assigned in *Fords Manual 2004*. As a result of added and modified codes however, the numeric code sequence may deviate from the order in which descriptions of the surgical procedures are listed.

   Example: A rectosigmoid primary surgically treated by polypectomy with electrocautery, which is listed after polypectomy alone, is coded 22.

   20 Local tumor excision, NOS
   26 Polypectomy
   27 Excisional biopsy Combination of 20 or 26-27 WITH
   21 Photodynamic therapy (PDT)
   22 Electrocautery
   23 Cryosurgery
   24 Laser ablation

c. Special Code 98 applies to specific tumors that cannot be clearly defined in terms of primary or nonprimary site. Surgical Procedure of Primary Site should be coded 98 for *Unknown and Ill-defined Primary Sites and Hematopoietic/ Reticuloendothelial/ Immunoproliferative/Myeloproliferative Disease (*See *VCR Manual, Part Three, General Information* for a list of these sites and conditions). The item *RX Summ--Surg Oth Reg/Dis Site* is used to indicate whether surgery was performed for these tumors.

6. Total Resection – If a surgical procedure removes the remaining portion of an organ which had been partially resected previously for any condition, code as total removal of the organ. If none of the primary organ remains, the code should indicate this is the case.

   Example 1: Resection of a stomach which had been partially excised previously is coded as total removal of stomach.

   Example 2: Removal of a cervical stump is coded as total removal of uterus.

   Example 3: Lobectomy of a lung with a previous wedge resection is coded as total removal of lobe.

7. Biopsies that remove all of the tumor and/or leave only microscopic margins are to be coded in this item.

8. Extranodal Lymphomas – Surgery for extranodal lymphomas should be recorded using the scheme for the extranodal site.

   Example: Use the scheme for the stomach to record a gastrectomy for a primary lymphoma of the stomach.

9. Surgery for Multiple Primaries – If multiple primaries are treated by a single surgical event, code the appropriate surgical items for each primary.

   Example 1: If a total abdominal hysterectomy was done for a patient with two primaries, one of the cervix and one of the endometrium, code each as having had a total abdominal hysterectomy.

   Example 2: If a total colectomy was done for a patient with multiple primaries in several segments of the colon, code total colectomy for each of the primary segments.

10. Regional tissue or organs – Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted in the *VCR Manual, Appendix I*.

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery.*

RX Summ – Scope of Regional Lymph Node Surgery NAACCR Item #1292

Record 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. This data item can be used to compare and evaluate the extent of surgical treatment.

Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx) or a more extensive dissection of regional lymph nodes, or a combination of both sentinel lymph node biopsy and regional lymph node dissection (LND). The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and LND or a combination of the two procedures.

Codes and Definitions

Code	Definition	Additional Notes Specific to Breast (C50.x)
0	*None*- No regional lymph node surgery. No lymph nodes found in pathologic specimen. Diagnosed at autopsy.	
1	*Biopsy or aspiration of regional lymph node, NOS* - Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease. • Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed. If additional procedures were performed on the lymph nodes, use the appropriate code 2 – 7.	Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary LND, use the appropriate code 2 – 7.
2	*Sentinel lymph node biopsy- Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.* • *The operative report states that a SLNBx was performed.* • *Code 2 SLNBx when the operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node(s) for removal/examination.* • *When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes may be discovered by the pathologist tor selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. If review of the operative report confirms that a LND followed the SLNBx, code these cases as 6.*	• If a relatively large number of lymph nodes – generally more than 5 – are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an axillary lymph node dissection (ALND) • Infrequently, a SLNBx is attempted and the patient fails to map(i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. Review the operative report to confirm that an axillary incision was made and a node exploration was conducted. Patients undergoing SLNBx who fail to map will often undergo ALND. Code these cases as 2 if no ALND was performed, or 6 when the ALND was performed during the same operative event.

Code	Definition	Additional Notes Specific to Breast (C50.x)
3	*The operative report states that a LND was performed (a SLNBx was not done during this procedure or in a prior procedure).* *Number of regional nodes removed unknown or not stated; regional lymph nodes removed NOS- Sampling or dissection of regional lymph node and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel node biopsy.* • *Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with LND (code 6 or 7).*	Generally, ALND removes at least 7 – 9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive LND during the same procedure (code 6 or 7).
4	*1–3 regional lymph nodes removed- Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.* • *This should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only.*	
5	*4 or more regional lymph nodes removed- Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.* • *If a relatively small number of lymph nodes was examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes was examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive LND during the same, or separate, procedure (code 6 or 7).* • *Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Codes these cases as 2 if no further dissection of regional nodes was undertaken, or 6 when regional lymph nodes were dissected during the same operative event.*	

Code	Definition	Additional Notes Specific to Breast (C50.x)
6	*Sentinel node biopsy and code 3, 4,or 5 at same time, or timing not stated- Code 2 was performed in a single surgical event with code 3, 4, or 5. Or, code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.* • *SLNBx and LND (code 3, 4, or 5) during the same surgical event, or timing is not known.* • *Generally, SLNBx followed by a LND sill yield a relatively large number of nodes. However, it is possible for these procedure to harvest only a few nodes.* • *If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.* • *Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6*	• Generally, SLNBx followed by ALND will yield a minimum of 7 – 9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed.
7	*Sentinel node biopsy and code 3, 4, or 5 at different times- Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.* • *SLNBx and LND (codes 3, 4, or5) in separate surgical events.* • *Generally, SLNBx followed by a regional LND will yield a relatively large number of nodes. However, it is possible for these procedure to harvest only a few nodes.* • *If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only*	• Generally, SLNBx followed by ALND will yield a minimum of 7 – 9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed.
9	*Unknown or not applicable*- It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.	

Recording Scope of Regional Lymph Node Surgery

1. Refer to *VCR Manual Appendix I* for site-specific regional lymph node listings. All other nodes not listed are considered distant sites and must be coded in the data item *RX Summ - Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s).*
2. Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item.
3. There is no minimum number of nodes that must be removed; code to the farthest regional lymph nodes removed regardless of involvement with disease (e.g., the biopsy of contralateral lung lymph nodes).

4. Codes 0 – 7 are hierarchical; code the procedure that is numerically higher
   a. *Example 1:* There was an attempt at sentinel lymph node dissection but no lymph nodes were found in the pathological specimen: Code 2
   b. *Example 2:* Aspiration of a regional node for a pharynx primary to confirm histology of widespread metastasis: Code 1
   c. *Example 3:* Patient has a melanoma of the back; a sentinel lymph node dissection was done with the removal of one lymph node with the node confirmed to be negative: Code 2
   d. *Example 4:* Sentinel lymph node biopsy (SLNBx) of right axilla followed by right axillary lymph node dissection (ALND) during the same surgical procedure: Code 6
   e. *Example 5:* SLNBx of left axilla followed by a second procedure 5 days later by a left ALND: Code 7
5. Of two or more surgical procedures of regional lymph nodes are performed, the codes entered in the registry for each subsequent procedure must include the cumulative effect of all preceding procedures. Do not rely on software to determine the cumulative code.
   Example: A sentinel lymph node biopsy followed by a regional lymph node dissection at a later time is coded as 7.
6. For primaries of the meninges, brain, spinal cord, cranial nerves and other parts of the central nervous system (C70.0- C70.9, C71.0-C71.9, C72.0-C72.9), code to 9.
7. For lymphomas with a lymph node primary site, code 9. For extranodal lymphomas, refer to the site-specific codes for the primary site.
8. Unknown or ill-defined primary site or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease, code to 9. See *VCR Manual, Part Three, General Information* for a list of these sites and conditions.
9. This data item may not be blank. If no regional lymph nodes were removed or no surgery was performed, record 0.
   Example 1: Aspiration of regional lymph node of a pharynx primary to confirm histology of widely metastatic disease is coded to 1.
   Example 2: A patient with a breast primary has a sentinel lymph node biopsy of the right axilla, followed by right axillary lymph node dissection during the same surgical event, code to 6.
9. Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field *Surgical Procedure/Other Site*
10. Refer to the current *AJCC Cancer Staging Manual* for site-specific identification of regional lymph nodes.
11. If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care*

Special Instructions

If you can record multiple surgical procedures in your registry software, make sure the data item transmitted to the VCR as *RX Summ - Scope Reg LN Surg* reflects most extensive code.

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery.*

RX Summ – Surgical Procedure/Other Site NAACCR Item #1294

Record the surgical removal of *distant lymph nodes* or other tissue(s) or organ(s) removed beyond the primary site. The removal of nonprimary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement

Codes and Definitions

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

Recording Surgery to Other Sites

1. If other tissue or organs are removed during primary site surgery that are not specifically defined by the site specific *Surgical Procedure of the Primary Site* code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
2. Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
3. Assign the highest numbered code that describes the surgical resection of *distant lymph node(s).*
4. Incidental removal of tissue or organs is not a "Surgical Procedure/Other Site."
5. *Surgical Procedure/Other Site* is collected for each surgical event even if surgery of the primary site was not performed.
6. Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0–76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992).
7. If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care*.

Special Instructions

If you can record multiple surgical procedures in your registry software, make sure the data item transmitted to the VCR as *RX Summ - Surg Oth Reg/Dis* reflects the most extensive (numerically highest) code.

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery.*

Reason for No surgery of Primary Site NAACCR Item #1340

Record the reason for no Surgery of Primary Site. Codes 1-9 are valid only when *RX Summ - Surg Prim Site* is coded 00. This data item provides information related to the quality of care and describes why primary site surgery was not performed.

Codes and Definitions

Code	Definition
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in patient record.
7	Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only.

Recording Reason for No Surgery of Primary Site

1. Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include surgery of the primary site, or if the option of "no treatment" was accepted by the patient.
2. If *Surgical Procedure of Primary Site* is coded 98, code *Reason for No Surgery* to 1.
3. If the patient refused recommended surgical treatment, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended, code to 7.
4. If the treatment plan offered multiple choices, but it is unknown which treatment, if any, was provided, code to 9.

   Example 1: A patient with a primary tumor of the liver is not recommended for surgery due to advanced cirrhosis, code to 2.

   Example 2: A patient is referred to another facility for recommended surgical resection of a gastric carcinoma, but further information from the facility to which the patient was referred is not available, code to 8.

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery.*

Date Radiation Started NAACCR Item # 1210

Record the date radiation started. It is important to be able to sequence the use of multiple treatment modalities and to evaluate the time intervals between the treatments. For some diseases, the sequence of radiation and surgical therapy is important when determining the analytic utility of pathologic stage information.

Beginning in 2010, the way dates are transmitted between facility registries and central registries was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. Interoperable dates are displayed in CCYYMMDD form, with the unknown portions of the date filled with blank spaces. If a date is entirely blank, an associated date flag is used to explain the missing date. Flags are not used for software-generated dates.

For more information regarding dates, please see *Virginia Cancer Registry Manual, Part Three: Data Item Instructions, General Information, Coding Dates*

Recording RX Date- Radiation

1. Record the date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, and the day in the last two spaces. A zero must precede single-digit months and days. See *VCR Manual Part Three, General Instructions* for allowable values.

   Example: Record February 12, 2015 as 20150212.

2. Collecting dates for each treatment modality allows sequencing of multiple treatments and evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

   Example: A patient enters your facility for interstitial radiation boost for prostate cancer that is performed on August 6, 2015. Just prior to this, the patient had external beam therapy to the lower pelvis that was stated on June 2, 2015 at another facility. Record the date as 20150603

3. If the date radiation started is unknown, leave blank. If any part of the date is unknown, leave that part blank in the field.

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Radiation (Beam)* or *RX Text - Radiation Other*.

RX Date – Radiation Flag NAACCR Item #1211

This flag explains why there is no appropriate value in the corresponding date field, *RX Date - Radiation.*

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes and Definitions

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any radiation was given).
11	No proper value is applicable in this context. (for example, no radiation given).
12	A proper value is applicable but is not known. This event occurred but the date is unknown (that is, radiation was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (for example, 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 the item *RX Date - Radiation.*

Recording RX Date – Radiation Flag

1. Leave this item blank if *RX Date - Radiation* has a full or partial date recorded.

2. Code 12 if *RX Date - Radiation* cannot be determined, but the patient did receive first course radiation.

3. Code 10 if it is unknown whether any radiation was given

4. Code 11 if no radiation is planned or given.

5. Code 15 if radiation is planned, but has not yet started and the start date is not yet available. Follow this patient for radiation treatment and update this item, *Date Radiation Started*, and all other radiation items.

Regional Treatment Modality NAACCR Item #1570

Record the dominant modality of radiation therapy used to deliver the most clinically significant regional dose to the primary volume of interest during the first course of treatment

Codes and Definitions

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosis at autopsy
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt- 60 or Cesium-137 source. Intracavitary use of these sources is coded 50 or 51.
23	Photons (2–5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2–5 MV.
24	Photons (6–10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6–10 MV.
25	Photons (11–19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11–19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons & electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, w/ or w/o photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, radioembolization, or intracavitary applicators of radioactive materials not otherwise specified.

Code	Label	Definition
51	Brachytherapy, Intracavitary, LDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavitary,	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
80*	Combination modality, specified*	Combination of external beam radiation and either radioactive implants or radioisotopes* **This is a converted code and should not be coded for cases diagnosed on or after 1/1/2003.**
85*	Combination modality, NOS*	Combination of radiation treatment modalities not specified in code 80.* **This is a converted code and should not be coded for cases diagnosed on or after 1/1/2003.**
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered. Death certificate only

Recording Radiation Regional Treatment Modality

1. Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
2. Radiation treatment is frequently delivered in two or more phases which can be summarized as "regional" and "boost" treatments.
   a. Regional Radiation is directed at the cancer site and a larger area of surrounding tissue.
   b. Boost Radiation is a supplemental radiation dose targeted directly to the tumor site (or site of the original tumor). It is provided to a smaller area within the same volume as regional, in order to enhance the effect of the regional treatment.

   The VCR only requires Regional Radiation to be reported.
3. If only one radiation treatment modality is delivered to a patient and it is not specified as either regional or boost treatment, assume it is regional treatment and code accordingly.
4. In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality.

5. In some circumstances, the boost treatment may precede the regional treatment.

   Example 1: A patient treated with breast conserving surgery has an interstitial boost at the time of the excisional biopsy. The implant uses Ir-192 and is left in place for three days. This is followed by 6 MV photon treatment of the entire breast. The boost was given before the regional treatment; code to 24.

6. For purposes of this data item, photons and x-rays are equivalent.

   Example 1: Patient receives 15 MV external pelvic treatment to 4,500 cGy for cervical carcinoma, and then receives two Fletcher intracavitary implants is coded to 25.

   Example 2: A patient with carcinoma of the parotid receives daily treatments of which 60% are delivered by 15 MV photons and 40% of the dose is delivered by 16 MV electrons is coded to 29.

7. Code IMRT or conformal 3D whenever either is explicitly mentioned.

8. Code radioembolization as brachytherapy.

9. Code PUVA (psoralen and long-wave ultraviolet radiation) *Other Treatment (*NAACCR Item #1420, Code 1)

10. A patient who is treated with I-125 seeds is coded as low dose brachytherapy (Code 53)

11. A patient who is treated with 4500cGy using 15 MV external pelvic radiation, then receives two Fletcher intracavitary implants; code to the external beam (Code 25)

12. A patient with prostate carcinoma receives pelvic irradiation at the reporting facility, then is referred to another facility for experimental proton therapy boost; code to External Beam, NOS (Code 20)

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Radiation (Beam) or RX Text - Radiation Other.*

Radiation/Surgery Sequence NAACCR Item # 1380

Record the sequencing of radiation and surgical procedures given as part of first course of treatment.

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

Codes and Definitions

Code	Definition
0	*No radiation therapy and/or surgical procedures*- No radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node (s). Diagnosed at autopsy. *Example*: Due to other medical conditions surgery was not performed.
2	*Radiation therapy before surgery*- Radiation therapy given before surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s). *Example*: A patient has a large lung lesion and received radiation therapy prior to resection.
3	*Radiation therapy after surgery*- Radiation therapy given after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s). *Example*: A patient received a wedge resection of a right breast mass with axillary lymph node dissection followed by radiation to the right breast.
4	*Radiation therapy both before and after surgery*- Radiation therapy given before and after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s). *Example*: Preoperative radiation was given to a large, bulky vulvar lesion and was followed by lymph node dissection. This was then followed by radiation therapy to treat positive lymph nodes.
5	*Intraoperative radiation therapy*- Intraoperative therapy given during surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s). *Example*: A cone biopsy of the cervix is followed by intracavitary implant for IIIB cervical
6	*Intraoperative radiation therapy with other therapy administered before or after surgery* – Intraoperative radiation therapy given during surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node (s) with other radiation administered before or after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	*Sequence unknown*- Administration of radiation therapy and surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record.

Recording Radiation/Surgery Sequence

1. Surgical procedures include:
   a. *RX Summ-Surg Prim Site* (surgery of the primary site)
   b. *RX Summ-Scope LN Surg* (scope of regional lymph node surgery)
   c. *RX Summ-Surg Oth Reg/Dis* (surgery to other regional site, distant site, or distant lymph node)
2. If all surgery procedures listed above are coded to 0, then this item should be coded to 0.

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery, RX Text - Radiation (Beam) and RX Text - Radiation Other.*

Reason for No Radiation NAACCR Item #1430

This field records the reason that no regional radiation therapy was administered. When evaluating the quality of care, it is useful to know the reason that various methods of therapy were not used, and whether the failure to provide a given type of therapy was due to the physician's failure to recommended that treatment or due to the refusal of the patient, a family member or the patient's guardian.

Codes and Instructions

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

Recording Reason for No Radiation

1. If *Regional Treatment Modality* (NAACCR Item #1570) is coded 00, then record the reason based on documentation in patient record.
2. Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include radiation therapy.
3. Code 7 if the patient refused radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
4. Code 8 if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.
5. Code 8 to indicate referral to a radiation oncologist was made and the registry should follow to determine whether radiation was administered. If follow-up to the specialist or facility determines the patient was never there and no other documentation can be found, code 1.
   a. Cases coded to 8 should be followed and updated to a more definitive code as appropriate.
6. Code 9 if the treatment plan offered multiple alternative treatment options, but it is unknown which treatment, if any, was provided.

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Surgery, RX Text - Radiation (Beam) and RX Text - Radiation Other.*

Date Chemotherapy Started NAACCR Item #1220

Record the date chemotherapy started. It is important to be able to sequence the use of multiple treatment modalities and to evaluate the time intervals between the treatments.

Beginning in 2010, the way dates are transmitted between facility registries and central registries was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. Interoperable dates are displayed in CCYYMMDD form, with the unknown portions of the date filled with blank spaces. If a date is entirely blank, an associated date flag is used to explain the missing date. Flags are not used for software-generated dates.

For more information regarding dates, please see *Virginia Cancer Registry Manual, Part Three: Data Item Instructions, General Information, Coding Dates*

Recording Date Chemotherapy Started

1. Record the date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, and the day in the last two spaces. A zero must precede single-digit months and days. See *VCR Manual Part Three, General Instructions* for allowable values.

   Example: Record February 12, 2015 as 20150212.

   a. Record the first or earliest date on which chemotherapy was administered. This date corresponds to administration of the agents coded in *Chemotherapy* (NAACCR Item #1390)

2. Collecting dates for each treatment modality allows sequencing of multiple treatments and evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

   Example: A patient enters your facility for radiation therapy for breast cancer that is performed on August 6, 2015. Just prior to this, the patient had two courses of Taxotere that was stated on June 2, 2015 at another facility. Record the date as 20150603

3. If the date radiation started is unknown, leave blank. If any part of the date is unknown, leave that part blank in the field.

   a. If the exact date chemotherapy started is not available, record an approximate date; refer to *VCR Manual Part Three, General Instructions*

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, Chemo Text*

RX Date – Chemo Flag NAACCR Item #1221

This flag explains why there is no appropriate value in the corresponding date field, *RX Date - Chemo.*
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes and Definitions

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any chemotherapy was given).
11	No proper value is applicable in this context (for example, no chemotherapy given).
12	A proper value is applicable but is not known. This event occurred but the date is unknown (that is, chemotherapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (for example, 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 the item *RX Date - Chemo*

Recording RX Date – Chemo Flag

1. Leave this item blank if *RX Date - Chemo* has a full or partial date recorded.
2. Code 12 if *RX Date - Chemo* cannot be determined, but the patient did receive first course chemotherapy.
3. Code 10 if it is unknown whether any chemotherapy was given
4. Code 11 if no chemotherapy is planned or given.
5. Code 15 if chemotherapy is planned, but has not yet started and the start date is not yet available. Follow this patient for chemotherapy treatment and update this item, *Date Chemo Started*, and all other chemotherapy items.

Chemotherapy NAACCR Item #1390

Record the type of chemotherapy administered as first course of treatment at your institution and at all other institutions. If chemotherapy was not administered, then this item records the reason it was not administered to the patient. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

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

Codes and Definitions

Code	Definition
00	None- chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Chemotherapy NOS- Chemotherapy administered as first course therapy, but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as first course therapy
03	Multiagent chemotherapy administered as first course therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only

Recording Chemotherapy

1. If chemotherapy was not administered to the patient, and it is known it is not usually administered for this stage of cancer or type of condition, code to 00.
2. If the treatment plan offered multiple options and the patient selected treatment that did not include chemotherapy or if the patient selected no treatment, code to 00.
3. If it is known chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
4. If the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended, code to 87.

5. If it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered, code to 99.
6. Code 88 if it is known that a physician recommended the patient receive chemotherapy but no further documentation is yet available to confirm its administration.
7. Chemo embolization should be coded to 01, 02, or 03, depending on the number of chemotherapeutic agents administered.
8. If chemotherapy was given as a radiosensitizer or radioprotectant, DO NOT code as chemotherapy
9. If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (See *VCR Manual, Part Three, Chemotherapy Group Classifications*) than the original agent, the new regimen represents the start of subsequent therapy, and *only the original agent or regimen is recorded as first course therapy*.

   Example: The physician documents a multimodality treatment plan that includes a combination regimen of chemotherapy. Velban is one of the drugs in the chemotherapy regimen. After two cycles of chemotherapy, the physician says the Velban will be replaced with Oncovin and the chemotherapy will continue as planned. This is a continuation of the planned first course of therapy since they are in the same group.
10. If chemotherapy is given to prolong the patient's life by controlling symptoms, alleviating pain, or to make the patient more comfortable, then also record the chemotherapy administered in the item Palliative Care (NAACCR Item #3270)
11. Use *SEER RX* to determine if a drug is a chemotherapy agent. *SEER RX* is an interactive antineoplastic drug data base and it can be downloaded from this website:

    http://seer.cancer.gov/seertools/seerrx
12. The six drugs listed below were previously classified as chemotherapy are now classified as BRM/Immunotherapy. **This change is effective for cases diagnosed January 1, 2013 and forward.** For cases prior to 2013, the drugs should continue to be recorded as chemotherapy.

    a. Alemtuzumab/Campath
    b. Bevacizumab/Avastin
    c. Rituximab
    d. Trastuzumab/Herceptin
    e. Pertuzumab/Perjeta
    f. Cetuxumab/Erbitux

    Note: According to the standard set by *SEER RX Interleukin* are considered chemotherapy drugs, ***not*** immunotherapy.

Methods of Administration

Method	Definition
Intravenous (IV) Infusion	A small plastic needle is inserted into a vein. Chemotherapy flows from the IV bag/bottle, through the needle and catheter into the bloodstream.
Orally	Medication taken in the form of either a pill or liquid taken by mouth.
Intrathecal	Administered directly into the cerebrospinal fluid through a lumbar puncture needle into an implanted access device (e.g., Ommaya reservoir).
Pleural/pericardial	Injected directly into pleural or pericardial space to control malignant effusions.
Intraperitoneal	Injected into the peritoneal cavity.
Hepatic artery	Injected into a catheter inserted into artery that supplies blood to liver.

Clarification of Terms

Term	Definition
Adjuvant chemotherapy	Chemotherapy given after other methods have destroyed the clinically detectable cancer cells. Chemotherapy given to destroy micrometastases (undetectable cancer cells). The intent is to prevent or delay a recurrence. *Example:* The patient has breast cancer with positive nodes. The patient is clinically free of disease after a modified radical mastectomy. The patient is treated with adjuvant chemotherapy to prevent or delay disease recurrence.
Multimodality therapy Combined modality therapy Concurrent therapy	Chemotherapy given before, during, or after other treatment modalities (surgery, radiation) as a part of the treatment plan.
Neo-adjuvant therapy	Given prior to surgical resection or radiation therapy to reduce the bulk of a locally advanced primary cancer. *Example*: A patient with locally advanced breast cancer receives chemotherapy to reduce tumor size. Chemotherapy is followed by a modified radical mastectomy.
Treatment cycles	Chemotherapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more chemotherapy drugs. The interval of a treatment cycle varies and chemotherapy may be administered for several weeks or several years.

Chemotherapy Group Classifications

Group	Subgroup	Example
Alkylating agents	Nitrogen mustard	Mechlorethamine (Mutagens), phenylalanine mustard (Memphians),
	Ethylenimine derivatives	Triethylene-thiophosphoramide (Thio-TEPA)
	Alkyl sulfonates	Busulfan (Myleran)
	Nitrosoureas	Carmustine (Lomustine)
	Triazines	DTIC (Dacarbazine)
Antimetabolites	Folic acid analogues	Methotrexate (Amethopterin, MTX)
	Pyrimidine analogues	5-fluorouracil (5-FU)
	Purine analogues	6-mercaptopurine (6-MP)
Natural products	Anti-tumor	Dactinomycin (Actinomycin D), doxorubicin (Adriamycin), daunorubicin (Daunomycin), bleomycin (Blenoxane), mitomycin C (Mutamycin)
	Plant alkaloids	Vinblastine (Velban, VBL), vincristine (Oncovin, VCR)
	Enzymes	l-asparaginase (Elspar)
Miscellaneous		Cis-diammine dichloroplatinum II (Cisplatin), hydroxyurea (Hydrea), procarbazine (Matulane)

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Chemo.*

Date Hormone Started NAACCR Item #1230

Record the date hormone therapy started. It is important to be able to sequence the use of multiple treatment modalities and to evaluate the time intervals between the treatments.

Beginning in 2010, the way dates are transmitted between facility registries and central registries was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. Interoperable dates are displayed in CCYYMMDD form, with the unknown portions of the date filled with blank spaces. If a date is entirely blank, an associated date flag is used to explain the missing date. Flags are not used for software-generated dates.

For more information regarding dates, please see *Virginia Cancer Registry Manual, Part Three: Data Item Instructions, General Information, Coding Dates*

Recording Date Hormone Therapy Started

1. Record the date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, and the day in the last two spaces. A zero must precede single-digit months and days. See *VCR Manual Part Three, General Instructions* for allowable values.

   Example: Record February 12, 2015 as 20150212.

   a. Record the first or earliest date on which hormones were administered. This date corresponds to administration of the agents coded in *Hormone* (NAACCR Item #1400

2. Collecting dates for each treatment modality allows sequencing of multiple treatments and evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

3. If the date hormes started is unknown, leave blank. If any part of the date is unknown, leave that part blank in the field.

   a. If the exact date hormone therapy started is not available, record a partial date; refer to *VCR Manual Part Three, General Instructions*

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, Chemo Text*

Rx Date – Hormone Flag NAACCR Item #1231

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

Codes and Definitions

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any hormone therapy was given).
11	No proper value is applicable in this context (for example, no hormone therapy given).
12	A proper value is applicable but is not known. This event occurred but the date is unknown (that is, hormone therapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (for example, 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 the item *RX Date - Hormone*

Recording RX Date – Hormone Flag

1. Leave this item blank if *RX Date – Hormone* has a full or partial date recorded.
2. Code 12 if *RX Date - Hormone* cannot be determined, but the patient did receive first course hormone therapy.
3. Code 10 if it is unknown whether any hormone therapy was given
4. Code 11 if no hormone therapy is planned or given.
5. Code 15 if hormone therapy is planned, but has not yet started and the start date is not yet available. Follow this patient for hormone therapy treatment and update this item, *Date Hormone Started*, and all other hormone therapy items.

Hormone Therapy (Hormone/Steroid Therapy) NAACCR Item #1400

Record the type of hormone therapy the patient received as a part of first course of treatment at your institution and all other institutions. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Hormone therapy achieves its effect on cancer tissue through change of the hormone balance. Included are the administration of hormones, agents acting via hormonal mechanisms, antihormones, and steroids.

Codes and Definitions

Code	Definition
00	None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.
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 the first course of therapy. No reason was stated in patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only

Recording Hormone Therapy

1. Hormones, agents acting via hormonal mechanisms, and antihormones (cancer-directed only) are to be coded for all sites (primary and metastatic).
2. Prednisone
   a. Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
   b. Do not code prednisone as hormone therapy when it is administered for reasons other than cancer treatment.

      Example 1: A patient has advanced lung cancer with metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormone therapy.

Example 2: A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Do not code the prednisone as hormone therapy.

3. Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.

   Example: Patients with breast cancer may be treated with aminoglutethimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. These patients must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (Florinef) as a replacement therapy. Code Rx Summ- Hormone to 00, None.

4. If hormone therapy was not administered to the patient, and it is known it is not usually administered for this type and stage of cancer, code to 00.
5. If the treatment plan offered multiple options, and the patient selected treatment that did not include hormone therapy, code to 00.
6. Code 01 for thyroid replacement therapy which inhibits TSH (thyroid stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
7. If it is known hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
8. If the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended, code to 87.
9. If it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered, code to 99.
10. Use *SEER RX* to determine if a drug is a hormonal agent. *SEER RX* is an interactive antineoplastic drug data base and it can be downloaded from this website: http://seer.cancer.gov/seertools/seerrx/

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Hormone.*

Date Immunotherapy (BRM) Started NAACCR Item #1240

Record the date immunotherapy started. It is important to be able to sequence the use of multiple treatment modalities and to evaluate the time intervals between the treatments.

Beginning in 2010, the way dates are transmitted between facility registries and central registries was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. Interoperable dates are displayed in CCYYMMDD form, with the unknown portions of the date filled with blank spaces. If a date is entirely blank, an associated date flag is used to explain the missing date. Flags are not used for software-generated dates.

For more information regarding dates, please see *Virginia Cancer Registry Manual, Part Three: Data Item Instructions, General Information, Coding Dates.*

Recording Date Immunotherapy Started

1. Record the date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, and the day in the last two spaces. A zero must precede single-digit months and days. See *VCR Manual Part Three, General Instructions* for allowable values.

   Example: Record February 12, 2015 as 20150212.

   a. Record the first or earliest date on which immunotherapy were administered. This date corresponds to administration of the agents coded in *Immunotherapy* (NAACCR Item #1240)

2. Collecting dates for each treatment modality allows sequencing of multiple treatments and evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

3. If the date Immunotherapy started is unknown, leave blank. If any part of the date is unknown, leave that part blank in the field.

   a. If the exact date Immunotherapy started is not available, record a partial date; refer to *VCR Manual Part Three, General Instructions*

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, BRM Text*

Rx Date – BRM Flag NAACCR Item #1241

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

Codes and Definitions

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any immunotherapy was given).
11	No proper value is applicable in this context (for example, no immunotherapy given).
12	A proper value is applicable but is not known. This event occurred but the date is unknown (that is, immunotherapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (for example, immunotherapy 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 the item *RX Date - BRM*

Recording RX Date – Immunotherapy Flag

1. Leave this item blank if *RX Date – Immunotherapy* has a full or partial date recorded.
2. Code 12 if *RX Date - Immunotherapy* cannot be determined, but the patient did receive first course hormone therapy.
3. Code 10 if it is unknown whether any immunotherapy was given
4. Code 11 if no immunotherapy is planned or given.
5. Code 15 if immunotherapy is planned, but has not yet started and the start date is not yet available. Follow this patient for immunotherapy treatment and update this item, *Date Immunotherapy Started*.

Immunotherapy (BRM) NAACCR Item #1410

Record the immunotherapy (biological response modifier, BRM) the patient received as a part of first course of treatment at the reporting institution and all other institutions. If immunotherapy was not administered, then this item records the reason it was not administered to the patient. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells.

Codes and Definitions

Code	Definition
00	None, immunotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Immunotherapy administered as first course therapy.
82	Immunotherapy was not recommended/administered because it was contra-indicated 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 the first course of therapy. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	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.

Recording Immunotherapy

1. If immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer, code to 00.
2. If the treatment plan offered multiple options, and the patient selected treatment that did not include immunotherapy, code to 00.
3. If it is known immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
4. If the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended, code to 87.
5. If it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered, code to 99.

6. Use *SEER RX* to determine if a drug is an immunotherapy agent. *SEER RX* is an interactive antineoplastic drug data base and it can be downloaded from this website:

   http://seer.cancer.gov/tools/seerrx/

7. Immunotherapy includes:

Allogeneic cells	**Herceptin (Trastuzumab)***	**Perjeta (Pertuzumab)***
Avastin (bevacizumab)*	Interferon	Pyran copolymer
BCG	LAK cells	**Rituximab***
Campath (Alemtuzumab)*	Levamisole	Thymosin
Erbitux (Cetuxumab)*	MVE - 2	Vaccine therapy
		Virus therapy

**** changed for cases diagnosed 1/1/2013 and forward from chemotherapy***

Note: According to the standard set by *SEER RX* **Interleukin** is considered chemotherapy drugs, not immunotherapy.

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - BRM.*

Hematologic Transplant and Endocrine Procedures NAACCR Item #3250

Record the 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.

Codes and Definitions

Code	Definition
00	No transplant procedure or endocrine therapy was administered as part of first course therapy. Diagnosed at autopsy.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant- autologous.
12	Bone marrow transplant- allogeneic.
20	Stem cell harvest and infusion.
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 the first course of therapy. No reason was stated in patient record.
87	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record. Death certificate only.

Recording Hematologic Transplant and Endocrine Procedures

1. Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.
2. Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation.

3. Endocrine irradiation and/or endocrine surgery
    a. Procedures that suppress the naturally occurring hormonal activity of the patient and thus alter or effect the long-term control of the cancer's growth.
    b. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.
4. Code 00 if a transplant or endocrine procedure was not administered to the patient, and it is known these procedures are not usually administered for this type and stage of cancer.
5. Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include a transplant or endocrine procedure.
6. it is known a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to patient, use code 82, 85, 86, or 87 to record reason why it was not.
7. If the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended, code to 87.
8. Use code 88 if a bone marrow or stem cell harvest was undertaken, but was not followed by a rescue or reinfusion as part of the first course treatment.
9. If the hematologic transplant or endocrine procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hematologic transplant or endocrine procedure provided in the item *Palliative Care* (NAACCR Item #3270)
10. If it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered, code to 99.

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text – Other*

Systemic/Surgery Sequence NAACCR Item#1639

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

Codes and Definitions

Code	Definition
0	*No systemic therapy and/or surgical procedures*- No systemic therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s). Diagnosed at autopsy. *Example*: Due to other medical conditions surgery was not performed.
2	*Systemic therapy before surgery*- Systemic therapy given before surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s). *Example*: A patient with prostate cancer received hormone therapy prior to radical prostatectomy.
3	*Systemic therapy after surgery*- Systemic therapy given after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s). *Example*: A patient underwent a colon resection followed by a 5-FU based chemotherapy regimen.
4	*Systemic therapy both before and after surgery*- Systemic therapy given before and after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s). *Example*: A patient with breast cancer receives pre-operative chemotherapy followed by postoperative Tamoxifen.
5	*Intraoperative systemic therapy*- Intraoperative systemic therapy given during surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s). *Example*: Patient with an intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity
6	*Intraoperative systemic therapy with other therapy administered before or after surgery*- Intraoperative systemic therapy given during surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node (s) with other systemic therapy administered before or after surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s). *Example*: Patient with metastatic colon cancer receives intraoperative chemotherapy to the liver and postoperative 5-FU and leucovorin with irinotecan.
9	*Sequence unknown*- Administration of systemic therapy and surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is unknown if systemic therapy was administered and/or it is unknown if surgery of the primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed. Death Certificate only. *Example:* An unknown primary of the head and neck was treated with surgery and chemotherapy prior to admission, but the sequence is unknown.

Recording RX Summ-Systemic Sur Seq

1. *Systemic/Surgery Sequence* id used for patients diagnosed on or after January 1, 2006.
2. Surgical procedures include surgery of the primary site, scope of regional lymph node surgery, and surgery to other regional site, distant site, or distant lymph nodes.
3. If all surgery procedures listed above are coded to 0, then this item should be coded to 0.
4. If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

   Example: The sequence: chemo then surgery then hormone therapy then surgery. This would be coded 4: Chemo then surgery then hormones.

Text

Text to support this data item must be recorded in specific text field. See *VCR Manual Part Three, Data Item Instructions, RX Text – Surgery; RX Text – Chemo; RX Text – BRM;* and *RX Text – Hormone.*

Date Other Treatment Started NAACCR Item #1250

Record the date on which other treatment started. It is important to be able to sequence the use of multiple treatment modalities and to evaluate the time intervals between the treatments.

Beginning in 2010, the way dates are transmitted between facility registries and central registries was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. Interoperable dates are displayed in CCYYMMDD form, with the unknown portions of the date filled with blank spaces. If a date is entirely blank, an associated date flag is used to explain the missing date. Flags are not used for software-generated dates.

For more information regarding dates, please see *Virginia Cancer Registry Manual, Part Three: Data Item Instructions, General Information, Coding Dates.*

Recording Date Other Treatment Started

1. Record the date in year, month, day format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, and the day in the last two spaces. A zero must precede single-digit months and days. See *VCR Manual Part Three, General Instructions* for allowable values.

   Example: Record February 12, 2015 as 20150212.

   a. Record the first or earliest date on which immunotherapy were administered. This date corresponds to administration of the agents coded in *Immunotherapy* (NAACCR Item #1240)

2. Collecting dates for each treatment modality allows sequencing of multiple treatments and evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

3. If the date when *Other Treatment* started is unknown, leave blank. If any part of the date is unknown, leave that part blank in the field.

   a. If the exact date *Other Therapy* started is not available, record a partial date; refer to *VCR Manual Part Three, General Instructions*

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text: Other*

RX Date –Other Flag NAACCR Item #1251

This flag explains where there is no appropriate value in the corresponding date field, *Date Other Treatment Started*

Codes and Definitions

Code	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any *Other Treatment* was given).
11	No proper value is applicable in this context (for example, no Other Treatment was given).
12	A proper value is applicable but is not known. This event occurred but the date is unknown (that is, Other Treatment was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (for example, Other Treatment 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 the item *RX Date - BRM*

Recording RX Date – Immunotherapy Flag

1. Leave this item blank if *RX Date – Other Treatment* has a full or partial date recorded.
2. Code 12 if *RX Date – Other Treatment* cannot be determined, but the patient did receive first course Other Treatment.
3. Code 10 if it is unknown whether any Other Treatment was given
4. Code 11 if no Other Treatment is planned or given.
5. Code 15 if Other Treatment is planned, but has not yet started and the start date is not yet available. Follow this patient for immunotherapy treatment and update this item, *Date Immunotherapy Started*.

Other Treatment NAACCR Item #1420

Record other cancer-directed therapy received by the patient as part of the first course of treatment at the reporting institution and all other institutions. Other treatment includes therapies designed to modify or control the cancer cells that are not defined in *Surgery, Radiation,* or *Systemic Therapy* fields.

Codes and Definitions

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

Recording Other Treatment

1. 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, and should be coded 1.
    a. Phlebotomy may be called blood removal, bloodletting, or venisection.
    b. Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.
    c. Aspirin (also known as ASA, acetylsalicylic acid, or by a brand name) is used as a treatment for essential thrombocythemia. Record ONLY aspirin therapy to thin the blood for symptomatic control of thrombocythemia.
        1. To determine whether aspirin is administered for pain, cardiovascular protection, or thinning of platelets in the blood, use the following general guideline:
            a. Pain control is approximately 325–1000 mg every 3–4 hours.

b. Cardiovascular protection starts at about 160 mg/day.

c. Aspirin treatment for essential thrombocythemia is low dose, approximately 70-100 mg/day.

2. Do not code presurgical embolization that given for a purpose to shrink the tumor.
   a. Code 1 for embolization using alcohol as an embolizing agent.
   b. Code 1 for embolization to a site other than the liver where the embolizing agent is unknown.

3. Do not code ancillary drugs in this field. There is no coding scheme for ancillary drugs.

Examples: Aredia, Allopurinol, G-CSF (growth stimulating factors), Epogen, Nupogen/Neupogen, Leucovorin

Note: This is a partial list. See *SEER RX* to determine if a drug is an ancillary drug. *SEER RX* is an interactive antineoplastic drug data base and it can be downloaded from this website:

http://seer.cancer.gov/seertools/seerrx/

Text

Text to support this data item must be recorded in specific text fields. See *VCR Manual Part Three, Data Item Instructions, RX Text - Other.*

Guidelines for Reporting Text

Text Requirements

The VCR requires all records to include text information to support specified fields. The purpose of text is quality control. Text is used to validate data items, verify potential errors identified through standard edits, document clarifications, determine multiple primaries, and reconcile data item discrepancies when the same patient is submitted by several facilities. Defensive abstracting, as this documentation is often called, is an absolute necessity for quality data.

Cancer abstracting software must include specific fields designed to document text as defined by NAACCR fields. These fields must be transmitted to the VCR in addition to the other required data items when electronic shipments are prepared.

Completion of Text Fields

Text should be complete but concise. The text fields must summarize all cancer information recorded in the medical record. Text must be completed for primary site, laterality, histology, grade, and collaborative stage or summary stage on every record. Text should be completed for pathology and other diagnostic and treatment text fields as appropriate for studies performed and treatment provided. If information is missing from the record, state that it is missing. The text fields should be used to document information that will support the accuracy of data so anyone reviewing the abstract will be able to justify the coded information.

Amount of Text

Quality of text is more important than amount or quantity of text. The most useful text is brief, concise, and addresses pertinent issues. Often it is necessary to use abbreviations to provide adequate descriptions within the limited size of the text fields. Use standard medical abbreviations whenever possible. Refer to *VCR Manual Appendix J* for a list of VCR acceptable abbreviations. Include dates (month, day, and year) when appropriate.

Note the maximum field lengths for each text field. These lengths indicate how many characters will be transmitted to the VCR. Since your abstracting software may provide you with more characters in each of these fields, make sure the most **important information is documented at the beginning** of the text field. 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. Do not include irrelevant information. *Do not repeat information from other text fields*.

Text – DX Proc/PE NAACCR Item #2520

Information documenting the disease process should be entered manually from the medical record. Record text information from the history/physical examination that supports the diagnosis and history of the tumor as applicable. If information is missing from the record, state that it is missing. **Do not include irrelevant information.**

Source Records

The history/physical examination findings may be found in, but are not limited to, the following source records:

1. History and Physical Report
2. Consultation Reports
3. Progress Notes

Suggestions for Text

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Date of physical exam
2. **Age, sex, race/ethnicity**
3. History that relates to cancer diagnosis.
4. Primary site.
5. Histology (if diagnosis prior to this admission).
6. Tumor location.
7. Tumor size.
8. Palpable lymph nodes.
9. Record positive and negative clinical findings. Record positive results first.
10. Impression (when stated and pertains to cancer diagnosis).
11. Treatment plan.

Data Item(s) to be verified using the text entered in this field

1. Date of 1st Contact
2. Date of Diagnosis
3. Age at Diagnosis
4. Race 1 – 5
5. Spanish Hispanic Origin
6. Sex

Text – Dx Proc - X-Rays/Scans NAACCR Item #2530

Information documenting the disease process should be entered manually from the medical record. Record text information from diagnostic imaging reports as applicable. Document both positive and negative findings and the date(s) of the imaging result(s). If information is missing from the record, state that it is missing. Do not include irrelevant information

Source Records

The diagnostic imaging findings may be found in, but are not limited to, the following source records:

1. All Diagnostic X-ray reports including mammograms and CT scans
2. History and Physical Report
3. Consultation Reports
4. Discharge Summary

Suggestions for Text

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Date(s) of X-ray/Scan(s).
2. Age, sex, race/ethnicity (when given).
3. Primary site.
4. Histology (if given).
5. Tumor location.
6. Tumor size.
7. Lymph nodes.
8. Record positive and negative clinical findings. Record positive results first.
9. Distant disease or metastasis.

Data Item(s) to be verified/validated using the text entered in this field

1. Date of Diagnosis
2. Primary Site
3. Laterality
4. Collaborative Stage variables
5. SEER Summary Stage 2000

Text – Dx Proc – Scopes NAACCR Item #2540

Information documenting the disease process should be entered manually from the medical record. Record text information from endoscopic examinations as applicable. Document both positive and negative findings and the date(s) of the scope(s). If information is missing from the record, state that it is missing. Do not include irrelevant information.

Source Records:

The endoscopic examination findings may be found in, but are not limited to, the following source records:

1. Endoscopy Reports (i.e. Bronchoscopy, Colonoscopy, Laryngoscopy, Esophagoscopy)
2. History and Physical Report
3. Discharge Summary
4. Consultation Reports

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Date(s) of endoscopic exam(s).
2. Primary site.
3. Histology (if given).
4. Tumor location.
5. Tumor size.
6. Lymph nodes.
7. Record positive and negative clinical findings. Record positive results first.

Data Item(s) to be verified/validated using the text entered in this field

1. Date of Diagnosis
2. Primary Site
3. Laterality
4. Histology
5. Collaborative Stage variables
6. SEER Summary Stage 2000
7. Surg Prim Site

Text – Dx Proc – Lab Tests NAACCR Item # 2550

Information documenting the disease process should be entered manually from the medical record. Record information from laboratory tests or marker studies other than cytology/histopathology that are clinically diagnostic of cancer as applicable. Document pertinent positive and negative findings and the result(s) and date(s) of these test(s). If information is missing from the record, state that it is missing. Do not include irrelevant information.

Source Records*:*

The laboratory examination findings may be found in, but are not limited to, the following source records:

1. Laboratory Reports
2. History and Physical Reports
3. Consultation Reports

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Type of laboratory test/tissue specimen(s).
2. Record both positive and negative findings. Record positive test results first.
3. Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
4. Date(s) of laboratory test(s).
5. Tumor markers included, but are not limited to:
   a. Breast Cancer: Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu.
   b. Prostate Cancer: Prostatic Specific Antigen (PSA).
   c. Testicular Cancer: Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH).

Data Item(s) to be verified/validated using the text entered in this field:

1. Primary Site
2. Grade
3. Diagnostic Confirmation
4. Collaborative Stage variables
5. Date of Diagnosis

Text – Dx Proc – Op NAACCR Item #2560

Information documenting the disease process should be entered manually from the medical record. *Record text information from all surgical procedures that provide information for staging*. Document both positive and negative findings and the date(s) of the procedure(s). If information is missing from the record, state that it is missing. Do not include irrelevant information.

Source Records:

The operative findings may be found in, but are not limited to, the following source records:

1. Operative Reports
2. Consultation Reports

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived.
2. Information gained from "exploration" of tumor area, especially observations that indicate metastases but are not biopsied
3. Tissue removed
4. Size of tumor removed.
5. Documentation of residual tumor.
6. Number of lymph nodes removed.
7. Evidence of invasion of surrounding areas.
8. Evidence of invasion of surrounding areas
9. Evidence of metastases
10. Reason primary site surgery could not be completed

Data Item(s) to be verified/validated using the text entered in this field:

1. Date of Diagnosis
2. RX Summ--Dx/Stg Proc
3. Diagnostic Confirmation
4. Primary Site
5. RX Summ--Surg Prim Site
6. Collaborative Stage SSF's
7. SEER Summary Stage 2000
8. Clinical and/or Pathological TNM and Stage
9. Reason for No Surgery

Text – Dx Proc – Path NAACCR Item #2570

Record text from cytology and histopathology reports to support the final pathologic diagnosis. Include all descriptive terms from the histology or cytology report to describe the specific diagnosis including nouns, adjectives, and phrases. Also include differential diagnoses, documentation to support unusual site/histology combinations, notes, comments, addenda, and results of consults and second opinions. Record the final diagnosis from slide reviews if applicable.

Either *Text-Histology Title* or *Text-Dx Proc-Path* must be completed on each record. Information to support the exact diagnosis has to appear in one of these two fields. *Text-Histology Title* is a 100 character field generally used to record clinical or other non-pathologic diagnoses; *Text-Dx Proc-Path* is a 1000 character field generally used to record histologically and cytologically confirmed diagnoses from pathology reports.

This field should also include text to support multiple primaries diagnosed simultaneously and discrepancies between pathology reports. For example, if a definitive surgery pathology report has a more specific or differing diagnosis than the biopsy report, document the physician's final diagnosis. Include text to clarify site and/or histology information for cases discussed at Cancer Conference, especially if the site was unknown.

Terminology

If the reporting facility considers the terminology of severe dysplasia or high grade dysplasia of the colon as synonymous with carcinoma in-situ, follow the procedure described in *VCR Manual Part Three, Behavior*. Include text in this field to support the final pathologic diagnosis along with the statement "in-situ per pathologist". If any colon cases diagnosed with severe dysplasia and/or high grade dysplasia are submitted to the VCR without the text documentation "in-situ per pathologist", the cases will either not be entered in the VCR database or they will be deleted since the terminology alone is not reportable.

Mixed or multiple histologies may have documentation of various phrases describing the tumor. When documenting the description of the tissue, include the terminology type in the description. These terms are important because they impact the ICD-O code assignment.

1. **Principal Tumor Type** - Phrases such as "predominantly" and "with features of" are often used to identify the principal tumor type. Use this information when recording text to support the histologic diagnosis.
2. **Non-Principal Tumor Type** - The phrases "with foci of", "areas of" or "elements of" do not describe the majority of the tumor. These terms should be included in text even though they are not used to code the histologic type.

Source Records:

The pathology findings may be found in, but are not limited to, the following source records:

1. Pathology and Cytology Reports
2. Slide Consultation Reports
3. Autopsy Reports

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Date(s) of procedure(s)
2. Anatomic source of specimen
3. Type of tissue specimen(s)
4. Tumor type and grade (include all modifying adjectives [i.e., predominantly, with features of, with foci of, elements of, etc])
5. Gross tumor size
6. Extent of tumor spread
7. Involvement of resection margins
8. Number of lymph nodes involved and examined
9. Record both positive and negative findings. Record positive test results first
10. Note if pathology report is a slide review or a second opinion from an outside source (i.e., AFIP, Mayo, etc)
11. Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored.

Data Item(s) to be verified/validated using the text entered in this field:

1. Date of Diagnosis
2. Primary Site
3. Laterality
4. Histologic Type ICD-O-3
5. Grade
6. Collaborative Stage SSF's
7. Diagnostic confirmation
8. Surg Prim Site
9. Scope Reg LN Sur
10. Surg Oth Reg/Dis
11. SEER Summary Stage 2000
12. Clinical and/or Pathological TNM and Stage
13. Regional Nodes Positive
14. Regional Nodes Examined
15. RX Date--Surgery
16. Reason for No Surgery
17. Surg/Rad Seq
18. Systemic/Sur Seq

Text – Primary Site Title NAACCR Item #2580

Record text describing the primary site including subsite information. Always document laterality when the site is paired. Refer to the listing of Paired Sites in *VCR Manual Part Three, Laterality. Text-Primary Site Title* must be completed on each record. Information documenting the disease process should be entered manually from the medical record. If information is missing from the record, state that it is missing. Do not include irrelevant information.

Source Records:

The primary site and laterality may be found in, but are not limited to, the following source records:

1. Pathology Report
2. Operative Report
3. Xrays/Scans
4. Discharge Summary
5. Consultation Reports

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Include information on the location of the primary site of the tumor.
2. Include available information on tumor laterality.

Data Item(s) to be verified/validated using the text entered in this field:

1. Primary site
2. Laterality

Text – Histology NAACCR Item #2590

Information documenting the disease process should be entered manually from the medical record. Record text to support the patient's final diagnosis: clinical, other non-pathologic diagnosis, or histologic diagnosis including cell type, behavior, and grade (differentiation). If information is missing from the record, state that it is missing. Do not include irrelevant information.

Either *Text-Histology Title* or *Text-Dx Proc-Path* must be completed on each record. Information to support the exact diagnosis has to appear in one of these two fields. *Text-Histology Title* is a 100 character field generally used to record clinical or other non-pathologic diagnoses; *Text-Dx Proc-Path* is a 1000 character field generally used to record histologically and cytologically confirmed diagnoses from pathology reports.

Source Records:

The histologic diagnosis may be found in, but is not limited to, the following source records:

1. Pathology and Cytology Reports
2. History and Physical Report
3. Discharge Summary
4. Consultation Reports
5. Slide Consultation Reports

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Information on histologic type and behavior.
2. Information on differentiation from scoring systems such as Gleason's Score, Bloom-Richardson, Grade, etc.

Data Item(s) to be verified/validated using the text entered in this field:

1. Histologic Type ICD-O-3
2. Behavior Code ICD-O-3
3. Grade

Text – Staging NAACCR Item #2600

Information documenting the disease process should be entered manually from the medical record. If information is missing from the record, state that it is missing. Do not include irrelevant information. Record text to support any Collaborative Stage SSF's not already supported in other text fields. This field is to record the T, N, M and Stage as either documented in the medical record or as assigned by a Cancer Registrar.

Example: The only information available is the TNM stage, record *Physician stated this case is a T1N1MO*.

Record text information to support the Summary Stage code assigned according to SEER Summary Stage 2000 (SS2000) (see VCR Manual Part Three, Data Item Instructions, SEER Summary Stage). Document the extension of the disease that justifies the Summary Stage based on imaging studies, lab tests, scopes, and operative procedures performed. Also include both positive and negative findings and appropriate dates not already recorded in other *Text-DX* fields. If information is not sufficient to support a specific Summary Stage code, record *unknown* in this field.

Source Records:

Information to determine Collaborative Stage data items and Summary Stage may be found in, but is not limited to, the following reports:

- Pathology Reports
- Operative procedures
- X-Rays/Scans
- Scopes
- Lab Tests
- Discharge Summary
- Consultations

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Date(s) of procedure(s), including clinical procedures that provided information for assigning stage.
2. Organs involved by direct extension.
3. Size of tumor.
4. Status of margins.
5. Number and sites of positive lymph nodes.
6. Site(s) of distant metastasis.
7. Physician's specialty and comments.

Data Item(s) to be verified/validated using the text entered in this field:

1. RX Date--DX/Stg Proc
2. Collaborative Stage variables
3. SEER Summary Stage 2000
4. Regional Nodes Positive
5. Regional Nodes Examined
6. Surg Prim Site
7. Scope Reg LN Sur
8. Surg Oth Reg/Dis
9. Mult Tum Rept as One Prim
10. Laterality

Examples:

1. Work up and initial treatment for prostate primary included lung scan, bone scan, and CT/Pelvis. Based on these procedures, the Summary Stage is determined to be *Distant,* code 7. Document the following in the appropriate text fields:

   Text-Dx Proc-X-ray/Scan: Bone Scan 1/15/16 mets to pelvis; Lung scan 1/20/16 no evidence of metastatic disease; CT/Pelvis-1/15/16-positive iliac adenopathy

   Text-Staging: Pelvic bone mets

2. Diagnosis of lymphoma and workup included CT scans and a bone marrow biopsy. Based on these procedures, the Summary Stage is determined to be *Regional NOS*, code Document the following in the appropriate text fields:

   Text-Dx Proc-X-ray/Scan: CT scans 1/15/16 - mediastinal and axillary LN suspicious for lymphoma, no pelvic or retroperitoneal adenopathy

   Text-Dx Proc-Path: Bone marrow 2/01/16 negative

   Text-Staging: Multiple LN regions above diaphragm

3. If the only documentation is that the patient was diagnosed two years ago and now is admitted in January 2016 for treatment of recently discovered bone metastases, record:

   Text-Staging: unknown at initial dx, bone mets 1/16

RX Text – Surgery NAACCR Item #2610

Information documenting the disease process should be entered manually from the medical record. If information is missing from the record, state that it is missing. Do not include irrelevant information. *Record all surgical procedures, including dates, performed as first course of treatment as applicable. Surgical procedures used to treat regional lymph nodes and other regional and/or distant sites as first course of treatment should be documented*. If applicable, text should also be included to describe the number of regional lymph nodes examined as part of the first course of treatment.

Source Records:

The surgical procedure information may be found in, but is not limited to, the following source records:

1. Operative Reports
2. Discharge Summary
3. Consultation Reports
4. History and Physical Report

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Date of each procedure
2. Facility where each procedure was performed
3. Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites
4. Regional tissues removed

Data Item(s) to be verified/validated using the text entered in this field:

1. Date of 1st Course RX
2. RX Date Surgery
3. Surg Prim Site
4. Scope Reg LN Sur
5. Surg Oth Reg/Dis
6. Reason for No Surgery
7. Surgical Margins
8. Palliative Proc
9. Text-Place of Diagnosis
10. Surg/Rad Seq
11. Systemic/Sur Seq

RX Text – Radiation (Beam) NAACCR Item #2620

Information documenting the disease process should be entered manually from the medical record. If information is missing from the record, state that it is missing. Do not include irrelevant information. Record all beam radiation, including dates, given as first course of treatment as applicable.

Source Records:

The radiation information may be found in, but is not limited to, the following source records:

1. Radiation Records or treatment letters
2. Discharge Summary
3. Consultation Reports

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Date when radiation treatment began
2. Where treatment was given (e.g., at this facility, at another facility)
3. Type(s) of beam radiation (e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities)
4. Other treatment information (e.g., patient discontinued after five treatments; unknown if radiation was given)

Data Item(s) to be verified/validated using the text entered in this field:

1. Date of 1st Course RX
2. Radiation
3. Surg/Rad Seq
4. RX Date-Radiation
5. Rad Regional RX Modality
6. RX Date Radiation Ended
7. Rad Treatment Volume
8. Rad Location of RX

RX Text – Radiation Other NAACCR Item #2620

Information documenting the disease process should be entered manually from the medical record. If information is missing from the record, state that it is missing. Do not include irrelevant information. Record all other radiation, including dates, given as first course of treatment as applicable.

Source Records:

The other radiation treatment may be found in, but is not limited to, the following source records:

1. Radiation treatment letters
2. Discharge Summary
3. Consultation Reports

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Date treatment was started
2. Where treatment was given (e.g., at this facility, at another facility)
3. Type(s) of non-beam radiation (e.g., High Dose rate brachytherapy, seed implant, Radioisotopes [I-131])
4. Other treatment information (e.g., unknown if radiation was given)

Data Item(s) to be verified/validated using the text entered in this field:

1. Date of 1st Course RX
2. Radiation
3. Surg/Rad Seq
4. RX Date-Radiation
5. Rad Regional RX Modality
6. RX Date Radiation Ended
7. Rad Treatment Volume
8. Rad Location of RX
9. Rad Boost RX Modality

RX Text – Chemo NAACCR Item #2640

Information documenting the disease process should be entered manually from the medical record. If information is missing from the record, state that it is missing. Do not include irrelevant information. Record all chemotherapy, including dates, administered as first course of treatment as applicable.

Source Records:

The chemotherapy treatment information may be found in, but is not limited to, the following source records:

1. Chemotherapy logbooks or treatment letters
2. Discharge Summary
3. Consultation Reports
4. History and Physical Report

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Date when chemotherapy began
2. Where treatment was given (e.g., at this facility, at another facility)
3. Type of chemotherapy (e.g., name of agent(s) or protocol)
4. Other treatment information (e.g., treatment cycle incomplete, unknown if chemotherapy was given)

Data Item(s) to be verified/validated using the text entered in this field:

1. Date of 1st Course RX--CoC
2. RX Chemo
3. RX Date--Systemic
4. RX Date--Chemo
5. RX Summ--Systemic/Sur Seq

RX Text – Hormone NAACCR Item #2650

Information documenting the disease process should be entered manually from the medical record. If information is missing from the record, state that it is missing. Do not include irrelevant information. Record all hormone therapy, including dates, administered as first course of treatment as applicable.

Source Records:

The hormone therapy information may be found in, but is not limited to, the following source records:

1. Discharge Summary
2. Consultation Reports
3. History and Physical Report

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Date treatment was started
2. Where treatment was given (e.g., at this facility, at another facility)
3. Type of hormone or antihormone (e.g., Tamoxifen)
4. Type of endocrine surgery or radiation (e.g., orchiectomy)
5. Other treatment information (e.g., treatment cycle incomplete; unknown if hormones were given)

Data Item(s) to be verified/validated using the text entered in this field:

1. Date of 1st Course RX--CoC
2. RX --Hormone
3. RX Date--Systemic
4. RX Date--Hormone
5. RX Summ--Systemic/Sur Seq

RX Text – BRM NAACCR Item # 2660

Information documenting the disease process should be entered manually from the medical record. If information is missing from the record, state that it is missing. Do not include irrelevant information. Record biological- response modifier treatment, including dates, administered as first course of therapy for cancer as applicable. This is also referred to as immunotherapy.

Source Records:

The biological-response modifier treatment information may be found in, but is not limited to, the following source records:

- Discharge Summary
- Consultation Reports
- History and Physical Report

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

- Date treatment began
- When treatment was given (e.g., at this facility; at another facility)
- Type of BRM agent (e.g., Interferon, BCG)
- BRM procedures (e.g., bone marrow transplant, stem cell transplant)
- Other treatment information (e.g., treatment cycle incomplete; unknown if BRM was given)

Data Item(s) to be verified/validated using the text entered in this field:

Date of 1st Course RX – CoC
RX--BRM
RX Date--BRM
RX -- Date Systemic
RX --Transplant/Endocrine RX --BRM
RX Summ--Systemic/Sur Seq

RX Text – Other NAACCR Item #2670

Information documenting the disease process should be entered manually from the medical record. If information is missing from the record, state that it is missing. Do not include irrelevant information. Record all other treatment, including dates, performed as first course of treatment as applicable.

Source Records:

Other treatment may be found in, but is not limited to, the following source records:

1. Discharge Summary
2. Consultation Reports
3. History and Physical Reports

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Date treatment was started
2. Where treatment was given (e.g., at this facility, at another facility)
3. Type of other treatment (e.g., blinded clinical trial, hyperthermia)
4. Other treatment information (e.g., treatment cycle incomplete; unknown if other treatment was given)

Data Item(s) to be verified/validated using the text entered in this field:

1. Date of 1st Crs RX
2. RX Date--Other
3. RX--Other

Text – Remarks *NAACCR Item #2670*

Information documenting the disease process should be entered manually from the medical record. If information is missing from the record, state that it is missing. Do not include irrelevant information.

1. Record text information not elsewhere provided for or as an overflow from other text fields. The following information should be included in this field as applicable to the case:
   a. Document the site, laterality if applicable, histology, and date of diagnosis for all known previous primaries.
   b. Document text to explain any unusual or potentially questionable entry on the abstract. This will reduce the need to re-pull medical records at a later date.
   c. Document text to note particular issues or clarifications that were resolved prior to completion of the abstract. For example, clarifications made with a physician through quality assurance studies.

Source Records*:*

Information for this field may be found in, but is not limited to, the following source records:

1. History and Physical Report
2. Pathology Reports
3. Discharge Summary
4. Consultation Reports
5. Cancer Conference Documentation

Suggestions for Text:

VCR-approved abbreviations should be utilized. Do not repeat information from other text fields. Prioritize entered information in the order of the fields listed below:

1. Personal and family history of cancer.
2. Smoking, alcohol history
3. Comorbidities.
4. Information on sequence numbers if a person was diagnosed with another cancer out-of-state or before the registry's reference date.
5. Place of birth
6. Justification for unusual site/histology combinations.
7. 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."

VIRGINIA SPECIFIC FIELD – DIOXIN EXPOSURE

Record the incidence of exposure to Agent Orange/Dioxin.

Codes and Definitions

CODE	DEFINITION
0	No evidence of dioxin exposure
1	Evidence of dioxin exposure
8	NA; patient is not a Viet Nam Veteran
9	Unknown if any dioxin exposure

Recording Dioxin Exposure

The Viet Nam war ended in 1972, with no further soldiers sent to Viet Nam. Therefore, if the patient is born after 1954, you may assume the patient is not a veteran of that war; code to 8.

VIRGINIA SATE SPECIFIC FIELD – VIET NAM VETERAN

Record the patient's Viet Nam service status

Codes and Definitions

Code	Definition
0	Patient is not a Viet Nam veteran
1	Patient is a Viet Nam Veteran
8	NA; Patient was born after 12/31/1954
9	Unknown if the patient is a Viet Nam veteran

Recording Viet Nam Veteran

The Viet Nam war ended in 1972, with no further soldiers sent to Viet Nam. Therefore, if the patient is born after 1954, you may assume the patient is not a veteran of that war; code to 8.

VIRGINIA STATE SPECIFIC FIELD – TOBACCO HISTORY

Record the patient's history of tobacco use.

Codes and Definitions

CODE	DEFINITION
0	Never used
1	Cigarette smoker, current
2	Cigar/pipe smoker, current
3	Snuff/chew/smokeless, current
4	Combination use, current
5	Previous use
9	Unknown

Recording Tobacco History

1. If the patient has smoked in the past year, document the patient as a current smoker.
2. More than one year without having smoked is coded as 5 – Previous use.

VIRGINIA STATE SPECIFIC FIELD – NUMBER OF YEARS SMOKED

Record the number of pack years for the patient's smoking history.

Codes and Definitions

Code	Definition
000	Never used any tobacco products
001 - 249	Actual number of pack years between 1 and 249
250	>/= 250 pack years
995	Combination tobacco user
996	Cigar/pipe smoker
997	Smokeless tobacco user
998	Smoked, number of pack years unknown/not stated
999	Unknown if patient ever used tobacco products

Recording Number of Years Smoked

1. To calculate pack years, multiply the number of packs (of cigarettes) the patient smokes by the number of years the patient has smoked.

   Example 1: The patient states he has smoked 2 packs of cigarettes a day for 40 years. Code Number of Years smoked to 080.

   Example 2: The patient states he has smoked 2 cigars plus 1 pack of cigarettes per day for 50 years. Code to 995 – Combination tobacco user

   Example 3: The patient states he is not a smoker but he does chew tobacco. Code to 997 – Smokeless tobacco user.

   Example 4: The patient states he uses vapor cigarettes. Code to 997 – Smokeless tobacco user.

VIRGINIA STATE SPECIFIC FIELD – ALCOHOL USE HISTORY

Record the patient's alcohol use.

Codes and Definitions

Code	Definition
0	Never drank alcohol
1	Social Drinker; drinks 1 – 2 drinks/day
2	Drinks > 2 drinks/day
3	Social Drinker, NOS
4	Previous use of alcohol
9	Unknown if patient drinks alcohol

Recording Alcohol History

1. Document any information regarding the use of alcohol, including beer, wine and other alcoholic beverages.

   Example 1: The patient states he only drinks 2 or 3 beers per day on weekends. Code to 2 – drinks more than 2 drinks/day

   Example 2: The patient states she drinks a glass of wine with dinner every day. Code to 1 – Social drinker

   Example 3: The patient states he is a social drinker without further information. Code to 3, Social drinker, NOS

2. The patient must be alcohol free for at least one year before they can be coded as previous use of alcohol

VIRGINIA STATE SPECIFIC FIELD – FAMILY HISTORY

Record any information regarding family history of cancer

Codes and Definitions

CODE	DEFINITION
0	No family history of cancer
1	Positive family history of cancer, NOS
2	Family history of this cancer
3	Family history of other cancer
4	Family history of this AND other cancer
9	Unknown if patient has a family history of cancer

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Outcomes

Date of Last Contact or Death NAACCR Item # 1750

Record the date of last contact or the date of death

Beginning in 2010, the way dates are transmitted between facility registries and central registries was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. Interoperable dates are displayed in CCYYMMDD form, with the unknown portions of the date filled with blank spaces. If a date is entirely blank, an associated date flag is used to explain the missing date. Flags are not used for software-generated dates.

For more information regarding dates, please see *Virginia Cancer Registry Manual, Part Three: Data Item Instructions, General Information, Coding Dates.*

Recording Date of Last Contact

1. Record date in month, day and year format (CCYYMMDD). Record the year in the first four spaces, the month in the fifth and sixth spaces, and the day in the last two spaces. A zero must precede single- digit months and days. See *VCR Manual Part Three, General Instructions* for allowable values.

2. Unknown (99) or approximation of month, day, century, or year is not acceptable when reporting to the VCR. Fictitious dates or default values are also not acceptable.

   Exception: If a patient is known to have expired after discharge from your facility, the month and/or day may be reported as blank if the exact month and/or day is not known.

3. If the last contact with a patient is an inpatient admission, record the date of discharge.

4. If the last contact with the patient was an outpatient visit, record the outpatient date.

5. If the patient receives treatment after discharge record the date of the treatment.

   Example: The patient is admitted on November 1, 2006 and is discharged on November 3, 2003 and then starts his radiation treatment on December 1, 2006. The date of last contact is 20061201.

6. If a patient has multiple primaries, all records should have the same date of last contact.

7. If the patient is deceased, record the date of death.

   Note: *Date of Last Contact* does not have to be submitted as a change or update if the patient is readmitted or expires after the initial record was submitted.

Date of Last Contact Flag NAACCR Item # 1751

This flag explains why there is no appropriate value in the corresponding date field, *Date of Last Contact or Death.*
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes and Definitions

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

Recording Date of Last Contact Flag

1. Leave this item blank if *Date of Last Contact* has a full or partial date recorded.
2. Code 12 if *Date of Last Contact* cannot be determined.

Vital Status NAACCR Item #1760

Record the appropriate code for the patient's vital status as of the date recorded in data item *Date of Last Contact*. Use the most accurate information available.

Codes and Definitions

Code	Definition
0	Dead
1	Alive

Notes on Vital Status

1. Failure to find a patient on a list of deceased individuals does not constitute evidence that the patient is alive. *Vital Status* is not changed, but is neither the *Date of Last Contact or Death* changed. Unless more information is located, follow up of this patient has failed.

2. Vital Status does not have to be submitted as a change or update if the patient expires after the initial record was submitted.

3. The VCR periodically matches records on the VCR database against Virginia death certificate files. As a result of this match, ***the VCR will send to each hospital on a yearly basis a list of its reported patients who have expired.***

Follow up Source NAACCR Item #1790

This data item records the source from which the latest follow-up was obtained. It is used by registries to identify the most recent follow-up source.

Codes and Definitions

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

Case Administration

Abstracted By NAACCR Item #570

Record the initials of the individual completing the abstract.

Special Instructions

1. Record the initials or assigned code of the individual who abstracted this record. Do not code the data entry person unless that person is also the abstractor.

Reporting Hospital/Facility Identification Number NAACCR Item #540

Record the reporting facility identification (ID) number as described under special instructions below.

Special Instructions

1. For facilities with seven-digit FIN's in the range of 6020009 – 6953290 that were assigned by the CoC before January 1, 2001, the coded FIN with consist of three leading zeros followed by the full seven-digit number.
2. For facilities with eight-digit FIN's greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded FIN will consist of two leading zeros followed by the full eight-digit number
3. Facilities that are part of an Integrated Network Cancer Program (INCP) *must* use the hospital-specific FIN in their data submission to the VCR.
4. Facilities that are not part of the CoC accreditation program may still have a FIN number; please see *Appendix XXX* for information.

Override Site/TNM Stage Group NAACCR Item #1989

This is used with the EDITS software to override the edits of the type *Primary Site, AJCC Stage Group,* for AJCC staging editions and later. This override flag allows identification of pediatric cancers that were staged according to a system other than the AJCC staging manual if they are not also AJCC-staged. In that situation and otherwise stageable case may be coded 88 (not applicable) for all AJCC items.

Edits of the type, *Primary Site, AJCC Stage Group*, check that the pathologic and clinical AJCC stage group codes are valid for the site and histology group according to the applicable *AJCC Cancer Staging Manual*, using the codes described for the items *Clinical Stage Group* (NAACCR Item #970) and *Pathological Stage Group* (NAACCR Item #910). Combination of site and histology not represented in any AJCC schema must be coded 88. Unknown codes must be coded to 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, use *Override Site/TNM-Stage Group* to indicate the case was coded according to a pediatric staging system if it was not also coded according to the AJCC manual. Pediatric stage groups should not be recorded in the *Clinical Stage Group* or *Pathological Stage Group* items. When neither clinical nor pathological AJCC staging is used for pediatric cases, code all AJCC items to 88. When any AJCC component is used to stage a pediatric case, follow the instructions for coding AJCC items and leave *Override Site/TNM Stage Group* blank.

Codes and Definitions

Code	Definition
Blank	Not reviewed; reviewed and corrected
1	Reviewed and confirmed as reported

Recording Override Site/TNM Stage Group

1. Leave bland if the EDITS program does not generate an error message for the edits
2. Leave blank and correct any errors for the case if an item is discovered to be incorrect
3. Code 1 if the case if confirmed to be a pediatric case that was coded using a pediatric coding system

Override Age/Site/Morph NAACCR Item # 1990

This is used with the EDITS software to override edits of the type *Age, Primary Site, Morphology; Age, Primary Site Morph ICDO3-Adult,* and *Age, Primary Site, Morph IDCO3-Pediatric*

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 on future runs of the EDITS program.

Edits of the type *Age, Primary Site, Morphology; Age, Primary Site Morph ICDO3-Adult,* and *Age, Primary Site, Morph IDCO3-Pediatric* require review if a site-morphology combination occurs in an age group for which it is extremely rare or if the cancer was diagnosed in utero.

If the edit generates an error or warning message, check that the primary site and histologic type are coded correctly and that the age, date of birth, and date of diagnosis are correct.

Codes and Definitions

Code	Definition
Blank	Not reviewed; reviewed and corrected
1	Reviewed; age, site and morphology combination confirmed as reported
2	Reviewed; diagnosis in utero
3	Reviewed; both conditions apply

Recording Override Age/Site/Morph

1. Leave blank if the EDITS program does not generate an error message
2. Leave blank and correct any errors for the case if an item is discovered to be incorrect
3. Code 1 for an unusual occurrence of a particular age/site/histology combination for a given age has been confirmed by review to be correct
4. Code 2 if the case was diagnosed in utero
5. Code 3 if both conditions apply

Override Surg/DX Conf NAACCR Item # 2020

This item is used with EDITS software to override the edits *RX Summ-Surg Prim Site, Diag Conf (SEER IF76); RX Summ-Surgery Type, Diag Conf (SEER IF46);* and/or the edit *RX Summ – Surg Site 98-02, Diag Conf (SEER 106).*

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 on future runs of the EDITS program.

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.

Codes and Definitions

Code	Definition
Blank	Not reviewed; reviewed and corrected
1	Reviewed and confirmed as reported

Recording Override Surg/DX Conf

1. Verify the surgery and diagnostic confirmation codes and correct any errors
2. Sometimes there are valid reasons why no microscopic confirmation is achieved with the surgery, for example, the tissue removed may be inadequate for evaluation.
3. Leave blank if the EDITS program does not generate an error message for edits of the type, *RX Summ-Surg Prim Site, Diag Conf*
4. Leave bland and correct any errors for the case if an item was discovered to be incorrect
5. Code 1 if review of all item in the error or warning message confirms that all are correct

System Codes (Electronic Reporting Only)

System codes reflect types of coding systems used, record processing dates, and other information regarding how the data were collected. These codes are required to be transmitted on cases submitted electronically. System codes are added to cases submitted on the VCR Report Form at the time of data entry at the VCR.

1. Registry hospitals using commercial or hospital-developed software are responsible for making sure the correct system codes are submitted. Since most are computer generated, the registrar must communicate problems in complying with VCR code requirements to software vendors or facility Information Systems personnel.

Required Codes and Definitions

VCR Required Data Item	NAACCR Item #	VCR Specific Instructions
Record Type	10	Must always contain "**A**" for *Full case abstract type, including text data item;* length=22824.
Registry Type	30	Allowable codes: "**2**" for central registry or hospital consortium (not population based); and "**3**" for single hospital/freestanding center.
FIN Coding System	35	Must always contain "**2**" for COC FIN 10-digit codes.
NAACCR Record	50	Must always contain "**160**" for 2016 version (Version V16).
Race Coding Sys— Current	170	Must always contain "**7**" indicating 2000+ SEER & COC(added codes 15,16,17; removed 09)
Site Coding Sys— Current	450	Cases diagnosed on or after 01/1/2001 must always contain "**5**" for ICD-O-3; cases diagnosed before 1/1/2001 must always contain "**4**" for ICD- O-2; cases with an unknown *Date of Diagnosis* (99999999) and *Date of 1st Contact* on or after 01/01/2001 must always contain **"5"** for ICD-O-3; cases with an unknown *Date of Diagnosis* (99999999) and *Date of 1st Contact* prior to 01/01/2001 must always contain **"4"** for ICD-O-2.
Morph Coding Sys— Current	470	Cases diagnosed on or after 01/1/2001 must always contain "8" for ICD-O-3 plus 2008 WHO hematopoietic/lymphoid new terms used for conditions diagnosed 1/1/2010 and later; cases diagnosed before 1/1/2001 must always contain "**6**" for ICD- O-2 plus REAL and FAB codes; cases with an unknown *Date of Diagnosis* (99999999) and *Date of 1st Contact* on or after 01/01/2001 must always contain **"7"** for ICD-O-3; cases with an unknown *Date of Diagnosis* (99999999) and *Date of 1st Contact* prior to 01/01/2001
RX Coding Sys— Current	1460	Must always contain "**06**" for *Treatment data coded according to FORDS.*
Date Case	2090	Must contain the date abstract first passed all edits applied. Blank is not acceptable in any portion of the date.
Date Case Last	2100	Contains the latest date the case was modified after completion at the reporting facility.
Date Case Report Exported	2110	Must contain the date the reporting facility exported the electronic abstract to a file for transmission to the central registry. Blank is not acceptable in any portion of the date.
ICD-O-3 Conversion Flag	2116	Cases diagnosed on or after 1/1/2001 must contain "**0**" for *Primary site and morphology originally coded in ICD-O-3.*
COC Coding Sys— Current	2140	Cases diagnosed on or after 1/1/2003 must contain "**08**" for *FORDS.* Cases diagnosed prior to 1/1/2003 must contain "**07**" for *ROADS and 1998 supplement.*

VCR Required Data Item	NAACCR Item #	VCR Specific Instructions
Vendor Name	2170	*Commercial Software*: name and version number must always be included; *Hospital-Developed Software*: must always enter "HOSP" for name followed by version number or month/year system was developed or last modified; *AbstractPlus*: will contain name and version number as specified by the VCR.

PART FOUR:

QUALITY CONTROL

Quality Control

The purpose of cancer data collection varies with the type and goals of the registry. The primary goal of hospital- based cancer registries is the improvement of patient care, and the primary goal of non-registry hospitals is to provide data to the central cancer registry. The primary objective of the central or population based incidence registries is the determination of cancer rates and trends in the population. Whether data are reported to the Virginia Cancer Registry (VCR) or reported by the VCR, there is a universal need for the data collected in any type of registry to be of the highest quality.

Quality can be defined as fitness for use. To assure data are of sufficient quality for use in meeting registry goals, quality control must be an integral component of the data collection system. Quality control involves the systematic execution of a carefully planned set of activities to monitor data quality and take appropriate action to positively affect future quality.

Activities and procedures to assure data quality should focus on three areas: completeness, accuracy and timeliness. Completeness refers to both case ascertainment and data collection. Accuracy refers to how well the abstracted data reflect the patient's diagnosis and treatment. Timeliness measures how the abstracting and reporting process are accomplished according to an expected schedule.

Evaluation of completeness, accuracy, and timeliness is the first step in quality control. To be effective, the registry's quality control plan must also involve a continuous loop of monitoring, communication, and feedback.

The following two sections describe various strategies used by reporting facilities and the VCR to assure data are as complete, accurate and timely as possible. The activities described for reporting facilities will enhance compliance to VCR reporting standards. Since communication and feedback are essential to the success of any quality control program, the major quality control procedures used by the VCR are described in order for hospital contacts to more fully understand the rationale for VCR requirements as well as verbal and written requests and questions made by the VCR.

Quality Control: Reporting Facilities

Reporting facilities must insure cancer data collected and submitted to the VCR are complete, accurate, and timely. Although some facilities may incorporate additional activities to assure quality, at a minimum, all facilities must include the following procedures to meet VCR reporting requirements and standards.

Completeness

1. All areas where cancer patients are diagnosed or treated must be included in the casefinding system. This includes outpatient treatment areas, e.g., Radiation Therapy, Chemotherapy, Same Day Surgery Units, and Emergency Room. Review of pathology reports including private outpatient specimens and autopsy reports should also be included in casefinding.

2. Review of a Disease Index should be performed to verify all reportable cases are submitted to the VCR. If performed monthly, this review will simplify the annual reconciliation procedure (See *VCR Manual Part Four, Quality Control: VCR*) and aid in timeliness of reporting.

3. Facilities should check completeness of transmissions as follows:

    a. Check Totals: Verify the number of cases transmitted equals the number received by the VCR as indicated on the report *Records Accessioned by the Virginia Cancer Registry,* which is the report facilities receive back after the VCR has processed a shipment.

    b. Compare Listings: Compare the names on the report *Records Accessioned by the Virginia Cancer Registry* against your transmit list. If the lists differ, resolve the discrepancies or contact the VCR.

    c. Maintain Listings: Keep all copies of the *Records Accessioned by the Virginia Cancer Registry* as verification of records received by the VCR. Retention for at least five years is strongly recommended; however, if space is limited, maintaining copies until your facility has had a VCR Quality Assessment Review for that specific year would be an acceptable alternative.

4. All data items required by the VCR must be submitted for each record. For a listing of these items, refer to *VCR Manual Appendix K, Required Data Set for Reporting Facilities.* Entries for each required data item must include specific demographic, diagnostic and treatment information that accurately reflects what is documented in the health record.

Accuracy

1. The *Required Data Set for Reporting Facilities* includes text fields (See *VCR Manual Appendix K, Required Data Set for Reporting Facilities*). The reason for requiring text is to enhance data accuracy. These fields give hospitals the ability to convey information to validate data items, document clarifications, reconcile data item discrepancies, support unusual site/histology combinations, provide history of previous cancers/reportable tumors, and explain any unusual or potentially questionable entry on the abstract. Required text information must be recorded in the designated text fields. (See also *VCR Manual Part Three, Data Item Instructions, Guidelines for Reporting Text).*

2. Computer edits should be an integral component of any electronic abstracting system. These edits should check for completion of all required fields, allowable values and ranges, and interfield consistency. Edit checks should be performed on each completed abstract. Abstracts should be re-edited if any changes are made.

   AbstractPlus includes the VCR required edits. A copy of the VCR edits is also provided to the cancer registry software vendors.

3. The completed abstract should be visually reviewed to identify errors not detectable by the computer. Inconsistencies among data items could be identified when comparing text to coded items, e.g., stage coded to local with text indicating lymph node involvement.

4. Physicians should serve as resources to the abstractor. They should be consulted when questions arise during abstracting. Physician input may assist in identifying a primary site or provide clarification of conflicting statements or reports in the health record. Documentation of the physician input should be included in the text to support abstracted data.

Timeliness

1. 90% of the records must be received by the VCR within 180 days from *Date of Inpatient Disch* if an inpatient *or Date of 1st Contact* if an outpatient.
2. The first working day in July is the deadline for submitting all reportable cases seen at the reporting facility during the previous year.
3. This schedule should be followed to assure abstracts are received by the VCR within the required 180 days.

Cases with a Date of Inpatient Disch/Date of 1st Contact in:	Submit on or before the 1st of:
January	June of same year
February	July of same year
March	August of same year
April	September of same year
May	October of same year
June	November of same year
July	December of same year
August	January of following year
September	February of following year
October	March of following year
November	April of following year
December	May** of following year

Example 1: All cases with a Date of Inpatient Disch/Date of 1st Contact on or between January 1 and January 31, 2006 must be mailed by June 1, 2006.

Example 2: All cases with a Date of Inpatient Disch/Date of 1st Contact on or between December 1 and December 31, 2006 should be mailed by June 1, 2007

** The VCR deadline has not changed. The four weeks between June 1st and July 1st should be used to perform Quality Assurance procedures to ensure all cases for the year have been identified and reported. These cases may fall into the 10% over 180 days. This is expected and acceptable.

Note: This schedule should be used by reporting facilities as a guideline to assess timeliness of reporting but will not be used by the VCR to determine exact timeliness rates for reporting facilities. Reports provided by the VCR will show specific timeliness rates based on the number of days from *Date of Inpatient Disch* or *Date of 1st Contact* and the date the abstract was received by the VCR.

4. At a registry hospital, after identifying a potential case for the registry from a casefinding source, cases unable to be completely abstracted may be placed in an electronic suspense file. At a non-registry hospital using AbstractPlus software, incomplete abstracts may be saved as incomplete creating an electronic suspense file. A system should be in place to monitor these cases so they are completed and reported to the VCR in a timely manner. A case will not export out of AbstractPlus if it is incomplete.
5. Review the Disease Index monthly using the reporting schedule as a guide to verify all reportable cases have been submitted within the 180-day timeframe.

Quality Control – VCR

Quality control activities are conducted by the VCR to assure data in the central registry are complete, accurate, and timely. These activities fall into three categories: 1) internal procedures as data are processed, 2) on-site quality assessment reviews, and 3) trainings conducted by VCR staff or in conjunction with other organizations. These three major aspects of the VCR quality control program are described below.

Internal Quality Control Procedures

The quality control procedures described below are performed by the VCR routinely to enhance the quality of cancer data in the central cancer registry.

1. Completeness
    a. The VCR establishes reporting from sources required to report and reporting through state data exchange agreements to assure all reportable cases are received. The VCR reporting sources (See *VCR Manual Part One, Reporting Requirements, VCR Reporting Sources)* include the following:
        i. Acute Care Hospitals
        ii. Laboratories
        iii. Non Hospital Sources
        iv. States with Data Exchange Agreements
    b. All hospitals, laboratories, outpatient care centers, and physicians are required to submit on the 1st of every month or the last working day before the 1st if the 1st falls on a weekend or holiday. A listing of hospitals that have not submitted for two consecutive months is generated monthly at the VCR. A VCR Representative will contacts hospitals appearing on this list and appropriate action is taken.
    c. An annual comparison is made of each hospital's Disease Index with the VCR database to assure all cases have been reported. Each hospital receives a listing of cases identified as not being reported to the VCR with instructions to review each record to determine if the case is reportable. Cases missed, but now identified, must be reported. Cases that are not reportable must have justification documented on the listing explaining why the case is not reportable. Missed cases and listings must be returned to the VCR by the specified deadline.
    d. VCR conducts a Death Clearance procedure annually. This process involves identifying Virginia Death Certificates with a reportable cause of death and matching them to the VCR files. Non-matched death certificates are potentially missed cases. Hospital contacts receive a listing of non-matched patients who expired at their hospital to determine if they were reportable. Missed cases must be reported. Cases that were not reportable must have justification documented on the listing. Missed cases and listings must be returned to the VCR by a specified deadline. At the conclusion of this process, the remaining non-matched cases are reviewed and may be abstracted at the VCR from the death certificates and defined as Death Certificate Only (DCO) cases. A DCO percentage (The number of DCO cases divided by the total number of incidence cases for that year) is computed. The VCR DCO percentage is measured against the North American Association of Central Cancer Registries (NAACCR) DCO standard, which states a registry should have fewer than 5% DCO's in a given year of incidence cases.

2. Accuracy

   a. Computer edits are performed on 100% of abstracts and consolidated records. The VCR utilizes a combination of North American Association of Central Cancer Registries (NAACCR), Surveillance, Epidemiology and End Results Reporting Program (SEER), and Commission on Cancer (COC) edits from the NAACCR metafile with VCR-developed edits added. These edits check for completion of all required fields, allowable ranges, allowable values, and interfield consistency. They check for invalid entries such as impossible site/histology combinations or flag unusual entries for review. VCR Field Representatives follow-up with hospital contacts and provide feedback on errors found.

   b. Records are reviewed for consistency between coded data items and text documentation. This type of review is performed to detect discrepancies not detectable by the computer. VCR Field Representatives provide hospital contacts with feedback on these reviews.

   c. The frequency of *"unknown"* or code for unknown in data items, such as age at diagnosis, sex, race, state, and county is monitored and follow-up is performed to eliminate as many unknowns as possible.

   d. To assure accuracy of incidence statistics, an incidence file containing all cases for a specified time period is created and a report is generated listing all cases alphabetically by last name. Cases with the same name are identified. Those determined to be the same person are then reviewed manually to determine whether they represent multiple primaries or duplications. While cases determined to be duplicates are deleted from the file, source records are retained and attached to the appropriate tumor in the VCR database.

3. Timeliness

   a. VCR Timeliness Standard - At least 90% of the records must be received by the VCR within 180 days from *Date of Inpatient Disch* if an inpatient or *Date of 1st Contact* if an outpatient.

   b. The first working in July is the deadline for submitting all reportable cases diagnosed/treated in the prior year.

   c. Hospitals are notified annually of the closeout deadline and requested to notify the VCR when they anticipate closing out. Failure to meet the July deadline results in referral of the hospital to the Department of Health, Bureau of Facility Licensure and Certification.

On-Site Quality Assessment Review

Quality Assessment Reviews are routinely conducted at hospitals. Hospitals are scheduled for a review when certain criteria are met, such as unsatisfactory results from previous review, inability to perform annual reconciliation, reporting problems, and time lapse since last review. The reviews are designed to determine the quality of reporting to the VCR. During the review, casefinding completeness, data quality and timeliness of reporting are evaluated by VCR.

1. Hospitals receive a scheduling letter one month prior to the date of review. The scheduling letter includes:
   a. Date and time of the review
   b. *Hospital Index Verification* list of patients included on the hospital's Disease Index not reported to the VCR (Index from previous year's reconciliation is used)
   c. Request to have autopsy reports from the year being reviewed available the day of the review
   d. *Data Quality Evaluation* list of randomly selected cases reported to the VCR within the last twelve months that will be re-abstracted by a VCR Field Representative
   e. Request for private area with adequate work space for the VCR Field Representative

   Note: If a hospital did not submit a Disease Index during the reconciliation procedure, they will receive their scheduling letter two months prior to the review. The hospitals have three weeks from the date of the letter to submit a Disease Index to the VCR.

2. Hospitals must have the following available the day of the review:
   a. Health records for the patients on the *Hospital Index Verification* list. The patient's complete health record must be pulled including all inpatient and outpatient records.
   b. Autopsy reports for the year being reviewed.
   c. Health records and copies of corresponding abstracts for all the cases on the *Data Quality Evaluation* list. All admissions used to abstract the case must be pulled. *Note*: Additional health records may be requested on the day of review.
3. The VCR Representative will evaluate the following during their visit:
   a. The first component of the quality assessment review is the casefinding audit. The audit is a review and evaluation of the effectiveness of a facility's casefinding mechanisms used in submitting reportable cases to the VCR. The objective of the audit is to determine whether all reportable records are being identified and submitted to the VCR to insure VCR data accurately reflect cancer incidence in Virginia.

      The VCR Representative reviews the health records (and/or cancer registry files, if applicable) from the *Hospital Index Verification* list to determine if these records are reportable and to identify any weaknesses or trends in a hospital's casefinding procedures. The autopsy reports are reviewed to insure all autopsy reports with a reportable condition have been reported to the VCR, including incidental findings.

If not included in the Disease Index, pathology, cytology, autopsy, chemotherapy, radiation therapy, and other outpatient clinic information and related health records are reviewed to insure the reporting of eligible records from these sources.

The results of the casefinding audit are defined in terms of a completeness rate. The completeness rate indicates the percentage of reportable records submitted by the hospital to the VCR. The VCR acceptable completeness rate is 97 to 100%.

b. The second component of the quality assessment review is a reabstracting study to evaluate data quality. Reabstracting compares the information in the health record to the previously abstracted data to determine the accuracy and completeness of the data. The VCR Representative re-abstracts the cases on the Data Quality Evaluation list to identify any inaccurate information or misunderstandings of reporting guidelines.

   The results of the reabstracting study are defined in terms of an accuracy rate. The accuracy rate indicates the percentage of data items reported correctly. The VCR standard for data quality is an accuracy rate of 97 to 100%.

c. The third component of the quality assessment review is timeliness of reporting. For the VCR to provide timely statistics and reports, facilities must submit data in a timely manner.

   The timeliness standard established by the VCR to monitor hospital reporting requires at least 90% of the hospital's records be received by the VCR within 180 days from *Date of Inpatient Disch* if an inpatient or *Date of 1st Contact* if an outpatient. To evaluate timeliness, the VCR Field Representative uses reports generated by the VCR and assessment of cases currently being abstracted based on the reporting schedule (See *VCR Manual, Quality Control, VCR Reporting Schedule*).

d. At the conclusion of the review, the VCR Field Representative discusses findings and recommendations with appropriate hospital personnel during a summation conference. This provides the VCR Field Representative the opportunity to provide feedback relative to areas of compliance and concern. It also enables hospital personnel to be aware of the results of the review and ask questions regarding the findings and recommendations.

e. The VCR sends a written report documenting findings, problems, recommendations, and rates to the hospital. A listing of missed records identified as reportable to the VCR and a listing of data items requiring correction are included in the report.

f. Hospital staff must submit the missed records and corrections to the VCR within 30 days of when they receive the report.

g. Upon completion of the Quality Assessment Review Report, completeness and accuracy rates by year review performed are entered into a tracking system at the VCR. This information provides a concise summary of review results for use in determining a hospital’s performance over time and in identifying hospitals requiring more intense follow up.

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APPENDIX A:

CODE OF VIRGINIA

Code of Virginia

Sections from the *Code of Virginia related* to reporting cancer to the Virginia Cancer Registry

The entire *Code* can be accessed at:

http://law.lis.virginia.gov/vacode/32.1-70/

§ 32.1-70. Information from hospitals, clinics, certain laboratories and physicians supplied to Commissioner; statewide cancer registry.

A. Each hospital, clinic and independent pathology laboratory shall make available to the Commissioner or his agents information on patients having malignant tumors or cancers. A physician shall report information on patients having cancers unless he has determined that a hospital, clinic or in-state pathology laboratory has reported the information. This reporting requirement shall not apply to basal and squamous cell carcinoma of the skin. *Such information shall include the name, address, sex, race, diagnosis and any other pertinent identifying information regarding each such patient and shall include information regarding possible exposure to Agent Orange or other defoliants through their development, testing or use or through service in the Vietnam War. Each hospital, clinic, independent pathology laboratory, or physician shall provide other available clinical information as defined by the Board of Health.*

B. From such information the Commissioner shall establish and maintain a statewide cancer registry. The purpose of the statewide cancer registry shall include but not be limited to:

1. Determining means of improving the diagnosis and treatment of cancer patients.
2. Determining the need for and means of providing better long-term, follow-up care of cancer patients.
   2a. Conducting epidemiological analyses of the incidence, prevalence, survival, and risk factors associated with the occurrence of cancer in Virginia.
3. Collecting data to evaluate the possible carcinogenic effects of environmental hazards including exposure to dioxin and the defoliant, Agent Orange.
4. Improving rehabilitative programs for cancer patients.
5. Assisting in the training of hospital personnel.
6. Determining other needs of cancer patients and health personnel.

§ 32.1-70.2. Collection of cancer case information by the Commissioner.

A. Using such funds as may be appropriated therefore, the C*ommissioner or his designee may perform on-site data collection of the records of patients having malignant tumors or cancers at those consenting hospitals, clinics, independent pathology laboratories and physician offices required to report information of such patients pursuant to the reporting requirements of § 32.1- 70, in order to ensure the completeness and accuracy of the statewide cancer registry.*

B. The selection criteria for determining which consenting hospitals, clinics, independent pathology laboratories and physician offices may be subject to on-site data collection under the provisions of this section shall include, but shall not be limited to: (i) expected annual number of cancer case reports, (ii) historical completeness and accuracy of reporting rates, and (iii) whether the facility maintains its own cancer registry.

C. The Board of Health shall promulgate regulations necessary to implement the provisions of this section.

§ 32.1-71. Confidential nature of information supplied; publication; reciprocal data-sharing agreements.

A. The Commissioner and all persons to whom information is submitted in accordance with § 32.1-70 shall keep such information confidential. Except as authorized by the Commissioner in accordance with the provisions of § 32.1-41, no release of any such information shall be made except in the form of statistical or other studies which do not identify individual cases.

B. The Commissioner may enter into reciprocal data-sharing agreements with other cancer registries for the exchange of information. Upon the provision of satisfactory assurances for the preservation of the confidentiality of such information, patient-identifying information may be exchanged with other cancer registries which have entered into reciprocal data-sharing agreements with the Commissioner.

§ 32.1-40. Authority of Commissioner to examine medical records.

Every practitioner of the healing arts and every person in charge of any medical care facility shall permit the Commissioner or his designee to examine and review any medical records which he has in his possession or to which he has access upon request of the Commissioner or his designee in the course of investigation, research or studies of diseases or deaths of public health importance. No such practitioner or person shall be liable in any action at law for permitting such examination and review.

§ 32.1-41. Anonymity of patients and practitioners to be preserved in use of medical records.

The Commissioner or his designee shall preserve the anonymity of each patient and practitioner of the healing arts whose records are examined pursuant to § 32.1-40 except that the Commissioner, in his sole discretion, may divulge the identity of such patients and practitioners if pertinent to an investigation, research or study. Any person to whom such identities are divulged shall preserve their anonymity.

§ 32.1-27. Penalties, injunctions, civil penalties and charges for violations.

A. Any person willfully violating or refusing, failing or neglecting to comply with any regulation or order of the Board or Commissioner or any provision of this title shall be guilty of a Class 1 misdemeanor unless a different penalty is specified.

B. Any person violating or failing, neglecting, or refusing to obey any lawful regulation or order of the Board or Commissioner or any provision of this title may be compelled in a proceeding instituted in an appropriate court by the Board or Commissioner to obey such regulation, order or provision of this title and to comply therewith by injunction, mandamus, or other appropriate remedy or, pursuant to § 32.1-27.1, imposition of a civil penalty or appointment of a receiver.

C. Without limiting the remedies which may be obtained in subsection B of this section, any person violating or failing, neglecting or refusing to obey any injunction, mandamus or other remedy obtained pursuant to subsection B shall be subject, in the discretion of the court, to a civil penalty not to exceed $25,000 for each violation, which shall be paid to the general fund, except that civil penalties for environmental pollution shall be paid into the state treasury and credited to the Water Supply Assistance Grant Fund created pursuant to § 32.1-171.2. Each day of violation shall constitute a separate offense.

D. With the consent of any person who has violated or failed, neglected or refused to obey any regulation or order of the Board or Commissioner or any provision of this title, the Board may provide, in an order issued by the Board against such person, for the payment of civil charges for past violations in specific sums, not to exceed the limits specified in § 32.1-27.1 and subsection C of this section. Such civil charges shall be instead of any appropriate civil penalty which could be imposed under § 32.1-27.1 and subsection C of this section.

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APPENDIX B:

REGULATIONS FOR DISEASE REPORTING AND CONTROL

VIRGINIA BOARD OF HEALTH

Board of Health Regulations

The Board of Health Regulations for the Virginia Cancer Registry are currently undergoing revision. The new regulations will be posted for addition when they are finalized.

APPENDIX C:

REPORTABLE CONDITIONS

Reportable Conditions

This *List of Reportable Conditions* provides documentation of all conditions reportable to the Virginia Cancer Registry (VCR). It is structured alphabetically by the main histologic term. Qualifiers and/or adjectives associated with the main term are included only if needed to specify when the condition is reportable. The abbreviation "NOS" means "Not Otherwise Specified."

Determining Reportable Conditions Using Histologic Terms

Conditions are to be reported if the diagnosis includes the terms cancer, carcinoma, malignant**,** and lymphoma**.** Most leukemias and sarcomas are reportable except as noted as exclusions on the listing. Other reportable conditions not containing these terms (i.e., refractory anemia, stromal endometriosis, Ewing tumor, carcinofibroma) are also included in this listing.

All primary intracranial and central nervous system (CNS) tumors are reportable. This includes benign, malignant and borderline tumors for the following sites:

Intracranial and Central Nervous System Sites	
Meninges (C70.0 - C70.9)	Other CNS (C72.8, C72.9)
Brain (C71.0 - C71.9)	Pituitary gland (C75.1)
Spinal Cord (C72.0)	Craniopharyngeal duct (C75.2)
Cauda equina (C72.1)	Pineal gland (C75.3)
Cranial nerves (C72.2 - C72.5)	

Determining Reportable Conditions Using *ICD-O* Behavior Codes

All cases with a behavior code of **/2** (in situ) or **/3** (malignant) in the *International Classification of Diseases for Oncology* (*ICD-O*), are reportable neoplasms. In addition, juvenile or pilocytic astrocytoma with a behavior code of **/1** (uncertain/borderline) in ICD-*O, Third Edition* is also reportable using a behavior code of **/3**.

Note: If a pathologist verifies a neoplasm with an ICD-O behavior code of /0 (benign) or /1 (uncertain) as "in situ" or "malignant", these cases are reportable.

Cases diagnosed with primary intracranial and central nervous system tumors with a behavior code of **/0** or **/1** (benign and borderline or "non-malignant") regardless of histologic type for sites listed above under *Intracranial and Central Nervous System Sites* are reportable

Exclusions

Conditions that are not to be reported to the VCR if the diagnosis includes:

1. Cancers primary to the skin (C44.0-C44.9) with the following histologies:
   a. Neoplasms, malignant, NOS of the skin
   b. Epithelial carcinomas of the skin
   c. Squamous cell carcinomas (SCC) of the skin
   d. Basal cell carcinomas (BCC) of the skin

Note: These lesions ***are*** reportable for squamous and basal cell cancers originating in mucoepidermoid sites: lip, anus, vulva, vagina, penis or scrotum (*ICD-O* codes C00.0- C00.9, C21.0, C51.0-C51.9, C52.9, C60.0-60.9 & C63.2).

2. Cervical intraepithelial neoplasia (CIN)
3. Prostatic intraepithelial neoplasia (PIN)
4. The following conditions are *only reportable if diagnosed* **prior to January 1, 2001**:
   a. Cystadenoma
      i. Mucinous, borderline malignancy
      ii. Papillary, borderline malignancy
      iii. Papillary mucinous, borderline malignancy
      iv. Papillary pseudomucinous, borderline malignancy
      v. Papillary serous, borderline malignancy
      vi. Pseudomucinous, borderline malignancy
      vii. Serous, borderline malignancy
   b. Tumor
      i. Mucinous, of low malignant potential
      ii. Papillary mucinous, of low malignant potential
      iii. Papillary serous, of low malignant potential
      iv. Serous, NOS, of low malignant potential
      v. Serous, papillary, of low malignant potential
   c. Squamous cell intraepithelial neoplasia, grade 3 (SIN, grIII)
      i. All SIN,gr III are reportable with the exceptions noted in 1. a-d above

Legend for List of Reportable Conditions

Use this legend to interpret special designations used on the following list of currently reportable conditions:

1. **Bold Print-** Benign and borderline behaviors of these conditions are only reportable if the primary site is listed under *Intracranial and Central Nervous System Sites* on page 3 of *Appendix C*

2. (Single asterisk)- Not reportable if primary to skin as specified under Exclusions

3. ** (Double asterisk) - Reportable only if the date of diagnosis is on or after January 1, 2001.

4. ***Bold Italic print*** are for conditions reportable beginning in 2016

Adamantinoma (long bones, malignant, tibial only
Adenoacanthoma
Adenocarcinofibroma**
Adenocarcinoma
Adenofibroma (malignant endometrioid only)
Adenoma
Adenosarcoma
AIN III (anal intraepithelial neoplasia, grade III)**
ALK positive large B-cell lymphoma
Ameloblastoma (malignant only)
Androblastoma (malignant only)
Anemia, refractory**
Angioendotheliomatosis
Angiolipoma
Angiomyosarcoma
Angiosarcoma
Argentaffinoma (malignant only)
Arrhenoblastoma (malignant only)
Astroblastoma
Astrocytoma
Astroglioma
Blastoma
Cancer*
Carcinoid (Exclude stromal; argentaffin tumor, NOS; Enterochromaffin-like cell, NOS; & tubular
Carcinofibroma**
Carcinoma*
Carcinomatosis*
Carcinosarcoma
CASTLE (carcinoma showing thymus-like element
Chloroma
Cholangiocarcinoma
Chondroblastoma (malignant only)
Chondrosarcoma
Chordoma
Cholangiocarcinoma
Chondroblastoma (malignant only)
Chondrosarcoma
Chordoma
Choriocarcinoma
Chorioepithelioma
Chorionepithelioma
Class IV cytology
Class V cytology
Comedocarcinoma
CPNET (central primitive neuroectodermal, NOS)**
Craniopharyngioma
Cylindroma (exclude eccrine dermal & skin)
Cyst, dermoid (w/malignant transformation only or w/ Secondary tumor**, **NOS**
Cystenadenocarcinofibroma**
Cystadenocarcinoma
Cystadenofibroma (malignant endometrioid only)
Cystosarcoma phyllodes (malignant only)
Cytopenia, refractory w/multilineage dysplasia**
Dermatofibrosarcoma
Diktyoma(malignant only)**
DIN III (ductal intraepithelial neoplasia, grade III)**
Disease – include:
- Alpha heavy chain
- Bowen*
- D Guglielmo
- Franklin
- Gamma heavy chain
- Heavy chain, NOS**
- Hodgkin
- Immunoproliferative (NOS & small intestine only)
- Letterer-Siwe
- Mast Cell, systemic tissue
- Mu heavy chain
- Myeloproliferative, chronic**
- Padget* (exclude of bone)
- Sezar

Disorder, myeloproliferative, chronic**
Disorder, primary cutaneous DC30+ T-cell lymphoproliferative**
Dysgerminoma
Ectomesenchymoma**
Endometriosis, stromal**
Enteroglucagonoma (malignant only)**
Ependymoblastoma
Ependymoma
Epithelioma*(NOS, basal cell, malignant & squamous Cell only)
Erythremia (acute and chronic only)
Erythroleukemia
Erythroplasia, Queyrat*
Esophageal squamous intraepithelial neoplasia, gr III
Esophageal intraepithelial dysplasia, grade III
Esthesioneuroblastoma
Esthesioneruoepithelioma
Fibroblastic reticular cell tumor
Fibrochondrosarcoma
Fibrodentinosarcoma**
Fibroepithelioma, of Pinkus type or NOS*/**
Fibrolipoma
Fibroliopsarcoma
Fibroma, NOS
Fibromyxosarcoma
Fibro-odontosarcoma**

See page C / 2 of *Appendix C for* legend of special designations

Fibrosarcoma
Fibroxanthoma (malignant only)
Gangliocytoma
Ganglioglioma (anaplastic**)
Ganglioneuroblastoma
Ganglioneuroma
Gastrinoma (malignant only)
Gemistocytoma
Germinoma
GIST-Gastrointestinal stromal tumor (malig only)**
Glioblastoma
Gliofibroma
Glioma, astrocytic, malignant, NOS, **chordoid, Subependymal**
Gliomatosis cerebri
Gliosarcoma
Glomangiosarcoma
Glucagonoma (malignant only)
Granuloma (Hodgkin only)
Hemangioblastoma
Hemangioendothelioma
Hemangiopericytoma
Hemangiosarcoma
Hepatoblastoma
Hepatocarcinoma
Hepatocholangiocarcinoma
Hepatoma (malignant only)
Hepatosplenic T-cell lymphoma
Hidradenocarcinoma**
Hidradenoma (malignant only)**
Histiocytoma (malignant fibrous only)
Histiocytosis (malig & acute progressive X only)
Histiocytosis, Langerhans cell, disseminated or generalized only**
Hutchinson melanotic freckle (melanoma in only)
Hydroa vacciniforme-like lymphoma
Hypernephroma
Immunocytoma
Insulinoma (malignant only)
Intraductal papillary mucinous neoplasm with high grade dysplasia
Intravascular large B-cell lymphoma
Langerhans cell histiocytosis
Large B-cell lymphoma arising in HHV8 associated Multicentric Castleman disease
LCIS, NOS (lobular carcinoma in situ)**
Leiomyoma (NOS)
Leiomyomatosis (NOS)
Leiomyosarcoma
Lentigo maligna
Leukemia (exclude granular lymphocytic)
Linitis plastica
Lipoma (atypical or NOS)
Liposarcoma (exclude well differentiated liposarcoma, Superficial)
LN III, LN3 (of breast, also called lobular neoplasia Grade 3 only)
Lymphangioendothelioma (malignant only)
Lymphangiosarcoma
Lymphoblastoma
Lymphoepithelioma*
Lymphoma
Lymphosarcoma
Macroglobulinemia, Waldenstrom
Malignancy*
Malignant*
MANEC
Mastocytoma (malignant only)
Mastocytosis (malignant only)
Medulloblastoma
Medulloepithelioma
Medullomyoblastoma
Melanocytosis, diffuse
Melanocytoma, meningeal
Melanoma (except juvenile)
Melanomatosis, meningeal**
Melanosis (precancerous only)
Meningioma (anaplastic, papillary, rhabdoid**)
Meningiomatosis (NOS)
Mesenchymoma (malignant only)
Mesenchymoma (malignant only)
Mesonephroma (exclude benign)
Mesothelioma (exclude benign and cystic)
Metaplasia, agnogenic myeloid**
Microglioma
Micropapillary carcinoma, NOS
Mixed adenoendocrine carcinoma (MANEC)
Mixed pancreatic endocrine & exocrine tumor, Malignant
Mixed Islet cell & exocrine adenocarcinoma
Mixed acinar-endocrine-ductal carcinoma
MPNST, NOS (malig peripheral nerve sheath tumor)**
Mycosis fungoides
Myelofibrosis (acute, chronic idiopathic, w/myeloid dysplasia** or as a result of myeloproliferative disease**only)

See page C/2 of Appendix C for legend of special designations.

Myeloma
Myelomatosis
Myelosclerosis (megakaryocytic, acute, malignant, or With myeloid metaplasia)**
Myelosis
Myoblastoma (malignant granular cell only)
Myoepithelioma (malignant only)**
Myosarcoma
Myosis, stromal NOS or endolymphatic stromal**
Myxoliposarcoma
Myxosarcoma
Neoplasia, ductal intraepithelial, grade 3 (of breast - Also called DIN III)**
Neoplasia, Intratubular germ cell**
Neoplasia, lobular grade 3 only of breast (also called LN III, LN3)
Neoplasia, squamous intraepithelial, grade 3
Neoplasm
Nephroblastoma
Nephroma (exclude mesoblastic)
Neurilemmoma
Neurilemmosarcoma
Neurinomatosis
Neuroblastoma
Neurocytoma (olfactory**)
Neuroendocrine tumor, grade 2
Neuroendocrine carcinoma
Neuroepithelioma
Neurofibroma
Neurofibromatosis (NOS)
Neurofibrosarcoma
Neuroma (NOS)
Neurosarcoma
Neurothekoma
Nevus (malignant blue only)
Odontosarcoma
Oligoastrocytoma, mixed
Oligodendroblastoma
Oligodendroglioma
Orchioblastoma
Osteochondrosarcoma
Osteosarcoma
Pancreatic endocrine tumor, malignant
Pancreatoblastoma
Panmyelosis, acute only
Pancreatic endocrine tumor, malignant
Pancreatoblastoma
Panmyelosis, acute only
Papillary neoplasm, pancreatobillary type w/high grade intraepithelial neoplasia
Pancreatobilliary type carcinoma
Papilloma
Papulosis, lymphomatoid**
Paraganglioma
Paragranuloma, Hodgkin
Perineural MPNST**
Perineurioma (malignant**)
Pheochromoblastoma
Pheochromocytoma (malignant only)
Pilomatrixoma* (malignant only)
Pinelanoma (NOS)
Pineoblastoma
Pineocytoma
Plasmablastic lymphoma
Plasmacytoma
PNET (primitive neuroectodermal tumor)**
Pneumoblastoma
Polycythemia (proliferative, rubra vera, or vera)**
Polyenbryoma
Polyposis (malignant, lymphomatous only)
Porocarcinoma**
Poroma, eccrine (malignant only)**
PPNET (peripheral primitive neuroectodermal tumor)**
Preleukemia**
Primary cutaneous gamma-delta T-cell lymphoma
Prolactinoma
Pseudomyxoma peritonei
Queyrat erythroplasia*
Refractory neutropenia
Refractory thrombocytopenia
Reticuloendotheliosis
Reticulosarcoma
Reticulosis (histiocytic medullary, malignant, pagetoid** and polymorphic only)
Rhabdomyoma (NOS)
Rhabdomyosarcoma
Sarcoma (exclude well differentiated liposarcoma, superficial)
Sarcomatosis (meningeal only)
Schwannoma (malignant only)
Seminoma
SETTLE (spindle epithelial tumor w/thymus-like element)**
Serrated adenocarcinoma
Somatostatinoma (malignant only)**

See page C/2 of Appendix C for legend of special designations.

Spermatocytoma
Spiradenoma (malignant only)**
Spongioblastoma (polar or malignant only)**
Spongioneuroblastoma
Squamous intraepithelial neoplasia, grade III (SIN III)
Stromatosis, endometrial**
Struma (malignant ovarii & Wuchernde Langhans only)
Subependymoma
Sympathicoblastoma
Syndrome:
- 5q deletion w/myelodysplastic syndrome**
- Hypereosinophilic**
- Myelodysplastic**
  - NOS**
  - w/ 5q deletion syndrome**
  - therapy-related, NOS**
  - therapy-related, alkylating agent related**
  - therapy-related, epidopophyllotoxin related**
  - Preleukemic**
  - Sezary

Synovioma (NOS and malignant only)**
Systemic EBV positive T-cell lymphoproliferative disease of childhood
Teratoblastoma, malignant
Teratocarcinoma
Teratoma
Thecoma (malignant only)
Thrombocythemia (essential, essential hemorrhagic, idiopathic, or idiopathic hemorrhagic)
Tumor – include only:
- adenocarcinoid
- adrenal cortical (malignant only)
- alpha cell (malignant only)
- Askin
- Bednar
- beta cell (malignant only)
- Brenner (malignant only)
- Burkitt
- carcinoid, NOS
- carcinoid (malignant only)
- **cells**
- desmoplastic small round cell
- **dysembryoplastic neuroepithelial**
- embolus*
- endodermal sinus
- **epithelial***
- Ewing

Tumor – include only, *continued*
- **fibrous, solitary** (malignant**)
- follicular dendritic cell**
- fusiform cell type* (malignant only)
- G cell (malignant only)
- gastrin cell (malignant only)
- gastrointestinal stromal (malignant only)**
- germ cell
- giant cell (malignant only)
- glomus (malignant only)**
- **granular cell**
- granulosa cell (malig or sarcomatoid** only)
- Grawitz
- interstitial cell (malignant only)
- intravascular bronchial alveolar**
- Klatskin
- Krukenberg
- Leydig cell (malignant only)
- mast cell (malignant only)
- Merkel cell
- mesenchymal (malignant only)
- mesodermal, mixed
- metastatic*
- mixed pineal**
- mixed salivary gland type (malignant only)
- mucocarcinoid
- Mullerian mixed
- neuroectodermal (exclude melanotic)
- nonencapsulating sclerosing
- odontogenic (malignant only)
- olfactory, neurogenic
- Pancoast
- peripheral neuroectodermal or peripheral primitive neuroectodermal, NOS
- peripheral nerve sheath (malignant only)**
- phyllodes (malignant only)
- pineal parenchymal of intermediate differentiation**
- Pinkus*/**
- plasma cell
- polyvesicular vitelline
- primitive neuroectodermal
- rhabdoid, NOS**
- rhabdoid/teratoid, atypical**
- round cell, desmoplastic, small**
- Schminke
- secondary*
- sinus, endodermal

See page C/2 of Appendix C for legend of special designations.

Tumor – include only, *continued*
- Sertoli-Leydig cell (poorly diff, w/heterologus elements, sarcomatoid, malignant)**
- small cell type* (malignant only)
- **smooth muscle (NOS)**
- **soft tissue**
- spindle cell type* (malignant only)
- spindle epithelial w/thymus-like element or thymus like differentiation
- steroid cell (malignant only)**
- sweat gland (malignant only)
- teratoid/rhabdoid, atypical
- transitional pineal**
- triton, malignant
- trophoblastic, epithelioid**
- vitelline, polyvesicular
- Wilm
- yolk sac

Ulcer, rodent*
VAIN III (vaginal intraepithelial neoplasia, grade 3)
VIN III (vulvar intraepithelial neoplasia, grade 3)
Vipoma (malignant only)**
Xanthoastrocytoma, pleomorphic

See page C/2 of Appendix C for legend of special designations.

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Appendix D:

Multiple Primary Determination

For all cases diagnosed January 1, 2007 and later, the *2007 Multiple Primary and Histology Coding Rules* (MP/H) should be utilized. MP/H represent the first site-specific multiple primary and histology rules developed to promote consistent and standardized coding. Physician guidance by specialty pathologists and clinicians was integral to the review and revision process. Regular consultation with the editors of ICD-O-3 clarified ICD-O-3 codes and ensured the new rules accurately reflect the ICD-O-3 editors' intent and purpose.

The 2007 MP/H rules include site specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, and malignant brain. A separate set of rules addresses the specific and general rules for malignant solid tumors originating in all other sites. The multiple primary rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions. For example, there are instructions and guidance for identifying histologic lineages, differentiating between general (NOS) terms and specific histologic types, and correctly assigning mixed and combination codes.

Determining Multiple Primaries for Solid Malignant Tumors – diagnosis dated January 1, 2007 and later

General Instructions

1. Use the MP/H rules to determine the number of reportable primaries. Do NOT use these rules to determine case reportability, stage or grade

2. The 2007 MP/H rules **replace all previous** multiple primary and histology coding **rules.**

3. The rules are **effective** for cases **diagnosed January 1, 2007** and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.

4. Read the **General instructions** and the **site-specific Equivalent Terms and Definitions** before using the multiple primary rules.

5. The MP/H rules are available in three formats: flowchart, text, and matrix. The **rules are identical,** only the formats differ. Use the rules in the format that is easiest for you to follow.

6. **Do not use** a physician's statement to decide whether the patient has a recurrence of a previous cancer or a new primary. Use the multiple primary rules as written **unless a pathologist compares** the present tumor to the "original" tumor and states that this tumor is a recurrence of cancer from the previous primary

How to use the MP/H Rules

1. Use the **Multiple Primary** rules to **make a decision on the number of primary malignancies** to be abstracted for reportable solid malignant tumors.
2. Use the **site-specific rules** for the following sites:
   a. Brain, malignant (intracranial and CNS)
   b. Brain, benign and borderline (intracranial and CNS)
   c. Breast
   d. Colon
   e. Head and Neck
   f. Kidney
   g. Lung
   h. Malignant Melanoma of the Skin
   i. Renal pelvis, ureter, bladder and other urinary
3. Use the **Other Site rules** for solid malignant tumors that occur in primary sites not covered by the site-specific rules.
4. Each module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors) is an independent, complete set of coding rules. To determine which set of rules to use:
   a. Where there is no tumor in the primary site, only metastatic lesions are present:
      i. Use the primary site documented by a physician and use the multiple primary and histology coding rules for that primary site
      ii. If no primary is documented, code the primary site as unknown and use the general multiple primary and histology coding rules. Use the "Unknown if Single or Multiple Tumors" module to determine multiple primaries and the "Single Tumor" module for coding histology.
   b. To choose the appropriate module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors):
      i. Use the multiple primary and histology coding rules for the primary site
      ii. Determine the number of tumors:
         a.) Do not count metastatic lesions
         b.) When the tumor is only described a multicentric or multifocal and the number of tumors is not mentioned, use the "Unknown if Single or Multiple Tumors" module
         c.) When there is a tumor or tumors with separate microscopic foci, ignore the separate microscopic foci and use the "Single Tumor" or "Multiple Tumor" modules as appropriate
         d.) When the patient has a single tumor, use the "Single Tumor" module
         e.) If there are multiple tumors, use the "Multiple Tumor" module
   c. See the Equivalent Terms and Definitions for Head and Neck for guidance in coding the primary site
   d. Use the primary site documented by the physician on the medical record

7. If a **single primary,** prepare **one abstract**
8. If there are **multiple primaries,** prepare **two or more abstracts**
9. Rules are in hierarchical order within each module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors). Use the first rule that applies and **STOP**

The MP/H Rules is available online at:
http://seer.cancer.gov/tools/mphrules/download.html

Determining Multiple Primaries for Solid Malignant Tumors – diagnosis prior to January 1, 2007

More Than One Malignant Cancer

If more than one primary malignant cancer is diagnosed, a separate report must be submitted for each primary. The VCR, like most central registries in the United States, follows the rules of the Surveillance, Epidemiology and End Results (SEER) Program for determination of multiple primary cancers. The reference information contained in this section is taken from the *SEER Program Code Manual, Third Edition, January 1998*.

The determination of how many primary cancers a patient has is, of course, a medical decision, but operational rules are needed in order to ensure consistency of reporting by all participants. Basic factors include the site of origin, the date of diagnosis, the histologic type, the behavior of the neoplasm (i.e., in situ versus malignant), and laterality.

In general, if there is a difference in the site where the cancer originates, it is fairly easy to determine whether it is a separate primary, regardless of dates of diagnosis and differences in histology.

Likewise, if there is a clear-cut difference in histology, other data such as site and time of diagnosis are not essential. In some neoplasms, however, one must be careful since different histologic terms are used, for example, *leukemic phase of* or *converting to*, to describe progressive stages of the same disease process.

Lymphatic or Hematopoietic Disease

The Hematopoietic Database and Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual should be used for all hematopoietic and lymphoid neoplasms, regardless of the date of diagnosis. This database also has a multiple primary calculator associated with it; this calculator should be used to determine whether the new disease is a recurrence of the original diagnosis or if it represents a new primary. This database and manual are also available at the SEER website: http://seer.cancer.gov/tools/heme/index.html

GUIDELINES FOR DETERMINING MULTIPLE PRIMARIES FOR LYMPHATIC AND HEMATOPOIETIC DISEASES

1. *Lymphoma* is a general term for hematopoietic solid malignancies of the lymphoid series. *Leukemia* is a general term for liquid malignancies of either the lymphoid or the myeloid series. While it is recognized some malignancies occur predominantly (or even exclusively) in liquid or solid form, because so many malignancies can potentially arise as either leukemias or lymphomas (or both), all hematopoietic malignancies are assumed to have this potential.

2. Malignancies of the lymphoid series are considered to be different from those of the myeloid series. Therefore a lymphoid malignancy arising after diagnosis of a myeloid malignancy (or myelodysplastic or myeloproliferative disorder) would be considered a subsequent (new) primary; however, a myeloid malignancy diagnosed after a previous myeloid malignancy would not count as a subsequent primary. Histiocytic malignancies are considered different from both lymphoid and myeloid malignancies.

3. Hodgkin lymphoma is considered to be different from non-Hodgkin lymphoma (NHL). Among the NHLs, B-cell malignancies are considered different from T- cell/NK cell malignancies. Therefore, a B-cell malignancy arising later in the course of a patient previously diagnosed with a T-cell malignancy would be considered a subsequent primary; however, a T- cell malignancy diagnosed later in the same patient would not be considered a subsequent primary.

4. The sequence of diagnosis affects whether a diagnosis represents a subsequent primary. In some cases, the order of occurrence of the two diagnoses being compared is a factor in the decision whether the second diagnosis is a new primary.

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASE

Both diseases diagnosed
on or after 01/01/2001

or

First diagnosis made prior to 2001 and second diagnosis made on or after 01/01/2001

The table that was used prior to the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and Hematopoietic Database SHOULD NO LONGER BE USED!!!!

<u>ALL CASES</u> *regardless* of date of diagnosis should be coded using the above noted references.

APPENDIX E: SEER GEOCODES

For Coding Place of Birth and Place of Death

SEER Geocodes

Continental United States and Hawaii

000 United States

001 New England & New Jersey
- 002 Maine
- 003 New Hampshire
- 004 Vermont
- 005 Massachusetts
- 006 Rhode Island
- 007 Connecticut
- 008New Jersey

010 North Mid-Atlantic States
- 011 New York
- 014 Pennsylvania
- 017 Delaware

020 South Mid-Atlantic States
- 21 Maryland
- 22 District of Columbia
- 23 Virginia
- 24 West Virginia
- 25 North Carolina
- 26 South Carolina

030 Southeastern States
- 031 Tennessee
- 033 Georgia
- 035 Florida
- 037 Alabama
- 039 Mississippi

040 North Central States
- 041 Michigan
- 043 Ohio
- 045 Indiana
- 047 Kentucky

050 Northern Midwest States
- 051 Wisconsin
- 052 Minnesota
- 053 Iowa
- 054 North Dakota
- 055 South Dakota
- 056 Montana

060 Central Midwest States
- 061 Illinois
- 063 Missouri
- 065 Kansas
- 067 Nebraska

070 Southern Midwest States
- 071 Arkansas
- 073 Louisiana
- 075 Oklahoma
- 077 Texas

080 Mountain States
- 081 Idaho
- 082 Wyoming
- 083 Colorado
- 084 Utah
- 085 Nevada
- 086 New Mexico
- 087 Arizona

090 Pacific Coast States
- 091 Alaska
- 093 Washington
- 095 Oregon
- 097 California
- 099 Hawaii

UNITED STATES POSSESSIONS

100 Atlantic/Caribbean Area

- 101 Puerto Rico
- 102 US Virginia Islands
- 109 Other Atlantic/Caribbean Area

110 Canal Zone

120 Pacific Area

121 American Samoa

122 Kiribati (Gilbert Islands, Line Islands, Phoenix Islands)

123 Micronesia [Federated States of] (Caroline Islands, Trust Territory of Pacific Islands)

124 Cook Islands (New Zealand)

125 Tuvalu (Ellice Islands)

126 Guam

127 Johnston Atoll

129 Northern Mariana Islands (Trust Territory of Pacific Islands)

131 Marshall Islands (Trust Territory of Pacific Islands)

132 Midway Islands/Atoll

133 Nampo-Shoto/Southern Islands

134 Ryukyu Islands (Japan)

135 Swan Islands

136 Tokelau Islands (New Zealand)

137 Wake Island

139 Palau (Trust Territory of Pacific Islands

North and South America, Exclusive of the United States and Is Possessions

210	Greenland		Trinidad and Tobago
			Turks and Caicos
220	Canada		West Indies, NOS
	221 Maritime Provinces		Windward Islands, NOS
	Labrador		246 Bermuda
	New Brunswick		247 Bahamas, The
	Newfoundland		249 St Pierre and Miquelon
	Nova Scotia		
	Prince Edward Island	250	Central America
	222 Quebec		251 Guatemala
	223 Ontario		252 Belize (British Honduras)
	224 Prairie Provinces		253 Honduras
	Alberta		254 El Salvador
	Manitoba		255 Nicaragua
	Saskatchewan		256 Costa Rica
	225 Northwest Territories		257 Panama
	Yukon Territory		
	226 British Columbia	260	North America, NOS
	227 Nunavut		265 Latin America, NOS
230	Mexico	300	South America, NOS
240	North American Islands		311 Columbia
	241 Cuba		321 Venezuela
	242 Haiti		331 Guyana (British Guiana)
	243 Dominican Republic		332 Suriname (Dutch Guiana)
	245 Other Caribbean Islands		333 French Guiana
	Anguilla		341 Brazil
	Antilles, NOS		345 Ecuador
	Barbados		351 Peru
	British Virgin Islands		355 Bolivia
	British West Indies, NOS		361 Chile
	Caribbean, NOS		365 Argentina
	Cayman Islands		371 Paraguay
	Curacao		375 Uruguay
	Dominica		
	Grenada	380	South American Islands
	Guadeloupe		381 Falkland Islands
	Leeward Islands, NOS		
	Martinique		
	Montserrat		
	Netherlands Antilles		
	St Kitts and Nevis		
	St Lucia		
	St Vincent and the Grenadines		

Europe – former or alternative names are in parentheses			
400	United Kingdom, NOS		449 Romania
	401 England		450 Slavic Countries
	Channel Islands		451 Poland
	Isle of Man		452 (former) Czechoslovakia reg
	402 Wales		Bohemia
	403 Scotland		Czech Republic
	404 Northern Ireland (Ulster)		Moravia
	410 Ireland (Eire)		Slovak Republic
	Ireland, NOS		Slovakia
	Republic of Ireland		453 (former) Yugoslavia region
	420 Scandinavia		Bonsia-Herzegovina
	Lapland, NOS		Croatia
	421 Iceland		Dalmatia
	423 Norway		Montenegro
	Svalbard		Macedonia
	425 Denmark		Serbia
	Faroe (Faeroe) Islands		Slavonia
	427 Sweden		Slovenia
	429 Finland		454 Bulgaria
	430 Germanic Countries		455 Russia
	431 Germany		Russian Federation (former
	East Germany, incl East Berlin		USSR)
	West Germany, incl West Berlin		Russia, NOS (Russian SFSR)
	432 Netherlands		456 Ukraine and Moldova
	433 Belgium		(Bessarabia)
	434 Luxembourg		457 Belarus (Byelorussian SSR)
	435 Switzerland		(White Russia)
	436 Austria		458 Estonia (Estonian SSR)
	437 Liechtenstein		459 Latvia (Latvian SSR)
	440 Romance-language Countries		461 Lithuania (Lithuanian SSR)
	441 France		463 Baltic Republic(s), NOS
	Corsica		(Baltic States, NOS)
	Monaco		470 Other Mainland Europe
	443 Spain		471 Greece
	Andorra		Crete
	Balearic Islands		475 Hungary
	Canary Islands		481 Albania
	445 Portugal		485 Gibraltar
	Azores		490 Other Mediterranean Islands
	447 Italy		491 Malta
	San Marino		495 Cyprus
	Sardinia		
	Sicily; Vatican City (Holy See)		

499	Europe, NOS		
	Central Europe, NOS		
	Northern Europe, NOS		
	Southern Europe, NOS		
	Western Europe, NOS		
	Africa		
500	Africa, NOS		541 Zaire (Congo-Leopoldville,
	Central Africa, NOS		Belgian Congo, Congo/
	Equatorial Africa, NOS		Kinshasa)
	510 North Africa, NOS		543 Angola (Sao Tome, Principe,
	511 Morocco		Cabinda)
	513 Algeria		545 Republic of South Africa
	515 Tunisia		(Bophuthatswana, Cape
	517 Libya (Tripoli, Tripolitania)		Colony, Ciskei, Natal, Free
	519 Egypt (United Arab Republic)		State [Orange Free State],
	520 Sudanese Countries		Transkei, Transvaal,
	Burkina Faso (Upper Volta)		Venda)
	Chad		Botswana (Bechuanaland)
	Mali		Lesotho (Basutoland)
	Mauritania		Namibia (South West Africa)
	Niger		Swaziland
	530 West Africa		547 Zimbabwe (Rhodesia,
	French West Africa, NOS		Southern Rhodesia)
	531 Nigeria		549 Zambia (Northern Rhodesia)
	539 Other West African Countries		551 Malawi (Nyasaland)
	Benin (Dahomey)		553 Mozambique
	Cameroon (Kameron)		555 Madagascar (Malagasy
	Central African Republic (French		Republic)
	Equatorial Africa)		570 East Africa
	Cote d'Ivoire (Ivory Coast)		571 Tanzania (Tanganyika,
	Congo (Congo-Brazzaville, French		Tanganyika, Zanzibar)
	Congo)		573 Uganda
	Equatorial Guinea (Spanish Guinea)		575 Kenya
	(Bioko[Fernando Poo]Rio Muni)		577 Rwanda (Ruanda)
	Gabon		579 Burundi (Urundi)
	Gambia		581 Somalia (Somali Republic,
	Guinea		Somaliland)
	Liberia		583 Djibouti (French Territory of
	Senegal		the Afars and Issus, French
	Sierra Leone		Somaliland
	Togo		585 Ethiopia (Abyssinia)
	540 South Africa, NOS		Eritrea

Asia			
600	Asia, NOS		641 India, Andaman Islands
	610 Near East		643 Nepal
	Mesopotamia, NOS		645 Bangladesh (East Pakistan)
	611 Turkey Anatolia		647 Sri Lanka (Ceylon)
	Armenia (Turkey)		649 Myanmar (Burma)
	Asia Minor, NOS		650 Southeast Asia
	620 Asian Arab Countries		651 Thailand (Siam)
	Iraq-Saudi Arabia Neutral Zone		660 Indochina
	621 Syria		661 Laos
	623 Lebanon		663 Cambodia, Kampuchea
	625 Jordan (Trans-Jordan, former		665 Vietnam (Tonkin, Annam,
	Arab Palestine)		Cochin China)
	627 Iraq		671 Malaysia, Singapore, Brunei
	629 Arabian Peninsula		673 Indonesia (Dutch East Indies)
	Bahrain		675 Philippians (Philippine Islands)
	Kuwait		680 East Asia
	Oman and Muscat		681 China, NOS
	Persian Gulf States, NOS		682 China (People's Republic of
	Qatar		China
	Saudi Arabia		683 Hong Kong
	United Arab Emirates Trucial States)		684 Taiwan (Formosa, Republic of
	Yemen (Aden, People's		China)
	Democratic Republic)		685 Tibet
	631 Israel and former Jewish		686 Macao (Macau)
	Palestine Gaza		691 Mongolia
	Palestine (Palestine National		693 Japan
	Authority [PNA])		695 Korea
	633 Caucasian Republics of the		North Korea
	former USSR		South Korea
	Armenia		
	Azerbaijan (Nagorno-Karabakh)		
	Georgia		
	634 Other Asian Republics of the		
	former USSR)		
	Kazakhstan (Kazakh SSR)		
	Kyrgyzstan (Kirghiz SSR, Kyrgyz)		
	Tajikistan (Turkmen SSR)		
	Uzbekistan (Uzbek SSR)		
	637 Iran (Persia)		
	638 Afghanistan		
	639 Pakistan (West Pakistan)		
	640 Mid-East Asia, NOS		
	Maldives		

Australia and Oceania					
	711	Australia & Australian New Guinea			
	715	New Zealand			
		Niue			
	720	Pacific Islands			
		Oceania, NOS			
		Polynesia, NOS			
	721	Melanesian Islands			
		Fiji			
		Futuna			
		New Hebrides			
		Solomon Islands	**Place of Birth Unknown**		
		Vanuatu			
		Wallis	998	Place of birth stated not to be in the	
	723	Micronesian Islands		United States, but no other	
	725	Polynesian Islands		information available	
	750	Antarctica	999	Place of birth unknown	

References: *CIA World Factbook*, 1995. U.S. Bureau of the Census Place of Birth Technical Documentation, 1997.

SEER Geocodes – Alphabetic Listing

A		633	Armenia (USSR)
585	Abyssinia	611	Armenia (Turkey)
629	Aden	245	Aruba
583	Afars and Issas	600	Asia, NOS
638	Afghanistan	680	Asia, East
500	Africa	640	Asia, Mid-East
570	Africa, East	610	Asia Minor, NOS
510	Africa, North	610	Asia, Near-East
540	Africa, South	650	Asia, Southeast
545	Africa, South West	620	Asian Arab countries
530	Africa, West	634	Asian Republics of the former USSR
580	African Costal Islands (previously	109	Atlantic/Caribbean area, other US
	included in 540)		US possessions
037	Alabama	100	Atlantic/Caribbean area, US
091	Alaska		possessions
481	Albania	711	Australia
224	Alberta	711	Australian New Guinea
513	Algeria	436	Austria
250	America, Central	633	Azerbaijan
260	America, North (use more specific	633	Azerbaijan, SSR
	term if possible)	445	Azores
300	America, South		
121	American Samoa	**B**	
611	Anatolia	247	Bahamas
641	Andaman Islands	629	Bahrain
443	Andorra	443	Balearic Islands
543	Angola	463	Baltic Republic, NOS
245	Anguilla	463	Baltic States, NOS
665	Annam	645	Bangladesh
750	Antarctica	245	Barbados
245	Antigua	245	Barbuda
245	Antilles, NOS	545	Basutoland
245	Antilles, Netherlands	431	Bavaria
625	Arab Palestine	545	Bechuanaland
629	Arabia, Saudi	547	Belarus
629	Arabian Peninsula	541	Belgian Congo
365	Argentina	433	Belgium
087	Arizona	252	Belize
071	Arkansas	539	Benin

246	Bermuda	499	Central Europe, NOS
456	Bessarabia	060	Central Midwest States
643	Bhutan	647	Ceylon
539	Bioko (Fernando Poo)	520	Chad
355	Bophuthatswana	401	Channel Islands (British
673	Borneo	361	Chile
453	Bosnia-Herzegovina	681	China, NOS
545	Botswana	665	China, Cochin
341	Brazil	682	China, People's Republic of
226	British Columbia	684	China, Republic of
331	British Guiana	723	Christmas Island
252	British Honduras	545	Ciskel
245	British Virgin Islands	665	Cochin China
245	British West Indies, NOS	711	Cocos (Keeling) Islands
671	Brunei	311	Columbia
454	Bulgaria	083	Colorado
520	Burkina Faso (Upper Volta)	580	Comoros
649	Burma (see Myanmar)	226	Columbia, British
579	Burundi	022	Columbia, District of
457	Byelorussian SSR	539	Congo – Brazzaville
		541	Congo – Leopoldville
C		539	Congo, French
543	Cabinda	541	Congo Kinshasa
245	Caicos Islands	007	Connecticut
097	California	124	Cook Islands
663	Cambodia	441	Corsica
539	Cameroon	256	Costa Rica
220	Canada	539	Cote d'Ivoire (Ivory Coast
110	Canal Zone	471	Crete
443	Canary Islands	453	Croatia
122	Canton Islands	241	Cuba
545	Cape Colony	245	Curacao
445	Cape Verde Islands	495	Cyprus
245	Caribbean Islands, NOS	517	Cyrenaica
245	Caribbean Islands, other	452	Czechoslovakia
123	Caroline Islands	452	Czech Republic
711	Cartier Islands		
633	Caucasian Republics of the former USSR	**D**	
245	Cayman Islands	539	Dahomey
539	Central African Republic	453	Dalmatia
250	Central America	017	Delaware

425	Denmark	721	Fortuna
022	District of Columbia	441	France
583	Djibouti	545	Free State (Orange Free State)
449	Dobruja	539	French Congo
245	Dominica	333	French Guiana
243	Dominican Republic	725	French Polynesia
673	Dutch East Indies	583	French Somaliland
332	Dutch Guiana	530	French West Africa, NOS
		245	French West Indies
E			
570	East Africa	**G**	
680	East Asia	539	Gabon
431	East Germany	345	Galapagos Islands
673	East Indies, Dutch	539	Gambia
645	East Pakistan	631	Gaza Strip
499	Eastern Europe, NOS	033	Georgia (USA)
345	Ecuador	633	Georgia (USSR)
419	Egypt	430	Germanic countries
410	Eire	431	German Democratic Republic
254	El Salvador	431	Germany
125	Ellice Islands	431	Germany, East
122	Enderbury Islands	431	Germany, Federal Republic of
401	England	539	Ghana
500	Equatorial Africa, NOS	485	Gibraltar
539	Equatorial Guinea (Spanish Guinea)	122	Gilbert Islands
585	Eritrea	471	Greece
458	Estonia	210	Greenland
458	Estonian SSR (Estonia)	245	Grenada
585	Ethiopia	245	Grenadines, The
499	Europe, NOS	245	Guadeloupe
470	Europe, other mainland	126	Guam
		251	Guatemala
F		401	Guernsey
420	Faroe (Faeroe) Islands	331	Guiana, British
381	Falkland Islands	332	Guiana, Dutch
431	Federal Republic of Germany	333	Guiana, French
539	Fernando Poo	539	Guinea
721	Fiji	539	Guinea-Bissau (Portuguese Guinea)
429	Finland	539	Guinea, Equatorial
035	Florida	---	Guinea, New (see New Guinea)
684	Formosa	539	Guinea, Portuguese

331	Guyana	625	Jordan
		453	Jugoslavia
H			
242	Haiti	**K**	
099	Hawaii	539	Kameron
432	Holland	663	Kampuchea
253	Honduras	065	Kansas
252	Honduras, British	634	Kazakh SSR
683	Hong Kong	634	Kazakhstan
475	Hungary	047	Kentucky
		575	Kenya
I		634	Kirghiz SSR
421	Iceland	122	Kiribati
081	Idaho	695	Korea
061	Illinois	695	Korea, North
641	India	695	Korea, South
045	Indiana	629	Kuwait
673	Indies, Dutch East	634	Kyrgyzstan
660	Indochina	634	Kyrgyz
673	Indonesia		
053	Iowa	**L**	
637	Iran	221	Labrador
627	Iraq	661	Laos
620	Iraq-Saudi Arabian Neutral Zone	420	Lapland, NOS
410	Ireland (Erie)	265	Latin America, NOS
404	Ireland, Northern	459	Latvia
410	Ireland, NOS	459	Latvian SSR (Latvia)
410	Ireland, Republic of	623	Lebanon
401	Isle of Man	245	Leeward Islands, NOS
631	Israel	545	Lesotho
583	Issas	539	Liberia
447	Italy	517	Libya
539	Ivory Coast	437	Liechtenstein
		122	Line Islands, Southern
J		461	Lithuania
244	Jamaica	461	Lithuanian SSR (Lithuania)
423	Jan Mayen	073	Louisiana
693	Java	434	Luxembourg
401	Jersey		
631	Jewish Palestine		
127	Johnston Atoll		

M		456	Moldavian SSR
686	Macao	456	Moldova
686	Macau	441	Monaco
453	Macedonia	691	Mongolia
555	Madagascar	056	Montana
445	Madeira Islands	453	Montenegro
002	Maine	245	Montserrat
555	Malagasy Republic	452	Moravia
551	Malawi	511	Morocco
671	Malay Peninsula	080	Mountain States
671	Malaysia	553	Mozambique
640	Maldives	629	Muscat
520	Mali	649	Myanmar (see Burma)
491	Malta		
224	Manitoba	**N**	
129	Mariana Islands	545	Namibia
221	Maritime Provinces, Canada	133	Nampo-Shoto, Southern
131	Marshall Islands	545	Natal
245	Martinique	723	Nauru
021	Maryland	610	Near-East Asia
005	Massachusetts	067	Nebraska
520	Mauritania	643	Nepal
580	Mauritius	432	Netherlands
580	Mayotte	245	Netherlands Antilles
490	Mediterranean Islands, Other	332	Netherlands Guiana
721	Melanesian Islands	085	Nevada
610	Mesopotamia, NOS	245	Nevis
230	Mexico	221	New Brunswick
041	Michigan	724	New Caledonia
123	Micronesian Islands (Federated States of)	001	New England
	(Caroline Islands, Trust Territory of	673	New Guinea, except Australian &
	Pacific Islands)		North East
723	Micronesian Islands (except possessions	711	New Guinea, North East
	of the United States)	003	New Hampshire
640	Mid-East Asia	721	New Hebrides
132	Midway Islands	008	New Jersey
052	Minnesota	086	New Mexico
249	Miquelon	011	New York
039	Mississippi	715	New Zealand
063	Missouri	711	Norfolk Island
456	Moldavia	510	North Africa, NOS

260	North America, NOS (use more specific	631	Palestine, Jewish
	term if possible	631	Palestine, NOS
240	North American Islands	631	Palestinian National Authority (PNA)
671	North Borneo (Malaysia)	257	Panama
025	North Carolina	711	Papua New Guinea
040	North Central States	371	Paraguay
054	North Dakota	014	Pennsylvania
711	North East New Guinea	629	People's Democratic Republic of
695	North Kores		Yemen
010	North Mid-Atlantic States	682	People's Republic of China
499	Northern Europe, NOS	637	Persia
404	Northern Ireland	629	Persian Gulf States, NOS
129	Northern Mariana Islands	351	Peru
050	Northern Midwest States	675	Philippine Islands
225	Northwest Territories (Canada)	675	Philippines
423	Norway	725	Pitcairn
998	Not United States, NOS	451	Poland
221	Nova Scotia	725	Polynesian Islands
227	Nunavut	445	Portugal
551	Nyasaland	539	Portuguese Guinea
		224	Prairie Provinces, Canada
O		221	Prince Edward Island
043	Ohio	543	Principe
075	Oklahoma	101	Puerto Rico
629	Oman		
223	Ontario	**Q**	
454	Orange Free State	629	Qatar
095	Oregon	222	Quebec
403	Orkney		
		R	
P		684	Republic of China
120	Pacific area, US Possessions	545	Republic of South Africa
090	Pacific Coast States	580	Reunion
720	Pacific Islands	006	Rhode Island
123	Pacific Islands, Trust Territory of (code to	547	Rhodesia
	island if possible)	549	Rhodesia, Northern
639	Pakistan	547	Rhodesia, Southern
645	Pakistan, East	539	Rio Muni
639	Pakistan, West	440	Romance-language countries
139	Palau (Trust Territory of the Pacific Islands)	449	Romania
625	Palestine, Arab	449	Roumania

577	Ruanda	581	Somali Republic
449	Rumania	581	Somalia
455	Russia, NOS	581	Somaliland
455	Russian, SFSR	583	Somaliland, French
457	Russian, White	540	South Africa
455	Russian Federation (former USSR)	545	South Africa, Republic of
577	Rwanda	545	South Africa, Union of
134	Ryukyu Islands	300	South America
		380	South American Islands
S		026	South Carolina
520	Sahara, Western	055	South Dakota
121	Samoa, American	695	South Korea
725	Samoa, Western	020	South Mid-Atlantic States
245	St Christopher-Nevis	545	South West Africa
580	St Helena	650	Southeast Asia
245	St Kitts (see St Christopher-Nevis)	030	Southeastern States
245	St Lucia	499	Southern Europe, NOS
249	St Pierre	122	Southern Line Islands
245	St Vincent	070	Southern Midwest States
447	San Marino	133	Southern Nampo-Shoto
543	Sao Tome	547	Southern Rhodesia
447	Sardinia	629	Southern Yemen
224	Saskatchewan	---	Soviet Union
629	Saudi Arabia	443	Spain
420	Scandinavia	520	Spanish Sahara
403	Scotland	647	Sri Lanka
539	Senegal	520	Sudan (Anglo-Egyptian Sudan)
453	Serbia	520	Sudanese countries
580	Seychelles	673	Sumatra
403	Shetland Islands	332	Suriname
651	Siam	423	Svalbard
447	Sicily	135	Swan Islands
539	Sierra Leone	545	Swaziland
643	Sikkim	427	Sweden
671	Singapore	435	Switzerland
450	Slavic countries	621	Syria
453	Slavonia		
452	Slovak Republics	**T**	
452	Slovakia	634	Tadzhik SSR
453	Slovenia	684	Taiwan
721	Solomon Islands	634	Tajikistan

571	Tanganyika	375	Uruguay
571	Tanzanyika	579	Urundi
031	Tennessee	084	Utah
077	Texas	634	Uzbekistan
651	Thailand (Siam)	634	Uzbek, SSR
685	Tibet		
245	Tobago	**V**	
539	Togo	721	Vanuatu
136	Tokelau Islands	447	Vatican City
725	Tonga	545	Venda
665	Tonkin	321	Venezuela
625	Trans-Jordan	004	Vermont
545	Transkei	665	Vietnam
545	Transvaal	245	Virgin Islands (British)
449	Transylvania	102	Virgin Islands (US)
245	Trinidad	023	Virginia
517	Tripoli		
517	Tripolitania	**W**	
629	Trucial States	137	Wake Island
515	Tunisia	402	Wales
611	Turkey	449	Wallachia
634	Turkmen SSR	721	Wallis
634	Turkmenistan	093	Washington (state)
245	Turks Islands	022	Washington DC
125	Truvalu	530	West Africa, NOS
		539	West African countries, other
U		631	West Bank
573	Uganda	431	West Germany
546	Ukraine	245	West Indies, NOS (see individual
456	Ukranian SSR		islands)
404	Ulster	639	West Pakistan
545	Union of South Africa	024	West Virginia
---	Union of Soviet Socialist Republics (USSR)	499	Western Europe, NOS
	(see individual republics)	520	Western Sahara
629	United Arab Emirates	725	Western Samoa
519	United Arab Republic	457	White Russia
400	United Kingdom	245	Windward Islands
000	United States	051	Wisconsin
102	US Virgin Islands	082	Wyoming
999	Unknown		
520	Upper Volta		

Y		Z	
629	Yemen	541	Zaire
629	Yemen, People's Democratic Republic of	549	Zambia
453	Yugoslavia (former Yugoslavia region)	571	Zanzibar
225	Yukon Territory	547	Zimbabwe

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Appendix F:

Federal Information Processing Standards (FIPS) County Codes for Virginia

Federal Information Processing Standards Publication, Counties and Equivalent Entities of the United States, its Possessions, and Associated Areas. US Department of Commerce, National Institute of Standards and Technology, Gaithersburg, MD, August 31, 1990

FIPS County Codes for Virginia

001 Accomack
003 Albemarle
005 Alleghany
007 Amelia
009 Amherst
011 Appomattox
013 Arlington
015 Augusta
017 Bath
019 Bedford
021 Bland
023 Botetourt
025 Brunswick
027 Buchanan
029 Buckingham
031 Campbell
033 Caroline
035 Carroll
036 Charles City
037 Charlotte
041 Chesterfield
043 Clarke
045 Craig
047 Culpepper
049 Cumberland
051 Dickenson
053 Dinwiddie
057 Essex
059 Fairfax
061 Fauquier
063 Floyd
065 Fluvanna
067 Franklin
069 Frederick
071 Giles
073 Gloucester
075 Goochland
077 Grayson
079 Greene
081 Greensville
083 Halifax
085 Hanover
087 Henrico
089 Henry
091 Highland
093 Isle of Wight
095 James City
097 King and Queen
099 King George
101 King William
103 Lancaster
105 Lee
107 Loudoun
109 Louisa
111 Lunenburg
113 Madison
115 Mathews
117 Mecklenburg
119 Middlesex
121 Montgomery
125 Nelson
127 New Kent
131 Northampton
133 Northumberland
135 Nottoway
137 Orange
139 Page
141 Patrick
143 Pittsylvania
145 Powhatan
147 Prince Edward
149 Prince George
153 Prince William
155 Pulaski
157 Rappahannock
159 Richmond
161 Roanoke
163 Rockbridge
165 Rockingham
167 Russell
173 Smyth
175 Southampton
177 Spotsylvania
179 Stafford
181 Surry
183 Sussex
185 Tazewell
187 Warren
191 Washington
193 Westmoreland
195 Wise
197 Wythe
199 York

510 Alexandria
515 Bedford City
520 Bristol
530 Buena Vista
540 Charlottesville
550 Chesapeake
560 Clifton Forge
570 Colonial Heights
582 Covington
590 Danville
595 Emporia
600 Fairfax City
610 Falls Church City
620 Franklin City
630 Fredericksburg
640 Galax
650 Hampton
660 Harrisonburg
670 Hopewell
678 Lexington
680 Lexington
683 Manassas
685 Manassas Park
690 Martinsville
700 Newport News
710 Norfolk

720 Norton
730 Petersburg
735 Poquoson
740 Portsmouth
750 Radford
760 Richmond
770 Roanoke
775 Salem
780 South Boston(now a town – use Halifax County)
790 Staunton
800 Suffolk
810 Virginia Beach
820 Waynesboro
830 Williamsburg
840 Winchester `

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Appendix G:

SEER Summary Staging Manual 2000

Please insert a copy of the SEER Summary Staging Manual 2000.
It is downloadable at:

http://seer.cancer.gov/tools/ssm/

Appendix H:

Surgical Codes
Regional Lymph Nodes by Site

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Oral Cavity

Lip C00.0 – C00.9; Base of Tongue C01.9; Other Parts of the Tongue C02.0 – C02.9; Gum C03.0 – C03.9; Floor of Mouth C04.0 – C04.9; Palate C05.0 – C05.9; Other Parts of Mouth C06.0 – C06.9

(Except for M-9727, 9733, 9741 – 9742, 9764 – 9809, 9832, 9840 – 9931, 9945 – 9946, 9975 – 9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

Specimen sent to pathology from surgical events 20–27.

30 Wide excision, NOS

Code 30 includes:
- Hemiglossectomy
- Partial glossectomy

40 Radical excision of tumor, NOS
- 41 Radical excision of tumor ONLY
- 42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
- 43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

Codes 40–43 include:
- Total glossectomy
- Radical glossectomy

Specimen sent to pathology from surgical events 20–43.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Oral Cavity

Cheek (Buccal) Mucosa, Vestibule

- Cervical, NOS
- Facial: Buccinator (buccal)
  - Nasolabial
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular
  - (submaxillary) Submental
- Parotid, NOS: Infra-auricular
- Preauricular

Floor of Mouth

- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
      - Middle
      - Upper, NOS:
        - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Sublingual

Gum

- Cervical, NOS
- Facial, NOS:
  - Buccinator (buccal)
  - Nasolabial
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS: Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Retropharyngeal **for upper gum**

Regional Lymph Nodes – Oral Cavity, *continued*

Hard Palate
- Buccinator
- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Retropharyngeal

Lip
- Cervical, NOS
- Facial, NOS
  - Buccinator (buccal) **for upper lip**
  - Nasolabial **for upper lip**
- Internal jugular, NOS
- Deep cervical, NOS
  - Lower, NOS
    - Jugulo-omohyoid (supraomohyoid) Middle
  - Upper, NOS
    - Jugulodigastric (subdigastric)
  - Mandibular **for lower lip:**
    - Submandibular
    - (submaxillary) Submental
  - Parotid:
    - Infra-auricular **for upper lip**
    - Preauricular **for upper lip**

Regional Lymph Nodes – Oral Cavity, *continued*

Other parts of mouth

- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Posterior triangle/supraclavicular

Soft Palate, Uvula

- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Retropharyngeal

Tongue

- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Sublingual

Parotid and other Unspecified Glands

Parotid Gland C07.9; Major Salivary Glands C08.0 – C08.9

Except for M-9727, 9733, 9741 – 9742, 9764 – 9809, 9832, 9840 – 9931, 9945 – 9946, 9950 – 9967, 9975 – 9992

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

Specimen sent to pathology from surgical events 20–27.

30 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS
- 31 Facial nerve spared
- 32 Facial nerve sacrificed

33 Superficial lobe ONLY
- 34 Facial nerve spared
- 35 Facial nerve sacrificed

36 Deep lobe (Total)
- 37 Facial nerve spared
- 38 Facial nerve sacrificed

40 Total parotidectomy, NOS; total removal of major salivary gland, NOS
- 41 Facial nerve spared
- 42 Facial nerve sacrificed

50 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
- 51 WITHOUT removal of temporal bone
- 52 WITH removal of temporal bone
- 53 WITH removal of overlying skin (requires graft or flap coverage)

80 Parotidectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Parotid and Other Unspecified Glands

All sites
- Cervical, NOS for **parotid gland and other major salivary glands**
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Retropharyngeal

Parotid gland
- Parotid node(s):
  - Infra-auricular
  - Intraparotid
  - Preauricular

Submandibular
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)

Pharynx

Tonsil C09.0 – C09.9; Oropharynx C10.0 – C10.9; Nasopharynx C11.0 – C11.9; Pyriform Sinus C12.9; Hypopharynx C13.0 – C13.9; Pharynx C14.0

Except for M-9727, 9733, 9741 – 9742, 9764 – 9809, 9832, 9840 – 9931, 9945 – 9946, 9950 – 9967, 9975 – 9992

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

28 Stripping

Specimens sent to pathology from surgical events 20–28.

30 Pharyngectomy, NOS
- 31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
- 32 Total pharyngectomy

40 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)
- 41 WITH Laryngectomy (laryngopharyngectomy)
- 42 WITH bone
- 43 WITH both 41 and 42

50 Radical pharyngectomy (includes total mandibular resection), NOS
- 51 WITHOUT laryngectomy
- 52 WITH laryngectomy

Specimen sent to pathology from surgical events 20–52.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes - Pharynx

Nasopharynx

Cervical, NOS Internal jugular, NOS:
Deep cervical, NOS:
Upper, NOS:
Jugulodigastric (subdigastric)
Mandibular, NOS:
Submandibular (submaxillary)
Submental
Retropharyngeal
Spinal accessory (posterior cervical)

Pyriform Sinus, Hypopharynx, Laryngopharynx

Cervical, NOS
Internal jugular, NOS:
Deep cervical, NOS:
Lower, NOS:
Jugulo-omohyoid (supraomohyoid)
Middle
Mandibular, NOS:
Submandibular (submaxillary)
Submental
Parapharyngeal
Paratracheal
Recurrent pharyngeal nerve chain
Prelaryngeal
Delphian node
Retropharyngeal

Pharynx, NOS

Cervical, NOS
Internal jugular, NOS:
Deep cervical, NOS:
Lower, NOS:
Jugulo-omohyoid (supraomohyoid)
Middle
Upper, NOS:
Jugulodigastric (subdigastric)
Mandibular, NOS:
Submandibular (submaxillary)
Submental
Parapharyngeal
Paratracheal
Recurrent pharyngeal nerve chain
Prelaryngeal
Delphian node
Retropharyngeal

Regional Lymph Nodes – Pharynx, *continued*

Tonsil, Oropharynx

- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Retropharyngeal

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Esophagus

C15.0 – C15.09

Except for M-9727, 9732, 9741 – 9742, 9762 – 9809, 9832, 9840 – 9931, 9945 – 9946, 9950 – 9967, 9975 – 9992

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

Specimen sent to pathology from surgical events 20–27.

30 Partial esophagectomy

40 Total esophagectomy, NOS

50 Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
- 51 WITH laryngectomy
- 52 WITH gastrectomy, NOS
- 53 Partial gastrectomy
- 54 Total gastrectomy
- 55 Combination of 51 WITH any of 52–54

80 Esophagectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes - Esophagus

Cervical Esophagus

- Cervical, NOS:
  - Anterior deep cervical (laterotracheal) (recurrent laryngeal)
  - Internal jugular, NOS:
    - Deep cervical, NOS:
      - Upper, NOS:
        - Jugulodigastric (subdigastric)
      - Lower, NOS
- Peri-/paraesophageal (upper and lower)
- Scalene (inferior deep cervical)
- Supraclavicular (transverse cervical)
- Peri-/paraesophageal

Intrathoracic, lower (abdominal) Esophagus

- Left gastric (superior gastric):
  - Cardiac (cardial)
  - Lesser curvature
  - Perigastric, NOS
- Peri-/paraesophageal
- Posterior mediastinal (tracheoesophageal)
- Subcarinal

Intrathoracic, upper thoracic or middle, Esophagus:

- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
      - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Intrabronchial:
  - Carinal (tracheobronchial) (tracheal bifurcation)
  - Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)
  - Peritracheal
- Left gastric (superior gastric):
  - Cardiac (cardial)
  - Lesser curvature
  - Perigastric, NOS
- Mediastinal Posterior (tracheoesophageal) and superior
- Peri-/paraesophageal (upper and lower)
- Subcarinal

Stomach

C16.0 – C16.9

Except for M-9727, 9733, 9741 – 9742, 9764 – 9809, 9832, 9840 – 9931, 9945 – 9946, 9950 – 9967, 9975 – 9992

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

Specimen sent to pathology from surgical events 20–27.

30 Gastrectomy, NOS (partial, subtotal, hemi-)
- 31 Antrectomy, lower (distal-less than 40% of stomach)***
- 32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
- 33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:

Partial gastrectomy, including a sleeve resection of the stomach
Billroth I: anastomosis to duodenum (duodenostomy)
Billroth II: anastomosis to jejunum (jejunostomy)

40 Near-total or total gastrectomy, NOS
- 41 Near-total gastrectomy
- 42 Total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach.

50 Gastrectomy, NOS WITH removal of a portion of esophagus
- 51 Partial or subtotal gastrectomy
- 52 Near total or total gastrectomy

Codes 50–52 are used for gastrectomy resection when only portions of esophagus are included in procedure.

60 Gastrectomy with a resection in continuity with the resection of other organs, NOS***
- 61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***
- 62 Near total or total gastrectomy, in continuity with the resection of other organs***
- 63 Radical gastrectomy, in continuity with the resection of other organs***

Codes 60–63 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection.

Surgery Codes – Stomach, *continued*

80 Gastrectomy, NOS

Specimen sent to pathology from surgical events 20–80

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included

Regional Lymph Nodes - Stomach

Gastroesophageal Junction

- Celiac
- Diaphragmatic
- Left gastric
- Lower esophageal
- Pericardial

Stomach

- Celiac
- Hepatic
- Left gastric (superior gastric), NOS:
  - Cardial
  - Cardioesophageal
  - Gastric, left
  - Gastropancreatic, left
  - Lesser curvature
  - Lesser omentum
  - Paracardial
- Pancreaticosplenic (pancreaticolienal)
- Perigastric, NOS
- Peripancreatic
- Right gastric (inferior gastric), NOS:
  - Gastrocolic
  - Gastroduodenal
  - Gastroepiploic (gastro-omental), right or NOS
  - Gastrohepatic
  - Greater curvature
  - Greater omental
  - Infrapyloric
  - Pancreaticoduodenal
  - Pyloric, NOS:
    - Infrapyloric (subpyloric)
    - Suprapyloric
- Splenic (lienal), NOS:
  - Gastroepiploic (gastro-omental), left
  - Splenic Hilar

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Colon

C18.0 – C18.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site.*

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy, NOS
- 28 Polypectomy-endoscopic
- 29 Polypectomy-surgical excision

Any combination of 20 or 26–29 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

Specimen sent to pathology from surgical events 20–29.

30 Partial colectomy, segmental resection
- 32 Plus resection of contiguous organ; example: small bowel, bladder

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)
- 41 Plus resection of contiguous organ; example: small bowel, bladder

50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)
- 51 Plus resection of contiguous organ; example: small bowel, bladder

60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
- 61 Plus resection of contiguous organ; example: small bowel, bladder

70 Colectomy or coloproctotectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)

Code 70 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

80 Colectomy, NOS

Specimen sent to pathology from surgical events 20–80.

Surgery Codes – Colon, *continued*

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes - Colon

All colon subsites:
Colic, NOS
Epicolic (adjacent to bowel wall) Mesenteric, NOS Paracolic/pericolic
Nodule(s) in pericolic fat

Ascending colon:
Ileocolic
Middle colic
Right colic

Cecum and Appendix:
Cecal, NOS
Anterior (prececal)
Posterior (retrocecal)
Ileocolic
Right colic

Descending colon:
Inferior mesenteric
Left colic
Sigmoid

Sigmoid:
Inferior mesenteric
Sigmoidal (sigmoid mesenteric)
Superior hemorrhoidal
Superior rectal

Transverse colon and flexures:
Inferior mesenteric **for splenic flexure only**
Left colic **for splenic flexure only**
Middle colic
Right colic **for hepatic flexure only**

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Rectosigmoid Colon

C19.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site*.

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Combination of 20 or 26–27

WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

Specimen sent to pathology from surgical events 20–27.

30 Wedge or segmental resection; partial proctosigmoidectomy, NOS
- 31 Plus resection of contiguous organs; example: small bowel, bladder

Procedures coded 30 include, but are not limited to:

Anterior resection
Hartmann operation
Low anterior resection (LAR)
Partial colectomy, NOS
Rectosigmoidectomy, NOS
Sigmoidectomy

40 Pull through WITH sphincter preservation (colo-anal anastomosis)

50 Total proctectomy

51 Total colectomy

55 Total colectomy WITH ileostomy, NOS
- 56 Ileorectal reconstruction
- 57 Total colectomy WITH other pouch; example: Koch pouch

Surgery Codes – Rectosigmoid, *continued*

60 Total proctocolectomy, NOS
65 Total proctocolectomy WITH ileostomy, NOS
66 Total proctocolectomy WITH ileostomy and pouch
Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.

70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration

80 Colectomy, NOS; Proctectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Rectosigmoid

Colic, NOS
    Left colic
Hemorrhoidal, superior or middle
Inferior mesenteric
Mesenteric, NOS
Paracolic/pericolic
Paravertebral Perirectal
Rectal
Sigmoidal (sigmoid mesenteric)
Superior rectal

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Rectum

C20.9
(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site.*

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 28 Curette and fulguration

Specimen sent to pathology from surgical events 20–28.

30 Wedge or segmental resection; partial proctectomy, NOS

Procedures coded 30 include, but are not limited to: Anterior resection
Hartmann's operation
Low anterior resection (LAR)
Transsacral Rectosigmoidectomy

40 Pull through WITH sphincter preservation (coloanal anastomosis)

50 Total proctectomy

Procedure coded 50 includes, but is not limited to:
Abdominoperineal resection (Miles Procedure) (APR)

60 Total proctocolectomy, NOS

70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration

80 Proctectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Rectum

Hemorrhoidal, superior, middle or inferior
Inferior mesenteric
Internal iliac (hypogastric), NOS:
    Obturator
Mesenteric, NOS
Perirectal
Rectal Sacral, NOS:
    Lateral (laterosacral)
    Middle sacral (promontorial) (Gerota's node)
    Presacral
Sigmoidal (sigmoid mesenteric)

Anus

C21.0 – C21.8

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal Ablation

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

Specimen sent to pathology from surgical events 20–27.

60 Abdominal perineal resection, NOS (APR; Miles procedure)
- 61 APR and sentinel node excision
- 62 APR and unilateral inguinal lymph node dissection
- 63 APR and bilateral inguinal lymph node dissection

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery*.

Specimen sent to pathology from surgical events 20–63.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Anus

Anorectal
    Inferior hemorrhoidal
Internal iliac (hypogastric), NOS: **for anus and anal canal:**
    Obturator **for anus and anal canal**
Lateral sacral (laterosacral)
Paravertebral
Perirectal
Superficial inguinal (femoral) **for anus and anal canal**

Liver and Intrahepatic Bile Ducts

C22.0 – C22.1

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Alcohol (Percutaneous Ethanol Injection-PEI)
- 16 Heat-Radio-frequency ablation (RFA)
- 17 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events 10–17.

20 Wedge or segmental resection, NOS
- 21 Wedge resection
- 22 Segmental resection, NOS
  - 23 One
  - 24 Two
  - 25 Three
  - 26 Segmental resection AND local tumor destruction

Specimen sent to pathology from surgical events 20–26.

30 Lobectomy, NOS
- 36 Right lobectomy
- 37 Left lobectomy
- 38 Lobectomy AND local tumor destruction

50 Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe)
- 51 Right lobectomy
- 52 Left lobectomy
- 59 Extended lobectomy AND local tumor destruction

60 Hepatectomy, NOS
- 61 Total hepatectomy and transplant

65 Excision of a bile duct (for an intra-hepatic bile duct primary only)
- 66 Excision of a bile duct PLUS partial hepatectomy

75 Bile duct and hepatectomy WITH transplant

Specimen sent to pathology from surgical events 20–75.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Liver and Intrahepatic Bile Ducts

Caval Hepatic, NOS:
- Hepatic artery
- Hepatic pedicle
- Inferior vena cava
- Porta hepatis (portal) (hilar) [in hilus of liver]

Hepatoduodenal ligament
Periportal

Pancreas

C25.0 – C25.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

25 Local excision of tumor, NOS

30 Partial pancreatectomy, NOS; example: distal

35 Local or partial pancreatectomy and duodenectomy
- 36 WITHOUT distal/partial gastrectomy
- 37 WITH partial gastrectomy (Whipple)

40 Total pancreatectomy

60 Total pancreatectomy and subtotal gastrectomy or duodenectomy

70 Extended pancreatoduodenectomy

80 Pancreatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Pancreas

- Celiac
- Hepatic
- Infrapyloric (subpyloric)
- Lateral aortic (lumbar)
- Pancreaticosplenic (pancreaticolienal)
- Peripancreatic, NOS:
  - Anterior, NOS:
    - Anterior pancreaticoduodenal
    - Anterior proximal mesenteric
    - Pyloric
  - Inferior to the head and body of pancreas
  - Posterior, NOS:
    - Pericholedochal (common bile duct)
    - Posterior pancreaticoduodenal
    - Posterior proximal mesentery
  - Superior to the head and body of pancreas
- Pyloric
- Retroperitoneal
- Splenic (lienal):
  - Gastroepiploic (gastro-omental), left
  - Splenic hilum
  - Suprapancreatic
- Superior mesenteric

Larynx

C32.0 – C32.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

28 Stripping

Specimen sent to pathology from surgical events 20–28.

30 Partial excision of primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy, NOS
- 31 Vertical laryngectomy
- 32 Anterior commissure laryngectomy
- 33 Supraglottic laryngectomy

40 Total or radical laryngectomy, NOS
- 41 Total laryngectomy ONLY
- 42 Radical laryngectomy ONLY

50 Pharyngolaryngectomy

80 Laryngectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Larynx

Anterior deep cervical (laterotracheal) (recurrent laryngeal):
- Paralaryngeal
- Paratracheal
- Prelaryngeal:
  - Delphian node
- Pretracheal

Cervical, NOS
Internal jugular, NOS:
- Deep cervical, NOS:
  - Lower, NOS:
    - Jugulo-omohyoid (supraomohyoid)
  - Middle
  - Upper, NOS:
    - Jugulodigastric (subdigastric)

Mandibular, NOS:
- Submandibular (submaxillary)
- Submental

Retropharyngeal

Lung

C34.0 – C34.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction, NOS
- 12 Laser ablation or cryosurgery
- 13 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

No specimen sent to pathology from surgical events 12–13 and 15.

20 Excision or resection of less than one lobe, NOS
- 23 Excision, NOS
- 24 Laser excision
- 25 Bronchial sleeve resection ONLY
- 21 Wedge resection
- 22 Segmental resection, including lingulectomy

Specimen sent to pathology from surgical events 20–25.

30 Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)
- 33 Lobectomy WITH mediastinal lymph node dissection

The lymph node dissection should be coded under *Scope of Regional Lymph Node Surgery.*

45 Lobe or bilobectomy extended, NOS
- 46 WITH chest wall
- 47 WITH pericardium
- 48 WITH diaphragm

55 Pneumonectomy, NOS
- 56 WITH mediastinal lymph node dissection (radical pneumonectomy)

The mediastinal lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery.*

65 Extended pneumonectomy
- 66 Extended pneumonectomy plus pleura or diaphragm

70 Extended radical pneumonectomy

The mediastinal lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery.*

80 Resection of lung, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Lung

Aortic [above diaphragm], NOS:
Peri-/para-aortic, NOS:
Ascending aorta (phrenic)
Subaortic (aortico-pulmonary window)
Bronchial
Carinal (tracheobronchial) (tracheal bifurcation)
Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)
Intrapulmonary, NOS:
Interlobar
Lobar
Segmental
Subsegmental
Intrathoracic
Mediastinal, NOS:
Anterior
Posterior (tracheoesophageal)
Pericardial
Peri-/parabronchial
Peri-
/paraesophageal
Peri-/paratracheal, NOS:
Azygos (lower peritracheal)
Pre- and retrotracheal, NOS:
Precarinal
Pulmonary ligament
Scalene
Subcarinal
Supraclavicular

Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease

C42.0, C42.1, C42.3, C42.4 with any histology or M 9727; 9733; 9741 – 9742; 9764 – 9809; 9832; 9840 – 9931; 9945 – 9946; 9950 – 9967; 9975 – 9992 with any site

Surgery Codes

98 All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment.

Surgical procedures for hematopoietic/reticuloendothelial/immunoproliferative/ myeloproliferative primaries are to be recorded using the data item *Surgical Procedure/Other Site.*

Regional Lymph Nodes – Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease

Not applicable. Code 9 for Scope Regional Lymph Node Surgery.

Bones, Joints and Articular Cartilage

C40.0 – C41.9

Peripheral Nerves and Autonomic Nervous System

C47.0 – C47.9

Connective, Subcutaneous and Other Soft Tissues

C49.0 – C49.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction
No specimen sent to pathology from surgical event 15.

25 Local excision

26 Partial resection
Specimen sent to pathology from surgical events 25–26.

30 Radical excision or resection of lesion WITH limb salvage

40 Amputation of limb
- 41 Partial amputation of limb
- 42 Total amputation of limb

50 Major amputation, NOS
- 51 Forequarter, including scapula
- 52 Hindquarter, including ileum/hip bone
- 53 Hemipelvectomy, NOS
- 54 Internal hemipelvectomy

Specimen sent to pathology from surgical events 25 – 54.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Lymph Nodes – Bones, Joints & Articular Cartilage; Peripheral Nerves & Autonomic Nervous System; Connective, Subcutaneous & Other Soft Tissue

Regional lymph node metastasis from bone tumors is extremely rare.

Abdomen:
- Celiac
- Iliac
- Para-aortic

Arm/shoulder:
- Axillary
- Epitrochlear **for hand/forearm**
- Spinal accessory (posterior cervical) **for shoulder**

Head and neck:
- All head and neck subsites: Cervical, NOS
- Eyelid/canthus:
  - Facial, NOS:
    - Buccinator (buccal)
    - Nasolabial
  - Mandibular, NOS:
    - Submandibular (submaxillary)
    - Submental
  - Parotid, NOS: Infra-auricular
- External ear/auditory canal:
  - Mastoid (post-/retro-auricular) Preauricular
- Face, Other (cheek, chin, forehead, jaw, nose and temple):
  - Facial, NOS:
    - Buccinator (buccal)
    - Nasolabial
  - Mandibular, NOS:
    - Submandibular (submaxillary)
    - Submental
  - Parotid, NOS:
    - Infra-auricular
    - Preauricular

Lymph Nodes – Bones, Joints & Articular Cartilage; Peripheral Nerves & Autonomic Nervous System; Connective, Subcutaneous & Other Soft Tissue, *continued*

Head and neck (continued):
- Lip:
  - Facial, NOS:
    - Buccinator (buccal)
    - Nasolabial
  - Mandibular, NOS:
    - Submandibular (submaxillary)
    - Submental
  - Parotid, NOS:
  - Infra-auricular
  - Preauricular
- Neck:
  - Axillary
  - Mandibular, NOS:
    - Submental
  - Mastoid (post-/retro-auricular)
  - Parotid, NOS:
    - Infra-auricular
    - Preauricular
  - Spinal accessory (posterior cervical)
    - Supraclavicular (transverse cervical)
- Scalp:
  - Mastoid (post-/retro-auricular)
  - Parotid, NOS:
    - Infra-auricular
    - Preauricular
  - Spinal accessory (posterior cervical)

Leg/hip:
- Popliteal **for heel and calf**
- Superficial inguinal (femoral)

Pelvis:
- Deep inguinal, NOS:
  - Node of Cloquet or Rosenmuller (highest deep inguinal)
- Superficial inguinal (femoral)

Thorax:
- Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)
- Mediastinal

Trunk, lower:
- Superficial inguinal (femoral)

Trunk, upper:
- Axillary
- Cervical
- Internal mammary
- Supraclavicular (transverse cervical)

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Spleen

C42.2

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

21 Partial splenectomy

22 Total splenectomy

80 Splenectomy, NOS

Specimen sent to pathology from surgical events 21–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Lymph Nodes – Spleen

Not applicable.

Code 9 for Scope Regional Lymph Node Surgery.

Skin

C44.0 – C44.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

Specimen sent to pathology from surgical events 20–27.

30 Biopsy of primary tumor followed by a gross excision of the lesion (does not have to be done under the same anesthesia)
- 31 Shave biopsy followed by a gross excision of the lesion
- 32 Punch biopsy followed by a gross excision of the lesion
- 33 Incisional biopsy followed by a gross excision of the lesion
- 34 Mohs surgery, NOS
- 35 Mohs with 1-cm margin or less
- 36 Mohs with more than 1-cm margin

45 Wide excision or re-excision of lesion or minor (local) amputation with margins more than 1 cm, NOS. Margins MUST be microscopically negative.
- 46 WITH margins more than 1 cm and less than or equal to 2 cm
- 47 WITH margins greater than 2 cm

If the excision does not have microscopically negative margins greater than 1 cm, use the appropriate code, 20-36.

60 Major amputation

Specimen sent to pathology from surgical events 20–60.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Lymph Nodes - Skin

Arm/shoulder:
- Axillary
- Epitrochlear **for hand/forearm**
- Spinal accessory (posterior cervical) **for shoulder**

Head and neck:
- All head and neck subsites:
  - Cervical, NOS
- External ear/auditory canal:
  - Mastoid (post-/retro-auricular)
  - Preauricular
- Face, Other (cheek, chin, forehead, jaw, nose and temple):
  - Facial, NOS:
    - Buccinator (buccal)
    - Nasolabial
  - Mandibular, NOS:
    - Submandibular (submaxillary)
    - Submental
  - Parotid, NOS:
    - Infra-auricular
    - Preauricular
- Lip:
  - Facial, NOS:
    - Buccinator (buccal)
    - Nasolabial
  - Mandibular, NOS:
    - Submandibular (submaxillary)
    - Submental
  - Parotid, NOS:
    - Infra-auricular
    - Preauricular
- Neck:
  - Axillary Mandibular, NOS:
    - Submental
  - Mastoid (post-/retro-auricular)
  - Parotid, NOS:
    - Infra-auricular
    - Preauricular
- Spinal accessory (posterior cervical)
  - Supraclavicular (transverse cervical)

Lymph Nodes, Skin, *continued*

Head and neck (continued):
- Scalp:
  - Mastoid (post-/retro-auricular)
  - Parotid, NOS:
    - Infra-auricular
    - Preauricular
  - Spinal accessory (posterior cervical)

Leg/hip:
- Popliteal **for heel and calf**
- Superficial inguinal (femoral)

Lower trunk:
- Superficial inguinal (femoral)

Upper trunk:
- Axillary
- Cervical
- Internal mammary
- Supraclavicular (transverse cervical)

Breast

C50.0 – C50.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS

No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

20 Partial mastectomy, NOS; less than total mastectomy, NOS
- 21 Partial mastectomy WITH nipple resection
- 22 Lumpectomy or excisional biopsy
- 23 Re-excision of the biopsy site for gross or microscopic residual disease
- 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast- conserving or preserving). There may be microscopic residual tumor.

30 Subcutaneous mastectomy

A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.

40 Total (simple) mastectomy
- 41 WITHOUT removal of uninvolved contralateral breast
- 43 Reconstruction NOS
  - 44 Tissue
  - 45 Implant
  - 46 Combined (Tissue and Implant)
- 42 WITH removal of uninvolved contralateral breast

47 Reconstruction NOS
- 48 Tissue
- 49 Implant
- 75 Combined (Tissue and Implant)

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site (NAACCR Item #1294).*

If the contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

Reconstruction that is planned as part of first course treatment is coded 43 – 49 or 75, whether it is done at the time of mastectomy or later.

Surgery Codes – Breast, *continued*

50 Modified radical mastectomy
- 51 WITHOUT removal of uninvolved contralateral breast
  - 53 Reconstruction, NOS
    - 54 Tissue
    - 55 Implant
    - 56 Combined (Tissue and Implant)
- 52 WITH removal of uninvolved contralateral breast
  - 57 Reconstruction, NOS
    - 58 Tissue
    - 59 Implant
    - 63 Combined (Tissue and Implant)

Removal of all breast tissue, nipple, areolar complex, and variable amounts of breast skin in continuity with the axilla. Specimen may or may not include portion of pectoralis major muscle.

If contralateral breast reveals a second primary, it is abstracted separately. *The surgical procedure is coded 51 for the first primary*. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site (NAACCR Item #1294).*

60 Radical mastectomy, NOS
- 61 WITHOUT removal of uninvolved contralateral breast
  - 64 Reconstruction, NOS
    - 65 Tissue
    - 66 Implant
    - 67 Combined (Tissue and Implant)
- 62 WITH removal of uninvolved contralateral breast
  - 68 Reconstruction, NOS
    - 69 Tissue
    - 73 Implant
    - 74 Combined (Tissue and Implant)

70 Extended radical mastectomy
- 71 WITHOUT removal of uninvolved contralateral breast
- 72 WITH removal of uninvolved contralateral breast

80 Mastectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Lymph Nodes – Breast

Axillary, NOS:
- Level I (low) (superficial), NOS [adjacent to tail of breast]:
  - Anterior (pectoral)
  - Lateral (brachial)
  - Posterior (subscapular)
- Level II (mid-level) (central), NOS:
  - Interpectoral (Rotter's)
- Level III (high) (deep), NOS:
  - Apical (subclavian)
  - Axillary vein

Infraclavicular (ipsilateral) (subclavicular)
Internal mammary (parasternal)
Intramammary
Subclavicular
Supraclavicular – lymph nodes in the supraclavicular fossa, a triangle defined by the omohyoid muscle and tendon (lateral and superior border), the internal jugular vein (medial border), and the clavicle and subclavian vein (lower border). Adjacent lymph nodes outside this triangle are considered to lower cervical and therefore are distant nodes.
Transpectoral

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Cervix Uteri

C53.0 – C53.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Laser ablation
- 17 Thermal ablation

No specimen sent to pathology from surgical events 10–17.

20 Local tumor excision, NOS
- 26 Excisional biopsy, NOS
- 27 Cone biopsy
- 24 Cone biopsy WITH gross excision of lesion
- 29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27 or 29 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

25 Dilatation and curettage; endocervical curettage (for in situ only)

28 Loop electrocautery excision procedure (LEEP)

Specimen sent to pathology from surgical events 20–29.

30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries

Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary

Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 51 Modified radical hysterectomy
- 52 Extended hysterectomy
- 53 Radical hysterectomy; Wertheim procedure
- 54 Extended radical hysterectomy

60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
- 61 WITHOUT removal of tubes and ovaries
- 62 WITH removal of tubes and ovaries

70 Pelvic exenteration
- 71 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

Surgery Codes – Cervix, *continued*

72 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

73 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20–74.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Lymph Nodes – Cervix

- Iliac, NOS:
  - Common
  - External
  - Internal (hypogastric), NOS:
    - Obturator
- Paracervical
- Parametrial
- Pelvic, NOS
- Sacral, NOS:
  - Lateral (laterosacral)
  - Middle (promontorial) (Gerota's node)
  - Presacral
- Uterosacral

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Corpus Uteri

C54.0 – C55.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Thermal ablation

No specimen sent to pathology from surgical events 10–16.

20 Local tumor excision, NOS; simple excision, NOS
- 24 Excisional biopsy
- 25 Polypectomy
- 26 Myomectomy

Any combination of 20 or 24–26 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

Specimen sent to pathology from surgical events 20–26.

30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies).
- 31 WITHOUT tube(s) and ovary(ies)
- 32 WITH tube(s) and ovary(ies)

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 61 Modified radical hysterectomy
- 62 Extended hysterectomy
- 63 Radical hysterectomy; Wertheim procedure
- 64 Extended radical hysterectomy

65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)
- 66 WITHOUT removal of tube(s) and ovary(ies)
- 67 WITH removal of tube(s) and ovary(ies)

Surgery Codes – Cervix, *continued*

Pelvic exenteration

76 Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

77 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

78 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

79 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20–79.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Corpus Uteri

- Aortic, NOS:
  - Lateral (lumbar) Para-aortic
  - Periaortic
- Iliac:
  - Common
  - External
  - Internal (hypogastric), NOS:
    - Obturator
- Paracervical
- Parametrial
- Pelvic, NOS
- Sacral, NOS:
  - Lateral (laterosacral)
  - Middle (promontorial) (Gerota's node)
  - Presacral
- Uterosacral

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Ovary

C56.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

17 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 17.

25 Total removal of tumor or (single) ovary, NOS
- 26 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
- 27 WITHOUT hysterectomy
- 28 WITH hysterectomy

35 Unilateral (salpingo-) oophorectomy; unknown if hysterectomy done
- 36 WITHOUT hysterectomy
- 37 WITH hysterectomy

50 Bilateral (salpingo-)oophorectomy; unknown if hysterectomy done
- 51 WITHOUT hysterectomy
- 52 WITH hysterectomy

55 Unilateral or bilateral (salpingo-)oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done
- 56 WITHOUT hysterectomy
- 57 WITH hysterectomy

60 Debulking; cytoreductive surgery, NOS
- 61 WITH colon (including appendix) and/or small intestine resection (not incidental)
- 62 WITH partial resection of urinary tract (not incidental)
- 63 Combination of 61 and 62

Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.

70 Pelvic exenteration, NOS
- 71 Anterior exenteration
  Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.
- 72 Posterior exenteration
  Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.
- 73 Total exenteration
  Includes removal of all pelvic contents and pelvic lymph nodes.
- 74 Extended exenteration
  Includes pelvic blood vessels or bony pelvis

80 (Salpingo-)oophorectomy, NOS

Specimen sent to pathology from surgical events 25–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Ovary

Aortic, NOS:
    Lateral
    (lumbar) Para-
    aortic
    Periaortic
Iliac, NOS:
    Common
    External
    Internal (hypogastric), NOS:
        Obturator
Inguinal
Lateral sacral
(laterosacral) Pelvic,
NOS Retroperitoneal,
NOS Sacral

Prostate

C61.9
(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item *Hematologic Transplant and Endocrine Procedures (NAACCR Item #3250).*

00 None; no surgery of primary site; autopsy ONLY

18 Local tumor destruction or excision, NOS

19 Transurethral resection (TURP), NOS
Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19 (principally for cases diagnosed prior to January 1, 2003.)

10 Local tumor destruction, NOS
- 14 Cryoprostatectomy
- 15 Laser ablation
- 16 Hyperthermia
- 17 Other method of local tumor destruction

No specimen sent to pathology from surgical events 10–17.

20 Local tumor excision, NOS
- 21 Transurethral resection (TURP), NOS, with specimen sent to pathology
- 22 TURP—cancer is incidental finding during surgery for benign disease
- 23 TURP—patient has suspected/known cancer

Any combination of 20–23 WITH
- 24 Cryosurgery
- 25 Laser
- 26 Hyperthermia

30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

50 Radical prostatectomy, NOS; total prostatectomy, NOS
Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.

80 Prostatectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Prostate

Iliac, NOS:
    External
    Internal (hypogastric), NOS:
        Obturator
Pelvic, NOS
Periprostatic
    Sacral, NOS:
        Lateral (laterosacral)
Middle (promontorial) (Gerota's node)
Presacral

Testis

C62.0 – C62.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

12 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 12.

20 Local or partial excision of testicle

30 Excision of testicle WITHOUT cord

40 Excision of testicle WITH cord/or cord not mentioned (radical orchiectomy)

80 Orchiectomy, NOS (unspecified whether partial or total testicle removed)

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Testis

- Aortic, NOS
  - Lateral
  - (lumbar)
  - Para-aortic
  - Periaortic
  - Preaortic
  - Retroaortic
- Pericaval, NOS
  - Interaortocaval
  - Paracaval
  - Precaval
- Retrocaval
- Pelvic, NOS
- Retroperitoneal, NOS
- Spermatic vein

Kidney, Renal Pelvis and Ureter

Kidney C64.9; Renal Pelvis C65.9; Ureter C66.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal ablation

No specimen sent to pathology from this surgical event 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)
Procedures coded 30 include, but are not limited to:
Segmental resection;
Wedge resection

40 Complete/total/simple nephrectomy—for kidney parenchyma
Nephroureterectomy
Includes bladder cuff for renal pelvis or ureter.

50 Radical nephrectomy
May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter.

70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) in continuity with the resection of other organ(s) (colon, bladder)
The other organs, such as colon or bladder, may be partially or totally removed.

80 Nephrectomy, NOS; Ureterectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Kidney, Renal Pelvis, Ureter

Kidney

- Aortic, NOS:
  - Lateral (lumbar)
  - Para-aortic
  - Periaortic
- Paracaval
- Renal hilar
- Retroperitoneal, NOS

Renal Pelvis

- Aortic, NOS:
  - Lateral (lumbar)
  - Para-aortic
  - Periaortic
- Paracaval
- Renal hilar
- Retroperitoneal, NOS

Ureter

- Iliac, NOS:
- Common
- External
- Internal (hypogastric), NOS:
  - Obturator
- Lateral aortic (lumbar)
- Paracaval
- Pelvic, NOS
- Periureteral
- Renal hilar
- Retroperitoneal, NOS

Bladder

C67.0 – C67.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Intravesical therapy
- 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy

Also code the introduction of immunotherapy in the immunotherapy items. If immunotherapy is followed by surgery of the type coded 20 – 80, code that surgery instead and code the immunotherapy only as immunotherapy.

No specimen sent to pathology from surgical events 10 – 16.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy
- 28 Combination of 20 or 26–27 WITH
  - 21 Photodynamic therapy (PDT)
  - 22 Electrocautery
  - 23 Cryosurgery
  - 24 Laser ablation
- 25 Laser excision

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Complete cystectomy with reconstruction
- 61 Radical cystectomy PLUS ileal conduit
- 62 Radical cystectomy PLUS continent reservoir or pouch, NOS
- 63 Radical cystectomy PLUS abdominal pouch (cutaneous)
- 64 Radical cystectomy PLUS in situ pouch (orthotopic)

When the procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64).

Surgery Codes – Bladder, *continued*

70 Pelvic exenteration, NOS

71 Radical cystectomy including anterior exenteration
For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra. For males, includes removal of the prostate. When a procedure is described as a pelvic exenteration for males, but the prostate is NOT removed, the surgery should be coded as a cystectomy (code 60 – 64).

72 Posterior exenteration
For females, also includes removal of vagina, rectum and anus. For males, also includes prostate, rectum and anus.

73 Total exenteration
Includes all tissue and organs removed for an anterior and posterior exenteration.

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

80 Cystectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Bladder

- Hypogastric
- Obturator
- Iliac, NOS:
  - Common
  - External
  - Internal
  - Pelvic, NOS
- Perivesical Pelvic, NOS
- Sacral, NOS
  - Lateral (laterosacral)
  - Middle (promontorial) (Gerota's node)
  - Presacral

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Brain, Meninges, Spinal Cord, Cranial Nerves & Other Parts of Central Nervous System

Meninges C70.0 – C70.9; Brain C71.0 – C71.9; Spinal Cord, Cranial Nerves, Other Parts of Central Nervous System C72.0 – C72.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

Do not code laminectomies for spinal cord primaries.

00 None; no surgery of primary site; autopsy ONLY

10 Tumor destruction, NOS

No specimen sent to pathology from surgical event 10.

Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as surgical tumor destruction. All these modalities are recorded in the radiation treatment fields.

20 Local excision (biopsy) of lesion or mass
- 21 Subtotal resection of tumor, lesion or mass in brain
- 22 Resection of tumor of spinal cord or nerve

30 Radical, total, gross resection of tumor, lesion or mass in brain

40 Partial resection of lobe of brain, when the surgery cannot be coded as 20 – 30

55 Gross total resection of lobe of brain (lobectomy)

Codes 30 – 55 are not applicable for spinal cord or spinal nerve primary sites.

Specimen sent to pathology from surgical events 20 – 55.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Meninges, Brain, Spinal Cord, Cranial Nerves of Other Parts of Central Nervous System

Not applicable.

Code 9 for Scope of Regional Lymph Node Surgery.

Thyroid

C73.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

13 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 13.

25 Removal of less than a lobe, NOS
- 26 Local surgical excision
- 27 Removal of a partial lobe ONLY

20 Lobectomy and/or isthmectomy
- 21 Lobectomy ONLY
- 22 Isthmectomy ONLY
- 23 Lobectomy WITH isthmus

30 Removal of a lobe and partial removal of the contralateral lobe

40 Subtotal or near total thyroidectomy

50 Total thyroidectomy

80 Thyroidectomy, NOS

Specimen sent to pathology from surgical events 25–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – Thyroid

Anterior deep cervical (laterotracheal) (recurrent laryngeal):
- Paralaryngeal
- Paratracheal
- Prelaryngeal:
  - Delphian node
- Pretracheal

Cervical, NOS
Internal jugular, NOS:
- Deep cervical, NOS:
  - Lower, NOS:
    - Jugulo-omohyoid (supraomohyoid)
  - Middle

Mediastinal, NOS
- Posterior mediastinal (tracheoesophageal)
- Upper anterior mediastinal

Retropharyngeal
Spinal accessory (posterior cervical)
Submandibular
Submental
Supraclavicular (transverse cervical)

Lymph Nodes

C77.0 – C77.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 15.

25 Local tumor excision, NOS
Less than a full chain, includes an excisional biopsy of a single lymph node.

30 Lymph node dissection, NOS
- 31 One chain
- 32 Two or more chains

40 Lymph node dissection, NOS PLUS splenectomy
- 41 One chain
- 42 Two or more chains

50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
- 51 One chain
- 52 Two or more chains

60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy. (Includes staging laparotomy for lymphoma.)
- 61 One chain
- 62 Two or more chains

Specimen sent to pathology for surgical events 25 – 62.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes - Lymph Nodes

Not applicable.

Code 9 for Scope of Regional Lymph Node Surgery.

All Other Sites

C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 28 Laser excision

Specimen sent to pathology from surgical events 20–27.

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation
- 41 Total enucleation (for eye surgery only)

50 Surgery stated to be “debulking”

60 Radical surgery

Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Regional Lymph Nodes – All Other Sites

Accessory Sinuses (maxillary sinus, ethmoid sinus, frontal sinus, sphenoid sinus)
- Cervical, NOS
- Internal jugular,
- NOS:
  - Deep cervical, NOS:
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Retropharyngeal

Adrenal gland
- Retroperitoneal

Ampulla of Vater
- Celiac Hepatic
- Infrapyloric (subpyloric)
- Lateral aortic (lumbar)
- Node of the foramen of Winslow (epiploic) (omental)
- Pancreaticoduodenal
- Peripancreatic
- Periportal
- Proximal mesenteric
- Pyloric
- Retroperitoneal
- Superior mesenteric

Lymph Nodes:
- Anterior to ampulla of Vater
- Inferior to ampulla of Vater
- Posterior to ampulla of Vater
- Superior to ampulla of Vater

Endocrine Glands, other and related structures (parathyroid gland, pituitary gland, craniopharyngeal duct, pineal gland, carotid body, aortic body, endocrine gland, NOS)
- Cervical **for carotid body and parathyroid only**
- Mediastinal **for aortic body and thymus only**

Not applicable, for the following sites:
- Craniopharyngeal duct (C75.2); Pituitary gland (C75.1); Pineal gland (C75.3)

Regional Lymph Nodes – Other Sites, *continued*

Epididymis, Spermatic cord, Scrotum, NOS, Other specified parts of male genital organs, overlapping lesion of male genital organs, Male genital organs, NOS

- Iliac, NOS:
  - External
  - Internal (hypogastric), NOS: Obturator
- Inguinal, NOS:
  - Deep, NOS
    - Node of Cloquet or Rosenmuller (highest deep inguinal)
  - Superficial inguinal (femoral)
- Pelvic, NOS

Extrahepatic bile duct

- Cystic duct (Calot's node)
- Node of the foramen of Winslow (epiploic) (omental)
- Pancreaticoduodenal
- Pericholedochal (common bile duct)
- Periduodenal
- Peripancreatic (near head of pancreas only)
- Periportal
- Porta hepatis (portal) (hilar) [in hilus of liver]

Eye and Adnexa

- Cervical
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Parotid, NOS:
    - Infra-auricular; Preauricular

Female Genital Organs (fallopian tube, broad ligament, round ligament, parametrium, uterine adnexa)

- Aortic, NOS
  - Lateral (lumbar); Para-aortic; Periaortic
- Iliac, NOS:
  - Common
  - External
  - Internal (hypogastric), NOS:
    - Obturator Inguinal
- Lateral sacral (laterosacral)
- Pelvic, NOS
- Presacral
- Retroperitoneal, NOS

Regional Lymph Nodes – Other Sites, *continued*

Gallbladder, Overlapping lesion of biliary tract and biliary tract, NOS
- Celiac
- Cystic duct (Calot's node)
- Node of the foramen of Winslow (epiploic) (omental)
- Pancreaticoduodenal
- Pericholedochal (common bile duct)
- Periduodenal
- Peripancreatic (near head of pancreas only)
- Periportal
- Porta hepatis (portal) (hilar) [in hilus of liver]
- Superior mesenteric

Heart and Mediastinum
- Aortic [above diaphragm], NOS:
  - Peri/para-aortic, NOS:
    - Ascending aorta (phrenic)
  - Subaortic (aortico-pulmonary window)
- Carinal (tracheobronchial) (tracheal bifurcation)
- Mediastinal, NOS:
  - Anterior;
  - Posterior (tracheoesophageal)
- Pericardial
- Peri/paraesophageal
- Peri/paratracheal, NOS:
  - Azygos (lower peritracheal)
- Pre- and retrotracheal, NOS: Precarinal
- Pulmonary ligament
- Subcarinal

Intestinal Tract, NOS, Overlapping lesion of digestive system, Gastrointestinal tract, NOS
- Intra-abdominal
- Paracaval Pelvic
- Subdiaphragmatic

Male Genital Organs (prepuce, glans penis, body of penis, penis, NOS)
- Iliac, NOS
  - External
  - Internal (hypogastric), NOS: Obturator
- Inguinal:
  - Deep, NOS: Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial (femoral)
- Pelvic, NOS

Regional Lymph Nodes – Other Sites, *continued*

Nasal Cavity and Middle Ear

Cervical, NOS Internal jugular, NOS:
Deep cervical, NOS:
Upper, NOS: Jugulodigastric (subdigastric)
Mandibular, NOS:
Submandibular (submaxillary)
Submental
Mastoid (post-/retro-auricular) **for middle ear**
Retropharyngeal

Placenta

Aortic, NOS: Lateral (lumbar)
Para-aortic
Peri-aortic
Iliac, NOS:
Common External
Internal (hypogastric), NOS:
Obturator
Parametrial
Pelvic, NOS
Sacral:
Lateral (laterosacral)
Middle (promontorial) (Gerota's node)
Presacral
Uterosacral

Pleura

Aortic [above diaphragm], NOS: Peri/para-aortic, NOS: Ascending aorta (phrenic)
Subaortic (aortico-pulmonary window)
Carinal (tracheobronchial) (tracheal bifurcation)
Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)
Internal Mammary
Intrapulmonary, NOS: Interlobar, Lobar, Segmental, Subsegmental
Intrathoracic
Mediastinal, NOS:
Anterior and Posterior (tracheoesophageal)
Pericardial
Peri/parabronchial Peri/paraesophageal
Peri/paratracheal, NOS:
Azygos (lower peritracheal)
Pre- and retrotracheal, NOS:
Precarinal
Pulmonary ligament
Scalene
Subcarinal
Supraclavicular

Regional Lymph Nodes – Other Sites, *continued*

Respiratory System and Intrathoracic Organs, Other and Ill-defined Sites

Aortic [above diaphragm], NOS:
Peri/para-aortic, NOS:
Ascending aorta (phrenic)
Subaortic (aortico-pulmonary window)
Carinal (tracheobronchial) (tracheal bifurcation)
Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)
Intrapulmonary, NOS:
Interlobar
Lobar
Segmental
Subsegmental
Mediastinal, NOS:
Anterior & Posterior (tracheoesophageal)
Pericardial
Peri/parabronchial
Peri/paraesophageal
Peri/paratracheal, NOS:
Azygos (lower peritracheal)
Pre-and retrotracheal, NOS:
Precarinal
Pulmonary ligament
Subcarinal

Retroperitoneum and Peritoneum

Intra-abdominal
Paracaval
Pelvic
Subdiaphragmatic

Small Intestine

Pericholedochal (common bile duct)
Superior mesenteric

Duodenum:

Duodenal
Gastroduodenal
Hepatic
Infrapyloric (subpyloric)
Pancreaticoduodenal
Pericholedochal
Pyloric
Superior mesenteric

Jejunum and Ileum:

Ileocolic **for terminal ileum only**
Mesenteric, NOS
Posterior cecal (retrocecal) **for terminal ileum only**
Superior mesenteric

Regional Lymph Nodes – Other Sites, *continued*

Thymus
- Mediastinal

Trachea
- Mediastinal, NOS
  - Posterior (tracheoesophageal)
- Paratracheal
- Pretracheal
- Tracheal, NOS

Urinary organs, other and unspecified (urethra, paraurethral gland)
- Iliac, NOS
  - Common
  - External
  - Internal (hypogastric), NOS: Obturator
- Inguinal:
  - Deep, NOS:
    - Node of Cloquet or Rosenmuller (highest deep inguinal)
  - Superficial (femoral)
- Pelvic, NOS
- Presacral
- Sacral, NOS

Vagina

All parts of vagina:
- Pelvic lymph nodes:
  - Iliac, NOS:
    - Common External
    - Internal (hypogastric), NOS:
      - Obturator Inguinal
  - Middle sacral (promontorial) (Gerota's node) Pelvic, NOS

Lower third of vagina:
- Ipsilateral or bilateral:
  - Inguinal, NOS: Superficial (femoral)

Upper two-thirds of vagina:
- Iliac, NOS:
  - External
  - Internal (hypogastric)
    - Obturator
- Pelvic, NOS

Vulva
- Inguinal, NOS:
  - Deep, NOS:
    - Node of Cloquet or Rosenmuller (highest deep inguinal)
- Superficial (femoral)

Regional Lymph Nodes – Other Sites, *continued*

Waldeyer ring and Overlapping lesion of lip, oral cavity and pharynx

- Cervical, NOS
- Internal jugular, NOS:
  - Deep cervical, NOS:
    - Lower, NOS:
      - Jugulo-omohyoid (supraomohyoid)
    - Middle
    - Upper, NOS:
      - Jugulodigastric (subdigastric)
- Mandibular, NOS:
  - Submandibular (submaxillary)
  - Submental
- Parapharyngeal
- Paratracheal
  - Recurrent pharyngeal nerve chain
- Prelaryngeal
  - Delphian node
- Retropharyngeal

Unknown and Ill-Defined Primary Sites

C76.0 – C76.8, C80.9

(Except for M-9727, 9732, 9741-9742, 9762–9809, 9832, 9840–9931, 9945–9946, 9950-9967, 9975–9992)

Surgery Codes

98 All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item *Surgical Procedure/Other Site (NAACCR Item #1294)*

Regional Lymph Nodes – Unknown and Ill-Defined Primary Sites

Other and ill-defined sites

Not applicable.

Code 9 for Scope Regional Lymph Node Surgery.

Unknown Primary Site

Not applicable.

Code 9 for Scope Regional Lymph Node Surgery

Appendix I:

Abbreviations and Symbols

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Abbreviations

The VCR requires all cases to include text information to support specific coded fields. Complete and descriptive text is vital to the quality control efforts of the VCR. Often it is necessary to use abbreviations to provide adequate descriptions within the limited size of the text fields. However, a reader may interpret many standard medical abbreviations differently. The VCR will rely on the attached abbreviation list to indicate how VCR staff will interpret the abbreviation when its use is unclear. It is a combination of the North American Association of Central Cancer Registries (NAACCR)'s *Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Sixteenth Edition; Layout Version 16.0 -- Appendix G: Recommended Abbreviations for Abstractors.*

The Abbreviations Listings consist of two main lists word/terms and their recommended abbreviations, as well as a special table delineating context-sensitive abbreviations and one for symbols. The first main listing is ordered by word/term to enable the look-up of a recommended abbreviation for a particular word or term, and the second main listing is ordered by abbreviation to enable the look-up of the word or term for a particular abbreviation. The context-sensitive abbreviations list consists of a subset of the abbreviations from the main lists where a different context for the same abbreviation conveys a different meaning (for example, CA may mean calcium or carcinoma/ML may mean milliliter or middle lobe). For these context-sensitive abbreviations, the meaning of the abbreviation should be readily apparent from the context in which it is used.

The listings are not exhaustive, but many of the most commonly used terms were included. Abbreviations for chemotherapy drugs and/or regimens are not included. For short names and acronyms of antineoplastic drugs, consult the SEER Program *Self Instructional Manual for Tumor Registrars: Book 8-Antineoplastic Drugs, Third Edition or SEER RX* at http://seer.cancer.gov/tools/seerrx/.

Please note that although abbreviations are presented in uppercase, either upper- or lowercase may be utilized when entering abbreviations within abstraction software. When abstracting into text fields, the use of abbreviations should be limited to those that appear on these lists whenever practical. Abbreviations and symbols should be used carefully.

The abbreviations list does not include an abbreviation for the word **cancer**. While the abbreviation "CA" is often used in the medical record to mean either the term **cancer** or **carcinoma**, it should be used in text reported to the VCR to indicate the histologic term of carcinoma. This distinction is very important when verifying histologic coding for cancer, NOS (8000/3) and carcinoma, NOS (8010/3).

This appendix contains two tables for abbreviations, one in term order and one in abbreviation order.

Ordered by Word/Term

WORD/TERM (S)	ABBREVIATION/SYMBOL
Abdomen (abdominal)	ABD
Abdominal hysterectomy	ABD HYST
Abdominal perineal (Abdominoperineal)	AP
Abdominoperineal resection	APR
Abnormal	ABN
Abnormal liver function test	ALFT
Above	^
Above knee (amputation)	AK(A)
Absent/Absence	ABS
Abstract/Abstracted	ABST
Achilles tendon reflex	ATR
Acid phosphatase	ACID PHOS
Acquired Immune Deficiency Syndrome	AIDS
Acral lentiginous melanoma	ALM
Activities of daily living	ADL
Acute erythroleukemia	AEL
Acute granulocytic leukemia	AGL
Acute leukemia	AL
Acute lymphocytic leukemia	ALL
Acute megakaryoblastic leukemia	AMEGL
Acute myeloblastic leukemia	AMBL
Acute myelogenous leukemia	AML
Acute myelomonocytic leukemia	AMML
Acute myocardial infarction	AMI
Acute promyelocytic leukemia	APL
Acute renal failure	ARF
Acute Respiratory Distress (Disease) Syndrome	ARDS
Acute tubular necrosis	ATN
Acute undifferentiated leukemia	AUL
Adenocarcinoma	ADENOCA, ACA
Adenosine triphosphate	ATP
Adjacent	ADJ
Admission/Admit	ADM
Adrenal cortex	AC
Adrenal cortical hormone	ACH
Adrenocorticotrophic hormone	ACTH
Adult T-cell leukemia	ATL
Adult T-cell leukemia/lymphoma	ATLL
Adult-onset Diabetes Mellitus	AODM
Affirmative	AFF
Against medical advice	AMA

WORD/TERM (S)	ABBREVIATION/SYMBOL
AIDS-related condition (complex)	ARC
AIDS-related disease	ARD
Air contrast barium enema	ACBE
Albumin	ALB
Alcohol	ETOH
Alkaline phosphatase	ALK PHOS
Alpha chain disease	ACD
Alpha-fetoprotein	AFP
Also known as	AKA
Alternate	ALT
Ambulatory	AMB
Amount	AMT
Amputation	AMP
Amyotrophic lateral sclerosis	ALS
Anal intraepithelial neoplasia, grade III	AIN III
Anaplastic	ANAP
And	&
Angioblastic immunoblastic lymphadenopathy	AIL
Angiography/Angiogram	ANGIO
Anterior	ANT
Anteroposterior	AP
Antidiuretic hormone	ADH
Antigen	AG
Aortic stenosis	A-STEN
Apparently	APPL'Y
Appendix	APP
Approximately	APPROX
Arrhythmia	ARRHY
Arterial blood gases	ABG
Arteriosclerosis/Arteriosclerotic	AS
Arteriosclerotic cardiovascular disease	ASCVD
Arteriosclerotic heart disease	ASHD
Arteriosclerotic Peripheral Vascular Disease	ASPVD
Arteriovenous	AV
Arteriovenous malformation	AVM
Artery (ial)	ART
As soon as possible	ASAP
Ascending	ASC
Ascending colon	A-COLON
Aspiration	ASP
Aspiration biopsy cytology	ABC
Aspirin, Acetylsalicylic acid	ASA
At	@

WORD/TERM (S)	ABBREVIATION/SYMBOL
Atrial fibrillation	A FIB
Atrial flutter	A FLUTTER
Atrial premature complexes	APC
Atrial stenosis/insufficiency/incompetence	AI
Auscultation & percussion	A&P
Autoimmune hemolytic anemia	AIHA
Autologous bone marrow	ABM
Autologous bone marrow transplantation	ABMT
Autonomic nervous system	ANS
Autopsy	AUT
Average	AVG
Axilla(ry)	AX
Bacillus Calmette-Guerin	BCG
Barium	BA
Barium enema	BE
Barium swallow	BAS
Bartholin's, Urethral & Skene's	BUS
Basal cell carcinoma	BCC
Before noon	AM
Below knee (amputation)	BK(A)
Benign prostatic hypertrophy/hyperplasia	BPH
Bilateral	BIL
Bilateral hilar lymphadenopathy	BHL
Bilateral lower lobes	BLL
Bilateral pelvic lymph node dissection	BPLND
Bilateral salpingo-oophorectomy	BSO
Bile duct	BD
Biological response modifier	BRM
Biopsy	BX
Bipolar affective disorder	BAD
Black female	B/F
Black male	B/M
Bladder outlet obstruction	BOO
Bladder tumor	BT
Blood pressure	BP
Blood urea nitrogen	BUN
Blood volume	BV
Bone Marrow	BM
Bone marrow aspirate	BMA
Bone marrow biopsy	BMBX
Bone Marrow Transplant	BMT
Bowel Movement	BM
Bowel sounds	BS
Breast self-examination	BSE

WORD/TERM (S)	ABBREVIATION/SYMBOL
Breath sounds	BRS
Bright red blood	BRB
Bright red blood per rectum	BRBPR
Bronchial lymph node	BLN
Bronchoalveolar washing	BAW
Bronchogenic carcinoma	BGCA
Burkitt lymphoma	BL
Calcium	CA
Capsule (s)	CAP(S)
Carcinoembryonic antigen	CEA
Carcinoma	CA
Carcinoma *in situ*	CIS
Carcinoma unknown primary	CUP
Cardioesophageal junction	CEJ
Cardiovascular disease	CVD
CAT/CT scan/Computerized axial tomography	CT
Ceased to breath	CTB
Centigram	CGM
Centigray	CGY
Centimeter	CM
Central nervous system	CNS
Cerebrospinal fluid	CSF
Cerebrovascular accident	CVA
Cervical intraepithelial neoplasia	CIN
Cervical intraepithelial neoplasia, grade III	CIN III
Cervical spine	C-SPINE
Cervical vertebrae	C1-C7
Cervix	CX
Change	CHG
Chemotherapy	CHEMO
Chest X-ray	CXR
Chief complaint	C/C
Cholecystectomy	CHOLE
Chronic	CHR
Chronic granulocytic leukemia	CGL
Chronic leukemia	CL
Chronic lymphocytic leukemia	CLL
Chronic lymphosarcoma leukemia	CLSL
Chronic myelodysplastic syndrome	CMS
Chronic myeloid (myelocytic) leukemia	CML
Chronic myelomonocytic leukemia	CMML
Chronic obstructive lung disease	COLD
Chronic obstructive pulmonary disease	COPD
Chronic renal failure	CRF

WORD/TERM (S)	ABBREVIATION/SYMBOL
Chronic ulcerative colitis	CUC
Cigarettes	CIG
Clear	CLR
Clinical tumor, nodes, metastases	CTNM
Cobalt 60	CO60
Collaborative stage	CS
Colon, Ascending	A-COLON
Colon, Descending	D-COLON
Colon, Sigmoid	SIG-COLON
Colon, Transverse	TRANS-COLON
Colony-stimulating factor	C-SF
Common bile duct	CBD
Complaint (-ning) of	C/O
Complete blood count	CBC
Complete continuous remission	CCR
Computerized axial tomography scan	CT, CAT
Congenital heart disease	CHD
Congestive heart failure	CHF
Consistent with	C/W
Continue/continuous	CONT
Contralateral	CONTRA
Coronary artery bypass graft	CABG
Coronary artery disease	CAD
Coronary care unit	CCU
Cubic centimeter	CC
Curie	CU
Cutaneous	CUT
Cutaneous T-cell lymphoma	CTCL
Cystic fibrosis	CF
Cystoscopy	CYSTO
Cytology	CYTO
Date of birth	DOB
Date of death	DOD
Dead on arrival	DOA
Debridement	DEB
Decrease(d)	DECR
Deep tendon reflex	DTR
Deep vein thrombosis	DVT
Deoxyribonucleic acid	DNA
Dermatofibrosarcoma protuberans	DFSP
Dermatology	DERM
Descending	DESC
Descending colon	D-COLON
Diabetes mellitus	DM

WORD/TERM (S)	ABBREVIATION/SYMBOL
Diagnosis	DX
Diagnostic laparoscopy	DL
Diameter	DIAM
Died of other causes	DOC
Died with disease	DWD
Diethylstilbestrol	DES
Differentiated/differential	DIFF
Digital rectal examination	DRE
Dilatation and curettage	D&C
Direct extension	DE
Discharge	DISCH
Discontinue(d)	DC
Disease	DZ
Disease free interval	DFI
Disseminated	DISSEM
Disseminated intravascular coagulopathy	DIC
Distant metastases	DM
Doctor	DR
Ductal carcinoma in situ	DCIS
Dyspnea on exertion	DOE
Ears, nose, and throat	ENT
Electrocardiogram	ECG/EKG
Electroencephalogram	EEG
Electromyogram	EMG
Emergency room	ER
Endoscopic retrograde cholangiopancreatography	ERCP
Enlarged	ENLGD
Equal(s)	=
esophagogastroduodenoscopy	EGD
Esophagus	ESO
Estrogen receptor assay	ERA
Evaluation	EVAL
Every	Q
Every day	QD
Examination	EXAM
Examination under anesthesia	EUA
Excision/excised	EXC(D)
Expired	EXP
Exploratory	EXPL
Exploratory laparotomy	EXPL LAP
Extend/extension	EXT
Extended care facility	ECF
External	EX
Extremity	EXTR

WORD/TERM (S)	ABBREVIATION/SYMBOL
Eyes, ears, nose and throat	EENT
Family history	FHX
Family medical history	FMH
Fever of unknown origin	FUO
Fine needle aspiration	FNA
Fine needle aspiration biopsy	FNAB
Fingerbreadth	FB
Flexible sigmoidoscopy	FLEX SIG
Floor of mouth	FOM
Fluid	FL
Fluoroscopy	FLURO
Follow-up	FU
For example	E.G
Fracture	FX
French-American-British	FAB
Frequent/Frequency	FREQ
Frozen section	FS
Full thickness skin graft	FTSG
Gallbladder	GB
Gastroesophageal	GE
Gastroesophageal reflux disease	GERD
Gastrointestinal	GI
General/Generalized	GEN
Genitourinary	GU
Grade	GR
Gram	GM
Greater/Greater than	>
Gynecology	GYN
Head, eyes, ears, nose, throat	HEENT
Hematocrit	HCT
Hematology	HEMO
Hemoglobin	HGB
Hepatitis A (virus)	HAV
Hepatitis B (virus)	HBV
Hepatitis C (virus)	HCV
Hepatitis D (virus)	HDV
Hepatocellular carcinoma	HCC
Hepatosplenomegaly	HSM
History	HX
History and physical	H&P
History of	H/O
History of present illness	HPI
Hodgkin disease	HD
Hormone	HORM

WORD/TERM (S)	ABBREVIATION/SYMBOL
Hospital	HOSP/HSP
Hour/Hours	HR(S)
Human chorionic gonadotropin	HCG
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymphotrophic Virus, (Type III)	HTLV
Hypertension	HTN
Hypertensive cardiovascular disease	HCVD
Hypertensive vascular disease	HVD
Hysterectomy	HYST
Idiopathic hypertrophic subaortic stenosis	IHSS
Idiopathic thrombocytopenia	ITP
Immunoglobulin	IG
Immunohistochemical	IHC
Impression	IMP
Inch	IN
Incision & drainage	I&D
Includes/Including	INCL
Increase(d)	INCR
Inferior	INF
Inferior vena cava	IVC
Infiltrating	INFILT
Inflammatory bowel disease	IBD
Inpatient	IP
Insulin-dependent diabetes mellitus	IDDM
Intensive care unit	ICU
Intercostal margin	ICM
Intercostal space	ICS
Intermittent positive pressure breathing	IPPB
Internal	INT
Internal mammary artery	IMA
Interstitial lung disease	ILD
Intra-abdominal	IAB
Intramuscular	IM
Intrathecal	IT
Intravenous	IV
Intravenous cholangiogram	IVCA
Intravenous pyelogram	IVP
Invade(s)/invading/invasion	INV
Involve(s)/involvement/involving	INVL
Iodine	I
Ipsilateral	IPSI
Irregular	IRREG
Joule	J

WORD/TERM (S)	ABBREVIATION/SYMBOL
Jugular venous distention	JVD
Junction	JCT, JX
Juvenile rheumatic arthritis	JRA
Kaposi sarcoma	KS
Kidneys, ureters, bladder	KUB
Kilogram	KG
Kilovolt	KV
Laboratory	LAB
Lactic Dehydrogenase	LDH
Laparotomy	LAP
Large	LRG
Large bowel resection	LBR
Large cleaved cell	LCC
Last menstrual period	LMP
Lateral	LAT
Left	LT
Left breast biopsy	LBBX
Left bundle branch block	LBBB
Left costal margin	LCM
Left eye	OS
Left lower extremity	LLE
Left lower lobe	LLL
Left lower quadrant	LLQ
Left salpingo-oophorectomy	LSO
Left upper extremity	LUE
Left upper lobe	LUL
Left upper outer quadrant	LUOQ
Left upper quadrant	LUQ
Left ureteral orifice	LUO
Less/Less than	<
Licensed practical nurse	LPN
Linear accelerator	LINAC
Liver, kidney, spleen	LKS
Liver, kidney, spleen, bladder	LKSB
Liver/spleen scan	LS SCAN
Lobular carcinoma in situ	LCIS
Lobular in situ	LIS
Lobular neoplasia, grade 2	LN2
Long Term Care Facility	LTCF
Lower extremity	LE
Lower inner quadrant	LIQ
Lower outer quadrant	LOQ
Lower right quadrant	LRQ
Lumbar puncture	LP

WORD/TERM (S)	ABBREVIATION/SYMBOL
Lumbar spine	L-SPINE
Lumbar vertebra	L1-L5
Lumbosacral	LS
Lupus erythematosus	LUP ERYTH
Lymph node biopsy	LNBX
Lymph node dissection	LND
Lymph node resection	LNR
Lymph node(s)	LN(S)
Lymphadenopathy-associated virus	LAV
Lymphangiography/lymphangiogram	LAG
Macrophage colony-stimulating factor	M-CSF
Magnetic resonance cholangiopancreatography	MRCP
Magnetic resonance imaging	MRI
Main stem bronchus	MSB
Malignant	MALIG
Malignant carcinoid syndrome	MCS
Malignant fibrous histiocytoma	MFH
Mandible/mandibular	MAND
Mastectomy	MAST, MX
Maximum	MAX
Medical center	MC
Medical history	MHX
Medication	MED
Melanoma associated antigen	MAA
Metastatic/Metastasis	METS
Methicillin Resistant Staphylococcus Aureus	MRSA
Microgram	MCG
Microscopic	MICRO
Midclavicular line	MCL
Middle	MID
Middle lobe	ML
Millicurie (hours)	MC(H)
Milligram (hours)	MG(H)
Milliliter	ML
Millimeter	MM
Million electron volts	MEV
Minimum	MIN
Minus	-
Minute	MIN
Mitral valve prolapse	MVP
Mixed combined immunodeficiency	MCID
Mixed connective tissue disease	MCTD
Moderate (ly)	MOD
Moderately differentiated	MD, MOD DIFF

WORD/TERM (S)	ABBREVIATION/SYMBOL
Modified radical mastectomy	MRM
Monoclonal antibody	MC-AB, MCAB, MAB, MOAB
More/More than	>
Multifocal arterial tachycardia	MAT
Multifocal premature ventricular contraction	MPVC
Multiple	MULT
Multiple myeloma	MM
Multiple sclerosis	MS
Myasthenia gravis	MG
Myelodysplasia/myelodysplastic syndrome	MDS
Myeloproliferative disease	MPD
Myocardial infarction	MI
Natural killer	NK
Nausea and vomiting	N&V
Neck vein distention	NVD
Needle biopsy	NBX
Needle liver biopsy	NLBX
Negative	NEG, -
Neoplasm	NEOPL
Neoplasm embryonic antigen	NEA
Nephrectomy	NX
Nerves, Cranial 1-12	N-I - N-XII
Neurology	NEURO
No acute/active disease	NAD
No evidence of disease	NED
No evidence of recurrence	NER
No significant findings	NSF
Nodular & diffuse lymphoma	NDL
Non small cell carcinoma	NSCCA
Non-Hodgkin malignant lymphoma	NHML
Non-Hodgkin lymphoma	NHL
Non-small cell lung cancer	NSCLC
Normal	NL
Not applicable	NA
Not elsewhere classified/classifiable	NEC
Not otherwise specified	NOS
Not recorded	NR
Number	#
Nursing home	NH
Obstetrics	OB
Obstructed (-ing, -ion)	OBST
Occult primary malignancy	OPM
Oncology	ONC
Operating room	OR

WORD/TERM (S)	ABBREVIATION/SYMBOL
Operation	OP
Operative report	OP RPT
Organic brain syndrome	OBS
Orthopedics	ORTHO
Otology	OTO
Ounce	OZ
Outpatient	OP
Outpatient surgery	OPS
Packs per day	PPD
Palpated (-able)	PALP
Papanicolaou smear	PAP
Papillary	PAP
Past/personal (medical) history	PMH
Pathologic tumor, nodes, metastases	PTNM
Pathology	PATH
Patient	PT
Pediatrics	PEDS
Pelvic inflammatory disease	PID
Peptic ulcer disease	PUD
Percussion and auscultation	P&A
Percutaneous	PERC
Percutaneous transhepatic cholecystogram	PTC
Peripheral vascular disease	PVD
Phosphorus 32	P32
Physical examination	PE
Physiotherapy/Physical therapy	PT
Plasma cell leukemia	PCL
Platelets	PLT
Plus	+
Polycythemia vera	PCV
Poorly differentiated	PD, POOR DIFF
Positive	POS, +
Positron emission tomography	PET
Possible	POSS
Posterior	POST
Posteroanterior	PA
Postoperative (-ly)	POST OP
Pound(s)	LB(S), #
Premature atrial contraction	PAC
Preoperative (-ly)	PRE OP
Prescription	RX
Present illness	PI
Previous	PREV
Primitive neuroectodermal tumor	PNET

WORD/TERM (S)	ABBREVIATION/SYMBOL
Prior to admission	PTA
Probable (-ly)	PROB
Proctoscopy	PROCTO
Progesterone receptor assay	PRA
Prolymphocyctic leukemia	PLL
Prostatic intraepithelial neoplasia	PIN
Prostatic intraepithelial neoplasia, grade III	PIN III
Prostatic specific antigen	PSA
Pulmonary	PULM
Pulmonary artery	PULM ART
Quadrant	QUAD
Radiation absorbed dose	RAD
Radiation therapy	RT
Radical neck dissection	RND
Radioactive iodine	RAI
Radioimmunoassay	RIA
Received	REC'D
Red blood cells (count)	RBC
Regarding	RE
Regional medical center R	MC
Regular	REG
Regular sinus rhythm	RSR
Resection (ed)	RESEC
Respiratory	RESPIR, RESP
Review of outside films	ROF
Review of outside slides	ROS
Rheumatic heart disease	RHD
Rheumatoid arthritis	RA
Right	RT
Right breast biopsy	RBBX
Right bundle branch block	RBBB
Right costal margin	RCM
Right eye	OD
Right inner quadrant	RIQ
Right lower extremity	RLE
Right lower lobe	RLL
Right lower quadrant	RLQ
Right middle lobe	RML
Right outer quadrant	ROQ
Right salpingo-oophorectomy	RSO
Right upper extremity	RUE
Right upper lobe	RUL
Right upper quadrant	RUQ
Right ureteral orifice	RUO

WORD/TERM (S)	ABBREVIATION/SYMBOL
Rule out	R/O
Sacral spine	S-SPINE
Sacral vertebra	S1-S5
Salpingo-oophorectomy	SO
Sarcoma	SARC
Satisfactory	SATIS
Sequential multiple analysis	SMA
Serum glutamic oxaloacetic transaminase	SGOT
Serum glutamic pyruvic transaminase	SGPT
Severe combined immunodeficiency syndrome	SCID
Short(ness) of breath	SOB
Sick sinus syndrome	SSS
Sigmoid colon	SIG COLON
Skilled nursing facility	SNF
Small	SM
Small bowel	SB
Small bowel obstruction	SBO
Small bowel resection	SBR
Small cell lung carcinoma	SCLC
Specimen	SPEC
Spine, Cervical	C-SPINE
Spine, Lumbar	L-SPINE
Spine, Sacral	S-SPINE
Spine, Thoracic	T-SPINE
Split thickness skin graft	STSG
Squamous	SQ
Squamous cell carcinoma	SCC
Status post	S/P
Subcutaneous	SUBQ
Summary stage	SS
Superior vena cava	SVC
Surgery/Surgical	SURG
Suspicious/suspected	SUSP
Symptoms	SX
Syndrome of inappropriate ADH	SIADH
Systemic lupus erythematosus	SLE
T-cell acute lymphoblastic leukemia	T-ALL
T-cell chronic lymphatic leukemia	T-CLL
Thoracic spine	T-SPINE
Thromboticthrombocytopenia purpura	TTP
Times	X
Total abdominal hysterectomy	TAH
Total abdominal hysterectomy- bilateral salpingo-oophorectomy	TAH-BSO
Total axial (lymph) node irradiation	TANI

WORD/TERM (S)	ABBREVIATION/SYMBOL
Total parenteral nutrition	TPN
Total vaginal hysterectomy	TVH
Transbronchial biopsy	TBBX
Transient ischemic attack	TIA
Transitional cell carcinoma	TCC
Transrectal ultrasound	TRUS
Transrectal ultrasound of prostate	TRUSP
Transurethral resection	TUR
Transurethral resection bladder	TURB
Transurethral resection bladder tumor	TURBT
Transurethral resection prostate	TURP
Transverse colon	TRANS-COLON
Transverse rectus abdominous myocutaneous	TRAM
Treatment	TX
True vocal cord	TVC
Tumor size	TS
Tumor, node, metastasis	TNM
Twice a day (daily)	BID
Ultrasound	US
Undetermined	UNDET
Undetermined origin	UDO
Undifferentiated	UNDIFF
Unilateral salpingo-oophorectomy	USO
Unknown	UNK
Upper extremity	UE
Upper gastrointestinal (series)	UGI
Upper inner quadrant	UIQ
Upper outer quadrant	UOQ
Upper respiratory infection	URI
Upper right quadrant	URQ
Urinary tract infection	UTI
Vagina/Vaginal	VAG
Vaginal hysterectomy	VAG HYST
Vaginal intraepithelial neoplasia	VAIN
Vaginal intraepithelial neoplasia (grade III)	VAIN III
Vascular	VASC
Versus	VS
Vulvar intraepithelial neoplasia	VIN
Vulvar intraepithelial neoplasia (grade III)	VIN III
Well differentiated	WD, WELL DIFF
White blood cells (count)	WBC
White female	W/F
White male	W/M
Will follow (in) office	WF-O

WORD/TERM (S)	ABBREVIATION/SYMBOL
Wilms (tumor), aniridia, genitourinary (abnormalities), and	WAGR
With	W/
Within normal limits	WNL
Without	W/O
Wolff-Parkinson-White Syndrome	WPW
Work-up	W/U
Xray	XR
Year	YR
Yolk Sac Tumor	YST

Ordered by Abbreviation

ABBREVIATION	WORD/TERM (S)
A FIB	Atrial fibrillation
A FLUTTER	Atrial flutter
A&P	Auscultation & percussion
ABC	Aspiration biopsy cytology
ABD	Abdomen (abdominal)
ABD HYST	Abdominal hysterectomy
ABG	Arterial blood gases
ABM	Autologous bone marrow
ABMT	Autologous bone marrow transplantation
ABN	Abnormal
ABS	Absent/Absence
ABST	Abstract/Abstracted
AC	Adrenal cortex
ACA	Adenocarcinoma
ACBE	Air contrast barium enema
ACD	Alpha chain disease
ACH	Adrenal cortical hormone
ACID PHOS	Acid phosphatase
A-COLON	Ascending colon
ACTH	Adrenocorticotrophic hormone
ADENOCA, ACA	Adenocarcinoma
ADH	Antidiuretic hormone
ADH SIADH	Syndrome of inappropriate ADH
ADJ	Adjacent
ADL	Activities of daily living
ADM	Admission/Admit
AEL	Acute erythroleukemia
AFF	Affirmative
AFP	Alpha-fetoprotein
AG	Antigen
AGL	Acute granulocytic leukemia
AI	Atrial stenosis/insufficiency/incompetence
AIDS	Acquired Immune Deficiency Syndrome
AIHA	Autoimmune hemolytic anemia
AIL	Angioblastic immunoblastic lymphadenopathy
AIN III	Anal intraepithelial neoplasia, grade III
AK(A)	Above knee (amputation)
AKA	Also known as
AL	Acute leukemia
ALB	Albumin
ALFT	Abnormal liver function test
ALK PHOS	Alkaline phosphatase

ABBREVIATION	WORD/TERM (S)
ALL	Acute lymphocytic leukemia
ALM	Acral lentiginous melanoma
ALS	Amyotrophic lateral sclerosis
ALT	Alternate
AM	Before noon
AMA	Against medical advice
AMB	Ambulatory
AMBL	Acute myeloblastic leukemia
AMEGL	Acute megakaryoblastic leukemia
AMI	Acute myocardial infarction
AML	Acute myelogenous leukemia
AMML	Acute myelomonocytic leukemia
AMP	Amputation
AMT	Amount
ANAP	Anaplastic
ANGIO	Angiography/Angiogram
ANS	Autonomic nervous system
ANT	Anterior
AODM	Adult-onset Diabetes Mellitus
AP	Abdominal perineal (Abdominoperineal)
AP	Anteroposterior
APC	Atrial premature complexes
APL	Acute promyelocytic leukemia
APP	Appendix
APPL'Y	Apparently
APPROX	Approximately
APR	Abdominoperineal resection
ARC	AIDS-related condition (complex)
ARD	AIDS-related disease
ARDS	Acute Respiratory Distress (Disease) Syndrome
ARF	Acute renal failure
ARRHY	Arrhythmia
ART	Artery (ial)
AS	Arteriosclerosis/Arteriosclerotic
ASA	Aspirin, Acetylsalicylic acid
ASAP	As soon as possible
ASC	Ascending
ASCVD	Arteriosclerotic cardiovascular disease
ASHD	Arteriosclerotic heart disease
ASP	Aspiration
ASPVD	Arteriosclerotic Peripheral Vascular Disease
A-STEN	Aortic stenosis
ATL	Adult T-cell leukemia
ATLL	Adult T-cell leukemia/lymphoma
ATN	Acute tubular necrosis

ABBREVIATION	WORD/TERM (S)
ATP	Adenosine triphosphate
ATR	Achilles tendon reflex
AUL	Acute undifferentiated leukemia
AUT	Autopsy
AV	Arteriovenous
AVG	Average
AVM	Arteriovenous malformation
AX	Axilla(ry)
B/F	Black female
B/M	Black male
BA	Barium
BAD	Bipolar affective disorder
BAS	Barium swallow
BAW	Bronchoalveolar washing
BCC	Basal cell carcinoma
BCG	Bacillus Calmette-Guerin
BD	Bile duct
BE	Barium enema
BGCA	Bronchogenic carcinoma
BHL	Bilateral hilar lymphadenopathy
BID	Twice a day (daily)
BIL	Bilateral
BK(A)	Below knee (amputation)
BKA	Below knee amputation
BL	Burkitt lymphoma
BLL	Bilateral lower lobes
BLN	Bronchial lymph node
BM	Bone Marrow
BM	Bowel Movement
BMA	Bone marrow aspirate
BMBX	Bone marrow biopsy
BMT	Bone Marrow Transplant
BOO	Bladder outlet obstruction
BP	Blood pressure
BPH	Benign prostatic hypertrophy/hyperplasia
BPLND	Bilateral pelvic lymph node dissection
BRB	Bright red blood
BRBPR	Bright red blood per rectum
BRM	Biological response modifier
BRS	Breath sounds
BS	Bowel sounds
BSE	Breast self-examination
BSO	Bilateral salpingo-oophorectomy
BT	Bladder tumor

ABBREVIATION	WORD/TERM (S)
BUN	Blood urea nitrogen
BUS	Bartholin's, Urethral & Skene's
BV	Blood volume
BX	Biopsy
C/C	Chief complaint
C/O	Complaint (-ning) of
C/W	Consistent with
C1-C7	Cervical vertebrae
CA	Calcium
CA	Carcinoma
CABG	Coronary artery bypass graft
CAD	Coronary artery disease
CAP(S)	Capsule (s)
CBC	Complete blood count
CBD	Common bile duct
CC	Cubic centimeter
CCR	Complete continuous remission
CCU	Coronary care unit
CEA	Carcinoembryonic antigen
CEJ	Cardioesophageal junction
CF	Cystic fibrosis
CGL	Chronic granulocytic leukemia
CGM	Centigram
CGY	Centigray
CHD	Congenital heart disease
CHEMO	Chemotherapy
CHF	Congestive heart failure
CHG	Change
CHOLE	Cholecystectomy
CHR	Chronic
CIG	Cigarettes
CIN	Cervical intraepithelial neoplasia
CIN III	Cervical intraepithelial neoplasia, grade III
CIS	Carcinoma in situ
CL	Chronic leukemia
CLL	Chronic lymphocytic leukemia
CLR	Clear
CLSL	Chronic lymphosarcoma leukemia
CM	Centimeter
CML	Chronic myeloid (myelocytic) leukemia
CMML	Chronic myelomonocytic leukemia
CMS	Chronic myelodysplastic syndrome
CNS	Central nervous system
CO60	Cobalt 60

ABBREVIATION	WORD/TERM (S)
COLD	Chronic obstructive lung disease
CONT	Continue/continuous
CONTRA	Contralateral
COPD	Chronic obstructive pulmonary disease
CRF	Chronic renal failure
CS	Collaborative stage
CSF	Cerebrospinal fluid
C-SF	Colony-stimulating factor
C-SPINE	Cervical spine
CT	CAT/CT scan/Computerized axial tomography
CT, CAT	Computerized axial tomography scan
CTB	Ceased to breath
CTCL	Cutaneous T-cell lymphoma
CTNM	Clinical tumor, nodes, metastases
CU	Curie
CUC	Chronic ulcerative colitis
CUP	Carcinoma unknown primary
CUT	Cutaneous
CVA	Cerebrovascular accident
CVD	Cardiovascular disease
CX	Cervix
CXR	Chest X-ray
CYSTO	Cystoscopy
CYTO	Cytology
D&C	Dilatation and curettage
DC	Discontinue(d)
DCIS	Ductal carcinoma in situ
D-COLON	Descending colon
DE	Direct extension
DEB	Debridement
DECR	Decrease(d)
DERM	Dermatology
DES	Diethylstilbestrol
DESC	Descending
DFI	Disease free interval
DFSP	Dermatofibrosarcoma protuberans
DIAM	Diameter
DIC	Disseminated intravascular coagulopathy
DIFF	Differentiated/differential
DISCH	Discharge
DISSEM	Disseminated
DL	Diagnostic laparoscopy
DM	Diabetes mellitus
DM	Distant metastases

ABBREVIATION	WORD/TERM (S)
DNA	Deoxyribonucleic acid
DOA	Dead on arrival
DOB	Date of birth
DOC	Died of other causes
DOD	Date of death
DOE	Dyspnea on exertion
DR	Doctor
DRE	Digital rectal examination
DTR	Deep tendon reflex
DVT	Deep vein thrombosis
DWD	Died with disease
DX	Diagnosis
DZ	Disease
E.G	For example
ECF	Extended care facility
ECG/EKG	Electrocardiogram
EEG	Electroencephalogram
EENT	Eyes, ears, nose and throat
EGD	Esophagogastroduodenoscopy
EMG	Electromyogram
ENLGD	Enlarged
ENT	Ears, nose, and throat
ER	Emergency room
ERA	Estrogen receptor assay
ERCP	Endoscopic retrograde cholangiopancreatography
ESO	Esophagus
ETOH	Alcohol
EUA	Examination under anesthesia
EVAL	Evaluation
EX	External
EXAM	Examination
EXC(D)	Excision/excised
EXP	Expired
EXPL	Exploratory
EXPL LAP	Exploratory laparotomy
EXT	Extend/extension
EXTR	Extremity
FAB	French-American-British
FB	Fingerbreadth
FHX	Family history
FL	Fluid
FLEX SIG	Flexible sigmoidoscopy
FLURO	Fluoroscopy
FMH	Family medical history

ABBREVIATION	WORD/TERM (S)
FNA	Fine needle aspiration
FNAB	Fine needle aspiration biopsy
FOM	Floor of mouth
FREQ	Frequent/Frequency
FS	Frozen section
FTSG	Full thickness skin graft
FU	Follow-up
FUO	Fever of unknown origin
FX	Fracture
GB	Gallbladder
GE	Gastroesophageal
GEN	General/Generalized
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GM	Gram
GR	Grade
GU	Genitourinary
GYN	Gynecology
H&P	History and physical
H/O	History of
HAV	Hepatitis A (virus)
HBV	Hepatitis B (virus)
HCC	Hepatocellular carcinoma
HCG	Human chorionic gonadotropin
HCT	Hematocrit
HCV	Hepatitis C (virus)
HCVD	Hypertensive cardiovascular disease
HD	Hodgkin disease
HDV	Hepatitis D (virus)
HEENT	Head, eyes, ears, nose, throat
HEMO	Hematology
HGB	Hemoglobin
HIV	Human Immunodeficiency Virus
HORM	Hormone
HOSP	Hospital
HPI	History of present illness
HPV	Human Papilloma Virus
HR(S)	Hour/Hours
HSM	Hepatosplenomegaly
HTLV	Human T-Lymphotrophic Virus, (Type III)
HTN	Hypertension
HVD	Hypertensive vascular disease
HX	History
HYST	Hysterectomy

ABBREVIATION	WORD/TERM (S)
I	Iodine
I&D	Incision & drainage
IAB	Intra-abdominal
IBD	Inflammatory bowel disease
ICM	Intercostal margin
ICS	Intercostal space
ICU	Intensive care unit
IDDM	Insulin-dependent diabetes mellitus
IG	Immunoglobulin
IHC	Immunohistochemical
IHSS	Idiopathic hypertrophic subaortic stenosis
ILD	Interstitial lung disease
IM	Intramuscular
IMA	Internal mammary artery
IMP	Impression
IN	Inch
INCL	Includes/Including
INCR	Increase(d)
INF	Inferior
INFILT	Infiltrating
INT	Internal
INV	Invade(s)/invading/invasion
INVL	Involve(s)/involvement/involving
IP	Inpatient
IPPB	Intermittent positive pressure breathing
IPSI	Ipsilateral
IRREG	Irregular
IT	Intrathecal
ITP	Idiopathic thrombocytopenia
IV	Intravenous
IVC	Inferior vena cava
IVCA	Intravenous cholangiogram
IVP	Intravenous pyelogram
J	Joule
JCT	Junction
JRA	Juvenile rheumatic arthritis
JVD	Jugular venous distention
JX	Junction
KG	Kilogram
KS	Kaposi sarcoma
KUB	Kidneys, ureters, bladder
KV	Kilovolt
L1-L5	Lumbar vertebra
LAB	Laboratory

ABBREVIATION	WORD/TERM (S)
LAG	Lymphangiography/lymphangiogram
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-associated virus
LB(S)	Pound(s)
LBBB	Left bundle branch block
LBBX	Left breast biopsy
LBR	Large bowel resection
LCC	Large cleaved cell
LCIS	Lobular carcinoma in situ
LCM	Left costal margin
LDH	Lactic dehydrogenase
LE	Lower extremity
LINAC	Linear accelerator
LIQ	Lower inner quadrant
LIS	Lobular in situ
LKS	Liver, kidney, spleen
LKSB	Liver, kidney, spleen, bladder
LLE	Left lower extremity
LLL	Left lower lobe
LLQ	Left lower quadrant
LMP	Last menstrual period
LN(S)	Lymph node(s)
LN2	Lobular neoplasia, grade 2
LNBX	Lymph node biopsy
LND	Lymph node dissection
LNR	Lymph node resection
LOQ	Lower outer quadrant
LP	Lumbar puncture
LPN	Licensed practical nurse
LRG	Large
LRQ	Lower right quadrant
LS	Lumbosacral
LS SCAN	Liver/spleen scan
LSO	Left salpingo-oophorectomy
L-SPINE	Lumbar spine
LT	Left
LTCF	Long Term Care Facility
LUE	Left upper extremity
LUL	Left upper lobe
LUO	Left ureteral orifice
LUOQ	Left upper outer quadrant
LUP ERYTH	Lupus erythematosus
LUQ	Left upper quadrant

ABBREVIATION	WORD/TERM (S)
MAA	Melanoma associated antigen
MAB	Monoclonal antibody
MALIG	Malignant
MAND	Mandible/mandibular
MAST	Mastectomy
MAT	Multifocal arterial tachycardia
MAX	Maximum
MC	Medical center
MC(H)	Millicurie (hours)
MC-AB, MCAB	Monoclonal antibody
MCG	Microgram
MCID	Mixed combined immunodeficiency
MCL	Midclavicular line
MCS	Malignant carcinoid syndrome
M-CSF	Macrophage colony-stimulating factor
MCTD	Mixed connective tissue disease
MD	Moderately differentiated
MDS	Myelodysplasia/myelodysplastic syndrome
MED	Medication
MED	Medicine
METS	Metastatic/Metastasis
MEV	Million electron volts
MFH	Malignant fibrous histiocytoma
MG	Myasthenia gravis
MG(H)	Milligram (hours)
MHX	Medical history
MI	Myocardial infarction
MICRO	Microscopic
MID	Middle
MIN	Minimum
MIN	Minute
ML	Middle lobe
ML	Milliliter
MM	Millimeter
MM	Multiple myeloma
MOAB	Monoclonal antibody
MOD	Moderate (ly)
MOD DIFF	Moderately differentiated
MPD	Myeloproliferative disease
MPVC	Multifocal premature ventricular contraction
MRCP	Magnetic resonance cholangiopancreatography
MRI	Magnetic resonance imaging
MRM	Modified radical mastectomy
MRSA	Methicillin Resistant Staphylococcus Aureus

ABBREVIATION	WORD/TERM (S)
MS	Multiple sclerosis
MSB	Main stem bronchus
MULT	Multiple
MVP	Mitral valve prolapse
MX	Mastectomy
N&V	Nausea and vomiting
NA	Not applicable
NAD	No acute/active disease
NBX	Needle biopsy
NDL	Nodular & diffuse lymphoma
NEA	Neoplasm embryonic antigen
NEC	Not elsewhere classified/classifiable
NED	No evidence of disease
NEG	Negative
NEOPL	Neoplasm
NER	No evidence of recurrence
NEURO	Neurology
NH	Nursing home
NHL	Non-Hodgkin lymphoma
NHML	Non-Hodgkin malignant lymphoma
N-I - N-XII	Nerves, Cranial 1-12
NK	Natural killer
NL	Normal
NLBX	Needle liver biopsy
NOS	Not otherwise specified
NR	Not recorded
NSCCA	Non-small cell carcinoma
NSCLC	Non-small cell lung cancer
NSF	No significant findings
NVD	Neck vein distention
NX	Nephrectomy
OB	Obstetrics
OBS	Organic brain syndrome
OBST	Obstructed (-ing, -ion)
OD	Right eye
ONC	Oncology
OP	Operation
OP	Outpatient
OP RPT	Operative report
OPM	Occult primary malignancy
OPS	Outpatient surgery
OR	Operating room
ORTHO	Orthopedics
OS	Left eye

ABBREVIATION	WORD/TERM (S)
OTO	Otology
OZ	Ounce
P&A	Percussion and auscultation
P32	Phosphorus 32
PA	Posteroanterior
PAC	Premature atrial contraction
PALP	Palpated (-able)
PAP	Papanicolaou smear
PAP	Papillary
PATH	Pathology
PCL	Plasma cell leukemia
PCV	Polycythemia vera
PD	Poorly differentiated
PE	Physical examination
PEDS	Pediatrics
PERC	Percutaneous
PET	Positron emission tomography
PI	Present illness
PID	Pelvic inflammatory disease
PIN	Prostatic intraepithelial neoplasia
PIN III	Prostatic intraepithelial neoplasia, grade III
PLL	Prolymphocyctic leukemia
PLT	Platelets
PMH	Past/personal (medical) history
PMP	Primary medical physician
PNET	Primitive neuroectodermal tumor
POOR DIFF	Poorly differentiated
POS	Positive
POSS	Possible
POST	Posterior
POST OP	Postoperative (-ly)
PPD	Packs per day
PRA	Progesterone receptor assay
PRE OP	Preoperative (-ly)
PREV	Previous
PROB	Probable (-ly)
PROCTO	Proctoscopy
PSA	Prostatic specific antigen
PT	Patient
PT	Physiotherapy/Physical therapy
PTA	Prior to admission
PTC	Percutaneous transhepatic cholecystogram
PTNM	Pathologic tumor, nodes, metastases
PUD	Peptic ulcer disease

ABBREVIATION	WORD/TERM (S)
PULM	Pulmonary
PULM ART	Pulmonary artery
PVD	Peripheral vascular disease
Q	Every
QD	Every day
QUAD	Quadrant
R/O	Rule out
RA	Rheumatoid arthritis
RAD	Radiation absorbed dose
RAI	Radioactive iodine
RBBB	Right bundle branch block
RBBX	Right breast biopsy
RBC	Red blood cells (count)
RCM	Right costal margin
RE	Regarding
REC'D	Received
REG	Regular
RESEC	Resection (ed)
RESP	Respiratory
RESPIR	Respiratory
RHD	Rheumatic heart disease
RIA	Radioimmunoassay
RIQ	Right inner quadrant
RLE	Right lower extremity
RLL	Right lower lobe
RLQ	Right lower quadrant
RMC	Regional medical center
RML	Right middle lobe
RND	Radical neck dissection
ROF	Review of outside films
ROQ	Right outer quadrant
ROS	Review of outside slides
RSO	Right salpingo-oophorectomy
RSR	Regular sinus rhythm
RT	Radiation therapy
RT	Right
RUE	Right upper extremity
RUL	Right upper lobe
RUO	Right ureteral orifice
RUQ	Right upper quadrant
RX	Prescription
S/P	Status post
S1-S5	Sacral vertebra
SARC	Sarcoma

ABBREVIATION	WORD/TERM (S)
SATIS	Satisfactory
SB	Small bowel
SBO	Small bowel obstruction
SBR	Small bowel resection
SCC	Squamous cell carcinoma
SCID	Severe combined immunodeficiency syndrome
SCLC	Small cell lung carcinoma
SGOT	Serum glutamic oxaloacetic transaminase
SGPT	Serum glutamic pyruvic transaminase
SIG COLON	Sigmoid colon
SLE	Systemic lupus erythematosus
SM	Small
SMA	Sequential multiple analysis
SNF	Skilled nursing facility
SO	Salpingo-oophorectomy
SOB	Short(ness) of breath
SPEC	Specimen
SQ	Squamous
SS	Summary stage
S-SPINE	Sacral spine
SSS	Sick sinus syndrome
STSG	Split thickness skin graft
SUBQ	Subcutaneous
SURG	Surgery/Surgical
SUSP	Suspicious/suspected
SVC	Superior vena cava
SX	Symptoms
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy- bilateral salpingo-oophorectomy
T-ALL	T-cell acute lymphoblastic leukemia
TANI	Total axial (lymph) node irradiation
TBBX	Transbronchial biopsy
TCC	Transitional cell carcinoma
T-CLL	T-cell chronic lymphatic leukemia
TIA	Transient ischemic attack
TNM	Tumor, node, metastasis
TPN	Total parenteral nutrition
TRAM	Transverse rectus abdominous myocutaneous
TRANS-COLON	Transverse colon
TRUS	Transrectal ultrasound
TRUSP	Transrectal ultrasound of prostate
TS	Tumor size
T-SPINE	Thoracic spine
TTP	Thromboticthrombocytopenia purpura

ABBREVIATION	WORD/TERM (S)
TUR	Transurethral resection
TURB	Transurethral resection bladder
TURBT	Transurethral resection bladder tumor
TURP	Transurethral resection prostate
TVC	True vocal cord
TVH	Total vaginal hysterectomy
TX	Treatment
UDO	Undetermined origin
UE	Upper extremity
UGI	Upper gastrointestinal (series)
UIQ	Upper inner quadrant
UNDET	Undetermined
UNDIFF	Undifferentiated
UNK	Unknown
UOQ	Upper outer quadrant
URI	Upper respiratory infection
URQ	Upper right quadrant
US	Ultrasound
USO	Unilateral salpingo-oophorectomy
UTI	Urinary tract infection
VAG	Vagina/Vaginal
VAG HYST	Vaginal hysterectomy
VAIN	Vaginal intraepithelial neoplasia
VAIN III	Vaginal intraepithelial neoplasia (grade III)
VASC	Vascular
VIN	Vulvar intraepithelial neoplasia
VIN III	Vulvar intraepithelial neoplasia (grade III)
VS	Versus
W/	With
W/F	White female W/F
W/M	White male
W/O	Without
W/U	Work-up
WAGR	Wilms (tumor), aniridia, genitourinary (abnormalities), and (mental)
WBC	White blood cells (count)
WD	Well differentiated
WELL DIFF	Well differentiated
WF-O	Will follow (in) office
WNL	Within normal limits
WPW	Wolff-Parkinson-White syndrome
XR	Xray
YR	Year
YST	Yolk Sac Tumor

Context-Sensitive Abbreviations

When using these abbreviations, make sure the meaning of the abbreviation is readily apparent in the context in which it is used.

ABBREVIATION	WORD/TERM(S)
AP	Anteroposterior Abdominal perineal
BM	Bone marrow Bowel movement
CA	Calcium Carcinoma
DM	Diabetes mellitus Distant metastases
MIN	Minimum Minute
ML	Milliliter Middle lobe
MM	Millimeter Multiple myeloma
OP	Operation Outpatient
PAP	Papillary Papanicolaou smear
PT	Patient Physiotherapy/Physical therapy
RT	Right Radiation therapy

Symbols

SYMBOL	WORD/TERM (S)
-	Negative, minus
#	Number, pound(s)
&	And
@	At
^	Above
+	Plus, Positive
<	Less/Less than
=	Equal(s)
>	Greater/Greater than, More/more than
X	Times

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APPENDIX J:

Required Data Set for Reporting Facilities

Required Data Set for Reporting Facilities

Effective 01/01/2016

VCR Required Data Item	Field Length	NAACCR Item #
Patient Identification		
Record Type	1	10
Accession Number	9	550
Sequence Number	2	560
Patient ID Number	8	20
Medical Record Number	11	2300
Social Security Number	9	2320
Last Name	40	2230
First Name	40	2240
Middle Name (Middle Initial)	40	2250
Name – Alias	40	2280
Name – Maiden	40	2390
Patient Address (# and Street) at Diagnosis	60	2330
Patient Address at Diagnosis – Supplemental	60	2335
City/Town at Diagnosis (City or Town	50	70
State at Diagnosis (State)	2	80
Postal Code at Diagnosis (Zip Code)	9	100
County at Diagnosis	3	90
Country at Diagnosis	3	102
Birthplace	3	250
Birthplace – State	3	252
Birthplace – Country	3	254
Date of Birth	8	240
Date of Birth Flag	2	241
Age at Diagnosis	3	230
Race 1	2	160
Race 2	2	161
Race 3	2	162
Race 4	2	163
Race 5	2	164
Spanish Origin – All Sources (Spanish/Hispanic Origin)	1	190
Sex	1	220
Age at Diagnosis	3	230
Text – Usual Occupation	100	310
Text – Usual Industry	100	320
Primary Payer at Diagnosis	2	630
Class of Case	2	610
Cancer Identification		
NPI – Reporting Facility	10	545
Date of 1st Contact	8	580
Date of 1st Contact Flag	1	581

Required Data Set for Reporting Facilities
continued

VCR Required Data Item	Field Length	NAACCR Item #
Date of Initial Diagnosis	8	390
Date of Initial Diagnosis Flag	2	391
Diagnostic Confirmation	1	490
Type of Reporting Source	1	500
Casefinding Source	2	501
Primary Site	4	400
Text – Primary Site Title	40	2580
Laterality	1	410
Histologic Type ICD-O-3	4	522
Text – Histology Title	40	2590
Behavior Code	1	523
Grade/Differentiation	1	440
Histologic Confirmation	1	490
Tumor Size Summary	3	756
Regional Lymph Nodes Examined	2	830
Regional Lymph Nodes Positive	2	820
Lymph vascular Invasion	1	1182
Mets at DX – Bone	1	1112
Mets at Dx – Brain	1	1113
Mets at Dx – Distant LN	1	1114
Mets at Dx – Liver	1	1115
Mets at Dx – Lung	1	1116
Mets at Dx – Other	1	1117
CS Site Specific Factor 1	3	2880
CS Site Specific Factor 2	3	2890
CS Site Specific Factor 5	3	2920
CS Site Specific Factor 6	3	2930
CS Site Specific Factor 8	3	2862
CS Site Specific Factor 9	3	2863
CS Site Specific Factor 11	3	2865
CS Site Specific Factor 13	3	2867
CS Site Specific Factor 14	3	2868
CS Site Specific Factor 15	3	2869
CS Site Specific Factor 16	3	2870
CS Site Specific Factor 25	3	2879
TNM Path T	4	880
TNM Path N	4	890
TNM Path M	4	900
TNM Path Stage Group	4	910
TNM Path Descriptor	1	920
TNM Path Staged By	2	930
TNM Clin T	4	940
TNM Clin N	4	950
TNM Clin M	4	960
TNM Clin Stage Group	4	970

Required Data Set for Reporting Facilities
continued

VCR Required Data Item	Field Length	NAACCR Item #
TNM Clin Stage Descriptor	1	980
TNM Clin Staged By	2	990
TNM Edition Number	2	1060
Seer Summary Stage 2000	1	759
Text – Staging	1000	2600
First Course of Treatment		
Date of First Course of Treatment	8	1270
Date of First Course of Treatment Flag	2	1271
Rx Date - Surgery	8	1200
Rx Date - Surgery Flag	2	1201
Rx Date – Radiation	8	1210
Rx Date – Radiation Flag	2	1211
Rx Date - Chemo	8	1220
Rx Date – Chemo Flag	2	1221
Rx Date – Hormone	8	1230
Rx Date – Hormone Flag	2	1231
Rx Date – BRM	8	1240
Rx Date – BRM Flag	2	1241
Rx Date – Other	8	1250
Rx Date – Other Flag	2	1251
Scope of Regional Lymph Node Surgery	1	1292
Surgical Procedure Oth Reg/Dis Site	1	1294
Rx Summ – Treatment Status	1	1285
RX Date Mst Defn Srg	8	3170
RX Date Mst Defn Srg Flag	1	3171
Rx Summ – Surg Primary Site	2	1290
Rx Summ – Scope Reg LN Surg	1	1294
Reason for No Surgery of Primary Site	1	1340
Rx Summ – Radiation	1	1360
Rad – Regional RX Modality	2	1570
Rx Summ – Rad/Surg Sequence	1	1380
Rx Summ – Transplant/Endocrine	2	3250
Rx Summ – Chemo	2	1390
Rx Summ – Hormone	2	1400
Rx Summ – BRM	2	1410
Rx Summ – Other	1	1420
Rx Summ – Systemic/Surg Seq	1	1639
Reason for No Radiation	1	1430
Text-Diagnostic:		
Dx Procedures – Lab Tests	1000	2550
Dx Procedures – Scopes	1000	2540
Dx Procedures – Op Procedures	1000	2560
Dx Procedures – Pathology	1000	2570
Dx Procedures – PE	1000	2520
Dx Procedures – X-Rays/Scans	1000	2530
Dx Procedures – Remarks	1000	2680

Required Data Set for Reporting Facilities
continued

VCR Required Data Item	Field Length	NAACCR Item #
Text - Treatment:		
Surgery	1000	2610
Radiation – Beam	1000	2620
Radiation – Other	1000	2630
Chemotherapy	1000	2640
Hormone	1000	2650
BRM	1000	2660
Other	1000	2670
Outcomes		
Date of Last Contact/Death	8	1750
Date of Last Contact/Death Flag	2	1751
Vital Status	1	1760
Cause of Death	4	1910
DC State File Number	6	2380
ICD Revision Number	1	1920
Place of Death – State	2	1942
Place of Death – Country	3	1944
Follow up Source	1	1790
Case Administration		
Abstracted By	3	570
Facility Identification Number (FIN)	10	540
Record Type	1	10
Over-ride SITE/TNM-STAGE GROUP	1	1989
Over-ride AGE/SITE/MORPH	1	1990
Over-ride SEQNO/DXCONF	1	2000
Over-ride SITE/LAT/SEQNO	1	2010
Over-ride SURG/DXCONF	1	2020
Over-ride SITE/TYPE	1	2030
Over-ride HISTOLOGY	1	2040
Over-ride REPORT SOURCE	1	2050
Over-ride ILL DEFINED SITE	1	2560
Over-ride LEUK,LYMPHOMA	1	2070
Over-ride SITE/BEHAVIOR	1	2071
Over-ride SITE/LAT/MORPH	1	2074
Over-ride CS 1	1	3750
Over-ride CS 2	1	3751
Over-ride CS 3	1	3752
Over-ride CS 4	1	3753
Over-ride CS 5	1	3754
Over-ride CS 6	1	3755
Over-ride CS 7	1	3756
Over-ride CS 8	1	3757
Over-ride CS 9	1	3758
Over-ride CS 10	1	3759

Required Data Set for Reporting Facilities
continued

VCR Required Data Item	Field Length	NAACCR Item #
Over-ride CS 11	1	3760
Over-ride CS 12	1	3761
Over-ride CS 13	1	3762
Over-ride CS 14	1	3763
Over-ride CS 15	1	3764
Over-ride CS 16	1	3765
Over-ride CS 17	1	3766
Over-ride CS 18	1	3767
Over-ride CS 19	1	3768
Over-ride CS 20	1	3769
Site Coding System – Current	1	450
Morphology Coding System – Current	1	470
ICD-O-3 Conversion Flag	1	2116
RX Coding System – Current	2	1460
CS Version Input Original	6	2935
CS Version Input Current	6	2937
NAACCR Record Version	1	50
Date Case Completed	8	2090
Date Case Report Exported	8	2110
Virginia State Specific		
Dioxin Exposure	1	2220
Vietnam Veteran	1	2220
Tobacco History	1	2220
Number of Years Smoked	3	2220
Alcohol History	1	2220
Family History	1	2220

2016 Required Data Set by Item Number

Item #	Item Name
10	Record Type
20	Patient ID Number
21	Patient System ID-Hosp
30	Registry Type
40	Registry ID
45	NPI--Registry ID
50	NAACCR Record Version
70	Addr at DX--City
80	Addr at DX--State
90	County at DX
100	Addr at DX--Postal Code
102	Addr at DX--Country
160	Race 1
161	Race 2
162	Race 3
163	Race 4
164	Race 5
190	Spanish/Hispanic Origin
220	Sex
230	Age at Diagnosis
240	Date of Birth
241	Date of Birth Flag
250	Birthplace
252	Birthplace--State
254	Birthplace--Country
390	Date of Diagnosis
391	Date of Diagnosis Flag
400	Primary Site
410	Laterality
420	Histology (92-00) ICD-O-2
430	Behavior (92-00) ICD-O-2
440	Grade
441	Grade Path Value
449	Grade Path System
450	Site Coding Sys--Current
470	Morph Coding Sys--Current
490	Diagnostic Confirmation
500	Type of Reporting Source
501	Casefinding Source
522	Histologic Type ICD-O-3

Item #	Item Name
523	Behavior Code ICD-O-3
540	Reporting Facility
545	NPI--Reporting Facility
550	Accession Number--Hosp
560	Sequence Number--Hospital
570	Abstracted By
580	Date of 1st Contact
581	Date of 1st Contact Flag
610	Class of Case
630	Primary Payer at DX
756	Tumor Size Summary
759	SEER Summary Stage 2000
820	Regional Nodes Positive
830	Regional Nodes Examined
880	TNM Path T
890	TNM Path N
900	TNM Path M
910	TNM Path Stage Group
920	TNM Path Descriptor
930	TNM Path Staged By
940	TNM Clin T
950	TNM Clin N
960	TNM Clin M
970	TNM Clin Stage Group
980	TNM Clin Descriptor
990	TNM Clin Staged By
1060	TNM Edition Number
1112	Mets at DX-Bone
1113	Mets at DX-Brain
1114	Mets at Dx-Distant LN
1115	Mets at DX-Liver
1116	Mets at DX-Lung
1117	Mets at DX-Other
1182	Lymph-vascular Invasion
1200	RX Date Surgery
1201	RX Date Surgery Flag
1210	RX Date Radiation
1211	RX Date Radiation Flag
1220	RX Date Chemo
1221	RX Date Chemo Flag
1230	RX Date Hormone
1231	RX Date Hormone Flag

Item #	Item Name
1240	RX Date BRM
1241	RX Date BRM Flag
1250	RX Date Other
1251	RX Date Other Flag
1260	Date Initial RX SEER
1261	Date Initial RX SEER Flag
1270	Date 1st Crs RX CoC
1271	Date 1st Crs RX CoC Flag
1285	RX Summ--Treatment Status
1290	RX Summ--Surg Prim Site
1292	RX Summ--Scope Reg LN Sur
1294	RX Summ--Surg Oth Reg/Dis
1340	Reason for No Surgery
1350	RX Summ--DX/Stg Proc
1360	RX Summ--Radiation
1380	RX Summ--Surg/Rad Seq
1390	RX Summ--Chemo
1400	RX Summ--Hormone
1410	RX Summ--BRM
1420	RX Summ--Other
1430	Reason for No Radiation
1460	RX Coding System--Current
1570	Rad--Regional RX Modality
1639	RX Summ--Systemic/Sur Seq
1750	Date of Last Contact
1751	Date of Last Contact Flag
1760	Vital Status
1790	Follow-Up Source
1910	Cause of Death
1920	ICD Revision Number
1940	Place of Death
1942	Place of Death--State
1944	Place of Death--Country
1989	Over-ride Site/TNM-StgGrp
1990	Over-ride Age/Site/Morph
2000	Over-ride SeqNo/DxConf
2010	Over-ride Site/Lat/SeqNo
2020	Over-ride Surg/DxConf
2030	Over-ride Site/Type
2040	Over-ride Histology
2050	Over-ride Report Source
2060	Over-ride Ill-define Site

Item #	Item Name
2070	Over-ride Leuk, Lymphoma
2071	Over-ride Site/Behavior
2074	Over-ride Site/Lat/Morph
2110	Date Case Report Exported
2116	ICD-O-3 Conversion Flag
2220	State/Requestor Items
2230	Name--Last
2240	Name--First
2250	Name--Middle
2260	Name--Prefix
2270	Name--Suffix
2280	Name--Alias
2300	Medical Record Number
2320	Social Security Number
2330	Addr at DX--No & Street
2335	Addr at DX--Supplementl
2380	DC State File Number
2390	Name--Maiden
2520	Text--DX Proc--PE
2530	Text--DX Proc--X-ray/Scan
2540	Text--DX Proc--Scopes
2550	Text--DX Proc--Lab Tests
2560	Text--DX Proc--Op
2570	Text--DX Proc--Path
2580	Text--Primary Site Title
2590	Text--Histology Title
2600	Text--Staging
2610	RX Text--Surgery
2620	RX Text--Radiation (Beam)
2630	RX Text--Radiation Other
2640	RX Text--Chemo
2650	RX Text--Hormone
2660	RX Text--BRM
2670	RX Text--Other
2680	Text--Remarks
2861	CS Site-Specific Factor 7
2862	CS Site-Specific Factor 8
2863	CS Site-Specific Factor 9
2865	CS Site-Specific Factor11
2867	CS Site-Specific Factor13
2868	CS Site-Specific Factor14
2869	CS Site-Specific Factor15

Item #	Item Name
2870	CS Site-Specific Factor16
2879	CS Site-Specific Factor25
2880	CS Site-Specific Factor 1
2890	CS Site-Specific Factor 2
2920	CS Site-Specific Factor 5
2930	CS Site-Specific Factor 6
2935	CS Version Input Original
2937	CS Version Input Current
3170	RX Date Mst Defn Srg
3171	RX Date Mst Defn Srg Flag
3250	RX Summ--Transplnt/Endocr
3720	NPCR Specific Field
3750	Over-ride CS 1
3751	Over-ride CS 2
3752	Over-ride CS 3
3753	Over-ride CS 4
3754	Over-ride CS 5
3755	Over-ride CS 6
3756	Over-ride CS 7
3757	Over-ride CS 8
3758	Over-ride CS 9
3759	Over-ride CS 10
3760	Over-ride CS 11
3761	Over-ride CS 12
3762	Over-ride CS 13
3763	Over-ride CS 14
3764	Over-ride CS 15
3765	Over-ride CS 16
3766	Over-ride CS 17
3767	Over-ride CS 18
3768	Over-ride CS 19
3769	Over-ride CS 20

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APPENDIX K:

Reporting Facilities and FIN Numbers

Alphabetic Facility Listing

CORPORATE AFFILIATION	FACILITY NAME	LOCATION	FACILITY TYPE
Augusta Health	Augusta Health	Fishersville	Acute care
	Bath County Community Hospital	Hot Springs	Critical Access
Centra	Bedford Memorial Hospital	Bedford	Acute care
Surgical Care Affiliates	Blue Ridge Surgery Center	Salem	Ambulatory surgery
Independent	Buchanan General Hospital	Grundy	Acute care
Sentara	Careplex Orthopaedic Ambulatory Surgery Center	Hampton	Ambulatory surgery
Carilion	Carilion Brambleton Surgical Center	Roanoke	Ambulatory surgery
Carilion	Carilion Franklin Memorial Hospital	Rocky Mount	Acute care
Carilion	Carilion Giles Community Hospital	Pearisburg	Critical Access
Carilion	Carilion Medical Center	Roanoke	Acute care
Carilion	Carilion New River Valley Medical Center	Christiansburg	Acute care
Carilion	Carilion Stonewall Jackson Hospital	Lexington	Critical Access
Carilion	Carilion Tazewell Community Hospital	Tazewell	Acute care
Centra	Centra Health	Lynchburg	Acute care
Osteopathic Surgical Ctrs, LLC	Charlottesville Surgical Center	Charlottesville	Ambulatory surgery
Independent	Chesapeake Regional Medical Center	Chesapeake	Acute care
VCU Health	Children's Hospital	Richmond	Acute care
CHKD Health System	Children's Hospital of the King's Daughters	Norfolk	Acute care
	CHKD Health & Surgery Center	Newport News	Ambulatory surgery
	CHKD Health & Surgery Center	Virginia Beach	Ambulatory surgery
HCA	CJW Medical Center	Richmond	Acute care
Duke Lifepoint	Clinch Valley Medical Center	Richlands	Acute care
HCA	Colonial Heights Surgery Center	Colonial Heights	Ambulatory Surgery
	Community Memorial Healthcenter	South Hill	Acute Care
Inova	Countryside Ambulatory Surgery Center	Sterling	Ambulatory Surgery

CORPORATE AFFILIATION	FACILITY NAME	LOCATION	FACILITY TYPE
Novant/UVa	Culpeper Regional Hospital	Culpeper	Acute Care
Duke Lifepoint	Danville Regional Medical Center	Danville	Acute Care
Bon Secours	DePaul Medical Center	Norfolk	Acute Care
Mountain State Health Alliance	Dickenson Community Hospital	Clintwood	Critical Access
Riverside	Doctor's Surgery Center	Williamsburg	Ambulatory Surgery
	Fairlawn Surgery Center, LLC	Roanoke	Ambulatory Surgery
Fauquier Health	Fauquier Hospital	Warrenton	Acute Care
Mary Washington Healthcare	Fredericksburg Ambulatory Surgery Center	Fredericksburg	Ambulatory Surgery
Sentara	Halifax Regional Hospital	South Boston	Acute Care
HCA	Hanover Outpatient Surgery Center	Mechanicsville	Ambulatory Surgery
Novant/UVA	Haymarket Medical Center	Haymarket	Acute Care
HCA	Henrico Doctor's Hospital	Richmond	Acute Care
Inova	Inova Alexandria Hospital	Alexandria	Acute Care
Inova	Inova Fair Oaks Hospital	Fairfax	Acute Care
Inova	Inova Fairfax Hospital	Falls Church	Acute Care
Inova	Inova Loudoun Ambulatory Surg Ctr	Leesburg	Ambulatory Surgery
Inova	Inova Loudoun Hospital	Leesburg	Acute Care
Inova	Inova Mount Vernon Hospital	Alexandria	Acute Care
Inova	Inova Surgery Center @ Franconia – Springfield	Alexandria	Ambulatory Surgery
Inova	Inova Woodburn Surgery Center, LLC	Annandale	Ambulatory Surgery
HCA	John Randolph Medical Center	Hopewell	Acute Care
Mountain State Health Alliance	Johnston Memorial Hospital	Abingdon	Acute Care
Kaiser Permanente	Kaiser Permanente Falls Church Med Ctr	Falls Church	Ambulatory Surgery
	Lakeview Medical Center	Suffolk	Ambulatory Surgery
HCA - LewisGale	LewisGale Hospital – Alleghany	Low Moor	Acute Care
HCA - LewisGale	LewisGale Hospital – Montgomery	Blacksburg	Acute Care
HCA - LewisGale	LewisGale Medical Center	Salem	Acute Care
Sentara	Martha Jefferson Hospital	Charlottesville	Acute Care
Sentara	Martha Jefferson Opt Surgery Center	Charlottesville	Ambulatory Surgery

CORPORATE AFFILIATION	FACILITY NAME	LOCATION	FACILITY TYPE
Bon Secours	Mary Immaculate Ambulatory Surg Ctr	Newport News	Ambulatory Surgery
Bon Secours	Mary Immaculate Hospital	Newport News	Acute Care
Mary Washington Healthcare	Mary Washington Hospital	Fredericksburg	Acute Care
Bon Secours	Maryview Medical Center	Portsmouth	Acute Care
Bon Secours	Memorial Ambulatory Surgery Center	Mechanicsville	Ambulatory Surgery
Duke Lifepoint	Memorial Hospital of Martinsburg & Henry County	Martinsville	Acute Care
Bon Secours	Memorial Regional Medical Center	Mechanicsville	Acute Care
Wellmont Healthcare System	Mountain View Regional Med Center	Norton	Acute Care
	Northern Virginia Surgery Center	Fairfax	Ambulatory Surgery
Valley Health	Page Memorial Hospital	Luray	Critical Access
HCA	Parham Surgery Center	Henrico	Ambulatory Surgery
Riverside	Peninsula Surgery Center	Newport News	Ambulatory Surgery
	Piedmont Day Surgery Center	Danville	Ambulatory Surgery
Pioneer Health Services	Pioneer Community Hospital of Patrick County, Inc	Stuart	Critical Access
	Potomac Ambulatory Surgery Center	Fairfax	Ambulatory Surgery
Novant/UVa	Prince William Ambulatory Surgery Center	Manassas	Ambulatory Surgery
Novant/UVa	Prince William Hospital	Manassas	Acute Care
Sentara	Princess Anne Ambulatory Surg Ctr	Virginia Beach	Ambulatory Surgery
HCA LewisGale	Pulaski Community Hospital	Pulaski	Acute Care
Bon Secours	Rappahannock General Hospital	Kilmarnock	Acute Care
	Regional Surgical Services	Bluefield	Ambulatory Surgery
HCA	Reston Hospital	Reston	Acute Care
HCA	Reston Surgery Center	Reston	Ambulatory Surgery
Bon Secours	Richmond Community Hospital	Richmond	Acute Care
Riverside	Riverside Hampton Surgery Center	Hampton	Ambulatory Surgery
Riverside	Riverside Regional Medical Center	Newport News	Acute Care
Riverside	Riverside Shore Memorial Hospital	Nassawadox	Acute Care
Riverside	Riverside Tappahannock Hospital	Tappahannock	Acute Care
Riverside	Riverside Walter Reed Hospital	Gloucester	Acute Care
Woodrum/ASD	Roanoke Ambulatory Surgical Center	Roanoke	Ambulatory Surgery
Sentara	Rockingham Memorial Hospital	Harrisonburg	Acute Care

CORPORATE AFFILIATION	FACILITY NAME	LOCATION	FACILITY TYPE
Mountain State Health Alliance	Russell County Medical Center	Lebanon	Acute Care
Sentara	Sentara Careplex Hospital	Hampton	Acute Care
Sentara	Sentara Leigh-Ambulatory Surgery	Hampton	Ambulatory Surgery
Sentara	Sentara Leigh Hospital	Norfolk	Acute Care
Sentara	Sentara Norfolk General Hospital	Norfolk	Acute Care
Sentara	Sentara Northern Virginia Med Center	Woodbridge	Acute Care
Sentara	Sentara Obici Ambulatory Surgery, LLC	Suffolk	Ambulatory Surgery
Sentara	Sentara Obici Hospital	Suffolk	Acute Care
Sentara	Sentara Port Warwick Surgery Center	Newport News	Ambulatory Surgery
Sentara	Sentara Princess Anne Hospital	Virginia Beach	Acute Care
Sentara	Sentara Virginia Beach Ambulatory Surgery Center	Virginia Beach	Ambulatory Surgery
Sentara	Sentara Williamsburg Community Ambulatory Surgical	Williamsburg	Ambulatory Surgery
Valley Health	Shenandoah Memorial Hospital	Woodstock	Critical Access
	Skin Cancer Outpatient Hospital	Vienna	Ambulatory Surgery
	Skin Surgery Center of Virginia	Henrico	Ambulatory Surgery
Mountain State Health Alliance	Smyth County Community Hospital	Marion	Acute Care
CHS	Southampton Memorial Hospital	Franklin	Acute Care
CHS	Southern Virginia Regional Med Center	Emporia	Acute Care
Centra	Southside Community Hospital	Farmville	Acute Care
CHS	Southside Regional Medical Center	Fredericksville	Acute Care
Bon Secours	St Francis Medical Center	Midlothian	Acute Care
Bon Secours	St Mary's Ambulatory Surgery Center	Richmond	Ambulatory Surgery
Bon Secours	St Mary's Hospital	Richmond	Acute Care
Mary Washington Healthcare	Stafford Hospital Center	Stafford	Acute Care
VA Urology	Stony Point Surgery Center	Richmond	Ambulatory Surgery
Bon Secours	Surgery Center at Harbor View	Suffolk	Ambulatory Surgery
Bon Secours	Surgery Center at Virginia Beach	Virginia Beach	Ambulatory Surgery
Chesapeake Reg Med Ctr	Surgery Center of Chesapeake	Chesapeake	Ambulatory Surgery
United Surgical Partners Intn'l	Surgi-Center of Central Virginia	Fredericksburg	Ambulatory Surgery
Valley Health	Surgi-Center of Winchester	Winchester	Ambulatory Surgery
Duke Lifepoint	Twin County Regional Hospital	Galax	Acute Care
UVa Health System	University of Virginia Medical Center	Charlottesville	Acute Care

CORPORATE AFFILIATION	FACILITY NAME	LOCATION	FACILITY TYPE
VA Urology	Urosurgical Center of Richmond	Richmond	Ambulatory Surgery
VA Urology	Urosurgical Center of Richmond - Monument	Richmond	Ambulatory Surgery
VA Urology	Urosurgical Center of Richmond – North	Mechanicsville	Ambulatory Surgery
VA Urology	Urosurgical Center of Richmond – South	Richmond	Ambulatory Surgery
VCU Health	VCU Health System	Richmond	Acute Care
	Virginia Hospital Center	Arlington	Acute Care
	Virginia Surgery Center, LLC	Norfolk	Ambulatory Surgery
Valley Health	Warren Memorial Hospital	Front Royal	Acute Care
Wellmont Healthcare System	Wellmont Lonesome Pine Hospital	Big Stone Gap	Acute Care
Valley Health	Winchester Medical Center	Winchester	Acute Care
Duke Lifepoint	Wythe County Community Hospital	Wytheville	Acute Cate
Critical Access: a hospital operating no more than 25 beds with no more than 15 used for acute inpatient care at any one time with a maximum stay of 96 hours. This has been funded by the federal government grant.			

FIN Numbers

NOTE: All facilities are given a FIN number, regardless of CoC Accreditation status.

City	Facility Name	FIN #
Abingdon	Johnston Memorial Hospital	6340010
Alexandria	Inova Alexandria Hospital	6340020
Alexandria	Inova Mount Vernon Hospital	6340030
Alexandria	Jefferson Memorial Hospital	6340026
Annandale	Woodburn Nuclear Medicine	20000318
Arlington	National Hospital for Ortho & Rehab	6340035
Arlington	Northern Virginia Community Hospital	6340045
Arlington	Virginia Hospital Center-Arlington	6340040
Bedford	Bedford Memorial Hospital	6340050
Big Stone Gap	Wellmont Lonesome Pine Hospital	6340055
Blacksburg	Montgomery Regional Hospital	6340140
Charlottesville	Martha Jefferson Hospital	6340120
Charlottesville	University of Virginia Health System	6340130
Chesapeake	Chesapeake General Hospital	6340145
Christiansburg	Carilion New River Valley Medical Center	10000395
Clintwood	Dickenson County Medical Center	6340855
Culpeper	Culpeper Regional Hospital	6340195
Danville	Danville Regional Medical Center	6340220
Emporia	Greensville Memorial Hospital	6340227
Fairfax	Georgetown Radiation Medicine-Fairfax	10000434
Fairfax	Inova Fair Oaks Hospital	6340231
Falls Church	Inova Fairfax Hospital	6340490
Farmville	Southside Community Hospital	6340230
Fishersville	Augusta Health	6341110
Fort Belvoir	Fort Belvoir Community Hospital	6340240
Fort Eustis	McDonald Army Community Hospital	6340250
Fort Lee	Kenner Army Community Hospital	6340090
Franklin	Southampton Memorial Hospital	6340280
Fredericksburg	Mary Washington Hospital	6340290
Fredericksburg	Spotsylvania Regional Medical Center	10001156
Front Royal	Warren Memorial Hospital	6340300
Gainesville	The Cancer Center at Lake Manassas	10000633
Galax	Twin County Community Hospital	6340315
Gloucester	Riverside Walter Reed Hospital	6340521
Grundy	Buchanan General Hospital	6340313
Hampton	Sentara Careplex Hospital	6340330
Hampton	U.S. Air Force Hospital	10000396
Hampton	VA Medical Center	6340370
Harrisonburg	Rockingham Memorial Hospital	6730340

City	Facility Name	FIN #
Harrisonburg	Sentara RMH Medical Center	6340340
Haymarket	Novant Health Haymarket Medical Center	20000265
Hopewell	John Randolph Medical Center	6340350
Hot Springs	Bath County Community Hospital	6340360
Kilmarnock	Rappahannock General Hospital	6340385
Langley AFB	US Air Force Regional Hospital	6340335
Lebanon	Russell County Medical Center	6340390
Leesburg	Inova Loudoun Hospital Center	6340400
Lexington	Stonewall Jackson Hospital	6340410
Low Moor	Alleghany Regional Hospital	6340148
Luray	Page Memorial Hospital	6340420
Lynchburg	Centra Health	6340430
Lynchburg	Centra Health - Alan B. Pearson Regional Cancer Center	10000397
Lynchburg	Virginia Baptist Hospital	6340450
Manassas	Novant Health Prince William Medical Center	6340454
Manassas	Prince William Ambulatory Surgery Center	10000621
Marion	Smyth County Community Hospital	6340460
Martinsville	Memorial Hospital	6340480
Mechanicsville	Memorial Regional Medical Center	6340896
Midlothian	Bon Secours St. Francis Medical Center	10000583
Nassawadox	Riverside Shore Memorial Hospital	6340500
Newport News	Mary Immaculate Hospital	6340510
Newport News	Newport News General Hospital	6340530
Newport News	Riverside Regional Medical Center	6340520
Norfolk	Bon Secours - DePaul Medical Center	6340550
Norfolk	Children's Hospital of King's Daughters	6340578
Norfolk	Norfolk Community Hospital	6340610
Norfolk	Rhodes Dental Hospital	6349105
Norfolk	Sentara Healthcare System	10000694
Norfolk	Sentara Lake Wright Radiation Oncology Center	10000584
Norfolk	Sentara Leigh Hospital	6340580
Norfolk	Sentara Norfolk General Hospital	6340620
Norton	Bon Secours St. Mary's Hospital	6340675
Norton	Norton Community Hospital	6340670
Norton	Wellmont Southwest Virginia Cancer Center	20000113
Pearisburg	Carilion Giles Memorial Hospital	6340677
Pennington Gap	Lee Regional Medical Center	6340680
Petersburg	Southside Regional Medical Center	6340710
Portsmouth	Bon Secours Maryview Medical Center	6340740
Portsmouth	Naval Medical Center Portsmouth	6340750
Portsmouth	Portsmouth General Hospital	6340730
Pulaski	Pulaski Community Hospital	6340760

City	Facility Name	FIN #
Radford	Radford Community Hospital	6340780
Reston	Reston Hospital Center	6340025
Richlands	Clinch Valley Medical Center	6340800
Richlands	Mattie Williams Hospital	6340810
Richmond	Bon Secours St. Mary's Hospital	6340921
Richmond	Bon Secours-Richmond Community Hospital	6340890
Richmond	Bostwick Laboratories, LLC	10000585
Richmond	Children's Hospital	6340830
Richmond	Chippenham Hospital	6340835
Richmond	CJW Medical Center	6340815
Richmond	Henrico Doctors' Hospital	10000547
Richmond	Henrico Doctor's Hospital - Forest	6340845
Richmond	Henrico Doctors Hospital - Parham	6340920
Richmond	Hunter Holmes McGuire VA Medical Center	6340960
Richmond	Medical College of Virginia Hospitals	6340860
Richmond	Metropolitan Hospital	6340825
Richmond	Retreat Hospital	6340880
Richmond	Richmond Eye & Ear Hospital	6340895
Richmond	Stuart Circle Hospital	6340940
Richmond	VCU Health Systems	10000399
Roanoke	Carilion Medical Center	10000058
Roanoke	Carilion Medical Center	6341040
Roanoke	Carilion Roanoke Community Hospital	6340995
Roanoke	Gill Memorial Event Hospital	6341000
Rocky Mount	Carilion Franklin Memorial Hospital	6341063
Salem	Lewis-Gale Medical Center	6341020
Salem	Salem VA Medical Center	6341060
South Boston	Halifax Regional Health System	6341075
South Hill	VCU Community Memorial Hospital	6341085
Stafford	Stafford Hospital Center	10000967
Stuart	R. J. Reynolds-Patrick County Hospital	6341136
Suffolk	Sentara Obici Hospital	6341153
Tappahannock	Riverside Tappahannock Hospital	6341161
Tazewell	Tazewell Community Hospital	6341175
Vienna	Northern Virginia Radiology URPI Inst.	10000143
Virginia Beach	Sentara Princess Anne Ambulatory Surgery Center	10000807
Virginia Beach	Sentara Princess Anne Hospital	6341145
Virginia Beach	Sentara Princess Anne Radiation Onc. Center	10000635
Virginia Beach	Sentara Virginia Beach General Hospital	6341162
Virginia Beach	Virginia Beach Ambulatory Surgery Center	10000575
Warrenton	Fauquier Hospital	6341165
Waynesboro	Waynesboro Community Hospital	6341170

City	Facility Name	FIN #
Williamsburg	Riverside Doctor's Hospital Williamsburg	20000070
Williamsburg	Sentara Williamsburg Regional Medical Center	6341195
Winchester	Winchester Medical Center	6341200
Wise	Wise Appalachian Regional Hospital	6341208
Woodbridge	Potomac Radiation Oncology Center	10000084
Woodbridge	Sentara Northern Virginia Medical Center	6341210
Woodbridge	Virginia Cancer Specialists	20000052
Woodstock	Shenandoah Memorial Hospital	6341215
Wytheville	Wythe County Community Hospital	6341230
Wytheville	Wytheville Hospital	6341225

KEY

Outpt or other non-acute care entity
Veteran's Hospital
DoD Hospitals

This table was taken from the CoC website. Any errors are those of the CoC and should be verified with them.

APPENDIX L:

Casefinding Lists

Reportable Neoplasms

REPORTABLE NEOPLASMS	
ICD-10-CM Code	**Explanation of ICD-10-CM Code**
C00.- - C43.-, C4A.-, C45.- - C96.-	Malignant neoplasms (excluding category C44), stated or presumed to be primary (of specified site) and certain specified histologies
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.10-, C44.19-	Unspecified/other malignant neoplasm of skin of eyelid
C44.20-, C44.29-	Unspecified/other malignant neoplasm skin of ear and external auricular canal
C44.30-, C44.39-	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.40, C44.49	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50-, C44.59-	Unspecified/other malignant neoplasm of skin of trunk
C44.60-, C44.69-	Unspecified/other malignant neoplasm of skin of upper limb, incl. shoulder
C44.70-, C44.79-	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin
D00.- - D09.-	In-situ neoplasms *Note: Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable*
D18.02	Hemangioma of intracranial structures and any site
D18.1	Lymphangioma, any site *Note: Includes Lymphangiomas of Brain, Other parts of nervous system and endocrine glands, which are reportable*
D32.-	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.-	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3) *ICD-10-CM Coding instruction note: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)*
D46.-	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3) *ICD-10-CM Coding instruction note: Excludes the following:* *Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_)* *Chronic myeloid leukemia BCR/ABL-positive (C92.1_)* *Myelofibrosis & Secondary myelofibrosis (D75.81)* *Myelophthisic anemia & Myelophthisis (D61.82)*
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) *Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia*

REPORTABLE NEOPLASMS	
ICD-10-CM Code	**Explanation of ICD-10-CM Code**
D47.4	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis Myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.Z-	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3)
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina

Note: Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. However, SEER registries will CONTINUE to report these cases and code behavior as /3 (malignant).

Supplemental Casefinding List

NOTE: Cases with the codes listed below should be screened as registry time allows. Experience in the SEER registries has shown that using the supplemental list increases casefinding for benign brain and CNS, hematopoietic neoplasms, and other reportable diseases.

SUPPLEMENTAL CODES	
ICD-10-CM Code	**Explanation of ICD-10-CM Code**
B20	Human immunodeficiency virus [HIV] disease with other diseases
B97.33, B97.34, B97.35	Human T-cell lymphotrophic virus,(type I [HTLV-1], type II [HTLV-II], type 2 [HIV 2]) as the cause of diseases classified elsewhere
B97.7	Papillomarvirus as the cause of diseases classified elsewhere
C44.01, C44.02	Basal/squamous cell carcinoma of skin of lip
C44.11-, C44.12-	Basal/squamous cell carcinoma of skin of eyelid
C44.21-, C44.22-	Basal/squamous cell carcinoma of skin of ear and external auricular canal
C44.31-, C44.32-	Basal/squamous cell carcinoma of skin of other and unspecified parts of face
C44.41, C44.42	Basal/squamous cell carcinoma of skin of scalp and neck
C44.51-, C44.52-	Basal/squamous cell carcinoma of skin of trunk
C44.61-, C44.62-	Basal/squamous cell carcinoma of skin of upper limb, including shoulder
C44.71-, C44.72-	Basal/squamous cell carcinoma of skin of lower limb, including hip
C44.81, C44.82	Basal/squamous cell carcinoma of skin of overlapping sites of skin
C44.91, C44.92	Basal/squamous cell carcinoma of skin of unspecified sites of skin
D10.- - D31.-, D34, D35.0, D35.1, D35.5-	Benign neoplasms (see "must collect" list for reportable benign neoplasms) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors*
D35.9, D36.-	*Note: Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. SEER registries are not required to collect these cases for diagnoses made 1/1/2001 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted and reported to SEER.*
D3A._	Benign carcinoid tumors
D37._ - D41._	Neoplasms of uncertain or unknown behavior (see "must collect" list for reportable neoplasms of uncertain or unknown behavior) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors*
D44.0 - D44.2, D44.6-D44.9	Neoplasm of uncertain or unknown behavior of other endocrine glands (see "must collect" list for D44.3-D44.5) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors*
D47.0	Histiocytic and mast cell tumors of uncertain behavior *ICD-10-CM Coding instruction note: Excludes: malignant mast cell tumor (C96.2), mastocytosis (congenital)(cutaneous) (Q852.2)*
D47.2	Monoclonal gammopathy *Note: Screen for incorrectly coded Waldenstrom's macroglobulinemia*
D48.-	Neoplasm of uncertain behavior of other and unspecified sites
D49.0 - D49.9	Neoplasm of unspecified behavior (except for D49.6 and D49.7)

SUPPLEMENTAL CODES	
ICD-10-CM Code	**Explanation of ICD-10-CM Code**
D61.1	Drug-induced aplastic anemia (also known as *"aplastic anemia due to antineoplastic chemotherapy")* *ICD-10-CM Coding instruction note: Use additional code for adverse effect, if applicable, to identify drug*
D61.810	Antineoplastic chemotherapy induced pancytopenia
D61.82	Myelophthisis *ICD-10-CM Coding instruction: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)*
D63.0	Anemia in neoplastic disease *ICD-10-CM Coding instruction: Code first neoplasm (C00-C49)*
D64.81	Anemia due to antineoplastic chemotherapy
D69.49, D69.59, D69.6	Other thrombocytopenia *Note: Screen for incorrectly coded thrombocythemia*
D70.1	Agranulocytosis secondary to cancer chemotherapy *ICD-10-CM Coding instruction: code also underlying neoplasm*
D72.1	Eosinophilia (*Note: Code for eosinophilia (9964/3). Not every case of eosinophilia is a malignancy. Reportable Diagnosis is "Hypereosonophilic syndrome."*)
D75.81	Myelofibrosis (note: this is not primary myelofibrosis [9961/3] *ICD-10-CM Coding instruction note: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)*
D76.-	Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue
D89.0, D89.1	Other disorders involving the immune mechanism, not elsewhere classified *Note: Review for miscodes*
E08	Diabetes mellitus due to underlying condition *ICD-10-CM Coding instruction note: Code first the underlying condition, such as:*
E31.2-	Multiple endocrine neoplasia [MEN] syndromes *ICD-10-CM Coding instruction: Code also any associated malignancies and other*
E34.0	Carcinoid syndrome *ICD-10-CM Coding instruction: May be used as an additional code to identify*
E83.52	Hypercalcemia
E88.09	Other disorders of plasma-protein metabolism, not elsewhere classified
E88.3	Tumor lysis syndrome (following antineoplastic chemotherapy)
G13.0	Paraneoplastic neuromyopathy and neuropathy *ICD-10-CM Coding instruction note:: Code first underlying neoplasm (C00-D49)*
G13.1	Other systemic atrophy primarily affecting central nervous system in neoplastic disease

SUPPLEMENTAL CODES	
ICD-10-CM Code	**Explanation of ICD-10-CM Code**
Y84.2	Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm (medical surveillance following completed treatment) *ICD-10-CM Coding instruction: Use additional code to identify the personal history of malignant neoplasm (Z85._)*
Z12.-	Encounter for screening for malignant neoplasms
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z15.0	Genetic susceptibility to malignant neoplasm *ICD-10-CM Coding instruction: Code first, if applicable, any current malignant neoplasm (C00-C75, C81-C96); Use additional code, if applicable, for any personal history of malignant neoplasm (Z85._)*
Z17.0, Z17.1	Estrogen receptor positive and negative status *ICD-10-CM Coding instruction: Code first malignant neoplasm of breast (C50._)*
Z40.0-	Encounter for prophylactic surgery for risk factors related to malignant neoplasms
Z42.1	Encounter for breast reconstruction following mastectomy
Z48.3	Aftercare following surgery for neoplasm
Z48.290	Encounter for aftercare following bone marrow transplant
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1-	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.5, Z51.89	Encounter for palliative care and other specified aftercare
Z79.81-	Long term (current) use of agents affecting estrogen receptors and estrogen
Z80.-	Family history of primary malignant neoplasm
	Personal history of malignant neoplasm
Z86.0-, Z86.01-,	Personal history of in situ and benign neoplasms and neoplasms of uncertain
Z92.21, Z92.23,	Personal history of antineoplastic chemotherapy, estrogen therapy,
Z94.81, Z94.84	Bone marrow and stem cell transplant status

^ *International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2016*