

NEW JERSEY STATE CANCER REGISTRY MANUAL
Instructions for Health Care Facilities
2010

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INTRODUCTION TO THE NEW JERSEY STATE CANCER REGISTRY

The New Jersey State Cancer Registry (NJSCR) is a population-based registry and includes all cancer cases diagnosed in New Jersey residents since October 1, 1978. The NJSCR serves the entire State of New Jersey, which includes a population of approximately 8.7 million people.

The purpose of the NJSCR is to track cancer in New Jersey in an effort to promote the following activities: scientific research; public and professional education programs; planning and implementation of cancer control and prevention activities. The NJSCR strives to improve the quality and enhance the usefulness of its data.

The NJSCR was established by legislation (NJSA 26:2-104 et.seq.) in 1977 in response to concern that New Jersey was suffering from the highest cancer incidence and mortality rates in the country. New Jersey regulations require the reporting of all newly-diagnosed cancer cases to the NJSCR within six months of diagnosis. All primary malignant and in situ neoplasms are reportable to the NJSCR, except carcinoma in situ of the cervix (since 1995) and basal cell and squamous cell carcinomas of the skin. Benign and borderline intracranial and central nervous system tumors are reportable if diagnosed January 1, 2004 and later. Hospitals, physicians, dentists, ambulatory care facilities, radiation facilities, independent laboratories, and any other facility that diagnoses and/or treats cancer patients also file reports with the NJSCR. In addition, reporting agreements are maintained with neighboring states so that New Jersey residents diagnosed in facilities out of state are identified.

The information collected by the NJSCR includes the following: demographic characteristics of the patient, medical information on each cancer such as primary site, histologic type, collaborative stage and cancer-directed treatment information. The vital status of each patient is followed annually until death. The cause of death is also incorporated into the data set if the information is available.

In February 2001, the NJSCR became a SEER (Surveillance, Epidemiology, and End Results) Registry. The SEER Program of the National Cancer Institute is the most authoritative source of information on cancer incidence and survival in the United States. Geographic areas selected for inclusion in the SEER Program are based on the Registries' ability to operate and maintain a high-quality population-based cancer reporting system and for their epidemiologically significant population subgroups. The SEER Program currently collects and publishes cancer incidence and survival data from 14 population-based cancer registries and three supplemental registries covering approximately 26 percent of the US population. Information on more than 3 million in situ and invasive cancer cases is included in the SEER database, and approximately 170,000 new cases are added each year within the SEER coverage areas.

The NJSCR participates in the National Program of Cancer Registries (NPCR), established by the Centers for Disease Control (CDC) in 1992 by the Federal Cancer Registries Amendment Act (Public Law 102-515). NPCR promotes statewide, population-based registries to collect uniform data elements in a standardized format. The NJSCR is also a member of the North American Association of Central Cancer Registries (NAACCR). The North American Association of Central Cancer Registries, Inc. (NAACCR, Inc.) is a professional organization that develops and promotes uniform data standards for cancer registration; provides education and training; certifies population-based registries; and publishes data from central cancer registries.

CONFIDENTIALITY

The New Jersey Cancer Registry Statute N.J.S.A.26:2-107 stipulates that reports of individual patients made to the NJSCR are held in the strictest confidence. Reports made pursuant to this act are used only by the State Department of Health and Senior Services and such other agencies as designated by the Commissioner of Health. N.J.S.A.26:2-108 stipulates that no individual or organization providing information to the State Department of Health in accordance with this act shall be held liable for divulging confidential information. Please note: reporting information about cases of cancer in accordance with the NJSCR authorizing statute and regulations *is permitted* by the Health Insurance Portability and Accountability Act. The privacy rule contains a specific provision authorizing covered entities to disclose protected health information as required by law. Public health reporting under the authority of State law is specifically exempted from the Privacy Rule regulations 45CFR154.512(b)(1)(i). A copy of the Cancer Reporting Statute, Regulations and Reportable List can be found on the NJSCR Website at <http://www.state.nj.us/health/cancer/regs.pdf>.

GENERAL REQUIREMENTS FOR REPORTING TO THE NEW JERSEY STATE CANCER REGISTRY (NJSCR)

The New Jersey State Cancer Registry Manual 2010 contains coding instructions for all cases diagnosed January 1, 2010 and later. Documentation and codes for historical items can be found in The New Jersey State Cancer Registry Manual 2005 and 2008.

A case *must* be reported to the NJSCR if it is **diagnosed on or after October 1, 1978**.

WHAT CANCER SHOULD BE REPORTED TO THE NJSCR?

All diseases listed in the List of Reportable Diseases and Conditions in Appendix A, "Cancer Registry Legislation and Regulations" should be reported to the NJSCR.

The following are **exclusions**:

- Carcinoma in situ (any/2) and CIN III of the cervix (C5.30-C53.9) (cases diagnosed after April 1, 1995)
- Benign and borderline neoplasms of the ovary
- Gastrointestinal stromal tumors (GIST), unless stated to be malignant
- Prostatic intraepithelial neoplasia (PIN III) of the prostate (C619) (collection stopped effective with cases diagnosed 1/1/2001 and later)
- Basal and squamous cell carcinomas of the skin (C44.0-C44.9)

Epithelial carcinomas, papillary and squamous cell carcinomas and basal cell carcinomas of the skin of the following **genital** sites **are** reportable regardless of stage: vagina, clitoris, vulva, prepuce, penis, and scrotum (sites C52.9, C5.10-C51.9, C60.0, C60.9, C63.2).

Note: Effective with the revised Cancer Registry Regulations, basal and squamous cell carcinomas of the skin will no longer be reportable to NJSCR with the exception of the aforementioned sites. It is anticipated that these regulations will become effective February 2011.

- **Benign and borderline primary intracranial and CNS tumors** with a behavior code of /0 or /1 in ICD-O-3 are collected effective with cases diagnosed 1/1/2004 and later).
 - **Pilocytic/Juvenile astrocytomas** are reportable; code the histology and behavior code 9421/3. **Note:** Benign and borderline tumors of the cranial bones (C410) are **not reportable**.

- All cancer patients diagnosed or treated in the **inpatient** or **outpatient department, emergency room, clinic, ambulatory care centers**, radiation therapy centers, or any other healthcare facility, must be reported including patients receiving transient care.
- **Certain benign and borderline conditions are reportable.** Refer to the reportable list in on the NJSCR website <http://www.state.nj.us/health/cancer/regs.pdf> for a list of these conditions.
- New Jersey residents and non-residents must be reported including residents of foreign countries.
- Cases diagnosed at **autopsy** must be reported and patients dead on arrival (DOA) with a cancer diagnosis must be reported.
- Patients diagnosed elsewhere and admitted for additional work-up and/ or treatment, cancer-directed or non cancer-directed must be reported.
- Patients with a **clinical diagnosis** of cancer which was based on clinical judgment only must be reported.
- Patients with a **history of cancer with active disease** must be reported.
- If more than one primary cancer is diagnosed in a patient, **a separate report must be submitted for each primary.**
- **Consult-only cases are reportable.** A consult may be done to confirm a diagnosis or treatment plan.
- Private outpatient specimens are reportable. Generally, these specimens are submitted from a physician's office to be read by the hospital pathologist and the patient is not registered as an inpatient or outpatient at the hospital.
- **Slide reviews are encouraged** to be reported but are not required. Slide review cases are slides that have been sent to your hospital's pathologist for an opinion. Please do not confuse these with private outpatient or consult-only cases.
- When the distinction between a free-standing facility and hospital-based department cannot be made such as a radiation therapy group practice versus a hospital unit, the ownership of the medical record should be used to determine who is responsible for reporting the case.
- Ambiguous terms that must be reported include the following: **apparent(ly), appears, appears to, comparable with, compatible with, consistent with, favor(s), malignant appearing, most likely, presumed, probable, suspected, suspicious, typical of.**
 - **Note:** The terms “neoplasm” and “tumor” are reportable for benign nervous system tumors only.
 - **Note:** If the **ambiguous** diagnosis is proven to be **not reportable** by biopsy, cytology, or physician’s statement, **do not accession** the case.
 - **Exception:** If a cytology is reported as *suspicious*, do not interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician’s clinical impression of cancer supports the cytology findings. (*FORDS 2010 page 4*)

WHEN TO REPORT TO THE NJSCR

All cases of cancer and other specified tumors and precancerous diseases must be reported to the NJSCR within six months of diagnosis or within three months of the date of discharge from the reporting facility, whichever is sooner. (*Chapter 57A, Cancer Registry Reporting of Cancer; General Requirements, 8:57A-1.1 (b)*)

A health care facility that fails to report cases of cancer electronically, as required by regulation, within six months of the confirmed diagnosis shall be liable to pay a penalty as stated in N.J.S.A. 26:2-106. You may reference the NJSCR website <http://www.state.nj.us/health/cancer/regs.pdf> for the Statute, Regulations and Reportable List, or refer to Appendix A in this manual.

HOW TO REPORT TO THE NJSCR

A cancer registry abstract must be completed for each newly-diagnosed case of malignancy, as well as certain benign and borderline conditions. A separate abstract must be completed for each malignancy and required benign or borderline condition. All abstracts from health care facilities must be submitted electronically in the latest NAACCR format (currently Version 12.1). All cases must be submitted electronically to the NJSCR via e-mail with either attached encrypted file or with an e-mail link to a secure encrypted e-mail server on a monthly basis. Please see Appendix F for further clarifications.

WHO REPORTS TO THE NJSCR

Health care facilities, physicians, dentists, independent clinical laboratories that diagnose or provide treatment for cancer patients should report cancer cases to the NJSCR. All abstracting work performed by a health care facility which diagnoses or treats 100 or more cases per year must be performed by a certified tumor registrar who is certified by the National Cancer Registrars Association's Council on Certification.

METHODS OF REPORTING CHANGES, UPDATES, DELETIONS, AND FOLLOW-UPS TO THE NJSCR

Changes, deletions or updates to cases must be submitted in *paper format*. A printed copy of the hospital abstract highlighting the fields that have been changed, deleted and/or updated must be submitted via mail to the NJSCR address (given on the cover sheet of this manual) or faxed to (609) 588-3638. It is important that you notify the NJSCR of any changes in your data base so that the NJSCR can maintain an up-to-date registry.

METHODS TO RECEIVE FOLLOW-UP INFORMATION FROM THE NJSCR

The NJSCR can provide hospitals with vital status and dates of last follow-up on cases submitted by their own facilities. Hospitals interested in receiving this information should contact the NJSCR for further instructions regarding compression software and required passwords to ensure confidentiality in the transmission of this data.

NJSCR GUIDELINES FOR THE SUBMISSION OF TEXT INFORMATION

The NJSCR requires the submission of text information to validate coded data items. Text is used for quality control purposes to justify codes for various data items. Text is also used to identify errors, to determine multiple primaries and to resolve discrepancies in data submitted on the same patient by multiple facilities.

All cancer registry software must include specific fields, which have been designed to record text information. These fields are transmitted to the NJSCR along with the other required data fields when you make your monthly electronic submission. Please refer to the table in Appendix C, Table of Required Data Items, NAACCR Version 12.1, for the maximum number of characters per field. Please refer to Appendix E for a list of acceptable medical abbreviations. Recording text information should include but not be limited to the following:

- Record text to support primary site, laterality, histology, grade, collaborative stage, and treatment codes.
- Record text to justify any unusual information about the case which could result in potential questions, e.g. record text to support unusual site/histology combinations, such as age/site combinations, gender/site combinations.
- Record text to clarify modifications or dates on the abstract.
- If limited information is available in the medical record about a case, utilize the text field to state that limited information was available in the medical record.

CASE FINDING

Case finding is the system used to identify patients with reportable neoplasms. Case finding involves thorough, systematic monitoring of records maintained by various departments throughout the hospital. Multiple sources must be used to ensure complete reporting of all cases.

Case finding sources include, but are not limited to:

- Admission and discharge documents
- Disease indices
- Surgery schedules/ logs
- Pathology and Cytology reports
- Hematology reports
- Autopsy reports
- Outpatient medical records/logs, including Radiation Oncology and Medical Oncology logs
- Nuclear medicine documents

HOW TO USE AMBIGUOUS TERMINOLOGY FOR CASE ASCERTAINMENT (SEER Program Manual 2010, page 5)

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

a. 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.), accession the case.

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

Negative Example: The final diagnosis on the outpatient report reads: Rule out pancreatic cancer. Do not accession the case.

b. Discrepancies

i. Accession the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record.

1. Do not accession a case when subsequent documents refer to history of cancer and the original source document used a non-reportable ambiguous term.

Example: Report from the dermatologist is "probable melanoma." Patient admitted later for unrelated procedure and physician listed history of melanoma. Give priority to the information from the dermatologist. The later information is less reliable in this case.

ii. When there is a single report, accept the reportable term and accession the case when one section of a report uses a reportable term such as "apparently" and another section of the same report uses a term that is not on the reportable list.

Example: Abdominal CT reveals a 1 cm liver lesion. "The lesion is consistent with hepatocellular carcinoma" appears in the discussion section of the report. The final diagnosis is "1 cm liver lesion, possibly hepatocellular carcinoma." Accession the case. "Consistent with" is a reportable ambiguous term. Accept "consistent with" over the non-reportable term "possibly."

Exception: Do not accession a case based ONLY on suspicious cytology.

c. Use these terms when **screening** diagnoses on pathology reports, operative reports, scans, mammograms, and other diagnostic testing other than tumor markers. (SEER Program Manual 2010 page 5)

i. Do not accession a case when resection, excision, biopsy, cytology, or physician's statement proves the ambiguous diagnosis is not reportable.

Example 1: Mammogram shows calcifications suspicious for intraductal carcinoma. The biopsy of the area surrounding the calcifications is negative for malignancy. Do not accession the case.

Example 2: CT report states "mass in the right kidney, highly suspicious for renal cell carcinoma." CT-guided needle biopsy with final diagnosis "Neoplasm suggestive of oncocytoma. A malignant neoplasm cannot be excluded." Discharged back to the nursing home and no other information is available. Do not accession the case. The suspicious CT finding was biopsied and not proven to be malignant. "Suggestive of" is not a reportable ambiguous term.

Example 3: Stereotactic biopsy of the left breast is "focally suspicious for DCIS" and is followed by a negative needle localization excisional biopsy. Do not accession the case. The needle localization excisional biopsy was performed to further evaluate the suspicious stereotactic biopsy finding. The suspicious diagnosis was proven to be false.

Example 4: Esophageal biopsy with diagnosis of "focal areas suspicious for adenocarcinoma in situ change." Diagnosis on partial esophagectomy specimen "with foci of high grade dysplasia; no invasive carcinoma identified." Do not accession the case. The esophagectomy proved that the suspicious biopsy result was false.

SCREENING LISTS OF ICD-9-CM AND ICD-10-CM CODES FOR CASE FINDING

Certain ICD-9-CM* and/or ICD-10-CM** codes are used by medical records departments for discharge diagnoses to identify cases of neoplasms that are reportable. Case finding procedures should include the review of medical records coded with the ICD-9-CM codes found in Appendix G, or ICD-10 CM codes found in Appendix H.

***ICD-9-CM Codes:**

International Classification of Disease, 9th Revision, Clinical Modification (4th ed., October 1991)

****ICD-10 CM Codes:**

International Classification of Diseases, Tenth Revision, Clinical Modification (June 2003)

CLASS OF CASE

The NJSCR requires the submission of analytic and non-analytic cases. Please note that Class of Case was modified to two digits beginning with 2010 cases and forward. Please consult the Facility Oncology Registry Data Standards Manual (FORDS) 2010, pages 5 and 97-98, for exact coding information. (<http://www.facs.org/cancer/coc/fordsmanual.html>)

DEMOGRAPHIC DATA

LAST NAME, FIRST NAME, MIDDLE NAME

Record patient's last name, first name and middle name, if the middle name is not available, use the middle initial of the patient. Do not use any spaces or punctuation (e.g., ONEIL). Hyphenated names are allowed (e.g., SMITH-BROWN). Please spell names correctly.

- **Note:** Please record patient's middle initial or middle name in the space designated for that purpose. Please do not record middle initial or middle name in the same space as patient's first name.

ALIAS OR MAIDEN NAME

If maiden or alias name is known, record it in the designated space. If the patient has a maiden name, record the maiden (last) name only. If the patient uses an alias for the first name, last name or both first and last name, record the last name or alias followed by a blank space and the first name or alias. Leave the designated space blank if the patient does not have a maiden name or an alias.

NAME—PREFIX/SUFFIX

Abbreviated titles may be used. Do not use periods or spaces (e.g., MS, MD). Please record abbreviations in the space designated for that purpose. Do not record them in the same space as the first name or the last name.

ADDRESS AT DIAGNOSIS

SEER registries collect information of place of residence at diagnosis. The SEER rules for determining residency at diagnosis are either identical or comparable to rules used by the U.S. Census Bureau, http://www.census.gov/population/www/cen2010/resid_rules/resid_rules.html.

Record the patient's residence when the tumor was first diagnosed and treated. It should be noted the patient's address at diagnosis may be different than the patient's current address. The address should be the residence, not the mailing address. If the patient has multiple tumors, the address at diagnosis may be different for each subsequent primary. If the address is unknown, record UNKNOWN.

Special Notes About Address:

In general, use the address of the location where a person lives and sleeps **most** of the time, or the place the person says is his or her usual home. Please note that a patient's citizenship has no bearing on residency rules.

- A patient originally diagnosed in a foreign country may come to the United States for a second opinion and/or treatment. If possible, the patient's home address should be recorded. Do not record a temporary NJ residence, such as a friend's or relative's address.
 - For "state", there are special abbreviations for the some foreign locations. Please see table on page 15 in this manual, or on page 50 in *FORDS 2010*.
 - If the patient is a resident of a country other than the United States (including U.S. territories, commonwealths, or possessions), or is a resident of a country other than Canada, AND the country is **known**, record **XX** in the "state" field.
 - If the patient is a resident of a country other than the United States (including U.S. territories, commonwealths, or possessions), or is a resident of a country other than Canada, AND the country is **unknown**, record **YY** in the "state" field.
 - If the residence is **unknown**, code the "state" field as **ZZ**.
- Use a street address if available when a P.O. Box is given. Post Office Box is not a reliable source to identify the residency at diagnosis; it does not provide accurate geographical information for analyzing cancer incidence.
- Homeless people and transients are examples of persons with no usual residence. Code the patient's residence at the time of diagnosis such as the shelter or the hospital where the diagnosis was confirmed.
- For "snowbirds", code the residence where the patient spends the majority of time (usual residence). If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.
- For **armed forces military personnel** and their family members, code the address of the military installation or surrounding community as stated by the patient
- For personnel assigned to **Navy, Coast Guard, and Maritime Ships**, the U.S. Census Bureau has detailed rules for determining residency. Refer to www.census.gov for detailed rules.
- Code the place of usual residence rather than the temporary address for:
 - Migrant workers
 - Educators temporarily assigned to a university in the SEER area
 - Persons temporarily residing with family during cancer treatment

- Military personnel on **temporary** duty assignments (TDY)
 - **Boarding school** students below college level (code the parent's residence)
 - Code the residence where the student is living while attending **college**.
 - Code the address of the institution for persons in institutions
- Please see the SEER Program Manual 2010 for additional information concerning address.

NUMBER AND STREET ADDRESS

Record the number and street address at the time of diagnosis. Use a blank between numbers and words; do not use commas, periods, or other punctuation symbols when coding address (e.g., 123 Fifth Avenue NW Apt 7B not 123 Fifth Avenue, N.W., Apt. 7B.).

A street address should include:

- street number
- prefix directional (e.g., E, W, SE, NW, etc.)
- street name
- street type (e.g., St, Ave, Ln, Tpk., etc.)
- suffix directional (e.g., W, NE, S, etc.)

For example, an address with four of the most commonly given components would look like:
427 E Maple St or 211 Broadway Ave SW

Apartment numbers, building numbers, etc., can be included but they **MUST** be added at the end if there is space. Whenever possible, avoid using facility names (e.g., nursing home, hospital), Rural Routes and P.O. Box numbers in the ADDRESS field. Enter the patient's street address of residence whenever possible.

SUPPLEMENTAL ADDRESS

Use this field to record information such as the name of the nursing home or apartment complex where the patient resides. Do not use this space for the street address.

CITY

Enter the name of the city or town of residence, not the location of the post office box number. Do not use abbreviations. If city is unknown, type out the word UNKNOWN.

ZIP CODE

Record the patient's five-digit or nine-digit ZIP code corresponding to the street address.

- Code **999999999** if the patient is a US or Canadian resident but the postal code is unknown.
- Code **888888888** if the patient is a foreign resident and the foreign country's postal code is unknown.

STATE

Record the standard two-letter U.S. Postal Service abbreviation for the patient's state of residence at the time of diagnosis. For foreign residents, code the state abbreviation as XX.

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	NM	West Virginia	WV
Iowa	IA	New York	NY	Wisconsin	WI
Kansas	KS	North Carolina	NC	Wyoming	WY

Canada:

Alberta	AB	Nova Scotia	NS
British Columbia	BC	Ontario	ON
Labrador	LB	Prince Edward Island	PE
Manitoba	MB	Quebec	PQ
New Brunswick	NB	Saskatchewan	SK
Newfoundland	NF	Yukon	YT
Northwest Territories	NT	Canada, NOS	CN

Other:

American Samoa	AS
Guam	GU
Mexico	MX
Puerto Rico	PR
Virgin Islands	VI
Palau	PW
Micronesia	FM
Marshall Islands	MH
Outlying Island	UM
APO/FPO Armed Services America	AA

APO/FPO Armed Services Europe	AE
APO/FPO Armed Services Pacific	AP
Resident of a country other than the US (including US territories, commonwealths, or possessions); OR Resident of a country other than Canada; AND The country is known	XX
Resident of a country other than the US (including US territories, commonwealths, or possessions); OR Resident of a country other than Canada; AND The country is unknown	YY
Residence unknown	ZZ

COUNTY

Record the *three-digit* county code listed below for the address at diagnosis:

COUNTY NAME	CODE	COUNTY NAME	CODE
<i>Atlantic</i>	<i>001</i>	<i>Middlesex</i>	<i>023</i>
<i>Bergen</i>	<i>003</i>	<i>Monmouth</i>	<i>025</i>
<i>Burlington</i>	<i>005</i>	<i>Morris</i>	<i>027</i>
<i>Camden</i>	<i>007</i>	<i>Ocean</i>	<i>029</i>
<i>Cape May</i>	<i>009</i>	<i>Passaic</i>	<i>031</i>
<i>Cumberland</i>	<i>011</i>	<i>Salem</i>	<i>033</i>
<i>Essex</i>	<i>013</i>	<i>Somerset</i>	<i>035</i>
<i>Gloucester</i>	<i>015</i>	<i>Sussex</i>	<i>037</i>
<i>Hudson</i>	<i>017</i>	<i>Union</i>	<i>039</i>
<i>Hunterdon</i>	<i>019</i>	<i>Warren</i>	<i>041</i>
<i>Mercer</i>	<i>021</i>	<i>Non-NJ Resident</i>	<i>998</i>

CURRENT ADDRESS

This field is different from Patient's Address at Diagnosis and should be updated throughout the lifetime of the patient. It provides useful information necessary for follow-up. List the patient's current street name and number, city, state and zip code.

SOCIAL SECURITY NUMBER

Record the patient's social security number. This is an important identification field. Numbers should be accurately listed without the use of dashes. Use 9's for unknown numbers. Do not enter a Social Security number that ends with a B or D. This is the spouse's social security number.

Please Note: The Medicare claim number is *not* always identical to the social security number.

SEX

Record the patient's sex:

- 1 Male
- 2 Female
- 3 Other (hermaphrodite)
- 4 Transsexual (Surgically altered gender)
- 9 Not stated/ Unknown

AGE AT DIAGNOSIS

Record the patient's age at the time of initial diagnosis, in completed years. Some registry software automatically calculate age when date of birth and date of diagnosis are recorded.

- 000 Less than one year old
- 001 One year old, but less than two years old
- 002 Two years old
- " (Actual age in years)
- 100 One hundred years old
- 999 Unknown age

If year of birth and year of diagnosis are known, but age is unknown, calculate age at diagnosis by subtracting the patient's age at diagnosis from the year of diagnosis. Leave the month and day blank. (SEER Program Manual page 30)

DATE OF BIRTH

Record the exact date of the patient's birth in month, day, century and year. Estimate the year of birth when exact information is not available. It is preferable to estimate rather than to code the year as unknown. If there is no basis for estimating birth year, enter **9999** for the year.

Example: Patient is 50 years old when diagnosed on May 1, 2005. The medical record does not contain the birth date. Record **99** for month, **99** for day and estimate the birth year as 1955. The complete birth date would be 99/99/1955.

DATE OF BIRTH FLAG (SEER Program Manual 2010 page 31 and FORDS 2010 page 62)

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., such as 99999999 to indicate "unknown". This flag explains why there is no appropriate value in the corresponding date field, *Date of Birth*. (NAACCR Item #240).

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

PLACE OF BIRTH

Enter the name of the state, county or territory where the patient was born. Assign the most specific code possible using the three-digit Geocodes for Place of Birth as listed in *Appendix B of this document*. These codes were taken from *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, version 12.1*. These codes contain all states as well as foreign countries. Additionally, SEER Program Manual 2010 has Special Codes when needed:

- 000 United States, NOS
- 998 Non-United States, NOS
- 999 Unknown

Assign the most specific code possible from Appendix B of this manual.

RACE 1, 2, 3, 4, 5

Code the primary race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5. Race (and ethnicity) is defined by specific physical, hereditary and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship. "Origin" is defined by the U.S. Census Bureau as the heritage, nationality group, lineage, or in some cases, the country of birth of the person or the person's parents or ancestors before their arrival in the United States.

The five race fields (Race 1 - Race 5) allow for the coding of multiple races consistent with the 2000 Census. All resources in the facility, including the medical record, face sheet, physician and

nursing notes, photographs, and any other sources, must be used to determine race. If a facility does not print race in the medical record but does maintain it in electronic form, the electronic data must also be reviewed.

Please note that race is coded separately from “Hispanic ethnicity”. “Hispanic” is NOT a race and should not be coded in the race field. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do NOT code a patient stated to be Hispanic or Latino as 98 Other Race in Race 1 and 88 in Race 2 through Race 5.

Race Codes (NAACCR Registry Data Standards and Data Dictionary, Vol. II, version 12.1)

CODE	DESCRIPTION	CODE	DESCRIPTION
01	White, Caucasian	19	Not Used
02	Black	20	Micronesian, NOS
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	21	Chamorroan
04	Chinese	22	Guamanian, NOS
05	Japanese	23	Not Used
06	Filipino	24	Not Used
07	Hawaiian	25	Polynesian, NOS
08	Korean	26	Tahitian
09	*Code 09 was retired effective with NAACCR Version 12. See codes 15-17.	27	Samoan
10	Vietnamese	28	Tongan
11	Laotian	29	Not Used
12	Hmong	30	Melanesian NOS
13	Kampuchean (Cambodian)	31	Fiji Islander
14	Thai	32	New Guinean
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)	88	No further race documented
16	Asian Indian	96	Other Asian, including Asian, NOS and Oriental, NOS
17	Pakistani	97	Pacific Islander, NOS
18	Not Used	98	Other
		99	Unknown

Priorities for Coding Multiple Races (SEER Program Manual 2010 page 34)

1. Code 07 takes priority over all other codes.
 - Example:** Patient is described as Japanese and Hawaiian. Code Race 1 as 07 (Hawaiian), Race 2 as 05 (Japanese).
2. Codes 02-98 take priority over code 01.
3. Code only the specific race when both a specific race code and a non-specific race code apply.
 - a. Codes 04-17 take priority over code 96
 - b. Codes 16-17 take priority over code 15
 - c. Codes 20-32 take priority over code 97
 - d. Codes 01-32 and 96-97 take priority over code 98
 - e. Code 98 takes priority over code 99

Coding Instructions for Race

1. Do **not** use patient name as the basis for coding race.
 - a. See Coding Instruction 13, Exception, for the only situation in which name is taken into account when coding race.
2. Code race using the highest priority source available according to the list below (a is the highest and c is the lowest) when race is reported differently by two or more sources.

Sources in Priority Order

- a. The patient's self-declared identification
 - b. Documentation in the medical record
 - c. Death certificate
3. Assign the same race code(s) for all tumors for one patient.
 4. Code the race(s) of the patient in fields Race 1, Race 2, Race 3, Race 4, and Race 5.
 - a. Code 88 for the remaining race fields (Race 2 - Race 5) when only one race is reported
 5. Use the associated text field to document
 - a. Why a particular race code was chosen when there are discrepancies in race information
Example: The patient is identified as Black in nursing notes and White in a dictated physical exam. Use a text field to document why one race was coded rather than the other.
 - b. That no race information is available
 6. Code as 01 (White) when
 - a. The race is described as White or Caucasian regardless of place of birth
 - b. There is a statement that the patient is Hispanic or Latino(a) and no further information is available
Example: Sabrina Fitzsimmons is a Latina. Code race as 01 (White).
Note: Do not code 98 (Other) in this situation
Note: Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually White.
 7. Code race as 02 (Black) when the stated race is African-American, Black, or Negro.
 8. Assign code 03 for any person stated to be
 - a. Native American (western hemisphere)
OR
 - b. Indian, whether from North, Central, South, or Latin America.
 9. Assign a specific code when a specific Asian race is stated. Code 96 is not applicable when a specific race is known.
Example: Patient is described as Asian in a consult note and as second generation Korean-American in the history. Code Race 1 as 08 (Korean) and Race 2 through Race 5 as 88.
Note: Do not code 96 (Other Asian including Asian, NOS and Oriental, NOS) in a subsequent race field when a specific Asian race has been coded.
 10. Code the race based on birthplace information when the race is recorded as Oriental, Mongolian, or Asian and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation.
Example 1: Race is recorded as Asian and the place of birth is recorded as Japan. Code race as 05 (Japanese) because it is more specific than 96.
Example 2: The person describes himself as an Asian-American born in Laos. Code race as 11 (Laotian) because it is more specific than 96.
 11. Use the appropriate non-specific code 96 (Other Asian including Asian, NOS and Oriental, NOS), 97 (Pacific Islander, NOS) or 98 (Other) when there is no race code for a specific race.
Note: Document the specified race in a text field
 12. All race fields must be coded 99 (Unknown) when Race 1 is coded 99 (Unknown).
Note: Assign code 99 in Race 2-5 *only when* Race 1 is coded 99

13. Refer to the SEER Program Manual 2010, Appendix D “Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics” when race is unknown or not stated in the medical record and birth place is recorded.

a. In some cases, race may be inferred from the nationality. Use Appendix D to identify nationalities from which race codes may be inferred.

Example 1: Record states: “this native of Portugal...” Code race as 01 (White) per the Appendix.

Example 2: Record states: “this patient was Nigerian...” Code race as 02 (Black) per the Appendix.

Exception: Code Race 1 through Race 5 as 99 (Unknown) when patient’s name is incongruous with the race inferred on the basis of nationality. Do not code the inferred race when then patient’s name is incongruent with the race inferred on the basis of nationality.

Example 1: Patient’s name is Siddhartha Rao and birthplace is listed as England. Code Race 1 through Race 5 as 99 (Unknown).

Example 2: Patient’s name is Ping Chen and birthplace is Ethiopia. Code Race 1 through Race 5 as 99 (Unknown).

Coding Examples for Race:

Example 1: Patient is stated to be Japanese. Code as 05 (Japanese).

Example 2: Patient is stated to be German-Irish. Code as 01 (White).

Example 3: Patient is described as Arabian. Code as 01 (White).

Example 4: Patient described as a black female. Code as 02 (Black).

Example 5: 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.

Example 6: 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 7: The patient is described as Asian-American with Korean parents. Code race as 08 (Korean) because it is more specific than 96 (Asian) [-American].

Example 8: Race 1 through Race 5 in the cancer record are coded as 99 (Unknown). The death certificate states race as black. Change cancer record for Race 1 to 02 (Black) and Race 2 through Race 5 to 88.

Example 9: Race 1 is coded in the cancer record as 96 (Asian). Death certificate gives birthplace as China. Change Race 1 in the cancer record to 04 (Chinese) and code Race 2 through Race 5 as 88

SPANISH/HISPANIC SURNAME (SEER Program Manual 2010 page 40)

Code Spanish/Hispanic origin in this field. All available information should be used to determine the Spanish/Hispanic origin including the stated ethnicity in the medical record, stated Hispanic Origin on the death certificate, birthplace information in the history, and or language spoken. A person of Spanish/Hispanic origin may be of any race. Record applicable codes 1-8 if the patient has identified himself/herself as a specific Hispanic subgroup. Code 7 is assigned by the NJSCR.

Code	Description
0	Non-Spanish/Non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS; 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 of the categories 1-5.
7	Spanish surname only (effective with diagnosis on or after 1/1/1994) The only evidence of the person's Hispanic origin is the surname or maiden name and there is no evidence that he/she is not Hispanic .
8	Dominican Republic (effective with diagnosis on or after 1/1/2005)
9	Unknown whether Spanish/Hispanic or not

Coding Instructions

1. Coding Spanish surname or origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.
2. Assign code 7 when the only evidence of the patient's Hispanic origin is a surname or maiden name and there is no evidence that the patient is not Hispanic. Code 7 is ordinarily for central registry use only.
3. Portuguese, Brazilians and Filipinos are not presumed to be Spanish or non-Spanish.
 - a. Assign code 7 when the patient is Portuguese, Brazilian, or Filipino and their name appears on a Hispanic surname list.
 - b. Assign code 0 when the patient is Portuguese, Brazilian, or Filipino and their name does NOT appear on a Hispanic surname list.
4. Use all information to determine the Spanish/Hispanic Origin including
 - a. The ethnicity stated in the medical record
 - b. Hispanic origin stated on the death certificate
 - c. Birthplace
 - d. Information about life history and/or language spoken found in the abstracting process
 - e. A last name or maiden name found on a list of Hispanic/Spanish names

MARITAL STATUS

The field reflects the patient's marital status at diagnosis for each primary tumor.

- 1 Single (never married)
- 2 Married (including common law)
- 3 Separated
- 4 Divorced
- 5 Widowed
- 9 Unknown

Persons of the opposite sex living together as part of a long-term personal relationship would be coded to 2, Married (including common law). Also code "2" when the patient declares him/herself as married. Marriage is a self-reported state.

Persons of the same sex living together as part of a long-term personal relationship would be coded according to their legal status (usually single, separated, divorced, or widowed).

Note: if the patient has multiple tumors, marital status may be different for each tumor.

USUAL OCCUPATION

Record the patient's usual occupation **regardless of whether the patient is currently employed or retired**. Usual occupation refers to the type of job the individual performed during most of his/her working life. If the patient was a housewife/house husband and did **NOT** work outside the home for most of her/his adult life, record housewife or house husband. If the patient is a student and has never been employed, record as "never worked." If no information is available record "unknown." This data item applies only to patients who are 14 years or older at the time of diagnosis.

USUAL INDUSTRY

Record the type of activity carried on by the business/industry where the patient was employed for the longest time before diagnosis of this tumor (e.g., school, auto repair, food preparation). If possible, try to distinguish among "manufacturing," "wholesale," "retail," and "service". If type of industry is not known, record the name of company. If no information is available, code as unknown. Do not record retired.

MANAGING PHYSICIAN

This is the person responsible for the overall management of the patient during diagnosis and/or treatment of this primary. The physician's name may change with subsequent primaries. If so, record physician's name for each primary separately.

MEDICAL RECORD NUMBER

Record the medical record number or patient's identification number found in the patient's chart. This number is usually assigned by the reporting institution's Health Information Management (HIM) Department. If a patient has not been assigned one, record UNK. Record standard abbreviations for departments that do not use HIM medical record numbers such as Radiation Therapy.

PRIMARY PAYER AT DIAGNOSIS (SEER Program Manual 2010 page 46)

Primary Payer at Diagnosis identifies the patient's primary insurance carrier or method of payment at the time of initial diagnosis and/or treatment.

Coding Instructions

1. Code the type of insurance reported on the patient's admission record.
 2. Code the first insurance mentioned when multiple insurance carriers are listed on the patient's admission record.
 3. Code the patient's insurance at the time of initial diagnosis and/or treatment. Do not change the insurance information based on subsequent information.
- Please see table below.

Code	Label	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 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. "Gate-keeper model" is another term for describing this type of insurance.
21	Private Insurance: Fee-for-service	An insurance plan that does not have negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs. Medicaid other than described in code 35
35	Medicaid – administered through a managed care plan	Patient is enrolled in Medicaid through a Managed Care program (e.g. HMO or PPO). The managed care plan pays for all incurred costs.
60	Medicare/ Medicare, NOS	Federal government funded insurance for persons who are 62 years of age or older, or are chronically disabled (social security insurance eligible). Includes Medicare without supplement. 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. (See also, codes 63 and 64.)
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.
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare
64	Medicare with Medicaid	Federal government Medicare insurance with state-administered Medicaid supplement.

	eligibility	
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 treated at a military facility.
67	Veterans Affairs	Veterans treated in Department of Veterans Affairs facilities.
68	Indian/Public Health Service	Patient receives care at an Indian Health Service facility or at another facility and medical 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	Patient's medical record does not indicate whether or not the patient is insured.

DATE OF DIAGNOSIS (SEER Program Manual 2010 page 49)

The date of diagnosis is the month, day and year the tumor was first diagnosed, clinically or microscopically, by a recognized medical practitioner. If date of diagnosis is unknown, **year of diagnosis must be known or estimated**. Leave the month and/or day blank when they cannot be estimated or are unknown; year of diagnosis **cannot be blank or unknown**.

Coding Instructions

1. When the only information available is a positive pathology or cytology report, code the date the biopsy was done, not the date the report was dictated or transcribed.
2. The first diagnosis of cancer may be **clinical** (i.e., based on clinical findings or physician's documentation)

Note: Do not change the date of diagnosis when a clinical diagnosis is subsequently confirmed by positive histology or cytology.

Example: On May 15, 2010, physician states that patient has lung cancer based on clinical findings. The patient has a positive biopsy of the lung in June 3, 2010. The date of diagnosis remains May 15, 2010.

3. If no information about the date of diagnosis is available
 - a. Use the date of admission as the date of diagnosis
 - b. In the absence of an admission date, code the date of first treatment as the date of diagnosis
4. Positive **tumor markers** alone are not diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.

Example 1: The patient has an elevated PSA and the physical examination is negative. The physician documents only that the patient is referred for a needle biopsy of the prostate. The biopsy is positive for adenocarcinoma. The date of diagnosis is the date of the biopsy (do not code the date the procedure was dictated or transcribed).

Example 2: The patient has an elevated PSA and the physical examination is negative. The physician documents that he/she suspects that the patient has prostatic cancer and is referring the patient for a needle biopsy. The needle biopsy is positive. The date of diagnosis is the date the physician documented that he/she **suspects** that the patient has prostatic cancer.

Note: Positive tumor markers alone are never used for case ascertainment.

5. **Suspicious cytology alone** is not diagnostic of cancer. Use the date of clinical, histologic, or **positive** cytologic confirmation as the date of diagnosis.

Note: Do **not** use suspicious cytology alone for case ascertainment

6. Code the earlier date as the date of diagnosis when

a. A recognized medical practitioner says that, in **retrospect**, the patient had cancer at an earlier date

b. The original slides are reviewed and the pathologist documents that cancer was present
Code the diagnosis date as the date the original slides were made

Example: The patient had an excision of a benign fibrous histiocytoma in January 2010. Six months later, a wide re-excision was positive for malignant fibrous histiocytoma. The physician documents in the chart that the previous tumor must have been malignant. Code the diagnosis date as January 2010.

Note: Do not back-date the diagnosis

a. When the information on the previous tumor is unclear **AND/OR**

b. There is **no review** of previous slides **AND/OR**

c. There is **no physician's statement** that, in retrospect, the previous tumor was malignant

Example: The patient had a total hysterectomy and a bilateral salpingo oophorectomy (BSO) in June 2010 with pathology diagnosis of papillary cystadenoma of the ovaries. In December 2010 the patient is diagnosed with widespread metastatic papillary cystadenocarcinoma. The slides from June 2010 are not reviewed and there is no physician statement saying the previous tumor was malignant. The date of diagnosis is December 2010.

7. Code the **date of death** as the date of diagnosis for autopsy-only cases

8. Death Certificate Only (DCO) Cases: See the [NAACCR Death Clearance Manual](#), pg 42, for coding instructions

9. **Estimate the date of diagnosis** if an exact date is not available. Use all information available to calculate the month and year of diagnosis.

a. Estimating the **month**

i. Code "spring" to April

ii. Code "summer" or "middle of the year" to July

iii. Code "fall" or "autumn" as October

iv. For "winter" try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month of diagnosis.

v. Code "early in year" to January

vi. Code "late in year" to December

vii. Use whatever information is available to calculate the month of diagnosis

Example 1: Admitted October 2010. History states that the patient was diagnosed 7 months ago. Subtract 7 from the month of admission and code date of diagnosis to March 2010.

Example 2: Outpatient bone scan done January 2010 that states history of prostate cancer. The physician says the patient was diagnosed in 2010. Assume bone scan was part of initial workup and code date of diagnosis to January 2010.

viii. Code the month of admission when there is no basis for estimation

ix. Leave month blank (or convert 99 to blank) if there is no basis for approximation

b. Estimating the **year**

i. Code "a couple of years" to two years earlier

ii. Code "a few years" to three years earlier

iii. Use whatever information is available to calculate the year of diagnosis

iv. Code the year of admission when there is no basis for estimation

NURSING HOME AND HOSPICE RESIDENTS (Not hospitalized for their cancer; no information other than nursing home or hospice records and/or death certificate)

1. Use the best approximation for the date of diagnosis when the only information available is that the patient **had cancer while in the nursing home** and it is unknown whether the patient had cancer when admitted.
2. Code the date of admission to the nursing home as the date of diagnosis when:
 - a. The only information available is that the patient **had cancer when admitted** to the nursing home, or
 - b. The only information available is that the patient had cancer while in the nursing home, it is unknown whether the patient had cancer when admitted, and there is no basis for approximation.

IN UTERO DIAGNOSIS

Diagnoses made in utero are reportable only when the pregnancy results in a live birth. In the absence of documentation of stillbirth, abortion or fetal death, assume there was a live birth and report the case (SEER Program Manual 2010 page 3).

Example: Teratoma diagnosed via imaging at 37 weeks gestation (1/31/2010). Live birth by C-section 2/9/2010. Code the date of diagnosis as 01/31/2010. (SEER Program Manual page 52).

When a reportable diagnosis is confirmed prior to birth and the disease is not evident at birth due to regression, accession the case based on the pre-birth diagnosis, even if the disease is not evident at birth due to regression or treatment. (SEER Program Manual 2010 page 3)

DATE OF DIAGNOSIS FLAG (SEER Program Manual 2010 page 53)

Date flag fields were added beginning with diagnoses on or after 1/1/2010 as part of an initiative to standardize date fields. Date flags replace nondate information that had previously been transmitted in date fields. Coding 99999999 to indicate “unknown” is an example of nondate information that had been transmitted in date fields.

Coding Instructions:

Always leave blank. Date of Diagnosis will always have a full or partial date recorded.

GRADE PATH VALUE (Collaborative Staging Manual, version 2, page I-81)

Description

This field documents the numerator or first number of a tumor grade reported in a 2, 3, or 4 grade system. It supplements but does not replace the field Grade/Differentiation (NAACCR Item #440), which is part of the ICD-O-3 morphology code structure and may be converted from another grading system or coded by a different set of rules. Grade Path Value is paired with Grade Path System to describe the original grade of the tumor.

Note: This data item is separate from the CS data items but is included in this manual because of its relationship to the Collaborative Stage Data Collection System.

Code
1
2
3
4
Blank No 2, 3, or 4 grade system available

Instructions for Coding

1. **Code the histologic grade** or differentiation reported in the medical record. Do not convert the grade described in the pathology report.
 - a. Code this field from the same tissue used to code the sixth digit of the ICD-O-3 morphology code (Grade/Differentiation). This field identifies how the original grade of the tumor was described.
 - b. Do not convert the terms *well*, *moderately*, or *poorly differentiated*, *low/high*, or *anaplastic* into codes in this field.
 - c. Code the histologic grade/differentiation in priority over a nuclear or architectural grade.
 - d. If grade is described in the medical record as a fraction (x/y), this data field is the numerator. In other words, this field is the first or upper number of a grade expressed in two parts.

Examples: Synoptic report states grade ii of iii. *Code Grade Path Value as 2.*
Final pathologic diagnosis listed as grade 1/4. *Code Grade Path Value as 1.*
Microscopic description reports high grade III of III. *Code Grade Path Value as 3.*
 - e. Do not report grading systems such as Bloom-Richardson for breast or Fuhrman for kidney or Gleason for prostate or WHO grade as coded values in this field. These grading systems are coded in a site-specific factor in their respective schemas.
 - f. The code in this field cannot be greater than the corresponding code in Grade Path System.
 - g. For lymphomas and hematopoietic malignancies, this field is blank.

GRADE PATH SYSTEM (Collaborative Staging Manual, version 2, page I-82)

Description

This field documents the denominator or second number of a tumor grade reported in a 2, 3, or 4 grade system. It supplements but does not replace the field Grade/Differentiation (NAACCR Item #440), which is part of the ICD-O-3 morphology code structure and may be converted from another grading system or coded by a different set of rules. Grade Path System is paired with Grade Path Value to describe the original grade of the tumor.

Note: This data item is separate from the CS data items but is included in this manual because of its relationship to the Collaborative Stage Data Collection System.

Code
2
3
4
Blank
No 2, 3, or 4 grade system available

Instructions for Coding

1. **Code the grading system** reported in the medical record. Do not convert the grade described in the pathology report.
 - a. Code this field from the same tissue used to code the sixth digit of the ICD-O-3 morphology code (Grade/Differentiation). This field identifies how the original grade of the tumor was described.

b. If grade is described in the medical record as a fraction (x/y), this data field is the denominator. In other words, this field is the second or lower number of a grade expressed in two parts.

Examples: Synoptic report states grade ii of iii. *Code Grade Path System as 3.*

Final pathologic diagnosis listed as grade 1/4. *Code Grade Path System as 4.*

Microscopic description reports high grade III of III. *Code Grade Path System as 3.*

c. Leave this field blank if another grading system is used in the pathology report. For example, do not report grading systems such as Bloom-Richardson for breast or Fuhrman for kidney or Gleason for prostate or WHO grade as coded values in this field. These grading systems are coded in a site-specific factor in their respective schemas.

d. For lymphomas and hematopoietic malignancies, this field is blank.

LYMPH-VASCULAR INVASION (Collaborative Staging Manual, version 2, page I-79)

Description

This field records the absence or presence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist. The presence of lymph-vascular invasion may affect the patient’s prognosis.

Note: This data item is separate from the CS data items but is included in this manual because of its relationship to the Collaborative Stage Data Collection System. Lymph-vascular invasion is an item of interest to both pathologists and clinicians and is mentioned in many chapters of the AJCC Cancer Staging Manual, seventh edition.

Note: This field is *required* for mapping of T in some sites, such as testis and penis.

Code
0
1
8
9
Unknown if lymph-vascular invasion present

Definition

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.

Instructions for Coding

1. **Code from pathology report(s).** Code the absence or presence of lymph-vascular invasion as described in the medical record.
 - 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.

2. Use of codes.

a. Use code 0 when the pathology report indicates that there is no lymph-vascular invasion.

b. 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.

c. Use code 8 for cases that have no microscopic examination of a primary specimen and for the following primary sites:

- Hodgkin and Non-Hodgkin lymphoma
- Leukemias
- Hematopoietic and reticuloendothelial disorders
- Myelodysplastic syndromes including refractory anemias and refractory cytopenias
- Myeloproliferative disorders

d. Use code 9 when it is not possible to determine whether lymph-vascular invasion is present.

COLLABORATIVE STAGE

Please refer to the Collaborative Staging Manual and Coding Instructions for codes and instructions. Schemas for the collaborative staging system apply to cases diagnosed January 1, 2004 and later. For cases diagnosed prior to January 1, 2004 please refer to the coding system applicable to the time of diagnosis.

The Collaborative Staging System is a carefully selected set of data items that describe how far a cancer has spread at the time of diagnosis. Most of the data items have traditionally been collected by cancer registries, including tumor size, extension, lymph node status, and metastatic status. New items were created to collect information necessary for the conversion algorithms, including the evaluation fields that describe how the collected data were determined, and site/histology-specific factors that are necessary to derive the final stage grouping for certain primary cancers. In addition to the items coded by the registrar, this unified data set also includes several data items derived from the computer algorithms that classify each case in multiple staging systems: the sixth edition of the AJCC TNM system (TNM), the seventh edition of the AJCC TNM System (TNM), Summary Stage 1977 (SS77), and SEER Summary Stage 2000 (SS2000).

Please note that there are distinct versions of the Collaborative Staging System based on year of diagnosis. For those cases diagnosed 2004 through 2009, version 1 should be consulted. For cases diagnosed 2010 and later, please refer to version 2. Manuals are available online at <http://www.cancerstaging.org/cstage/>.

FIRST COURSE OF THERAPY: SPECIAL NOTES FOR NJ FACILITIES

NO CANCER-DIRECTED THERAPY

Definition of Cancer-directed therapy: Treatment administered to the patient in an attempt to destroy or modify cancer tissue.

"Cancer tissue" means proliferating malignant cells or an area of active production of malignant cells such as adjacent tissues or distant sites. In some instances, malignant cells are found in tissues where they did not originate and where they do not reproduce, such as malignant cells

found at thoracentesis or paracentesis. Procedures that remove malignant cells, but do not treat a site of proliferating cells are not considered cancer therapy.

If the patient only receives supportive or symptomatic therapy, it is not considered cancer-directed therapy. The term "palliative" can mean either non-curative or alleviation of symptoms. Therefore "palliative" can fall within the definition of cancer-directed treatment or non-cancer directed therapy. Surgical procedures performed to diagnose/stage disease (exploratory) or for relief of symptoms (palliative) are considered diagnostic, staging, and palliative procedures.

Please refer to the SEER Program Manual 2010, pages 96 through 100, for additional details.

DATE THERAPY INITIATED

Record the start date of the first-course of therapy. This may be the start date of any type of treatment for this tumor; surgery, chemotherapy, radiation therapy, or other types of therapy. Treatment might be given in a hospital or non-hospital setting. Date fields are recorded in the month, day, century, year format (MMDDCCYY). Any unknown values should be left blank. Therefore, a therapy date of March, 2010 would appear as 03__ 2010.

NJSCR is a SEER Registry, and must abide by SEER coding rules. Please see the SEER coding instructions that follow:

Coding Instructions (SEER Program Manual 2010 page 102)

1. Code the **start date** of the first therapy. The first therapy may be recorded in the following data items:
 - Surgery of Primary Site
 - Scope of Regional Lymph Node Surgery
 - Surgical Procedure of Other Sites
 - Radiation Therapy
 - Chemotherapy
 - Hormone Therapy
 - Code the date that the prescription was written
 - Immunotherapy
 - Hematologic Transplant and Endocrine Procedures
 - Other Therapy
2. Code the date of **excisional biopsy** as the date therapy initiated when it is the first treatment. Code the date of a biopsy documented as incisional if further surgery reveals no residual or only microscopic residual.

Example: Breast core needle biopsy with diagnosis of infiltrating duct carcinoma; subsequent re-excision with no residual tumor noted. Code the date of the needle biopsy as the excisional biopsy date.
3. Record the actual date of treatment when treatment is performed prior to birth. Record the type of treatment in the appropriate data item, for example, Surgery of Primary Site, or Radiation.

Example: 1-3-2010 fetus diagnosed with malignant teratoma. The teratoma is resected in utero 1-10-2010. Live birth on 4-18-2010. Code the date therapy initiated as January 10, 2010.
4. Code the **date** unproven therapy was initiated as the date therapy initiated.
5. Code the date of admission to the hospital for inpatient or outpatient treatment when the exact date of the first treatment is **unknown**.
6. Leave **blank**
 - a. When it is known the patient had first course therapy, but it is impossible to estimate the date

- b. When it is unknown whether the patient had treatment
- c. Autopsy only cases

A new item, *RX Summ–Treatment Status* (NAACCR Item #1285), implemented in 2010, summarizes whether the patient received any first course treatment, no treatment, or is being managed by active surveillance.

Estimating Dates

Estimating the **month**:

1. Code “spring of” to April
2. Code “summer” or “middle of the year” to July
3. Code “fall” or “autumn” as October
4. For “winter of,” try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month.
5. Code “early in year” to January
6. Code “late in year” to December
7. Use whatever information is available to calculate the month
8. Code the month of admission when there is no basis for estimation
9. Leave month blank if there is no basis for approximation

Estimating the **year**

1. Code “a couple of years” to two years earlier
2. Code “a few years” to three years earlier
3. Use whatever information is available to calculate the year
4. Code the year of admission when there is no basis for estimation

DATE THERAPY INITIATED FLAG (SEER Program Manual 2010 page 104)

Date flag fields were added beginning with diagnoses on or after 1/1/2010 as part of an initiative to standardize date fields. Date flags replace nondate information that had previously been transmitted in date fields. Coding 99999999 to indicate “unknown” is an example of nondate information that was previously transmitted in date fields.

Code	Label	Definition
Blank		A valid date value is provided in Date of Initial Treatment
10	No information	No information whatsoever can be inferred
11	Not applicable	No proper value is applicable in this context
12	Unknown	A proper value is applicable but not known

- Code 12 if the *Date of First Course of Treatment* can not be determined, but the patient did receive first course treatment.
- Code 10 if it is unknown whether any treatment was administered.
- Code 11 if the initial diagnosis was at autopsy.

- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Please note there are also Rx Date Flags for all treatments: Surgery, Radiation, Chemotherapy, Hormones, BRM, and Other. The flags, and the coding instructions for these fields differ slightly; please consult the appropriate manuals.

TREATMENT STATUS (SEER Program Coding & Staging Manual 2010 page 105)

Treatment Status documents active surveillance (watchful waiting). Before this data item was implemented, active surveillance or watchful waiting was deduced from the codes in each of the treatment fields. This data item is effective for cases diagnosed January 1, 2010 and later.

Code	Label	Definition
0	No treatment given	The patient did not receive any treatment
1	Treatment given	The patient received treatment
2	Active surveillance (watchful waiting)	The patient was under active surveillance or watchful waiting during the first course of treatment
9	Unknown if treatment given	It is unknown whether or not the patient received treatment

Leave blank for cases diagnosed before 2010.

IN UTERO DIAGNOSIS AND TREATMENT

Beginning in 2009, diagnosis and treatment dates for a fetus prior to birth are to be assigned the actual date of the event. In the past, those dates were set by rule to the date the baby was born. The exact date may be used for cases diagnosed prior to 2009. (FORDS 2010 page 14)

According to NAACCR, diagnoses made in utero are reportable if the pregnancy results in a live birth. When a reportable diagnosis is confirmed prior to birth and the disease is not evident at birth due to regression, accession the case based on the pre-birth diagnosis, even if the disease is not evident at birth due to regression or treatment. (NAACCR version 12.1, Vol. II, Chapter III, page 20)

CANCER-DIRECTED THERAPY

GENERAL SURGERY CODING RULES

The NJSCR collects the following site specific surgery scheme:

Surgery of Primary Site	2 digits
Scope of Regional Lymph Node Surgery	1 digit
Number of Regional Lymph Nodes Examined	2 digits
Surgical Procedure of Other Site	1 digit

The surgery codes that should be used can be found in site specific chapter of the SEER Program Coding and Staging Manual 2010 Appendix C or FORDS 2010 Appendix B. The NJSCR does not require surgical approach or margins to be coded. Surgery codes for cases diagnosed prior to 2010 can be found at

<http://seer.cancer.gov/tools/SEER2003.surg.prim.site.codes.pdf> .

- Once it is determined that cancer-directed surgery was performed, use the best information in the operative/pathology reports to determine the operative procedure. Do *NOT depend on the name of the procedure since it may be incomplete or incorrect.*
- 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.
- 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 that this is the case.
For example:
 1. Resection of a stomach which had been partially excised previously is coded as total removal of stomach.
 2. Removal of a cervical stump is coded as total removal of uterus.
 3. Lobectomy of a lung with a previous wedge resection is coded as total removal of lobe.
- Any lymph node dissection done as a separate procedure within the first-course of cancer-directed therapy is to be coded.
- If an excisional biopsy is followed by "re-excision" or "wide excision" within the first-course of cancer-directed therapy, include that later information in coding site-specific surgery.
- If multiple primaries are excised at the same time, code the appropriate surgery for each site. Examples:
 - 1) If a total abdominal hysterectomy was done for a patient with two primaries, one of the cervix and one of the endometrium, code each as having had a total abdominal hysterectomy.
 - 2) If a total colectomy was done for a patient with multiple primaries in several segments of the colon, code total colectomy for each of the primary segments.
- Ignore the use of laser if used only for the initial incision.
- Surgical procedures performed solely for the purpose of establishing a diagnosis/stage or for the relief of symptoms, and procedures such as brushings, washings, and aspiration of cells as well as hematologic findings (peripheral blood smears) are not considered cancer therapy and are not to be coded.
- Surgery for extranodal lymphomas should be coded using the scheme for the extranodal site. Example:
 - Lymphoma of the stomach is to be coded using the scheme for stomach.

RADIATION THERAPY (SEER Program Coding & Staging Manual page 114)

Record the type and date (MMDDCCYY) of radiation administered to the primary or metastatic site. Record any type of radiation in this field regardless of source, field being treated or intent of treatment (curative or palliative). Include all procedures that are a part of the first-course of treatment, whether delivered at the reporting institution or at others.

Regional Treatment Modality

Record the method or source of radiation administered as a part of the first course of treatment. Record all radiation that is given as part of first course therapy, even if it is palliative.

The Commission on Cancer (CoC) does not require the collection of the radiation summary data field effective 1/1/2002. If this data item is not reported by a CoC hospital, SEER central registries can generate the code for this field by combining information from the **Regional Treatment**

Modality and/or Boost Treatment fields required by CoC. Tables for deriving the radiation summary field are included in this section.

Code	Description
0	None; diagnosed at autopsy
1	Beam radiation
2	Radioactive implants
3	Radioisotopes
4	Combination of 1 with 2 or 3
5	Radiation, NOS – method or source not specified
7	Patient or patient’s guardian refused radiation therapy
8	Radiation recommended, unknown if administered
9	Unknown if radiation administered

Coding Instructions

1. Assign **code 0** when
 - a. There is no information in the patient’s medical record about radiation AND
 - i. It is known that radiation is not usually performed for this type and/or stage of cancer
 - OR
 - ii. There is no reason to suspect that the patient would have had radiation
 - b. The treatment plan offered multiple treatment options and the patient selected treatment that did not include radiation
 - c. Patient elected to pursue no treatment following the discussion of radiation treatment. Discussion does not equal a recommendation.
 - d. Watchful waiting/active surveillance (prostate)
 - e. Patient diagnosed at autopsy
 - f. Radiotherapy recommended, but patient died before receiving radiotherapy

Note: SEER does not collect the Reason For No Radiation field. However, those who abstract using software that captures this data item can identify these cases.
2. Assign **code 1** for
 - a. Beam radiation directed to cancer tissue. The source of the beam radiation is not coded. Sources may include, but are not limited to: X-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, stereotactic radiosurgery such as gamma knife, and proton beam.
 - b. Total body irradiation (TBI) prior to a bone marrow transplant
3. Assign **code 2** when the radiation is delivered by interstitial implant, molds, seeds, needles or intracavitary applicators. The radioactive material used in implants includes, but is not limited to: cesium, radium, radon, radioactive gold, and iodine.

Example: Brachytherapy with 125 seeds. Assign code 2. Seeds are always low dose therapy because they are left in place and the radioactivity decays over time.
4. Assign **code 3** when radioactive isotopes are given orally, intracavitary or by intravenous injection. Radioactive isotopes include but are not limited to: I-131 or P-32.
5. Assign **code 3** for 90-Yttrium and for 131-Iodine when given with Rituxan as treatment for lymphoma. (Code Rituxan as **chemotherapy**).

Note: Rituxan is given in combination with the monoclonal antibody Zevalin conjugated to 90-Yttrium or the monoclonal antibody Bexxar conjugated to 131-Iodine in the treatment of NHL. The monoclonal antibody is only the delivery agent for the radioisotope. Do not code Zevalin or Bexxar as chemotherapy. See the definition of [Monoclonal Antibodies](#).

6. Assign **code 4** when the patient has beam radiation **and** either radioactive implants or radioisotopes.
7. Assign **code 8** when
 - a. Radiation has been recommended, but there is no confirmation of its actually being delivered
 - b. The only information available is that the patient was referred to a radiation oncologist

Note: Review cases coded 8 periodically for later confirmation of radiation therapy

Example: Mammocyte intracavitary radiation therapy device was placed in the breast, but there is no documentation of radiation actually being given. Assign code 8. Check this case periodically and update the code when further information becomes available.
8. Assign **code 9** when there is no documentation that radiation was recommended or performed

DATE SYSTEMIC THERAPY STARTED

Records the date of initiation for systemic therapy that is part of the first-course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormonal agents, biological response modifiers, bone marrow transplants, stem cell harvests and surgical and/or radiation endocrine therapy. This data field should include dates for agents that have been administered locally such as those given intravesical or intrathecal therapy, such as BCG instilled into the bladder.

Record the first or earliest date on which systemic therapy was administered. Systemic therapy includes Chemotherapy, Hormonal Therapy, Immunotherapy, Hematologic Transplant and Endocrine Procedures.

Code	Definition
MMDDCCYY	The date systemic therapy started is the month, day, and year that systemic therapy was first administered. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year. If the exact date on which systemic therapy was started is not available, then record an approximate date.
Leave blank	When no systemic therapy is administered. Diagnosed at autopsy.

CHEMOTHERAPY (SEER Program Coding & Staging Manual page 120)

The data item Chemotherapy records the chemotherapy given as a part of the first-course of treatment or the reason that chemotherapy was not given. See SEER*Rx <http://seer.cancer.gov/tools/seerrx/> for chemotherapy drug codes for cases diagnosed 1/1/2005 and after.

Chemotherapeutic agents are chemicals that affect cancer tissue by means other than hormonal manipulation. The agents inhibit the production of cancer cells by interfering with DNA synthesis and mitosis. They may be divided into three classes with respect to their dependence on the cell cycle.

1. Alkylating agents are **not cell-cycle-specific**. Although they are toxic to all cells, they are especially toxic to proliferating cells.
2. Other drugs are **cell-cycle-specific**. Cells must be proliferating for these drugs to be effective.
3. Cell-cycle-specific drugs may also be **cell-cycle phase-specific**; such drugs are active only in one stage of the cell cycle.

Chemotherapy agents are also grouped by their ingredients and the way they attack the cells. Those groups are:

1. Alkylating
2. Antimetabolites
3. Natural products
4. Other miscellaneous

Codes

00	None, chemotherapy was not part of the planned first-course of therapy; diagnosed at autopsy.
01	Chemotherapy administered as first-course therapy, but the type and number of agents is not documented in the patient's 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's risk factors (comorbid conditions, advanced age, etc.).
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first-course of therapy. No reason was stated in patient's record.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but the treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient's record.
88	Chemotherapy 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 the patient's record. Death certificate only.

Code 00:

- If chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- If the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy.
- If follow-up with the specified specialist or facility indicates the patient was never there.
- If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

Code 87:

- If the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

Code 88:

- If it is known that a physician recommended the patient receive chemotherapy but no further documentation is available yet to confirm its administration
- To indicate referral was made medical oncologist and the registry must follow to determine whether it was given.
- Cases coded 88 must be followed to determine what kind of chemotherapy was administered or why it was not.

Code 99:

- 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.

Definitions

Chemotherapy recommended: There was a consult recommending chemotherapy or the attending physician documented that chemotherapy was recommended. **A referral to a clinical oncologist does not equal a recommendation.**

Multiple agent chemotherapy: Two or more chemotherapeutic agents were administered to destroy cancer tissue during the first-course of therapy. The chemotherapeutic agents may or may not have been administered with other drugs classified as immunotherapy, hormone therapy, ancillary or other treatment.

Single agent chemotherapy: Only one chemotherapeutic agent was administered to destroy cancer tissue during the first-course of therapy. The chemotherapeutic agent may or may not have been administered with other drugs classified as immunotherapy, hormone therapy, ancillary, or other treatment.

HORMONE THERAPY (SEER Program Coding & Staging Manual page 125)

The data item Hormone Therapy records therapy administered as first course treatment that affects cancer tissue by adding, blocking, or removing the action or production of hormones. See [SEER*Rx](#) for hormone therapy drug codes.

Note: **Surgical removal of organs** for hormone manipulation is **not** coded in this data item. Code these procedures in the data field Hematologic Transplant and Endocrine Procedures.

Code	Description
00	None, hormone therapy was not part of the planned first course of therapy; not usually administered for this type and/or stage of cancer; diagnosed at autopsy only
01	Hormone therapy administered as first course therapy
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy
86	Hormone therapy was not administered. It was recommended by the patient's physician but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered.

Coding Instructions

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

2. Assign **code 00** when

- a. There is no information in the patient's medical record about hormone therapy **AND**
 - i. It is known that hormone therapy is not usually performed for this type and/or stage of cancer

OR

- ii. There is no reason to suspect that the patient would have had hormone therapy

- b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include hormone therapy
- c. Patient elected to pursue no treatment following the discussion of hormone therapy treatment. Discussion does not equal a recommendation.
- d. Watchful waiting, active surveillance (prostate)
- e. Patient diagnosed at autopsy
- f. Hormone treatment was given for a non-reportable condition or as chemoprevention prior to diagnosis of a reportable condition

Example 1: Tamoxifen given for hyperplasia of breast four years prior to breast cancer diagnosis. Code 00 in Hormone therapy. Do not code tamoxifen given for hyperplasia as treatment for breast cancer.

Example 2: Patient with a genetic predisposition to breast cancer is on preventative hormone therapy. Do not code hormone therapy given before cancer is diagnosed.

3. Assign **code 88** when the only information available is that the patient was referred to an oncologist.

Note: Review cases coded 88 periodically for later confirmation of hormone therapy

4. Assign **code 99** when there is no documentation that hormone therapy was recommended or performed.

Coding Examples

Example 1: Endometrial cancer may be treated with progesterone. Code all administration of progesterone to patients with endometrial cancer in this field. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer.

Example 2: Follicular and papillary cancers of the thyroid are often treated with thyroid hormone to suppress serum thyroid-stimulating hormone (TSH). If a patient with papillary and/or follicular cancer of the thyroid is given a thyroid hormone, code the treatment in this field.

Example 3: Bromocriptine suppresses the production of prolactin, which causes growth in pituitary adenoma. Code Bromocriptine as hormone treatment for pituitary adenoma.

Hormone Categories

Hormones may be divided into several categories

- Androgens: Fluoxymesterone
- Anti-androgens: Bicalutamide (Casodex), flutamide (Eulexin), and nilutamde (Nilandron)
- Corticosteroids: Adrenocorticotrophic agents
- Estrogens
 - Progestins
- Estrogen antagonists, Anti-estrogens: Fulvestrant (Faslodex), tamoxifen, and toremifene (Fareston).
- Aromatase inhibitors, Antiaromatase: Anastrozole (Arimidex), exemestane (Aromasin), and letrozole (Femara)
- GnRH or LH-RH: Lupron, Zoladex

IMMUNOTHERAPY (BIOLOGICAL RESPONSE MODIFIER THERAPY) (SEER Program Coding & Staging Manual page 127)

The data item Immunotherapy records immunotherapeutic (biological therapy, biotherapy or biological response modifier) agents administered as first course of therapy. See SEER*RX for immunotherapy codes. Immunotherapy **uses** the body's **immune system**, either directly or indirectly, to fight cancer or to lessen the side effects that may be caused by some cancer treatments. Record only those treatments that are administered to affect the cancer cells.

See [SEER*Rx](#) for immunotherapy drug codes.

Immunotherapy is **designed** to:

1. Make **cancer cells** more **recognizable** and therefore more **susceptible** to destruction by the immune system.
2. **Boost** the killing power of **immune** system cells, such as T-cells, NK-cells, and macrophages.
3. **Alter** the **growth patterns** of cancer cells to promote behavior like that of healthy cells.
4. **Block** or **reverse** the process that **changes** a normal cell or a pre-cancerous cell into a cancerous cell.
5. **Enhance** the body's ability to **repair** or **replace** normal cells damaged or destroyed by other forms of cancer treatment, such as chemotherapy or radiation.
6. **Prevent** cancer cells from **spreading** to other parts of the body.

Code	Description
00	None, immunotherapy was not part of the planned first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only
01	Immunotherapy was administered as first course therapy
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy
86	Immunotherapy was not administered; it was recommended by the patient's physician but was not administered as part of the first-course of therapy. No reason was noted in the patient's 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 the patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered
99	It is unknown if immunotherapy was recommended or administered because it is not stated in patient record.

Types of immunotherapy

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

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

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

Monoclonal Antibodies: Monoclonal antibodies (Mab) are produced in a laboratory. The artificial antibodies are used in a variety of ways in systemic therapy. Some are injected into the patient to seek out and disrupt cancer cell activities, such as rituximab (Rituxan) for lymphoma and trastuzumab (Herceptin) for breast. **When the monoclonal antibody disrupts tumor growth, it is coded as chemotherapy.**

Other Mabs are linked to radioisotopes (conjugated monoclonal antibodies). The Mab finds and attaches to the target tumor cells and brings with it the radioisotope that actually kills the tumor cell. The monoclonal antibody itself does nothing to enhance the immune system. **Conjugated monoclonal antibodies such as tositumomab (Bexxar) or ibritumomab (Zevalin) are coded to the part of the drug that actually kills the cells, usually radioisotopes.**

A third function of Mabs is to enhance the immune response against the cancer, either by identifying tumor cells that are mimicking normal cells, or by boosting the body's natural defenses that destroy foreign cells. At the present time (2006), there are no FDA-approved monoclonal antibodies that are pure immunotherapy for cancer. **Consult SEER*Rx for the treatment category in which each monoclonal antibody should be coded.**

Special Notes about Immunotherapy (Biological Response Modifiers):

Drugs such as Neulasta (a growth factor) and Procrit (stimulates red blood cell production) are ancillary agents. **Do not code these drugs as immunotherapy agents.** If unsure, please consult SEER*Rx for the correct treatment category.

Instructions for Coding

1. Assign **code 00**

- a. When there is no information in the patient's medical record about immunotherapy **AND**
 - i. It is known that immunotherapy is not usually performed for this type and/or stage of cancer

OR

- ii. There is no reason to suspect that the patient would have had immunotherapy
- b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include immunotherapy.
- c. Patient elects to pursue no treatment following the discussion of immunotherapy. Discussion does not equal a recommendation.
- d. Watchful waiting, active surveillance (prostate)
- e. Patient diagnosed at autopsy
- f. For anti-thymocyte globulin treatment. Anti-thymocyte globulin is used to treat transplant rejection. Do not code as immunotherapy.

OTHER THERAPY (SEER Program Coding & Staging Manual 2010 page 134)

Other Therapy identifies treatment given that cannot be classified as surgery, radiation, systemic therapy, or ancillary treatment. This data item includes all complementary and alternative medicine used by the patient in conjunction with conventional therapy or in place of conventional therapy.

Code	Description
0	None
1	Other
2	Other-Experimental
3	Other-Double Blind
6	Other-Unproven
7	Refusal
8	Recommended, unknown if administered
9	Unknown

1. Assign **Code 0** when
 - a. There is no information in the patient's medical record about other therapy
AND
 - i. It is known that other therapy is not usually performed for this type and/or stage of cancer **OR**
 - ii. There is no reason to suspect that the patient would have had other therapy
 - b. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include other therapy.
 - c. Patient elects to pursue no treatment following the discussion of other therapy. Discussion does not equal a recommendation.
 - d. Patient diagnosed at autopsy.
2. Assign **code 1** for
 - a. Hematopoietic treatments such as: phlebotomy, transfusions, or aspirin
 - b. PUVA (Psoralen (P) and long-wave ultraviolet radiation (UVA)) in the **RARE** event that it is used as treatment for extremely thin melanomas or cutaneous T-cell lymphomas (e.g., mycosis fungoides)
 - c. Cancer treatment that could not be assigned to the previous treatment fields (surgery, radiation, chemotherapy, immunotherapy, or systemic therapy)
3. Assign **code 2** for any experimental or newly developed treatment, such as a clinical trial, that differs greatly from proven types of cancer therapy.
Note: Hyperbaric oxygen has been used to treat cancer in clinical trials, but it is also used to promote tissue healing following head and neck surgeries. Do not code the administration of hyperbaric oxygen to promote healing as an experimental treatment.
4. Assign **code 3** when the patient is enrolled in a double blind clinical trial. When the trial is complete and the code is broken, review and recode the therapy.
5. Assign **code 6** for
 - a. **Unconventional** methods whether they are the only therapy or are given **in combination** with conventional therapy
 - b. Alternative therapy **ONLY** if the patient receives no other type of treatment
6. Assign **code 8** When **other therapy** was recommended by the physician **but there is no information** that the treatment was given.
7. Assign **code 9** when **there is no** documentation that other therapy was recommended or performed

A quote from the website for the National Cancer Institute (NCI), Office of Cancer Complementary and Alternative Medicine (OCCAM) defines Complementary and Alternative Medicine (CAM) as any medical system, practice, or product that is not thought of as "western medicine" or standard medical care. See complete information on types of complementary and alternative medicine at <http://nccam.nih.gov/health/whatisacam/>

DATE OF LAST FOLLOW-UP OR DEATH

The date of last follow-up or death consists of eight digits recorded in the month, day, century, year format (MMDDCCYY) with 99 for unknown day or month and 9999 for unknown year. This data item records the date of last follow up or the date of death.

NJSCR is required by SEER to update the follow up information on all cases on an annual basis. The exception is carcinoma in situ of the cervix diagnosed on or after 1/1/1996. Follow-up is a very important aspect of the NJSCR reporting system. Follow-up is the annual monitoring of patients throughout their life to ascertain and calculate survival rates. Hospital programs approved by ACoS must also update follow-up data annually. Information on vital status can be obtained from the medical records (patient may be readmitted), the patient's physician, contact letters, and telephone calls. The NJSCR obtains follow up information from passive sources using

a case matching software. However, hospitals will be contacted for follow up information for special populations such as pediatric cases and as needed for specific studies. This contact will be initiated by a phone call usually followed by a faxed list of cases that had been reported by that facility.

If a second/multiple primary is diagnosed, a separate abstract must be submitted electronically for the new primary.

Coding instructions

1. Code the date the patient was actually seen by the physician or contacted by the hospital registry as the follow up date. Do not code the date the follow up report was received.
2. Do not change the follow up date unless new information is available.
3. The field is associated with the patient, not the cancer, so all records (primary sites) for the same patient will have the same follow up date.

DATE OF LAST FOLLOW-UP OR DEATH FLAG (SEER Program Coding & Staging Manual 2010 page 140)

Date flag fields were added beginning with diagnoses on or after 1/1/2010 as part of an initiative to standardize date fields. Date flags replace nondate information that had previously been transmitted in date fields. Coding 99999999 to indicate “unknown” is an example of nondate information that was previously transmitted in date fields.

Code	Label	Definition
Blank	A valid date value is provided in Date of Last Follow up or Death	
12	Unknown	A proper value is applicable but not known

FOLLOW-UP SOURCE

Identifies the source of the latest follow-up information:

- 0 Reported hospitalization
- 1 Readmission
- 2 Physician
- 3 Patient
- 4 Department of Motor Vehicles
- 5 Medicare/Medicaid file
- 7 Death certificate
- 8 Other
- 9 Unknown

PATIENT'S VITAL STATUS

Record the patient's vital status as of the date recorded in the "Date of Last Contact or Death" field. Use the most accurate information available.

- 1 Alive
- 0 Dead

UNDERLYING CAUSE OF DEATH

Record the cause of death listed on the death certificate by recording the underlying cause of death ICD code. This is the official underlying cause of death coded from the death certificate using ICD-10 for all deaths beginning the year of 1999. For prior years use the respective versions of ICD-7, ICDA-8, or ICD-9 codes based on year of death.

Beginning for deaths in 1999, the United States agreed to code all deaths using the *International Statistical Classification of Diseases and Related Health Problems*, Tenth Revision (ICD-10). The ICD-10 codes have up to four characters: a letter followed by 2 or 3 digits.

Special Codes

- 0000 Patient alive at last follow-up
- 7777 State death certificate or listing not available
- 7797 State death certificate or listing available, but underlying cause of death not coded

Coding Instructions for ICD-10

1. Use the underlying cause of death as coded by a State Health Department even if the code seems to be in error.
2. Report the coded underlying cause of death code from another source such as NDI plus or state data exchange if the coded death certificate is not available.
3. If the coded underlying cause of death code is not on the death certificate and is not available from other sources, code 7797.
4. If neither the death certificate nor the coded underlying cause of death is available, code 7777.
 - Example:** Medical doctor states patient died, but death certificate not available (not on state death file, not available through federal or state agencies), code 7777.
5. Ignore (do not record) decimal points when copying codes.
6. The cause of death code is commonly four characters. Ignore (do not code) a fifth character if present.
7. Left justify the codes; if less than four characters, left justify and add a 9 to the right.
8. If the underlying cause of death code is not available, do not attempt to code the underlying cause of death unless you have a trained ICD-10 nosologist on staff or on consult.

The ICD-10 codes consist of four characters- a letter followed by two or three digits.

Examples:

UNDERLYING CAUSE OF DEATH	ICD-10	CODE
Cancer of the thyroid	C73	C739
Adenocarcinoma of stomach	C16.9	C169

DEATH CERTIFICATE-ONLY CASES

Death certificate-only cases contain information which was derived from a death certificate that was reported to the New Jersey Bureau of Vital Statistics with a cancer diagnosis.

On a periodic basis the NJSCR electronically matches death certificates with a cancer diagnosis to its files to update vital status. This also serves as another source of case finding. Cases that are not linked to existing cases are termed as "death certificate-only" cases. "Death certificate-only" cases may include but not be limited to: malignancies diagnosed prior to a hospital registry date, prior to the NJSCR reference date October 1978, patients dead on arrival in the Emergency Department, or to patients who were erroneously coded as having a malignancy.

On occasion, a patient may be on the "death certificate-only" list that has already been reported to the NJSCR but was not properly linked during the electronic matching process. Periodically, hospitals will be sent a listing of patients who have been identified as "death certificate-only" cases. Every effort should be made to locate information on these patients. Once the case is identified, it should be abstracted and then submitted electronically to the NJSCR.

ACKNOWLEDGMENTS

Adamo M., Johnson C.H., Ruhl J., Dickie, L. (eds.). **2010 SEER Program Coding and Staging Manual**. National Cancer Institute, NIH Publication number 10-5581, Bethesda, MD

Collaborative Stage Work Group of the American Joint Committee on Cancer. **Collaborative Stage Data Collection System Coding Instructions, version 02.00.00** Incorporates updates through January 1, 2010.

Fritz, A., Percy, C., Jack, A., Shanmugaratnam, K., Sobin, L., Parkin, D., Whelan, S. (eds). **International Classification of Diseases for Oncology, Third Edition**. World Health Organization, Geneva, Switzerland, 2000.

Thornton M. (ed). **Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1**, 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.

We acknowledge the Centers for Disease Control and Prevention for its support of the New Jersey State Cancer Registry under cooperative agreement DP07-703 awarded to the New Jersey Department of Health and Senior Services.

APPENDIX A

CANCER REGISTRY LEGISLATION AND REGULATIONS

CANCER REPORTING

CANCER REGISTRY STATUTE

26:2-104 Legislative findings and declaration

The Legislature hereby finds and declares:

- (a) That New Jersey is currently suffering from the highest overall mortality rates for cancer in the Nation;
- (b) That certain forms of cancer are now believed to be attributable to environmental factors which, if controlled, can significantly reduce incidence in this State;
- (c) That more complete and more precise statistical data are necessary to determine the correlations between cancer incidence and possible environmental factors and to evaluate cancer treatment and prevention measures that are currently in progress; and,
- (d) That a cancer registry would thus provide a vital foundation for a concerted State effort to reduce the incidence of environmentally related cancer in this State.

L.1997, c266, s.1.

26:2-105 Establishment and maintenance; Inclusions

The Department of Health and Senior Services shall establish and maintain an up-to-date registry which shall include a record of cases of cancer and specified cases of tumorous or precancerous disease that occur in New Jersey, and such information concerning these cases as it shall deem necessary and appropriate in order to conduct thorough and complete epidemiologic surveys of cancer and cancer-related diseases in this State and to apply appropriate preventive and control measures.

L.1977, c.266, s.2; amended 2001, c.99, s.1.

26:2-106 Reports and submissions by health care providers; rules and regulations

(a) The Commissioner of Health and Senior Services, in consultation with the Public Health Council, shall require the reporting of cases of cancer and other specified tumorous and precancerous diseases, and the submission of such specified additional information on reported cases or control populations as he deems necessary and appropriate for the recognition, prevention, cure or control of such diseases.

(b) Pursuant to subsection a. of this section, the Commissioner of Health and Senior Services is hereby authorized to adopt and promulgate, in the manner prescribed by the applicable provisions of the Administrative Procedure Act (P.L.1968,C.410;C.52:14B-1 et seq.), rules and regulations specifying the health care providers, individuals, and other organizations obliged to make the report and submissions required by subsection a. of this section, the related information to be included in such reports, and the methods for such reporting.

(c) All abstracting work performed by a health care facility in accordance with this section shall be performed by a certified tumor registrar.

(d) 1. The Department of Health and Senior Services

shall contract out its registry services to health care facilities which lack adequate internal capabilities to report cases on a timely basis, as provided in the regulations adopted pursuant to this section. Such health care facilities shall reimburse the department for services rendered.

2.If a health care facility fails to correct deficiencies in its reporting that are discovered on audit by the Department of Health and Senior Services within 30 days, the department will conduct the appropriate registrar activities and charge the facility for all costs related to its services.

(e) Health insurers and other third party health care payers providing health benefits plans to residents of the State shall report to the Department of Health and Senior Services cases of cancer of State residents based upon selection criteria and in a format specified by the department.

(f) 1.A health care facility, health care provider or health insurer that fails to comply with the provisions of this section shall be liable to a penalty of up to \$500 per unreported cancer case.

2.A health care facility that fails to report cases of cancer electronically, as required by regulation, within six months of the confirmed diagnosis shall be liable to a penalty not to exceed \$1,000 per business day.

3.A penalty sued for under the provisions of this subsection shall be recovered by and in the name of the Department of Health and Senior Services and shall be dedicated to the cancer registry.

(g) All information reported to the Department of Health and Senior Services for inclusion in the cancer registry pursuant to this section shall be verified for accuracy by the department within six months of receiving the information and shall be incorporated in the registry. Aggregate or summary information, to include gender distribution, age groupings of cases, and cancer types, shall be made available to the public no later than six months after verification by the department. The department shall not make public any information reported to the department which discloses the identity of any person to whom the information relates.

L.1997, c.266, s.3; amended 1996, c.74, s.1; 2001, c.99, s.2.

26:2-107 Confidentiality of reports

The reports made pursuant to this act are to be used only by the State Department of Health and Senior Services and such other agencies as may be designated by the Commissioner of Health and Senior Services and shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate; and to that end, such reports shall not be included under materials available to public inspection pursuant to P.L.1963,c73 (C.47:1A-1 et seq.).

L.1977, c.266, s.4; amended 2001, c.99, s.3

26:2-108 Non-liability for divulging confidential information

No individual or organization providing information to the Department of Health and Senior Services in accordance with this act shall be deemed to be, or be held liable for, divulging confidential information.

26:2-109 Inapplicability of act to compel individuals to submit to medical or health department examination or supervision

Nothing in this act shall be construed to compel any individual to submit to medical or health department examination or supervision.

CHAPTER 57A

CANCER REGISTRY

Authority

N.J.S.A. 26:2-104 et. seq.

Source and Effective Date

R.1995 d.241, effective April 12, 2000,
See: 27 N.J.R. 629(a), 27 N.J.R. 1988(a),

Executive Order No. 66(1978) Expiration Date
Chapter 57A, Cancer Registry, expires on October 3, 2010

Chapter Historical Note

Chapter 57 A, Cancer Registry, became effective June 16, 1986, as R.1986 d2.77, as Subchapter 6 of N.J.A.C. 8:57. See: 17 N.J.R. 2836(b), 18 N.J.R. 1283(a). The text was recodified with amendments to N.J.A.C. 8:57A by R.1990 d.242 effective May 21, 1990. See: 21 N.J.R. 3909(a), 22 N.J.R. 1596(a).

Pursuant to Executive Order No. 66(1978), Chapter 57A was readopted as R.1995 d.241. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. CANCER REGISTRY

8:57A-1.1 Reporting of cancer; general requirements

(a) Cases of cancer and other specified tumorous and precancerous diseases shall be reported to the New Jersey Department of Health and Senior Services. The reportable diseases and conditions shall be specified in a listing promulgated by the Commissioner of the New Jersey Department of Health and Senior Services, at N.J.A.C. 8:57A-1.8.

(b) All case reports shall be submitted within six months of the date of diagnosis or within three months of the date of discharge from the reporting facility, whichever is sooner.

(c) Follow-up reports shall be submitted on each cancer case at least annually to confirm the patient's vital status. These follow-up reports shall be required until the patient's death.

Amended by R.1990 d.242, effective May 21, 1990.
See: 21 N.J.R. 3909(a), 22 N.J.R. 1596(a).

Third party payers permitted to report cases to the Registry; machine readable submissions permitted.
Amended by R.1995 d.241, effective May 15, 1995.
See: 27 N.J.R. 629(a), 27 N.J.R. 1988(a).
Amended by R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).

Rewrote the section.

8:57A-1.2 Health care facility reporting

(a) The administrative officer of every health care facility shall report to the New Jersey Department of Health and Senior Services every case of cancer or other specified tumors and precancerous disease when it is initially diagnosed or when the patient is first admitted or treated for any reason in that facility. A report shall also be submitted for each subsequent primary cancer diagnosed in that individual.

1. Health care facility means a facility as defined at N.J.S.A. 26:2H-1 et. seq. and amendments thereto.

(b) All abstracting work performed by a health care facility which diagnoses or treats 100 or more cancer cases per year shall be performed by a certified tumor registrar who is certified by the National Cancer Registrars Association's Council on Certification, 1340 Braddock Avenue, Alexandria, VA 22314; <http://www.ctrexam.org>; telephone: (703) 299-6640; telefacsimile: (703) 299-6620; e-mail: ctrexam@ncra-usa.org. The certified tumor registrar shall be either employed by the health care facility or employed by an abstract-coding service under contract by the health care facility.

1. The health care facility shall have until August 3, 2000 to comply with the provisions of (b) above.

(c) The information to be reported shall:

1. Be submitted electronically in a standard format which is specified by the New Jersey Department of Health and Senior Services; and

2. Include patient identifying information, medical history, cancer treatment, and an annual report to confirm the patient's vital status until the patient's death.

(d) Health care facilities which lack adequate internal capabilities to report cases in accordance with the requirements of (b) and (c) above shall contract with the New Jersey Department of Health and Senior Services to provide abstracting services.

(e) The New Jersey Department of Health and Senior Services shall charge a fee to health care facilities for the provision of services set forth at (d) above. The fee shall be based upon the fair market value of services.

(f) A health care facility which fails to comply with the provisions of this subchapter shall be liable for a penalty of up to \$500.00 per unreported case of cancer or other specified tumorous and precancerous disease.

(g) A health care facility which fails to report cases of cancer or other specified tumorous and precancerous diseases electronically shall be liable to a penalty not to exceed \$1,000 per business day.

Recodified from N.J.A.C. 8:57A-1.1(b) and amended by R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903 (b).

Rewrote the section. Former N.J.A.C. 8:57A-1.2, Reportable list, was recodified to N.J.A.C. 8:57A-1.8.

8:57A-1.3 Physician, dentist, and other health care provider reporting

(a) Every physician, dentist, or other health care provider who diagnoses or provides treatment for cancer patients shall report to the New Jersey Department of Health and Senior Services an initial diagnosis of each case of cancer or other specified tumorous and precancerous disease not referred to or previously diagnosed in a health care facility in the State of New Jersey. A report shall also be submitted for each subsequent primary cancer diagnosed in that individual.

(b) The information to be reported shall:

1. Be submitted on forms specified by the New Jersey Department of Health and Senior Services; and

2. Include patient identifying information, medical history, and cancer treatment.

(c) The physician, dentist, or other health care provider may submit the reports electronically in a standard format which is specified by the New Jersey Department of Health and Senior Services.

(d) A physician, dentist or other health care provider who fails to comply with the provisions of this subchapter shall be liable for a penalty of up to \$500.00 per unreported case of cancer or other specified tumorous and precancerous disease.

Recodified from N.J.A.C. 8:57A-1.1 (c) and amended by R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759 (a), 30 N.J.R. 2903(b).

Rewrote the section.

8:57A-1.4 Clinical laboratory reporting

(a) The director of every independent clinical laboratory shall report to the New Jersey Department of Health and Senior Services the results of examinations of tissue specimens and/or hematology examinations which are positive for the existence of cancer or other specified tumorous and precancerous disease not previously reported from that laboratory.

(b) The information to be reported shall:

1. Be submitted on forms specified by the New Jersey Department of Health and Senior Services; and

2. Include all available patient identifying information and the name, address, and/or telephone number of the referring physician.

(c) The director of the independent clinical laboratory may submit the reports electronically in a standard format which is specified by the New Jersey Department of Health and Senior Services.

(d) An independent clinical laboratory which fails to comply with the provisions of this subchapter shall be liable for a penalty of up to \$500.00 per unreported case of cancer or other specified tumorous and precancerous disease.

Recodified from N.J.A.C. 8:57A-1.1(d) and amended by R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903 (b).

Rewrote the section.

8:57A-1.5 Health care insurer reporting

(a) Health care insurers and other third party health care payers providing benefit plans to residents of the State may report to the New Jersey Department of Health and Senior Services cases of cancer or other specified tumorous and precancerous diseases based upon selection criteria specified by the Cancer Registry.

(b) If reported, the information shall:

1. Be submitted on forms specified by the New Jersey Department of Health and Senior Services; and

2. Include patient identifying information, medical history, cancer treatment, and an annual report to confirm the patient's vital status until the patient's death.

(c) Health care insurers and other third party health care payers providing benefit plans to residents of the State may submit the reports electronically in a standard format which is specified by the New Jersey Department of Health and Senior Services.

Recodified from N.J.A.C. 8:57A-1.1(e) and amended by R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).

Rewrote the section.

8:57A-1.6 Supplemental information

Information necessary to clarify medical or demographic data shall be supplied upon request of the New Jersey

Department of Health and Senior Services. This supplemental information shall include, but not be limited to: copies of pathology and/or hematology reports, operative reports, treatment information, history and physical sections of the medical records, and discharge summaries.

Recodified from N.J.A.C. 8:57A-1.1(f) and amended by R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J. R. 2903(b).
Rewrote the section.

8:57A1-7. Access to information and records

(a) Every health care facility, independent clinical laboratory, physician, dentist, or other health care provider who diagnoses or provides treatment for cancer patients and health care insurers and other third party health care payers providing benefit plans to residents of the State shall allow representatives of the New Jersey Department of Health and Senior Services to obtain information from all medical, pathological, and other pertinent records and logs related to cancer cases, as necessary for fulfilling the functions of the cancer registry program.

(b) Every health care facility, independent clinical laboratory, physician, dentist, or other health care provider who diagnoses or provides treatment for cancer patients and health care insurers and other third party health care payers providing benefit plans to residents of the State shall permit representatives of the New Jersey Department of Health and Senior Services access to information or provide necessary information on specified cancer patients and other patients specified by characteristics for research studies related to cancer etiology, prevention, and control which are conducted by the New Jersey Department of Health and Senior Services. These studies, shall have been approved by the Commissioner of the New Jersey Department of Health and Senior Services after appropriate review to assure protection of human subjects. This access or provision of information shall include patients who came under the care of the health care facility, physician, dentist, or other health care provider prior to November 18, 1977.

(c) The reports made pursuant to this subchapter shall be used only by the New Jersey Department of Health and Senior Services and such other agencies as may be designated by the Commissioner of the New Jersey Department of Health and Senior Services. These reports shall not be otherwise divulged or made public. Such reports shall not be subject to public inspection and copying pursuant to the Right-to-Know Act, N.J.S.A. 47:1A-1 et seq.

(d) No individual or organization providing information to the New Jersey Department of Health and Senior Services in accordance with this subchapter shall be deemed to be, or held liable for, divulging confidential information.

(e) Any individual or organization which reveals or discloses any information or data in violation of (c) above shall be the subject of penalties as permitted by law. All violations shall be reported to the appropriate professional licensing authorities and public financing programs.

(f) Failures to permit access to information and records to representatives of the New Jersey Department of

Health and Senior Services shall be cause for the imposition of penalties as permitted by law.

Recodified from N.J.A.C. 8:57A-1.1(i) and (j) and amended by R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).
Rewrote the section.

8:57A-1.8 List of reportable diseases and conditions

(a) If a diagnosis includes any of the following words, the case shall be reported to the New Jersey Department of Health and Senior Services in accordance with the provisions of this subchapter:

Cancer;
Carcinoma;
Leukemia;
Malignant; and/or
Sarcoma.

(b) Any case having a diagnosis listed at (g) below and which contains any of the following terms in the final diagnosis shall be reported to the New Jersey Department of Health and Senior Services in accordance with the provisions of this subchapter:

Compatible with;
Consistent with;
Most likely;
Probable;
Suspect; and/or
Suspicious.

(c) Basal cell carcinomas of the skin shall not be reported to the New Jersey Department of Health and Senior Services except when they are diagnosed in the labia, clitoris, vulva, prepuce, penis, or scrotum.

(d) Carcinoma *in situ* of the cervix shall not be reported to the New Jersey Department of Health and Senior Services.

(e) Insofar as soft tissue tumors can arise in almost any body site, the primary site of the soft tissue tumor shall also be examined for any questionable neoplasm.

(f) If any uncertainty regarding the reporting of a particular case exists, the New Jersey Department of Health and Senior Services shall be contacted for guidance.

(g) Every New Jersey health care facility, physician, dentist, other health care provider, or independent clinical laboratory shall report the following conditions to the New Jersey Department of Health and Senior Services in accordance with the provisions of this subchapter:

ADRENAL

Adrenal cortical carcinoma
Ganglioneuroblastoma
Neuroblastoma
Neuroendocrine carcinoma
Neuroepithelioma
Paranglioma (+)
Pheochromocytoma, malignant only
Sympathicoblastoma

ANUS (see G-I tract)

APPENDIX (see G-I tract)

BILE DUCTS (see gall bladder and bile ducts)

BLOOD (see Hematopoietic/Lymphoid)

BLOOD VESSELS (see soft tissues)

BONE AND JOINTS

Adamantinoma
Ameloblastoma, malignant
Angioblastoma (+)
Angiosarcoma
Chondrosarcoma
Chordoma
Ewing's Sarcoma
Fibrosarcoma (medullary, periosteal, central, endosteal)
Giant cell tumor of bone (+)
Giant cell tumor, malignant
Hemangioendothelioma, malignant
Mesenchymal chondrosarcoma
Myeloma
Osteoclastoma (+)
Osteogenic Sarcoma
Osteosarcoma
Periosteal osteoma
Plasmacytoma

BONE MARROW (see Hematopoietic/Lymphoid)

BRAIN, SPINAL CORD, CRANIAL NERVES

MENINGES, Central Nervous System

Acoustic neuroma (O)
Angiolipoma (O)
Angiomatous meningioma (O)
Astroblastoma
Astrocytoma (any type)
Atypical choroid plexus papilloma (+)
Atypical lipoma (+)
Atypical meningioma (+)
Capillary hemangioma (O)
Cavernous hemangioma (O)
Central neurocytoma (+)
Chordoid glioma (+)
Chordoid plexus papilloma, malignant
Choroid plexus papilloma (O)
Clear cell meningioma (+)
Dermoid cyst (O)
Desmoplastic infantile astrocytoma (+)
Diffuse melanocytosis (O)
Dysembryoplastic neuroepithelial tumor (O)
Dyplastic gangliocytoma of cerebellum (O) (Lhermitte-Ducios)
Ependymoblastoma
Ependymoma
Fibrolipoma (O)
Fibroma (O)
Fibrous meningioma (O)
Gangliocytoma (O)
Ganglioglioma (+)
Ganglioneuroblastoma
Ganglioneuroma (O)
Germinoma
Glioblastoma multiforme
Gliofibroma (+)
Glioma, all types
Gliomatosis cerebri (+)

Hemangioblastoma (+)
Hemangioendothelioma, benign (O)
Hemangioendothelioma (+)
Hemangioma (O)
Hemangiopericytoma, benign (O)
Hemangiopericytoma (+)
Hemangiopericytoma, malignant
Leiomyoma (O)
Leiomyomatosis (+)
Lipoma (O)
Medulloblastoma
Medulloepithelioma (O)
Melanotic neurofibroma (O)
Meningeal melanocytoma (+)
Meningioma, malignant
Meningioma (O)
Meningiomatosis (+)
Meningiothelomatous meningioma (O)
Meningiothelial meningioma (O)
Myxopapillary ependymoma (+)
Neoplasm, benign (O)
Neoplasm, uncertain whether benign or malignant (+)
Neurilemoma (O)
Neurinomatosis (+)
Neuroblastoma
Neurofibroma (O)
Neurofibromatosis (+)
Neuroma (O)
Neurothekeoma (O)
Oligodendrocytoma or
 Oligodendroblastoma
Oligodendroglioma
Papillary meningioma
Paraganglioma (+)
Perineurioma (O)
Pineal teratoma, malignant
Pinealoma
Pineoblastoma
Pineocytoma
Plexiform neurofibroma (O)
Polarespongioblastoma
Psammomatous meningioma (O)
Rhabdomyoma (O)
Schwannoma (any)
Smooth muscle tumor (+)
Soft tissue tumor, benign (O)
Solitary fibrous tumor (O)
Spongioblastoma
Subependymal astrocytoma
Subependymal giant cell astrocytoma (+)
Subependymoma (+)
Teratoma, benign (O)
Teratoma (+)
Transitional meningioma (O)
Tumor cells, benign (O)
Tumor cells, malignant
Venous hemangioma (O)

BREAST

Adenocarcinoma
Apocrine carcinoma
Colloid carcinoma
Comedocarcinoma
Cribriform carcinoma
Cystosarcoma phyllodes, malignant only
Ductal carcinoma, in situ
Fibroadenoma, malignant only
Glycogen rich carcinoma

Infiltrating carcinoma of the breast such as:

- Carcinoma, NOS
- Duct adenocarcinoma
- Duct and lobular
- Duct carcinoma
- Duct and Paget's disease
- Ductular
- Lobular
- Lipid-rich carcinoma
- Lobular carcinoma, in situ
- Lobular and intraductal, in situ
- Lobular neoplasia
- Medullary carcinoma
- Papillary carcinoma, in situ
- Paget's disease
- Phyllodes tumor, malignant
- Stromal sarcoma of breast
- Tubular carcinoma

BRONCHUS (see lung)

CERVIX (see uterus)

COLON (see G-I tract)

EAR (see skin, soft tissue)

ENDOMETRIUM (see uterus)

ESOPHAGUS (see G-I tract)

EYE

- Epidermoid carcinoma
- Melanoma, malignant
- Retinoblastoma
- Squamous cell carcinoma
- Squamous cell epithelioma
- (Tumors of the orbit:
See soft tissues and Hematopoietic/Lymphoid)

EXTRA-ADRENAL PARAGANGLIA (see adrenal)

FALLOPIAN TUBE (see uterus)

GALL BLADDER AND BILE DUCTS

- Adenocarcinoma
- Carcinoma (other)

GASTRO-INTESTINAL TRACT

(esophagus, stomach, intestine, appendix, colon, anus)

- Adenoacanthoma
- Adenocarcinoma
- Adenoidcystic carcinoma
- (Adeno) carcinoma in Adenomatous polyp with or without invasion of stalk
- Adenosarcoma
- AIN
- Apudoma (+)
- Argentaffinoma (+)
- Bowen's disease of anus
- Carcinoid (except benign - e.g. appendix)
- Carcinosarcoma
- Cloacogenic carcinoma
- Epidermoid carcinoma
- Gastrinoma (+)
- Immunoproliferative disease, small intestinal
- Kaposi's Sarcoma

- Leiomyosarcoma, malignant only
- Lenitis plastica
- Lymphoma
- Mixed tumor or esophagus, malignant only
- Neuroendocrine carcinoma
- Paget's disease of anus
- Polypoid adenoma, malignant only
- Signet ring cell carcinoma
- Squamous cell carcinoma
- Squamous cell epithelioma
- Transitional cell carcinoma

HEMATOPOIETIC/LYMPHOID (Including blood, bone marrow, lymph nodes, spleen, and tumors of hematopoietic or lymphoid histogenesis found in other sites.)

- Acute erythremic myelosis
- Acute megakaryocytic myelosis
- Chronic myeloproliferative disease
- DiGuglielmo's syndrome
- Erythroleukemia
- Essential thrombocythemia
- Gamma heavy chain disease (Franklin's Disease)
- Histiocytic medullary reticulosis
- Histiocytosis, malignant
- Histiocytosis-X, malignant only
- Hodgkin's Disease, all such as:
 - Histiocyte predominant
 - Lymphocyte depleted
 - Lymphocyte predominant
 - Mixed cellularity
 - Nodular sclerosing
- Hypereosinophilic syndrome
- Idiopathic thrombocythemia
- Immunoproliferative Disease, NOS
- Letterer-Siwe's Disease
- Leukemia, all
- Leukemic reticuloendotheliosis
- Lymphoma, all
- Lymphosarcoma
- Lymphoreticular process, malignant
- Megakaryocytosis, malignant
- Multiple myeloma
- Mycosis fungoides
- Myelodysplastic syndrome, 5q- syndrome
- Myelofibrosis with myeloid metaplasia, malignant only
- Myeloma
- Myeloproliferative disease (+)
- Myelosclerosis
- Panmyelosis, acute
- Polycythemia Vera
- Refractory anemia
- Reticulosis, malignant
- Reticulum cell sarcoma
- Sezary's disease or syndrome
- Therapy related myelodysplastic syndrome
- Waldenstrom's macroglobulinemia or syndrome

HYPOPHARYNX (See oral cavity)

KIDNEY

- Adenocarcinoma
- Adenomyosarcoma
- Clear cell carcinoma
- Hypernephroma
- Nephroblastoma
- Renal cell carcinoma

Squamous cell carcinoma
Transitional cell carcinoma
Tubular adenoma, borderline or malignant only
Wilms's Tumor

LARYNX AND TRACHEA

Adenocarcinoma
Adenocystic carcinoma
Cylindroma
Squamous cell carcinoma

LIP (see oral cavity)

LIVER

Angiosarcoma
Bile duct carcinoma
Cholangiocarcinoma
Hepatoblastoma
Hepatocellular carcinoma
Hepatoma, malignant only

LUNG AND BRONCHUS

Adenocarcinoma
Adenoid cystic carcinoma
Apudoma (+)
Argentaffinoma (+)
Bronchial adenoma (+)
Bronchial adenoma (carcinoid type)
Cylindroma
Epidermoid carcinoma
Intravascular bronchial alveolar tumor
Large cell (anaplastic) carcinoma
Neuroendocrine carcinoma
Oat cell carcinoma
Pulmonary blastoma
Small cell (anaplastic) carcinoma
Squamous cell carcinoma
Undifferentiated carcinoma

LYMPH NODE (See Hematopoietic/Lymphoid)

MEDIASTINUM

(see Hematopoietic/Lymphoid, soft tissue, or thymus)

MENINGES (see brain)

MUSCLE (see soft tissue)

NERVE (see soft tissue)

NOSE (Nasal cavity, Para-nasal sinus and Nasopharynx)

Adenocarcinoma
Epidermoid carcinoma
Esthesioneuroblastoma
Lymphoepithelioma
Mesenchymoma, malignant
Neuroblastoma
Rhabdomyosarcoma
Sarcoma botryoides
Squamous cell carcinoma

ORAL CAVITY AND SALIVARY GLANDS

Adenocarcinoma
Adenoid cystic carcinoma
Acinic cell carcinoma
Acinic cell tumor (+)

Cylindroma
Epidermoid carcinoma
Lymphoepithelioma
Melanoma
Mixed tumor, salivary gland type, malignant only
Mucoepidermoid carcinoma
Mucoepidermoid tumor (+)
Pleomorphic adenoma, malignant only
Squamous cell carcinoma
Transitional cell carcinoma
Undifferentiated carcinoma
Verrucous carcinoma

OROPHARYNX (see oral cavity)

OVARY

Adenocarcinoma, NOS
Arrhenoblastoma, malignant
Brenner tumor, malignant only
Choriocarcinoma
Clear cell carcinoma
Dysgerminoma
Embryonal carcinoma
Endodermal sinus tumor
Endometrioid carcinoma
Granulosa cell tumor (+)
Granulosa cell carcinoma
Granulosa cell tumor, malignant
Granulosa-theca cell tumor (+)
Gonadoblastoma (+)
Gynandroblastoma (+)
Leydig cell tumor, malignant
Mesonephroid carcinoma
Mucinous cystadenoma, borderline malignancy (pseudomucinous cystadenoma, borderline malignancy) (+)
Mucinous cystadenocarcinoma
Mucinous cystic tumor of borderline malignancy (+)
Mucinous papillary cystadenoma of borderline malignancy (+)
Mucinous papillary cystadenoma with low malignant potential (+)
Papillary cystadenoma, borderline malignancy (+)
Papillary mucinous cystadenoma, borderline malignancy (+)
Papillary mucinous tumor of low malignant potential (+)
Papillary serous cystadenoma, borderline malignancy (+) (papillary serous tumor of low malignant potential)
Papillary serous cystadenocarcinoma
Pseudomucinous cystadenocarcinoma
Seminoma
Serous cystadenoma, borderline malignancy (+)
Serous papillary cystadenocarcinoma
Serous papillary cystadenoma of borderline malignancy (+)
Serous papillary cystadenoma with low malignant potential (+)
Serous papillary cystic tumor borderline malignancy (+)
Sertoli-leydig cell carcinoma
Teratoma, malignant
Theca-granulosa cell tumor (+)
Yolk-sac tumor

PANCREAS

Adenocarcinoma
Cystadenocarcinoma
Gastrinoma (+)
Glucagonoma, malignant only

Islet cell adenoma (+)
Islet cell carcinoma
Pancreatoblastoma
Papillary cystic tumor (+)
Squamous cell carcinoma

PARAGANGLIA

Non-chromaffin paraganglioma (+)
(see also adrenal gland)

PARATHYROID

Carcinoma, all

PARANASAL SINUSES (see nose)

PENIS

Basal cell carcinoma of Penis and Prepuce (skin of)
Bowen's disease
Erythroplasia of Queyrat
Squamous cell carcinoma
Verrucous carcinoma

PERICARDIUM (see pleura)

PERITONEUM (see pleura)

PHARYNX (see oral cavity)

PINEAL

Dermoid cyst (O)
Epithelial tumor, benign (O)
Gangliocytoma (O)
Ganglioglioma (+)
Neoplasm, benign (O)
Pinealoma (+)
Pineoblastoma
Pineocytoma (+)
Teratoma, benign (O)
Teratoma (+)

PITUITARY and CRANIOPHARYNGEAL DUCT

Acidophil adenoma (O)
Adamantinomatous craniopharyngioma (+)
Adenoma (O)
Basophil adenoma (O)
Chromophobe adenoma (O)
Clear cell adenoma (O)
Clear cell tumor (O)
Craniopharyngioma (any type) (+)
Craniopharyngioma, malignant
Epithelial tumor, benign (O)
Granular cell tumor (O)
Lipoma (O)
Mixed acidophil-basophil adenoma (O)
Mixed cell adenoma (O)
Monomorphic adenoma (O)
Neoplasm, uncertain (+)
Neoplasm, benign (O)
Oxyphilic adenoma (O)
Papillary adenoma (O)
Papillary craniopharyngioma (+)
Pituitary adenoma (O)
Prolactinoma (O)
Rathke Pouch tumor (+)
Soft tissue tumor, benign (O)
Teratoma, benign (O)
Teratoma (+)
Tumor cells, benign or uncertain

PLACENTA

Choriocarcinoma
Chorioepithelioma
Hydatiform mole, malignant (+)
Invasive mole (+)

PLEURA, PERITONEUM, PERICARDIUM

Fibrosarcoma
Mesothelioma
Sarcoma

PROSTATE AND SEMINAL VESICLE

Adenocarcinoma
Adenoid cystic carcinoma
Alveolar rhabdomyosarcoma
Carcinosarcoma
Endometrioid carcinoma
Rhabdomyosarcoma

RECTUM (see G-I Tract)

SALIVARY GLANDS (see oral cavity)

SKIN

Amelanotic melanoma
Basal cell carcinoma of labia, clitoris, vulva, prepuce,
penis and scrotum
Bowen's disease of anus and penis
Hutchinson's melanotic freckle
Lentigo maligna
Melanocarcinoma
Melanoma
Melanosarcoma
Merkel cell tumor
Mycosis Fungoides
Pilomatrix carcinoma
Squamous cell carcinoma with regional or distant
spread only
Superficial spreading melanoma
Sweat gland carcinoma

SOFT TISSUE (Including retroperitoneum, peripheral nerve)

Alveolar rhabdomyosarcoma
Alveolar soft parts sarcoma
Angiofibrosarcoma
Angiosarcoma
Angiomyxoma (+)
Chondrosarcoma
Clear cell sarcoma of tendons
Dermatofibrosarcoma protuberans
Embryonal rhabdomyosarcoma
Fibromyxosarcoma
Fibrosarcoma
Fibrous histiocytoma, malignant
Granular cell tumor, malignant
Hemangioendothelial sarcoma
Hemangioendothelioma, malignant only
Hemangiopericytoma, malignant only
Juvenile rhabdomyosarcoma
Kaposi's sarcoma
Leiomyosarcoma
Liposarcoma
Lymphangioendothelioma, malignant
Lymphangiosarcoma
Mesenchymoma, malignant
Metastasizing leiomyoma (+)
Myosarcoma

Myxosarcoma
Neuroblastoma
Neurogenic sarcoma
Neurilemmoma, malignant
Neurilemmosarcoma
Osteosarcoma
Paraganglioma, malignant
Pigmented dermatofibrosarcoma protuberans Bednar tumor
Reticulum cell sarcoma
Rhabdomyoma, malignant
Rhabdomyosarcoma
Sarcoma botryoides
Schwannoma, malignant
Schwannoma, malignant with rhabdomyoblastomatous differentiation
Synovial sarcoma
Xanthofibroma, malignant

SPINAL CORD (see brain)

SPLEEN (see Hematopoietic/Lymphoid)

STOMACH (see G-I Tract)

TESTIS

Carcinoid tumor (+)
Choriocarcinoma
Chorioepithelioma
Embryoma
Embryonal carcinoma
Embryonal teratoma
Endodermal sinus tumor
Germ cell carcinoma
Gonadal stromal tumor, malignant only
Gonadoblastoma (+)
Interstitial cell carcinoma
Leydig cell carcinoma
Mesonephric adenocarcinoma (infantile, juvenile embryonal carcinoma)
Polyembryoma
Seminoma
Sertoli cell carcinoma
Spermatoblastoma
Spermatocytic seminoma
Spermatocytoma
Teratoblastoma
Teratocarcinoma
Teratoma (+)
Vitelline tumor
Yolk sac tumor

THYMUS

Epithelioid thymoma, malignant only
Lymphocytic thymoma, malignant only
Seminoma
Spindle cell thymoma, malignant only
Thymic carcinoid
Thymoma, malignant

THYROID

Adenocarcinoma
Anaplastic carcinoma
Follicular carcinoma
Giant cell carcinoma
Hurthle cell adenoma, malignant only
Hurthle cell tumor, malignant only
Medullary carcinoma

Occult sclerosing carcinoma
Papillary carcinoma = papillary adenocarcinoma
Undifferentiated carcinoma

TRACHEA (see Larvnx)

URINARY BLADDER, URETER, URETHRA

Adenocarcinoma
Adenosarcoma
Carcinosarcoma
Chemodectoma, malignant only
Mullerian mixed tumors
Papillary transitional cell carcinoma
Paraganglioma (+)
Pheochromocytoma, malignant only
Rhabdomyosarcoma
Squamous cell carcinoma
Transitional cell carcinoma

UTERUS, UTERINE TUBES, CERVIX

Adenoacanthoma
Adenocarcinoma
Adenosarcoma
Adenosquamous carcinoma
Endolymphatic stromal myosis
Endometrial stromal sarcoma
Endometrioid carcinoma
Leiomyosarcoma
Mesonephric carcinoma
Mixed mesodermal tumor
Squamous cell carcinoma

VULVA AND VAGINA

Basal cell carcinoma of vulva, clitoris, and labia
Clear cell carcinoma
Mesonephroid carcinoma
Paget's disease
Squamous cell carcinoma
Vaginal intraepithelial neoplasia (VAIN III)
Vulvar intraepithelial neoplasia (VIN III)

NOTE: The following superscript indicates the nature of the other than overtly malignant reportable tumors listed:

(+) Borderline, reportable

(O) Benign, reportable

Amended by R.1990 d.242, effective May 21, 1990.

See: 21 N.J.R. 3909(a), 22 N.J.R. 1596(a).

Fourteen conditions added to list.

Repeal and New Rule, R.1995 d.241, effective May 15, 1995.

See: 27 N.J.R. 629(a), 27 N.J.R. 1998(a).

Recodified from N.J.A.C. 8:57A-1.2 and amended by

R.1998 d.393, effective August 3, 1998.

See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).

Rewrote the section.

8:57A-1.9 Audit, notice of violations, and enforcement actions

(a) A health care facility, physician's, dentist's, other health care provider's office, or independent clinical laboratory shall be subject to audit at the discretion of the Commissioner by authorized representatives of the New Jersey Department of Health and Senior Services.

(b) The New Jersey Department of Health and Senior Services shall evaluate completeness and timeliness of reporting as specified by this chapter. Records which shall be reviewed shall include, but not be limited to: medical records, diagnostic indices; such as, radiation, laboratory, cytology, and/or pathology reports, and discharge records.

(c) The audit shall be conducted during normal operating hours.

(d) A deficiency may be cited upon a determination that the health care facility, physician's, dentist's, other health care provider's office, or independent clinical laboratory does not comply with the reporting requirements to this chapter.

(e) At the conclusion of the audit or within 10 business days thereafter, the New Jersey Department of Health and Senior Services shall provide the health care facility, physician's, dentist's, other health care provider's office, or independent clinical laboratory with a written summary of any factual findings used as a basis to determine that reporting has not been complete or timely. This notice shall set forth the proposed assessment of civil monetary penalties, setting forth the specific reasons for the action. Such notice shall be served on a facility, physician, dentist, other health care provider, or independent clinical laboratory or its, his or her registered agent in person or by certified mail.

(f) A health care facility, physician, dentist, other health care provider, or independent clinical laboratory shall have 30 business days in which to correct all deficiencies in its reporting that were discovered during the audit.

1. If a health care facility, physician, dentist, other health care provider, or independent clinical laboratory fails to correct deficiencies in its reporting that were discovered during the audit within 30 days, the New Jersey Department of Health and Senior Services will act as registrar and shall charge the facility, physician, dentist, other health care provider, or independent clinical laboratory for all costs related to these services, including, but not limited to, the retrieval of case information and the cost of the audit. This fee shall be based upon the fair market value of such services.

i. All checks for fees for the Department's audit services shall be made payable to Treasurer, State of New Jersey and forwarded to:

Cancer Epidemiology Services
New Jersey State Cancer Registry
New Jersey Department of Health and Senior Services
PO Box 369
Trenton, New Jersey 08625-0369

New Rule, R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903 (b).

8:57A-1.10 Civil monetary penalties

(a) Pursuant to N.J.S.A. 26:2-106f(3) and notwithstanding the provisions of N.J.A.C. 8:57A-1.9(f)1 above, the Commissioner may assess a penalty for violation of reporting requirements in accordance with the following standards:

1. For failure of a health care facility, physician, dentist, other health care provider, or independent clinical laboratory to report pursuant to the provisions of this chapter, up to \$500.00 per unreported case of cancer or other specified tumorous and precancerous disease; and/or

2. For failure of a health care facility to report electronically, up to \$1,000 per business day.

(b) The Department may decrease the penalties in (a) above based upon compliance history, the number and frequency of the deficiencies, the measures taken to mitigate or prevent future deficiencies, the deterrent effect of the penalty, and/or other specific circumstances of the facility or violation.

New Rule, R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).

8:57A-1.11 Effective date of enforcement action

The assessment of civil monetary penalties shall become effective 30 days after the date of mailing or the date personally served, unless the health care facility, physician, dentist, other health care provider, or independent clinical laboratory files with the Department a written answer to the charges and gives written notice to the Department of its desire for a hearing. In this case, the assessment shall be held in abeyance until the administrative hearing has been conducted and a final decision is rendered by the Commissioner. Hearings shall be conducted in accordance with N.J.A.C. 8:57A-1.13.

New Rule, R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).

8:57A-1.12 Failure to pay a penalty; remedies

(a) Upon receipt of a Notice of Proposed Assessment of a Penalty, a health care facility, physician, dentist, other health care provider, or independent clinical laboratory has 30 days in which to notify the Department of its request for a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(b) The penalty becomes due and owing upon the 30th day from receipt of the Notice of Proposed Assessment of Penalties if a notice requesting a hearing has not been received by the Department. If a hearing has been requested, the penalty is due 45 days after the issuance of a Final Agency Decision by the Commissioner, if the Department's assessment has not been withdrawn, rescinded, or reversed, and an appeal has not been timely filed with the Appellate Division pursuant to Rule 2:2-3 of the New Jersey Court Rules.

(c) Failure to pay a penalty within 30 days of the date it is due and owing pursuant to (b) above may result in the institution of a summary civil proceeding by the State pursuant to the Penalty Enforcement Law, N.J.S.A. 2A:58-1 et seq.

New Rule, R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).

8:57A-1.13 Hearings

(a) Upon request, a hearing shall be afforded to a health care facility, physician, dentist, other health care provider, or independent clinical laboratory pursuant to N.J.A.C. 8:57A-1.9.

(b) A health care facility, physician, dentist, other health care provider, independent clinical laboratory shall notify the Department, in writing, of its request for a hearing within 30 days of receipt of a Notice of Proposed Assessment of Penalties.

(c) The Department shall transmit the hearing request to the Office of Administrative Law.

(d) Hearings shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et. seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1.1.

New Rule, R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).

8:57A-1.14 Settlement of enforcement actions

(a) A health care facility, physician, dentist, other health care provider, or independent clinical laboratory may request that the matter be settled in lieu of conducting an administrative hearing concerning an enforcement action.

(b) If the Department and the health care facility, physician, dentist, other health care provider, or independent clinical laboratory agree on the terms of a settlement, a written agreement specifying these terms shall be executed.

(c) The Department may agree to accept payment of penalties over a schedule not exceeding 18 months where a health care facility, physician, dentist, other health care provider, or independent clinical laboratory demonstrates financial hardship.

(d) All funds received in payment of penalties shall be recovered by and in the name of the Department and shall be dedicated to the New Jersey State Cancer Registry.

New Rule, R.1998 d.393, effective August 3, 1998.
See: 29 N.J.R. 2759(a), 30 N.J.R. 2903(b).

APPENDIX B

GEOCODES FOR PLACES OF BIRTH

APPENDIX B:

EDITS TABLES FOR SELECTED DATA ITEMS

Table Name: BPLACE.DBF (SEER GEOCODES FOR CODING PLACE OF BIRTH)

CONTINENTAL UNITED STATES AND HAWAII

000	United States
001	New England and New Jersey
002	Maine
003	New Hampshire
004	Vermont
005	Massachusetts
006	Rhode Island
007	Connecticut
008	New Jersey
010	North Mid-Atlantic States
011	New York
014	Pennsylvania
017	Delaware
020	South Mid-Atlantic States
021	Maryland
022	District of Columbia
023	Virginia
024	West Virginia
025	North Carolina
026	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

When SEER geocodes were originally assigned during the 1970s, the United States owned or controlled islands in the Pacific. Since then, many of these islands have either been given their independence or had control turned over to another country. In order to maintain consistent information over time, these islands are still to be coded to the original codes. Earlier designations are listed in parentheses.

100	Atlantic/Caribbean Area
101	Puerto Rico
102	U.S. Virgin Islands
109	Other Atlantic/Caribbean Area (Navassa Island, Bajo Nuevo Bank, Serranilla Bank)
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 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)
141	Other Pacific area (Kingman Reef, Palmyra Atoll, Jarvis Island, Baker Island, Howland Island)

NORTH AND SOUTH AMERICA, EXCLUSIVE OF THE UNITED STATES AND ITS POSSESSIONS

210	Greenland	300	South America, NOS
		311	Colombia
		321	Venezuela
220	Canada	331	Guyana (British Guiana)
221	Labrador	332	Suriname (Dutch Guiana)
	Maritime provinces	333	French Guiana
	New Brunswick	341	Brazil
	Newfoundland and Labrador	345	Ecuador
	Nova Scotia	351	Peru
	Prince Edward Island	355	Bolivia
222	Quebec	361	Chile
223	Ontario	365	Argentina
224	Prairie provinces	371	Paraguay
	Alberta	375	Uruguay
	Manitoba		
	Saskatchewan	380	South American Islands
225	Northwest Territories	381	Falkland Islands
	Yukon Territory		
226	British Columbia		
227	Nunavut (Nunavut became an official Territory of Canada on April 1, 1999.)		
230	Mexico		
240	North American Islands		
241	Cuba		
242	Haiti		
243	Dominican Republic		
244	Jamaica		
245	Other Caribbean Islands		
	Anguilla		
	Antigua and Barbuda		
	Barbados		
	British Virgin Islands		
	Cayman Islands		
	Dominica		
	Grenada		
	Guadeloupe		
	Martinique		
	Montserrat		
	Netherlands Antilles		
	St. Kitts and Nevis		
	St. Lucia		
	St. Vincent and the Grenadines		
	Trinidad and Tobago		
	Turks and Caicos		
	Antilles, NOS		
	British West Indies, NOS		
	Caribbean, NOS		
	Leeward Islands, NOS		
	West Indies, NOS		
	Windward islands, NOS		
246	Bermuda		
247	Bahamas		
249	St. Pierre and Miquelon		
250	Central America		
251	Guatemala		
252	Belize (British Honduras)		
253	Honduras		
254	El Salvador		
255	Nicaragua		
256	Costa Rica		
257	Panama		
260	North America, NOS		
265	Latin America, NOS		

EUROPE

Former or alternative names are in parentheses

Europe, NOS (See code 499) *

* *Effective tumors diagnosed 1/1/92.*

400	United Kingdom, NOS
401	England
	Channel Islands
	Isle of Man
402	Wales
403	Scotland
404	Northern Ireland (Ulster)
410	Ireland (Eire)
	Ireland, NOS
	Republic of Ireland
420	Scandinavia
	Lapland, NOS
421	Iceland
423	Norway
	Svalbard
	Jan Mayen
425	Denmark
	Faroe Islands
427	Sweden
429	Finland
430	Germanic countries
431	Germany
	(East Germany including East Berlin)
	(West Germany including West Berlin)
432	Netherlands
433	Belgium
434	Luxembourg
435	Switzerland
436	Austria
437	Liechtenstein
440	Romance-language countries
441	France
	Corsica
	Monaco
443	Spain
	Andorra
	Balearic Islands
	Canary Islands

445	Portugal		AFRICA	
	Azores			
	Cape Verde Islands	500	Africa, NOS	
	Madeira Islands		Central Africa, NOS	
447	Italy		Equatorial Africa, NOS	
	San Marino			
	Sardinia	510	North Africa, NOS	
	Sicily	511	Morocco	
	Vatican City (Holy See)	513	Algeria	
449	Romania	515	Tunisia	
		517	Libya	
450	Slavic countries		(Cyrenaica)	
451	Poland		(Tripoli)	
452	(former) Czechoslovakia region		(Tripolitania)	
	Bohemia	519	Egypt (United Arab Republic)	
	Czech Republic			
	Moravia	520	Sudanese countries	
	Slovak Republic		Burkina Faso (Upper Volta)	
	Slovakia		Chad	
453	(former) Yugoslavia region		Mali	
	Bosnia-Herzegovina		Mauritania	
	Croatia		Niger	
	Dalmatia		Sudan (Anglo-Egyptian Sudan)	
	Montenegro		Western (Spanish) Sahara	
	Macedonia			
	Serbia	530	West Africa, NOS	
	Slavonia		French West Africa, NOS	
	Slovenia	531	Nigeria	
454	Bulgaria	539	Other West African Countries	
455	Russia		Benin (Dahomey)	
	Russian Federation		Cameroon (Kameroun)	
	(former) U.S.S.R.		Central African Republic (French	
	Russia, NOS		Equatorial Africa)	
	(Russian S.F.S.R.)		Cote d'Ivoire (Ivory Coast)	
456	Ukraine and Moldova		Congo (Congo-Brazzaville, French Congo)	
	(Bessarabia)		Equatorial Guinea (Spanish Guinea) (Bioko [Fernando	
	Moldavia		Poo], Rio Muni)	
	(Moldavian S.S.R.)		Gambia	
	(Ukranian S.S.R.)		Gabon	
457	Belarus		Ghana	
	(Byelorussian S.S.R.)		Guinea	
	(White Russia)		Guinea Bissau (Portuguese Guinea)	
458	Estonia (Estonian S.S.R.)		Liberia	
459	Latvia (Latvian S.S.R.)		Senegal	
461	Lithuania		Sierra Leone	
	(Lithuanian S.S.R.)		Togo	
463	Baltic Republic(s), NOS	540	South Africa, NOS	
	(Baltic States, NOS)	541	Zaire (Congo-Leopoldville, Belgian Congo,	
470	Other mainland Europe		Congo/Kinshasa)	
471	Greece	543	Angola (Sao Tome, Principe, Cabinda)	
475	Hungary	545	Republic of South Africa	
481	Albania		(Bophuthatswana, Cape Colony, Ciskei, Natal, Free State	
485	Gibraltar		[Orange Free State], Transkei, Transvaal, Venda)	
			Botswana (Bechuanaland)	
490	Other Mediterranean islands		Lesotho (Basutoland)	
491	Malta		Namibia (South West Africa)	
495	Cyprus		Swaziland	
499	Europe, NOS*	547	Zimbabwe (Rhodesia, Southern Rhodesia)	
	Central Europe, NOS	549	Zambia (Northern Rhodesia)	
	Eastern Europe, NOS	551	Malawi (Nyasaland)	
	Northern Europe, NOS	553	Mozambique	
	Southern Europe, NOS	555	Madagascar (Malagasy Republic)	
	Western Europe, NOS			
		570	East Africa	
		571	Tanzania (Tanganyika, Tanzanyika, Zanzibar)	
		573	Uganda	
		575	Kenya	
		577	Rwanda (Ruanda)	
		579	Burundi (Urundi)	
		581	Somalia (Somali Republic, Somaliland)	

* Effective tumors diagnosed 1/1/92.

583 Djibouti (French Territory of the Afars and Issas, French Somaliland)
 585 Ethiopia (Abyssinia)
 Eritrea
 580 African Coastal Islands (previously included in 540)
 Comoros
 Mauritius
 Mayotte
 Reunion
 St. Helena
 Seychelles

* *Effective tumors diagnosed 1/1/92.*

ASIA

600 Asia, NOS*
 610 Near East
 Mesopotamia, NOS
 611 Turkey
 Anatolia
 Asia Minor, NOS
 620 Asian Arab Countries
 Iraq-Saudi Arabia Neutral Zone
 621 Syria
 623 Lebanon
 625 Jordan (Transjordan, former Arab Palestine)
 627 Iraq
 629 Arabian Peninsula
 Bahrain
 Kuwait
 Oman and Muscat
 Persian Gulf States, NOS
 Qatar
 Saudi Arabia
 United Arab Emirates (Trucial States)
 Yemen (Aden, People's Democratic Republic of Yemen, Southern Yemen)
 631 Israel and former Jewish Palestine
 Gaza
 Palestine, NOS
 Palestine (Palestinian National Authority [PNA])
 West Bank
 633 Caucasian Republics of the former U.S.S.R.
 Armenia
 Azerbaijan (Nagorno-Karabakh)
 Georgia
 634 Other Asian Republics of the former U.S.S.R.
 Kazakhstan (Kazakh S.S.R.)
 Kyrgystan (Kirghiz S.S.R., Kyrgyz)
 Tajikistan (Tadzhik S.S.R.)
 Turkmenistan (Turkmen S.S.R.)
 Uzbekistan (Uzbek S.S.R.)
 637 Iran (Persia)
 638 Afghanistan
 639 Pakistan (West Pakistan)
 640 Mid-East Asia, NOS
 Maldives

641 India, Andaman Islands
 643 Nepal, Bhutan, Sikkim
 645 Bangladesh (East Pakistan)
 647 Sri Lanka (Ceylon)
 649 Myanmar (Burma)
 650 Southeast Asia
 651 Thailand (Siam)
 660 Indochina
 661 Laos
 663 Cambodia, Kampuchea
 665 Vietnam (Tonkin, Annam, Cochin China)
 671 Malaysia, Singapore, Brunei
 673 Indonesia (Dutch East Indies)
 675 Philippines (Philippine Islands)
 680 East Asia
 681 China, NOS
 682 China (People's Republic of China)
 683 Hong Kong
 684 Taiwan (Formosa, Republic of China)
 685 Tibet
 686 Macao (Macau)
 691 Mongolia
 693 Japan
 695 Korea
 North Korea
 South Korea

* *Effective tumors diagnosed 1/1/92.*

AUSTRALIA AND OCEANIA

711 Australia and Australian New Guinea
 715 New Zealand
 Niue
 720 Pacific Islands
 Oceania, NOS
 Polynesia, NOS
 721 Melanesian Islands
 Solomon Islands
 Fiji
 Fotuna
 New Hebrides
 Vanuatu
 Wallis
 723 Micronesian Islands
 725 Polynesian Islands
 750 Antarctica

Except possessions of the United States.

PLACE OF BIRTH UNKNOWN

998 Place of Birth stated not to be in United States, but no other information available
 999 Place of Birth unknown

References: *CIA World Factbook*, 1995. U.S. Bureau of the Census Place of Birth Technical Documentation, 1997.

ALPHABETICAL LISTING

* Effective tumors diagnosed 1/1/92.

A

585	Abyssinia	247
629	Aden	629
583	Afars and Issas	443
638	Afghanistan	463
500	Africa	645
570	Africa, East	245
510	Africa, North	245
540	Africa, South	431
545	Africa, South West	545
530	Africa, West	545
580	African Coastal Islands (previously included in 540)	457
037	Alabama	541
091	Alaska	433
481	Albania	252
224	Alberta	539
513	Algeria	246
250	America, Central	456
260	America, North (see also North America)	643
300	America, South	539
121	American Samoa	246
611	Anatolia	456
641	Andaman Islands	643
443	Andorra	539
543	Angola	452
245	Anguilla	355
665	Annam	545
750	Antarctica	673
245	Antigua	453
245	Antilles, NOS	545
245	Antilles, Netherlands	341
625	Arab Palestine	226
629	Arabia, Saudi	331
629	Arabian Peninsula	252
365	Argentina	245
087	Arizona	245
071	Arkansas	671
633	Armenia (U.S.S.R.)	454
611	Armenia (Turkey)	520
750	Antarctica	649
245	Aruba	
600	Asia, NOS*	
680	Asia, East	
640	Asia, Mid-East	
610	Asia Minor, NOS	
610	Asia, Near-East	
650	Asia, Southeast	
634	Asian Republics of the former U.S.S.R.	
620	Asian Arab countries	
100	Atlantic/Caribbean area, U.S. possessions	
109	Atlantic/Caribbean area, other U.S. possessions	
711	Australia	
711	Australian New Guinea	
436	Austria	
633	Azerbaijan	
633	Azerbaijan S.S.R.	
445	Azores	

B

Bahamas	361
Bahrain	681
Balearic islands	665
Baltic Republic, NOS	682
Baltic States, NOS	684
Bangladesh	723
Barbados	545
Barbuda	665
Bavaria	711
Basutoland	311
Bechuanaland	083
Belarus	580
Belgian Congo	226
Belgium	022
Belize	539
Benin	541
Bermuda	539
Bessarabia	541
Bhutan	007
Bioko (Fernando Poo)	124
Bohemia	441
Bolivia	256
Bophuthatswana	539
Borneo	471
Bosnia-Herzegovina	453
Botswana	241
Brazil	245
British Columbia	495
British Guiana	517
British Honduras	452
British Virgin Islands	452
British West Indies, NOS	
Brunei	
Bulgaria	
Burkina Faso (Upper Volta)	539
Burma (see Myanmar)	453
Burundi	017
Byelorussian S.S.R.	425

C

Cabinda	
Caicos Islands	
California	
Cambodia	
Cameroon	
Canada	
Canal Zone	570
Canary islands	680
Canton islands	431
Cape Colony	673
Cape Verde islands	645
Caribbean, NOS	499
Caribbean islands, other	345
Caroline Islands	519
Cartier Islands	410
Caucasian Republics of the former U.S.S.R.	254
Cayman Islands	125
Central Africa, NOS	122
Central African Republic	401
Central America	500
Central Europe, NOS	539
Central Midwest States	585
Ceylon	458
Chad	458
Channel Islands (British)	585

Chile

Chile	361
China	681
(not otherwise specified)	
China, Cochin	665
China, People's Republic of	682
China, Republic of	684
Christmas Island	723
Ciskel	545
Cochin China	665
Cocos (Keeling) Islands	711
Colombia	311
Colorado	083
Comoros	580
Columbia, British	226
Columbia, District of	022
Congo-Brazzaville	539
Congo-Leopoldville	541
Congo, Belgian	541
Congo, French	539
Congo Kinshasa	541
Connecticut	007
Cook Islands	124
Corsica	441
Costa Rica	256
Cote d'Ivoire (Ivory Coast)	539
Crete	471
Croatia	453
Cuba	241
Curacao	245
Cyprus	495
Cyrenaica	517
Czechoslovakia	452
Czech Republic	452

D

Dahomey	539
Dalmatia	453
Delaware	017
Denmark	425
District of Columbia	022
Djibouti	583
Dobruja	449
Dominica	245
Dominican Republic	243
Dutch East Indies	673
Dutch Guiana	332

E

East Africa	570
East Asia	680
East Germany	431
East Indies, Dutch	673
East Pakistan	645
Eastern Europe, NOS	499
Ecuador	345
Egypt	519
Eire	410
El Salvador	254
Ellice Islands	125
Enderbury Islands	122
England	401
Equatorial Africa, NOS	500
Equatorial Guinea (Spanish Guinea)	539
Eritrea	585
Estonia	458
Estonian S.S.R. (Estonia)	458
Ethiopia	585

499	Europe, NOS*		I	461	Lithuanian S.S.R. (Lithuania)
470	Europe, other mainland			073	Louisiana
		421	Iceland	434	Luxembourg
	F	081	Idaho		M
		061	Illinois		
425	Faroe (Faeroe) Islands	641	India		
381	Falkland Islands	045	Indiana	686	Macao
431	Federal Republic of Germany	673	Indies, Dutch East	686	Macao
539	Fernando Poo	660	Indochina	453	Madagascar
721	Fiji	673	Indonesia	555	Madagascar
429	Finland	053	Iowa	445	Madeira islands
035	Florida	637	Iran	002	Maine
684	Formosa	627	Iraq	555	Malagasy Republic
721	Fotuna	620	Iraq-Saudi Arabian Neutral Zone	551	Malawi
441	France	410	Ireland (Eire)	671	Malay Peninsula
545	Free State (Orange Free State)	404	Ireland, Northern	671	Malaysia
539	French Congo	410	Ireland, NOS	640	Maldives
333	French Guiana	410	Ireland, Republic of	520	Mali
725	French Polynesia	401	Isle of Man	491	Malta
583	French Somaliland	631	Israel	224	Manitoba
530	French West Africa, NOS	583	Issas	129	Mariana Islands
245	French West Indies	447	Italy	221	Maritime provinces, Canada
		539	Ivory Coast	131	Marshall Islands
	G			245	Martinique
			J	021	Maryland
539	Gabon		Jan Mayen	005	Massachusetts
345	Galapagos Islands	423	Jamaica	520	Mauritania
539	Gambia	244	Japan	580	Mauritius
631	Gaza Strip	693	Java	580	Mayotte
033	Georgia (U.S.A.)	673	Jersey	490	Mediterranean Islands, Other
633	Georgia (U.S.S.R.)	401	Jewish Palestine	721	Melanesian islands
430	Germanic countries	631	Johnston Atoll	610	Mesopotamia, NOS
431	German Democratic Republic	127	Jordan	230	Mexico
431	Germany	625	Jugoslavia	041	Michigan
431	Germany, East	453		123	Micronesian islands
431	Germany, Federal Republic of			640	Mid-East Asia
431	Germany, West		K	132	Midway Islands
539	Ghana		Kameroun	052	Minnesota
485	Gibraltar	539	Kampuchea	249	Miquelon
122	Gilbert Islands	663	Kansas	039	Mississippi
471	Greece	065	Kazakh S.S.R.	063	Missouri
210	Greenland	634	Kazakhstan	456	Moldavia
245	Grenada	634	Kentucky	456	Moldavian S.S.R.
245	Grenadines, The	047	Kenya	456	Moldova
245	Guadaloupe	575	Kirghiz S.S.R.	441	Monaco
126	Guam	634	Kiribati	691	Mongolia
251	Guatamala	122	Korea	056	Montana
401	Guernsey	695	Korea, North	453	Montenegro
331	Guiana, British	695	Korea, South	245	Montserrat
332	Guiana, Dutch	695	Kuwait	452	Moravia
333	Guiana, French	629	Kyrgystan	511	Morocco
539	Guinea	634	Kyrgyz	080	Mountain States
539	Guinea-Bissau	634		553	Mozambique
	(Portuguese Guinea)			629	Muscat
539	Guinea, Equatorial		L	649	Myanmar
—	Guinea, New		Labrador		(See Burma)
	(see New Guinea)	221	Laos		N
539	Guinea, Portuguese	661	Latin America, NOS		
331	Guyana	265	Lapland, NOS	545	Namibia
		420	Latvia	133	Nampo-shoto, Southern
	H	459	Latvian S.S.R. (Latvia)	545	Natal
		459	Lebanon	723	Nauru
242	Haiti	623	Leeward Islands, NOS	610	Near-East Asia
099	Hawaii	245	Lesotho	067	Nebraska
432	Holland	545	Liberia	643	Nepal
253	Honduras	539	Libya	432	Netherlands
252	Honduras, British	517	Liechtenstein	245	Netherlands Antilles
683	Hong Kong	437	Line Islands, Southern	332	Netherlands Guiana
475	Hungary	122	Lithuania	085	Nevada
		461			

245	Nevis	631	Palestinian National Authority (PNA)	403	Scotland
221	New Brunswick		Panama	539	Senegal
725	New Caledonia	257	Papua New Guinea	453	Serbia
001	New England	711	Paraguay	580	Seychelles
673	New Guinea, except Australian and North East	371	Pennsylvania	403	Shetland Islands
711	New Guinea, Australian	014	People's Democratic Republic of Yemen	651	Siam
711	New Guinea, North East	629	People's Republic of China	447	Sicily
003	New Hampshire	682	Persia	539	Sierra Leone
721	New Hebrides	637	Persian Gulf States, NOS	643	Sikkim
008	New Jersey	629	Peru	671	Singapore
086	New Mexico	351	Philippine Islands	450	Slavic countries
011	New York	675	Philippines	453	Slavonia
715	New Zealand	675	Pitcairn	452	Slovak Republic
221	Newfoundland	725	Poland	452	Slovakia
255	Nicaragua	451	Polynesia islands	453	Slovenia
520	Niger	725	Portugal	721	Solomon Islands
531	Nigeria	445	Portuguese Guinea	581	Somali Republic
715	Niue	539	Prairie Provinces, Canada	581	Somalia
711	Norfolk Island	224	Prince Edward Island	581	Somaliland
671	North Borneo (Malaysia)	221	Principe	583	Somaliland, French
510	North Africa, NOS	543	Puerto Rico	540	South Africa
260	North America, NOS (use more specific term if possible)	101		545	South Africa, Republic of
240	North American islands		Q	545	South Africa, Union of
025	North Carolina		Qatar	300	South America
040	North Central States	629	Quebec	380	South American islands
054	North Dakota	222		026	South Carolina
711	North East New Guinea			055	South Dakota
695	North Korea		R	695	South Korea
010	North Mid-Atlantic States		Republic of China	020	South Mid-Atlantic States
499	Northern Europe, NOS	684	Republic of South Africa	545	South West Africa
404	Northern Ireland	545	Reunion	650	Southeast Asia
129	Northern Mariana Islands	580	Rhode Island	030	Southeastern States
050	Northern Midwest States	006	Rhodesia	499	Southern Europe, NOS
549	Northern Rhodesia	547	Rhodesia, Northern	122	Southern Line Islands
225	Northwest Territories (Canada)	549	Rhodesia, Southern	070	Southern Midwest States
423	Norway	547	Rio Muni	133	Southern Nampo-shoto
998	Not United States, NOS	539	Romanance-language countries	547	Southern Rhodesia
221	Nova Scotia	440	Romania	629	Southern Yemen
227	Nunavut	449	Roumania	—	Soviet Union (see individual republics)
551	Nyasaland	449	Ruanda	443	Spain
	O	449	Rumania	520	Spanish Sahara
043	Ohio	455	Russia, NOS	647	Sri Lanka
075	Oklahoma	457	Russia, White	520	Sudan (Anglo-Egyptian Sudan)
629	Oman	455	Russian Federation (former U.S.S.R.)	673	Sudanese countries
223	Ontario	455	Russian S.F.S.R.	332	Sumatra
545	Orange Free State	577	Rwanda	423	Suriname
095	Oregon	134	Ryukyu Islands	423	Svalbard
403	Orkney Islands		S	135	Swan Islands
	P	520	Sahara, Western	545	Swaziland
120	Pacific area, U.S. possessions	121	Samoa, American	427	Sweden
720	Pacific islands	725	Samoa, Western	435	Switzerland
123	Pacific Islands, Trust Territory of the (code to specific islands if possible)	245	St. Christopher-Nevis	621	Syria
090	Pacific Coast States	580	St. Helena		T
639	Pakistan	245	St. Kitts (see St. Christopher-Nevis)	634	Tadzhik S.S.R.
645	Pakistan, East	245	St. Lucia	684	Taiwan
639	Pakistan, West	447	St. Pierre	634	Tajikistan
139	Palau (Trust Territory of the Pacific Islands)	543	St. Vincent	571	Tanzania
625	Palestine, Arab	447	San Marino	571	Tanganyika
631	Palestine, Jewish	224	Sao Tome	571	Tanzanyika
631	Palestine, NOS	629	Sardinia	031	Tennessee
		420	Saskatchewan	077	Texas
			Saudi Arabia	651	Thailand (Siam)
			Scandinavia	685	Tibet
				245	Tobago
				539	Togo
				136	Tokelau Islands

725	Tonga	004	Vermont
665	Tonkin	665	Vietnam
625	Trans-Jordan	102	Virgin Islands (U.S.)
545	Transkei	245	Virgin Islands (British)
545	Transvaal	023	Virginia
449	Transylvania		
245	Trinidad		W
517	Tripoli		
517	Tripolitania	137	Wake Island
629	Trucial States	402	Wales
515	Tunisia	721	Wallis
611	Turkey	449	Wallachia
634	Turkmen S.S.R.	093	Washington (state)
634	Turkmenistan	022	Washington D.C.
245	Turks Islands	530	West Africa, NOS
125	Tuvalu	539	West African countries, other
		631	West Bank
	U	431	West Germany
		245	West Indies, NOS (see also individual islands)
573	Uganda		West Pakistan
456	Ukraine	639	West Virginia
456	Ukrainian S.S.R.	024	West Virginia
404	Ulster	499	Western Europe, NOS
545	Union of South Africa	520	Western Sahara
—	Union of Soviet Socialist Republics (U.S.S.R.) (see individual republics)	725	Western Samoa
629	United Arab Emirates	457	White Russia
519	United Arab Republic	245	Windward islands
400	United Kingdom	051	Wisconsin
000	United States	082	Wyoming
102	U.S. Virgin Islands		Y
999	Unknown		
520	Upper Volta	629	Yemen
375	Uruguay	629	Yemen, People's Democratic Republic of
579	Urundi	453	Yugoslavia (former Yugoslavia region)
084	Utah		Yukon Territory
634	Uzbekistan	225	
634	Uzbek S.S.R.		Z
	V		
		541	Zaire
721	Vanuatu	549	Zambia
447	Vatican City	571	Zanzibar
545	Venda	547	Zimbabwe
321	Venezuela		

APPENDIX C

TABLE OF REQUIRED DATA ITEMS NAACCR VERSION 12.1

CHAPTER VIII:

REQUIRED STATUS TABLE (ITEM # ORDER)

The following table presents Version 12.1 of the NAACCR required status summarizing the requirements and recommendations for collection of each item by standard-setting groups. Differences from Version 12 are marked “Revised,” “New,” or “Retired” in the “Note” column of the table.

NPCR	Refers to requirements and recommendations of the NPCR regarding data items that should be collected or computed by NPCR state registries. The NPCR transmit column in the Required Status Table has been removed with Version 11.2. Transmit instructions will be provided by NPCR. <i>Note: Patient identifying data items collected are not transmitted to CDC.</i>
CoC	Refers to requirements of CoC. CoC-approved cancer program registries are required to collect the indicated items in the “Collect” column and are required to report items indicated in the “Transmit” column to the NCDB. Facilities should refer to the CoC <i>FORDS</i> manual for further clarification of required fields. <i>Note: Patient identifying data items collected are not transmitted to the NCDB.</i>
SEER	Refers to requirements of NCI’s SEER Program. Central registries are required to collect the indicated items in the “Collect” column and are required to report the items indicated in the “Transmit” column to NCI-SEER. Facilities and central registries should refer to the <i>SEER Program Code Manual</i> for further clarification of required fields.
CCCR	Refers to requirements of Canadian Council of Cancer Registries Provincial/Territorial Cancer Registries should refer to the <i>Canadian Cancer Registry System Guide</i> for further clarification of fields. Items indicated in the “Collect” column are required to be collected at the registry level and items indicated in the “Transmit” column are required to be reported to the Canadian Cancer Registry. CCCR requirements have been added to the Required Status Table with Version 11.2.

Exchange Elements for Hospital to Central and Central to Central

The target audience for this set of requirements is comprised of the various designers of registry software, at the hospital, central registry, and national levels. In the Exchange Elements columns, data items marked are either required by key national organizations for cancer reporting or are of special importance in the unambiguous communication of reports and the proper linking of records. A clear distinction is made between items required for facilities reporting to central registries (labeled Hosp → Central), and those items that central registries should use when sending cases to other central registries (labeled Central → Central). “T” is used when the data are vital to a complete exchange record. If a data item is unknown, it should have the proper code for unknown assigned. It is not specified how registries should handle records that have empty T fields. “T*” means the vendor should convey the data if they are available for any of the cases; otherwise, they can leave the field empty. The receiving end (central registry) may, of course, ignore these items if they so choose. “TH” means only certain historical cases may require these fields. Some central registries have additional required data fields. For these, vendors should contact the central registry directly.

Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
10	Record Type	R	.	R	.	R	.	.	T	T	NAACCR	
20	Patient ID Number	R	.	.	R	R	R*	R*	.	T	Reporting Registry	
21	Patient System ID-Hosp	.	.	.	.	.	.	.	T	.	NAACCR	
30	Registry Type	.	.	.	.	.	.	.	.	T	NAACCR	
35	FIN Coding System	.	.	.	.	.	R*	R*	.	.	NAACCR	
37	Reserved 00											
40	Registry ID	R	.	.	R	R	.	.	T	T	NAACCR	
45	NPI--Registry ID	.	.	.	R*	.	.	.	.	.	CMS	
50	NAACCR Record Version	R	.	R	.	.	.	.	T	T	NAACCR	
60	Tumor Record Number	.	.	.	S	S	R*	R*	T	T	NAACCR	
70	Addr at DX--City	R	R	R	R	.	R*	R*	T	T	CoC	
80	Addr at DX--State	R	R	R	R	.	.	.	T	T	CoC	
90	County at DX	R	R	R	R	R	.	.	T	T	FIPS/SEER	
100	Addr at DX--Postal Code	R	R	R	R	.	R*	R*	T	T	CoC	
110	Census Tract 1970/80/90	RH*	.	.	RH	RH	.	.	.	T*	SEER	
120	Census Cod Sys 1970/80/90	RH*	.	.	RH	RH	.	.	.	T*	SEER	
130	Census Tract 2000	R	.	.	R	R	.	.	.	T*	NAACCR	
135	Census Tract 2010	R*	.	.	.	.	.	.	.	.	NAACCR	New
140	Census Tract Cod Sys--Alt											Retired
150	Marital Status at DX	.	.	.	R	R	.	.	.	.	SEER	
160	Race 1	R	R	R	R	R	.	.	T	T	SEER/CoC	
161	Race 2	R	R	R	R	R	.	.	T	T	SEER/CoC	
162	Race 3	R	R	R	R	R	.	.	T	T	SEER/CoC	
163	Race 4	R	R	R	R	R	.	.	T	T	SEER/CoC	
164	Race 5	R	R	R	R	R	.	.	T	T	SEER/CoC	
170	Race Coding Sys--Current	.	R	R	.	.	.	.	T	T	NAACCR	
180	Race Coding Sys--Original	.	R	R	.	.	.	.	T	T	NAACCR	
190	Spanish/Hispanic Origin	R	R	R	R	R	.	.	T	T	SEER/CoC	
191	NHIA Derived Hisp Origin	D	.	.	D	R	.	.	.	.	NAACCR	
192	IHS Link	R*	.	.	.	R	.	.	.	.	NPCR	
193	Race--NAPIIA(derived API)	R	.	.	D	R	.	.	.	.	NAACCR	

Codes for Recommendations: R = Required. RH = Historically collected and currently transmitted. RC = Collected by SEER from CoC-approved hospitals. RS = Required, site specific. S = Supplementary/recommended. D = Derived. . = No recommendations. * = When available. # = Central registries may code available data using either the SEER or CoC data item and associated rules. ^ = These text requirements may be met with one or several text block fields. T = data is vital to complete exchange record. TH = only certain historical cases may require these fields. T* = transmit data if available for any case in exchange record.

Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
200	Computed Ethnicity	R	.	.	D	R	.	.	.	.	SEER	
210	Computed Ethnicity Source	R	.	.	R	R	.	.	.	.	SEER	
220	Sex	R	R	R	R	R	R*	R*	T	T	SEER/CoC	
230	Age at Diagnosis	R	R	R	R	R	D	D	.	.	SEER/CoC	
240	Date of Birth	R	R	R	R	R	R*	R*	T	T	SEER/CoC	
241	Date of Birth Flag	R	R	R	R	R	R*	R*	T	T	NAACCR	Revised
250	Birthplace	R*	R	R	R	R	R*	R*	T*	T	SEER/CoC	
260	Religion											Retired
270	Occupation Code--Census	R*	.	.	.	.	.	.	.	.	Census/NPCR	
280	Industry Code--Census	R*	.	.	.	.	.	.	.	.	Census/NPCR	
290	Occupation Source	R*	.	.	.	.	.	.	.	.	NPCR	
300	Industry Source	R*	.	.	.	.	.	.	.	.	NPCR	
310	Text--Usual Occupation	R*	.	.	.	.	.	.	T*	T*	NPCR	
320	Text--Usual Industry	R*	.	.	.	.	.	.	T*	T*	NPCR	
330	Occup/Ind Coding System	R*	.	.	.	.	.	.	.	.	NPCR	
340	Tobacco History											Retired
350	Alcohol History											Retired
360	Family History of Cancer											Retired
362	Census Block Group 2000	.	.	.	S	.	.	.	.	.	Census	
363	Census Block Group 2010	.	.	.	.	.	.	.	.	.	Census	New
364	Census Tr Cert 1970/80/90	RH*	.	.	RH	RH	.	.	.	.	SEER	
365	Census Tr Certainty 2000	R	.	.	R	R	.	.	.	.	NAACCR	
366	GIS Coordinate Quality	R*	.	.	S	.	.	.	.	.	NAACCR	
367	Census Tr Certainty 2010	R*	.	.	.	.	.	.	.	.	NAACCR	New
368	CensusBlockGroup 70/80/90	.	.	.	S	.	.	.	.	.	Census	
370	Reserved 01											
380	Sequence Number--Central	R	.	.	R	R	D	D	.	T	SEER	
390	Date of Diagnosis	R	R	R	R	R	R*	R*	T	T	SEER/CoC	
391	Date of Diagnosis Flag	R	.	.	R	R	R*	R*	T	T	NAACCR	Revised
400	Primary Site	R	R	R	R	R	.	.	T	T	SEER/CoC	
410	Laterality	R	R	R	R	R	R*	R*	T	T	SEER/CoC	

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Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
419	Morph--Type&Behav ICD-O-2	.	.	.	.	.	.	.	.	.
420	Histology (92-00) ICD-O-2	RH	RH	RH	RH	RH	RH	RH	TH	TH	SEER/CoC	
430	Behavior (92-00) ICD-O-2	RH	RH	RH	RH	RH	RH	RH	TH	TH	SEER/CoC	
439	Date of Mult Tumors Flag	.	R	R	R	R	.	.	.	.	NAACCR	
440	Grade	R	R	R	R	R	R*	R*	T	T	SEER/CoC	
441	Grade Path Value	R*	R	R	R	R	R*	R*	T*	T*	AJCC	Revised
442	Ambiguous Terminology DX	.	R	R	R	R	S	S	.	.	SEER	
443	Date of Conclusive DX	.	R	R	R	R	S	S	.	.	SEER	
444	Mult Tum Rpt as One Prim	.	R	R	R	R	S	S	.	.	SEER	
445	Date of Multiple Tumors	.	R	R	R	R	S	S	.	.	SEER	
446	Multiplicity Counter	.	R	R	R	R	S	S	.	.	SEER	
447	Number of Tumors/Hist										Retired	Retired
448	Date Conclusive DX Flag	.	R	R	R	R	R*	R*	.	.	NAACCR	Revised
449	Grade Path System	R*	R	R	R	R	R*	R*	T*	T*	AJCC	Revised
450	Site Coding Sys--Current	R	R	R	.	.	.	.	T	T	NAACCR	
460	Site Coding Sys--Original	.	R	R	.	.	R*	R*	T	T	NAACCR	
470	Morph Coding Sys--Current	R	R	R	.	.			T	T	NAACCR	
480	Morph Coding Sys--Originl	.	R	R	.	.	R*	R*	T	T	NAACCR	
490	Diagnostic Confirmation	R	R	R	R	R	.	.	T	T	SEER/CoC	
500	Type of Reporting Source	R	.	.	R	R	.	.	T	T	SEER	
501	Casefinding Source	.	.	.	.	.	.	.	T*	T*	NAACCR	
510	Screening Date											Retired
520	Screening Result											Retired
521	Morph--Type&Behav ICD-O-3	.	.	.	.	.	.	.
522	Histologic Type ICD-O-3	R	R	R	R	R	R*	R*	T	T	SEER/CoC	
523	Behavior Code ICD-O-3	R	R	R	R	R	R*	R*	T	T	SEER/CoC	
530	Reserved 02											
538	Reporting Hospital FAN											Retired
540	Reporting Facility	R	R	R	R	.	.	.	T	.	CoC	
545	NPI--Reporting Facility	R*	R	R	R*	CMS	

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Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
550	Accession Number--Hosp	.	R	R	R	.	.	.	T*	.	CoC	
560	Sequence Number--Hospital	.	R	R	R	.	.	.	T	.	CoC	
570	Abstracted By	.	R	R	R	.	.	.	.	.	CoC	
580	Date of 1st Contact	R	R	R	.	.	.	.	T	.	CoC	
581	Date of 1st Contact Flag	R	R	R	.	.	.	.	T	.	NAACCR	
590	Date of Inpatient Adm	.	.	.	.	.	.	.	.	.	NAACCR	
591	Date of Inpt Adm Flag	.	.	.	.	.	.	.	.	.	NAACCR	
600	Date of Inpatient Disch	.	.	.	.	.	.	.	.	.	NAACCR	
601	Date of Inpt Disch Flag	.	.	.	.	.	.	.	.	.	NAACCR	
605	Inpatient Status	.	.	.	.	.	.	.	.	.	NAACCR	
610	Class of Case	R	R	R	RC	.	.	.	T	.	CoC	
620	Year First Seen This CA											Retired
630	Primary Payer at DX	R*	R	R	R	R	.	.	.	.	CoC	
640	Inpatient/Outpt Status											Retired
650	Presentation at CA Conf											Retired
660	Date of CA Conference											Retired
665	RX Hosp--ASA Class	.	.	.	.	.	.	.	.	.		Retired
668	RX Hosp--Surg App 2010	.	R	R	.	.	.	.	T*	.	CoC	
670	RX Hosp--Surg Prim Site	.	R	R	R	.	.	.	T*	.	CoC	
672	RX Hosp--Scope Reg LN Sur	.	R	R	R	.	.	.	T*	.	CoC	
674	RX Hosp--Surg Oth Reg/Dis	.	R	R	R	.	.	.	T*	.	CoC	
676	RX Hosp--Reg LN Removed	.	RH	RH	.	.	.	.	T*	.	CoC	
678	RX Hosp--Surg Timing	.	.	.	.	.	.	.	.	.		Retired
680	Reserved 03											
690	RX Hosp--Radiation	.	.	.	RH	.	.	.	TH*	.	SEER	
700	RX Hosp--Chemo	.	R	R	R	.	.	.	T*	.	CoC	
710	RX Hosp--Hormone	.	R	R	R	.	.	.	T*	.	CoC	
720	RX Hosp--BRM	.	R	R	R	.	.	.	T*	.	CoC	
730	RX Hosp--Other	.	R	R	R	.	.	.	T*	.	CoC	
740	RX Hosp--DX/Stg Proc	.	R	R	CoC	
742	RX Hosp--Screen/BX Procl											Retired

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		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
743	RX Hosp--Screen/BX Proc2											Retired
744	RX Hosp--Screen/BX Proc3											Retired
745	RX Hosp--Screen/BX Proc4											Retired
746	RX Hosp--Surg Site 98-02	.	RH	RH	RH	.	.	.	TH*	.	CoC	
747	RX Hosp--Scope Reg 98-02	.	RH	RH	RH	.	.	.	TH*	.	CoC	
748	RX Hosp--Surg Oth 98-02	.	RH	RH	RH	.	.	.	TH*	.	CoC	
750	Reserved 04											
759	SEER Summary Stage 2000	RH	RH	RH	.	S	.	.	TH*	TH*	SEER	
760	SEER Summary Stage 1977	RH	RH	RH	.	S	.	.	TH*	TH*	SEER	
770	Loc/Reg/Distant Stage											Retired
779	Extent of Disease 10-Dig	.	.	.	.	.	.	.
780	EOD--Tumor Size	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER/CoC	
790	EOD--Extension	.	.	.	RH	RH	.	.	TH*	TH*	SEER	
800	EOD--Extension Prost Path	.	.	.	RH	RH	.	.	TH*	TH*	SEER	
810	EOD--Lymph Node Involv	.	.	.	RH	RH	.	.	TH*	TH*	SEER	
820	Regional Nodes Positive	R*	R	R	R	R	R*	R*	T*	T*	SEER/CoC	Revised
830	Regional Nodes Examined	R*	R	R	R	R	R*	R*	T*	T*	SEER/CoC	Revised
840	EOD--Old 13 Digit	.	.	.	RH	RH	.	.	.	.	SEER	
850	EOD--Old 2 Digit	.	.	.	RH	RH	.	.	.	.	SEER	
860	EOD--Old 4 Digit	.	.	.	RH	RH	.	.	.	.	SEER	
870	Coding System for EOD	.	.	.	RH	RH	.	.	.	TH*	SEER	
880	TNM Path T	.	R*	R*	.	.	.	.	T*	T*	AJCC	
890	TNM Path N	.	R*	R*	.	.	.	.	T*	T*	AJCC	
900	TNM Path M	.	R*	R*	.	.	.	.	T*	T*	AJCC	
910	TNM Path Stage Group	.	R*	R*	.	.	.	.	T*	T*	AJCC	
920	TNM Path Descriptor	.	R*	R*	.	.	.	.	T*	T*	CoC	
930	TNM Path Staged By	.	R*	R*	.	.	.	.	T*	T*	CoC	
940	TNM Clin T	.	R	R	.	.	.	.	T*	T*	AJCC	
950	TNM Clin N	.	R	R	T*	T*	AJCC	
960	TNM Clin M	.	R	R	T*	T*	AJCC	
970	TNM Clin Stage Group	.	R	R	T*	T*	AJCC	

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		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
980	TNM Clin Descriptor	.	R	R	.	.	.	.	T*	T*	CoC	
990	TNM Clin Staged By	.	R	R	.	.	.	.	T*	T*	CoC	
1000	TNM Other T											Retired
1010	TNM Other N											Retired
1020	TNM Other M											Retired
1030	TNM Other Stage Group											Retired
1040	TNM Other Staged By											Retired
1050	TNM Other Descriptor											Retired
1060	TNM Edition Number	.	R	R	.	.	.	.	T*	T*	CoC	
1070	Other Staging System											Retired
1080	Date of 1st Positive BX											Retired
1090	Site of Distant Met 1											Retired
1100	Site of Distant Met 2											Retired
1110	Site of Distant Met 3											Retired
1120	Pediatric Stage	.	.	.	.	.	.	.	.	.	CoC	
1130	Pediatric Staging System	.	.	.	.	.	.	.	.	.	CoC	
1140	Pediatric Staged By	.	.	.	.	.	.	.	.	.	CoC	
1150	Tumor Marker 1	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER	
1160	Tumor Marker 2	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER	
1170	Tumor Marker 3	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER	
1180	Reserved 05											
1182	Lymph-vascular Invasion	.	R	R	RS	RS	R*	R*	T*	T*	AJCC	Revised
1190	Reserved 06											
1200	RX Date--Surgery	R	R	R	S	.	.	.	T*	T*	CoC	Revised
1201	RX Date--Surgery Flag	R	R	R	S	.	.	.	T*	T*	NAACCR	Revised
1210	RX Date--Radiation	R	R	R	S	.	.	.	T*	T*	CoC	Revised
1211	RX Date--Radiation Flag	R	R	R	S	.	.	.	T*	T*	NAACCR	Revised
1220	RX Date--Chemo	R	R	R	.	.	.	.	T*	T*	CoC	Revised
1221	RX Date--Chemo Flag	R	R	R	.	.	.	.	T*	T*	NAACCR	Revised
1230	RX Date--Hormone	R	R	R	T*	T*	CoC	Revised
1231	RX Date--Hormone Flag	R	R	R	T*	T*	NAACCR	Revised

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		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
1240	RX Date--BRM	R	R	R	S	.	.	.	T*	T*	CoC	Revised
1241	RX Date--BRM Flag	R	R	R	S	.	.	.	T*	T*	NAACCR	Revised
1250	RX Date--Other	R	R	R	S	.	.	.	T*	T*	CoC	Revised
1251	RX Date--Other Flag	R	R	R	S	.	.	.	T*	T*	NAACCR	Revised
1260	Date of Initial RX--SEER	R#	.	.	R	R	.	.	T*	T*	SEER	
1261	Date of Initial RX Flag	R#	.	.	R	R	.	.	T*	T*	NAACCR	
1270	Date of 1st Crs RX--CoC	R#	R	R	.	.	.	.	T*	T*	CoC	
1271	Date of 1st Crs Rx Flag	R#	R	R	.	.	.	.	T*	T*	NAACCR	
1280	RX Date--DX/Stg Proc	.	R	R	.	.	.	.	.	.	CoC	
1281	RX Date--Dx/Stg Proc Flag	.	R	R	.	.	.	.	.	.	NAACCR	
1285	RX Summ--Treatment Status	R#	R	R	R	R	.	.	T*	T*	SEER/CoC	Revised
1290	RX Summ--Surg Prim Site	R	R	R	R	R	.	.	T	T*	SEER/CoC	
1292	RX Summ--Scope Reg LN Sur	R	R	R	R	R	.	.	T	T*	SEER/CoC	
1294	RX Summ--Surg Oth Reg/Dis	R	R	R	R	R	.	.	T	T*	SEER/CoC	
1296	RX Summ--Reg LN Examined	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER/CoC	
1300	Reserved 07											
1310	RX Summ--Surgical Approach	.	RH	RH	.	.	.	.	.	.	CoC	
1320	RX Summ--Surgical Margins	.	R	R	.	.	.	.	.	.	CoC	
1330	RX Summ--Reconstruct 1st	.	RH	RH	RH	RH	.	.	.	.	SEER	
1340	Reason for No Surgery	R	R	R	R	R	.	.	T	T*	SEER/CoC	
1350	RX Summ--DX/Stg Proc	.	R	R	.	.	.	.	.	.	CoC	
1360	RX Summ--Radiation	D	.	.	R	R	.	.	TH*	TH*	SEER	
1370	RX Summ--Rad to CNS	.	.	.	R	R	.	.	.	.	SEER/CoC	
1380	RX Summ--Surg/Rad Seq	R	R	R	R	R	.	.	T	T*	SEER/CoC	
1390	RX Summ--Chemo	R	R	R	R	R	.	.	T*	T*	SEER/CoC	
1400	RX Summ--Hormone	R	R	R	R	R	.	.	T*	T*	SEER/CoC	
1410	RX Summ--BRM	R	R	R	R	R	.	.	T*	T*	SEER/CoC	
1420	RX Summ--Other	R	R	R	R	R	.	.	T*	T*	SEER/CoC	
1430	Reason for No Radiation	R	R	R	CoC	Revised
1440	Reason for No Chemo											Retired
1450	Reason for No Hormone											Retired

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		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
1460	RX Coding System--Current	R	R	R	.	RH	.	.	T*	T*	NAACCR	
1470	Protocol Eligibility Stat											Retired
1480	Protocol Participation											Retired
1490	Referral to Support Serv											Retired
1500	First Course Calc Method	R	.	.	.	.	.	.	.	.	NAACCR	
1510	Rad--Regional Dose: CGY	.	R	R	.	.	.	.	T	.	CoC	
1520	Rad--No of Treatment Vol	.	R	R	.	.	.	.	T	.	CoC	
1530	Rad--Elapsed RX Days											Retired
1540	Rad--Treatment Volume	.	R	R	.	.	.	.	T	.	CoC	
1550	Rad--Location of RX	.	R	R	.	.	.	.	T	.	CoC	
1560	Rad--Intent of Treatment											Retired
1570	Rad--Regional RX Modality	R	R	R	RC	.	.	.	T	T*	CoC	
1580	Rad--RX Completion Status											Retired
1590	Rad--Local Control Status											Retired
1600	Chemotherapy Field 1											Retired
1610	Chemotherapy Field 2											Retired
1620	Chemotherapy Field 3											Retired
1630	Chemotherapy Field 4											Retired
1639	RX Summ--Systemic/Sur Seq	R	R	R	R	R	.	.	T	T	CoC	
1640	RX Summ--Surgery Type	.	.	.	RH	RH	.	.	TH*	TH*	SEER	
1642	RX Summ--Screen/BX Proc1											Retired
1643	RX Summ--Screen/BX Proc2											Retired
1644	RX Summ--Screen/BX Proc3											Retired
1645	RX Summ--Screen/BX Proc4											Retired
1646	RX Summ--Surg Site 98-02	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER/CoC	
1647	RX Summ--Scope Reg 98-02	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER/CoC	
1648	RX Summ--Surg Oth 98-02	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER/CoC	
1650	Reserved 08											
1660	Subsq RX 2nd Course Date	CoC	
1661	Subsq RX 2ndCrS Date Flag	NAACCR	
1670	Subsq RX 2nd Course Codes		

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		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
1671	Subsq RX 2nd Course Surg	.	.	.	.	.	.	.	.	.	CoC	
1672	Subsq RX 2nd Course Rad	.	.	.	.	.	.	.	.	.	CoC	
1673	Subsq RX 2nd Course Chemo	.	.	.	.	.	.	.	.	.	CoC	
1674	Subsq RX 2nd Course Horm	.	.	.	.	.	.	.	.	.	CoC	
1675	Subsq RX 2nd Course BRM	.	.	.	.	.	.	.	.	.	CoC	
1676	Subsq RX 2nd Course Oth	.	.	.	.	.	.	.	.	.	CoC	
1677	Subsq RX 2nd--Scope LN SU	.	.	.	.	.	.	.	.	.	CoC	
1678	Subsq RX 2nd--Surg Oth	.	.	.	.	.	.	.	.	.	CoC	
1679	Subsq RX 2nd--Reg LN Rem	.	.	.	.	.	.	.	.	.	CoC	
1680	Subsq RX 3rd Course Date	.	.	.	.	.	.	.	.	.	CoC	
1681	Subsq RX 3rdCrS Date Flag	.	.	.	.	.	.	.	.	.	NAACCR	
1690	Subsq RX 3rd Course Codes	.	.	.	.	.	.	.	.	.
1691	Subsq RX 3rd Course Surg	.	.	.	.	.	.	.	.	.	CoC	
1692	Subsq RX 3rd Course Rad	.	.	.	.	.	.	.	.	.	CoC	
1693	Subsq RX 3rd Course Chemo	.	.	.	.	.	.	.	.	.	CoC	
1694	Subsq RX 3rd Course Horm	.	.	.	.	.	.	.	.	.	CoC	
1695	Subsq RX 3rd Course BRM	.	.	.	.	.	.	.	.	.	CoC	
1696	Subsq RX 3rd Course Oth	.	.	.	.	.	.	.	.	.	CoC	
1697	Subsq RX 3rd--Scope LN Su	.	.	.	.	.	.	.	.	.	CoC	
1698	Subsq RX 3rd--Surg Oth	.	.	.	.	.	.	.	.	.	CoC	
1699	Subsq RX 3rd--Reg LN Rem	.	.	.	.	.	.	.	.	.	CoC	
1700	Subsq RX 4th Course Date	.	.	.	.	.	.	.	.	.	CoC	
1701	Subsq RX 4thCrS Date Flag	.	.	.	.	.	.	.	.	.	NAACCR	
1710	Subsq RX 4th Course Codes	.	.	.	.	.	.	.	.	.
1711	Subsq RX 4th Course Surg	.	.	.	.	.	.	.	.	.	CoC	
1712	Subsq RX 4th Course Rad	.	.	.	.	.	.	.	.	.	CoC	
1713	Subsq RX 4th Course Chemo	.	.	.	.	.	.	.	.	.	CoC	
1714	Subsq RX 4th Course Horm	.	.	.	.	.	.	.	.	.	CoC	
1715	Subsq RX 4th Course BRM	CoC	
1716	Subsq RX 4th Course Oth	CoC	
1717	Subsq RX 4th--Scope LN Su	CoC	

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Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
1718	Subsq RX 4th--Surg Oth	.	.	.	.	.	.	.	.	.	CoC	
1719	Subsq RX 4th--Reg LN Rem	.	.	.	.	.	.	.	.	.	CoC	
1720	Subsq RX 5th Course Date											Retired
1730	Subsq RX 5th Course Codes											Retired
1731	Subsq RX 5th Course Surg											Retired
1732	Subsq RX 5th Course Rad											Retired
1733	Subsq RX 5th Course Chemo											Retired
1734	Subsq RX 5th Course Horm											Retired
1735	Subsq RX 5th Course BRM											Retired
1736	Subsq RX 5th Course Oth											Retired
1737	Subsq RX 5th--Scope LN Su											Retired
1738	Subsq RX 5th--Surg Oth											Retired
1739	Subsq RX 5th--Reg LN Rem											Retired
1740	Reserved 09											
1741	Subsq RX--Reconstruct Del	.	.	.	.	.	.	.	.	.	CoC	
1750	Date of Last Contact	R	R	R	R	R	.	.	T	T	SEER/CoC	
1751	Date of Last Contact Flag	R	R	R	R	R	.	.	T	T	NAACCR	
1755	Date of Death--Canada	.	.	.	.	.	R*	R*	.	.	CCCR	
1756	Date of Death--CanadaFlag	.	.	.	.	.	R*	R*	.	.	NAACCR	Revised
1760	Vital Status	R	R	R	R	R	D	D	T	T	SEER/CoC	
1770	Cancer Status	.	R	R	.	.	.	.	.	.	CoC	
1780	Quality of Survival	.	.	.	.	.	.	.	.	.	CoC	
1790	Follow-Up Source	R*	R	.	.	.	.	.	T*	.	CoC	
1791	Follow-up Source Central	R	.	.	.	.	.	.	.	T*	NAACCR	
1800	Next Follow-Up Source	.	R	.	.	.	.	.	.	.	CoC	
1810	Addr Current--City	.	R	.	R	.	.	.	T*	.	CoC	
1820	Addr Current--State	.	R	.	R	.	.	.	T*	.	CoC	
1830	Addr Current--Postal Code	.	R	.	R	.	.	.	T*	.	CoC	
1835	Reserved 10											
1840	County--Current	NAACCR	
1842	Follow-Up Contact--City	.	.	.	R	.	.	.	T*	.	SEER	

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Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
1844	Follow-Up Contact--State	.	.	.	R	.	.	.	T*	.	SEER	
1846	Follow-Up Contact--Postal	.	.	.	R	.	.	.	T*	.	SEER	
1850	Unusual Follow-Up Method	.	.	.	.	.	.	.	.	.	CoC	
1860	Recurrence Date--1st	.	R	R	RC	.	.	.	T*	.	CoC	
1861	Recurrence Date--1st Flag	.	R	R	RC	.	.	.	T*	.	NAACCR	
1870	Recurrence Distant Sites											Retired
1871	Recurrence Distant Site 1											Retired
1872	Recurrence Distant Site 2											Retired
1873	Recurrence Distant Site 3											Retired
1880	Recurrence Type--1st	.	R	R	RC	.	.	.	T*	.	CoC	
1890	Recurrence Type--1st--Oth											Retired
1900	Reserved 11											
1910	Cause of Death	R	.	.	R	R	R*	R*	.	T	SEER	
1920	ICD Revision Number	R	.	.	R	R	.	.	.	T	SEER	
1930	Autopsy	.	.	.	.	.	R*	R*	.	.	NAACCR	
1940	Place of Death	R	.	.	.	.	R*	R*	T*	T*	NPCR	
1960	Site (73-91) ICD-O-1	.	.	.	RH	RH	.	.	.	.	SEER	
1970	Morph (73-91) ICD-O-1											
1971	Histology (73-91) ICD-O-1	.	.	.	RH	RH	.	.	.	.	SEER	
1972	Behavior (73-91) ICD-O-1	.	.	.	RH	RH	.	.	.	.	SEER	
1973	Grade (73-91) ICD-O-1	.	.	.	RH	RH	.	.	.	.	SEER	
1980	ICD-O-2 Conversion Flag	.	RH	RH	R	R	.	.	T*	T*	SEER	
1981	Over-ride SS/NodesPos	.	.	.	.	.	.	.	T*	T*	NAACCR	
1982	Over-ride SS/TNM-N	.	.	.	.	.	.	.	T*	T*	NAACCR	
1983	Over-ride SS/TNM-M	.	.	.	.	.	.	.	T*	T*	NAACCR	
1984	Over-ride SS/DisMet1											Retired
1985	Over-ride Acsn/Class/Seq	.	R	R	.	.	.	.	T*	T*	CoC	
1986	Over-ride HospSeq/DxConf	.	R	R	.	.	.	.	T*	T*	CoC	
1987	Over-ride CoC-Site/Type	.	R	R	.	.	.	.	T*	T*	CoC	
1988	Over-ride HospSeq/Site	.	R	R	T*	T*	CoC	
1989	Over-ride Site/TNM-StgGrp	.	R	R	T*	T*	CoC	

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		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
1990	Over-ride Age/Site/Morph	R	R	R	R	R	.	.	T*	T*	SEER	
2000	Over-ride SeqNo/DxConf	R	.	.	R	R	.	.	T*	T*	SEER	
2010	Over-ride Site/Lat/SeqNo	R	.	.	R	R	.	.	T*	T*	SEER	
2020	Over-ride Surg/DxConf	R	R	R	R	R	.	.	T*	T*	SEER	
2030	Over-ride Site/Type	R	R	R	R	R	.	.	T*	T*	SEER	
2040	Over-ride Histology	R	R	R	R	R	.	.	T*	T*	SEER	
2050	Over-ride Report Source	R	.	.	R	R	.	.	T*	T*	SEER	
2060	Over-ride Ill-define Site	R	.	.	R	R	.	.	T*	T*	SEER	
2070	Over-ride Leuk, Lymphoma	R	R	R	R	R	.	.	T*	T*	SEER	
2071	Over-ride Site/Behavior	R	R	R	R	R	.	.	T*	T*	SEER	
2072	Over-ride Site/EOD/DX Dt	.	.	.	R	R	.	.	T*	T*	SEER	
2073	Over-ride Site/Lat/EOD	.	.	.	R	R	.	.	T*	T*	SEER	
2074	Over-ride Site/Lat/Morph	R	R	R	R	R	.	.	T*	T*	SEER	
2080	Reserved 13											
2081	CRC CHECKSUM	.	.	.	S	S	.	.	.	.	NAACCR	
2085	Date Case Initiated	.	.	.	.	.	.	.	.	.	NAACCR	
2090	Date Case Completed	.	.	.	.	.	.	.	.	.	NAACCR	
2092	Date Case Completed--CoC	.	R	R	.	.	.	.	.	.	CoC	
2100	Date Case Last Changed	.	D	R	.	.	.	.	.	.	NAACCR	Revised
2110	Date Case Report Exported	R	.	.	.	.	.	.	T	.	NPCR	
2111	Date Case Report Received	R	.	.	.	.	.	.	.	.	NPCR	
2112	Date Case Report Loaded	R	.	.	.	.	.	.	.	.	NPCR	
2113	Date Tumor Record Availbl	R	.	.	.	.	.	.	.	.	NPCR	
2114	Future Use Timeliness 1											Retired
2115	Future Use Timeliness 2											Retired
2116	ICD-O-3 Conversion Flag	R	.	.	R	R	.	.	T	T	SEER/CoC	
2120	SEER Coding Sys--Current	.	.	.	.	R	.	.	T*	T*	NAACCR	
2130	SEER Coding Sys--Original	.	.	.	.	R	.	.	T*	T*	NAACCR	
2140	CoC Coding Sys--Current	.	R	R	.	.	.	.	T*	T*	CoC	
2150	CoC Coding Sys--Original	.	R	R	T*	T*	CoC	
2160	Subsq Report for Primary											Retired

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		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
2170	Vendor Name	.	R	R	.	.	.	.	T	T	NAACCR	
2180	SEER Type of Follow-Up	.	.	.	R	R	.	.	.	.	SEER	
2190	SEER Record Number	.	.	.	.	R	.	.	.	.	SEER	
2200	Diagnostic Proc 73-87	.	.	.	RH	RH	.	.	.	.	SEER	
2210	Reserved 14											
2220	State/Requestor Items	.	.	.	.	.	.	.	.	.	Varies	
2230	Name--Last	R	R	.	R	.	R*	R*	T	T	CoC	
2240	Name--First	R	R	.	R	.	R*	R*	T	T	CoC	
2250	Name--Middle	R	R	.	R	.	R*	R*	T*	T*	CoC	
2260	Name--Prefix	.	.	.	.	.	.	.	.	.	CoC	
2270	Name--Suffix	.	.	.	R	.	.	.	T*	T*	CoC	
2280	Name--Alias	R	.	.	R	.	.	.	T*	T*	CoC	
2290	Name--Spouse/Parent	.	.	.	.	.	.	.	.	.	NAACCR	
2300	Medical Record Number	R	R	.	R	.	.	.	T	.	CoC	
2310	Military Record No Suffix	.	.	.	.	.	.	.	.	.	CoC	Revised
2320	Social Security Number	R	R	.	R	.	.	.	T	T	CoC	
2330	Addr at DX--No & Street	R	R	.	R	.	.	.	T	T	CoC	
2335	Addr at DX--Supplementl	R	R*	.	R	.	.	.	T*	T*	CoC	
2350	Addr Current--No & Street	.	R	.	R	.	.	.	T*	T*	CoC	
2352	Latitude	R*	.	.	S	.	.	.	.	.	NAACCR	
2354	Longitude	R*	.	.	S	.	.	.	.	.	NAACCR	
2355	Addr Current--Supplementl	.	R*	.	R	.	.	.	T*	.	CoC	
2360	Telephone	.	R	.	R	.	.	.	T*	T*	CoC	
2370	DC State											Retired
2380	DC State File Number	R	.	.	R*	.	.	.	.	T*	State	
2390	Name--Maiden	R	.	.	R	.	.	.	T*	T*	CoC	
2392	Follow-Up Contact--No&St	.	.	.	R	.	.	.	.	.	SEER	
2393	Follow-Up Contact--Suppl	.	.	.	R	.	.	.	.	.	SEER	
2394	Follow-Up Contact--Name	.	.	.	R	SEER	
2400	Reserved 16											
2410	Institution Referred From	T*	.	CoC	Revised

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		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
2415	NPI--Inst Referred From	.	R	.	.	.	.	.	.	.	CMS	
2420	Institution Referred To	.	.	.	.	.	.	.	T*	.	CoC	Revised
2425	NPI--Inst Referred To	.	R	.	.	.	.	.	.	.	CMS	
2430	Last Follow-Up Hospital											Retired
2440	Following Registry	.	.	.	R	.	.	.	.	.	CoC	
2445	NPI--Following Registry	.	.	.	R*	.	.	.	.	.	CMS	
2450	Reserved 17											
2460	Physician--Managing	.	.	.	.	.	.	.	.	.	NAACCR	
2465	NPI--Physician--Managing	.	R	.	.	.	.	.	.	.	CMS	
2470	Physician--Follow-Up	.	.	.	R	.	.	.	T*	T*	CoC	Revised
2475	NPI--Physician--Follow-Up	.	R	.	R*	.	.	.	.	.	CMS	
2480	Physician--Primary Surg	.	.	.	.	.	.	.	.	.	CoC	Revised
2485	NPI--Physician--Primary Surg	.	R	R	.	.	.	.	.	.	CMS	
2490	Physician 3	.	.	.	.	.	.	.	.	.	CoC	Revised
2495	NPI--Physician 3	.	R	R	.	.	.	.	.	.	CMS	
2500	Physician 4	.	.	.	.	.	.	.	.	.	CoC	Revised
2505	NPI--Physician 4	.	R	R	.	.	.	.	.	.	CMS	
2510	Reserved 12											
2520	Text--DX Proc--PE	R^	.	.	R	.	.	.	T*	T*	NPCR	
2530	Text--DX Proc--X-ray/Scan	R^	.	.	R	.	.	.	T*	T*	NPCR	
2540	Text--DX Proc--Scopes	R^	.	.	R	.	.	.	T*	T*	NPCR	
2550	Text--DX Proc--Lab Tests	R^	.	.	R	.	.	.	T*	T*	NPCR	
2560	Text--DX Proc--Op	R^	.	.	R	.	.	.	T*	T*	NPCR	
2570	Text--DX Proc--Path	R^	.	.	R	.	.	.	T*	T*	NPCR	
2580	Text--Primary Site Title	R^	.	.	R	.	.	.	T*	T*	NPCR	
2590	Text--Histology Title	R^	.	.	R	.	.	.	T*	T*	NPCR	
2600	Text--Staging	R^	.	.	R	.	.	.	T*	T*	NPCR	
2610	RX Text--Surgery	R^	.	.	R	.	.	.	T*	T*	NPCR	
2620	RX Text--Radiation (Beam)	R^	.	.	R	.	.	.	T*	T*	NPCR	
2630	RX Text--Radiation Other	R^	.	.	R	.	.	.	T*	T*	NPCR	
2640	RX Text--Chemo	R^	.	.	R	.	.	.	T*	T*	NPCR	

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		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
2650	RX Text--Hormone	R^	.	.	R	.	.	.	T*	T*	NPCR	
2660	RX Text--BRM	R^	.	.	R	.	.	.	T*	T*	NPCR	
2670	RX Text--Other	R^	.	.	R	.	.	.	T*	T*	NPCR	
2680	Text--Remarks	.	.	.	R	.	.	.	T*	T*	NPCR	
2690	Text--Place of Diagnosis	.	.	.	.	.	.	.	.	.	NPCR	
2730	CS PreRx Tumor Size	.	.	.	.	.	.	.	.	.	AJCC	Revised
2735	CS PreRx Extension	.	.	.	.	.	.	.	.	.	AJCC	Revised
2740	CS PreRx Tum Sz/Ext Eval	.	.	.	.	.	.	.	.	.	AJCC	Revised
2750	CS PreRx Lymph Nodes	.	.	.	.	.	.	.	.	.	AJCC	Revised
2755	CS PreRx Reg Nodes Eval	.	.	.	.	.	.	.	.	.	AJCC	Revised
2760	CS PreRx Mets at DX	.	.	.	.	.	.	.	.	.	AJCC	Revised
2765	CS PreRx Mets Eval	.	.	.	.	.	.	.	.	.	AJCC	Revised
2770	CS PostRx Tumor Size	.	.	.	.	.	.	.	.	.	AJCC	Revised
2775	CS PostRx Extension	.	.	.	.	.	.	.	.	.	AJCC	Revised
2780	CS PostRx Lymph Nodes	.	.	.	.	.	.	.	.	.	AJCC	Revised
2785	CS PostRx Mets at DX	.	.	.	.	.	.	.	.	.	AJCC	Revised
2800	CS Tumor Size	R	R	R	R	R	R*	R*	T	T	AJCC	
2810	CS Extension	R	R	R	R	R	R*	R*	T	T	AJCC	
2820	CS Tumor Size/Ext Eval	R	R	R	R	R	R*	R*	T*	T*	AJCC	
2830	CS Lymph Nodes	R	R	R	R	R	R*	R*	T	T	AJCC	
2840	CS Lymph Nodes Eval	R*	R	R	R	R	R*	R*	T*	T*	AJCC	Revised
2850	CS Mets at DX	R	R	R	R	R	R*	R*	T	T	AJCC	
2851	CS Mets at Dx-Bone	.	R	R	R	R	.	.	T*	T*	AJCC	
2852	CS Mets at Dx-Brain	.	R	R	R	R	.	.	T*	T*	AJCC	
2853	CS Mets at Dx-Liver	.	R	R	R	R	.	.	T*	T*	AJCC	
2854	CS Mets at Dx-Lung	.	R	R	R	R	.	.	T*	T*	AJCC	
2860	CS Mets Eval	R*	R	R	R	R	R*	R*	T*	T*	AJCC	Revised
2861	CS Site-Specific Factor 7	RS*	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2862	CS Site-Specific Factor 8	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2863	CS Site-Specific Factor 9	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2864	CS Site-Specific Factor10	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised

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		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
2865	CS Site-Specific Factor11	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2866	CS Site-Specific Factor12	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2867	CS Site-Specific Factor13	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2868	CS Site-Specific Factor14	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2869	CS Site-Specific Factor15	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2870	CS Site-Specific Factor16	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2871	CS Site-Specific Factor17	RS*	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2872	CS Site-Specific Factor18	RS*	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2873	CS Site-Specific Factor19	RS*	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2874	CS Site-Specific Factor20	RS*	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2875	CS Site-Specific Factor21	RS*	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2876	CS Site-Specific Factor22	RS*	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2877	CS Site-Specific Factor23	RS*	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2878	CS Site-Specific Factor24	RS*	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2879	CS Site-Specific Factor25	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC	Revised
2880	CS Site-Specific Factor 1	RS	RS	RS	R	R	RS	RS	T*	T*	AJCC	Revised
2890	CS Site-Specific Factor 2	RS	RS	RS	R	R	RS	RS	T*	T*	AJCC	Revised
2900	CS Site-Specific Factor 3	RS	RS	RS	R	R	RS	RS	T*	T*	AJCC	Revised
2910	CS Site-Specific Factor 4	RS*	RS	RS	R	R	RS	RS	T*	T*	AJCC	Revised
2920	CS Site-Specific Factor 5	RS*	RS	RS	R	R	RS	RS	T*	T*	AJCC	Revised
2930	CS Site-Specific Factor 6	RS*	RS	RS	R	R	RS	RS	T*	T*	AJCC	Revised
2935	CS Version Input Original	R	R	R	D	R	R*	R*	.	.	AJCC	
2936	CS Version Derived	R	R	R	D	R	D	D	.	.	AJCC	
2937	CS Version Input Current	R	R	R	D	R	.	.	T*	T*	AJCC	
2940	Derived AJCC-6 T	.	D	R	D	R	D	D	T*	T*	AJCC	
2950	Derived AJCC-6 T Descript	.	D	R	D	R	D	D	T*	T*	AJCC	
2960	Derived AJCC-6 N	.	D	R	D	R	D	D	T*	T*	AJCC	
2970	Derived AJCC-6 N Descript	.	D	R	D	R	D	D	T*	T*	AJCC	
2980	Derived AJCC-6 M	.	D	R	D	R	D	D	T*	T*	AJCC	
2990	Derived AJCC-6 M Descript	.	D	R	D	R	D	D	T*	T*	AJCC	
3000	Derived AJCC-6 Stage Grp	.	D	R	D	R	D	D	T*	T*	AJCC	

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		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
3010	Derived SS1977	.	D	R	D	R	D	D	T*	T*	AJCC	
3020	Derived SS2000	D	D	R	D	R	D	D	T*	T*	AJCC	
3030	Derived AJCC--Flag	.	D	R	D	R	D	D	T*	T*	AJCC	
3040	Derived SS1977--Flag	.	D	R	D	R	D	D	T*	T*	AJCC	
3050	Derived SS2000--Flag	D	D	R	D	R	D	D	T*	T*	AJCC	
3100	Archive FIN	.	R	R	.	.	.	.	.	.	CoC	
3105	NPI--Archive FIN	.	R	R	.	.	.	.	.	.	CMS	
3110	Comorbid/Complication 1	.	R	R	.	.	.	.	T*	.	CoC	
3120	Comorbid/Complication 2	.	R	R	.	.	.	.	T*	.	CoC	
3130	Comorbid/Complication 3	.	R	R	.	.	.	.	T*	.	CoC	
3140	Comorbid/Complication 4	.	R	R	.	.	.	.	T*	.	CoC	
3150	Comorbid/Complication 5	.	R	R	.	.	.	.	T*	.	CoC	
3160	Comorbid/Complication 6	.	R	R	.	.	.	.	T*	.	CoC	
3161	Comorbid/Complication 7	.	R	R	.	.	.	.	T*	.	CoC	
3162	Comorbid/Complication 8	.	R	R	.	.	.	.	T*	.	CoC	
3163	Comorbid/Complication 9	.	R	R	.	.	.	.	T*	.	CoC	
3164	Comorbid/Complication 10	.	R	R	.	.	.	.	T*	.	CoC	
3165	ICD Revision Comorbid	.	R	R	.	.	.	.	T*	.	CoC	
3170	RX Date--Most Defin Surg	.	R	R	.	.	.	.	T*	.	CoC	
3171	RX Date Mst Defn Srg Flag	.	R	R	.	.	.	.	T*	.	NAACCR	
3180	RX Date--Surgical Disch	.	R	R	.	.	.	.	.	.	CoC	
3181	RX Date Surg Disch Flag	.	R	R	.	.	.	.	.	.	NAACCR	
3190	Readm Same Hosp 30 Days	.	R	R	.	.	.	.	.	.	CoC	
3200	Rad--Boost RX Modality	.	R	R	RC	.	.	.	T*	T*	CoC	
3210	Rad--Boost Dose cGy	.	R	R	.	.	.	.	.	.	CoC	
3220	RX Date--Radiation Ended	.	R	R	.	.	.	.	.	.	CoC	
3221	RX Date Rad Ended Flag	.	R	R	.	.	.	.	.	.	NAACCR	
3230	RX Date--Systemic	.	R	R	S	.	.	.	T*	T*	CoC	
3231	RX Date Systemic Flag	.	R	R	S	.	.	.	T*	T*	NAACCR	
3250	RX Summ--Transplnt/Endocr	R	R	R	R	R	.	.	T*	T*	CoC	
3260	Pain Assessment											Retired

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		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
3270	RX Summ--Palliative Proc	.	R	R	.	.	.	.	T*	.	CoC	
3280	RX Hosp--Palliative Proc	.	R	R	.	.	.	.	T*	.	CoC	
3300	RuralUrban Continuum 1993	D	.	.	.	.	.	.	.	.	NAACCR	
3310	RuralUrban Continuum 2003	D	.	.	.	.	.	.	.	.	NAACCR	
3400	Derived AJCC-7 T	D*	D	R	D	R	D	D	T*	T*	AJCC	Revised
3402	Derived AJCC-7 T Descript	D*	D	R	D	R	D	D	T*	T*	AJCC	Revised
3410	Derived AJCC-7 N	D*	D	R	D	R	D	D	T*	T*	AJCC	Revised
3412	Derived AJCC-7 N Descript	D*	D	R	D	R	D	D	T*	T*	AJCC	Revised
3420	Derived AJCC-7 M	D*	D	R	D	R	D	D	T*	T*	AJCC	Revised
3422	Derived AJCC-7 M Descript	D*	D	R	D	R	D	D	T*	T*	AJCC	Revised
3430	Derived AJCC-7 Stage Grp	D*	D	R	D	R	D	D	T*	T*	AJCC	Revised
3440	Derived PreRx-7 T	.	.	.	.	.	D	D	.	.	AJCC	Revised
3442	Derived PreRx-7 T Descrip	.	.	.	.	.	D	D	.	.	AJCC	Revised
3450	Derived PreRx-7 N	.	.	.	.	.	D	D	.	.	AJCC	Revised
3452	Derived PreRx-7 N Descrip	.	.	.	.	.	D	D	.	.	AJCC	Revised
3460	Derived PreRx-7 M	.	.	.	.	.	D	D	.	.	AJCC	Revised
3462	Derived PreRx-7 M Descrip	.	.	.	.	.	D	D	.	.	AJCC	Revised
3470	Derived PreRx-7 Stage Grp	.	.	.	.	.	D	D	.	.	AJCC	Revised
3480	Derived PostRx-7 T	.	.	.	.	.	D	D	.	.	AJCC	Revised
3482	Derived PostRx-7 N	.	.	.	.	.	D	D	.	.	AJCC	Revised
3490	Derived PostRx-7 M	.	.	.	.	.	D	D	.	.	AJCC	Revised
3492	Derived PostRx-7 Stge Grp	.	.	.	.	.	D	D	.	.	AJCC	Revised
3600	Derived Neoadjuv Rx Flag	.	.	.	.	.	D	D	T*	T*	AJCC	
3700	SEER Site-Specific Fact 1	.	.	.	.	.	.	.	.	.	SEER	
3702	SEER Site-Specific Fact 2	.	.	.	.	.	.	.	.	.	SEER	
3704	SEER Site-Specific Fact 3	.	.	.	.	.	.	.	.	.	SEER	
3706	SEER Site-Specific Fact 4	.	.	.	.	.	.	.	.	.	SEER	
3708	SEER Site-Specific Fact 5	.	.	.	.	.	.	.	.	.	SEER	
3710	SEER Site-Specific Fact 6	.	.	.	.	.	.	.	.	.	SEER	
3750	Over-ride CS 1	.	.	.	.	.	.	.	.	.	AJCC	New
3751	Over-ride CS 2	.	.	.	.	.	.	.	.	.	AJCC	New

Codes for Recommendations: R = Required. RH = Historically collected and currently transmitted. RC = Collected by SEER from CoC-approved hospitals. RS = Required, site specific. S = Supplementary/recommended. D = Derived. • = No recommendations. * = When available. # = Central registries may code available data using either the SEER or CoC data item and associated rules. ^ = These text requirements may be met with one or several text block fields. T = data is vital to complete exchange record. TH = only certain historical cases may require these fields. T* = transmit data if available for any case in exchange record.

Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
3752	Over-ride CS 3	.	.	.	.	.	.	.	.	.	AJCC	New
3753	Over-ride CS 4	.	.	.	.	.	.	.	.	.	AJCC	New
3754	Over-ride CS 5	.	.	.	.	.	.	.	.	.	AJCC	New
3755	Over-ride CS 6	.	.	.	.	.	.	.	.	.	AJCC	New
3756	Over-ride CS 7	.	.	.	.	.	.	.	.	.	AJCC	New
3757	Over-ride CS 8	.	.	.	.	.	.	.	.	.	AJCC	New
3758	Over-ride CS 9	.	.	.	.	.	.	.	.	.	AJCC	New
3759	Over-ride CS 10	.	.	.	.	.	.	.	.	.	AJCC	New
3760	Over-ride CS 11	.	.	.	.	.	.	.	.	.	AJCC	New
3761	Over-ride CS 12	.	.	.	.	.	.	.	.	.	AJCC	New
3762	Over-ride CS 13	.	.	.	.	.	.	.	.	.	AJCC	New
3763	Over-ride CS 14	.	.	.	.	.	.	.	.	.	AJCC	New
3764	Over-ride CS 15	.	.	.	.	.	.	.	.	.	AJCC	New
3765	Over-ride CS 16	.	.	.	.	.	.	.	.	.	AJCC	New
3766	Over-ride CS 17	.	.	.	.	.	.	.	.	.	AJCC	New
3767	Over-ride CS 18	.	.	.	.	.	.	.	.	.	AJCC	New
3768	Over-ride CS 19	.	.	.	.	.	.	.	.	.	AJCC	New
3769	Over-ride CS 20	.	.	.	.	.	.	.	.	.	AJCC	New
7010	Path Reporting Fac ID 1	.	.	.	.	.	.	.	.	.	HL7	
7011	Path Reporting Fac ID 2	.	.	.	.	.	.	.	.	.	HL7	
7012	Path Reporting Fac ID 3	.	.	.	.	.	.	.	.	.	HL7	
7013	Path Reporting Fac ID 4	.	.	.	.	.	.	.	.	.	HL7	
7014	Path Reporting Fac ID 5	.	.	.	.	.	.	.	.	.	HL7	
7090	Path Report Number 1	.	.	.	.	.	.	.	.	.	HL7	
7091	Path Report Number 2	.	.	.	.	.	.	.	.	.	HL7	
7092	Path Report Number 3	.	.	.	.	.	.	.	.	.	HL7	
7093	Path Report Number 4	.	.	.	.	.	.	.	.	.	HL7	
7094	Path Report Number 5	.	.	.	.	.	.	.	.	.	HL7	
7100	Path Order Phys Lic No 1	.	.	.	.	.	.	.	.	.	HL7	
7101	Path Order Phys Lic No 2	.	.	.	.	.	.	.	.	.	HL7	
7102	Path Order Phys Lic No 3	.	.	.	.	.	.	.	.	.	HL7	

Codes for Recommendations: R = Required. RH = Historically collected and currently transmitted. RC = Collected by SEER from CoC-approved hospitals. RS = Required, site specific. S = Supplementary/recommended. D = Derived. • = No recommendations. * = When available. # = Central registries may code available data using either the SEER or CoC data item and associated rules. ^ = These text requirements may be met with one or several text block fields. T = data is vital to complete exchange record. TH = only certain historical cases may require these fields. T* = transmit data if available for any case in exchange record.

Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements		Source of Standard	Note
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central		
7103	Path Order Phys Lic No 4	.	.	.	.	.	.	.	.	.	HL7	
7104	Path Order Phys Lic No 5	.	.	.	.	.	.	.	.	.	HL7	
7190	Path Ordering Fac No 1	.	.	.	.	.	.	.	.	.	HL7	
7191	Path Ordering Fac No 2	.	.	.	.	.	.	.	.	.	HL7	
7192	Path Ordering Fac No 3	.	.	.	.	.	.	.	.	.	HL7	
7193	Path Ordering Fac No 4	.	.	.	.	.	.	.	.	.	HL7	
7194	Path Ordering Fac No 5	.	.	.	.	.	.	.	.	.	HL7	
7320	Path Date Spec Collect 1	.	.	.	.	.	.	.	.	.	HL7	
7321	Path Date Spec Collect 2	.	.	.	.	.	.	.	.	.	HL7	
7322	Path Date Spec Collect 3	.	.	.	.	.	.	.	.	.	HL7	
7323	Path Date Spec Collect 4	.	.	.	.	.	.	.	.	.	HL7	
7324	Path Date Spec Collect 5	.	.	.	.	.	.	.	.	.	HL7	
7480	Path Report Type 1	.	.	.	.	.	.	.	.	.	HL7	
7481	Path Report Type 2	.	.	.	.	.	.	.	.	.	HL7	
7482	Path Report Type 3	.	.	.	.	.	.	.	.	.	HL7	
7483	Path Report Type 4	.	.	.	.	.	.	.	.	.	HL7	
7484	Path Report Type 5	.	.	.	.	.	.	.	.	.	HL7	

Codes for Recommendations: R = Required. RH = Historically collected and currently transmitted. RC = Collected by SEER from CoC-approved hospitals. RS = Required, site specific. S = Supplementary/recommended. D = Derived. • = No recommendations. * = When available. # = Central registries may code available data using either the SEER or CoC data item and associated rules. ^ = These text requirements may be met with one or several text block fields. T = data is vital to complete exchange record. TH = only certain historical cases may require these fields. T* = transmit data if available for any case in exchange record.

APPENDIX D

REFERENCES AND RESOURCES

STAGING AND CODING MANUALS BY EDITION AND DATE IMPLEMENTED

International Classification of Diseases for Oncology

First Edition	1976 - 1991
Second Edition	1992 - 2000
Third Edition	2001 +

American Joint Committee on Cancer TNM Staging System

Second Edition	1983 - 1988
Third Edition	1989 - 1992
Fourth Edition	1993 - 1997
Fifth Edition	1998 - 2002
Sixth Edition	2003 - 2009
Seventh Edition	2010 -

SEER Extent of Disease Manual (not required in NJ until 2000)

First Edition	1988 - 1991
Second Edition	1992 - 1997
Third Edition	1998 - 2003

Summary Staging

Summary Staging Guide	1977 - 2000
SEER Summary Staging Manual 2000	2001 -

Collaborative Staging System

Version 1	2004 - 2009
Version 2	2010 -

Data Collection

Data Acquisition Manual	1988-1994
1 st revision 10/89	
2 nd revision 10/90	
Data Acquisition Manual, revised	1994-1995

Registry Operations and Data Standards

(ROADS Manual)	1996 - 2002
2-digit surgery codes	1988 - 1997
"New" surgery codes	1998 - 2002

Facility Oncology Registry Data Standards

(FORDS)	2003
FORDS revised for 2004	2004- 2006
FORDS revised for 2007	2007- 2009
FORDS revised for 2010	2010 -

SEER Program Code Manual

First Edition	1988 - 1991
Second Edition	1992 - 1997
Third Edition	1998 - 2003

SEER Program Coding and Staging Manuals

2004	2004 - 2006
2007	2007 – 2009
2010	2010 -

SEER Book 8 Antineoplastic drugs 1981- 2004

SEER*Rx, Antineoplastic drug database 2005 -
<http://www.seer.cancer.gov/seerrx>.

SEER Hematopoietic Database 2010 –
<http://seer.cancer.gov/tools/heme/>

SEER Multiple Primary and Histology Coding Rules 2007 -

Cancer Program Standards

Cancer Program Manual 1986	1986 - 1990
Cancer Program Manual 1991	1991 - 1995
Cancer Program Standards (Volume 1)	1996 - 6/2003
Revised Cancer Program Standards for 2004	7/2003 - 2006
Revised Cancer Program Standards for 2007	2007 - 2008
Revised Cancer Program Standards for 2010	2010 -

APPENDIX E

COMMON MEDICAL ABBREVIATIONS

LIST OF COMMON MEDICAL ABBREVIATIONS

Note: These symbols and abbreviations are a useful speedwriting technique for the tumor registrar as well as for the medical staff. However, when there is any possibility of confusion, words should be written out.

This list, as well as the cautionary note, is taken from http://www.training.seer.cancer.gov/terminology/abbr_symb_acro/

A	Allergy
A	Annum
A	Anode
A	Anterior
A	Aortic
A	Artery
A	Axial
AB	Abort(miscarry)
AB	About
AB	Antibody
AB	Asthmatic bronchitis
ABD, ABDOM	Abdomen
ABN	Abnormal
ABP	Arterial blood pressure
ABST	Abstract
AC	Adrenal cortex
AC	Air contrast
AC	Anterior chamber
ACH	Adrenal cortical hormone
ACID PHOS	Acid phosphatase
ACID P'TASE	Acid phosphatase
ACTH	Adrenocorticotrophic hormone
ADENOCA	Adenocarcinoma
ADH	Antidiuretic hormone (vasopressin)
ADJ	Adjacent
ADM	Admission
ADM	Admit
AFF	Afferent
AFF	Affirmative
AFP	Alpha-fetoprotein
AG	Atrial gallop

AG	Antigen
AG	Argentum (silver, chemical symbol for)
AGL	Acute granulocytic leukemia
A/G RATIO	Albumin-globulin ratio
AGNO3	Silver nitrate
AIDS	Acquired immunodeficiency syndrome
AK(A)	Above knee (amputation)
AKA	Also known as
ALB	Albumin
ALK PHOS	Alkaline phosphatase
ALL	Acute lymphocytic leukemia
AMA	Against medical advice
AMB	Ambulatory
AML	Acute myelogenous leukemia
AMP	Amputation
ANAP	Anaplastic
ANAT	Anatomy
ANES(TH)	Anesthesia, anesthetic
ANT	Anterior
ANTE	Before
A&P	Auscultation& percussion
AP	Abdominal perineal
AP	Anteroposterior
AP	Anterior pituitary
AP&LAT	Anteroposterior and lateral
APP	Appendix
APPROX	Approximately
ARC	Aids related complex
ARD(S)	Acute respiratory disease (syndrome)
ART	Artery(ial)
AS	Aortic stenosis
AS	Arteriosclerosis
ASCVD	Arteriosclerotic cardiovascular disease
ASHD	Arteriosclerotic heart disease
ASP	Aspiration
ASR	Aldosterone secretion rate
ASS	Anterior superior spine (of ilium)
A STEN	Aortic stenosis

ATP	Adenosine triphosphate
ATR	Achilles tendon reflex
ATR	Atrophy
AU	Angstrom unit
AU	Aurum (gold, chemical symbol for)
AUT	Autopsy
AV	Aortic valve
AV	Arteriovenous
AV	Atrioventricular
A & W	Alive and well
AX	Axilla(ry)
AX	Axis(dial)
B	Bacillus
B	Black
B	Blue
B	Born
B	Brother
BA	Bachelor of Arts
BA	Barium (chemical symbol for)
BA	Bronchial asthma
BAS	Basal
BASOS	Basophil(s) (granular leukocyte)
BBB	Blood-brain barrier
BBB	Bundle-branch block
BBT	Basal body temperature
BC	Birth control
BC	Bone conduction
BC	Buccocervical
BCC	Basal cell carcinoma
B-CELLS	Special lymphocytes formed in bone marrow (derived from bursa of Fabricius)
BCG	Bacillus Calmette-Guerin
BD	Bile duct
BE	Barium enema
B/F	Black female
BIL	Bilateral
BK(A)	BElow knee (amputation)
BM	Bone marrow

BM	Bowel movement
B/M	Black male
BMR	Basal metabolism rate
BP	Blood pressure
BPH	Benign prostatic hypertrophy/hyperplasia
BRM	Biological response modifier
BSC	Bone scan
BSO	Bilateral salpingo-oophorectomy
BT	Brain tumor
BUN	Blood urea nitrogen
BUS	Bartholin's, uethral & Skene's glands
BX	Biopsy
C	Centigrade
Ca	Ca—Journal of the American Cancer Society
C1-C7	Cervical vertebrae
CA	Calcium
CA	Carcinoma
CA-125	Cancer Antigen 125
CAT	See CT SN
CBC	Complete blood count
CBD	Common bile duct
CC	Chief complaint
CC	Cubic centimeter
CCU	Coronary care unit
CEA	Carcinoembryonic antigen
CGL	Chronic granulocytic leukemia
CHF	Congestive heart failure
CHR	Chronic
CIG	Cigarettes
CIN	Cervical intraepithelial neoplasia
CIS	Carcinoma-in situ
CLL	Chronic lymphocytic leukemia
CM	Centimeter
CM	Costal margin
CML	Chronic myeloid/myelocytic
CMV	Cytomegalovirus
CNS	Central nervous system
C/O	Complaining of

CO2	Carbon dioxide
Co60	Cobalt 60
COR	Heart
CS	Cesium
CSF	Cerebrospinal fluid
CSF	Colony-stimulating factor
C-SPINE	Cervical spine
CTR	Certified Tumor Registrar
CT SC	Computerized (axial) tomography scan
CVA	Cerebrovascular accident
CVA	Constovertebral angle
C/W	Consistent with
CX	Cervix
CXR	Chest X-ray
CYSTO	Cystoscopy
CYTO	Cytology
D1, D2, ETC	First dorsal, second , etc.
D&C	Dilatation and curettage
DC	Discharge
DC	Discontinued
DERM	Dermatology
DD	Discharge diagnosis
DIAM	Diameter
DIFF	Differentiated, differential
DIS, DISCH	Disease; Discharge
DNA	Deoxyribonucleic Acid
DO	Doctor of Osteopathy
DOA	Dead on arrival
DOB	Date of birth
DOD	Date of death
DOE	Dyspnea on exertion
DR	(Medical) Doctor
DS	Discharge
DTR	Deep tendon reflex
DX	Diagnosis
ECF	Extended care facility
ECG, EKG	Electrocardiogram
EENT	Eyes, ears, nose & throat

EGD	Esophagogastroduodenoscopy
EMG	Electromyogram
ENL	Enlarged
ENT	Ears, nose & throat
EPA	Erect (standing), posterior, anterior
ER	Emergency room
ER(A)	Estrogen receptor (assay)
ERCP	Endoscopic retrograde cholangiopancreatography
EST	Electroshock therapy
EUA	Exam under anesthesia
EXAM	Examination
EXC	Excision
EXP LAP	Exploratory laparotomy
EXT	Extend, extension
F	Fahrenheit
FB	Fingerbreadth
FBS	Fasting blood sugar
FISH	Fluorescence in situ hybridization
F(M)H	Family (medical) history
FLURO	Fluoroscopy
FOM	Floor of mouth
FP	Flat plate
FU	Follow up
FUO	Fever unknown origin
FX	Fracture
FX	Frozen section
GA	Gastric analysis
GB	Gallbladder
GE	Gastroenterostomy
GE	Gastroesophageal
GEN	Generalized
GI	Gastrointestinal
GM	Gram
GP	General practitioner
GR	Grade, grain(s)
GU	Genitourinary
GYN	Gynecology
HB	Hemoglobin

HCG	Human chorionic gonadotropin
HCT	Hematocrit
HCVD	Hypertensive cardiovascular disease
HD	Heart disease
HEENT	Head, eyes, ears, nose & throat
HER2	Human Epidermal Receptor #2
HGB	Hemoglobin
HIV	Human immunodeficiency virus
HN2	Nitrogen mustard
H2O	Water
H/O	History of
HORM	Hormone
HOSP	hospital
H&P	History and physical
HPF	High power field
HPI	History of present illness
HPV	Human papilloma virus
HR(S)	Hour(s)
HTLV-III	Human T-lymphotrophic virus type III
HVD	Hypertensive vascular disease
HX	History
HYST	Hysterectomy
I	Iodine
ICD-O-1	International Classification of Diseases for Oncology, 1st Ed., 1976
ICD-O-2	International Classification of Disease for Oncology, 2nd Ed., 1992
ICD-O-3	International Classification of Disease for Oncology, 3rd Ed., 2000
ICM	intercostal margin
ICS	Intercostal space
ICU	Intensive care unit
IG	Immunoglobulin
IHC	Immunohistochemical
IM	Intramuscular
IMA	Internal mammary artery
IMP	Impression
INCL	Includes, including
INF	Inferior

INF	Infarction
INF	Infusion
INFILT	Infiltrating
INJ	Injection
INT MED	Internal medicine
IP	Inpatient
IPI	International Prognostic Index (for lymphomas)
IPPB	Intermittent positive pressure breathing
IT	Intrathecal
ITC	Isolated tumor cells
IV	Intravenous
IVC	Interior
IVP	Intravenous pyelogram
JVD	Jugular venous distention
K	Potassium
KG	Kilogram
KJ	Knee jerk
KK	Knee kick
KUB	Kidneys, ureters, bladder
KV	Kilovolt
L	Left
L	Liter
L	Lower
L1-L5	Lumbar vertebrae
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-associated virus
LCM	Left costal margin
LDH	Lactic dehydrogenase
LE	Lower extremity; Lupus erythematosus
LFT	Liver function test
LG	Large
LIF	Left iliac fossa
LINAC	Linear accelerator
LIQ	Lower inner quadrant (breast)
LKS(B)	Liver, kidney, spleen, (bladder)
LLE	Left lower extremity
LLL	Left lower lobe (lung)

LLQ	Left lower quadrant (abdomen)
LMD	Local medical doctor
LMP	Last menstrual period
LN(S)	Lymph node(s)
LOP	Lower outer quadrant (breast)
LP	Lumbar puncture
LPF	Low power field
LPN	Licensed practical nurse
LS	Lumbosacral
LSK, LKS	Liver, spleen, kidneys
LSO	Left salpingo-oophorectomy
L-SPINE	Lumbar spine
LT	Left
LUE	Left upper extremity
LUL	Left upper lobe (lung)
LUQ	Left upper quadrant (abdomen)
L&W	Living and well
M	Monocytes, meter
MAL	Malignant
MALIG	Malignant
MAND	Mandible
MAST	Mastectomy
M-CSF	Macrophage Colony-Stimulating Factor
MC	Millicurie
MCH	Mean corpuscular hemoglobin
MCHC	Mean corpuscular hemoglobin count
MCL	Mid clavicular line
MCV	Million electron volts
MH	Marital history
MH	Mental health
MG	Milligram
MICRO	Microscopic
ML	Middle lobe
ML	Milliliter
MM	Millimeter
MOD	Moderate
MOD DIFF	Moderately differentiated
MRI	Magnetic resonance imaging

MRM	Modified radical mastectomy
MS	Mitral stenosis
MS	Multiple sclerosis
MSL	Mid sternal line
MX	Microscopic
MX	Maxilla(ry), maximum
NA	Not applicable
NBS	Normal bowel sounds
NEC	Not elsewhere classified
NED	No evidence of disease
NEG or -	Negative
NEURO	Neurology
NL	Normal
NOS	Not otherwise specified
NR	Not recorded
NR	Not reportable
NSF	No significant findings
NTP	Normal temperature and pressure
N&V	Nausea and vomiting
NVD	Neck vein distention
OB	Obstetrics
OBST	Obstructed (ing, ion)
OD	Right eye (oculus dexter)
OH	Occupational history
OP	Operation
OP	Outpatient
OPD	Outpatient clinic; department
OPHTH	Ophthalmology
OR	Operating room
ORTH	Orthopedics
OS	Bone
OS	Left eye (oculus sinister)
OS	Mouth
OS	Opening
OSTEO	Osteomyelitis
OT	Occupational therapy
OTO	Otology
OU	Each eye (oculus uterque)

OV	Office visit
OZ	Ounce
P	Pulse
P&A	Percussion and auscultation
PA	Posteroanterior
PA	Pulmonary artery
PALP	Palpable, palpated, palpation
PAP	Papanicolaou smear
PAP	Papillary
PAR	Post anesthesia room
PARA	Number of pregnancies resulting in viable infants
PATH	Pathology
PCV	Packed cell volume
PD	Poorly differentiated
PDR	Physicians' Desk Reference
PE	Physical examination
PED	Pediatrics
PEG	Pneumoencephalography
PH	Past or personal tomography
PH	Past or personal history
PI	Present illness
PID	Pelvic inflammatory disease
PLT	Platelets
PM	Post mortem (after death)
PMD	Personal (primary) medical doctor
PMH	Past medical history
PND	Postnasal drip
PO, POSTOP	postoperative(ly)
POD	Postoperative day
POOR DIFF	poorly differentiated
POS or +	Positive
POSS	Possible
POST	Posterior
POST	Postmortem examination
POSTOP	Postoperative(ly)
PPD	Purified protein derivative (Tuberculin skin test)
PPD	Packs per day
PR(A)	Progesterone receptor (assay)

PREOP	Preoperative(ly)
PROB	Probably(ly)
PSA	Prostatic Specific Antigen
PT	Patient
PT	Physiotherapy
PTA	Prior to admission
PUO	Pyrexia of undetermined origin
PULM	Pulmonary
Q	Quadrant
R	Roentgen
R	Respiration
R	Right
RA	Radium
RAD	Radiation
RAD	Radiation Absorbed Dose
RAD	Radical
RAIU	Radioactive iodine (I 131) uptake
RBC	Red blood cells
RCM	Right Costal Margin
RCS	Reticulum cell sarcoma
REG	Radioencephalogram
RES	Reticuloendothelial system
RESEC	Resection
RESPIR	Respiratory
RH	Rhesus (monkey) factor in blood
RIA	Radioimmunoassay
RIF	Right iliac fossa
RIQ	Right inner quadrant (abdomen)
RLE	Right lower extremity
RLL	Right lower lobe (lung)
RLQ	Right inner quadrant (abdomen)
RML	Right middle lobe (lung)
RN	Registered nurse
RNA	Ribonucleic acid
RO, R/O	Rule out
ROF	Review of outside films
ROM	Range of motion
ROS	Review of outside slides

ROS	Review of systems
ROQ	Right outer quadrant (abdomen)
RSO	Right salpingo-oophorectomy
R-S cells	Reed-Sternberg cells
RT	Radiation therapy
RT	Right
RUE	Right upper extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
R-V	Rectovaginal
RX	Treatment
S1-S5	Sacral vertebra
SARC	Sarcoma
SB	Small bowel
SBE	Subacute bacterial endocarditis
SCC	Squamous cell carcinoma
SGOT	Serum glutamic oxaloacetic transaminase
SGPT	Serum hepatitis
SH	Social history
SH	Serum hepatitis
SM	Small
SMA	sequential multiple analysis (Biochem profile)
SML	Small
SML BWL	Small bowel
SNF	Skilled nursing facility
SO	Salpingo-oophorectomy
SOB	Shortness of breath
SOL	Solution
S/P	Status post
SPEC	Specimen
SP GR	Specific gravity
S-Q, SQ	Subcutaneous
SQ, SQUAM	Squamous
SQ CELL CA	Squamous cell carcinoma
SR	Sedimentation rate
S-SPINE	Sacral spine
STAPH	Staphylococcus
STAT	Immediately (statim)

STREP	Streptococcus
STSG	Split thickness skin graft
SUB-Q, SUBQ	Subcutaneous
SURG	Surgery, surgical
SVC	Superior vena cava
SX	Symptoms
T	Temperature
T	Thoracic
TA	Toxin-antitoxin
T1-T12	Thoracic vertebra
T&A	Tonsillectomy and adenoidectomy
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy-bilateral salpingo-oophorectomy
TB, TBC	Tuberculosis
TCC	Transitional cell carcinoma
TD	Tumor dose
TNM	Tumor, Nodes, Metastasis
TP	Total protein
TPR	Temperature, pulse and respiration
TS	Tumor size
T-SPINE	Thoracic spine
TUR	Transurethral resection
TURB	Transurethral resection - Bladder
TURP	Transurethral resection - Prostate
TVH	Total vaginal hysterectomy
TX	Treatment
U	Unit
UCHD	Usual childhood disease
UE	Upper extremity
UGI	Upper gastrointestinal
UIQ	Upper inner quadrant (breast)
UMB	Navel (umbilicus)
UNDIFF	Undifferentiated
UOQ	Upper outer quadrant (abdomen)
UR	Urine
URI	Upper respiratory infection
UROL	Urology
VAG	Vagina, Vaginal

VAG HYST	Vaginal hysterectomy
VAIN	Vaginal intraepithelial neoplasia
VASC	Vascular
VD	Venereal disease
VIN	Vulvar intraepithelial neoplasia
VS	Vital signs
W/	With
WBC	White blood cells
B/D	Well developed
WE, WELL DIFF	Well differentiated
W/F	White female
W/M	White male
WNL	Within normal limits
W/O	Without
WT	Weight
W/U	Work-up
XR	X-ray
Y/O	Year old
YR	Year

APPENDIX F

ELECTRONIC SUBMISSION INSTRUCTIONS

ELECTRONIC TRANSMISSIONS FROM HEALTH CARE FACILITIES

PURPOSE:

All hospitals in New Jersey are required to submit data records electronically in an approved data format in the current NAACCR version. NJSCR also accepts electronic records from non-hospital sources and encourages non-hospital sources to submit electronically.

Files are to be of predetermined length and contain all current data fields. Individual vendors that supply cancer data base software are required to keep up with changes. Records must be sent as full abstract type records. Files' names must begin with the NJSCR-assigned three letters facility identifier. All files submitted electronically must be encrypted either at file level attached to email or be placed on secure encrypted email server. PGP and GPG Encryption software are the only approved encryption applications for encrypting individual files.

Secure email servers must be reviewed for security, ease of use and dependability by LAN administrator. Files that do not meet these criteria are rejected and facilities are requested to resubmit data.

The NJSCR requires all data submitted to the program be in latest NAACCR version of full abstract type, encrypted and sent electronically.

- Data files are sent to a designated email address NJSCRDAT@doh.state.nj.us or are made available for down load from secure email server.
- Files must be either encrypted with approved software or on approved encrypted email sever.
- Data files are detached from email or down loaded from secure email server and placed on appropriate network drive at NJSCR. Encrypted files are unencrypted and reviewed. The number of records in the file are counted and the exact length of each record is reviewed. This will verify proper file type length and that records received will match number of records that have been sent.
- Files that fail to pass the inspection i.e. are not right type, format, length or have erroneous values are rejected and sender notified by email of this rejection with reason for the failure. The sender is by requested in an email to correct, modify or otherwise make file acceptable and resubmit.
- Files that pass inspection/edit checks are accepted. The reporting facility receives an e-mail acknowledgement of receipt.

APPENDIX G

ICD-9 CODES FOR CASEFINDING BY DISEASE INDEX SCREENING

Some ranges are expressed with only 1 decimal place (e.g. 237.0-237.9) while some codes within that range may have two decimal places (e.g. 237.71 and 237.72). All codes in the range are included.

COMPREHENSIVE ICD-9-CM CASEFINDING CODE LIST FOR REPORTABLE TUMORS (EFFECTIVE DATE: 1/1/2010)^	
ICD-9-CM Code^	Explanation of Code
140.0 – 208.92	Malignant Neoplasms
209.00 – 209.29	Neuroendocrine tumors
209.30	Malignant poorly differentiated neuroendocrine carcinoma, any site <i>Reportable inclusion terms:</i> <i>High grade neuroendocrine carcinoma, any site</i> <i>Malignant poorly differentiated neuroendocrine tumor NOS</i>
209.31 – 209.36	Merkel cell carcinoma Note: Effective date 10/1/09
209.70 – 209.79	Secondary neuroendocrine tumors Note: Effective Date 10/1/09 <i>Reportable inclusion terms:</i> <i>Secondary carcinoid tumors</i> Note: All neuroendocrine or carcinoid tumors specified as secondary are malignant
225.0 – 225.9	Benign neoplasm of brain and spinal cord neoplasm
227.3	Benign neoplasm of pituitary gland and craniopharyngeal duct (pouch) <i>Reportable inclusion terms:</i> <i>Benign neoplasm of craniobuccal pouch, hypophysis, Rathke's pouch or sella turcica</i>
227.4	Benign neoplasm of pineal gland
227.9	Benign neoplasm; endocrine gland, site unspecified
228.02	Hemangioma; of intracranial structures <i>Reportable inclusion terms:</i> <i>Angioma NOS, Cavernous nevus, Glomus tumor, Hemangioma (benign)</i>
228.1	Lymphangioma, any site
230.0 – 234.9	Carcinoma in situ <i>Reportable inclusion terms:</i> <i>Intraepithelial neoplasia III</i>
236.0	Endometrial stroma, low grade (8931/1) <i>Reportable inclusion terms:</i> <i>Stromal endometriosis (8931/3 per ICD-O-3)</i> <i>Stromal myosis (endolymphatic) (8931/3 per ICD-O-3)</i> <i>Stromatosis, endometrial (8931/3 per ICD-O-3)</i>
237.0 – 237.9	Neoplasm of uncertain behavior [borderline] of endocrine glands and nervous system

COMPREHENSIVE ICD-9-CM CASEFINDING CODE LIST FOR REPORTABLE TUMORS (EFFECTIVE DATE: 1/1/2010)^	
ICD-9-CM Code^	Explanation of Code
238.4	Polycythemia vera (9950/3)
238.6	Neoplasm of uncertain behavior of other and unspecified sites and tissues, Plasma cells (Plasmacytoma, extramedullary, 9734/3) <i>Reportable inclusion terms:</i> <i>Plasmacytoma NOS (9731/3)</i> <i>Solitary myeloma (9731/3)</i>
238.7	Other lymphatic and hematopoietic tissues Note: This code was expanded 10/2006. It is now a subcategory and is no longer valid for use for coding purposes. It should be included in extract programs for quality control purposes.)
238.71	Essential thrombocythemia (9962/3) <i>Reportable inclusion terms:</i> <i>Essential hemorrhagic thrombocythemia</i> <i>Idiopathic (hemorrhagic) thrombocythemia</i>
238.72	Low grade myelodysplastic syndrome lesions (includes 9980/3, 9982/3, 9983/3, 9985/3) <i>Reportable inclusion terms:</i> <i>Refractory anemia (RA) (9980/3)</i> <i>Refractory anemia with excess blasts-1 (RAEB-1) (9983/3)</i> <i>Refractory anemia with ringed sideroblasts (RARS) (9982/3)</i> <i>Refractory cytopenia with multilineage dysplasia (RCMD) (9985/3)</i> <i>Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS) (9985/3)</i>
238.73	High grade myelodysplastic syndrome lesions (includes 9983/3) <i>Reportable inclusion terms:</i> <i>Refractory anemia with excess blasts-2 (RAEB-2)</i>
238.74	Myelodysplastic syndrome with 5q deletion (9986/3) <i>Reportable inclusion terms:</i> <i>5q minus syndrome NOS</i>
238.75	Myelodysplastic syndrome, unspecified (9985/3, 9987/3)
238.76	Myelofibrosis with myeloid metaplasia (9961/3) <i>Reportable inclusion terms:</i> <i>Agnogenic myeloid metaplasia</i> <i>Idiopathic myelofibrosis (chronic)</i> <i>Myelosclerosis with myeloid metaplasia</i>
238.77	Post transplant lymphoproliferative disorder (9987/3)
238.79	Other lymphatic and hematopoietic tissues (includes 9960/3, 9961/3, 9970/1, 9931/3) <i>Reportable inclusion terms:</i>

COMPREHENSIVE ICD-9-CM CASEFINDING CODE LIST FOR REPORTABLE TUMORS (EFFECTIVE DATE: 1/1/2010)^	
ICD-9-CM Code^	Explanation of Code
	<i>Lymphoproliferative disease (chronic) NOS (9970/1)</i> <i>Megakaryocytic myelosclerosis (9961/3)</i> <i>Myeloproliferative disease (chronic) NOS (9960/3)</i> <i>Panmyelosis (acute) (9931/3)</i>
239.6	Neoplasms of unspecified nature, brain
239.7	Neoplasms of unspecified nature; endocrine glands and other parts of nervous system
239.81 – 239.89	Neoplasms of unspecified nature; other specified sites Note: Effective Date 10/1/09
273.2	Other paraproteinemias <i>Reportable inclusion terms:</i> <i>Franklin's disease (heavy chain) (9762/3)</i> <i>Heavy chain disease (9762/3)</i> <i>Mu-chain disease (9762/3)</i>
273.3	Macroglobulinemia <i>Reportable inclusion terms:</i> <i>Waldenström's macroglobulinemia (9761/3)</i> <i>Waldenström's (macroglobulinemia) syndrome</i>
288.3	Eosinophilia Note: This code is for eosinophilia, which is not reportable. Do not abstract unless diagnosis is "Hypereosinophilic syndrome (9964/3)."
795.06	Papanicolaou smear of cervix with cytologic evidence of malignancy
795.16	Papanicolaou smear of vagina with cytologic evidence of malignancy
796.76	Papanicolaou smear of anus with cytologic evidence of malignancy
V10.0 – V10.89	Personal history of malignancy Note: Screen for recurrences, subsequent primaries, and/or subsequent treatment
V10.90	Personal history of unspecified malignant neoplasm Note: Effective Date: 10/1/09. Screen for recurrences, subsequent primaries, and/or subsequent treatment
V10.91	Personal history of malignant neuroendocrine tumor, carcinoid tumor, Merkel cell carcinoma Note: Effective Date: 10/1/09. Screen for recurrences, subsequent primaries, and/or subsequent treatment
V12.41	Personal history of benign neoplasm of the brain

The following codes are not reportable per se, but they should alert registrars to look for the first malignant neoplasm associated with these codes.

SUPPLEMENTARY LIST #1-ICD-9-CM CODES THAT SHOULD BE FOLLOWED BY or ASSOCIATED WITH A NEOPLASM CODE^	
ICD-9-CM Code^	Explanation of Code
258.02 – 258.03	Multiple endocrine neoplasia (MEN) type IIA and IIB (rare familial cancer syndrome) Note: Use additional codes to identify any malignancies and other conditions associated with the syndrome
285.22	Anemia in neoplastic disease Note: Assign also a code for the neoplasm causing the anemia Excludes: anemia due to antineoplastic chemotherapy, new code 285.3
289.83	Myelofibrosis (NOS) (9961/3) Note: Not every case of myelofibrosis is associated with a malignancy. Review terms included in ICD-O-3 to determine if case is reportable. See ICD-9-CM
338.3	Neoplasm related pain (acute, chronic); Cancer associated pain; Pain due to malignancy (primary/secondary); Tumor associated pain
511.81	Malignant pleural effusion Note : Code first malignant neoplasm if known. If the primary site is not known, code 199.0, disseminated carcinomatosis, or code 199.1, malignancy NOS, should be assigned
789.51	Malignant ascites Note : Code first malignant neoplasm if known. If the primary site is not known, code 199.0, disseminated carcinomatosis, or code 199.1, malignancy NOS, should be assigned

NOTE: Cases with these codes should be screened as registry time allows. These are neoplasm-related secondary conditions for which there should also be a primary diagnosis of a reportable neoplasm. Experience in the SEER registries has shown that using the supplementary list increases casefinding for benign brain and CNS, hematopoietic neoplasms, and other reportable diseases.

SUPPLEMENTARY LIST #2-ICD-9-CM CODE LIST TO SCREEN FOR CANCER CASES NOT IDENTIFIED BY OTHER CODES (EFFECTIVE DATE: 1/1/2010)^	
ICD-9-CM Code^	Explanation of Code
042	Acquired Immunodeficiency Syndrome (AIDS) Note: This is not a malignancy. Medical coders are instructed to add codes for AIDS-associated malignancies. Screen 042 for history of cancers that might not be coded.
079.4	Human papillomavirus
079.50 – 079.59	Retrovirus (HTLV, types I, II and 2)

SUPPLEMENTARY LIST #2-ICD-9-CM CODE LIST TO SCREEN FOR CANCER CASES NOT IDENTIFIED BY OTHER CODES (EFFECTIVE DATE: 1/1/2010)^	
ICD-9-CM Code^	Explanation of Code
209.40-209.69	Benign carcinoid tumors
210.0 – 229.9	Benign neoplasms (except for 225.0-225.9, 227.3, 227.4, 227.9, 228.02, and 228.1, which are listed in the Reportable list) Note: Screen for incorrectly coded malignancies or reportable by agreement tumors.
235.0 – 236.6	Neoplasms of uncertain behavior (except for 236.0, which is listed in the Reportable list) Note: Screen for incorrectly coded malignancies or reportable by agreement tumors
238.0 – 239.9	Neoplasms of uncertain behavior (except for 238.4, 238.6, 238.71-238.79, 239.6, 239.7, 239.81 and 239.89, which are listed in the Reportable list) Note: Screen for incorrectly coded malignancies or reportable by agreement tumors
253.6	Syndrome of inappropriate secretion of antidiuretic hormone Note: Part of the paraneoplastic syndrome. See note of explanation in the “notes” section.
259.2	Carcinoid Syndrome
259.8	Other specified endocrine disorders
273.0	Polyclonal hypergammaglobulinemia (Waldenstrom) Note: Review for miscodes
273.1	Monoclonal gammopathy of undetermined significance (9765/1) Note: Screen for incorrectly coded Waldenstrom macroglobulinemia or progression
273.9	Unspecified disorder of plasma protein metabolism Note: Screen for incorrectly coded Waldenstrom’s macroglobulinemia
275.42	Hypercalcemia Note: Part of the paraneoplastic syndrome. See note of explanation in the “notes” section.
277.88	Tumor lysis syndrome/Tumor lysis syndrome following antineoplastic drug therapy Note: Effective Date: 10/1/09
279.00	Hypogammaglobulinemia Note: Predisposed to lymphoma or stomach cancer
279.02 – 279.06	Selective IgM immunodeficiency Note: Associated with lymphoproliferative disorders
279.10	Immunodeficiency with predominant T-cell defect, NOS
279.12	Wiskott-Aldrich Syndrome
279.13	Nezelof’s Syndrome
279.2 – 279.9	Combined immunity deficiency – Unspecified disorder of immune mechanism

SUPPLEMENTARY LIST #2-ICD-9-CM CODE LIST TO SCREEN FOR CANCER CASES NOT IDENTIFIED BY OTHER CODES (EFFECTIVE DATE: 1/1/2010)^	
ICD-9-CM Code^	Explanation of Code
284.81	Red cell aplasia (acquired, adult, with thymoma)
284.89	Other specified aplastic anemias due to drugs (chemotherapy or immunotherapy), infection, radiation
284.9	Aplastic anemia, unspecified Note: Review for miscodes
285.0	Sideroblastic anemia
285.3	Antineoplastic chemotherapy induced anemia (Anemia due to antineoplastic chemotherapy) Note: Effective Date: 10/1/09
288.03	Drug induced neutropenia
289.89	Other specified diseases of blood and blood-forming organs Note: Review for miscodes
323.81	Encephalomyelitis; specified cause NEC Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.
379.59	Opsoclonia Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.
528.01	Mucositis due to antineoplastic therapy
630	Hydatidiform Mole (9100/0) Note: This is a benign tumor that can become malignant. If malignant, it should be reported as Choriocarcinoma (9100/3) and will have a malignancy code in the 140-209 range.
686.01	Pyoderma gangrenosum Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.
695.89	Sweet's syndrome Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.
701.2	Acanthosis nigricans Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.
710.3	Dermatomyositis Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.
710.4	Polymyositis Note: Part of the paraneoplastic syndrome. See note of explanation in the "notes" section.
785.6	Enlargement of lymph nodes
790.93	Elevated prostate specific antigen [PSA]

SUPPLEMENTARY LIST #2-ICD-9-CM CODE LIST TO SCREEN FOR CANCER CASES NOT IDENTIFIED BY OTHER CODES (EFFECTIVE DATE: 1/1/2010)^	
ICD-9-CM Code^	Explanation of Code
795.8	Abnormal tumor markers; Elevated tumor associated antigens [TAA]; Elevated tumor specific antigens [TSA]; Excludes: Elevated prostate specific antigen [PSA] (790.93)
795.81	Elevated carcinoembryonic antigen [CEA]
795.82	Elevated cancer antigen 125 [CA 125]
795.89	Other abnormal tumor markers
999.31	Infection due to central venous catheter (porta-cath)
999.81	Extravasation of vesicant chemotherapy
E879.2	Adverse effect of radiation therapy
E930.7	Adverse effect of antineoplastic therapy
E933.1	Adverse effect of immunosuppressive drugs
V07.31, V07.39	Other prophylactic chemotherapy
V07.8	Other specified prophylactic measure
V12.72	Colonic polyps (history of)
V15.3	Irradiation: previous exposure to therapeutic or ionizing radiation
V42.81	Organ or tissue replaced by transplant, Bone marrow transplant
V42.82	Transplant; Peripheral stem cells
V51.0	Encounter for breast reconstruction following mastectomy
V52.4	Breast prosthesis and implant
V54.2	Aftercare for healing pathologic fracture
V58.0	Encounter for radiation therapy
V58.1	Encounter for antineoplastic chemotherapy and immunotherapy Note: This code was discontinued as of 10/2006 but should be included in extract programs for quality control purposes
V58.11	Encounter for antineoplastic chemotherapy
V58.12	Encounter for antineoplastic immunotherapy
V58.42	Aftercare following surgery for neoplasm
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow up
V67.2	Chemotherapy follow up
V71.1	Observation for suspected malignant neoplasm
V76.0 – V76.9	Special screening for malignant neoplasm
V78.0 – V78.9	Special screening for disorders of blood and blood-forming organs
V82.71	Screening for genetic disease carrier status
V82.79	Other genetic screening
V82.89	Genetic screening for other specified conditions
V82.9	Genetic screening for unspecified condition
V84.01 – V84.09	Genetic susceptibility to malignant neoplasm

SUPPLEMENTARY LIST #2-ICD-9-CM CODE LIST TO SCREEN FOR CANCER CASES NOT IDENTIFIED BY OTHER CODES (EFFECTIVE DATE: 1/1/2010)^	
ICD-9-CM Code^	Explanation of Code
V84.81	Genetic susceptibility to multiple endocrine neoplasia [MEN]
V86.0	Estrogen receptor positive status [ER+]
V86.1	Estrogen receptor negative status [ER-]
V87.41	Personal history of antineoplastic chemotherapy

NOTES:

- Prostatic Intraepithelial Neoplasia (PIN III) M-8148/2 is not required by SEER.
- 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 a /3 (malignant) .
- 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.
- These diseases are part of the paraneoplastic syndrome. “Paraneoplastic syndrome isn’t cancer. It’s a disease or symptom that is the consequence of cancer but is not due to the local presence of cancer cells. A paraneoplastic syndrome may be the first sign of cancer.”

[^] *International Classification of Diseases, Ninth Revision, Clinical Modification, 2010.*

APPENDIX H
ICD-10 CODES FOR CASEFINDING BY
DISEASE INDEX SCREENING

ICD-10 CODES FOR CASEFINDING BY DISEASE INDEX SCREENING

Casefinding in medical records/health information should be done using both inpatient and outpatient disease/diagnostic indices. Review all records with the following International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes.

CODES	DESCRIPTION
B21.0—B21.9	HIV Disease resulting in malignant neoplasms
C00.0—C75.9	Malignant Neoplasms of specified sites
C76.0—C80	Malignant neoplasms of ill-defined, secondary and unspecified sites
C81.0-C96.9	Malignant neoplasms of lymphoid, hematopoietic and related tissue
C97	Malignant neoplasms of independent (primary) multiple sites
D00.0—D00.9	In situ neoplasms
D10.0—D36.9	Benign neoplasms, including the following: D32.0—D32.9 Benign neoplasms of meninges D33.0—D33.9 Benign neoplasm of brain and other parts of central nervous system D35.0—D35.9 Benign neoplasm of other and unspecified endocrine glands (excludes endocrine pancreas, ovary, testis and thymus) D36.1 Peripheral nerves and autonomic nervous system
D37.0—D48.9	Neoplasms of uncertain or unknown behavior, including the following: D45— Polycythemia vera D46.0— Refractory anemia without sideroblasts, so stated D46.1— Refractory anemia with sideroblasts D46.2— Refractory anemia with excess blasts D46.3— Refractory anemia with excess blasts in transformation D46.4— Refractory anemia, unspecified D46.7— Myelodysplastic syndrome with 5q-syndrome; Therapy-related myelodysplastic syndrome D46.73-- Myelodysplastic syndrome with 5q deleted D46.9— Myelodysplastic syndrome, unspecified; Myelodysplasia NOS; Preleukemia (syndrome), NOS D47.1— Chronic myeloproliferative disease; Myelosclerosis with myeloid metaplasia;

	Refractory cytopenia with multilineage dysplasia D47.3 —Essential (Idiopathic) thrombocytopenia; Essential (hemorrhagic) thrombocythemia D47.7 —Other specified neoplasms of uncertain/ unknown behavior of lymphoid, hematopoietic
D72.1	Hypereosinophilic syndrome
D76.0	Langerhans' cell histiocytosis, not elsewhere classified
Q90.9	Down's Syndrome
Z03.1	Observation for suspected malignant neoplasm
Z08.0—Z08.9	Follow-up examination after treatment for malignant neoplasm
Z12.0—Z12.9	Special screening for neoplasms
Z13.0	Special screening examination for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z29.2	Other prophylactic chemotherapy (screen for miscoded chemotherapy for malignancy)
Z29.8	Other specified prophylactic measures
Z51.0	Radiotherapy session
Z51.1	Chemotherapy session for neoplasm
Z51.2	Other chemotherapy (maintenance)
Z54.1	Convalescence for radiotherapy
Z54.2	Convalescence for chemotherapy
Z85.0-Z85.9	Personal history of malignant neoplasm

Sources for these codes:

The World Health Organization (<http://apps.who.int/classifications/apps/icd/icd10online/>) and
SEER Hematopoietic Data Base (<http://seer.cancer.gov/tools/heme/index.html>)