Standards for Cancer Registries, Volume I

Data Exchange Standards and Record Descriptions

Version 11.1
June 2006

Edited by
Lori A. Havener, CTR

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Comments and suggestions on this and other NAACCR standards documents are welcome. Please send your comments to the editor or to any member of the NAACCR Board of Directors.

The other volumes in the series, Standards for Cancer Registries, are:

Volume II, *Data Standards and Data Dictionary*. Intended for hospital and central cancer registries, programmers, and analysts, this provides detailed specifications and codes for each data item in the data exchange record layout.

Volume III, *Standards for Completeness, Quality, Analysis, and Management of Data*. Intended for central registries, this provides detailed standards for many aspects of the operation of a population-based cancer registry.

Volume IV, *Standard Data Edits.* This standard document currently is only made available electronically as a program code and a database. It documents standard computerized edits for data corresponding to the data standards Volume II.

Volume V, *Pathology Laboratory Electronic Reporting.* Recommends message or format standards for electronic transmission of reports (pathology, cytology and hematology) from pathology laboratories to central cancer registries.

Copies of the standards documents can be viewed or downloaded from NAACCR's website at http://www.naaccr.org. For additional paper copies, contact the NAACCR Executive office.

Suggested citation
Havener L ed. Standards for Cancer Registries Volume I: Data Exchange Standards and Record Descriptions, Version 11.1. Springfield, IL: North American Association of Central Cancer Registries, June 2006.

The NAACCR Board of Directors has approved the adoption of these standards.

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1. INTRODUCTION

1.1 Version 11.1 of the Record Layout

Version 11.1 of the NAACCR (all abbreviations are listed in Appendix A) data exchange record layout reflects the needed changes for the reporting of tumors diagnosed from January 1, 2007 onward. New data items reflect changes introduced for the needs of the various standard setting organizations. These changes are reported in detail in the companion volume, Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary*, Eleventh Edition, Record Layout Version 11.1.

Introductions from prior versions of Volume I have been retained as a historical reference in Appendix B.

2. PURPOSE AND USE OF DATA EXCHANGE LAYOUTS

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

The layouts were intended to provide a common language for cancer registry systems. It was not NAACCR's intent to require that systems would use the NAACCR data item names and layouts internally. However, it has proven convenient for some systems to do so. The standard has been widely accepted both for data exchange and local use.

2.1. RECORD LAYOUT DESIGN DECISIONS

The simplest method for encompassing the Incidence, Confidential and Full Case Abstract record types was chosen: each longer record type builds on the next shorter record type by adding fields. The incidence-only records use only the first section of the overall layout, while the case abstract records use the full layout. Thus shorter, efficient records can be used for the smaller data set without requiring separate formats.

In selecting data items, it was decided to include more rather than less. All data items that currently are standardized by NAACCR, SEER, or the Commission on Cancer have been included. Additional items were added that are currently used by several systems and which probably could become standardized. Other fields were added to help coordinate the data exchange. Data items that were used in the past are usually maintained in the record so that historically collected information can still be exchanged.

2.1.1. Data Exchange Records

2.1.1.1. Incidence Record

These records include all the coded fields for each case, including demographic, tumor, staging, treatment, and follow-up fields. The primary use of the incidence record is to transmit data for multi-registry research projects or surveillance. See Appendix C for the Incidence Record layout (columns 1-1946).

2.1.1.2. Confidential Record

These records include all the data items in the incidence record, plus items such as patient name and Social Security Number that identify the case. Also included are quasi-confidential data items such as referring hospital or primary physician, items, which some agencies are required to keep confidential**.** This record type can be used to exchange cases between registries, whether central-based or hospital-based. See Appendix C for the Confidential Record layout (columns 1-2644).

2.1.1.3. Full Case Abstracts

These records contain all fields noted above, plus the supportive text required for the transmission of full case abstracts. The full case abstract allows the receiving registry to perform a higher degree of

quality control with each case report. See Appendix C for the Full Case Abstract Record layout (columns 1-6694).

2.1.1.4. Pathology Laboratory Records

The Pathology Laboratory record is designed for electronic transmission of reports from pathology laboratories to central registries. Health Level 7 (HL7) or a character delimited flat file is recommended as the data format for transmitting pathology laboratory reports. A standard pathology laboratory dataset, data dictionary, and HL7 transmission format and flat file were developed to enhance the completeness, timeliness, consistency, and efficiency with which tumor data are transmitted by pathology laboratories and received and processed by central cancer registries (see Standards for Cancer Registries, Volume V).

2.1.1.5. Update/Correction and Modified Records

Two record layout types, an update/correction record and a modified record, provide data layouts to transmit changes or revisions to data that have already been sent to a receiving registry. The Update/ Correction, record type U, is a short format record that can be used to transmit individual, field specific corrections to data already submitted. The record length is 850 bytes. This record type is for use by those registries and software providers that do not already have a well-functioning corrections system, or who wish to use a standardized format. In this volume, version 11 of the update/correction record is documented. Version 11 of the "U" record can be used only to update data that are already coded according to the standards documented in version 11 of the NAACCR data exchange record types I, C, and A. See Appendix D for the Update/Correction Record layout.

The Modified Record, record type M, is the same length (6694 characters) and contains the same fields, in the same locations, as the Full Case Abstract, record type A. A Modified Record represents an alternative way for submitting changed information to a receiving registry, on tumor records that have already been submitted. It is designed for transmitting an entire tumor record in which one or more modifications, updates, or corrections have been made since the last time the tumor record was submitted to the receiving registry. Like record type 'U', the 'M' record may be used to transmit corrections or follow-up.

Like the "U" record, a version 11.1 "M" record can be used only to update data already coded according to the standards documented in version 11.1 of the NAACCR data exchange record. This is because the definitions, data length, and code meanings for certain variables changed between versions 9 and 10. See Appendix C for the Modified Record layout.

2.1.1.6. Canadian Data

The NAACCR data standards thus far adopted do not cover all Canadian data. Changes have been made to accommodate postal codes, standard abbreviations for provinces, and other fields. As Canadian standards are adopted by NAACCR, future versions will incorporate these additional standards into the layout.

2.2. SUMMARY OF NAACCR DATA EXCHANGE RECORD TYPES

Record Type is a generated field that identifies which of the seven NAACCR data exchange record types is being used in a file of data exchange records. Data dictionary descriptions for record types I, C, A, and M (data item numbers 10 – 3310) can be found in the NAACCR Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary*. The record layout for these record types can be found in Appendix C of this document.

RECORD TYPE I: INCIDENCE RECORD (coded data without direct personal identifiers)

Contents: Demographic, Tumor and Staging, Treatment, and Follow-up (Optional)
Use: Combined studies
Length: 1946 characters

RECORD TYPE C: CONFIDENTIAL RECORD (incidence record plus personal identifiers)

Contents: Demographic, Tumor and Staging, Treatment, and Follow-up, plus Patient Identifiers and Physicians
Use: Case sharing between central registries
Length: 2644 characters

RECORD TYPE A: FULL CASE ABSTRACT (confidential record plus text; used for reporting to central registry)

Contents: Demographic, Tumor and Staging, Treatment, and Follow-up, Patient Identifiers & Physicians, plus Text
Use: Sending abstracts between registries
Length: 6694 characters

RECORD TYPE L: PATHOLOGY LABORATORY

Contents: Demographic, Tumor, and partial Staging (content varies dependent on availability at pathology laboratories and agreement between pathology laboratory and central registry)
Use: Electronic transmission of tumor reports from pathology laboratories to central registries
Length: No standard length

RECORD TYPE U: UPDATE/CORRECTION RECORD (short format record used to submit changes to data already submitted)

Contents: Sender ID Section, Record ID Section, Correction Section
Use: Transmitting changes for previously submitted cases
Length: 850 characters

RECORD TYPE M: RECORD MODIFIED SINCE PREVIOUS SUBMISSION TO CENTRAL REGISTRY (identical in format to the A record type; used to submit changes to data already submitted)

Contents: Demographic, Tumor and Staging, Treatment, and Follow-up, Patient Identifiers and Physicians, plus Text
Use: Transmitting changes for previously submitted cases
Length: 6694 characters

RECORD TYPE R: ANALYSIS/RESEARCH RECORD (incidence record plus appended error flags and recoded values) Record type R is not currently in use, but if used, the format described in Appendix E should be used. The old layout is described in Appendix F for historical and informational purposes.

Contents: Record ID Section, Group Recodes/Conversions
Use: Data analysis
Length: 2215 characters

2.3. RECORD TYPES FOR SUBMISSION OF CORRECTED, UPDATED, OR MODIFIED DATA

Two record types, an update/correction record and a modified record, provide data layouts to transmit changes or revisions to records that have already been sent to a receiving registry. Two methods exist because of parallel development that occurred in the registry community. Both methods work. Some central registries require changes to be submitted using the "U" record type; other central registries require changes to be submitted using the "M" record type.

2.3.1. Record Type "U": Update/Correction Record

2.3.1.1. Data Dictionary Descriptions

Each item in the Update/Correction record is described briefly. The standard item number in square brackets follows the item name. For data items with numbers 1-4999, see NAACCR Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary* for more information.

2.3.1.2. Sender ID Section of Update/Correction Record

The Sender ID section includes data items that identify the registry that is sending the update or correction to another registry. This section also includes the items that identify the records as NAACCR correction records.

Record Type [10]
Each update/correction record must have a 'U' in this field.

Update/Correction Record Version [9000]
1 = Version 1, first approved version, September 1997
2 = Version 2, February 1998
7 = Version 7, June 2000
A = Version 10, June 2003
B = Version 11, January 2006 (layout same as A; content, however may be different),

Vendor Name [2170]
Name and version number of the cancer registry software used to create the update/correction record. Entered by the software.

Registry Type [30]
Registry Type of the data source generating the update/correction record; combined with Registry ID, identifies a unique cancer registry or data source.

Registry ID [40]
Registry ID of the data source generating the update/correction record; combined with Registry Type, identifies a unique cancer registry or data source.

Patient System ID Hosp [21]
Unique number assigned to each person in its database by the source (sending) registry identified in the fields Registry Type + Registry ID (e.g., a hospital cancer registry). The Patient System ID + Tumor Record Number together identify a unique case in the sending registry's database. If the sending registry is central registry rather than a hospital, then use the Patient ID Number field [20] from the central registry.

Tumor Record Number [60]
Unique number assigned to each tumor in its database for a specific patient by the source (sending) registry identified in the fields Registry Type + Registry ID (e.g., a hospital cancer registry). The Patient ID Number + Tumor Record Number together identify a unique case in the sending registry's database.

2.3.1.3. Record ID Section of Update/Correction Record

This section includes items that identify the patient and tumor that were previously reported. The items are used by the receiving registry to link the update/correction record with the previously submitted tumor report. Many identifying items are included to increase the probability of successful linkage.

Patient ID Number—Receiver [9010]
Unique number assigned by the receiving registry to each person in its database. This usually corresponds to NAACCR field [20] in the central registry. The Patient ID Number—Receiver + Tumor Record Number—Receiver together identify a unique case in the receiving registry database. This number may be unknown to the sender. If unknown, leave blank.

Tumor Record Number—Receiver [9011]
Unique number assigned by the receiving registry to each tumor in its database for a specific patient. The Patient ID Number—Receiver + Tumor Record Number—Receiver together identify a unique case in the receiving registry's database. This number may be unknown to the sender. If unknown, leave blank**.**

Name—Last [2230], Name—First [2240], Name—Middle [2250], Social Security Number [2320], Sex [220], Birth Date [240], Date of Diagnosis [390], Primary Site [400], Laterality [410], Histology (92-00) ICD-O-2 [420], Histologic Type ICD-O-3 [522], Behavior (92-00) ICD-O-2 [430], Behavior Code ICD-O-3 [523]
Consolidated value for each item as reflected in the sending registry's database. There should be one value for each item for each patient or tumor. If the value of any of these items is being changed in the update/correction record, the ORIGINAL unchanged value should be included in the Record ID segment of the update/correction record.

Medical Record Number [2300], Military Record No Suffix [2310], Reporting Hospital [540], Accession Number—Hosp [550], Sequence Number—Hospital [560]
Entries of these fields can vary with the nature of the sending and receiving registries. When the sending registry is a single reporting facility, or is a central registry that has only one value for each of these items in its database, include those values in these fields. When the sending registry is a central registry and has multiple values for each field, the item(s) may be left blank. Whenever these items are filled in, the values must be those that correspond to the facility that is coded in Reporting Hospital [540].

2.3.1.4. Correction Section of the Update/Correction Record

This section identifies the data item that is being changed and the new value. It also includes date and time stamps and an area for text comments.

Date of This Change [9005]
System-generated date written in the standard format for all dates in the NAACCR layouts.

Time of This Change [9006]
System-generated, HHMMSS format, using a 24-hour clock.

CRC CHECKSUM [2081]
Cyclic Redundancy Code (CRC) CHECKSUM for the NAACCR record in which it resides. A unique value is calculated for each unique record in a NAACCR file. The value is calculated by applying a CRC algorithm to all data fields of the NAACCR record (excluding the CRC CHECKSUM field). Following a transmission, the CRC CHECKSUM can be recalculated and compared with the transmitted CHECKSUM. Identical values indicate an error-free transmission; differing values indicate an error in transmission.

Those using this field at this time must provide recipients of the data with the algorithm used to create the data transmission file. Otherwise the item should be left blank.

A subcommittee of the NAACCR Information and Technology Committee has prepared recommendations for a CRC algorithm to be used with NAACCR-formatted data transmissions. See their report on the NAACCR website (www.naaccr.org), under the Registration Standards page.

Correction Comments [9020]
Free text explaining reason or source of correction, entered either manually or by the software. The comments should justify the change to the receiving registry so that they can evaluate the validity of the new information compared with what they already have.

Examples of manually entered comments:

1) Autopsy: small cell CA RUL lung, mets to L lung, lymph nodes, and brain
2) Pt remarried 6/5/97; new husband is Hispanic, pt is not
3) Slide review AFIP 6/5/97 final DX neuroblastoma
4) Name spelling changed per patient signature on 3 admissions
5) Per MD follow up letter, pt initially dx'd while resident of New Jersey

Examples of software-entered comments:

1) ICD-O-1 to ICD-O-2 conversion rerun
2) Correct Japanese cases miscoded Chinese
3) Convert MD codes to state license numbers
4) Address corrections per geocoding vendor

Changed Item [9030]
The NAACCR item number of the data item to be changed. For example, if reporting a change in the sex field, the value 220 (the NAACCR item number for sex) would be placed in this field.

Changed Item New Value [9040]
The new value for the changed data item referred to in NAACCR item number 9030. For example, if the sex of the patient were being changed from 9, for unknown, to 1, for male, the value 1 would be entered in this field.

2.3.1.5. Answers to Frequently Asked Questions about the Update/Correction Record

2.3.1.5.1. What is an update/correction record?

An update/correction record is a record for transmitting changed data on a case already transmitted. It conveys the changed data along with all items necessary to link the update/correction to the original

full record. The update/correction record may be used to transmit corrections or follow-up, i.e., any change to any item, including abstracting text.

2.3.1.5.2. When should an update/correction record be generated by my software?
Update/Correction records should be system-generated whenever a change is made to a data item on a case that has already been transmitted, or written to a transmit file. (The Date Case Transmitted Date Case Report Exported field can be used to identify tumor records that have already been transmitted). The vendor software should write out the new, corrected values, in addition to writing out the Sender ID Section and Record ID Section data items. The pre-change values must be used in the Sender ID Section and Record ID Section whenever a correction is made to one of these fields. The current date and time are written out on the update/correction record, and the Date Case Last Changed field in the case database is updated as well.

Central registries may negotiate with software vendors/data sources to provide corrections only on a subset of all possible items. For example, a central registry may not wish to receive corrections to items it does not store in its database. At this time there is no standard set of items for which corrections are to be required. Systems should have the potential to allow correction of any field.

2.3.1.5.3. When should update/correction records be transmitted?
There is no standard frequency for transmitting files of accumulated update/correction records. Frequency will vary with caseload and frequency of transmission of new cases. The most common approach is to send accumulated update/correction records each time a transmittal of new cases is generated. It might also be useful to allow ad hoc submissions of update/correction records for those times when numerous corrections are made at once.

2.3.1.5.4. Who should receive update/corrections records?
Update/Correction records should be sent to any agency to which the original case was sent, unless prior arrangements have been made to not receive corrections.

2.3.1.5.5. Does my registry software need to capture corrections to all data elements?
It is probably best for the sending (hospital) system to have the capability to generate corrections to all data elements, though in any particular installation, the capability might not be used for all elements. It is probably also best for the receiving (central) system to be able to accommodate corrections to any data element, though, again, in a particular application, not all capabilities may be implemented. The central system should have the ability to ignore and skip over corrections to any fields they have no interest in.

2.3.1.5.6. How do I accommodate sending update/corrections to multiple requesters?
We suggest that you use the same methods you use to handle multiple case transmits (e.g. selecting on case State of DX to decide which file to send the update/corrections to). The software would not need to select which fields to send each party, since receiving parties will have the ability to ignore data they are not requesting.

2.3.1.5.7. What is the purpose of the patient identifiers in the update/correction record?
The Record ID Section of the record contains all fields that might be needed to correctly link the update/correction record to the original case. Experience has shown that all identifier fields may change in value, and Registry ID may be incorrectly keyed; either of these could cause an update/correction to be applied to the wrong record. Allowing the match to be over-determined by comparing multiple fields reduces this possibility.

2.3.1.5.8. If several corrections are made to record at one time, generating an equal number of update/correction records, should the Sender ID Section and Record ID Section of the update/correction records be the same for each update/correction record?
Yes, all update/correction records for a *specific patient-tumor-facility with identical date and time stamps* should have identical Sender ID and Record ID Sections. Later corrections to the same record, with later date or time stamps, could have different Sender ID and Record ID Sections. At the central registry, correction transactions should be applied in order by facility, by date, by time.

2.3.1.5.9. How about corrections made to the same record during two different work sessions (i.e., changes made one day and subsequent changes to the same record made on the next day)? Should the Record ID Section of the update/correction records be the same?
Same answer as number 8. Since they have different time stamps, they can have different Record ID values.

2.3.1.5.10. How will a system recognize and update/correction records?
NAACCR-format update/correction records will be identified by a '**U**' in the first position, in, Record Type [10].

2.3.1.5.11. Is additional programming needed to incorporate update/correction records into the central registry?
At a minimum, programming will be required to link and then print or display the update/correction record with the original record so that someone can make corrections to the database manually. More elaborate programming is desirable, so that some or all of the update/correction transactions can be applied automatically.

2.3.1.5.12. What is required for internal processing?
See answer to number 11.

2.3.1.5.13. What are the advantages of a uniform update/correction record to a central registry?
A standardized update/correction record format means that the central registry will only have to process one type of record. Communications with vendors are simplified.

2.3.1.5.14. How will a vendor of central registry software assist in incorporating corrections into the central system?
This may vary. The vendor needs to provide basic capabilities for receiving, linking, and displaying the contents of update/correction records. The vendor may also need to apply consolidation/reconciliation procedures that exist in ordinary records processing to the update/correction records.

2.3.1.5.15. How can update/correction records be edited? Can the EDITS program be used to edit incoming records?
The EDITS program cannot be used against the update/correction format per se. However, the update/correction record format could be converted to a NAACCR standard record layout, with most fields blank, and then item edits could be run against the reformatted records.

2.3.1.5.16. What about corrections to state-specific items?
NAACCR will consider reserving a block of item numbers for use by states/requestors to identify their user fields. Details will be forthcoming.

2.3.1.5.17. Will central registries that already have a different functioning system for receiving update/correction records be required to change to this new system?
No. As always, compliance with NAACCR standards is voluntary. The new update/correction record is provided as a service to registries that do not now have a functioning method or that wish to standardize to this approach.

This format for updating records is recommended as a standard for central cancer registries that have not already implemented an effective system for updating records with information from multiple sources. The format is designed to provide a standard for central registries that receive data from a variety of different computer software programs. Central registries, which do not receive data from software supported by multiple vendors, may be able to take advantage of alternative approaches.

2.3.2. Record Type 'M' Modified Record

2.3.2.1. Data Dictionary Descriptions and Record Layout
Changes to previously submitted data records could also be submitted using the "M" record type. The Uniform Data Standards and Information & Technology Committees first approved this record type in 2002. As explained below, the "M" record is identical in format to the "A" record type. Thus, the data dictionary descriptions are found in NAACCR Standards for Cancer Registries Volume II. The record layout table is also found in Appendix C of this document.

2.3.2.2. Questions & Answers about the "M" record

2.3.2.2.1. What is the "M" (modified) record?
An "M" (modified) record represents an alternative way for submitting changed information to a receiving registry, on tumor records that have already been submitted. The "M" record is identical in format to NAACCR record type "A", the case abstract record. "A" and "M" refer to possible values of Record Type [10], found in column 1 of the NAACCR exchange record. The "M" record is designed for transmitting an entire tumor record in which one or more modifications / updates / corrections have been made since the last time the tumor record was submitted to the receiving registry. Like record type "U" (the update/change record), the "M" record may be used to transmit corrections or follow-up, i.e., any change to any item, including abstracting text.

2.3.2.2.2. When should an "M" record be generated by my software?
It depends upon the central registry to which you report. Some central registries require that updates be submitted in the "U" record format; other central registries require the "M" format. If a central registry requires "M" records, then "M" records should be system-generated whenever a transmit file is created (see also #3). Tumor records that have not been reported to the central registry should be written in the "A" format, and tumor records that have already been transmitted but that have had an update to any field, should be written in the "M" format. (The Date Case Report Exported field [2110] can be used to identify tumor records, which have already been transmitted, and a comparison of item #2110 to the Date Case Last Changed field [2100] can be used to identify records that have been modified since the last time they were exported. Also, it is assumed that the Date Case Report Exported field will be updated when an "M" record is generated.) Note that the only difference between an "A" record and an "M" record is the code found in the Record Type field [10]. Some central registries will require that a submission file contain only "A" or only "M" records; other central registries may allow both "A" and "M" records to be within the same file. At this time there is no standard set of items for which "M" records are to be required. Systems should have the potential to note a change/correction/update to any field.

2.3.2.2.3. When should "M" records be transmitted?
There is no standard frequency for transmitting files of accumulated, modified records. Frequency will vary with caseload and frequency of transmission of new reports. The most common approach is to send accumulated modified records each time a transmittal of new reports is generated. It might also be useful to allow ad hoc submissions of "M" records for those times when numerous corrections are made at once.

2.3.2.2.4. Who should receive "M" records?
"M" records should be sent to any agency to which the original tumor record was sent, unless prior arrangements have been made to not receive corrections.

2.3.2.2.5. Does my registry software need to capture corrections to all data elements?
It is simplest for the sending (hospital) system to update the "Date Case Last Changed" field whenever any modification is made to the record. The central registry's software system should have the ability to ignore changes to any fields they have no interest. If a central registry requiring the "M" record wants to limit the number of modified records received, it should specify which data items should trigger an "M" record upon update.

2.3.2.2.6. How do I accommodate sending update/corrections to multiple requesters?
We suggest that you use the same methods you use to handle multiple case transmits (e.g. selecting on case State of DX to decide which file to send the update/corrections to). The software would not need to select which fields to send each party, since receiving parties will have the ability to ignore data they are not requesting. If you submit data to some registries that require "U" records and some that require "M" records, then "U" records should be generated according to the guidelines provided in NAACCR Standards Volume 1 (http://www.naaccr.org/Standards/files/Vol1v9.pdf).

2.3.2.2.7. If several corrections are made to a record between two data submissions, how should the transmitting software handle this?
The submitting software should only include the version of the record that is current at the time the transmittal file is generated.

2.3.2.2.8. How will a system recognize update/correction records?
NAACCR-format modified records will be identified by an "M" in column 1 Record Type [10].

2.3.2.2.9. How are comments about the reason for the update(s) provided in the "M" record?
No narrative field specific to changes exists within the "M" record, since it is identical in format to the "A" record. When any coded data item is changed, its associated text field(s) should also be modified. If a registry does not use data item Text--Remarks[2680] for other purposes, it could use that field to provide some documentation of the overall reason the record was updated.

2.3.2.2.10. Is additional programming needed to incorporate "M" records into the central registry?
Yes. At a minimum, programming will be required to link the incoming records with the source records previously received from the submitting facility, to compare the record pairs data item-by-data item, and then print or display the update/correction record with the original record so that someone can make corrections to the database manually. More elaborate programming is desirable, so that some or all of the changes can be applied automatically, as well as to flag "M" records for which no previously submitted record is found in the database.

2.3.2.2.11. What is required for internal processing?
The central registry should maintain and be able to update the source records submitted by each facility. See also answer to number 10.

2.3.2.2.12. Why use the "M" record when we already have the "U" record?
Several central registries were already using the "A" record format for updates before the "U" record was developed. These central registries and some of the vendors reporting to them did not see an advantage in changing their data processing programs. The addition of the code "M" to the NAACCR Record Type field allows a consistent way to identify the "A" records that actually contain changed information on a previously submitted record.

2.3.2.2.13. How will a vendor of central registry software assist in incorporating corrections into the central system?
This may vary. The vendor needs to provide basic capabilities for receiving, linking, and displaying the contents of modified records. The vendor may also need to apply consolidation/ reconciliation procedures that exist in ordinary records processing to the modified records. See also answer to number 10.

2.3.2.2.14. How can "M" records be edit-checked?
The EDITS program can be used against the "M" record because its format is identical to the "A" record. The version 10 metafile, and forward, has the ability to recognize and process "M" records.

2.3.2.2.15. Can the "M" record be used to report corrections to state-specific items?
Yes. Because the "M" record is identical in format to an "A" record, changes to state-specific data items will be included without any additional programming, assuming that any change to the hospital's registry record triggers the generation of an "M" record. The central registry has the challenge of programming a method to process the incoming "M" records in an efficient way.

2.3.2.2.16. Will central registries that already have a different functioning system for receiving update/correction records be required to change to this new system?
No. As always, compliance with NAACCR standards is voluntary. The new "M" record is provided as a service to several registries that have been requiring that updates be submitted in the "A" format, with a code in the Record Type field indicating that the record is an update of a previous submission. Adding the "M" value allows vendors and central registries to agree on which code indicates a full case abstract that contains new or modified information in a previously submitted record.

3. CODING STANDARDS

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

- *AJCC Cancer Staging Manual Sixth Edition (TNM)*
- *Canadian Cancer Registry Data Dictionary*
- *COC Facility Oncology Registry Data Standards (FORDS)*
- *Collaborative Staging Manual and Coding Instructions*
- *NAACCR Standards for Cancer Registries Volume I: Data Exchange Standards and Record Description*
- *NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary*
- *SEER Extent of Disease--1988: Codes and Coding Instructions*
- *SEER Program Code Manual*
- *SEER Summary Stage 2000*
- *WHO ICD-O Third Edition*

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

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

The standard format for all dates is numeric (MMDDCCYY), with 99 for unknown day, month, year, or century (i.e., 1899 = year 1899, 1999 = year 1999, and 9999 = year unknown). Standard edits check that all dates are earlier than today's date.

If a registry departs from these standards in any fields when submitting or sharing data, they must send accompanying documentation of the codes used along with the data being submitted.

3.1. REQUIRED FIELDS FOR DATA EXCHANGE

Some fields must always be completed on each data record. These are considered the absolute minimum required to identify the data record, specify the coding system used, and allow for basic incidence counts (e.g., Birth Date or Age at Diagnosis must be present). Additional fields are usually required to carry out meaningful data exchange (see Appendix C) such as:

- Stage (using any of the stage coding systems)
- Date of Last Contact and Vital Status
- Summary treatment fields

3.2. NAACCR NAMING AND NUMBERING CONVENTIONS

Item names are a maximum of 25 characters. Standardized abbreviations are used when necessary. Standardized punctuation and spacing are also used. Related fields are sometimes named with an identical stem and changing suffix. For example, names of all modalities of treatment in the first course of therapy have the identical stem "RX Summ", for Treatment Summary, followed by an indicator of the type of treatment, for example, "Chemo". Item names, while relatively stable, can change and have changed with different versions of the layout. Item numbers, in contrast, are unchanging during the life of the data item. Item numbers have been retired when items have been deleted from the layout, but item numbers will never be reused for a different item. Ranges of available item numbers have been assigned to different uses, as follows:

Range	**Use**
00001 - 04999	Data items in new case layouts, record types I, C, or A
05000 - 06999	Data items in Analysis/Research record only
07000 - 08999	Pathology Laboratory record
09000 - 09099	Data items in Update/Correction record only
09100 - 09499	Future use
09500 - 09999	Data items for Local use
10000 - 10499	System variables for Local use
20000 - 20999	Data items for International use (These data items are not within the purview of NAACCR, and NAACCR will not use the data item numbers in this range.)
99000 - 99999	Data items for Patient Care Evaluation studies. ACoS or others may assign these. A large range is allotted because many new items may be assigned each year for individual studies.

APPENDIX A: Abbreviations And Symbols Used

ACoS	American College of Surgeons
ACS	American Cancer Society
AJCC	American Joint Committee on Cancer
CDC	Centers for Disease Control and Prevention
COC	Commission on Cancer (of the American College of Surgeons)
CTR	Certified Tumor Registrar
DAM	*Data Acquisition Manual* (manual of ACoS)
EOD	Extent of Disease
FIPS	Federal Information Processing Standards
FORDS	Facility Oncology Registry Data Standards (manual of ACoS)
FTRO	*Fundamental Tumor Registry Operations Program* (of the American College of Surgeons)
HIM	Health Information Management
HL7	Health Level 7
IACR	International Association of Cancer Registries
IARC	International Agency for Research on Cancer
ICD	International Classification of Diseases
ICD-O	*International Classification of Diseases for Oncology*
ICD-O-1	*International Classification of Diseases for Oncology*, First edition
ICD-O-2	*International Classification of Diseases for Oncology*, Second edition
ICD-O-3	*International Classification of Diseases for Oncology*, Third edition
NAACCR	North American Association of Central Cancer Registries, Inc.
NCDB	National Cancer Data Base
NCI	National Cancer Institute
NCRA	National Cancer Registrars Association
N.d.	No date (bibliographic term: no ascertainable date of publication)
NOS	Not Otherwise Specified
N.p.	No place (bibliographic term: no ascertainable place of publication)
NPCR	National Program of Cancer Registries
ROADS	*Registry Operations and Data Standards* (manual of ACoS)
SEER	Surveillance, Epidemiology, and End Results Program (of the National Cancer Institute)
TNM	Tumor, Nodes, and Metastasis: staging system of AJCC and UICC
UDSC	Uniform Data Standards Committee (of NAACCR)
UICC	Union Internationale Contre le Cancer (in English, International Union Against Cancer)
WHO	World Health Organization

APPENDIX B. Historical Reference Of All Introductions To Previous Versions Of Volume I

The following sections repeat actual verbiage from previous introductions to Volume I. These have been preserved for historical reference of changes to Volume I.

Version 3
There were three reasons that caused a revision in the standard record format. First, the NAACCR Data Exchange Committee in its April 1993 meeting decided to add one field (smoking history) and make two other fields required (County at Diagnosis and Diagnostic Confirmation). Secondly, the Uniform Data Standards Committee decided in November to add a data item for Name-Derived Ethnicity. Thirdly, some minor changes in item names and references were made to bring this document into agreement with the newly written Standards for Cancer registries, Volume II.

Version 4
The changes between version 3.0 and 4.0 comprised the minimum set of changes needed to allow the NAACCR standard record layout to meet two immediate needs for 1995 cases: 1) Accommodating the data changes approved by the NAACCR UDSC effective with 1995 cases. 2) Incorporating all missing items from the SEER record layout, so that standardized SEER edits in the EDITS software could be performed against the NAACCR record layout.

NO existing data items were moved or changed in length. New items were added in previously unused spaces.

A major revision of this layout and the corresponding data dictionary (Volume II of the series) was anticipated later in 1995 to accommodate primarily changes necessitated by the revised data set recommendations of the American College of Surgeons.

Version 5
This was the first major change in the NAACCR layout. The American College of Surgeons had added more than 50 new fields for 1996. It was the Data Exchange Committee's mission to include all registry data items for which data standards exist. There was not enough room in the existing expansion areas in the 1995 record, so the committee decided to revise the entire format. The goals were to make sure fields were grouped by their appropriate category, and to add new empty expansion areas so that the overall layout would not require expansion for the next few years.

The new record layout increased in length from 850 to 1525 for non-confidential records, and from 5300 to 5966 for full abstracts. In addition to the 55 new CoC items, the NAACCR Uniform Data Standards Committee and Data Exchange Committee added eight items, and NPCR revised its recommendations on some items. The State- and Site-specific studies field areas were combined into a single State/Requestor area, and expanded to a total of 500 characters.

Version 6
This volume was intended to be a companion to *Volume II: Data Standards and Data Dictionary* released in March 1998. This volume also introduced two new record types and layouts; type U an Update/Correction record, and type R an Analysis/Research record. We hope that both new record types served to enhance the data processing and analytic capabilities of our member registries.

Version 7
Beginning with the release of version 6, the NAACCR Board of Directors agreed that the NAACCR layout would change once a year only. All approved revisions occurring during the year were to be released in April for implementation in January of the following year. Thus, changes scheduled to take effect in January 1999 were released in April 1998 as version 7 of the record layout. This was published as a small supplementary revision of the Volume II standards, since it included data dictionary entries for the few changed items as well as the revised layout.

Version 8
Version 8 of the NAACCR data exchange record layout completed the changes required to accommodate the major revision of cancer registry treatment coding that began in 1996. The 1996 revision that resulted in version 5 was the most extensive revision since the standard was first established. A new layout had been required to accommodate the publication of the Commission on Cancer's ROADS Manual. The Information and Technology Committee (formerly called the Data Exchange Committee) chose to take the opportunity at that time to reorganize the record format and lengthen it to 5,966 bytes, inserting room for expansion in each content area to accommodate changes to the layout for the next several years.

With the publication of the 1998 ROADS Supplement, the third edition of the SEER Program Code Manual, and the fifth edition of AJCC's TNM manual, additional changes in the NAACCR data exchange layout were required, resulting in version 6. Version 6 was first published in the revised NAACCR Standards, Volume II, Data Standards and Data Dictionary, dated March 20, 1998.

Version 9
Version 9 of the NAACCR data exchange record layout reflected the needed changes for the reporting of cancer cases diagnosed from January 1, 2001 onward. New data items reflected changes to some histologic codes as a result of the introduction of the *International Classification of Diseases for Oncology, Third Edition.* Also new was a field for SEER Summary Stage 2000 data as were a number of new override flags. Other changes were reflective of the needs of the various standards setting organizations and those changes were reported in detail in the companion volume, *Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifth Edition.*

Version 10.1
Version 10.1 of the NAACCR (All abbreviations are listed in Appendix A) data exchange record layout reflects the needed changes for the reporting of tumors diagnosed from January 1, 2004 onward. New data items reflect changes introduced with FORDS and AJCC Sixth Edition. Other changes are reflective of the needs of the various standard setting organizations and these changes are reported in detail in the companion volume, Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary*. The following changes were made to this volume: format of the document; addition of Record Type M, Modified Record; addition of the Coding Standards section; change of the data numbering range to include data items for International use; Appendix E, Data Descriptor Table for Record Types R and U; and, editorial revisions. Track change lines were not used within this document due to the extent of the changes.

With this latest version of the standards, the Research/Analysis Record (Type R) will be retired due to nonuse by the NAACCR community. It is the feeling of the IT Committee that the recoded data items that are a part of the Type R record may be generated by recode algorithms that are part of the SEER*Stat and SEER*Prep systems. For informational and historical purposes, we will continue to list these recoded data items as part of Volume I of the NAACCR standards.

The electronic pathology lab reporting recommendations, previously Chapter 6 in NAACCR Standards for Cancer Registries Volume II, are currently undergoing a major revision. The E-Path Transmission Work Group is developing an HL7 implementation guide for the reporting of pathology laboratory results to cancer registries and plans to have the new guide available in the fall of 2004. Upon completion, the HL7 implementation guide will be incorporated into the NAACCR Standards for Cancer Registries Volume I.

Version 11

Version 11.0 of the NAACCR (all abbreviations are listed in Appendix A) data exchange record layout reflects the needed changes for the reporting of tumors diagnosed from January 1, 2006 onward. New data items reflect changes introduced for the needs of the various standard setting organizations. These changes are reported in detail in the companion volume, Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary*, Tenth Edition, Record Layout Version 11.

The electronic pathology lab reporting recommendations, previously Chapter VI in NAACCR Standards for Cancer Registries Volume II, has had major revisions. The E-path Transmission Work Group developed an HL7 implementation guide for the reporting of pathology laboratory results to cancer registries. As a result of work on the HL7 implementation guide, a new NAACCR Standards Volume (Volume V) document will contain information on electronic reporting of pathology specimen data from pathology laboratories to cancer registries and is expected to be published in 2005.

Introductions from prior versions of Volume I have been retained as a historical reference in Appendix B.

APPENDIX C. NAACCR Case Record Layout, Version 11.1 For Implementation 1/1/2007 Record Types I, C, A, And M

Note: The target audience for the "Exchange Elements" columns is comprised primarily of the various designers of registry software, at the hospital, central registry, and national levels. In these two columns we mark fields that 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. We make a clear distinction between items required for facilities reporting to central registries (labeled hosp -> central), and those items that central registries should use when sending cases to other central registries (labeled central -> central). Some central and national registries have additional required data fields. For these, vendors should contact the registry directly.

T - used when the data is vital to a complete exchange record. If data item is unknown, it should have the proper code for unknown assigned. The set of data items designated as 'T' is designed to include variables that every registry collects; thus every record must have a valid code for the field. (Note that the instructions in Chapter IX of Volume II, to blank-fill columns for data items not collected by a registry do not apply here.) T* - means the vendor should convey the data if collected and present. If it is normally not collected, leave blank. If collected but missing, use the code for unknown or not applicable. The receiving end may, of course, ignore these items if they so choose. TH - means only certain cases diagnosed before 2004 may require these fields.

Item #	Data Item Name	Begin	End	Length	NPCR Collect	NPCR Transmit	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Hosp -> Central	Central -> Central	Source of Standard
10	Record Type	1	1	1	.	R	.	R	.	R	T	T	NAACCR
20	Patient ID Number	2	9	8	R	R	.	.	R	R	.	T	Reporting Registry
30	Registry Type	10	10	1	.	.	.	.	.	.	.	T	NAACCR
35	FIN Coding System	11	11	1	.	.	.	.	.	.	.	.	NAACCR
37	Reserved 00	12	18	7	.	.	.	.	.	.	.	.	
50	NAACCR Record Version	19	19	1	.	R	.	R	.	.	T	T	NAACCR
40	Registry ID	20	29	10	.	R	.	.	R	R	T	T	NAACCR
60	Tumor Record Number	30	31	2	.	.	.	.	S	S	T	T	NAACCR
21	Patient System ID-Hosp	32	39	8	.	.	.	.	.	.	T	.	NAACCR
45	NPI--Registry ID	40	49	10	.	R*	.	.	R	R	.	.	NAACCR
370	Reserved 01	50	51	2	.	.	.	.	.	.	.	.	
70	Addr at DX--City	52	71	20	R	.	R	R	R	.	T	T	COC
80	Addr at DX--State	72	73	2	R	R	R	R	R	.	T	T	COC
100	Addr at DX--Postal Code	74	82	9	R	R	R	R	R	.	T	T	COC
90	County at DX	83	85	3	R	R	R	R	R	R	T	T	FIPS/SEER
110	Census Tract 1970/80/90	86	91	6	RH*	RH*	.	.	RH	RH	.	T*	SEER
120	Census Cod Sys 1970/80/90	92	92	1	RH*	RH*	.	.	RH	RH	.	T*	SEER
130	Census Tract 2000	93	98	6	R	R	.	.	R	R	.	T*	NAACCR
362	Census Tract Block Group	99	99	1	.	.	.	.	.	.	.	.	Census
364	Census Tr Cert 1970/80/90	100	100	1	RH*	RH*	.	.	RH	RH	.	.	SEER
365	Census Tr Certainty 2000	101	101	1	R	R	.	.	R	R	.	.	NAACCR
150	Marital Status at DX	102	102	1	.	.	.	.	R	R	.	.	SEER
160	Race 1	103	104	2	R	R	R	R	R	R	T	T	SEER/COC
161	Race 2	105	106	2	R	R	R	R	R	R	T	T	SEER/COC
162	Race 3	107	108	2	R	R	R	R	R	R	T	T	SEER/COC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	NPCR Transmit	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Hosp -> Central	Central -> Central	Source of Standard
163	Race 4	109	110	2	R	R	R	R	R	R	T	T	SEER/COC
164	Race 5	111	112	2	R	R	R	R	R	R	T	T	SEER/COC
170	Race Coding Sys--Current	113	113	1	.	.	R	R	.	.	T	T	NAACCR
180	Race Coding Sys--Original	114	114	1	.	.	R	R	.	.	T	T	NAACCR
190	Spanish/Hispanic Origin	115	115	1	R	R	R	R	R	R	T	T	SEER/COC
200	Computed Ethnicity	116	116	1	R	R	.	.	D	R	.	.	SEER
210	Computed Ethnicity Source	117	117	1	R	R	.	.	R	R	.	.	SEER
220	Sex	118	118	1	R	R	R	R	R	R	T	T	SEER/COC
230	Age at Diagnosis	119	121	3	R	R	R	R	R	R	.	.	SEER/COC
240	Birth Date	122	129	8	R	R	R	R	R	R	T	T	SEER/COC
250	Birthplace	130	132	3	R*	R*	R	R	R	R	T*	T	SEER/COC
260	Religion	133	134	2	.	.	.	.	.	.	.	.	Varies
270	Occupation Code--Census	135	137	3	R*	R*	.	.	.	.	.	.	Census/ NPCR
280	Industry Code--Census	138	140	3	R*	R*	.	.	.	.	.	.	Census/ NPCR
290	Occupation Source	141	141	1	R*	R*	.	.	.	.	.	.	NPCR
300	Industry Source	142	142	1	R*	R*	.	.	.	.	.	.	NPCR
310	Text--Usual Occupation	143	182	40	R*	.	.	.	.	.	T*	T*	NPCR
320	Text--Usual Industry	183	222	40	R*	.	.	.	.	.	T*	T*	NPCR
330	Occup/Ind Coding System	223	223	1	R*	R*	.	.	.	.	.	.	NPCR
340	Tobacco History	224	224	1	.	.	.	.	.	.	.	.	Varies
350	Alcohol History	225	225	1	.	.	.	.	.	.	.	.	Varies
360	Family History of Cancer	226	226	1	.	.	.	.	.	.	.	.	Varies
3300	RuralUrban Continuum 1993	227	228	2	D	.	.	.	.	.	.	.	NAACCR
3310	RuralUrban Continuum 2003	229	230	2	D	.	.	.	.	.	.	.	NAACCR
191	NHIA Derived Hisp Origin	231	231	1	D	R	.	.	D	R	.	.	NAACCR
192	IHS Link	232	232	1	R*	R*	.	.	.	R	.	.	NPCR
366	GIS Coordinate Quality	233	234	2	R*	R*	.	.	S	.	.	.	NAACCR
530	Reserved 02	235	280	46	.	.	.	.	.	.	.	.	
380	Sequence Number--Central	281	282	2	R	R	.	.	R	R	.	T	SEER
390	Date of Diagnosis	283	290	8	R	R	R	R	R	R	T	T	SEER/COC
400	Primary Site	291	294	4	R	R	R	R	R	R	T	T	SEER/COC
410	Laterality	295	295	1	R	R	R	R	R	R	T	T	SEER/COC
420	Histology (92-00) ICD-O-2	296	299	4	RH	RH	RH.	RH	RH	RH	TH	TH	SEER/COC
419	Morph--Type&Behav ICD-O-2	296	300	5									
430	Behavior (92-00) ICD-O-2	300	300	1	RH	RH	RH	RH	RH	RH	TH	TH	SEER/COC
522	Histologic Type ICD-O-3	301	304	4	R	R	R	R	R	R	T	T	SEER/COC
521	Morph--Type&Behav ICD-O-3	301	305	5									
523	Behavior Code ICD-O-3	305	305	1	R	R	R	R	R	R	T	T	SEER/COC
440	Grade	306	306	1	R	R	R	R	R	R	T	T	SEER/COC
450	Site Coding Sys--Current	307	307	1	R	R	R	R	.	.	T	T	NAACCR
460	Site Coding Sys--Original	308	308	1	.	.	R	R	.	.	T	T	NAACCR
470	Morph Coding Sys--Current	309	309	1	R	R	R	R	.	.	T	T	NAACCR
480	Morph Coding Sys--Originl	310	310	1	.	.	R	R	.	.	T	T	NAACCR

Item #	Data Item Name	Begin	End	Length	NPCR Collect	NPCR Transmit	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Hosp -> Central	Central -> Central	Source of Standard
490	Diagnostic Confirmation	311	311	1	R	R	R	R	R	R	T	T	SEER/COC
500	Type of Reporting Source	312	312	1	R	R	.	.	R	R	T	T	SEER
510	Screening Date	313	320	8	.	.	.	.	.	.	.	.	NAACCR
520	Screening Result	321	321	1	.	.	.	.	.	.	.	.	NAACCR
501	Casefinding Source	322	323	2	.	.	.	.	R	R	T*	T*	NAACCR
442	Ambiguous Terminology DX	324	324	1	.	.	.	.	R	R	.	.	SEER
443	Date of Conclusive DX	325	332	8	.	.	.	.	R	R	.	.	SEER
444	Mult Tum Rpt as One Prim	333	334	2	.	.	.	.	R	R	.	.	SEER
445	Date of Multiple Tumors	335	342	8	.	.	.	.	R	R	.	.	SEER
446	Multiplicity Counter	343	344	2	.	.	.	.	R	R	.	.	SEER
447	Number of Tumors/Hist	345	346	2	.	.	.	.	.	.	.	.	NAACCR
680	Reserved 03	347	371	25	.	.	.	.	.	.	.	.	
545	NPI--Reporting Facility	372	381	10	R*	.	.	.	R	.	.	.	NAACCR
540	Reporting Facility	382	391	10	R	.	R	R	R	.	T	.	COC
3100	Archive FIN	392	401	10	.	.	R	R	.	.	.	.	COC
550	Accession Number--Hosp	402	410	9	.	.	R	R	R	.	T*	.	COC
560	Sequence Number--Hospital	411	412	2	.	.	R	R	R	.	T	.	COC
570	Abstracted By	413	415	3	.	.	R	R	R	.	.	.	COC
580	Date of 1st Contact	416	423	8	R	.	R	R	.	.	T	.	COC
590	Date of Inpatient Adm	424	431	8	.	.	.	.	.	.	.	.	NAACCR
600	Date of Inpatient Disch	432	439	8	.	.	.	.	.	.	.	.	NAACCR
610	Class of Case	440	440	1	R	.	R	R	RC	.	T	.	COC
615	Reserved 26	441	444	4	.	.	.	.	.	.	.	.	
630	Primary Payer at DX	445	446	2	.	.	R	R	R	R	.	.	COC
3105	NPI--Archive FIN	447	456	10	.	.	.	.	.	.	.	.	NAACCR
670	RX Hosp--Surg Prim Site	457	458	2	.	.	R	R	R	.	T*	.	COC
672	RX Hosp--Scope Reg LN Sur	459	459	1	.	.	R	R	R	.	T*	.	COC
674	RX Hosp--Surg Oth Reg/Dis	460	460	1	.	.	R	R	R	.	T*	.	COC
676	RX Hosp--Reg LN Removed	461	462	2	.	.	.	RH	.	.	T*	.	COC
690	RX Hosp--Radiation	463	463	1	.	.	.	.	RH	.	TH*	.	SEER/COC
700	RX Hosp--Chemo	464	465	2	.	.	R	R	R	.	T*	.	COC
710	RX Hosp--Hormone	466	467	2	.	.	R	R	R	.	T*	.	COC
720	RX Hosp--BRM	468	469	2	.	.	R	R	R	.	T*	.	COC
730	RX Hosp--Other	470	470	1	.	.	R	R	R	.	T*	.	COC
740	RX Hosp--DX/Stg Proc	471	472	2	.	.	R	R	.	.	.	.	COC
3280	RX Hosp--Palliative Proc	473	473	1	.	.	R	R	.	.	T*	.	COC
741	Reserved 28	474	477	4	.	.	.	.	.	.	.	.	
746	RX Hosp--Surg Site 98-02	478	479	2	.	.	.	RH	RH	.	TH*	.	COC
747	RX Hosp--Scope Reg 98-02	480	480	1	.	.	.	RH	RH	.	TH*	.	COC
748	RX Hosp--Surg Oth 98-02	481	481	1	.	.	.	RH	RH	.	TH*	.	COC
750	Reserved 04	482	527	46	.	.	.	.	.	.	.	.	
759	SEER Summary Stage 2000	528	528	1	RH	RH	RH	RH	S	S	TH*	TH*	SEER
760	SEER Summary Stage 1977	529	529	1	RH	RH	RH	RH	.	S	TH*	TH*	SEER
765	Reserved 29	530	530	1	.	.	.	.	.	.	.	.	

Item #	Data Item Name	Begin	End	Length	NPCR Collect	NPCR Transmit	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Hosp -> Central	Central -> Central	Source of Standard
780	EOD--Tumor Size	531	533	3	.	.	RH	RH	RH	RH	TH*	TH*	SEER/COC
779	Extent of Disease 10-Dig	531	542	12									
790	EOD--Extension	534	535	2	.	.	.	.	RH	RH	TH*	TH*	SEER
800	EOD--Extension Prost Path	536	537	2	.	.	.	.	RH	RH	TH*	TH*	SEER
810	EOD--Lymph Node Involv	538	538	1	.	.	.	.	RH	RH	TH*	TH*	SEER
820	Regional Nodes Positive	539	540	2	.	.	R	R	R	R	T*	T*	SEER/COC
830	Regional Nodes Examined	541	542	2	.	.	R	R	R	R	T*	T*	SEER/COC
840	EOD--Old 13 Digit	543	555	13	.	.	.	.	RH	RH	.	.	SEER
850	EOD--Old 2 Digit	556	557	2	.	.	.	.	RH	RH	.	.	SEER
860	EOD--Old 4 Digit	558	561	4	.	.	.	.	RH	RH	.	.	SEER
870	Coding System for EOD	562	562	1	.	.	.	.	RH	RH	.	TH*	SEER
880	TNM Path T	563	564	2	.	.	R	R	.	.	T*	T*	AJCC
890	TNM Path N	565	566	2	.	.	R	R	.	.	T*	T*	AJCC
900	TNM Path M	567	568	2	.	.	R	R	.	.	T*	T*	AJCC
910	TNM Path Stage Group	569	570	2	.	.	R	R	.	.	T*	T*	AJCC
920	TNM Path Descriptor	571	571	1	.	.	R	R	.	.	T*	T*	COC
930	TNM Path Staged By	572	572	1	.	.	R	R	.	.	T*	T*	COC
940	TNM Clin T	573	574	2	.	.	R	R	.	.	T*	T*	AJCC
950	TNM Clin N	575	576	2	.	.	R	R	.	.	T*	T*	AJCC
960	TNM Clin M	577	578	2	.	.	R	R	.	.	T*	T*	AJCC
970	TNM Clin Stage Group	579	580	2	.	.	R	R	.	.	T*	T*	AJCC
980	TNM Clin Descriptor	581	581	1	.	.	R	R	.	.	T*	T*	COC
990	TNM Clin Staged By	582	582	1	.	.	R	R	.	.	T*	T*	COC
995	Reserved 30	583	592	10	.	.	.	.	.	.	.	.	
1060	TNM Edition Number	593	594	2	.	.	R	R	.	.	T*	T*	COC
1065	Reserved 31	595	609	15	.	.	.	.	.	.	.	.	
1080	Date of 1st Positive BX	610	617	8	.	.	.	.	.	.	.	.	NAACCR
1090	Site of Distant Met 1	618	618	1	.	.	.	RH	.	.	.	.	COC
1100	Site of Distant Met 2	619	619	1	.	.	.	RH	.	.	.	.	COC
1110	Site of Distant Met 3	620	620	1	.	.	.	RH	.	.	.	.	COC
1120	Pediatric Stage	621	622	2	.	.	.	.	.	.	.	.	COC
1130	Pediatric Staging System	623	624	2	.	.	.	.	.	.	.	.	COC
1140	Pediatric Staged By	625	625	1	.	.	.	.	.	.	.	.	COC
1150	Tumor Marker 1	626	626	1	.	.	.	RH	RH	RH	TH*	TH*	SEER
1160	Tumor Marker 2	627	627	1	.	.	.	RH	RH	RH	TH*	TH*	SEER
1170	Tumor Marker 3	628	628	1	.	.	.	RH	RH	RH	TH*	TH*	SEER
2800	CS Tumor Size	629	631	3	.	.	R	R	R	R	T	T	AJCC
2810	CS Extension	632	633	2	R	.	R	R	R	R	T	T	AJCC
2820	CS Tumor Size/Ext Eval	634	634	1	.	.	R	R	.	.	T*	T*	AJCC
2830	CS Lymph Nodes	635	636	2	R	.	R	R	R	R	T	T	AJCC
2840	CS Reg Node Eval	637	637	1	.	.	R	R	.	.	T*	T*	AJCC
2850	CS Mets at DX	638	639	2	R	.	R	R	R	R	T	T	AJCC
2860	CS Mets Eval	640	640	1	.	.	R	R	.	.	T*	T*	AJCC
2880	CS Site-Specific Factor 1	641	643	3	RS	.	R	R	R	R	T	T	AJCC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	NPCR Transmit	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Hosp -> Central	Central -> Central	Source of Standard
2890	CS Site-Specific Factor 2	644	646	3	.	.	R	R	R	R	T	T	AJCC
2900	CS Site-Specific Factor 3	647	649	3	RS	.	R	R	R	R	T	T	AJCC
2910	CS Site-Specific Factor 4	650	652	3	.	.	R	R	R	R	T	T	AJCC
2920	CS Site-Specific Factor 5	653	655	3	.	.	R	R	R	R	T	T	AJCC
2930	CS Site-Specific Factor 6	656	658	3	.	.	R	R	R	R	T	T	AJCC
2940	Derived AJCC T	659	660	2	.	.	D	D	D	D	T*	T*	AJCC
2950	Derived AJCC T Descriptor	661	661	1	.	.	D	D	.	.	T*	T*	AJCC
2960	Derived AJCC N	662	663	2	.	.	D	D	D	D	T*	T*	AJCC
2970	Derived AJCC N Descriptor	664	664	1	.	.	D	D	.	.	T*	T*	AJCC
2980	Derived AJCC M	665	666	2	.	.	D	D	D	D	T*	T*	AJCC
2990	Derived AJCC M Descriptor	667	667	1	.	.	D	D	.	.	T*	T*	AJCC
3000	Derived AJCC Stage Group	668	669	2	.	.	D	D	D	D	T*	T*	AJCC
3010	Derived SS1977	670	670	1	.	.	D	D	D	D	T*	T*	AJCC
3020	Derived SS2000	671	671	1	D	R	D	D	D	D	T*	T*	AJCC
3030	Derived AJCC--Flag	672	672	1	.	.	R	R	D	D	T*	T*	AJCC
3040	Derived SS1977--Flag	673	673	1	.	.	R	R	D	D	T*	T*	AJCC
3050	Derived SS2000--Flag	674	674	1	D	R	R	R	D	D	T*	T*	AJCC
3110	Comorbid/Complication 1	675	679	5	.	.	R	R	.	.	T*	.	COC
3120	Comorbid/Complication 2	680	684	5	.	.	R	R	.	.	T*	.	COC
3130	Comorbid/Complication 3	685	689	5	.	.	R	R	.	.	T*	.	COC
3140	Comorbid/Complication 4	690	694	5	.	.	R	R	.	.	T*	.	COC
3150	Comorbid/Complication 5	695	699	5	.	.	R	R	.	.	T*	.	COC
3160	Comorbid/Complication 6	700	704	5	.	.	R	R	.	.	T*	.	COC
2935	CS Version 1st	705	710	6	R	.	R	R	R	R	.	.	AJCC
2936	CS Version Latest	711	716	6	R	.	R	R	R	R	.	.	AJCC
3161	Comorbid/Complication 7	717	721	5	.	.	R	R	.	.	T*	.	COC
3162	Comorbid/Complication 8	722	726	5	.	.	R	R	.	.	T*	.	COC
3163	Comorbid/Complication 9	727	731	5	.	.	R	R	.	.	T*	.	COC
3164	Comorbid/Complication 10	732	736	5	.	.	R	R	.	.	T*	.	COC
3165	ICD Revision Comorbid	737	737	1	.	.	R	R	.	.	T*	.	COC
1180	Reserved 05	738	754	17	.	.	.	.	.	.	.	.	
1200	RX Date--Surgery	755	762	8	.	.	R	R	S	.	T*	T*	COC
3170	RX Date--Most Defin Surg	763	770	8	.	.	R	R	.	.	T*	.	COC
3180	RX Date--Surgical Disch	771	778	8	.	.	R	R	.	.	.	.	COC
1210	RX Date--Radiation	779	786	8	.	.	R	R	S	.	T*	T*	COC
3220	RX Date--Radiation Ended	787	794	8	.	.	R	R	.	.	.	.	COC
3230	RX Date--Systemic	795	802	8	.	.	R	R	S	.	T*	T*	COC
1220	RX Date--Chemo	803	810	8	.	.	.	.	.	.	TH*	TH*	NAACCR
1230	RX Date--Hormone	811	818	8	.	.	.	.	.	.	TH*	TH*	NAACCR
1240	RX Date--BRM	819	826	8	.	.	.	.	S	.	TH*	TH*	NAACCR
1250	RX Date--Other	827	834	8	.	.	R	R	S	.	T*	T*	COC
1260	Date of Initial RX--SEER	835	842	8	R#	R#	.	.	R	R	T*	T*	SEER
1270	Date of 1st Crs RX--COC	843	850	8	R#	R#	R	R	.	.	T*	T*	COC
1280	RX Date--DX/Stg Proc	851	858	8	.	.	R	R	.	.	.	.	COC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	NPCR Transmit	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Hosp -> Central	Central -> Central	Source of Standard
1290	RX Summ--Surg Prim Site	859	860	2	R	R	R	R	R	R	T	T*	SEER/COC
1292	RX Summ--Scope Reg LN Sur	861	861	1	R	R	R	R	R	R	T	T*	SEER/COC
1294	RX Summ--Surg Oth Reg/Dis	862	862	1	R	R	R	R	R	R	T	T*	SEER/COC
1296	RX Summ--Reg LN Examined	863	864	2	.	.	.	RH	RH	RH	TH*	TH*	SEER/COC
1310	RX Summ--Surgical Approch	865	865	1	.	.	.	RH	.	.	.	.	COC
1320	RX Summ--Surgical Margins	866	866	1	.	.	R	R	.	.	.	.	COC
1330	RX Summ--Reconstruct 1st	867	867	1	.	.	.	.	RH	RH	.	.	SEER
1340	Reason for No Surgery	868	868	1	R	R	R	R	R	R	T	T*	SEER/COC
1350	RX Summ--DX/Stg Proc	869	870	2	.	.	R	R	.	.	.	.	COC
3270	RX Summ--Palliative Proc	871	871	1	.	.	R	R	.	.	T*	.	COC
1355	Reserved 22	872	872	1	.	.	.	.	.	.	.	.	
1360	RX Summ--Radiation	873	873	1	.	.	.	.	R	R	TH*	TH*	SEER
1370	RX Summ--Rad to CNS	874	874	1	.	.	.	.	R	R	.	.	SEER/COC
1380	RX Summ--Surg/Rad Seq	875	875	1	R	R	R	R	R	R	T	T*	SEER/COC
3250	RX Summ--Transplnt/Endocr	876	877	2	R	R	R	R	R	R	T*	T*	COC
1390	RX Summ--Chemo	878	879	2	R	R	R	R	R	R	T*	T*	SEER/COC
1400	RX Summ--Hormone	880	881	2	R	R	R	R	R	R	T*	T*	SEER/COC
1410	RX Summ--BRM	882	883	2	R	R	R	R	R	R	T*	T*	SEER/COC
1420	RX Summ--Other	884	884	1	R	R	R	R	R	R	T*	T*	SEER/COC
1430	Reason for No Radiation	885	885	1	.	.	R	R	.	.	.	.	COC
1435	Reserved 32	886	887	2	.	.	.	.	.	.	.	.	
1460	RX Coding System--Current	888	889	2	R	R	R	R	.	RH	T*	T*	NAACCR
1465	Reserved 33	890	893	4	.	.	.	.	.	.	.	.	
1500	First Course Calc Method	894	894	1	.	.	.	.	.	.	.	.	NAACCR
1510	Rad--Regional Dose: CGY	895	899	5	.	.	R	R	.	.	T	.	COC
1520	Rad--No of Treatment Vol	900	901	2	.	.	R	R	.	.	T	.	COC
1535	Reserved 34	902	904	3	.	.	.	.	.	.	.	.	
1540	Rad--Treatment Volume	905	906	2	.	.	R	R	.	.	T	.	COC
1550	Rad--Location of RX	907	907	1	.	.	R	R	.	.	T	.	COC
1555	Reserved 35	908	908	1	.	.	.	.	.	.	.	.	
1570	Rad--Regional RX Modality	909	910	2	R	R	R	R	RC	.	T	T*	COC
3200	Rad--Boost RX Modality	911	912	2	.	.	R	R	RC	.	T*	T*	COC
3210	Rad--Boost Dose cGy	913	917	5	.	.	R	R	.	.	.	.	COC
1635	Reserved 23	918	930	13	.	.	.	.	.	.	.	.	
1639	RX Summ--Systemic/Sur Seq	931	931	1	R	R	R	R	R	R	T	T	COC
1640	RX Summ--Surgery Type	932	933	2	.	.	.	.	RH	RH	TH*	TH*	SEER
1641	Reserved 36	934	937	4	.	.	.	.	.	.	.	.	
3190	Readm Same Hosp 30 Days	938	938	1	.	.	R	R	.	.	.	.	COC
1646	RX Summ--Surg Site 98-02	939	940	2	.	.	RH	RH	RH	RH	TH*	TH*	SEER/COC
1647	RX Summ--Scope Reg 98-02	941	941	1	.	.	RH	RH	RH	RH	TH*	TH*	SEER/COC
1648	RX Summ--Surg Oth 98-02	942	942	1	.	.	RH	RH	RH	RH	TH*	TH*	SEER/COC
1190	Reserved 06	943	987	45	.	.	.	.	.	.	.	.	
1660	Subsq RX 2nd Course Date	988	995	8	.	.	.	.	.	.	.	.	COC
1670	Subsq RX 2nd Course Codes	996	1002	7									

Item #	Data Item Name	Begin	End	Length	NPCR Collect	NPCR Transmit	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Hosp -> Central	Central -> Central	Source of Standard
1671	Subsq RX 2nd Course Surg	996	997	2	.	.	.	.	.	.	.	.	COC
1672	Subsq RX 2nd Course Rad	998	998	1	.	.	.	.	.	.	.	.	COC
1673	Subsq RX 2nd Course Chemo	999	999	1	.	.	.	.	.	.	.	.	COC
1674	Subsq RX 2nd Course Horm	1000	1000	1	.	.	.	.	.	.	.	.	COC
1675	Subsq RX 2nd Course BRM	1001	1001	1	.	.	.	.	.	.	.	.	COC
1676	Subsq RX 2nd Course Oth	1002	1002	1	.	.	.	.	.	.	.	.	COC
1680	Subsq RX 3rd Course Date	1003	1010	8	.	.	.	.	.	.	.	.	COC
1690	Subsq RX 3rd Course Codes	1011	1017	7									
1691	Subsq RX 3rd Course Surg	1011	1012	2	.	.	.	.	.	.	.	.	COC
1692	Subsq RX 3rd Course Rad	1013	1013	1	.	.	.	.	.	.	.	.	COC
1693	Subsq RX 3rd Course Chemo	1014	1014	1	.	.	.	.	.	.	.	.	COC
1694	Subsq RX 3rd Course Horm	1015	1015	1	.	.	.	.	.	.	.	.	COC
1695	Subsq RX 3rd Course BRM	1016	1016	1	.	.	.	.	.	.	.	.	COC
1696	Subsq RX 3rd Course Oth	1017	1017	1	.	.	.	.	.	.	.	.	COC
1700	Subsq RX 4th Course Date	1018	1025	8	.	.	.	.	.	.	.	.	COC
1710	Subsq RX 4th Course Codes	1026	1032	7									
1711	Subsq RX 4th Course Surg	1026	1027	2	.	.	.	.	.	.	.	.	COC
1712	Subsq RX 4th Course Rad	1028	1028	1	.	.	.	.	.	.	.	.	COC
1713	Subsq RX 4th Course Chemo	1029	1029	1	.	.	.	.	.	.	.	.	COC
1714	Subsq RX 4th Course Horm	1030	1030	1	.	.	.	.	.	.	.	.	COC
1715	Subsq RX 4th Course BRM	1031	1031	1	.	.	.	.	.	.	.	.	COC
1716	Subsq RX 4th Course Oth	1032	1032	1	.	.	.	.	.	.	.	.	COC
1725	Reserved 37	1033	1047	15	.	.	.	.	.	.	.	.	
1677	Subsq RX 2nd--Scope LN SU	1048	1048	1	.	.	.	.	.	.	.	.	COC
1678	Subsq RX 2nd--Surg Oth	1049	1049	1	.	.	.	.	.	.	.	.	COC
1679	Subsq RX 2nd--Reg LN Rem	1050	1051	2	.	.	.	.	.	.	.	.	COC
1697	Subsq RX 3rd--Scope LN Su	1052	1052	1	.	.	.	.	.	.	.	.	COC
1698	Subsq RX 3rd--Surg Oth	1053	1053	1	.	.	.	.	.	.	.	.	COC
1699	Subsq RX 3rd--Reg LN Rem	1054	1055	2	.	.	.	.	.	.	.	.	COC
1717	Subsq RX 4th--Scope LN Su	1056	1056	1	.	.	.	.	.	.	.	.	COC
1718	Subsq RX 4th--Surg Oth	1057	1057	1	.	.	.	.	.	.	.	.	COC
1719	Subsq RX 4th--Reg LN Rem	1058	1059	2	.	.	.	.	.	.	.	.	COC
1726	Reserved 38	1060	1063	4	.	.	.	.	.	.	.	.	
1741	Subsq RX--Reconstruct Del	1064	1064	1	.	.	.	.	.	.	.	.	COC
1300	Reserved 07	1065	1114	50	.	.	.	.	.	.	.	.	
1981	Over-ride SS/NodesPos	1115	1115	1	.	.	.	.	.	.	T*	T*	NAACCR
1982	Over-ride SS/TNM-N	1116	1116	1	.	.	.	.	.	.	T*	T*	NAACCR
1983	Over-ride SS/TNM-M	1117	1117	1	.	.	.	.	.	.	T*	T*	NAACCR
1984	Over-ride SS/DisMet1	1118	1118	1	.	.	.	.	.	.	T*	T*	NAACCR
1985	Over-ride Acsn/Class/Seq	1119	1119	1	.	.	R	R	.	.	T*	T*	COC
1986	Over-ride HospSeq/DxConf	1120	1120	1	.	.	R	R	.	.	T*	T*	COC
1987	Over-ride COC-Site/Type	1121	1121	1	.	.	R	R	.	.	T*	T*	COC
1988	Over-ride HospSeq/Site	1122	1122	1	.	.	R	R	.	.	T*	T*	COC
1989	Over-ride Site/TNM-StgGrp	1123	1123	1	.	.	R	R	.	.	T*	T*	COC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	NPCR Transmit	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Hosp -> Central	Central -> Central	Source of Standard
1990	Over-ride Age/Site/Morph	1124	1124	1	R	R	R	R	R	R	T*	T*	SEER
2000	Over-ride SeqNo/DxConf	1125	1125	1	R	R	.	.	R	R	T*	T*	SEER
2010	Over-ride Site/Lat/SeqNo	1126	1126	1	R	R	.	.	R	R	T*	T*	SEER
2020	Over-ride Surg/DxConf	1127	1127	1	R	R	R	R	R	R	T*	T*	SEER
2030	Over-ride Site/Type	1128	1128	1	R	R	R	R	R	R	T*	T*	SEER
2040	Over-ride Histology	1129	1129	1	R	R	R	R	R	R	T*	T*	SEER
2050	Over-ride Report Source	1130	1130	1	R	R	.	.	R	R	T*	T*	SEER
2060	Over-ride Ill-define Site	1131	1131	1	R	R	.	.	R	R	T*	T*	SEER
2070	Over-ride Leuk, Lymphoma	1132	1132	1	R	R	R	R	R	R	T*	T*	SEER
2071	Over-ride Site/Behavior	1133	1133	1	R	R	R	R	R	R	T*	T*	SEER
2072	Over-ride Site/EOD/DX Dt	1134	1134	1	.	.	.	.	R	R	T*	T*	SEER
2073	Over-ride Site/Lat/EOD	1135	1135	1	.	.	.	.	R	R	T*	T*	SEER
2074	Over-ride Site/Lat/Morph	1136	1136	1	R	R	R	R	R	R	T*	T*	SEER
1960	Site (73-91) ICD-O-1	1137	1140	4	.	.	.	.	RH	RH	.	.	SEER
1971	Histology (73-91) ICD-O-1	1141	1144	4	.	.	.	.	RH	RH	.	.	SEER
1970	Morph (73-91) ICD-O-1	1141	1146	6									
1972	Behavior (73-91) ICD-O-1	1145	1145	1	.	.	.	.	RH	RH	.	.	SEER
1973	Grade (73-91) ICD-O-1	1146	1146	1	.	.	.	.	RH	RH	.	.	SEER
1980	ICD-O-2 Conversion Flag	1147	1147	1	.	.	R	R	R	R	T*	T*	SEER
2082	Reserved 24	1148	1163	16	.	.	.	.	.	.	.	.	
2081	CRC CHECKSUM	1164	1173	10	.	.	.	.	S	S	.	.	NAACCR
2090	Date Case Completed	1174	1181	8	.	.	.	.	.	.	.	.	NAACCR
2100	Date Case Last Changed	1182	1189	8	.	.	.	.	.	.	.	.	NAACCR
2110	Date Case Report Exported	1190	1197	8	R	.	.	R	.	.	T	.	NPCR
2120	SEER Coding Sys--Current	1198	1198	1	.	.	.	.	.	R	T*	T*	NAACCR
2130	SEER Coding Sys--Original	1199	1199	1	.	.	.	.	.	R	T*	T*	NAACCR
2140	COC Coding Sys--Current	1200	1201	2	.	.	R	R	.	.	T*	T*	COC
2150	COC Coding Sys--Original	1202	1203	2	.	.	R	R	.	.	T*	T*	COC
2170	Vendor Name	1204	1213	10	.	.	.	R	.	.	T	T	NAACCR
2180	SEER Type of Follow-Up	1214	1214	1	.	.	.	.	R	R	.	.	SEER
2190	SEER Record Number	1215	1216	2	.	.	.	.	.	R	.	.	SEER
2200	Diagnostic Proc 73-87	1217	1218	2	.	.	.	.	RH	RH	.	.	SEER
2111	Date Case Report Received	1219	1226	8	R	.	.	.	.	.	.	.	NPCR
2112	Date Case Report Loaded	1227	1234	8	R	.	.	.	.	.	.	.	NPCR
2113	Date Tumor Record Availbl	1235	1242	8	R	.	.	.	.	.	.	.	NPCR
2116	ICD-O-3 Conversion Flag	1243	1243	1	R	R	R	R	R	R	T	T	SEER/COC
1650	Reserved 08	1244	1293	50	.	.	.	.	.	.	.	.	
1750	Date of Last Contact	1294	1301	8	R	R	R	R	R	R	T	T	SEER/COC
1760	Vital Status	1302	1302	1	R	R	R	R	R	R	T	T	SEER/COC
1770	Cancer Status	1303	1303	1	.	.	R	R	.	.	.	.	COC
1780	Quality of Survival	1304	1304	1	.	.	.	.	.	.	.	.	COC
1790	Follow-Up Source	1305	1305	1	.	.	R	R	.	.	T*	.	COC
1800	Next Follow-Up Source	1306	1306	1	.	.	R	.	.	.	.	.	COC
1810	Addr Current--City	1307	1326	20	.	.	R	.	R	.	T*	.	COC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	NPCR Transmit	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Hosp -> Central	Central -> Central	Source of Standard
1820	Addr Current--State	1327	1328	2	.	.	R	.	R	.	T*	.	COC
1830	Addr Current--Postal Code	1329	1337	9	.	.	R	.	R	.	T*	.	COC
1840	County--Current	1338	1340	3	.	.	.	.	.	.	.	.	NAACCR
1850	Unusual Follow-Up Method	1341	1341	1	.	.	.	.	.	.	.	.	COC
1860	Recurrence Date--1st	1342	1349	8	.	.	R	R	RC	.	T*	.	COC
1871	Recurrence Distant Site 1	1350	1350	1	.	.	.	.	.	.	.	.	NAACCR
1872	Recurrence Distant Site 2	1351	1351	1	.	.	.	.	.	.	.	.	NAACCR
1873	Recurrence Distant Site 3	1352	1352	1	.	.	.	.	.	.	.	.	NAACCR
1880	Recurrence Type--1st	1353	1354	2	.	.	R	R	RC	.	T*	.	COC
1895	Reserved 39	1355	1356	2	.	.	.	.	.	.	.	.	
1842	Follow-Up Contact--City	1357	1376	20	.	.	.	.	R	.	T*	.	SEER
1844	Follow-Up Contact--State	1377	1378	2	.	.	.	.	R	.	T*	.	SEER
1846	Follow-Up Contact--Postal	1379	1387	9	.	.	.	.	R	.	T*	.	SEER
1910	Cause of Death	1388	1391	4	R	R	.	.	R	R	.	T	SEER
1920	ICD Revision Number	1392	1392	1	R	R	.	.	R	R	.	T	SEER
1930	Autopsy	1393	1393	1	.	.	.	.	.	.	.	.	NAACCR
1940	Place of Death	1394	1396	3	R	.	.	.	.	.	T*	T*	NPCR
1791	Follow-up Source Central	1397	1398	2	R	R	.	.	.	.	.	T*	NAACCR
1740	Reserved 09	1399	1446	48	.	.	.	.	.	.	.	.	
2220	State/Requestor Items	1447	1946	500	.	.	.	.	.	.	.	.	Varies
2230	Name--Last	1947	1971	25	R	.	R	.	R	.	T	T	NAACCR
2240	Name--First	1972	1985	14	R	.	R	.	R	.	T	T	NAACCR
2250	Name--Middle	1986	1999	14	R	.	R	.	R	.	T*	T*	COC
2260	Name--Prefix	2000	2002	3	.	.	.	.	.	.	.	.	SEER
2270	Name--Suffix	2003	2005	3	.	.	.	.	R	.	T*	T*	SEER
2280	Name--Alias	2006	2020	15	R	.	.	.	R	.	T*	T*	SEER
2390	Name--Maiden	2021	2035	15	R	.	.	.	R	.	T*	T*	SEER
2290	Name--Spouse/Parent	2036	2085	50	.	.	.	.	.	.	.	.	NAACCR
2300	Medical Record Number	2086	2096	11	R	.	R	.	R	.	T	.	COC
2310	Military Record No Suffix	2097	2098	2	.	.	R	.	.	.	.	.	COC
2320	Social Security Number	2099	2107	9	R	.	R	.	R	.	T	T	COC
2330	Addr at DX--No & Street	2108	2147	40	R	.	R	.	R	.	T	T	COC
2335	Addr at DX--Supplementl	2148	2187	40	R	.	R	.	R	.	T*	T*	COC
2350	Addr Current--No & Street	2188	2227	40	.	.	R	.	R	.	T*	T*	COC
2355	Addr Current--Supplementl	2228	2267	40	.	.	R	.	R	.	T*	.	COC
2360	Telephone	2268	2277	10	.	.	R	.	R	.	T*	T*	COC
2380	DC State File Number	2278	2283	6	R	.	.	.	R*	.	.	T*	State
2394	Follow-Up Contact--Name	2284	2313	30	.	.	.	.	R	.	.	.	SEER
2392	Follow-Up Contact--No&St	2314	2353	40	.	.	.	.	R	.	.	.	SEER
2393	Follow-Up Contact--Suppl	2354	2393	40	.	.	.	.	R	.	.	.	SEER
2352	Latitude	2394	2403	10	R*	R*	.	.	S	.	.	.	NAACCR
2354	Longitude	2404	2414	11	R*	R*	.	.	S	.	.	.	NAACCR
1835	Reserved 10	2415	2464	50	.	.	.	.	.	.	.	.	
2435	Reserved 40	2465	2474	10	.	.	.	.	.	.	.	.	

Item #	Data Item Name	Begin	End	Length	NPCR Collect	NPCR Transmit	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Hosp -> Central	Central -> Central	Source of Standard
2440	Following Registry	2475	2484	10	.	.	R	.	R	.	.	.	COC
2410	Institution Referred From	2485	2494	10	.	.	R	.	.	.	T*	.	COC
2420	Institution Referred To	2495	2504	10	.	.	R	.	.	.	T*	.	COC
2415	NPI--Inst Referred From	2505	2514	10	.	.	.	.	.	.	.	.	NAACCR
2425	NPI--Inst Referred To	2515	2524	10	.	.	.	.	.	.	.	.	NAACCR
2445	NPI--Following Registry	2525	2534	10	.	.	.	.	R	.	.	.	NAACCR
1900	Reserved 11	2535	2554	20	.	.	.	.	.	.	.	.	
2460	Physician--Managing	2555	2562	8	.	.	.	.	.	.	.	.	NAACCR
2470	Physician--Follow-Up	2563	2570	8	.	.	R	.	R	.	T*	T*	COC
2480	Physician--Primary Surg	2571	2578	8	.	.	R	.	.	.	.	.	COC
2490	Physician 3	2579	2586	8	.	.	R	.	.	.	.	.	COC
2500	Physician 4	2587	2594	8	.	.	R	.	.	.	.	.	COC
2465	NPI--Physician--Managing	2595	2604	10	.	.	.	.	.	.	.	.	NAACCR
2475	NPI--Physician--Follow-Up	2605	2614	10	.	.	.	.	R	.	.	.	NAACCR
2485	NPI--Physician--Primary Surg	2615	2624	10	.	.	.	.	.	.	.	.	NAACCR
2495	NPI--Physician 3	2625	2634	10	.	.	.	.	.	.	.	.	NAACCR
2505	NPI--Physician 4	2635	2644	10	.	.	.	.	.	.	.	.	NAACCR
2520	Text--DX Proc--PE	2645	2844	200	R^	.	.	.	R	.	T*	T*	NPCR
2530	Text--DX Proc--X-ray/Scan	2845	3094	250	R^	.	.	.	R	.	T*	T*	NPCR
2540	Text--DX Proc--Scopes	3095	3344	250	R^	.	.	.	R	.	T*	T*	NPCR
2550	Text--DX Proc--Lab Tests	3345	3594	250	R^	.	.	.	R	.	T*	T*	NPCR
2560	Text--DX Proc--Op	3595	3844	250	R^	.	.	.	R	.	T*	T*	NPCR
2570	Text--DX Proc--Path	3845	4094	250	R^	.	.	.	R	.	T*	T*	NPCR
2580	Text--Primary Site Title	4095	4134	40	R^	.	.	.	R	.	T*	T*	NPCR
2590	Text--Histology Title	4135	4174	40	R^	.	.	.	R	.	T*	T*	NPCR
2600	Text--Staging	4175	4474	300	R^	.	.	.	R	.	T*	T*	NPCR
2610	RX Text--Surgery	4475	4624	150	R^	.	.	.	R	.	T*	T*	NPCR
2620	RX Text--Radiation (Beam)	4625	4774	150	R^	.	.	.	R	.	T*	T*	NPCR
2630	RX Text--Radiation Other	4775	4924	150	R^	.	.	.	R	.	T*	T*	NPCR
2640	RX Text--Chemo	4925	5124	200	R^	.	.	.	R	.	T*	T*	NPCR
2650	RX Text--Hormone	5125	5324	200	R^	.	.	.	R	.	T*	T*	NPCR
2660	RX Text--BRM	5325	5424	100	R^	.	.	.	R	.	T*	T*	NPCR
2670	RX Text--Other	5425	5524	100	R^	.	.	.	R	.	T*	T*	NPCR
2680	Text--Remarks	5525	5874	350	.	.	.	.	R	.	T*	T*	NPCR
2690	Text--Place of Diagnosis	5875	5924	50	.	.	.	.	.	.	.	.	NPCR
2700	Reserved 19	5925	6694	770	.	.	.	.	.	.	.	.	

Codes for Recommendation: 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. • = Not in data set but available. * = 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. TH = Cases diagnosed before 2004, transmit data if available in exchange record. T = Data is vital to complete exchange record. T* = Transmit data if available for any case in exchange record.

APPENDIX D. NAACCR Update/Correction Record, Version 11 Record Type U

Item #	Item Name	Length	Begin	End	* Required for Central	* Required for Hospital	Notes
	Sender ID Section						
10	Record Type	1	1	- 1	R	R	U=Correction
9000	Update/Correction Record Version	1	2	- 2	R	R	B=Version 11
2170	Vendor Name	10	3	- 12	R	R	Vendor of correction record
30	Registry Type	1	13	- 13	R		Sending registry
9001	Reserved for expansion	6	14	- 19			
40	Registry ID	10	20	- 29	R	R	Sending registry
21	Patient System ID-Hosp	8	30	- 37	R		Sending registry
60	Tumor Record Number	2	38	- 39	R	R	Sending registry
9002	Reserved for expansion	20	40	- 59			
	Record ID Section						
9010	Patient ID Number--Receiver	8	60	- 67			Receiving registry
9011	Tumor Record Number--Receiver	2	68	- 69			Receiving registry
2230	Name--Last	25	70	- 94			
2240	Name--First	14	95	- 108			
2250	Name--Middle	14	109	- 122			
2300	Medical Record Number	11	123	- 133		R	
2310	Military Record No Suffix	2	134	- 135			
9003	Reserved for expansion	25	136	- 160			
2320	Social Security Number	9	161	- 169			
220	Sex	1	170	- 170			
240	Birth Date	8	171	- 178			
9004	Reserved for expansion	6	179	- 184			
540	Reporting Hospital	10	185	- 194		R	
9007	Reserved for expansion	0					item number retired
550	Accession Number--Hosp	9	195	- 203		R	CCYY12345
390	Date of Diagnosis	8	204	- 211			

Item #	Item Name	Length	Begin	End	* Required for Central	* Required for Hospital	Notes
560	Sequence Number--Hospital	2	212	213		R	
400	Primary Site	4	214	217			
410	Laterality	1	218	218			
420	Histology (92-00) ICD-O-2	4	219	222			
430	Behavior (92-00) ICD-O-2	1	223	223			
522	Histologic Type ICD-O-3	4	224	227			
523	Behavior Code ICD-O-3	1	228	228			
9050	Reserved for Expansion	43	229	271			
	Correction Section						
9005	Date of This Change	8	272	279	R	R	
9006	Time of This Change	6	280	285	R	R	
2081	CRC CHECKSUM	10	286	295			
9020	Correction Comments	200	296	495			
9030	Changed Item NAACCR Number	5	496	500	R	R	
9040	Changed Item New Value	350	501	850	R	R	Left-justify

APPENDIX E. NAACCR Data Descriptor Table for Record Types R and U

Item #	Item Name	Format	Allowable Values	Length	Source of Standard	Record Type*
10	Record Type		I, C, A, U, R, M, L	1	NAACCR	R, U
20	Patient ID Number	Right justified, zero filled		8	Reporting Registry	R, U
30	Registry Type		1-3	1	NAACCR	R, U
35	FIN Coding System		1-2, 9	1	NAACCR	R
37	Reserved 00			7		R
40	Registry ID	Right justified, zero filled	10-digit number. Reference to EDITS table REGID.DBF in Appendix B	10	NAACCR	R, U
50	NAACCR Record Version		Blank, 1, 4-9, A, B	1	NAACCR	R
60	Tumor Record Number	Right justified, zero filled	01-99	2	NAACCR	R, U
220	Sex		1-4, 9	1	SEER/COC	U
240	Birth Date	MMDDCCYY	Valid date or 99999999	8	SEER/COC	U
370	Reserved 01			20		R
390	Date of Diagnosis	MMDDCCYY	Valid date or 99999999	8	SEER/COC	U
400	Primary Site	C followed by 3 digits, no special characters, no embedded blanks	Reference ICD-O-3 for valid entries	4	SEER/COC	U
410	Laterality		0-4, 9	1	SEER/COC	U
420	Histology (92-00) ICD-O-2		Reference to ICD-0-2	4	SEER/COC	U
430	Behavior (92-00) ICD-O-2		0-3; Reference to ICD-0-2	1	SEER/COC	U
522	Histologic Type ICD-O-3		Reference to ICD-O-3	4	SEER/COC	U
523	Behavior Code ICD-O-3		0-3; Reference to ICD-O-3	1	SEER/COC	U
540	Reporting Hospital	Right justified, zero filled	10-digit number	10	COC	U
550	Accession Number--Hosp		9-digit number	9	COC	U
560	Sequence Number--Hospital	Right justified, zero filled	00-59, 60-87, 88, 99	2	COC	U
2081	CRC CHECKSUM		Calculated or blank	10	NAACCR	U
2170	Vendor Name	Embedded spaces allowed		10	NAACCR	U
2230	Name--Last	Mixed case, no embedded spaces, left justified, blank filled. Embedded hyphen allowed, but no other special characters		25	NAACCR	U
2240	Name--First	Mixed case, no embedded spaces, no special characters, left justified, blank filled		14	NAACCR	U
2250	Name--Middle	Mixed case, no embedded spaces, no special characters, left justified, blank filled		14	COC	U
2300	Medical Record Number	Leading spaces, right justified		11	NAACCR	U
2310	Military Record No Suffix	Right justified, zero filled	01-20, 30-69, 98, 99, or blank	2	COC	U
2320	Social Security Number	9 digits, no dashes	Any 9-digit number except 000000000	9	COC	U
5000	Group Age at Diagnosis			2	SEER	R
5010	Group Primary Site			5	SEER	R
5020	Group First Course RX A			4	SEER	R
5030	Group First Course RX B			2	SEER	R
5040	Group Race B, W, O			1	SEER	R
5050	Conv Cause Death to Site			5	SEER	R
5060	Group non-Hodgkins Lymp			2	SEER	R
5070	Conv ICDO2-to-1 Topog Cd			4	SEER	R
5080	Conv ICDO2-to-1 Topog Rev			1	SEER	R
5090	Conv ICDO2-to-1 Morph Cd			6	SEER	R
5100	Conv ICDO2-to-1 Morph Rev			1	SEER	R
5110	Conv ICDO2-to-1 Morph Mul			1	SEER	R
5120	Conv ICDO2-to-1 Morph Mat			1	SEER	R
5130	Conv ICDO1-to-2 Topog Cd			4	SEER	R

Item #	Item Name	Format	Allowable Values	Length	Source of Standard	Record Type*
5140	Conv ICDO1-to-2 Topog Rev			1	SEER	R
5150	Conv ICDO1-to-2 Morph Cd			6	SEER	R
5160	Conv ICDO1-to-2 Morph Rev			1	SEER	R
5170	Conv ICDO1-to-2 Morph Dif			1	SEER	R
5180	Conv ICDO1-to-2 MDI 86-88			1	SEER	R
5190	Conv ICDO1-to-2 Matr Term			1	SEER	R
5200	Conv ICDO2-to-9 Topog Cd			4	SEER	R
5210	Conv ICDO2-to-9 CM			5	SEER	R
5220	Conv ICDO2-to-9 Matr Term			1	SEER	R
5235	Conv ICDO2-to-9 Review 9			1	SEER	R
5240	Conv ICDO2-to-9 Inval Sex			1	SEER	R
5250	Conv ICDO2-to-9 Inval Sit			1	SEER	R
5260	Conv ICDO2-to-9 Inval His			1	SEER	R
5270	Conv 10-dig to Sum St Bk6			2	SEER	R
5280	Conv 10-dig to Sum Stage			2	SEER	R
5290	Conv 10-dig to Hi SEER St			2	SEER	R
5300	Conv 10-dig EOD to AJCC T			2	SEER	R
5310	Conv 10-dig EOD to AJCC N			2	SEER	R
5320	Conv 10-dig EOD to AJCC M			2	SEER	R
5330	Conv 10-dig EOD to AJC St			2	SEER	R
5340	Conv 10-dig EOD to Mod AJ			2	SEER	R
5350	Group Pediatric Cancers			3	IARC	R
5360	Group Histol Within Site			8	SEER	R
5370	Survival-Group Race			2	SEER	R
5380	Survival-Recoded Date DX			6	SEER	R
5390	Survival-DateDX-DateFU Er			1	SEER	R
5400	Survival-Date DX Error			1	SEER	R
5410	Survival-Recoded Date FU			4	SEER	R
5420	Survival-Date FU Error			1	SEER	R
5430	Survival-Recoded Vital St			1	SEER	R
5440	Survival-Restore Life Flg			1	SEER	R
5450	Survival-Vital Stat Error			1	SEER	R
5460	Survival Time-YYMM			4	SEER	R
5470	Survival Time Error			1	SEER	R
5480	Survival-Grouped COD			1	SEER	R
5490	Survival-COD Error			1	SEER	R
5500	Reserved for Expansion			150		R
9000	Update/Correction Record Version		1, 2, 7, A, B	1		U
9001	Reserved for expansion			6		U
9002	Reserved for expansion			20		U
9003	Reserved for expansion			25		U
9004	Reserved for expansion			6		U
9005	Date of this Change	MMDDCCYY		8		U
9006	Time of this Change	HHMMSS		6		U
9007	Reserved for expansion (retired)					U
9010	Patient ID Number-Receiver		Blank	8		U
9011	Tumor Record Number-Receiver		Blank	2		U
9020	Correction comments			200		U
9030	Changed Item NAACCR Number			5		U
9040	Changed Item New Value			350		U
9050	Reserved for expansion			48		U

*Record Types I, C, A, and M (data item #10 –3310) see NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary; Chapter IX Data Descriptor Table.

APPENDIX F. Historical NAACCR Analysis/Research Record Layout, Version 11 Record Type R

Item #	Item Name	Length	Begin	End	Source of Std	Notes
	Record ID & Demographic Section					
10	Record Type	1	1-	1	NAACCR	"R" for Analysis/Research record
20	Patient ID Number	8	2-	9	Reporting registry	Numeric only
30	Registry Type	1	10-	10	NAACCR	1=central registry (population-based)
35	FIN Coding System	1	11-	11	NAACCR	
37	Reserved 00	7	12-	18		
50	NAACCR Record Version	1	19-	19	NAACCR	"B" is for version 11
40	Registry ID	10	20-	29	NAACCR	
60	Tumor Record Number	2	30-	31	NAACCR	01-99 Perm.
370	Reserved 01	20	32-	51		
	Group Recodes/Conversions					
5000	Group Age at Diagnosis	2	1947-	1948	SEER	
5010	Group Primary Site ICD-O-2	5	1949-	1953	SEER	
5011	Group Primary Site ICD-O-3	5	1954-	1958	SEER	
5020	Group First Course RX A	4	1959-	1962	SEER	
5030	Group First Course RX B	2	1963-	1964	SEER	
5040	Group Race B,W,O	1	1965-	1965	SEER	
5050	Conv Cause Death to Site	5	1966-	1970	SEER	
5060	Group Non-Hodgkin's Lymp	2	1971-	1972	SEER	
5070	Conv ICDO2-to-1 Topog Cd	4	1973-	1976	SEER	
5080	Conv ICDO2-to-1 Topog Rev	1	1977-	1977	SEER	
5090	Conv ICDO2-to-1 Morph Cd	6	1978-	1983	SEER	
5100	Conv ICDO2-to-1 Morph Rev	1	1984-	1984	SEER	
5110	Conv ICDO2-to-1 Morph Mul	1	1985-	1985	SEER	
5120	Conv ICDO2-to-1 Morph Mat	1	1986-	1986	SEER	
5130	Conv ICDO1-to-2 Topog Cd	4	1987-	1990	SEER	
5140	Conv ICDO1-to-2 Topog Rev	1	1991-	1991	SEER	
5150	Conv ICDO1-to-2 Morph Cd	6	1992-	1997	SEER	
5160	Conv ICDO1-to-2 Morph Rev	1	1998-	1998	SEER	
5170	Conv ICDO1-to-2 Morph Dif	1	1999-	1999	SEER	
5180	Conv ICDO1-to-2 MDI 86-88	1	2000-	2000	SEER	
5190	Conv ICDO1-to-2 Matr Term	1	2001-	2001	SEER	
5200	Conv ICDO2-to-9 Topog Cd	4	2002-	2005	SEER	
5210	Conv ICDO2-to-9 CM	5	2006-	2010	SEER	
5220	Conv ICDO2-to-9 Matr Term	1	2011-	2011	SEER	
5230	Conv ICDO2-to-9 Review CM	1	2012-	2012	SEER	
5235	Conv ICDO2-to-9 Review 9	1	2013-	2013	SEER	
5240	Conv ICDO2-to-9 Inval Sex	1	2014-	2014	SEER	
5250	Conv ICDO2-to-9 Inval Sit	1	2015-	2015	SEER	
5260	Conv ICDO2-to-9 Inval His	1	2016-	2016	SEER	
5270	Conv 10-dig to Sum St Bk6	2	2017-	2018	SEER	
5280	Conv 10-dig to Sum Stage	2	2019-	2020	SEER	
5290	Conv 10-dig to Hi SEER St	2	2021-	2022	SEER	
5300	Conv 10-dig EOD to AJCC T	2	2023-	2024	SEER	

Item #	Item Name	Length	Begin	End	Source of Std	Notes
5310	Conv 10-dig EOD to AJCC N	2	2025-	2026	SEER	
5320	Conv 10-dig EOD to AJCC M	2	2027-	2028	SEER	
5330	Conv 10-dig EOD to AJC St	2	2029-	2030	SEER	
5340	Conv 10-dig EOD to Mod AJ	2	2031-	2032	SEER	
5350	Group Pediatric Cancers	3	2033-	2035	IARC	
5360	Group Histol Within Site	8	2036-	2043	SEER	
5370	Survival-Group Race	2	2044-	2045	SEER	
5380	Survival-Recoded Date Dx	6	2046-	2051	SEER	
5390	Survival-DateDX-DateFU Er	1	2052-	2052	SEER	
5400	Survival-Date DX Error	1	2053-	2053	SEER	
5410	Survival-Recoded Date FU	6	2054-	2059	SEER	
5420	Survival-Date FU Error	1	2060-	2060	SEER	
5430	Survival-Recoded Vital St	1	2061-	2061	SEER	
5440	Survival-Restore Life Flg	1	2062-	2062	SEER	
5450	Survival-Vital Stat Error	1	2063-	2063	SEER	
5460	Survival Time-YYMM	4	2064-	2067	SEER	
5470	Survival Time Error	1	2068-	2068	SEER	
5480	Survival-Grouped COD	1	2069-	2069	SEER	
5490	Survival-COD Error	1	2070-	2070	SEER	
5500	Reserved for Expansion	145	2071-	2215		