Standards for Cancer Registries, Volume II

DATA STANDARDS AND DATA DICTIONARY

Fifteenth Edition, Record Layout Version 12.1

(Effective January 1, 2011)

Edited by Monica Thornton

June 2010

SPONSORING ORGANIZATIONS:
Canadian Partnership Against Cancer
Centers for Disease Control and Prevention
College of American Pathologists
National Cancer Institute
National Cancer Registrars Association
Public Health Agency of Canada

SPONSORS WITH DISTINCTION:
American Cancer Society
American College of Surgeons
American Joint Committee on Cancer

NAACCR
North American Association of Central Cancer Registries

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

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

❖ **Volume I, *Data Exchange Standards and Record Description***
Intended for programmers and selected users of central cancer registry data, this Volume provides the record layouts and specifications for a number of standard NAACCR record formats, including: the standard record layouts for data exchange among central cancer registries; an update/correction record layout; and an analysis record layout that provides standard recodes for grouping selected variables such as race and primary site, as well as algorithms for converting data from one version of the *International Classification of Diseases for Oncology* to another.

❖ **Volume III, *Standards for Completeness, Quality, Analysis, Management, Security and Confidentiality 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 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 all standards documents can be viewed or downloaded from NAACCR's website at: http://www.naaccr.org.

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PREFACE TO THE FIFTEENTH EDITION

NAACCR continues with our strong commitment to maintain standardization of cancer registry data. The collaboration and cooperation of our sponsoring members is vital for achieving consensus on how each data variable will be coded. Standardization of cancer registry data is a core component of cancer registration and surveillance and provides the foundation for developing comparable data among registries throughout North America. Standardization also allows data from different registries to be used for comparison of variations in cancer rates among different populations and across geographic boundaries.

This edition of the Standards for Cancer Registries, Volume II, Data Standards and Data Dictionary includes new data items, addition of new codes to existing data items, and clarification of descriptions, rationales and coding instructions. New data items for 2011 implementation include: Census Tract 2010 [135], Census TR Certainty 2010 [367], Census Block Group 2010 [363], and Over-ride CS 1-20 [3750 - 3769]. There are two fields with new codes Multiplicity Counter [446] and Marital Status at DX [150].

The CS PostRX and CS PreRX input and derived data items have been delayed for 2012 implementation.

Please note that black vertical lines in the outside margins highlight revisions from the previous version.

I would like thank Jan Snodgrass, Chair of the Volume II Subcommittee and co-Chair of the Uniform Data Standards Committee (UDSC) and Nancy Schlag, co-Chair of the UDSC, for their leadership, dedication and hard work on Standards Volume II. A special thank you and acknowledgement goes to Monica Thornton for her commitment and diligent efforts in bringing this document to completion.

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CHAPTER I:

PROBLEM STATEMENT, GOALS, AND SCOPE OF THIS DOCUMENT

THE PROBLEM

In the late 1980s, increased efforts to pool data collected by different cancer registries drew attention to problems resulting from insufficient data standardization. This lack of standardization had a substantial cost and limited more widespread use of valuable data. Three groups especially felt the impact: state registries receiving data from hospital registries, the NAACCR Data Evaluation and Publication committee, and the Commission on Cancer's (CoC) National Cancer Data Base (NCDB).

The lack of standardization took many forms. Data items used by different registries or software systems varied in their definition and codes, even when they had the same name and were intended to represent the same information. Blanks, dashes, and defined codes were all used to indicate "unknown" data. Other substantial discrepancies were less easy to detect and correct. Hospitals and software providers faced conflicting standards and requirements when they were reporting to a central registry and maintaining a database consistent with CoC standards.

THE SOLUTION

Many of NAACCR's sponsoring organizations, including the National Cancer Institute (NCI), the Centers for Disease Control and Prevention (CDC), and CoC, recognized that increasing standardization is an essential step in decreasing the costs associated with data collection, making more efficient use of increasingly limited human resources needed for data collection, management, and analysis, and obtaining more useful data that can be compared across registries and geographic areas.

Preparation of a statement of consensus on data standards for cancer registries was proposed by the NAACCR Data Exchange Committee (originally called the Data Exchange Standards Committee) spearheaded by NCDB, and the task fell to the newly formed Committee on a Unified Database which later morphed into NAACCR's Uniform Data Standards Committee. Later, the CDC entered into an agreement with NAACCR, and one of the projects under that agreement was the preparation of broader standards for population-based cancer registries. These efforts were complementary. Continued support from the NCI, the CoC, and the CDC has enabled continued development and maintenance of standards. The results of these efforts are the following standards documents published to date:

NAACCR Standards Volume I:

Havener LA (ed). *Standards for Cancer Registries Volume I: Data Exchange Standards and Record Descriptions, Record Layout Version 12*. Springfield, Ill.: North American Association of Central Cancer Registries, February 2009, revised January 2010.

Havener LA (ed). *Standards for Cancer Registries Volume I: Data Exchange Standards and Record Descriptions, Record Layout Version 11.3*. Springfield, Ill.: North American Association of Central Cancer Registries, June 2008.

Havener LA (ed). *Standards for Cancer Registries Volume I: Data Exchange Standards and Record Descriptions, Record Layout Version 11.2*. Springfield, Ill.: North American Association of Central Cancer Registries, June 2007.

Havener LA (ed). *Standards for Cancer Registries Volume I: Data Exchange Standards and Record Descriptions, Record Layout Version 11.1*. Springfield, Ill.: North American Association of Central Cancer Registries, June 2006.

Havener LA, Abe T, Bushhouse S, Gordon B, Hamlyn E, Hill KB, Hurlbut AA, Menck HR (eds). *Standards for Cancer Registries Volume I: Data Exchange Standards and Record Descriptions, Record Layout Version 11*. Springfield, Ill.: North American Association of Central Cancer Registries, November 2004.

Havener L, Abe T, Bushhouse S, Gordon B, Hill K, Hurlbut A, Seiffert J (eds). *Standards for Cancer Registries Volume I: Data Exchange Standards and Record Descriptions, Record Layout Version 10.1*. Springfield, Ill.: North American Association of Central Cancer Registries, November 2003.

Abe T and Seiffert J (eds). *Standards for Cancer Registries, Volume I, Data Exchange Standards and Record Description. Record Layout Version 9.* Springfield, Ill.: North American Association of Central Cancer Registries, September 7, 2000.

North American Association of Central Cancer Registries. *Standards for Cancer Registries, Volume I, Data Exchange Standards and Record Description. Version 7.* Sacramento, Cal.: North American Association of Central Cancer Registries, January 1, 1999.

North American Association of Central Cancer Registries. *Standards for Cancer Registries, Volume I, Data Exchange Standards and Record Description. Version 6.* Sacramento, Cal.: North American Association of Central Cancer Registries, March 20, 1998.

Gordon B and Seiffert J (eds). Standards for Cancer Registries, Volume I, *Data Exchange Standards and Record Description. Version 5.1.* Sacramento, Cal.: North American Association of Central Cancer Registries, 1997.

Gordon B (ed). *Standards for Cancer Registries, Volume I, Data Exchange Standards and Record Description. Version 3.0.* Sacramento, Cal.: American Association of Central Cancer Registries, February 1994.

NAACCR Standards Volume II:

Thornton ML, O'Connor, LC (eds). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary,* Fourteenth Edition. Record Layout Version 12. Springfield, Ill.: North American Association of Central Cancer Registries, February 2009, revised August 2009.

Havener LA, Thornton ML (eds). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary,* Thirteenth Edition. Record Layout Version 11.3. Springfield, Ill.: North American Association of Central Cancer Registries, April 2008.

Havener LA, Hofferkamp J (eds). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary,* Twelfth Edition. Record Layout Version 11.2. Springfield, Ill.: North American Association of Central Cancer Registries, April 2007.

Havener LA, Hultstrom D (eds). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary,* Eleventh Edition. Record Layout Version 11.1. Springfield, Ill.: North American Association of Central Cancer Registries, April 2006.

Havener LA, Hultstrom D (eds). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary,* Tenth Edition. Record Layout Version 11. Springfield, Ill.: North American Association of Central Cancer Registries, October 2004.

Havener LA, Hultstrom D (eds). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary,* Ninth Edition. Record Layout Version 10.2. Springfield, Ill.: North American Association of Central Cancer Registries, March 2004.

Hultstrom D, Havener LA (eds). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary,* Eighth Edition. Record Layout Version 10.1. Springfield, Ill.: North American Association of Central Cancer Registries, March 2003.

Hultstrom D (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary,* Seventh Edition. Record Layout Version 10. Springfield, Ill.: North American Association of Central Cancer Registries, March 2002.

Hultstrom D (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary,* Sixth Edition. Record Layout Version 9.1. Springfield, Ill.: North American Association of Central Cancer Registries, March 4, 2001.

Johnson CH (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary,* Fifth Edition. Version 9. Sacramento, Cal.: North American Association of Central Cancer Registries; May 15, 2000.

Johnson CH (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary,* Fourth Edition. Version 8. Sacramento, Cal.: North American Association of Central Cancer Registries; March 30, 1999.

Seiffert J (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary,* Changed Data Dictionary Entries Only. Sacramento, Cal.: North American Association of Central Cancer Registries; April 13, 1998.

Seiffert J (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary,* Third Edition. Version 6. Sacramento, Cal.: North American Association of Central Cancer Registries; March 20, 1998.

Seiffert J (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary,* Second Edition. Version 5.1. Sacramento, Cal.: North American Association of Central Cancer Registries; March 14, 1997.

Menck HR and Seiffert J (eds). *Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary.* Version 3.0. Sacramento, Cal.: American Association of Central Cancer Registries; February 14, 1994.

NAACCR Standards Volume III:
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Havener LA (ed). *Standards for Cancer Registries Volume III: Standards for Completeness, Quality, Analysis, and Management of Data.* Springfield, Ill.: North American Association of Central Cancer Registries, October 2004.

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Seiffert J (ed). *Standards for Cancer Registries Volume III: Standards for Completeness, Quality, Analysis, and Management of Data.* Sacramento, Cal.: American Association of Central Cancer Registries, February 14, 1994.

NAACCR Standards Volume IV:
Seiffert J, Capron S, and Tebbel J, (eds). *Standards for Cancer Registries Volume IV: Standard Data Edits.* Sacramento, Cal.: North American Association of Central Cancer Registries; April 4, 1996.

NAACCR Standards Volume V:
Havener LA (ed). *Standards for Cancer Registries Volume V: Pathology Laboratory Electronic Reporting, Version 3.0.* Springfield, Ill.: North American Association of Central Cancer Registries, Inc., July 2009.

Havener LA (ed). *Standards for Cancer Registries Volume V: Pathology Laboratory Electronic Reporting, Version 2.1.* Springfield, Ill.: North American Association of Central Cancer Registries, Inc., September 2007. (Revised January 2008 and May 2008.)

GOAL OF THIS DOCUMENT

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

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

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

This document will be used by new and existing facility-based and central cancer registries to ensure that their program and standard definitions and codes are consistent with those used by regional and national databases. Other potential users include registry software providers and those using registry data, especially if they are combining data from multiple sources or exchanging data. National standard-setting groups, such as CoC, CDC, NAACCR, NCI and the Canadian Council of Cancer Registries (CCCR) also will benefit.

This Data Dictionary describes all current data items. Those that are new or have been modified since the preceding Data Dictionary are listed in Chapter VII. Sidebars in Chapter X also indicate changes.

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

SCOPE OF THIS DOCUMENT: WHAT STANDARDS ARE INCLUDED?

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

- **Reportability**

Reportability defines the rules for inclusion of specific types of tumors in the registry (see Chapter III).

- **Data Items or Elements To Be Included**

Some data items are required or recommended by particular standard setters while others are optional or are retained because they were abstracted in the past. Chapter VIII specifies the required status for each.

Example: "Sex" is listed as a required standard data element in Chapter VIII by all standards setters represented.

- **Standardized Item Numbers and Item Names**

For ease and consistency of reference, all items are assigned both numbers and names (e.g., the item "Sex" is assigned the item number 220). The item number is intended to be permanent and will not change in future NAACCR standards publications. Assignment of permanent numbers was necessary because standard-setting organizations have changed item names over time or have applied similar names to items with different definitions. Item numbers allow the required precision of reference. When data items are deleted, the item numbers are retired and will never be reused for a different data item. Some data item numbers were intentionally left blank to allow the insertion of related items in the future. Ranges of available data item numbers have been assigned to different uses, as follows:

Range	Use
00001 - 04999	Data items in new case layouts, record types I, C, A, or M.
05000 - 06999	Data items in Analysis/Research record only. (These data items are not within the purview of NAACCR, and NAACCR will not use the data item numbers in this range.)
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. These may be assigned by CoC or others. A large range is allotted because many new items may be assigned each year for individual studies.

Refer to NAACCR Standards Volume I[1] for additional information on record layouts.

Where possible, the NAACCR item name is the same as that used by the standard setter. However, the following constraints are placed on the names:

- **Length**
  Data item names are limited to 25 characters because that is the maximum length for item names in the EDITS software system (see Chapter IV). Standardized abbreviations, punctuation, and spacing are used when necessary (i.e., the word "first" always is entered "1st," "treatment" is "RX," and so on). Other limitations will be imposed as needed. Thus, item names will be identical in this data standards volume and the NAACCR Metafile of standard edits.

- **Consistency**
  Consistency was a goal in formatting names and in using special characters. The character "--" is used to distinguish among item names built on the same stem name.

  Example: "Sequence Number--Hospital" and "Sequence Number--Central" are the names of two differently defined sequence numbers.

- **Interrelated Items, Fields, and Subfields**
  To make the relationship among items more apparent, a constant term was consistently added to the stem of the name.

  Example: Names of treatment fields related to radiation therapy begin with "Rad," so that in a list of item names they will appear together:
  Rad--No of Treatment Vol
  Rad--Elapsed RX Days

❖ **Record Layout/Data Exchange**

Record layout/data exchange identifies the position of the data item in a standard flat file data exchange record. These positions are indicated in Chapter VII. See Volume I[1] in this series for more extensive information on the data exchange and other NAACCR standard layouts.

Example: "Sex" is in character position 192 in the NAACCR Data Exchange Record Layout Version 12.1.

❖ Codes

Codes identify allowable values, their meanings, and data entry formats for data items. Chapters IX and X specify either the standard codes for each data item or the source for the codes.

Example for the item "Sex":
Codes
1 Male
2 Female
3 Other (Hermaphrodite)
4 Transsexual
9 Not stated

When it is necessary to collect more specific information than that represented by the standard codes, every effort should be made to ensure that the more specific codes will accurately collapse into the pre-existing codes. This approach permits diversity without compromising inter-registry comparability or meta-analyses.

❖ Coding Rules

Coding rules are the guidelines and interpretations for deciding the correct code for a given tumor and are defined in the documentation of other standard-setting organizations. For each data item, Chapters VIII and X list a "Source of Standard," and the documentation from this source should be consulted for coding rule standards.

Hypothetical Example: A coding rule might state what code to assign for sex when the medical record states the patient is female and the death certificate states male.

CHAPTER II:

HISTORICAL BACKGROUND AND STATUS OF NORTH AMERICAN STANDARDS

STANDARD-SETTING ORGANIZATIONS AND OTHER STANDARDS DOCUMENTS

Several organizations have played a major role in the development of cancer registry standards. They are listed in alphabetical order.

American Cancer Society
ACS historically has supported the development of standardized cancer classification systems, publishing the first code manual for the morphology of neoplasms in 1951. ACS has long supported the standard-setting programs of ACoS, including the Fundamental Tumor Registry Operations Education Program, the Registry Operations and Data Standards, and the American Joint Committee on Cancer (AJCC).

American College of Surgeons
Since the 1950s, ACoS has taken a leading role in establishing standards for hospital-based cancer programs and the cancer registries that are a part of such programs. Through its Approvals Program, CoC implements its requirements for case management, registry operation and case inclusion, and data set specifications as published in:

- *Cancer Program Standards*,[27] which presents standards for the full range of cancer program activities, including the registry.
- *Facility Oncology Registry Data Standards (FORDS): Revised for 2010*,[2] which specifies standards for cases to be included in the registry, data items to be collected, and the codes and coding rules for those items.

CoC requires approved cancer programs to use the codes and coding instructions published by CoC.

Through NCDB, CoC provides data quality feedback to approved cancer programs, software providers, and the general cancer registry community. Hospitals in the Accreditation Program are required to submit non-confidential registry data to NCDB, and CoC monitors the quality of data submissions in accordance with existing published standards for approved programs.

FORDS, the Cancer Program Standards, and the NCDB Call for Data announcements, instructions, and technical specifications are available to download at no charge at http://www.facs.org. CoC maintains an interactive Inquiry and Response Database to answer questions about all cancer-related requirements at the same site.

American Joint Committee on Cancer
AJCC formulates and publishes systems of classification of tumors by their anatomic site and histology through use of the Tumor, Node, Metastasis (TNM) staging system. The TNM staging system is the U.S. standard used by the medical profession to select the most effective treatments and determine prognosis to facilitate the management of cancer care. AJCC is dedicated to the ideal that all cancer cases should be staged, and it publishes the *Cancer Staging Manual*,[7] now in its Seventh Edition as well as the *Collaborative Stage Data Collection System*,[13] now in its Second Edition.

Canadian Council of Cancer Registries
The Canadian Council of Cancer Registries (CCCR) is the standard setting organization in Canada, originally established in 1978. This is a committee comprised of representatives (the directors) of each of the provincial and territorial cancer registries (PTCRs), Statistics Canada (STC) and other key stakeholders (e.g., Canadian Cancer Society [CCS], Public Health Agency of Canada [PHAC]).

The objectives of the CCCR include:

- To provide direction for data collection and use
- To provide leadership and support for standard setting and quality management
- To facilitate liaison and communication with partners to facilitate access to data for surveillance and research
- To promote the use and dissemination of Cancer Control information
- To provide leadership and support to the provinces and territories related to the National Cancer Registry System.

Canadian data are housed in the Canadian Cancer Registry (CCR) that is maintained by Statistics Canada. The CCR evolved from the event-oriented (1969) National Cancer Incidence Reporting System (NCIRS) and begins with patient-oriented cases diagnosed in 1992. Data are collected and reported by the PTCRs through annual calls for data. The CCR includes mechanisms for updating and clearing death records and identification of duplicates reported across PTCRs.

The CCCR is consistent with standards and practices outlined by IACR and NAACCR.

Sponsors and partners include:

- Canadian Association of Provincial Cancer Agencies (CAPCA)
- Statistics Canada (STC)
- National Cancer Institute of Canada (NCIC)/Canadian Cancer Society (CCS)
- Public Health Agency of Canada (PHAC)

Data partners are:

- Provincial Cancer organizations, Provincial/Territorial Ministries of Health
- Vital Statistics departments (provincial, territorial and federal)

National Cancer Registrars Association
An organization of cancer data professionals founded as the National Tumor Registrars Association in 1974, the National Cancer Registrars Association (NCRA) has been instrumental in the training and certification of cancer registrars. NCRA has produced a variety of educational materials, including guidelines for a college curriculum in cancer registry management, a planning manual for registry staffing, training materials for staging of cancer, and a publication on using cancer data to promote the services of the cancer registry. Their

publications also include a college-level cancer registry methods textbook (*Cancer Registry Management: Principles and Practice*, 2nd Edition, 2004).[37]

Since 1983, NCRA has promoted the certification of cancer registrars through a semi-annual examination. More than 4,000 Certified Tumor Registrars (CTRs) have successfully completed the exam, which evaluates technical knowledge of methods of cancer data collection, management, and quality control, as well as *International Classification of Diseases for Oncology* (ICD-O) topography and morphology coding and AJCC, Collaborative Staging and Surveillance, Epidemiology and End Results (SEER) Program staging systems. To maintain their credentials, CTRs are required to complete 20 hours of continuing education every 2 years, which can be obtained by participating in conferences and teleconferences that NCRA has precertified, and by obtaining a passing score on quizzes in NCRA's *Journal of Registry Management*.

Membership in NCRA is open to anyone interested in cancer data collection. For further information, contact NCRA on the Web at: http://www.ncra-usa.org.

National Coordinating Council for Cancer Surveillance

Founded in 1995, the National Coordinating Council for Cancer Surveillance (NCCCS) meets semi-annually to coordinate surveillance activities within the United States through communication and collaboration among major national cancer organizations, ensuring that the needs of cancer patients and the communities in which they live are fully served; that scarce resources are maximally used; and that the burden of cancer in the United States is adequately measured and ultimately reduced. NCCCS includes representatives from the Armed Forces Institute of Pathology, ACoS, ACS, AJCC, CDC-NPCR, CDC-NCHS, NCI-SEER, NCI-Applied Research Program, NCRA, and NAACCR. Current priorities for NCCCS include building coordination among cancer incidence surveillance and other cancer surveillance systems; electronic medical records and real-time reporting; improving source information to measure disparity (race, ethnicity, socioeconomic status); non-hospital reporting; and defining a decision process for incidence surveillance expansion, both in the addition of data elements and modification of surveillance systems.

National Program of Cancer Registries

CDC has worked to improve registry data nationwide since 1992, when Congress authorized the establishment of the National Program of Cancer Registries (NPCR) through the Cancer Registries Amendment Act (Public Law 102-515).[33] CDC provides funds to 46 states, 3 territories, and the District of Columbia to assist in planning or enhancing cancer registries, developing model legislation and regulations for programs to increase the viability of registry operations, setting standards for data, providing training for registry personnel, and helping establish computerized reporting and data processing systems.

CDC has contributed substantially to the development of data standards through its financial support of NAACCR, as well as by funding and developing EDITS, a software system that facilitates the coordination of data standards (see Chapter IV). In administering NPCR, CDC requires participating central registries to collect data items that conform to NAACCR's standards. NPCR staff also continues to maintain Registry Plus™, a suite of publicly accessible free software programs made available by CDC to facilitate the implementation of NPCR.

To maximize the benefits of state-based cancer registries, CDC uses the NPCR-Cancer Surveillance System (CSS) for receiving, assessing, enhancing, aggregating, and disseminating data from NPCR-funded registries. This system of cancer surveillance provides valuable feedback to improve the quality and usefulness of registry data and monitor the impact of cancer prevention and control programs. In 2002 the CDC published the first edition of the United States Cancer Statistics (USCS) in collaboration with NCI and with contributions from NAACCR. This report contained 1999 incidence data from 37 states and metropolitan areas. In 2007 the sixth edition of this joint publication was released. This edition contained 2004 incidence data from 49 states (40 NPCR-, 4 NPCR/SEER-, and 5 SEER-funded registries), 6 SEER metropolitan areas

and the District of Columbia (NPCR). In total, the cancer registries whose data are included in this report cover 98% of the U.S. population. For additional information on NPCR, visit the CDC/NPCR website at: http://www.cdc.gov/cancer/npcr/.

North American Association of Central Cancer Registries

The American Association of Central Cancer Registries (AACCR) was established in 1987, and with the addition in 1995 of Canadian registries as members, the name was changed to the North American Association of Central Cancer Registries (NAACCR). Members are population-based cancer registries in the United States and Canada, national cancer and vital statistics organizations in both countries, and other organizations and individuals interested in cancer registration and surveillance. NAACCR is a professional organization that develops and promotes uniform data standards for cancer registration; provides education and training; certifies population-based registries for high-quality data; evaluates, aggregates, and publishes data from central cancer registries; and promotes the use of cancer surveillance data and systems for cancer control and epidemiologic research, public health programs, and patient care to reduce the burden of cancer in North America. NAACCR welcomes membership from cancer registries and other organizations or individuals that are interested in the collection, analysis, and publication of data on cancer incidence.

Surveillance Epidemiology and End Results Program

NCI's SEER Program has collected standardized data to measure progress in cancer prevention and control for more than 30 years. Established by a Federal mandate--the National Cancer Act of 1971--the SEER Program is a sequel to two earlier NCI programs: the End Results Group (1956-72) and the Third National Cancer Survey (1969-71).

Seven population-based registries have provided data continuously since the SEER Program began in 1973: the States of Connecticut, Iowa, New Mexico, Utah, and Hawaii; and the Metropolitan Areas of Detroit and San Francisco-Oakland. In 1974-75, the regions of Seattle-Puget Sound and Metropolitan Atlanta were added. These areas, plus the rural Georgia region added in 1978, cover about 9.5 percent of the U.S. population. In 1992, the SEER Program added two additional regions in California--Los Angeles and San Jose-Monterey--bringing coverage of the U.S. population to 14 percent. In order to increase coverage of the American Indian/Alaska Native populations, SEER has included data from the Alaska Native Tumor Registry since 1984. These regions were selected for their epidemiologically significant population subgroups and, in fact, over-sample minority populations in the United States. In 2001, four states were added--Kentucky, Louisiana, New Jersey, and the remainder of California--resulting in coverage of about 26 percent of the U.S. population.

The purpose of the SEER Program, as stated in the National Cancer Act legislation, is to collect, analyze, and disseminate data useful in the prevention, diagnosis, and treatment of cancer. The goals of the Program are to:

- Monitor annual cancer incidence trends to identify patterns of cancer occurring in population subgroups
- Provide continuing information on changes over time in the extent of disease (EOD) at diagnosis, trends in therapy, and associated changes in patient survival
- Promote studies to identify factors that can be studied and applied to achieve cancer prevention and control

These goals illustrate that the aim of the SEER Program is providing cancer surveillance over time. As a result, changes in standards are carefully considered for their impact both on future data and compatibility with previous data.

Participating registries are required to submit data in a standard format using standardized definitions and codes (currently the *SEER Program Coding and Staging Manual 2007*,[3] and the *Collaborative Staging*

Manual and Coding Instructions.[13] However, the individual SEER registries have not used identical data collection methods or identical data management methods, and they differ in the extent to which they impose data requirements on the reporting facilities in their areas.

Standardized edits, developed by SEER and shared with participating registries, are applied to data submissions, and the results are returned to the participating registries.

SEER Program publications relating to data standards (http://www.seer.cancer.gov) include:

- A series of eight self-instructional manuals for cancer registrars[35] covering abstracting, coding, terminology, anatomy, treatment, statistics, and other aspects of cancer registry operations. Book 8 in the series is a comprehensive list of drugs used in treating cancer and, before January of 2005, was the standard reference for drug-treatment coding rules. For cancer diagnoses beginning in January of 2005, book 8 was replaced by SEER*Rx, an interactive antineoplastic drug database that is updated on a regular basis (http://www.seer.cancer.gov/tools/seerrx/). Additional instructional resources are available on the SEER website (http://seer.cancer.gov/registrars/).

- *SEER Extent of Disease-1998: Codes and Coding Instructions*, Third Edition.[8] This document includes site-specific codes and coding guidelines to describe spread of tumor in anatomic terms. EOD is a 10-digit code that includes 3 digits for size of tumor, 2 digits for tumor extension, 1 digit for lymph node involvement, 2 digits for the number of regional lymph nodes examined, and 2 digits for the number of positive regional lymph nodes. SEER always has collected EOD information and collapses this information into different staging schemes.

- The *SEER Program Coding and Staging 2007 Manual*.[3] This manual includes comprehensive codes and coding guidelines for the data elements required by SEER.

- *Comparative Staging Guide for Cancer*.[6] This guide illustrates the relationships among EOD codes, the summary staging system, and the Third Edition of the TNM Staging System. A revision updating the comparative staging to the Fifth Edition of the TNM Staging System is in development.

- *Summary Staging Guide for the Cancer Surveillance, Epidemiology and End Results Reporting Program*.[11] Originally published in April 1977, and most recently reprinted in July 1986, this is the standard for localized-regional-distant staging for tumors diagnosed between 1977 and 2000.

- *SEER Summary Staging Manual 2000*.[12] Published in 2001, is the standard for summary stage for cases diagnosed January 1, 2001, and after.

There is no charge for single copies of SEER Program publications. To place an order or to obtain further information, go to the SEER Program Website at: http://seer.cancer.gov/publications.

World Health Organization

The World Health Organization (WHO), an agency of the United Nations, is responsible for publishing and maintaining the international standard for diagnosis coding systems. Selected publications include:

- *International Classification of Diseases* (ICD-9, the Ninth Revision), as modified by the Health Care Financing Administration[15]

- *International Statistical Classification of Diseases and Related Health Problems* (ICD-10, the 10th Revision)[14]

- *International Classification of Diseases for Oncology*[16, 17]

These publications are world-standard diagnosis coding systems.

ICD-9 was adapted for use in the United States as the Clinical Modification of ICD-9 (ICD-9-CM),[15] and is the current standard for coding medical record diagnoses in health information management departments in U.S. health care facilities. ICD-10[14] was implemented for coding causes of death on death certificates in the United States effective January 1, 1999.

The Second Edition of ICD-O became the standard for coding cancer diagnoses in the United States in 1992. An extensive revision of the morphology codes, especially the Lymphoma and Leukemia Section, was field-tested for the 1999 and 2000 diagnosis years, and the Third Edition of ICD-O[16] was implemented for 2001 diagnoses.

WHO publications are sold through the following two agencies in the United States:

Q Corporation
49 Sheridan Avenue
Albany, NY 12210
(518) 436-9686

College of American Pathologists
325 Waukegan Road
Northfield, IL 60076
(800) 323-4040
http://www.cap.org/index.cfm

In the United States, the contact for further information on ICD-O is the Expert on Nomenclature and Coding at SEER (http://seer.cancer.gov).

HISTORICAL BACKGROUND OF STANDARDS COORDINATION

Because the various standard-setting organizations use their data for different purposes, some data elements had different meanings, depending on the organization using the data. A long history of cooperation has been evident among organizations interested in cancer data to resolve the discrepancies between organizations in their interpretation of data elements.

The earliest standard setters were CoC and SEER. The End Results Group, predecessor of SEER, published coding rules and guidelines as early as the 1950s; CoC published its first data collection manual, the *Supplement on the Tumor Registry*, in conjunction with its *Cancer Program Manual 1981*. At that time, hospital-based cancer registries often used CoC's recommended codes and coding rules, and SEER central registries used those of the SEER Program. The two systems were not always in agreement. As a result, CoC and SEER began working together in the early 1980s to make the codes and definitions in their manuals consistent.

CoC and SEER attempted to define one common set of data item definitions, field lengths, and codes for use by both SEER registries and hospital-based registries. By 1988, the collaboration resulted in the publication of both CoC's *Data Acquisition Manual* and the *SEER Program Code Manual*, with data items and codes in

substantial agreement. Having more congruent data sets allowed for easier data sharing and data comparisons, especially with the advent of personal computers that were sufficiently powerful to analyze large amounts of cancer data. This achievement helped set precedents for cooperation in data management, and maintaining congruence whenever possible has continued to be a top priority for these two groups.

During the same period, the California Cancer Registry was developing a statewide automated system that allowed facilities to report electronically to the state registry system. One region in California was a SEER registry at that time, and a large number of hospitals maintained CoC-approved programs. To facilitate implementation of standards within its program, the California Cancer Registry requested that SEER and CoC establish a formal committee to pursue data standardization and requested membership on this committee.

The function of that committee was transferred to NAACCR's Uniform Data Standards Committee (UDSC) when it was established in 1987. Membership was expanded to include all of the major standard-setting organizations and representation from registry software vendors and central registries. This Committee has made enormous progress toward standardization. A major success occurred when all of the participating groups agreed to implement the Second Edition of ICD-O simultaneously for tumors diagnosed in 1992 and later. In 1993, NAACCR convened a multidisciplinary conference to address the issue of collecting data on preinvasive cervical neoplasia, resulting in specific recommendations for member registries to cease collection of cervical carcinoma *in situ*. UDSC provides a national forum to discuss data issues and reach consensus on data standards. Given the extensive effort required to maintain uniform standards, in 2000, a subsidiary of UDSC, the Volume II Work Group, was formed to focus on the annual updates, revisions, and additions to compendiums of national standards.

CDC added another strong voice for standardization. CDC requires that the registries in 46 states, the District of Columbia, and U.S. Territories funded by NPCR use standard data items and codes. CDC is a sponsoring member of NAACCR, and has participated in committee activities of NAACCR. Through its contractor, CDC provides quality control activities for participants in NPCR and has facilitated the setting of standards and encouraged their adoption. The EDITS project described in Chapter IV is an example of the innovative approach CDC has supported.

At the time of this revision to Volume II, the major organizations agree in principle that their data standards will be consistent wherever possible. There are, however, areas where agreement has not been reached. These are discussed in detail in Chapter V.

Despite the progress made toward standardization and the near-universal agreement that standardization is desirable, much remains to be done. Implementation of existing standards is not uniform, and implementation of changes in standards is not always synchronized. SEER and CoC will continue to publish separate coding manuals on different update schedules. Standardized data edits must be updated, maintained, and used by all registries.

In Canada, cancer registries at the provincial and territorial level joined together with Statistics Canada, a national agency, to form the Canadian Council of Cancer Registries. This process started in 1986 and led to the development of common national standards for the Canadian Cancer Registry, which were implemented with a reference date of January 1, 1992. A Data Quality Committee, which reports to the Council, is responsible for making recommendations to set national standards, and will review and monitor data quality and resolve any inconsistencies in procedures, coding, or other activities affecting data comparability.

NAACCR hopes that documenting existing standards, recommending standards where they do not yet exist, and publishing the results in a concise and authoritative form will enable registries and software providers to move forward in achieving comparable data that can be more widely used.

Schedule of Revisions to NAACCR Standards Documents

In 2000, the NAACCR Board of Directors established a Standards Implementation Task Force to review the current timeline for changes to data standards and to recommend guidelines for a new timeline that would meet the needs of the standard-setting organizations, central cancer registries, vendors, and reporting facilities. The Standards Implementation Task Force developed guidelines for **major** changes to be implemented on a 3-year cycle, with all standard setters adhering to the same 3-year cycle. Implementation of the process began January 2003, with the next implementation date for major changes occurring on January 1, 2006, and then 2009. However, due to the AJCC TNM 7th Edition scheduled for January 2010 implementation the schedule for major changes was postponed one year i.e., from 2009 to 2010. Major changes took effect with cases diagnosed January 1, 2010, and based on a 3-year cycle, major changes can be implemented again in 2013, 2016, etc. These changes require the publication of a new Version of the NAACCR Volume II Data Dictionary and Data Standards (e.g., from Version 11.3 to Version 12). Minor changes will be published in an update of the current Version of the NAACCR Volume II Data Dictionary and Data Standards (e.g., Version 12.1 [*Exception:* An updated Version will not be published the year a new Version is published, minor changes will be included in the new Version]). The intent is to allow the ability to fix errors and clarify codes or add new codes should they be necessary during the interval between the scheduled major revisions and updates. See the *Standards Implementation Guidelines*[38] for definitions of major and minor changes and additional information.

The Cancer Registration Steering Committee (CRSC) was established in 2005 to provide regular communication among leaders of NAACCR and its sponsoring member organizations to facilitate coordination and promote consensus in the development and implementation of major data items, standards, and procedures related to cancer registration.

All NAACCR members are encouraged to present suggestions or comments on proposed changes to the standards to the Uniform Data Standards Committee with simultaneous notification to CRSC. The NAACCR website, http://www.naaccr.org, provides the name of the Committee Chair and forms for proposing additions or revisions.

Table 1. Record Layout Table With References.

NAACCR	Release Date	Effective Date*	Reference Manuals Accommodated	NAACCR Metafile Version
Version 12.1	06/2010	1/1/2011	CoC *FORDS Revised for 2010* *SEER Program Coding and Staging Manual* *WHO ICD-O-3*, 2000 *SEER Summary Staging Manual*, 2000 *AJCC Staging Manual*, Seventh Edition, 2010 ***Collaborative Stage Data Collection System, Version 02.02.00***	Metafile Version 12.1
Version 12	02/2009 Revised 08/2009	1/1/2010	**CoC *FORDS Revised for 2010*** *SEER Program Coding and Staging Manual* *WHO ICD-O-3*, 2000 *SEER Summary Staging Manual*, 2000 ***AJCC Staging Manual*, Seventh Edition, 2010** ***Collaborative Stage Data Collection System, Version 02.00.00***	Metafile Version 12
Version 11.3	4/1/2008	1/1/2009	CoC *FORDS* Revised for 2007 ***SEER Program Coding and Staging Manual 2007, Revision 1*** *WHO ICD-O-3*, 2000 *SEER Summary Staging Manual*, 2000 *AJCC Staging Manual*, Sixth Edition, 2002 ***Collaborative Staging Manual and Coding Instructions, Version 01.04.00***	Metafile Version 11.3
Version 11.2	4/1/2007	1/1/2008	Same as Version 11.1	Metafile Version 11.2
Version 11.1	4/1/2006	1/1/2007	**CoC *FORDS* Revised for 2007** ***SEER Program Coding and Staging Manual 2007*** *WHO ICD-O-3*, 2000 *SEER Summary Staging Manual*, 2000 *AJCC Staging Manual*, Sixth Edition, 2002 ***Collaborative Staging Manual and Coding Instructions, Version 01.03.00***	Metafile Version 11.1
Version 11	10/1/2004	1/1/2006	CoC *FORDS*: Revised for 2004 *SEER Program Code Manual* *WHO ICD-O-3*, 2000 *SEER Summary Staging Manual*, 2000 *AJCC Staging Manual*, Sixth Edition, 2002 ***Collaborative Staging Manual and Coding Instructions, Version 01.02.00***	Metafile Version 11
Version 10.2	3/1/2004	1/1/2005	Same as Version 10.1	Metafile Version 10
Version 10.1	3/1/2003	1/1/2004	**CoC *FORDS*: Revised for 2004** ***SEER Program Coding and Staging Manual 2004*** *WHO ICD-O-3*, 2000 *SEER Summary Staging Manual*, 2000 *AJCC Staging Manual*, Sixth Edition, 2002 ***Collaborative Staging Manual and Coding Instructions, Version 1.0*** **(implementation 01/01/2004)**	Metafile Version 10

Version 10	3/20/2002	1/1/2003	**CoC *FORDS* (2003)** *SEER Program Code Manual* *WHO ICD-O-3,* 2000 *SEER Summary Staging Manual,* 2000 *AJCC Staging Manual,* Sixth Edition, 2002	Metafile Version 10
Version 9.1	3/21/2001	1/1/2002	Same as Version 9	Metafile Version 9
Version 9	5/15/2000	1/1/2001	CoC/*ROADS*, 1996, Rev. 1998 *SEER Program Code Manual,* 1998 ***WHO ICD-O-3*, 2000** ***SEER Summary Staging Manual,* 2000** *AJCC Staging Manual,* Fifth Edition, 1997 *SEER Extent of Disease Manual,* 1998	Metafile Version 9
Version 8	3/30/1999	1/1/2000	Same as Versions 6 and 7	Metafile Version 8
Version 7	4/13/1998	1/1/1999	Same as Version 6	Metafile Version 7
Version 6	1/23/1998 Revised 3/20/1998	1/1/1998	**CoC/*ROADS*, 1996, Rev. 1998** *WHO ICD-O-2,* 1990 *SEER Summary Staging Guide,* 1977 ***AJCC Staging Manual,* Fifth Edition, 1997** ***SEER Extent of Disease Manual,* 1998**	Metafile Version 6
Version 5.1	3/12/1997	1/1/1997	Same as Version 5	Metafile Version 5
Version 5	4/10/1996	1/1/1996	**CoC/*ROADS*, 1996** *SEER Program Code Manual,* 1992 *WHO ICD-O-2,* 1990 *SEER Summary Staging Guide,* 1977 *AJCC Staging Manual,* Fourth Edition, 1992 *SEER Extent of Disease Manual,* 1992	Metafile Version 5
Version 4	2/14/1994	1/1/1994	CoC/ACoS *Data Acquisition Manual,* 1994 *SEER Program Code Manual,* 1992 *WHO ICD-O-2,* 1990 *SEER Summary Staging Guide,* 1977 *AJCC Staging Manual,* Fourth Edition, 1992 *SEER Extent of Disease Manual,* 1992	Metafile Version 4

Bolded text indicates changes from previous version.
* Either the date of diagnosis or year first seen for this cancer may have been used by some standard-setters. Refer to the Data Dictionary or to the standard-setter reference manuals for clarification of date requirements.

CHAPTER III:

STANDARDS FOR TUMOR INCLUSION AND REPORTABILITY

Due to continued efforts by standard-setting organizations, facility-based registries and population-based central registries now follow nearly identical standards for determining reportable tumors that are to be included in the registry; however, some differences in reportability remain. CoC stipulates the tumors that must be included in approved facility registries, while most population-based registries, at a minimum, follow the standards set by SEER or NPCR. *The Cancer Program Standards*,[27] the CoC *FORDS* manual,[2] *SEER Program Code* manuals,[3,8] NPCR Program Announcement,[36] and the *Canadian Cancer Registry System Guide*[5] should be consulted for more details.

Standards for tumor reportability are defined by the following criteria:

Reference Date
The reference date is the effective date cancer registration starts in a specified at-risk population or in a specific facility. It is not the date the registry is organized or the date work begins. Tumors diagnosed on or after the reference date must be included. The reference date typically begins on January 1 of a calendar year, but sometimes it is another date. It is important to be aware that the reference date of the regional, state or provincial registry may precede the reference date set by cancer registry hospitals or other individual facilities. If the regional, state or provincial registry is established by law, reporting entities will be required to submit their cases in accordance with the law regardless of their facility reference date.

Residency
For a population-based registry, it is essential to include all tumors occurring in the at-risk population, and rules must be in place for determining the members of that population. The goal is to use the same rules for the patients' demographic data at the time of diagnosis as those used by the Census Bureau in enumerating the population. For example, a population-based registry must have rules for determining residency of part-year residents, institutionalized persons, homeless persons, military personnel, and students. For U.S. registries see the *SEER Program Code Manual*[3] for specific instructions and for Canadian registries see appendix T of the *Canadian Cancer Registry System Guide*[5] for specific instructions.

NAACCR recommends that population-based registries include in their database tumor reports of non-residents from facilities in their catchment areas to:

- Share tumor information that otherwise may go unreported with the resident's population-based registry
- Facilitate death clearance and other record linkages
- Allow preparation of complete and accurate reports to individual facilities

Hospital-based registries are less concerned with residency of the patient than the reason for admission, and hospital registries might not collect data for certain categories of patients that the central registry must include, such as patients admitted to a hospice unit or transient patients who receive interim care to avoid interrupting a course of therapy. Also, CoC does not require complete abstracting of tumors that are "nonanalytic" for the facility. Therefore, for the central registry, clear rules that are well documented, widely distributed, and accepted are essential to prevent missed case reports (source records).

In utero Diagnosis

Diagnoses made in utero are reportable if the pregnancy results in a live birth. When a reportable diagnosis is confirmed prior to birth and 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.

Reportable List

CoC, NPCR, SEER and CCCR have achieved greater consensus on reportable tumors in the past few years (see Table 2). For all tumors diagnosed from January 1, 1992, through December 31, 2000, all three U.S. standard setters (CoC, NPCR, and SEER) required the inclusion of all neoplasms in the *International Classification of Diseases for Oncology*, Second Edition[17] (ICD-O-2) with a behavior code of 2 or 3 (*in situ* or malignant), with the exception of squamous cell and basal cell carcinoma of the skin and carcinoma *in situ* of the cervix uteri since 1996. (See the CARCINOMA *IN SITU* OF THE CERVIX, CIN, AND THE BETHESDA SYSTEM Section later in this Chapter). The CCCR adopted the ICD-O-2[17] in 1992.

For all tumors diagnosed on or after January 1, 2001, all four organizations require the inclusion of all neoplasms in the *International Classification of Diseases for Oncology*, Third Edition[16] (ICD-O-3) with a behavior code of 2 or 3 (*in situ* or malignant), with the exception of squamous cell and basal cell carcinoma of the skin, prostatic intraepithelial neoplasia (PIN) III, carcinoma *in situ* (CIS) of the cervix, and cervical intraepithelial neoplasia (CIN) III. Code M9421 (juvenile astrocytoma, pilocytic astrocytoma, or piloid astrocytoma), with a behavior code of 1 (borderline) in ICD-O-3, is reportable as M9421/3. Prior to 2003, CoC considered basal and squamous skin cancers that were AJCC stage group II or higher at diagnosis as reportable. Prior to 2004 CCCR considered CIS of the cervix and CIN III as reportable, prior to 2005 PIN III was considered as reportable.

In addition, the three U.S. organizations require the inclusion of all non-malignant primary intracranial and central nervous system (CNS) tumors diagnosed on or after January 1, 2004. Specifically, non-malignant primary intracranial and CNS tumors of any morphology in ICD-O-3[16] having a behavior code of 0 or 1 (benign/ borderline) occurring in the following sites: brain, meninges, spinal cord, cranial nerves and other parts of the CNS, pituitary gland, pineal gland, and craniopharyngeal duct are reportable (see Table 3). The CCCR requires inclusion of all non-malignant primary intracranial and central nervous system (CNS) tumors diagnosed on or after January 1, 1992. Specifically, non-malignant primary intracranial and CNS tumors of any morphology in ICD-O-3[16] having a behavior code of 0 or 1 (benign or borderline) occurring in the following sites: brain, meninges, spinal cord, cranial nerves and other parts of the CNS are reportable (see *Canadian Cancer Registry System Guide*[5]).

In Situ/Invasive

It is important to distinguish between the morphologic condition of *in situ* as it is represented in ICD-O-2 or ICD-O-3 behavior codes and Tis as it is defined for the purpose of prognostic staging in the *AJCC Cancer Staging Manual*. Some morphologic and disease descriptive terms that are invasive in ICD-O-2/ICD-O-3 or localized in the *SEER Summary Staging Guide*/*SEER Summary Staging Manual 2000* are Tis in the *AJCC Cancer Staging Manual*. Some examples are:

- Paget's disease of the nipple (8540/3) (an "invasive" code in ICD-O-2 and ICD-O-3) *with no underlying tumor* is classified as Tis in AJCC Seventh Edition

- For colon/rectum, "invasion of the lamina propria" (intramucosal) with no extension through the muscularis mucosae into the submucosa is classified as Tis according to AJCC Seventh Edition but localized in *SEER Summary Stage 2000*

Some tumors classified as invasive in the behavior code can be classified as Tis or Stage 0 when coded according to AJCC Seventh Edition or when Collaborative Staging (CS) codes are converted to AJCC Seventh Edition. These differences should be considered when data are being compared.

Multiple Primary Rules

SEER rules have been the *de facto* standard for determining the number of primary cancers in the U.S. for both central and hospital-based registries. See the SEER *Program Coding and Staging Manuals*[3] for details. CCCR rules were the Canadian standard for the Canadian Cancer Registry database between 1992 and 2006. See the *Canadian Cancer Registry System Guide*[5] for details. For cases diagnosed on or after January 1, 2007, the CCCR has adopted the SEER *Multiple Primary and Histology Coding Rules*.[4] Until all registries in Canada adopt the same set of rules to determine multiple primaries, the Canadian Cancer Registry publishes data nationally using the IARC rules.

SEER convened a multi-agency task force (with representation from Canada) to review and revise the multiple primary and histology (MP/H) coding rules in a manner that promotes consistent, standardized determination of multiple primaries and coding of histologies at the data collection level. The revised MP/H rules were implemented January 2007. Additional information is available on the SEER website.[4]

Neither the pre-2007 rules nor the 2007 MP/H rules are identical to the international standard recommended by the International Agency for Research on Cancer (IARC) and the International Association of Cancer Registries (IACR).[34] The IARC rules have the effect of defining fewer cases than do the pre-2007 SEER/CCCR or the 2007 MP/H rules. A computer algorithm is available through IACR/IARC which identifies which U.S. cases would not be reportable under IACR/IARC multiple primary rules.

A rule requiring that an invasive tumor diagnosed more than two months after an *in situ* tumor of the same site be reported as a subsequent primary was reviewed by UDSC and adopted on April 26, 1994, effective with tumors diagnosed in 1995 and later. This rule remains in effect and is incorporated into the 2007 MP/H rules as follows.

An invasive tumor following an *in situ* tumor more than 60 days after diagnosis are multiple primaries.

> *Note 1:* The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
>
> *Note 2:* Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.[4]

This important rule affects how the tumor will be counted in published statistics. With the exception of bladder, *in situ* tumors are not usually included in published incidence rates. Without the reporting of these invasive cancers, for example, rates of invasive breast cancer would be underreported. CoC, with its emphasis on clinical data, did not adopt this exception to the general rule until the 2007 MP/H rules were implemented.

In the Canadian Cancer Registry database 1992-2006, if there was an *in situ* followed by an invasive cancer at the same site and histology, only the invasive primary was retained, the date of diagnosis was linked to the invasive primary. The Canadian Cancer Registry multiple primary rules did not allow an *in situ* and invasive primary to be retained for the same site and histology.

CARCINOMA *IN SITU* OF THE CERVIX, CIN, AND THE BETHESDA SYSTEM

The term "pre-invasive cervical neoplasia" refers to carcinoma *in situ* of the cervix and conditions viewed as equivalent to it or on a continuum with it. Diagnostic terminology for pre-invasive cervical neoplasia has changed significantly over time, from the four-tiered system of dysplasia and carcinoma *in situ*, to the three-tiered system of CIN, to the two-tiered Bethesda System, with high- and low-grade squamous intraepithelial lesions (SIL). In the past, cancer registries generally considered carcinoma *in situ* of the cervix reportable, but they differed in which of these other terms they considered synonymous with carcinoma *in situ* and hence reportable. Consequently, data were not comparable over time or across registries.

NAACCR convened a multidisciplinary working group in April 1993 to review the problem and make recommendations for its membership. The recommendation was that "population-based registries discontinue routine collection of data on pre-invasive cervical neoplasia unless there is strong local need and interest and sufficient resources are available to collect all [high-grade squamous intraepithelial lesions] and its equivalent terms."[30] NAACCR and NPCR adopted this recommendation at that time. SEER and CoC adopted it effective for cases diagnosed January 1, 1996, forward. CCCR adopted it effective for cases diagnosed January 1, 2004.

Ambiguous Terminology

In most circumstances, the diagnosis of cancer, as recorded in the patient's medical record, clearly is synonymous with reportable cancer. However, in those situations where the physician is not certain of the diagnosis, the associated terminology in the medical record reflects that uncertainty and is ambiguous. CoC, NPCR, SEER and CCCR are in agreement in regard to the list of terms considered as diagnostic of cancer and a list of terms not considered as cancer. These terms are shown in Table 2.

Table 2. NAACCR Layout Version 12: Comparison of Reportable Cancers: CoC, SEER, NPCR and CCCR.

	CoC	SEER	NPCR	CCCR
Reportable Diagnoses	1. Behavior code of 2 or 3 in ICD-O-3. 2. Non-malignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in Table 3.	1. Behavior code of 2 or 3 in ICD-O-3. 2. Non-malignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in Table 3.	1. Behavior code of 2 or 3 in ICD-O-3 (includes VIN III, VAIN III, AIN III). 2. Non-malignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in Table 3.	1. Behavior code of 2 or 3 in ICD-O-3. 2. Benign (behavior code 0) tumors of the brain and central nervous system (ICD-O-3 Topographies C70.0-C72.9). 3. Borderline (behavior code 1) malignancies (all topographies in ICD-O-3)
Exceptions (not reportable)	1. Skin cancers (C44._) with histology 8000-8110 (after 1/1/2003); prior to that date, AJCC stage groups 2-4 in this group were reportable. 2. CIS of the cervix and CIN III (after 1/1/96). 3. PIN III (after 1/1/96). 4. VIN III (after 1/1/96). 5. VAIN III (after 1/1/96). 6. AIN (after 1/1/96).	1. Skin cancers (C44._) with histologies 8000-8005, 8010-8046, 8050-8084, 8090-8110. 2. CIS of the cervix and CIN III (after 1/1/96). 3. PIN III (after 1/1/2001).	1. Skin cancers (C44._) with histologies 8000-8005, 8010-8046, 8050-8084, 8090-8110. 2. CIS of the cervix and CIN III. 3. PIN III (after 1/1/2001).	1. Skin cancers (C44._) with histologies 8050-8084, 8090_-8110. 2. CIS of the cervix and CIN III (after 1/1/2004) 3. PIN III (after 1/1/2005)
Multiple Primary Rules	2007 Multiple Primary and Histology Coding Rules.	2007 Multiple Primary and Histology Coding Rules.	2007 Multiple Primary and Histology Coding Rules	2007 Multiple Primary and Histology Coding Rules
Ambiguous Terminology Considered as Diagnostic of Cancer	apparent(ly) appears comparable with compatible with consistent with favors malignant appearing most likely presumed probable suspect(ed) suspicious (for) typical of Exception: if the cytology is reported as "suspicious" and neither a positive biopsy nor a physician's clinical impression supports the cytology findings, do not consider as diagnosis of cancer.	apparent(ly) appears comparable with compatible with consistent with favors malignant appearing most likely presumed probable suspect(ed) suspicious (for) typical of Exception: if the cytology is reported as "suspicious" and neither a positive biopsy nor a physician's clinical impression supports the cytology findings, do not consider as diagnosis of cancer.	apparent(ly) appears comparable with compatible with consistent with favors malignant appearing most likely presumed probable suspect(ed) suspicious (for) typical of Exception: if the cytology is reported as "suspicious" and neither a positive biopsy nor a physician's clinical impression supports the cytology findings, do not consider as diagnosis of cancer.	apparent(ly) appears comparable with compatible with consistent with favors malignant appearing most likely presumed probable suspect(ed) suspicious (for) typical of Exception: if the cytology is reported as "suspicious" and neither a positive biopsy nor a physician's clinical impression supports the cytology findings, do not consider as diagnosis of cancer.
Ambiguous Terminology NOT Considered as Diagnostic of Cancer	cannot be ruled out equivocal possible potentially malignant questionable rule out suggests worrisome	cannot be ruled out equivocal possible potentially malignant questionable rule out suggests worrisome	cannot be ruled out equivocal possible potentially malignant questionable rule out suggests worrisome	cannot be ruled out equivocal possible potentially malignant questionable rule out suggests worrisome

* **Juvenile astrocytomas should be reported as 9421/3.**

Table 3. Primary Site Codes for Non-Malignant Primary Intracranial and Central Nervous System Tumors (non-malignant primary intracranial and central nervous system tumors with a behavior code of 0 or 1 [benign/borderline] are reportable regardless of histologic type for these topography codes).

Topography	
Codes	**Description**
	Meninges
C70.0	Cerebral Meninges
C70.1	Spinal meninges
C70.9	Meninges, NOS
	Brain
C71.0	Cerebrum
C71.1	Frontal lobe
C71.2	Temporal lobe
C71.3	Parietal lobe
C71.4	Occipital lobe
C71.5	Ventricle, NOS
C71.6	Cerebellum, NOS
C71.7	Brain stem
C71.8	Overlapping lesion of brain
C71.9	Brain, NOS
	Spinal Cord, Cranial Nerves, and Other Parts of the Central Nervous System
C72.0	Spinal cord
C72.1	Cauda equina
C72.2	Olfactory nerve
C72.3	Optic nerve
C72.4	Acoustic nerve
C72.5	Cranial nerve, NOS
C72.8	Overlapping lesion of brain and central nervous system
C72.9	Nervous system, NOS
	Other Endocrine Glands and Related Structures
C75.1	Pituitary gland
C75.2	Craniopharyngeal duct
C75.3	Pineal gland

CHAPTER IV:

RECOMMENDED DATA EDITS AND SOFTWARE COORDINATION OF STANDARDS

Definitions
"Data edits" refer to computer software algorithms that check the content of data fields against an encoded set of acceptable codes and subsequently provide feedback on the quality of the data. Data edits verify that only acceptable values are used for codes and, more importantly, enforce correct relationships between the codes recorded for related data items. Data edits can apply pass/fail criteria to data, so that a particular code or group of codes is determined to be either correct or incorrect. Identified errors are corrected, and edits are re-run to ensure that the error was appropriately resolved. Certain types of edits identify coding combinations that are so rare or unlikely that they are most likely errors. Cases containing errors identified by these edits need to be manually reviewed, and if documentation is found to confirm that the case is rare or unusual and was originally correctly coded, an "over-ride flag" is set for the edit; i.e., a '1' (2 or 3) is entered into the over-ride flag field associated with the edit. Setting the over-ride flag will prevent the case from generating an error when it is re-run through the edit. Over-ride flags should not be set unless the entire case has been reviewed and documentation is found to confirm that the case is rare or unusual, as the majority of errors identified by such edits are in fact coding errors that end up being corrected, not over-ridden.

Generally, there are three types of edits:

- Single-field edits or item edits are those that verify only one data item at a time. For example, an edit of the item "Sex" would verify that only valid values are used in the field.

- Inter-field edits or multi-field edits are those edits that compare the codes recorded for one data item with codes recorded for related data items. For example, a common inter-field edit compares the code for "Sex" with the code for "Primary Site" and identifies female prostate cancer as an error.

- Inter-record edits or multi-record edits compare data recorded across more than one record, and are commonly applied across tumor records for a patient that has multiple tumors. These edits compare codes or groups of codes recorded in the same data item(s) between each of the tumor records for the patient. For example, one inter-record edit compares the sequence numbers of multiple tumors for the same patient with their dates of diagnosis to ensure that the sequence numbers have been assigned in the correct chronological order based on diagnosis date.

Challenges
There are at least six challenges to the standardization of data edits across central and hospital-based cancer registries. These include:

- Registry systems that encode an edit from standard specifications may be written in different computer languages, with possible differences in detail due to differing translations

- Each implementation of an agreed-upon standard specification may be programmed differently, despite intent to encode a standard meaning

- Complete edits are not always performed at the time of data entry

- Documentation of the edit algorithms can be difficult for data analysts and collectors to obtain, and may not be in a user-friendly format

- Consolidated data collected from different reporting sources and via different data entry tools may encourage the equating of "apples" and "oranges" without the users' knowledge

- When standards change, synchronized implementation of associated revised edits is difficult, due to the differing release schedules of cancer software providers and their limited ability to rapidly respond to changes at a given time

Uniform, standardized edits must be applied to all cancer registry data in order to generate data that are comparable across registries.

The EDITS Software

The EDITS Software Project began with an informal discussion about promoting and supporting data processing standards after a 1990 meeting of the NAACCR Data Evaluation and Publication Committee. A small group of registry operators, software producers, and data consumers identified the missing element of standard setting at that time: an executable version of a standard that could be applied directly to data in a variety of processing scenarios without reinterpretation by programmers. At that time, producers of cancer registry software wishing to adhere to a published standard had to write their own computer code to implement any edit-checking algorithms. The solution would need to be flexible in many dimensions to accommodate the many technical, operational, scientific, economic, and agency-related considerations that make up the cancer registry milieu.

EDITS is a set of software tools that can be used to improve data quality and standardize the way data items are checked for validity. The EDITS tools have been developed by CDC and NPCR and currently include three applications: EditWriter, GenEDITS Plus, and the Application Program Interface. These tools can be built into interactive data collection systems to achieve real-time field-by-field editing during data entry. They can also be used in batch-editing processes for data already collected. EDITS provides software to support three types of data activities: defining standards for data quality, standardizing data collection processes, and analyzing data quality. The EDITS tools were recently modernized and converted to the Windows operating environment, resulting in significantly improved function, efficiency, and user-friendliness of the software.

EDITS can be used to apply single-field and inter-field type edits routinely and interactively to cancer registry data, and is used extensively at all levels of cancer reporting: facilities, central registries, standard setters, and cancer software vendors.

EditWriter

EditWriter is a versatile and complete development environment for defining, testing, documenting, and distributing data standards. It also provides a means of maintaining the definition of a standard as it matures and changes over time. Data checking can be as complete and as complicated as the applications require.

The output of EditWriter is: 1) the EDITS Metafile (.emf file), a database that contains all of the logic, tables, and constant values needed to check fields of data for validity; and 2) the EDITS Runtime Metafile (.rmf file), the compiled file that is used to actually apply the edits to data. Both single-field and inter-field checks are included in the NAACCR Metafile (described below). The metafiles produced by EditWriter can be copied and used on a variety of operating systems. EditWriter is used to define data items; create record layouts; specify editing algorithms, logic, and documentation; and generate metafiles (described below), and is used by standard setters and central cancer registries for generating data quality edits for cancer reporters.

EDITS Application Program Interface (API)
The EDITS API is used to incorporate EDITS into cancer data abstracting, reporting, or processing software. The EDITS API can be incorporated into programs of many descriptions, including programs for interactive data entry and after-the-fact verification of data. Any language product for Windows should be able to use the EDITS API. The EDITS API is distributed as a Windows Dynamic Link Library and as C source code, and is used by most cancer software vendors.

GenEDITS PLUS
GenEDITS Plus is used to apply data quality edits to data files using the metafiles produced within EditWriter, and to generate error reports for error resolution. GenEDITS Plus is the fastest way to apply standard edits to data and obtain a report of data errors. GenEDITS Plus accepts NAACCR-formatted files, and produces two reports, both a detail report containing record-level error information, and a summary report containing error summary statistics. Because GenEDITS Plus already incorporates the EDITS API, no programming is required.

The EDITS Language
The algorithms that check data are specified using the EDITS language, a simplified programming language designed to validate data. The language includes a collection of powerful and specialized built-in functions that often reduce the complete validation of a data item to a single program statement. When complicated data relationships exist within a record, the EDITS language can express a complex validation scheme, including multiple fields, multiple table lookups, nested control statements, and functions.

The EDITS Metafiles
EDITS Metafiles contain everything needed to edit a data file, except the data. Metafiles provide portability of edits, in that the same edits can be applied to different data formats for different purposes. EDITS Metafiles are created and modified using EditWriter. The key components of an EDITS Metafile include: agencies, data dictionary, record layouts, edits, edit sets, error messages, and user look-up tables. The EDITS Runtime Metafile (.rmf file) is generated from the EDITS Metafile (.emf file) using EditWriter.

For additional information about EDITS or to download the EDITS software, see CDC's Division of Cancer Prevention and Control Website at: http://www.cdc.gov/cancer/npcr/.

NAACCR Standard Edits and the NAACCR Metafile
NAACCR has made increased standardization of data edits a priority, facilitated by the EDITS software, which provides a mechanism for standardized, transportable, and updateable edits to be provided through a "public library." The goals are to help limit the proliferation of differing standards when there is no compelling need to be different, and to provide comprehensive public documentation in a current and readily accessible form in those instances where standards must differ.

The NAACCR Metafile is a comprehensive database of cancer registry standards and consists of a collection of tables that contain all the information needed to test data fields for validity and acceptability. The NAACCR Metafile specifically includes the following: standard-setter list; current data dictionary of standard fields; sets of fields defining standard records; executable single- and multi-field validation logic; text descriptions of edits; look-up tables; and error messages.

NAACCR first made standard edits available in 1996. These edits corresponded to NAACCR's 1995 record layout and data dictionary, and were documented as Volume IV in its Standards series.[28] Since that time, NAACCR has posted EDITS metafiles containing standard edits on the Internet that correspond to the annual NAACCR record layouts and data dictionaries. For example, "Revised Version 11 Metafile--NAACCR 11.1A" refers to the standard edits in the NAACCR Version 11.1 record layout. The "A" notation

indicates the first revision to the Version 11.1 record layout standard edits. The hardcopy of Volume IV has been discontinued in favor of electronic publication of EDITS documentation using EditWriter. The EDITS Software, along with general instructions, and various current and previous metafiles containing the most recent and historical public standards for cancer registry data, are available on the NAACCR website at www.naaccr.org. (Click on *Cancer Data Standards, NAACCR Data Standards for Cancer Registries,* and then *Standard Data Edits.*)

NPCR Inter-record Edits Utility

Mature central cancer registries can have up to 15-20% multiple primary data. In order to validate coded values across multiple tumor records for a single patient, inter-record edits must be applied to the data. In the early 1980's SEER developed an Inter-record Edits program for SEER registries. In 2000, NPCR began development of an Inter-record Edits Utility for use by NPCR registries; this software included similar logic, but had run-time differences from the SEER Inter-record Edits program. In 2003, NAACCR began using the NPCR Inter-record Edits Utility in their annual Calls for Data.

The NPCR Inter-record Edits Utility accepts NAACCR-formatted files, produces two reports, both a detail report and a summary report, and currently contains 22 edits. NPCR Inter-record Edits are applied to consolidated tumor data, i.e., files containing one record per tumor per patient. Identified inter-record errors are corrected, and the inter-record edits are re-run to ensure that the error was appropriately resolved.

SEER*Edits

For many years, the SEER Program has maintained a library of standardized edits which it applies to data submissions from the participating SEER registries. Over the years as experience and expertise increased, SEER has fine-tuned and expanded the edits and has made these edits available to SEER and other registries. In addition, the logic of the SEER edits has been used as the foundation for the EDITS project where SEER is the source of standard for the item or items.

Over time, as more and more computer processing moved away from the mainframe platform, the SEER Program re-programmed their edits in C++ (SEER*Edits). This change has allowed the SEER edit engine to be ported to and compiled on a variety of hardware platforms. The edit engine includes the entire SEER field, inter-field, and inter-record edits. SEER*Edits can be used as a stand-alone package for the SEER areas to use before submission of data to SEER, or the edits can be incorporated individually by SEER registries for use in their data entry programs or routine editing of data. Data files used as input into the stand-alone version of SEER*Edits must be stored in NAACCR format. The SEER*Edits package also includes report-generating functions including the display of errors to facilitate data corrections. Various follow-up, surveillance, and SEER registry requirement reports are also included. Any changes made to the SEER*Edits package also are made to both the SEER Data Management System (SEER*DMS) and to the corresponding edits in the NAACCR Metafile for the EDITS project and vice versa to keep them synchronized.

CHAPTER V:

UNRESOLVED ISSUES

Over time there have been inconsistencies in coding standards required by major standard-setting organizations concerning the item sets required, the codes and coding instructions employed, and the timing of adoption of new or revised codes that affect the use of data compiled over several years and from multiple sources. These issues are described below. The standards for tumor inclusion, reportability, and multiple primary rules are addressed separately in Chapter III.

The Uniform Data Standards Committee (UDSC) will continue to seek consensus on unresolved issues. Before new standards can be agreed upon, all interested parties must be provided sufficient time to study the proposals. Once UDSC approves new standards, there must be adequate time for implementation. All members are encouraged to present suggestions or comments on proposed changes to the standards to UDSC. The NAACCR website, http://www.naaccr.org, provides the name of the Committee Chair and forms for proposing additions or revisions.

This chapter describes coding issues affecting each of the following types of measures:

county
ethnicity
occupation and industry
sequence numbers
staging descriptors
treatment descriptors
timing of first course treatment
vital status codes

The descriptions in this chapter are intended to provide a summary of coding issues. The original manuals should be consulted when a particular data use requires more detail. This chapter does not track changes made in individual codes over time. Some changes are noted in the individual item dictionary descriptions, and further information can be obtained from historic versions of this volume and from the individual standard-setters associated with the items.

County-Current [1840] and County at DX [90]
NAACCR has adopted the Federal Information Processing Standards (FIPS) codes for county as the standard in this volume (see Appendix A for codes). However, standards for codes used vary somewhat by standard setter. For cancers diagnosed prior to 2002, the use of FIPS codes was not universally adopted. For this reason, users of data should determine which codes were used for coding County at DX in a particular file, since no field indicating "County at DX Coding System" is included in the NAACCR layout.

- The SEER Program requires the use of FIPS codes for counties in the United States, plus the special code 999 (unknown).

- CoC requires the use of FIPS county codes as their standard, plus the special codes 998 and 999. However, the *FORDS* manual also provides for use of geocodes for countries of residence outside the United States and Canada to be used in this field.

- NPCR requires the use of FIPS codes for counties in the United States, plus the special code 999, starting with cancers diagnosed on or after January 1, 2002.

Spanish/Hispanic Origin (Hispanic Ethnicity) [190-210]
Although agreement on standard codes for the data item "Spanish/Hispanic Origin [190]" has been reached, substantial variation persists among registries in how Hispanic ethnicity or Spanish/Hispanic Origin is determined. Procedures for determining ethnicity include:

- Recording ethnicity from information found in the medical record.

- Recording ethnicity based on a combination of patient demographic information that may include last name, maiden name, birthplace, or a statement of ethnicity in the record.

- Recording ethnicity based on a manual or computer matching of a documented surname, either last name or maiden name, against one or more listings of Spanish surnames. Common Spanish surname listings include: the 1980 and 1990 Census Bureau lists, the University of New Mexico GUESS list, and regional listings of Spanish surnames common to a particular geographic region (for example, the Florida list).

- Recording the ethnicity based on the application of a computer algorithm to available data items that may include last name, maiden name, birthplace, race, or sex to assign ethnicity.

Population-based registries should attempt to categorize their cases using a method that best approximates the method used by the Census Bureau to determine ethnicity in the population denominators. A standard best method has not been determined.

Attempts have been made to evaluate and improve numerator data based on various methodologic approaches to determining Spanish/Hispanic Origin. NAACCR sponsored a symposium in Atlanta, GA, in January 1996 to discuss methodologic issues faced when attempting to measure cancer among Hispanics. A report was prepared and is available on the NAACCR website (http://www.naaccr.org) under the heading "Epidemiologic Reports." In 1999, a research group was formed from representatives of NAACCR to address issues of definition and to produce comparable data for Hispanic ethnicities across the United States. The group, operating under the auspices of the NAACCR Data Evaluation and Publications Committee, led to the creation of the NAACCR Hispanic Identification Algorithm (NHIA), an algorithm that uses a combination of NAACCR variables to directly or indirectly assign ethnicity.

Registries continue to use different methods to code Hispanic ethnicity. Users of the data must be able to determine how Hispanic ethnicity coding was assigned in a particular file. Based on historical and current discussions, NAACCR includes the field Spanish/Hispanic Origin [190] for direct recording of ethnicity from the medical record, as well as fields for Computed Ethnicity [200], Computed Ethnicity Source [210], and NHIA Derived Hispanic Origin [191].

Occupation and Industry [270-330]
Most population-based registries have found the collection of usual occupation and industry data to be difficult and of limited utility, and for many years no consensus on data items and codes for occupation and industry had been achieved. In 1992, the Cancer Registries Amendment Act required central registries funded by NPCR to collect occupation or industry data to the extent available in the medical record.[33]

Data on usual occupation and industry are unavailable in an unknown, but significant, proportion of medical records. Even when available, the quality of the data in the medical record is generally untested and often limited to less useful information such as "retired." Concurrently, this information generally is available in text format on death certificates and, in some states, on the associated state mortality data files. Some state

mortality data files also contain the associated occupation and industry codes in addition to the text data. Much work remains to be done to improve the availability and capture of this potentially important information.

NAACCR will continue to discuss the quality and completeness of occupation and industry data and will reconsider the inclusion of occupation and industry in its recommended data sets.

Sequence Number [380 and 560]
As discussed in Chapter III, SEER, NPCR, and CoC have different standards for determining tumors that are reportable and are to be included in the registry. In addition to collecting these required tumors, some registries also collect and assign sequence numbers to other tumors such as cervix carcinoma *in situ* or PIN III.

Two sequence number data items, one assigned by the reporting facility, Sequence Number--Hospital [560], and one assigned by the central registry, Sequence Number--Central [380], are now in use. The time period of both Sequence Number data items is a person's lifetime, although with earlier definitions of Sequence Number--Central [380], central registries historically assigned the numbers from the reference date of the registry. When reportability of a particular tumor changes over time, both the type and the timing of tumors may affect the assignment of sequence numbers, so it is possible for two patients having similar cancer histories to be characterized by different sets of sequence numbers.

Numerous operational issues, such as storage of multiple facility-specific sequence numbers, appropriate linkage rules, and feedback of data to hospitals, have arisen because of policy differences from state to state. When attempting to use the Sequence Number--Central to identify individuals who have had only one lifetime cancer, it is important to realize the definitions used to make that determination vary and that sequencing may be handled differently in different systems.

CANCER STAGING
AJCC TNM Stage, SEER EOD, SEER Historic Stage, SEER Summary Stage (1977 and 2000), and Collaborative Staging [759-1070, 1090-1170, 2800-3050]
Historically, four major staging schemes have been widely used in cancer registries in the United States. The schemes, AJCC TNM, SEER Extent of Disease, SEER Historic Stage, and SEER Summary Stage, differ in complexity, purpose, structure, rules, and definitions. AJCC TNM staging provides forward flexibility and clinical utility. SEER EOD provides longitudinal stability for epidemiological studies. And, SEER Historic and Summary Stage provide population surveillance staging capability.

In January 2004, the Collaborative Staging System was introduced to reduce duplication of effort and provide a common staging schema for registry use and from which the other major staging categories could be electronically derived. All standard setters in the United States required the use of the Collaborative Staging System version 1 for cases diagnosed January 1, 2004- December 31, 2009, but not every standard setter required every data element. CS version 2 is based on AJCC 7th edition and was renamed the Collaborative Stage (CS) Data Collection System. CS version 2 is effective for cases diagnosed January 1, 2010, and later.

The historic schemes were designed for different purposes at different times, and are not easily compared. There have been several editions of the *AJCC TNM Cancer Staging Manual*, and conversion between versions is often not possible. Minor differences exist between the SEER Summary Staging guides of 1977 and 2000. SEER published the *Comparative Staging Guide for Cancer*[6] in 1993 as an attempt to present comprehensive, site-specific comparisons of the AJCC TNM, SEER EOD, and SEER Summary Staging schemes as an aid in data collection and interpretation. This guide covered the major cancer sites of colon and rectum, lung and bronchus, breast, female genital, prostate gland, and urinary bladder. According to the guide:

- Changes over time in methods of cancer screening, diagnosis, staging, and treatment have affected the distribution of stage of disease.

- Changes over time in the classification schemes themselves can complicate data analysis and obscure the meaning of time trends. Various other staging schemes also are in use. Several oncology subspecialties have developed staging systems applying to a limited number of cancer sites.

For these reasons, comparing cancer registry data by stage over time or across registries, or using pooled data collected by different registries applying different staging schema, is problematic.[6]

For a discussion of staging issues that affect rules for case inclusion and reportability, see Chapter III, especially the paragraphs "*In Situ*/Invasive" and "Multiple Primary Rules."

A summary of the major staging schemes is provided below.

- **The American Joint Committee on Cancer's TNM System (AJCC TNM)**
  The *AJCC Cancer Staging Manual* presents an anatomically oriented, site-specific staging system that consists of separate categories for the tumor, nodes, and metastases. The TNM categories then are grouped by stage, from 0 to IV.

- **SEER Extent of Disease (SEER EOD)**
  This site-specific 10-digit coding scheme[8] was required for SEER registries until December 31, 2003. Other state and central registries also used it. EOD was designed to allow collapse of the codes into the stage groupings of several different staging systems, including AJCC stage group.

- **SEER Summary Stage**
  Beginning for cases diagnosed 2004+, the SEER Summary Stage is contained in derived variables from the CS algorithm: Derived SS1977 [3010] and Derived SS2000 [3020] for SEER Summary Stage 1977 and SEER Summary Stage 2000, respectively. This site-specific single-digit coding scheme was required for NPCR registries until December 31, 2003, and it was also used by some SEER registries. In addition, CoC required the coding of SEER Summary Stage when a corresponding AJCC TNM site code scheme was not available until Collaborative Stage was implemented. There are two related data items: SEER Summary Stage 1977 [760] and SEER Summary Stage 2000 [759]. Cancers diagnosed on or after January 1, 2001, were assigned a summary stage according to the *SEER Summary Staging Manual, 2000,*[12] and the code should be reported in the SEER Summary Stage 2000 [759] data item. Cancers diagnosed before January 1, 2001, were assigned a summary stage according to *Summary Stage Guide, Cancer Surveillance Epidemiology and End Results Reporting, SEER Program, April 1977,*[11] and the code was reported in the SEER Summary Stage 1977 [760] data item (see NAACCR Guidelines for Implementation of SEER Summary Stage 2000).

- **SEER Historic Stage**
  When SEER stage data are published, the stage categories used are those used by an earlier program, the End Results Group. The Historic Stage variable has been defined consistently over time to facilitate trend analyses, and the categories are not identical to those in the SEER Summary Stage.

- **Collaborative Stage**
  The Collaborative Stage (CS) data set is a combination of data items (most of which have traditionally been collected as a part of regular cancer surveillance activities) that include tumor size, extension, lymph node status, metastatic status, evaluation fields describing the hierarchy of the data collected, and relevant site-specific information. This unified data set was specifically designed for cancer reporting and includes an algorithm which derives three different staging systems from the data collected and resolves subtle staging rule differences. The systems for which staging currently can be derived include *AJCC TNM 6th Edition*, *AJCC TNM 7th Edition*, *SEER Summary Stage 1977*, and *SEER Summary Stage 2000*. Not all standard setters require all CS elements to be collected.

Tumor Size Rules [780]
Over the years, some of the rules for describing tumor size changed several times, and discrepancies existed between the CoC and SEER data. With the implementation of the Collaborative Stage coding system in 2004, all the differences between the two groups' guidelines for tumor size have now been resolved.

The sites for which the tumor size guidelines differed are listed below. Users of registry data must be aware of possible discrepancies in the meaning of the information recorded in this variable before the diagnosis years indicated in parenthesis.

Melanomas (2002)
Microscopic foci (2003)
Most lesions smaller than 2 millimeters (2004)
Breast and Lung lesions smaller than 3 millimeters (2004)
Mycosis fungoides, Sezary disease, lymphomas, Kaposi sarcoma (2004)

TREATMENT
Historically, NPCR has recommended collecting the date and type of first course of definitive treatment when available.[29] For the 1996-1997 diagnosis years, NPCR-funded registries were required to collect and process available treatment information using either the (1995 or 1996) SEER Program treatment data set or the (1995 or 1996) CoC treatment data set.

For 1998-2000, NPCR had a similar recommendation. NPCR-funded registries adopted either the SEER 1998 or the CoC 1998 treatment data set, and were encouraged to use the data item "RX Coding System--Current" [1460] to indicate how treatment was coded for a specific record.

Beginning with 2003 diagnoses, the CoC *FORDS*[2] redefined some treatment fields and added others. Some new and redefined data fields along with dates of treatment are required by NPCR. For the 2003 and forward diagnosis years, NPCR will require the collection of first course of treatment data items when available and will require the submission of the NPCR required surgery data items. NPCR will use the same codes as CoC *FORDS*, but will not collect all the data fields. See the list of data items (Chapter VIII) that NPCR registries collect.

SEER will use the same codes as the CoC *FORDS* but may not collect all of the fields. For example, SEER areas will not collect Rad--Treatment Volume. See the list of data items (Chapter VIII) that SEER areas collect and that SEER requires the SEER registries to transmit to NCI. SEER areas will use the fields Rad--Regional RX Modality [1570] and Rad--Boost Rx Modality (3200) from CoC hospitals to complete RX Summ--Radiation [1360].

RX Summ--Rad to CNS [1370]
This item is maintained in the transmission file for use with historic data. CoC discontinued collection of the item for cases diagnosed on or after January 1, 1996, and SEER discontinued collecting it for tumors diagnosed beginning in 1998. Both organizations instructed coders to record radiation to the central nervous system following those dates as radiation. SEER retains the codes for earlier cases and also converts the data into an appropriate radiation field. The item is no longer supported in any form by CoC.

Time Period for First Course of Treatment [1260, 1270, 1500]
SEER and CoC have historically defined first course treatment differently. The differences affect representation of the date first course treatment begins and the instructions for determining what constitutes first course treatment. The NAACCR record layout contains a data item, First Course Calc Method [1500], to record which organization's definition was followed.

The NAACCR record layout provides two data items that indicate the date of the start of the first course of treatment: Date of 1st CRS RX--CoC [1270] as defined by CoC, and Date of Initial RX--SEER [1260] as defined by SEER. The difference between these two definitions is that CoC defines the date the physician decides not to treat the patient as the date of initial treatment, while SEER considers such a decision to be no treatment and the date field is left blank, and the corresponding date flag value is '11'.

The SEER and CoC definitions of treatment to be included as "first course" have become increasingly congruent, differing now primarily in their "fall-back" recommendations that apply when no treatment plan is recorded, no standard facility practice applies, no protocol applies, no physician is able to provide assistance, and no record of treatment failure or recurrence of disease is available. In that extreme instance, CoC recommends a 4-month cutoff for the beginning of first-course treatment, and SEER applies a 1-year cutoff for completion of first course of therapy.

Users of historical treatment data should be aware that the definitions of "first course" have changed over time and have been disjointed in the past. The applicable coding manuals and standard-setting organizations should be consulted for specifics.

Users of treatment data also should be aware that registries differ in the amount of treatment data collected in terms of the types of treatment included, non-hospital treatment locations surveyed, items covered (see the previous section), and the use of all codes provided for each item. Thus, treatment data are likely to be inconsistent among registries and to have varying levels of completeness, especially for treatment given in physicians' offices or other non-hospital settings.

Vital Status [1760]
Both SEER and CoC use code 1 in this field to indicate that the patient is alive. However, these programs use codes 4 and 0, respectively, to indicate that the patient is dead. Both programs have long-standing historical reasons to retain their coding. No agreement has been reached on this data item.

Canadian Data
The NAACCR data standards adopted thus far do not adequately deal with data from places outside the United States. Changes have been made to accommodate postal codes, standard abbreviations for provinces/territories, and other fields in the Canadian data set. A Canadian Council of Cancer Registries (CCCR) column has been added to the Required Status Table and future versions of this document will review and increasingly incorporate standards established for Canadian cancer registries.

CHAPTER VI:

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CHAPTER VII:

RECORD LAYOUT TABLE (COLUMN # ORDER)

The following table presents Version 12.1 of the NAACCR record layout. The table has column number, length, item number, item name, section, and note fields. Differences from Version 12 are marked "Revised" or "New" in the "Note" column of the table. Revised and new items are summarized in Appendix F. Please note that "Retired" items are not reflected in this table.

Column #	Length	Item #	Item Name	Section	Note
1-1	1	10	Record Type	Record ID	
2-2	1	30	Registry Type	Record ID	
3-3	1	35	FIN Coding System	Record ID	
4-16	13	37	Reserved 00	Record ID	
17-19	3	50	NAACCR Record Version	Record ID	
20-29	10	45	NPI--Registry ID	Record ID	
30-39	10	40	Registry ID	Record ID	
40-41	2	60	Tumor Record Number	Record ID	
42-49	8	20	Patient ID Number	Record ID	
50-57	8	21	Patient System ID-Hosp	Record ID	
58-94	37	370	Reserved 01	Record ID	
95-144	50	70	Addr at DX--City	Demographic	
145-146	2	80	Addr at DX--State	Demographic	
147-155	9	100	Addr at DX--Postal Code	Demographic	
156-158	3	90	County at DX	Demographic	
159-164	6	110	Census Tract 1970/80/90	Demographic	
165-165	1	368	CensusBlockGroup 70/80/90	Demographic	
166-166	1	120	Census Cod Sys 1970/80/90	Demographic	
167-167	1	364	Census Tr Cert 1970/80/90	Demographic	
168-173	6	130	Census Tract 2000	Demographic	
174-174	1	362	Census Block Group 2000	Demographic	
175-175	1	365	Census Tr Certainty 2000	Demographic	
176-176	1	150	Marital Status at DX	Demographic	
177-178	2	160	Race 1	Demographic	
179-180	2	161	Race 2	Demographic	
181-182	2	162	Race 3	Demographic	
183-184	2	163	Race 4	Demographic	
185-186	2	164	Race 5	Demographic	
187-187	1	170	Race Coding Sys--Current	Demographic	
188-188	1	180	Race Coding Sys--Original	Demographic	
189-189	1	190	Spanish/Hispanic Origin	Demographic	
190-190	1	200	Computed Ethnicity	Demographic	
191-191	1	210	Computed Ethnicity Source	Demographic	
192-192	1	220	Sex	Demographic	
193-195	3	230	Age at Diagnosis	Demographic	
196-203	8	240	Date of Birth	Demographic	
204-205	2	241	Date of Birth Flag	Demographic	

Column #	Length	Item #	Item Name	Section	Note
206-208	3	250	Birthplace	Demographic	
209-211	3	270	Occupation Code--Census	Demographic	
212-214	3	280	Industry Code--Census	Demographic	
215-215	1	290	Occupation Source	Demographic	
216-216	1	300	Industry Source	Demographic	
217-316	100	310	Text--Usual Occupation	Demographic	
317-416	100	320	Text--Usual Industry	Demographic	
417-417	1	330	Occup/Ind Coding System	Demographic	
418-418	1	191	NHIA Derived Hisp Origin	Demographic	
419-420	2	193	Race--NAPIIA(derived API)	Demographic	
421-421	1	192	IHS Link	Demographic	
422-423	2	366	GIS Coordinate Quality	Demographic	
424-425	2	3300	RuralUrban Continuum 1993	Demographic	
426-427	2	3310	RuralUrban Continuum 2003	Demographic	
428-433	6	135	Census Tract 2010	Demographic	New
434-434	1	363	Census Block Group 2010	Demographic	New
435-435	1	367	Census Tr Certainty 2010	Demographic	New
436-527	92	530	Reserved 02	Demographic	Revised
528-529	2	380	Sequence Number--Central	Cancer Identification	
530-537	8	390	Date of Diagnosis	Cancer Identification	
538-539	2	391	Date of Diagnosis Flag	Cancer Identification	
540-543	4	400	Primary Site	Cancer Identification	
544-544	1	410	Laterality	Cancer Identification	
545-549	5	419	Morph--Type&Behav ICD-O-2	Cancer Identification	Group
545-548	4	420	Histology (92-00) ICD-O-2	Cancer Identification	Subfield
549-549	1	430	Behavior (92-00) ICD-O-2	Cancer Identification	Subfield
550-554	5	521	Morph--Type&Behav ICD-O-3	Cancer Identification	Group
550-553	4	522	Histologic Type ICD-O-3	Cancer Identification	Subfield
554-554	1	523	Behavior Code ICD-O-3	Cancer Identification	Subfield
555-555	1	440	Grade	Cancer Identification	
556-556	1	441	Grade Path Value	Cancer Identification	
557-557	1	449	Grade Path System	Cancer Identification	
558-558	1	450	Site Coding Sys--Current	Cancer Identification	
559-559	1	460	Site Coding Sys--Original	Cancer Identification	
560-560	1	470	Morph Coding Sys--Current	Cancer Identification	
561-561	1	480	Morph Coding Sys--Originl	Cancer Identification	
562-562	1	490	Diagnostic Confirmation	Cancer Identification	

Column #	Length	Item #	Item Name	Section	Note
563-563	1	500	Type of Reporting Source	Cancer Identification	
564-565	2	501	Casefinding Source	Cancer Identification	
566-566	1	442	Ambiguous Terminology DX	Cancer Identification	
567-574	8	443	Date of Conclusive DX	Cancer Identification	
575-576	2	448	Date Conclusive DX Flag	Cancer Identification	
577-578	2	444	Mult Tum Rpt as One Prim	Cancer Identification	
579-586	8	445	Date of Multiple Tumors	Cancer Identification	
587-588	2	439	Date of Mult Tumors Flag	Cancer Identification	
589-590	2	446	Multiplicity Counter	Cancer Identification	
591-690	100	680	Reserved 03	Cancer Identification	
691-700	10	545	NPI--Reporting Facility	Hospital-Specific	
701-710	10	540	Reporting Facility	Hospital-Specific	
711-720	10	3105	NPI--Archive FIN	Hospital-Specific	
721-730	10	3100	Archive FIN	Hospital-Specific	
731-739	9	550	Accession Number--Hosp	Hospital-Specific	
740-741	2	560	Sequence Number--Hospital	Hospital-Specific	
742-744	3	570	Abstracted By	Hospital-Specific	
745-752	8	580	Date of 1st Contact	Hospital-Specific	
753-754	2	581	Date of 1st Contact Flag	Hospital-Specific	
755-762	8	590	Date of Inpatient Adm	Hospital-Specific	
763-764	2	591	Date of Inpt Adm Flag	Hospital-Specific	
765-772	8	600	Date of Inpatient Disch	Hospital-Specific	
773-774	2	601	Date of Inpt Disch Flag	Hospital-Specific	
775-775	1	605	Inpatient Status	Hospital-Specific	
776-777	2	610	Class of Case	Hospital-Specific	
778-779	2	630	Primary Payer at DX	Hospital-Specific	
780-780	1	2400	Reserved 16	Hospital-Specific	
781-781	1	668	RX Hosp--Surg App 2010	Hospital-Specific	
782-783	2	670	RX Hosp--Surg Prim Site	Hospital-Specific	
784-784	1	672	RX Hosp--Scope Reg LN Sur	Hospital-Specific	
785-785	1	674	RX Hosp--Surg Oth Reg/Dis	Hospital-Specific	
786-787	2	676	RX Hosp--Reg LN Removed	Hospital-Specific	
788-788		2450	Reserved 17	Hospital-Specific	
789-789	1	690	RX Hosp--Radiation	Hospital-Specific	
790-791	2	700	RX Hosp--Chemo	Hospital-Specific	
792-793	2	710	RX Hosp--Hormone	Hospital-Specific	
794-795	2	720	RX Hosp--BRM	Hospital-Specific	

Column #	Length	Item #	Item Name	Section	Note
796-796	1	730	RX Hosp--Other	Hospital-Specific	
797-798	2	740	RX Hosp--DX/Stg Proc	Hospital-Specific	
799-799	1	3280	RX Hosp--Palliative Proc	Hospital-Specific	
800-801	2	746	RX Hosp--Surg Site 98-02	Hospital-Specific	
802-802	1	747	RX Hosp--Scope Reg 98-02	Hospital-Specific	
803-803	1	748	RX Hosp--Surg Oth 98-02	Hospital-Specific	
804-903	100	750	Reserved 04	Hospital-Specific	
904-904	1	759	SEER Summary Stage 2000	Stage/Prognostic Factors	
905-905	1	760	SEER Summary Stage 1977	Stage/Prognostic Factors	
906-917	12	779	Extent of Disease 10-Dig	Stage/Prognostic Factors	Group
906-908	3	780	EOD--Tumor Size	Stage/Prognostic Factors	Subfield
909-910	2	790	EOD--Extension	Stage/Prognostic Factors	Subfield
911-912	2	800	EOD--Extension Prost Path	Stage/Prognostic Factors	Subfield
913-913	1	810	EOD--Lymph Node Involv	Stage/Prognostic Factors	Subfield
914-915	2	820	Regional Nodes Positive	Stage/Prognostic Factors	Subfield
916-917	2	830	Regional Nodes Examined	Stage/Prognostic Factors	Subfield
918-930	13	840	EOD--Old 13 Digit	Stage/Prognostic Factors	
931-932	2	850	EOD--Old 2 Digit	Stage/Prognostic Factors	
933-936	4	860	EOD--Old 4 Digit	Stage/Prognostic Factors	
937-937	1	870	Coding System for EOD	Stage/Prognostic Factors	
938-939	2	1060	TNM Edition Number	Stage/Prognostic Factors	
940-943	4	880	TNM Path T	Stage/Prognostic Factors	
944-947	4	890	TNM Path N	Stage/Prognostic Factors	
948-951	4	900	TNM Path M	Stage/Prognostic Factors	
952-955	4	910	TNM Path Stage Group	Stage/Prognostic Factors	
956-956	1	920	TNM Path Descriptor	Stage/Prognostic Factors	
957-957	1	930	TNM Path Staged By	Stage/Prognostic Factors	
958-961	4	940	TNM Clin T	Stage/Prognostic Factors	
962-965	4	950	TNM Clin N	Stage/Prognostic Factors	
966-969	4	960	TNM Clin M	Stage/Prognostic Factors	
970-973	4	970	TNM Clin Stage Group	Stage/Prognostic Factors	
974-974	1	980	TNM Clin Descriptor	Stage/Prognostic Factors	
975-975	1	990	TNM Clin Staged By	Stage/Prognostic Factors	
976-977	2	1120	Pediatric Stage	Stage/Prognostic Factors	
978-979	2	1130	Pediatric Staging System	Stage/Prognostic Factors	
980-980	1	1140	Pediatric Staged By	Stage/Prognostic Factors	
981-981	1	1150	Tumor Marker 1	Stage/Prognostic Factors	

Column #	Length	Item #	Item Name	Section	Note
982-982	1	1160	Tumor Marker 2	Stage/Prognostic Factors	
983-983	1	1170	Tumor Marker 3	Stage/Prognostic Factors	
984-984	1	1182	Lymph-vascular Invasion	Stage/Prognostic Factors	
985-987	3	2800	CS Tumor Size	Stage/Prognostic Factors	
988-990	3	2810	CS Extension	Stage/Prognostic Factors	
991-991	1	2820	CS Tumor Size/Ext Eval	Stage/Prognostic Factors	
992-994	3	2830	CS Lymph Nodes	Stage/Prognostic Factors	
995-995	1	2840	CS Lymph Nodes Eval	Stage/Prognostic Factors	
996-997	2	2850	CS Mets at DX	Stage/Prognostic Factors	
998-998	1	2860	CS Mets Eval	Stage/Prognostic Factors	
999-999	1	2851	CS Mets at Dx-Bone	Stage/Prognostic Factors	
1000-1000	1	2852	CS Mets at Dx-Brain	Stage/Prognostic Factors	
1001-1001	1	2853	CS Mets at Dx-Liver	Stage/Prognostic Factors	
1002-1002	1	2854	CS Mets at Dx-Lung	Stage/Prognostic Factors	
1003-1005	3	2880	CS Site-Specific Factor 1	Stage/Prognostic Factors	
1006-1008	3	2890	CS Site-Specific Factor 2	Stage/Prognostic Factors	
1009-1011	3	2900	CS Site-Specific Factor 3	Stage/Prognostic Factors	
1012-1014	3	2910	CS Site-Specific Factor 4	Stage/Prognostic Factors	
1015-1017	3	2920	CS Site-Specific Factor 5	Stage/Prognostic Factors	
1018-1020	3	2930	CS Site-Specific Factor 6	Stage/Prognostic Factors	
1021-1023	3	2861	CS Site-Specific Factor 7	Stage/Prognostic Factors	
1024-1026	3	2862	CS Site-Specific Factor 8	Stage/Prognostic Factors	
1027-1029	3	2863	CS Site-Specific Factor 9	Stage/Prognostic Factors	
1030-1032	3	2864	CS Site-Specific Factor10	Stage/Prognostic Factors	
1033-1035	3	2865	CS Site-Specific Factor11	Stage/Prognostic Factors	
1036-1038	3	2866	CS Site-Specific Factor12	Stage/Prognostic Factors	
1039-1041	3	2867	CS Site-Specific Factor13	Stage/Prognostic Factors	
1042-1044	3	2868	CS Site-Specific Factor14	Stage/Prognostic Factors	
1045-1047	3	2869	CS Site-Specific Factor15	Stage/Prognostic Factors	
1048-1050	3	2870	CS Site-Specific Factor16	Stage/Prognostic Factors	
1051-1053	3	2871	CS Site-Specific Factor17	Stage/Prognostic Factors	
1054-1056	3	2872	CS Site-Specific Factor18	Stage/Prognostic Factors	
1057-1059	3	2873	CS Site-Specific Factor19	Stage/Prognostic Factors	
1060-1062	3	2874	CS Site-Specific Factor20	Stage/Prognostic Factors	
1063-1065	3	2875	CS Site-Specific Factor21	Stage/Prognostic Factors	
1066-1068	3	2876	CS Site-Specific Factor22	Stage/Prognostic Factors	
1069-1071	3	2877	CS Site-Specific Factor23	Stage/Prognostic Factors	

Column #	Length	Item #	Item Name	Section	Note
1072-1074	3	2878	CS Site-Specific Factor24	Stage/Prognostic Factors	
1075-1077	3	2879	CS Site-Specific Factor25	Stage/Prognostic Factors	
1078-1080	3	2730	CS PreRx Tumor Size	Stage/Prognostic Factors	
1081-1083	3	2735	CS PreRx Extension	Stage/Prognostic Factors	
1084-1084	1	2740	CS PreRx Tum Sz/Ext Eval	Stage/Prognostic Factors	
1085-1087	3	2750	CS PreRx Lymph Nodes	Stage/Prognostic Factors	
1088-1088	1	2755	CS PreRx Reg Nodes Eval	Stage/Prognostic Factors	
1089-1090	2	2760	CS PreRx Mets at DX	Stage/Prognostic Factors	
1091-1091	1	2765	CS PreRx Mets Eval	Stage/Prognostic Factors	
1092-1094	3	2770	CS PostRx Tumor Size	Stage/Prognostic Factors	
1095-1097	3	2775	CS PostRx Extension	Stage/Prognostic Factors	
1098-1100	3	2780	CS PostRx Lymph Nodes	Stage/Prognostic Factors	
1101-1102	2	2785	CS PostRx Mets at DX	Stage/Prognostic Factors	
1103-1104	2	2940	Derived AJCC-6 T	Stage/Prognostic Factors	
1105-1105	1	2950	Derived AJCC-6 T Descript	Stage/Prognostic Factors	
1106-1107	2	2960	Derived AJCC-6 N	Stage/Prognostic Factors	
1108-1108	1	2970	Derived AJCC-6 N Descript	Stage/Prognostic Factors	
1109-1110	2	2980	Derived AJCC-6 M	Stage/Prognostic Factors	
1111-1111	1	2990	Derived AJCC-6 M Descript	Stage/Prognostic Factors	
1112-1113	2	3000	Derived AJCC-6 Stage Grp	Stage/Prognostic Factors	
1114-1116	3	3400	Derived AJCC-7 T	Stage/Prognostic Factors	
1117-1117	1	3402	Derived AJCC-7 T Descript	Stage/Prognostic Factors	
1118-1120	3	3410	Derived AJCC-7 N	Stage/Prognostic Factors	
1121-1121	1	3412	Derived AJCC-7 N Descript	Stage/Prognostic Factors	
1122-1124	3	3420	Derived AJCC-7 M	Stage/Prognostic Factors	
1125-1125	1	3422	Derived AJCC-7 M Descript	Stage/Prognostic Factors	
1126-1128	3	3430	Derived AJCC-7 Stage Grp	Stage/Prognostic Factors	
1129-1131	3	3440	Derived PreRx-7 T	Stage/Prognostic Factors	
1132-1132	1	3442	Derived PreRx-7 T Descrip	Stage/Prognostic Factors	
1133-1135	3	3450	Derived PreRx-7 N	Stage/Prognostic Factors	
1136-1136	1	3452	Derived PreRx-7 N Descrip	Stage/Prognostic Factors	
1137-1139	3	3460	Derived PreRx-7 M	Stage/Prognostic Factors	
1140-1140	1	3462	Derived PreRx-7 M Descrip	Stage/Prognostic Factors	
1141-1143	3	3470	Derived PreRx-7 Stage Grp	Stage/Prognostic Factors	
1144-1146	3	3480	Derived PostRx-7 T	Stage/Prognostic Factors	
1147-1149	3	3482	Derived PostRx-7 N	Stage/Prognostic Factors	
1150-1151	2	3490	Derived PostRx-7 M	Stage/Prognostic Factors	

Column #	Length	Item #	Item Name	Section	Note
1152-1154	3	3492	Derived PostRx-7 Stge Grp	Stage/Prognostic Factors	
1155-1155	1	3010	Derived SS1977	Stage/Prognostic Factors	
1156-1156	1	3020	Derived SS2000	Stage/Prognostic Factors	
1157-1157	1	3600	Derived Neoadjuv Rx Flag	Stage/Prognostic Factors	
1158-1158	1	3030	Derived AJCC--Flag	Stage/Prognostic Factors	
1159-1159	1	3040	Derived SS1977--Flag	Stage/Prognostic Factors	
1160-1160	1	3050	Derived SS2000--Flag	Stage/Prognostic Factors	
1161-1166	6	2937	CS Version Input Current	Stage/Prognostic Factors	
1167-1172	6	2935	CS Version Input Original	Stage/Prognostic Factors	
1173-1178	6	2936	CS Version Derived	Stage/Prognostic Factors	
1179-1179	1	3700	SEER Site-Specific Fact 1	Stage/Prognostic Factors	
1180-1180	1	3702	SEER Site-Specific Fact 2	Stage/Prognostic Factors	
1181-1181	1	3704	SEER Site-Specific Fact 3	Stage/Prognostic Factors	
1182-1182	1	3706	SEER Site-Specific Fact 4	Stage/Prognostic Factors	
1183-1183	1	3708	SEER Site-Specific Fact 5	Stage/Prognostic Factors	
1184-1184	1	3710	SEER Site-Specific Fact 6	Stage/Prognostic Factors	
1185-1185	1	3165	ICD Revision Comorbid	Stage/Prognostic Factors	
1186-1190	5	3110	Comorbid/Complication 1	Stage/Prognostic Factors	
1191-1195	5	3120	Comorbid/Complication 2	Stage/Prognostic Factors	
1196-1200	5	3130	Comorbid/Complication 3	Stage/Prognostic Factors	
1201-1205	5	3140	Comorbid/Complication 4	Stage/Prognostic Factors	
1206-1210	5	3150	Comorbid/Complication 5	Stage/Prognostic Factors	
1211-1215	5	3160	Comorbid/Complication 6	Stage/Prognostic Factors	
1216-1220	5	3161	Comorbid/Complication 7	Stage/Prognostic Factors	
1221-1225	5	3162	Comorbid/Complication 8	Stage/Prognostic Factors	
1226-1230	5	3163	Comorbid/Complication 9	Stage/Prognostic Factors	
1231-1235	5	3164	Comorbid/Complication 10	Stage/Prognostic Factors	
1236-1435	200	1180	Reserved 05	Stage/Prognostic Factors	
1436-1443	8	1260	Date of Initial RX--SEER	Treatment-1st Course	
1444-1445	2	1261	Date of Initial RX Flag	Treatment-1st Course	
1446-1453	8	1270	Date of 1st Crs RX--CoC	Treatment-1st Course	
1454-1455	2	1271	Date of 1st Crs Rx Flag	Treatment-1st Course	
1456-1463	8	1200	RX Date--Surgery	Treatment-1st Course	
1464-1465	2	1201	RX Date--Surgery Flag	Treatment-1st Course	
1466-1473	8	3170	RX Date--Most Defin Surg	Treatment-1st Course	
1474-1475	2	3171	RX Date Mst Defn Srg Flag	Treatment-1st Course	
1476-1483	8	3180	RX Date--Surgical Disch	Treatment-1st Course	

Column #	Length	Item #	Item Name	Section	Note
1484-1485	2	3181	RX Date Surg Disch Flag	Treatment-1st Course	
1486-1493	8	1210	RX Date--Radiation	Treatment-1st Course	
1494-1495	2	1211	RX Date--Radiation Flag	Treatment-1st Course	
1496-1503	8	3220	RX Date--Radiation Ended	Treatment-1st Course	
1504-1505	2	3221	RX Date Rad Ended Flag	Treatment-1st Course	
1506-1513	8	3230	RX Date--Systemic	Treatment-1st Course	
1514-1515	2	3231	RX Date Systemic Flag	Treatment-1st Course	
1516-1523	8	1220	RX Date--Chemo	Treatment-1st Course	
1524-1525	2	1221	RX Date--Chemo Flag	Treatment-1st Course	
1526-1533	8	1230	RX Date--Hormone	Treatment-1st Course	
1534-1535	2	1231	RX Date--Hormone Flag	Treatment-1st Course	
1536-1543	8	1240	RX Date--BRM	Treatment-1st Course	
1544-1545	2	1241	RX Date--BRM Flag	Treatment-1st Course	
1546-1553	8	1250	RX Date--Other	Treatment-1st Course	
1554-1555	2	1251	RX Date--Other Flag	Treatment-1st Course	
1556-1563	8	1280	RX Date--DX/Stg Proc	Treatment-1st Course	
1564-1565	2	1281	RX Date--Dx/Stg Proc Flag	Treatment-1st Course	
1566-1566	1	1285	RX Summ--Treatment Status	Treatment-1st Course	
1567-1568	2	1290	RX Summ--Surg Prim Site	Treatment-1st Course	
1569-1569	1	1292	RX Summ--Scope Reg LN Sur	Treatment-1st Course	
1570-1570	1	1294	RX Summ--Surg Oth Reg/Dis	Treatment-1st Course	
1571-1572	2	1296	RX Summ--Reg LN Examined	Treatment-1st Course	
1573-1573	1	1310	RX Summ--Surgical Approch	Treatment-1st Course	
1574-1574	1	1320	RX Summ--Surgical Margins	Treatment-1st Course	
1575-1575	1	1330	RX Summ--Reconstruct 1st	Treatment-1st Course	
1576-1576	1	1340	Reason for No Surgery	Treatment-1st Course	
1577-1578	2	1350	RX Summ--DX/Stg Proc	Treatment-1st Course	
1579-1579	1	3270	RX Summ--Palliative Proc	Treatment-1st Course	
1580-1580	1	1360	RX Summ--Radiation	Treatment-1st Course	
1581-1581	1	1370	RX Summ--Rad to CNS	Treatment-1st Course	
1582-1582	1	1380	RX Summ--Surg/Rad Seq	Treatment-1st Course	
1583-1584	2	3250	RX Summ--Transplnt/Endocr	Treatment-1st Course	
1585-1586	2	1390	RX Summ--Chemo	Treatment-1st Course	
1587-1588	2	1400	RX Summ--Hormone	Treatment-1st Course	
1589-1590	2	1410	RX Summ--BRM	Treatment-1st Course	
1591-1591	1	1420	RX Summ--Other	Treatment-1st Course	
1592-1592	1	1430	Reason for No Radiation	Treatment-1st Course	

Column #	Length	Item #	Item Name	Section	Note
1593-1594	2	1460	RX Coding System--Current	Treatment-1st Course	
1595-1595	1	1500	First Course Calc Method	Treatment-1st Course	
1596-1600	5	1510	Rad--Regional Dose: CGY	Treatment-1st Course	
1601-1603	3	1520	Rad--No of Treatment Vol	Treatment-1st Course	
1604-1605	2	1540	Rad--Treatment Volume	Treatment-1st Course	
1606-1606	1	1550	Rad--Location of RX	Treatment-1st Course	
1607-1608	2	1570	Rad--Regional RX Modality	Treatment-1st Course	
1609-1610	2	3200	Rad--Boost RX Modality	Treatment-1st Course	
1611-1615	5	3210	Rad--Boost Dose cGy	Treatment-1st Course	
1616-1616	1	1639	RX Summ--Systemic/Sur Seq	Treatment-1st Course	
1617-1618	2	1640	RX Summ--Surgery Type	Treatment-1st Course	
1619-1619	1	3190	Readm Same Hosp 30 Days	Treatment-1st Course	
1620-1621	2	1646	RX Summ--Surg Site 98-02	Treatment-1st Course	
1622-1622	1	1647	RX Summ--Scope Reg 98-02	Treatment-1st Course	
1623-1623	1	1648	RX Summ--Surg Oth 98-02	Treatment-1st Course	
1624-1723	100	1190	Reserved 06	Treatment-1st Course	
1724-1731	8	1660	Subsq RX 2nd Course Date	Treatment-Subsequent & Other	
1732-1733	2	1661	Subsq RX 2ndCrs Date Flag	Treatment-Subsequent & Other	
1734-1744	11	1670	Subsq RX 2nd Course Codes	Treatment-Subsequent & Other	Group
1734-1735	2	1671	Subsq RX 2nd Course Surg	Treatment-Subsequent & Other	Subfield
1736-1736	1	1677	Subsq RX 2nd--Scope LN SU	Treatment-Subsequent & Other	Subfield
1737-1737	1	1678	Subsq RX 2nd--Surg Oth	Treatment-Subsequent & Other	Subfield
1738-1739	2	1679	Subsq RX 2nd--Reg LN Rem	Treatment-Subsequent & Other	Subfield
1740-1740	1	1672	Subsq RX 2nd Course Rad	Treatment-Subsequent & Other	Subfield
1741-1741	1	1673	Subsq RX 2nd Course Chemo	Treatment-Subsequent & Other	Subfield
1742-1742	1	1674	Subsq RX 2nd Course Horm	Treatment-Subsequent & Other	Subfield
1743-1743	1	1675	Subsq RX 2nd Course BRM	Treatment-Subsequent & Other	Subfield
1744-1744	1	1676	Subsq RX 2nd Course Oth	Treatment-Subsequent & Other	Subfield
1745-1752	8	1680	Subsq RX 3rd Course Date	Treatment-Subsequent & Other	
1753-1754	2	1681	Subsq RX 3rdCrs Date Flag	Treatment-Subsequent & Other	
1755-1765	11	1690	Subsq RX 3rd Course Codes	Treatment-Subsequent & Other	Group
1755-1756	2	1691	Subsq RX 3rd Course Surg	Treatment-Subsequent & Other	Subfield
1757-1757	1	1697	Subsq RX 3rd--Scope LN Su	Treatment-Subsequent & Other	Subfield
1758-1758	1	1698	Subsq RX 3rd--Surg Oth	Treatment-Subsequent & Other	Subfield
1759-1760	2	1699	Subsq RX 3rd--Reg LN Rem	Treatment-Subsequent & Other	Subfield
1761-1761	1	1692	Subsq RX 3rd Course Rad	Treatment-Subsequent & Other	Subfield
1762-1762	1	1693	Subsq RX 3rd Course Chemo	Treatment-Subsequent & Other	Subfield

Column #	Length	Item #	Item Name	Section	Note
1763-1763	1	1694	Subsq RX 3rd Course Horm	Treatment-Subsequent & Other	Subfield
1764-1764	1	1695	Subsq RX 3rd Course BRM	Treatment-Subsequent & Other	Subfield
1765-1765	1	1696	Subsq RX 3rd Course Oth	Treatment-Subsequent & Other	Subfield
1766-1773	8	1700	Subsq RX 4th Course Date	Treatment-Subsequent & Other	
1774-1775	2	1701	Subsq RX 4thCrs Date Flag	Treatment-Subsequent & Other	
1776-1786	11	1710	Subsq RX 4th Course Codes	Treatment-Subsequent & Other	Group
1776-1777	2	1711	Subsq RX 4th Course Surg	Treatment-Subsequent & Other	Subfield
1778-1778	1	1717	Subsq RX 4th--Scope LN Su	Treatment-Subsequent & Other	Subfield
1779-1779	1	1718	Subsq RX 4th--Surg Oth	Treatment-Subsequent & Other	Subfield
1780-1781	2	1719	Subsq RX 4th--Reg LN Rem	Treatment-Subsequent & Other	Subfield
1782-1782	1	1712	Subsq RX 4th Course Rad	Treatment-Subsequent & Other	Subfield
1783-1783	1	1713	Subsq RX 4th Course Chemo	Treatment-Subsequent & Other	Subfield
1784-1784	1	1714	Subsq RX 4th Course Horm	Treatment-Subsequent & Other	Subfield
1785-1785	1	1715	Subsq RX 4th Course BRM	Treatment-Subsequent & Other	Subfield
1786-1786	1	1716	Subsq RX 4th Course Oth	Treatment-Subsequent & Other	Subfield
1787-1787	1	1741	Subsq RX--Reconstruct Del	Treatment-Subsequent & Other	
1788-1887	100	1300	Reserved 07	Treatment-Subsequent & Other	
1888-1888	1	1981	Over-ride SS/NodesPos	Edit Overrides/Conversion History/System Admin	
1889-1889	1	1982	Over-ride SS/TNM-N	Edit Overrides/Conversion History/System Admin	
1890-1890	1	1983	Over-ride SS/TNM-M	Edit Overrides/Conversion History/System Admin	
1891-1891	1	1985	Over-ride Acsn/Class/Seq	Edit Overrides/Conversion History/System Admin	
1892-1892	1	1986	Over-ride HospSeq/DxConf	Edit Overrides/Conversion History/System Admin	
1893-1893	1	1987	Over-ride CoC-Site/Type	Edit Overrides/Conversion History/System Admin	
1894-1894	1	1988	Over-ride HospSeq/Site	Edit Overrides/Conversion History/System Admin	
1895-1895	1	1989	Over-ride Site/TNM-StgGrp	Edit Overrides/Conversion History/System Admin	
1896-1896	1	1990	Over-ride Age/Site/Morph	Edit Overrides/Conversion History/System Admin	
1897-1897	1	2000	Over-ride SeqNo/DxConf	Edit Overrides/Conversion History/System Admin	
1898-1898	1	2010	Over-ride Site/Lat/SeqNo	Edit Overrides/Conversion History/System Admin	
1899-1899	1	2020	Over-ride Surg/DxConf	Edit Overrides/Conversion History/System Admin	
1900-1900	1	2030	Over-ride Site/Type	Edit Overrides/Conversion History/System Admin	
1901-1901	1	2040	Over-ride Histology	Edit Overrides/Conversion History/System Admin	
1902-1902	1	2050	Over-ride Report Source	Edit Overrides/Conversion History/System Admin	
1903-1903	1	2060	Over-ride Ill-define Site	Edit Overrides/Conversion History/System Admin	
1904-1904	1	2070	Over-ride Leuk, Lymphoma	Edit Overrides/Conversion History/System Admin	
1905-1905	1	2071	Over-ride Site/Behavior	Edit Overrides/Conversion History/System Admin	
1906-1906	1	2072	Over-ride Site/EOD/DX Dt	Edit Overrides/Conversion History/System Admin	
1907-1907	1	2073	Over-ride Site/Lat/EOD	Edit Overrides/Conversion History/System Admin	

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1908-1908	1	2074	Over-ride Site/Lat/Morph	Edit Overrides/Conversion History/System Admin	
1909-1912	4	1960	Site (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	
1913-1918	6	1970	Morph (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	Group
1913-1916	4	1971	Histology (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	Subfield
1917-1917	1	1972	Behavior (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	Subfield
1918-1918	1	1973	Grade (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	Subfield
1919-1919	1	1980	ICD-O-2 Conversion Flag	Edit Overrides/Conversion History/System Admin	
1920-1929	10	2081	CRC CHECKSUM	Edit Overrides/Conversion History/System Admin	
1930-1930	1	2120	SEER Coding Sys--Current	Edit Overrides/Conversion History/System Admin	
1931-1931	1	2130	SEER Coding Sys--Original	Edit Overrides/Conversion History/System Admin	
1932-1933	2	2140	CoC Coding Sys--Current	Edit Overrides/Conversion History/System Admin	
1934-1935	2	2150	CoC Coding Sys--Original	Edit Overrides/Conversion History/System Admin	
1936-1945	10	2170	Vendor Name	Edit Overrides/Conversion History/System Admin	
1946-1946	1	2180	SEER Type of Follow-Up	Edit Overrides/Conversion History/System Admin	
1947-1948	2	2190	SEER Record Number	Edit Overrides/Conversion History/System Admin	
1949-1950	2	2200	Diagnostic Proc 73-87	Edit Overrides/Conversion History/System Admin	
1951-1958	8	2085	Date Case Initiated	Edit Overrides/Conversion History/System Admin	
1959-1966	8	2090	Date Case Completed	Edit Overrides/Conversion History/System Admin	
1967-1974	8	2092	Date Case Completed--CoC	Edit Overrides/Conversion History/System Admin	
1975-1982	8	2100	Date Case Last Changed	Edit Overrides/Conversion History/System Admin	
1983-1990	8	2110	Date Case Report Exported	Edit Overrides/Conversion History/System Admin	
1991-1998	8	2111	Date Case Report Received	Edit Overrides/Conversion History/System Admin	
1999-2006	8	2112	Date Case Report Loaded	Edit Overrides/Conversion History/System Admin	
2007-2014	8	2113	Date Tumor Record Availbl	Edit Overrides/Conversion History/System Admin	
2015-2015	1	2116	ICD-O-3 Conversion Flag	Edit Overrides/Conversion History/System Admin	
2016-2016	1	3750	Over-ride CS 1	Edit Overrides/Conversion History/System Admin	New
2017-2017	1	3751	Over-ride CS 2	Edit Overrides/Conversion History/System Admin	New
2018-2018	1	3752	Over-ride CS 3	Edit Overrides/Conversion History/System Admin	New
2019-2019	1	3753	Over-ride CS 4	Edit Overrides/Conversion History/System Admin	New
2020-2020	1	3754	Over-ride CS 5	Edit Overrides/Conversion History/System Admin	New
2021-2021	1	3755	Over-ride CS 6	Edit Overrides/Conversion History/System Admin	New
2022-2022	1	3756	Over-ride CS 7	Edit Overrides/Conversion History/System Admin	New
2023-2023	1	3757	Over-ride CS 8	Edit Overrides/Conversion History/System Admin	New
2024-2024	1	3758	Over-ride CS 9	Edit Overrides/Conversion History/System Admin	New
2025-2025	1	3759	Over-ride CS 10	Edit Overrides/Conversion History/System Admin	New
2026-2026	1	3760	Over-ride CS 11	Edit Overrides/Conversion History/System Admin	New
2027-2027	1	3761	Over-ride CS 12	Edit Overrides/Conversion History/System Admin	New

Column #	Length	Item #	Item Name	Section	Note
2028-2028	1	3762	Over-ride CS 13	Edit Overrides/Conversion History/System Admin	New
2029-2029	1	3763	Over-ride CS 14	Edit Overrides/Conversion History/System Admin	New
2030-2030	1	3764	Over-ride CS 15	Edit Overrides/Conversion History/System Admin	New
2031-2031	1	3765	Over-ride CS 16	Edit Overrides/Conversion History/System Admin	New
2032-2032	1	3766	Over-ride CS 17	Edit Overrides/Conversion History/System Admin	New
2033-2033	1	3767	Over-ride CS 18	Edit Overrides/Conversion History/System Admin	New
2034-2034	1	3768	Over-ride CS 19	Edit Overrides/Conversion History/System Admin	New
2035-2035	1	3769	Over-ride CS 20	Edit Overrides/Conversion History/System Admin	New
2036-2115	80	1650	Reserved 08	Edit Overrides/Conversion History/System Admin	Revised
2116-2123	8	1750	Date of Last Contact	Follow-up/Recurrence/Death	
2124-2125	2	1751	Date of Last Contact Flag	Follow-up/Recurrence/Death	
2126-2126	1	1760	Vital Status	Follow-up/Recurrence/Death	
2127-2127	1	1770	Cancer Status	Follow-up/Recurrence/Death	
2128-2128	1	1780	Quality of Survival	Follow-up/Recurrence/Death	
2129-2129	1	1790	Follow-Up Source	Follow-up/Recurrence/Death	
2130-2130	1	1800	Next Follow-Up Source	Follow-up/Recurrence/Death	
2131-2180	50	1810	Addr Current--City	Follow-up/Recurrence/Death	
2181-2182	2	1820	Addr Current--State	Follow-up/Recurrence/Death	
2183-2191	9	1830	Addr Current--Postal Code	Follow-up/Recurrence/Death	
2192-2194	3	1840	County--Current	Follow-up/Recurrence/Death	
2195-2195	1	1850	Unusual Follow-Up Method	Follow-up/Recurrence/Death	
2196-2203	8	1860	Recurrence Date--1st	Follow-up/Recurrence/Death	
2204-2205	2	1861	Recurrence Date--1st Flag	Follow-up/Recurrence/Death	
2206-2207	2	1880	Recurrence Type--1st	Follow-up/Recurrence/Death	
2208-2257	50	1842	Follow-Up Contact--City	Follow-up/Recurrence/Death	
2258-2259	2	1844	Follow-Up Contact--State	Follow-up/Recurrence/Death	
2260-2268	9	1846	Follow-Up Contact--Postal	Follow-up/Recurrence/Death	
2269-2272	4	1910	Cause of Death	Follow-up/Recurrence/Death	
2273-2273	1	1920	ICD Revision Number	Follow-up/Recurrence/Death	
2274-2274	1	1930	Autopsy	Follow-up/Recurrence/Death	
2275-2277	3	1940	Place of Death	Follow-up/Recurrence/Death	
2278-2279	2	1791	Follow-up Source Central	Follow-up/Recurrence/Death	
2280-2287	8	1755	Date of Death--Canada	Follow-up/Recurrence/Death	
2288-2289	2	1756	Date of Death--CanadaFlag	Follow-up/Recurrence/Death	
2290-2339	50	1740	Reserved 09	Follow-up/Recurrence/Death	
2340-3339	1000	2220	State/Requestor Items	Special Use	
3340-3379	40	2230	Name--Last	Patient-Confidential	

Column #	Length	Item #	Item Name	Section	Note
3380-3419	40	2240	Name--First	Patient-Confidential	
3420-3459	40	2250	Name--Middle	Patient-Confidential	
3460-3462	3	2260	Name--Prefix	Patient-Confidential	
3463-3465	3	2270	Name--Suffix	Patient-Confidential	
3466-3505	40	2280	Name--Alias	Patient-Confidential	
3506-3545	40	2390	Name--Maiden	Patient-Confidential	
3546-3605	60	2290	Name--Spouse/Parent	Patient-Confidential	
3606-3616	11	2300	Medical Record Number	Patient-Confidential	
3617-3618	2	2310	Military Record No Suffix	Patient-Confidential	
3619-3627	9	2320	Social Security Number	Patient-Confidential	
3628-3687	60	2330	Addr at DX--No & Street	Patient-Confidential	
3688-3747	60	2335	Addr at DX--Supplementl	Patient-Confidential	
3748-3807	60	2350	Addr Current--No & Street	Patient-Confidential	
3808-3867	60	2355	Addr Current--Supplementl	Patient-Confidential	
3868-3877	10	2360	Telephone	Patient-Confidential	
3878-3883	6	2380	DC State File Number	Patient-Confidential	
3884-3943	60	2394	Follow-Up Contact--Name	Patient-Confidential	
3944-4003	60	2392	Follow-Up Contact--No&St	Patient-Confidential	
4004-4063	60	2393	Follow-Up Contact--Suppl	Patient-Confidential	
4064-4073	10	2352	Latitude	Patient-Confidential	
4074-4084	11	2354	Longitude	Patient-Confidential	
4085-4284	200	1835	Reserved 10	Patient-Confidential	
4285-4294	10	2445	NPI--Following Registry	Hospital-Confidential	
4295-4304	10	2440	Following Registry	Hospital-Confidential	
4305-4314	10	2415	NPI--Inst Referred From	Hospital-Confidential	
4315-4324	10	2410	Institution Referred From	Hospital-Confidential	
4325-4334	10	2425	NPI--Inst Referred To	Hospital-Confidential	
4335-4344	10	2420	Institution Referred To	Hospital-Confidential	
4345-4394	50	1900	Reserved 11	Hospital-Confidential	
4395-4404	10	2465	NPI--Physician--Managing	Other-Confidential	
4405-4412	8	2460	Physician--Managing	Other-Confidential	
4413-4422	10	2475	NPI--Physician--Follow-Up	Other-Confidential	
4423-4430	8	2470	Physician--Follow-Up	Other-Confidential	
4431-4440	10	2485	NPI--Physician--Primary Surg	Other-Confidential	
4441-4448	8	2480	Physician--Primary Surg	Other-Confidential	
4449-4458	10	2495	NPI--Physician 3	Other-Confidential	
4459-4466	8	2490	Physician 3	Other-Confidential	

Column #	Length	Item #	Item Name	Section	Note
4467-4476	10	2505	NPI--Physician 4	Other-Confidential	
4477-4484	8	2500	Physician 4	Other-Confidential	
4485-4534	50	2510	Reserved 12	Other-Confidential	
4535-4559	25	7010	Path Reporting Fac ID 1	Pathology	
4560-4579	20	7090	Path Report Number 1	Pathology	
4580-4593	14	7320	Path Date Spec Collect 1	Pathology	
4594-4595	2	7480	Path Report Type 1	Pathology	
4596-4620	25	7190	Path Ordering Fac No 1	Pathology	
4621-4640	20	7100	Path Order Phys Lic No 1	Pathology	
4641-4665	25	7011	Path Reporting Fac ID 2	Pathology	
4666-4685	20	7091	Path Report Number 2	Pathology	
4686-4699	14	7321	Path Date Spec Collect 2	Pathology	
4700-4701	2	7481	Path Report Type 2	Pathology	
4702-4726	25	7191	Path Ordering Fac No 2	Pathology	
4727-4746	20	7101	Path Order Phys Lic No 2	Pathology	
4747-4771	25	7012	Path Reporting Fac ID 3	Pathology	
4772-4791	20	7092	Path Report Number 3	Pathology	
4792-4805	14	7322	Path Date Spec Collect 3	Pathology	
4806-4807	2	7482	Path Report Type 3	Pathology	
4808-4832	25	7192	Path Ordering Fac No 3	Pathology	
4833-4852	20	7102	Path Order Phys Lic No 3	Pathology	
4853-4877	25	7013	Path Reporting Fac ID 4	Pathology	
4878-4897	20	7093	Path Report Number 4	Pathology	
4898-4911	14	7323	Path Date Spec Collect 4	Pathology	
4912-4913	2	7483	Path Report Type 4	Pathology	
4914-4938	25	7193	Path Ordering Fac No 4	Pathology	
4939-4958	20	7103	Path Order Phys Lic No 4	Pathology	
4959-4983	25	7014	Path Reporting Fac ID 5	Pathology	
4984-5003	20	7094	Path Report Number 5	Pathology	
5004-5017	14	7324	Path Date Spec Collect 5	Pathology	
5018-5019	2	7484	Path Report Type 5	Pathology	
5020-5044	25	7194	Path Ordering Fac No 5	Pathology	
5045-5064	20	7104	Path Order Phys Lic No 5	Pathology	
5065-5564	500	2080	Reserved 13	Pathology	
5565-6564	1000	2520	Text--DX Proc--PE	Text-Diagnosis	
6565-7564	1000	2530	Text--DX Proc--X-ray/Scan	Text-Diagnosis	
7565-8564	1000	2540	Text--DX Proc--Scopes	Text-Diagnosis	

Column #	Length	Item #	Item Name	Section	Note
8565-9564	1000	2550	Text--DX Proc--Lab Tests	Text-Diagnosis	
9565-10564	1000	2560	Text--DX Proc--Op	Text-Diagnosis	
10565-11564	1000	2570	Text--DX Proc--Path	Text-Diagnosis	
11565-11664	100	2580	Text--Primary Site Title	Text-Diagnosis	
11665-11764	100	2590	Text--Histology Title	Text-Diagnosis	
11765-12764	1000	2600	Text--Staging	Text-Diagnosis	
12765-13764	1000	2610	RX Text--Surgery	Text-Treatment	
13765-14764	1000	2620	RX Text--Radiation (Beam)	Text-Treatment	
14765-15764	1000	2630	RX Text--Radiation Other	Text-Treatment	
15765-16764	1000	2640	RX Text--Chemo	Text-Treatment	
16765-17764	1000	2650	RX Text--Hormone	Text-Treatment	
17765-18764	1000	2660	RX Text--BRM	Text-Treatment	
18765-19764	1000	2670	RX Text--Other	Text-Treatment	
19765-20764	1000	2680	Text--Remarks	Text-Miscellaneous	
20765-20824	60	2690	Text--Place of Diagnosis	Text-Miscellaneous	
20825-22824	2000	2210	Reserved 14	Text-Miscellaneous	

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. *Note: Patient identifying data items collected are not transmitted to CDC.*

CoC Refers to requirements of CoC. CoC-approved cancer program registries are required to collect the indicated items in the "Collect" column and are required to report items indicated in the "Transmit" column to the NCDB. Facilities should refer to the CoC *FORDS* manual for further clarification of required fields. Note: Patient identifying data items collected are not transmitted to the NCDB.

SEER Refers to requirements of NCI's SEER Program. Central registries are required to collect the indicated items in the "Collect" column and are required to report the items indicated in the "Transmit" column to NCI-SEER. Facilities and central registries should refer to the *SEER Program Code Manual* for further clarification of required fields.

CCCR Refers to requirements of Canadian Council of Cancer Registries Provincial/Territorial Cancer Registries should refer to the *Canadian Cancer Registry System Guide* 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.

		NPCR	CoC		SEER		CCCR		Exchange Elements			
Item	Item Name	Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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			
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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	

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.

		NPCR	CoC		SEER		CCCR		Exchange Elements			
Item	Item Name	Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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	

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			
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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 Proc1											Retired

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Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements			
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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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Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements			
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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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		NPCR	CoC		SEER		CCCR		Exchange Elements			
Item	Item Name	Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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 Approch	.	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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Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements			
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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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		NPCR	CoC		SEER		CCCR		Exchange Elements			
Item	Item Name	Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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			
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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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		NPCR	CoC		SEER		CCCR		Exchange Elements			
Item	Item Name	Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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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		NPCR	CoC		SEER		CCCR		Exchange Elements			
Item	Item Name	Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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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		NPCR	CoC		SEER		CCCR		Exchange Elements			
Item	Item Name	Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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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Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements			
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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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		NPCR	CoC		SEER		CCCR		Exchange Elements			
Item	Item Name	Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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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Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements			
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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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		NPCR	CoC		SEER		CCCR		Exchange Elements			
Item	Item Name	Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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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Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements			
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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

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		NPCR	CoC		SEER		CCCR		Exchange Elements			
Item	Item Name	Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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	

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Item	Item Name	NPCR	CoC		SEER		CCCR		Exchange Elements			
		Collect	Collect	Transmit	Collect	Transmit	Collect	Transmit	Hosp-> Central	Central-> Central	Source of Standard	Note
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	

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CHAPTER IX:

DATA DESCRIPTOR TABLE (ITEM # ORDER)

The following table presents Version 12.1 of the NAACCR data descriptor table summarizing the item number, item name, format, allowable values, and length of each item. The data type for all data items is "character." Differences from Version 12 are marked "Revised," "New," or "Retired" in the "Note" column of the table. Revised and new items are summarized in Appendix F. A program that generates a file of records in the NAACCR data exchange format should handle instances where information is unavailable for any given field.

General Rules:

- ❖ When ALL of the records in the file to be generated contain no information on a specific data item, then the corresponding columns in the exchange record should be left as blanks.

Example: You are submitting data in NAACCR 12 format, but your registry does not collect data on AJCC stage. The columns in the file you generate that are supposed to contain the information on AJCC stage should all contain blanks.

- ❖ When some of the records contain information for a given field, and other records will not contain information for that field, then the code that indicates "unknown," "not available," or "not applicable" (as appropriate) must be written in the corresponding columns in the exchange record.

Exception: You are submitting data in NAACCR Version 12, for diagnosis years 1995 through 2010. Collaborative staging fields were not defined prior to 2004. Therefore, all cases diagnosed prior to 2004 should have blanks transmitted in the "CS-" fields, unless your data recipient specifically instructs you otherwise.

All "blanks" must be transmitted as the appropriate number of "spaces" (ASCII 20h), never as nulls or as numeric fields with no value assigned. Nulls may shift the record contents out of column alignment, and numeric fields with no value assigned to them erroneously transmit zeroes as code content.

Date fields are recorded in the year, month, day format (YYYYMMDD). The field is fixed-length and left-justified. Any missing component should be replaced by spaces. If there are no known date components, the fixed-length variable will be completely blank. For example:

- `YYYYMMDD` – when complete date is known and valid
- `YYYYMM` – when year and month are known and valid, and day is unknown
- `YYYY` – when year is known and valid, and month and day are unknown
- Blank – when no known date applies

Item #	Item Name	Format	Allowable Values	Length	Note
10	Record Type		I, C, A, U, M, L	1	
20	Patient ID Number	Right justified, zero filled		8	
21	Patient System ID-Hosp	Right justified, zero filled		8	
30	Registry Type		1-3	1	
35	FIN Coding System		1, 2, 9	1	
37	Reserved 00			13	
40	Registry ID	Right justified, zero filled	10-digit number. Reference to EDITS table REGID.DBF in Appendix B	10	
45	NPI--Registry ID		10-digit NPI code (9-digit integer plus 1 check digit), blank	10	
50	NAACCR Record Version		120, 121	3	Revised
60	Tumor Record Number	Right justified, zero filled	01-99	2	
70	Addr at DX--City	Mixed case letters, special characters only as allowed by USPS, embedded spaces allowed, left justified, blank filled	City name or UNKNOWN	50	
80	Addr at DX--State	Upper case	Refer to EDITS table STATE.DBF in Appendix B; CD, US, XX, YY, ZZ	2	
90	County at DX	Right justified, zero filled	See Appendix A for county codes for each state. For non-U.S. residents, CoC uses Appendix B (BPLACE.DBF). Also 998, 999	3	
100	Addr at DX--Postal Code	Numbers or upper case letters. No special characters or embedded spaces allowed. Left justified, blank filled	5-digit or 9-digit U.S. ZIP codes; 6-character Canadian postal codes; valid postal codes from other countries, 888888888, 999999999, 88888+4 blanks (U.S.), 99999+4 blanks (U.S.), 999999+3 blanks (Canada)	9	
110	Census Tract 1970/80/90	Right justified, zero filled	Census Tract Codes 000100-949999, BNA Codes 950100-998999, 000000, 999999, blank	6	
120	Census Cod Sys 1970/80/90		0-3, blank	1	
130	Census Tract 2000	Right justified, zero filled	Census Tract Codes 000100-999998, 000000, 999999, blank	6	
135	Census Tract 2010		Census Tract Codes 000100-999998, 000000, 999999, blank	6	New
140	Census Tract Cod Sys--Alt				Retired
150	Marital Status at DX		1-6, 9	1	Revised
160	Race 1	Right justified, zero filled	01-08, 10-17, 20-22, 25-28, 30-32, 96-99	2	
161	Race 2	Right justified, zero filled	01-08, 10-17, 20-22, 25-28, 30-32, 88, 96-99, blank	2	
162	Race 3	Right justified, zero filled	01-08, 10-17, 20-22, 25-28, 30-32, 88, 96-99, blank	2	

Item #	Item Name	Format	Allowable Values	Length	Note
163	Race 4	Right justified, zero filled	01-08, 10-17, 20-22, 25-28, 30-32, 88, 96-99, blank	2	
164	Race 5	Right justified, zero filled	01-08, 10-17, 20-22, 25-28, 30-32, 88, 96-99, blank	2	
170	Race Coding Sys--Current		1-7, 9	1	
180	Race Coding Sys--Original		1-7, 9	1	
190	Spanish/Hispanic Origin		0-8, 9	1	
191	NHIA Derived Hisp Origin		0-8, blank	1	
192	IHS Link		0, 1, blank	1	
193	Race--NAPIIA(derived API)	Right justified, zero filled	01-08, 10-17, 20-22, 25-28, 30-32, 96, 99, blank	2	
200	Computed Ethnicity		0-7, blank	1	
210	Computed Ethnicity Source		0-9, blank	1	
220	Sex		1-4, 9	1	
230	Age at Diagnosis	Right justified, zero filled	000-120, 999	3	
240	Date of Birth	YYYYMMDD	Valid date	8	
241	Date of Birth Flag		10-20, blank	2	
250	Birthplace	Right justified, zero filled	Reference to EDITS table BPLACE.DBF in Appendix B	3	
260	Religion				Retired
270	Occupation Code--Census	Right justified, zero filled	Reference *Industry and Occupation Coding for Death Certificates*	3	
280	Industry Code--Census	Right justified, zero filled	Reference *Industry and Occupation Coding for Death Certificates*	3	
290	Occupation Source		0-3, 7-9, blank	1	
300	Industry Source		0-3, 7-9, blank	1	
310	Text--Usual Occupation	Free text	Neither carriage return nor line feed characters allowed	100	
320	Text--Usual Industry	Free text	Neither carriage return nor line feed characters allowed	100	
330	Occup/Ind Coding System		1-4, 7, 9, blank	1	
340	Tobacco History				Retired
350	Alcohol History				Retired
360	Family History of Cancer				Retired
362	Census Block Group 2000		0-9, blank	1	
363	Census Block Group 2010		0-9, blank	1	New
364	Census Tr Cert 1970/80/90		1-6, 9, blank	1	
365	Census Tr Certainty 2000		1-6, 9, blank	1	
366	GIS Coordinate Quality		00-12, 98, 99, blank	2	
367	Census Tr Certainty 2010		1-6, 9, blank	1	New
368	CensusBlockGroup 70/80/90		0-9, blank	1	
370	Reserved 01			37	
380	Sequence Number--Central	Right justified, zero filled	00-59, 60-87, 88, 98, 99	2	
390	Date of Diagnosis	YYYYMMDD	Valid date	8	
391	Date of Diagnosis Flag		10-20, blank	2	
400	Primary Site	C followed by 3 digits, no special characters, no embedded blanks	Refer to ICD-O-3 (decimals are dropped)	4	

Item #	Item Name	Format	Allowable Values	Length	Note
410	Laterality		0-5, 9	1	
419	Morph--Type&Behav ICD-O-2		Reference to ICD-0-2	5	
420	Histology (92-00) ICD-O-2		8000-9989, Refer to ICD-0-2	4	
430	Behavior (92-00) ICD-O-2		0-3, Refer to ICD-0-2	1	
439	Date of Mult Tumors Flag		10-20, blank	2	
440	Grade		1-9	1	
441	Grade Path Value		1-4, blank	1	
442	Ambiguous Terminology DX		0-2, 9	1	
443	Date of Conclusive DX	YYYYMMDD	Valid date	8	
444	Mult Tum Rpt as One Prim		00, 10-12, 20, 30-32, 40, 80, 88, 99	2	
445	Date of Multiple Tumors	YYYYMMDD	Valid date	8	
446	Multiplicity Counter		00-89, 99, blank	2	Revised
447	Number of Tumors/Hist				Retired
448	Date Conclusive DX Flag		10-20, blank	2	
449	Grade Path System		2-4, blank	1	
450	Site Coding Sys--Current		1-6, 9	1	
460	Site Coding Sys--Original		1-6, 9	1	
470	Morph Coding Sys--Current		1-9	1	
480	Morph Coding Sys--Originl		1-9	1	
490	Diagnostic Confirmation		1-9	1	
500	Type of Reporting Source		1-8	1	
501	Casefinding Source		10, 20-30, 40, 50, 60, 70, 75, 80, 85, 90, 95, 99	2	
510	Screening Date				Retired
520	Screening Result				Retired
521	Morph--Type&Behav ICD-O-3		Refer to ICD-O-3	5	
522	Histologic Type ICD-O-3		8000-9989, Refer to ICD-O-3	4	
523	Behavior Code ICD-O-3		0-3, Refer to ICD-O-3	1	
530	Reserved 02			92	Revised
538	Reporting Hospital FAN				Retired
540	Reporting Facility	Right justified, zero filled	10-digit number	10	
545	NPI--Reporting Facility		10-digit NPI code (9-digit NPI integer plus 1 check digit), blank	10	
550	Accession Number--Hosp		9-digit number	9	
560	Sequence Number--Hospital	Right justified, zero filled	00-59, 60-87, 88, 99	2	
570	Abstracted By	No special characters	Letters and numbers	3	
580	Date of 1st Contact	YYYYMMDD	Valid dates	8	
581	Date of 1st Contact Flag		10-20, blank	2	
590	Date of Inpatient Adm	YYYYMMDD	Valid dates	8	
591	Date of Inpt Adm Flag		10-20, blank	2	
600	Date of Inpatient Disch	YYYYMMDD	Valid dates	8	
601	Date of Inpt Disch Flag		10-20, blank	2	
605	Inpatient Status		0,1,9, blank	1	Revised
610	Class of Case		00, 10-14, 20-22, 30-38, 40-43, 49, 99	2	
620	Year First Seen This CA				Retired
630	Primary Payer at DX	Right justified, zero filled	01, 02, 10, 20, 21, 31, 35, 60-68, 99	2	

Item #	Item Name	Format	Allowable Values	Length	Note
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		0-5, 9	1	
670	RX Hosp--Surg Prim Site	Right justified, zero filled	00, 10-80, 90, 98, 99 (site-specific)	2	
672	RX Hosp--Scope Reg LN Sur		0-7, 9	1	
674	RX Hosp--Surg Oth Reg/Dis		0-5, 9	1	
676	RX Hosp--Reg LN Removed		00-90, 95-99	2	
678	RX Hosp--Surg Timing				Retired
680	Reserved 03			100	
690	RX Hosp--Radiation		0-5, 9	1	Revised
700	RX Hosp--Chemo	Right justified, zero filled	00-03, 82, 85-88, 99	2	
710	RX Hosp--Hormone	Right justified, zero filled	00, 01, 82, 85-88, 99	2	
720	RX Hosp--BRM	Right justified, zero filled	00, 01, 82, 85-88, 99	2	
730	RX Hosp--Other		0-3, 6-9	1	
740	RX Hosp--DX/Stg Proc	Right justified, zero filled	00-07, 09	2	
742	RX Hosp--Screen/BX Proc1				Retired
743	RX Hosp--Screen/BX Proc2				Retired
744	RX Hosp--Screen/BX Proc3				Retired
745	RX Hosp--Screen/BX Proc4				Retired
746	RX Hosp--Surg Site 98-02	Right justified, zero filled	00, 10-90, 99 (site-specific), blank	2	
747	RX Hosp--Scope Reg 98-02		0-9 (site-specific), blank	1	
748	RX Hosp--Surg Oth 98-02		0-9 (site-specific), blank	1	
750	Reserved 04			100	
759	SEER Summary Stage 2000		0-5, 7, 8, 9	1	
760	SEER Summary Stage 1977		0-5, 7, 8, 9	1	
770	Loc/Reg/Distant Stage				Retired
779	Extent of Disease 10-Dig			12	
780	EOD--Tumor Size	Right justified, zero filled	See respective source references	3	
790	EOD--Extension	Right justified, zero filled	Reference *SEER Extent of Disease* manual	2	
800	EOD--Extension Prost Path	Right justified, zero filled	Reference *SEER Extent of Disease* manual	2	
810	EOD--Lymph Node Involv		Reference *SEER Extent of Disease* manual	1	
820	Regional Nodes Positive	Right justified, zero filled	00-90, 95, 97-99	2	
830	Regional Nodes Examined	Right justified, zero filled	00-90, 95-99	2	
840	EOD--Old 13 Digit	Numeric and special characters		13	
850	EOD--Old 2 Digit	Numeric plus special characters "&" and "dash" ("-")		2	
860	EOD--Old 4 Digit			4	
870	Coding System for EOD		0-4, Blank	1	
880	TNM Path T	Upper case, alphanumeric, left justified, blank filled	See *AJCC Cancer Staging Manual* and *FORDS* manual; also 88, blank	4	
890	TNM Path N	Upper case, alphanumeric, left justified, blank filled	See *AJCC Cancer Staging Manual* and *FORDS* manual; also 88, blank	4	

Item #	Item Name	Format	Allowable Values	Length	Note
900	TNM Path M	Upper case, alphanumeric, left justified, blank filled	See *AJCC Cancer Staging Manual* and *FORDS* Manual; also 88, blank	4	
910	TNM Path Stage Group	Upper case, alphanumeric. Convert AJCC Roman numerals to Arabic numerals. Left justified, blank filled	See *AJCC Cancer Staging Manual* and *FORDS* Manual; also 88, 99	4	
920	TNM Path Descriptor		0-6, 9	1	
930	TNM Path Staged By		0-9	1	
940	TNM Clin T	Upper case, alphanumeric, left justified, blank filled	See *AJCC Cancer Staging Manual* and *FORDS* Manual; also 88, blank	4	
950	TNM Clin N	Upper case, alphanumeric, left justified, blank filled	See *AJCC Cancer Staging Manual* and *FORDS* Manual; also 88, blank	4	
960	TNM Clin M	Upper case, alphanumeric, left justified, blank filled	See *AJCC Cancer Staging Manual* and *FORDS* Manual; also 88, blank	4	
970	TNM Clin Stage Group	Upper case, alphanumeric. Convert AJCC Roman numerals to Arabic numerals. Left justified, blank filled	See *AJCC Cancer Staging Manual* and *FORDS* Manual; also 88, 99, blank	4	
980	TNM Clin Descriptor		0-3, 5, 9	1	Revised
990	TNM Clin Staged By		0-9	1	
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	Right justified, zero filled	00-07, 88, 99	2	
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	Alphanumeric	Refer to *ROADS Manual*	2	
1130	Pediatric Staging System		00-15, 88, 97, 99	2	
1140	Pediatric Staged By		0-9	1	
1150	Tumor Marker 1		0-6, 8, 9	1	
1160	Tumor Marker 2		0-6, 8, 9	1	
1170	Tumor Marker 3		0-6, 8, 9	1	
1180	Reserved 05			200	
1182	Lymph-vascular Invasion		0,1,8,9	1	
1190	Reserved 06			100	
1200	RX Date--Surgery	YYYYMMDD	Valid dates	8	
1201	RX Date--Surgery Flag		10-20, blank	2	
1210	RX Date--Radiation	YYYYMMDD	Valid dates	8	
1211	RX Date--Radiation Flag		10-20, blank	2	
1220	RX Date--Chemo	YYYYMMDD	Valid dates	8	
1221	RX Date--Chemo Flag		10-20, blank	2	
1230	RX Date--Hormone	YYYYMMDD	Valid dates	8	
1231	RX Date--Hormone Flag		10-20, blank	2	
1240	RX Date--BRM	YYYYMMDD	Valid dates	8	
1241	RX Date--BRM Flag		10-20, blank	2	

Item #	Item Name	Format	Allowable Values	Length	Note
1250	RX Date--Other	YYYYMMDD	Valid dates	8	
1251	RX Date--Other Flag		10-20, blank	2	
1260	Date of Initial RX--SEER	YYYYMMDD	Valid dates, blank	8	
1261	Date of Initial RX Flag		10-20, blank	2	
1270	Date of 1st Crs RX--CoC	YYYYMMDD	Valid dates	8	
1271	Date of 1st Crs Rx Flag		10-20, blank	2	
1280	RX Date--DX/Stg Proc	YYYYMMDD	Valid dates	8	
1281	RX Date--Dx/Stg Proc Flag		10-20, blank	2	
1285	RX Summ--Treatment Status		0-2, 9	1	
1290	RX Summ--Surg Prim Site	Right justified, zero filled	00, 10-80, 90, 98, 99 (site-specific)	2	
1292	RX Summ--Scope Reg LN Sur		0-7, 9	1	
1294	RX Summ--Surg Oth Reg/Dis		0-5, 9	1	
1296	RX Summ--Reg LN Examined	Right justified, zero filled	00-90, 95-99	2	
1300	Reserved 07			100	
1310	RX Summ--Surgical Approch		0-9 (site-specific)	1	
1320	RX Summ--Surgical Margins		0-3, 7-9	1	
1330	RX Summ--Reconstruct 1st		0-9 (site-specific)	1	
1340	Reason for No Surgery		0-2, 5-9	1	
1350	RX Summ--DX/Stg Proc	Right justified, zero filled	00-07, 09	2	
1360	RX Summ--Radiation		0-9	1	
1370	RX Summ--Rad to CNS		0, 1, 7-9	1	
1380	RX Summ--Surg/Rad Seq		0, 2-6, 9	1	
1390	RX Summ--Chemo	Right justified, zero filled	00-03, 82, 85-88, 99	2	
1400	RX Summ--Hormone	Right justified, zero filled	00, 01, 82, 85-88, 99	2	
1410	RX Summ--BRM	Right justified, zero filled	00, 01, 82, 85-88, 99	2	
1420	RX Summ--Other		0-3, 6-9	1	
1430	Reason for No Radiation		0-2, 5-9	1	
1440	Reason for No Chemo				Retired
1450	Reason for No Hormone				Retired
1460	RX Coding System--Current	Right justified, zero filled	00-07, 99	2	
1470	Protocol Eligibility Stat				Retired
1480	Protocol Participation				Retired
1490	Referral to Support Serv				Retired
1500	First Course Calc Method		1, 2, 9	1	
1510	Rad--Regional Dose: CGY	Right justified, zero filled	00000-99999	5	
1520	Rad--No of Treatment Vol	Right justified, zero filled	000-999	3	
1530	Rad--Elapsed RX Days				Retired
1540	Rad--Treatment Volume	Right justified, zero filled	00-41, 50, 60, 98, 99	2	
1550	Rad--Location of RX		0-4, 8, 9	1	
1560	Rad--Intent of Treatment				Retired
1570	Rad--Regional RX Modality	Right justified, zero filled	00, 20-32, 40-43, 50-55, 60-62, 80, 85, 98, 99	2	
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		0, 2-6, 9	1	

Item #	Item Name	Format	Allowable Values	Length	Note
1640	RX Summ--Surgery Type	Right justified, zero filled	00-99 (site-specific)	2	
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	Right justified, zero filled	00, 10-90, 99 (site-specific), blank	2	
1647	RX Summ--Scope Reg 98-02		0-9 (site-specific), blank	1	
1648	RX Summ--Surg Oth 98-02		0-9 (site-specific), blank	1	
1650	Reserved 08			80	Revised
1660	Subsq RX 2nd Course Date	YYYYMMDD	Valid dates	8	
1661	Subsq RX 2ndCrs Date Flag		10-20, blank	2	
1670	Subsq RX 2nd Course Codes			11	
1671	Subsq RX 2nd Course Surg	Right justified, zero filled	00, 10-90, 99	2	
1672	Subsq RX 2nd Course Rad		0-5, 9	1	
1673	Subsq RX 2nd Course Chemo		0-3, 9	1	
1674	Subsq RX 2nd Course Horm		0-3, 9	1	
1675	Subsq RX 2nd Course BRM		0-9	1	
1676	Subsq RX 2nd Course Oth		0-3, 6-9	1	
1677	Subsq RX 2nd--Scope LN SU		0-9	1	
1678	Subsq RX 2nd--Surg Oth		0-9	1	
1679	Subsq RX 2nd--Reg LN Rem	Right justified, zero filled	00-90, 95-99	2	
1680	Subsq RX 3rd Course Date	YYYYMMDD	Valid dates	8	
1681	Subsq RX 3rdCrs Date Flag		10-20, blank	2	
1690	Subsq RX 3rd Course Codes			11	
1691	Subsq RX 3rd Course Surg	Right justified, zero filled	00, 10-90, 99	2	
1692	Subsq RX 3rd Course Rad		0-5, 9	1	
1693	Subsq RX 3rd Course Chemo		0-3, 9	1	
1694	Subsq RX 3rd Course Horm		0-3, 9	1	
1695	Subsq RX 3rd Course BRM		0-9	1	
1696	Subsq RX 3rd Course Oth		0-3, 6-9	1	
1697	Subsq RX 3rd--Scope LN Su		0-9	1	
1698	Subsq RX 3rd--Surg Oth		0-9	1	
1699	Subsq RX 3rd--Reg LN Rem	Right justified, zero filled	00-90, 95-99	2	
1700	Subsq RX 4th Course Date	YYYYMMDD	Valid dates	8	
1701	Subsq RX 4thCrs Date Flag		10-20, blank	2	
1710	Subsq RX 4th Course Codes			11	
1711	Subsq RX 4th Course Surg	Right justified, zero filled	00, 10-90, 99	2	
1712	Subsq RX 4th Course Rad		0-5, 9	1	
1713	Subsq RX 4th Course Chemo		0-3, 9	1	
1714	Subsq RX 4th Course Horm		0-3, 9	1	
1715	Subsq RX 4th Course BRM		0-9	1	
1716	Subsq RX 4th Course Oth		0-3, 6-9	1	
1717	Subsq RX 4th--Scope LN Su		0-9	1	
1718	Subsq RX 4th--Surg Oth		0-9	1	
1719	Subsq RX 4th--Reg LN Rem	Right justified, zero filled	00-90, 95-99	2	
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

Item #	Item Name	Format	Allowable Values	Length	Note
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			50	
1741	Subsq RX--Reconstruct Del		Site-specific	1	
1750	Date of Last Contact	YYYYMMDD	Valid dates	8	
1751	Date of Last Contact Flag		10-20, blank	2	
1755	Date of Death--Canada	YYYYMMDD	Valid Dates	8	
1756	Date of Death--CanadaFlag		10-20, blank	2	
1760	Vital Status		0, 1, 4	1	
1770	Cancer Status		1, 2, 9	1	
1780	Quality of Survival		0-4, 8, 9	1	
1790	Follow-Up Source		0-5, 7-9	1	
1791	Follow-up Source Central		00-12, 29-35, 39-43, 48-51, 59-65, 98, 99	2	
1800	Next Follow-Up Source		0-5, 8, 9	1	
1810	Addr Current--City	Mixed case letters, special characters only as allowed by USPS, embedded spaces allowed, left justified, blank filled	City name or UNKNOWN	50	
1820	Addr Current--State	See EDITS table STATE.DBF in Appendix B; CD, US, XX, YY, ZZ		2	
1830	Addr Current--Postal Code	Numbers or upper case letters. No special characters or embedded spaces allowed. Left justified, blank filled.	5-digit or 9-digit U.S. ZIP codes; 6- character Canadian postal codes; valid postal codes from other countries, 888888888, 999999999, 88888+4 blanks (U.S.), 99999+4 blanks (U.S.), 999999+3 blanks (Canada)	9	
1835	Reserved 10			200	
1840	County--Current	Right justified, zero filled	See Appendix A for standard FIPS county codes. See EDITS table BPLACE.DBF in Appendix B for geocodes used by CoC for non-U.S. residents. Also 998, 999	3	
1842	Follow-Up Contact--City	Mixed case letters, special characters only as allowed by USPS, embedded spaces allowed, left justified, blank filled	City name or UNKNOWN	50	
1844	Follow-Up Contact--State	Upper case	See EDITS table STATE.DBF in Appendix B	2	
1846	Follow-Up Contact--Postal	Numbers or upper case letters. No special characters or embedded spaces allowed. Left justified, blank filled	5-digit or 9-digit U.S. ZIP codes; 6- character Canadian postal codes; valid postal codes from other countries, 888888888, 999999999, 88888+4 blanks (U.S.), 99999+4 blanks (U.S.), 999999+3 blanks (Canada)	9	
1850	Unusual Follow-Up Method		0-9	1	

Item #	Item Name	Format	Allowable Values	Length	Note
1860	Recurrence Date--1st	YYYYMMDD	Valid dates	8	
1861	Recurrence Date--1st Flag		10-20, blank	2	
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	Right justified, zero filled	00, 04, 06, 10, 13-17, 20-22, 25-27, 30, 36, 40, 46, 51-60, 62, 70, 88, 99	2	
1890	Recurrence Type--1st--Oth				Retired
1900	Reserved 11			50	
1910	Cause of Death	4 digits (for ICD-7, 8, 9); for ICD-10, upper case letter followed by 3 digits or upper case followed by 2 digits plus blank	Valid ICD-7, ICD-8, ICD-9, and ICD-10 codes; also 0000, 7777, 7797	4	
1920	ICD Revision Number		0, 1, 7, 8, 9	1	
1930	Autopsy		0-2, 9	1	
1940	Place of Death	Right justified, zero filled	Reference SEER Manual	3	
1960	Site (73-91) ICD-O-1	Four digits, first digit equals 1. Reference ICD-O-1 for valid entries	1400-1999	4	
1970	Morph (73-91) ICD-O-1		Reference ICD-O-1 for valid entries	6	
1971	Histology (73-91) ICD-O-1	Reference ICD-O-1 for valid entries	8000-9970	4	
1972	Behavior (73-91) ICD-O-1		Reference ICD-O-1 for valid entries	1	
1973	Grade (73-91) ICD-O-1		Reference ICD-O-1 for valid entries	1	
1980	ICD-O-2 Conversion Flag		0-6, blank	1	
1981	Over-ride SS/NodesPos		1 or blank	1	
1982	Over-ride SS/TNM-N		1 or blank	1	
1983	Over-ride SS/TNM-M		1 or blank	1	
1984	Over-ride SS/DisMet1				Retired
1985	Over-ride Acsn/Class/Seq		1 or blank	1	
1986	Over-ride HospSeq/DxConf		1 or blank	1	
1987	Over-ride CoC-Site/Type		1 or blank	1	
1988	Over-ride HospSeq/Site		1 or blank	1	
1989	Over-ride Site/TNM-StgGrp		1 or blank	1	
1990	Over-ride Age/Site/Morph		1-3 or blank	1	
2000	Over-ride SeqNo/DxConf		1 or blank	1	
2010	Over-ride Site/Lat/SeqNo		1 or blank	1	
2020	Over-ride Surg/DxConf		1 or blank	1	
2030	Over-ride Site/Type		1 or blank	1	
2040	Over-ride Histology		1-3 or blank	1	
2050	Over-ride Report Source		1 or blank	1	
2060	Over-ride Ill-define Site		1 or blank	1	
2070	Over-ride Leuk, Lymphoma		1 or blank	1	
2071	Over-ride Site/Behavior		1 or blank	1	
2072	Over-ride Site/EOD/DX Dt		1 or blank	1	
2073	Over-ride Site/Lat/EOD		1 or blank	1	
2074	Over-ride Site/Lat/Morph		1 or blank	1	
2080	Reserved 13			500	
2081	CRC CHECKSUM		Calculated or blank	10	
2085	Date Case Initiated	YYYYMMDD		8	

Item #	Item Name	Format	Allowable Values	Length	Note
2090	Date Case Completed	YYYYMMDD		8	
2092	Date Case Completed--CoC	YYYYMMDD		8	
2100	Date Case Last Changed	YYYYMMDD		8	
2110	Date Case Report Exported	YYYYMMDD		8	
2111	Date Case Report Received	YYYYMMDD		8	
2112	Date Case Report Loaded	YYYYMMDD		8	
2113	Date Tumor Record Availbl	YYYYMMDD		8	
2114	Future Use Timeliness 1				Retired
2115	Future Use Timeliness 2				Retired
2116	ICD-O-3 Conversion Flag		Blank, 0, 1, 3	1	
2120	SEER Coding Sys--Current		Alphanumeric	1	Revised
2130	SEER Coding Sys--Original		Alphanumeric	1	Revised
2140	CoC Coding Sys--Current	Right justified, zero filled	00-08, 99	2	
2150	CoC Coding Sys--Original	Right justified, zero filled	00-08, 99	2	
2160	Subsq Report for Primary				Retired
2170	Vendor Name			10	
2180	SEER Type of Follow-Up		1-4	1	
2190	SEER Record Number	Right justified, zero filled	01-99	2	
2200	Diagnostic Proc 73-87			2	
2210	Reserved 14			2000	
2220	State/Requestor Items			1000	
2230	Name--Last			40	
2240	Name--First			40	
2250	Name--Middle			40	
2260	Name--Prefix			3	
2270	Name--Suffix			3	
2280	Name--Alias			40	
2290	Name--Spouse/Parent			60	
2300	Medical Record Number	Leading spaces, right justified	Alphanumeric	11	
2310	Military Record No Suffix	Right justified, zero filled	01-20, 30-69, 98, 99, blank	2	
2320	Social Security Number	9 digits, no dashes	Any 9-digit number except 000000000	9	
2330	Addr at DX--No & Street	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled	Valid address or UNKNOWN	60	
2335	Addr at DX--Supplementl	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled	Valid address or blank	60	
2350	Addr Current--No & Street	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		60	
2352	Latitude	Right justified	Numbers, decimal point, negative sign	10	
2354	Longitude	Right justified	Numbers, decimal point, negative sign	11	
2355	Addr Current--Supplementl	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		60	
2360	Telephone	10-digit number	Any 10-digit number	10	
2370	DC State				Retired
2380	DC State File Number		Any characters or blank	6	
2390	Name--Maiden			40	

Item #	Item Name	Format	Allowable Values	Length	Note
2392	Follow-Up Contact--No&St	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		60	
2393	Follow-Up Contact--Suppl	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		60	
2394	Follow-Up Contact--Name			60	
2400	Reserved 16			1	
2410	Institution Referred From	Right justified and zero filled	10-digit number	10	
2415	NPI--Inst Referred From		10-digit NPI code (9-digit NPI integer plus 1 check digit), blank	10	
2420	Institution Referred To	Right justified and zero filled	10-digit number	10	
2425	NPI--Inst Referred To		10-digit NPI code (9-digit NPI integer plus 1 check digit), blank	10	
2430	Last Follow-Up Hospital				Retired
2440	Following Registry	Right justified and zero filled	10-digit number	10	
2445	NPI--Following Registry		10-digit NPI code (9-digit NPI integer plus 1 check digit), blank	10	
2450	Reserved 17				
2460	Physician--Managing	Left justified		8	
2465	NPI--Physician--Managing		10-digit NPI code (9-digit NPI integer plus 1 check digit), blank	10	
2470	Physician--Follow-Up	Left justified		8	
2475	NPI--Physician--Follow-Up		10-digit NPI codes (9-digit NPI integer plus 1 check digit), blank	10	
2480	Physician--Primary Surg	Left justified		8	
2485	NPI--Physician--Primary Surg		10-digit NPI code (9-digit NPI integer plus 1 check digit), blank	10	
2490	Physician 3	Left justified		8	
2495	NPI--Physician 3		10-digit NPI code (9-digit NPI integer plus 1 check digit), blank	10	
2500	Physician 4	Left justified		8	
2505	NPI--Physician 4		10-digit NPI code (9-digit NPI integer plus 1 check digit), blank	10	
2510	Reserved 12			50	
2520	Text--DX Proc--PE	Free text	Neither carriage return nor line feed characters allowed	1000	
2530	Text--DX Proc--X-ray/Scan	Free text	Neither carriage return nor line feed characters allowed	1000	
2540	Text--DX Proc--Scopes	Free text	Neither carriage return nor line feed characters allowed	1000	
2550	Text--DX Proc--Lab Tests	Free text	Neither carriage return nor line feed characters allowed	1000	
2560	Text--DX Proc--Op	Free text	Neither carriage return nor line feed characters allowed	1000	

Item #	Item Name	Format	Allowable Values	Length	Note
2570	Text--DX Proc--Path	Free text	Neither carriage return nor line feed characters allowed	1000	
2580	Text--Primary Site Title	Free text	Neither carriage return nor line feed characters allowed	100	
2590	Text--Histology Title	Free text	Neither carriage return nor line feed characters allowed	100	
2600	Text--Staging	Free text	Neither carriage return nor line feed characters allowed	1000	
2610	RX Text--Surgery	Free text	Neither carriage return nor line feed characters allowed	1000	
2620	RX Text--Radiation (Beam)	Free text	Neither carriage return nor line feed characters allowed	1000	
2630	RX Text--Radiation Other	Free text	Neither carriage return nor line feed characters allowed	1000	
2640	RX Text--Chemo	Free text	Neither carriage return nor line feed characters allowed	1000	
2650	RX Text--Hormone	Free text	Neither carriage return nor line feed characters allowed	1000	
2660	RX Text--BRM	Free text	Neither carriage return nor line feed characters allowed	1000	
2670	RX Text--Other	Free text	Neither carriage return nor line feed characters allowed	1000	
2680	Text--Remarks	Free text	Neither carriage return nor line feed characters allowed	1000	
2690	Text--Place of Diagnosis	Free text	Neither carriage return nor line feed characters allowed	60	
2730	CS PreRx Tumor Size		000-999 (site-specific)	3	
2735	CS PreRx Extension		000-999 (site-specific)	3	
2740	CS PreRx Tum Sz/Ext Eval		0-9 (site-specific)	1	
2750	CS PreRx Lymph Nodes		000-999 (site-specific)	3	
2755	CS PreRx Reg Nodes Eval		0-9 (site-specific)	1	
2760	CS PreRx Mets at DX		00-99 (site-specific)	2	
2765	CS PreRx Mets Eval		0-9 (site-specific)	1	
2770	CS PostRx Tumor Size		000-999 (site-specific)	3	
2775	CS PostRx Extension		000-999 (site-specific)	3	
2780	CS PostRx Lymph Nodes		000-999 (site-specific)	3	
2785	CS PostRx Mets at DX		00-99 (site-specific)	2	
2800	CS Tumor Size	Right justified, zero filled	000-999 (site-specific)	3	
2810	CS Extension	Right justified, zero filled	000-999 (site-specific)	3	
2820	CS Tumor Size/Ext Eval		0-9 (site-specific)	1	
2830	CS Lymph Nodes	Right justified, zero filled	000-999 (site-specific)	3	
2840	CS Lymph Nodes Eval		0-9 (site-specific)	1	
2850	CS Mets at DX	Right justified, zero filled	00-99 (site-specific)	2	
2851	CS Mets at Dx-Bone		0, 1, 8, 9	1	

Item #	Item Name	Format	Allowable Values	Length	Note
2852	CS Mets at Dx-Brain		0, 1, 8, 9	1	
2853	CS Mets at Dx-Liver		0, 1, 8, 9	1	
2854	CS Mets at Dx-Lung		0, 1, 8, 9	1	
2860	CS Mets Eval		0-9 (site-specific)	1	
2861	CS Site-Specific Factor 7	Right justified, zero filled	000-999 (site-specific)	3	
2862	CS Site-Specific Factor 8	Right justified, zero filled	000-999 (site-specific)	3	
2863	CS Site-Specific Factor 9	Right justified, zero filled	000-999 (site-specific)	3	
2864	CS Site-Specific Factor10	Right justified, zero filled	000-999 (site-specific)	3	
2865	CS Site-Specific Factor11	Right justified, zero filled	000-999 (site-specific)	3	
2866	CS Site-Specific Factor12	Right justified, zero filled	000-999 (site-specific)	3	
2867	CS Site-Specific Factor13	Right justified, zero filled	000-999 (site-specific)	3	
2868	CS Site-Specific Factor14	Right justified, zero filled	000-999 (site-specific)	3	
2869	CS Site-Specific Factor15	Right justified, zero filled	000-999 (site-specific)	3	
2870	CS Site-Specific Factor16	Right justified, zero filled	000-999 (site-specific)	3	
2871	CS Site-Specific Factor17	Right justified, zero filled	000-999 (site-specific)	3	
2872	CS Site-Specific Factor18	Right justified, zero filled	000-999 (site-specific)	3	
2873	CS Site-Specific Factor19	Right justified, zero filled	000-999 (site-specific)	3	
2874	CS Site-Specific Factor20	Right justified, zero filled	000-999 (site-specific)	3	
2875	CS Site-Specific Factor21	Right justified, zero filled	000-999 (site-specific)	3	
2876	CS Site-Specific Factor22	Right justified, zero filled	000-999 (site-specific)	3	
2877	CS Site-Specific Factor23	Right justified, zero filled	000-999 (site-specific)	3	
2878	CS Site-Specific Factor24	Right justified, zero filled	000-999 (site-specific)	3	
2879	CS Site-Specific Factor25	Right justified, zero filled	000-999 (site-specific)	3	
2880	CS Site-Specific Factor 1	Right justified, zero filled	000-999 (site-specific)	3	
2890	CS Site-Specific Factor 2	Right justified, zero filled	000-999 (site-specific)	3	
2900	CS Site-Specific Factor 3	Right justified, zero filled	000-999 (site-specific)	3	
2910	CS Site-Specific Factor 4	Right justified, zero filled	000-999 (site-specific)	3	
2920	CS Site-Specific Factor 5	Right justified, zero filled	000-999 (site-specific)	3	
2930	CS Site-Specific Factor 6	Right justified, zero filled	000-999 (site-specific)	3	
2935	CS Version Input Original	6-digit number	Any 6-digit number	6	
2936	CS Version Derived	6-digit number	Any 6-digit number	6	
2937	CS Version Input Current			6	
2940	Derived AJCC-6 T		site-specific (derived from Collaborative Stage fields), blank	2	
2950	Derived AJCC-6 T Descript		c, p, a, y, N, and blank (derived from Collaborative Stage fields)	1	
2960	Derived AJCC-6 N		site-specific (derived from Collaborative Stage fields), blank	2	
2970	Derived AJCC-6 N Descript		c, p, a, y, N, and blank (derived from Collaborative Stage fields)	1	
2980	Derived AJCC-6 M		site-specific (derived from Collaborative Stage fields), blank	2	
2990	Derived AJCC-6 M Descript		c, p, a, y, N, and blank (derived from Collaborative Stage fields)	1	
3000	Derived AJCC-6 Stage Grp		site-specific (derived from Collaborative Stage fields)	2	
3010	Derived SS1977		0-5, 7, 8, 9 (derived from Collaborative Stage fields)	1	

Item #	Item Name	Format	Allowable Values	Length	Note
3020	Derived SS2000		0-5, 7, 8, 9 (derived from Collaborative Stage fields)	1	
3030	Derived AJCC--Flag		1, 2, blank	1	
3040	Derived SS1977--Flag		1, 2, blank	1	
3050	Derived SS2000--Flag		1, 2, blank	1	
3100	Archive FIN	Right justified, zero filled	10-digit number	10	
3105	NPI--Archive FIN		10-digit NPI code (9-digit NPI integer plus 1 check digit), blank	10	
3110	Comorbid/Complication 1	Left justified, zero filled	00000, 00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	5	
3120	Comorbid/Complication 2	Left justified, zero filled	00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank	5	
3130	Comorbid/Complication 3	Left justified, zero filled	00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank	5	
3140	Comorbid/Complication 4	Left justified, zero filled	00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank	5	
3150	Comorbid/Complication 5	Left justified, zero filled	00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank	5	
3160	Comorbid/Complication 6	Left justified, zero filled	00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank	5	
3161	Comorbid/Complication 7	Left justified, zero filled	00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank	5	

Item #	Item Name	Format	Allowable Values	Length	Note
3162	Comorbid/Complication 8	Left justified, zero filled	00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank	5	
3163	Comorbid/Complication 9	Left justified, zero filled	00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank	5	
3164	Comorbid/Complication 10	Left justified, zero filled	00100-13980, 24000-99990, E8700-E8799, E9300-E9499, V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049, blank	5	
3165	ICD Revision Comorbid		0, 1, 9, blank	1	
3170	RX Date--Most Defin Surg	YYYYMMDD	Valid dates	8	
3171	RX Date Mst Defn Srg Flag		10-20, blank	2	
3180	RX Date--Surgical Disch	YYYYMMDD	Valid dates	8	
3181	RX Date Surg Disch Flag		10-20, blank	2	
3190	Readm Same Hosp 30 Days		0-3, 9	1	
3200	Rad--Boost RX Modality	Right justified, zero filled	00, 20-32, 40-43, 50-55, 60-62, 98, 99	2	
3210	Rad--Boost Dose cGy	Right justified, zero filled	00000-99999	5	
3220	RX Date--Radiation Ended	YYYYMMDD	Valid dates	8	
3221	RX Date Rad Ended Flag		10-20, blank	2	
3230	RX Date--Systemic	YYYYMMDD	Valid dates	8	
3231	RX Date Systemic Flag		10-20, blank	2	
3250	RX Summ--Transplnt/Endocr	Right justified, zero filled	00, 10-12, 20, 30, 40, 82, 85-88, 99	2	
3260	Pain Assessment				Retired
3270	RX Summ--Palliative Proc		0-7, 9	1	
3280	RX Hosp--Palliative Proc		0-7, 9	1	
3300	RuralUrban Continuum 1993	Right justified, zero filled	00-09, 98, 99, blank	2	
3310	RuralUrban Continuum 2003	Right justified, zero filled	01-09, 98, 99, blank	2	
3400	Derived AJCC-7 T		000-999	3	
3402	Derived AJCC-7 T Descript		c, p, a, y, N, blank	1	
3410	Derived AJCC-7 N		000-999	3	
3412	Derived AJCC-7 N Descript		c, p, a, y, N, blank	1	
3420	Derived AJCC-7 M		000-999	3	
3422	Derived AJCC-7 M Descript		c, p, a, y, N, blank	1	
3430	Derived AJCC-7 Stage Grp		000-999	3	
3440	Derived PreRx-7 T		000-999	3	
3442	Derived PreRx-7 T Descrip		c, N, blank	1	
3450	Derived PreRx-7 N		000-999	3	
3452	Derived PreRx-7 N Descrip		c, N, blank	1	
3460	Derived PreRx-7 M		000-999	3	
3462	Derived PreRx-7 M Descrip		c, N, blank	1	
3470	Derived PreRx-7 Stage Grp		000-999	3	
3480	Derived PostRx-7 T		000-999	3	

Item #	Item Name	Format	Allowable Values	Length	Note
3482	Derived PostRx-7 N		000-999	3	
3490	Derived PostRx-7 M		00-99	2	
3492	Derived PostRx-7 Stge Grp		000-999	3	
3600	Derived Neoadjuv Rx Flag		0,1,9	1	
3700	SEER Site-Specific Fact 1		0-9, blank	1	
3702	SEER Site-Specific Fact 2		0-9, blank	1	
3704	SEER Site-Specific Fact 3		0-9, blank	1	
3706	SEER Site-Specific Fact 4		0-9, blank	1	
3708	SEER Site-Specific Fact 5		0-9, blank	1	
3710	SEER Site-Specific Fact 6		0-9, blank	1	
3750	Over-ride CS 1		1, blank	1	New
3751	Over-ride CS 2		1, blank	1	New
3752	Over-ride CS 3		1, blank	1	New
3753	Over-ride CS 4		1, blank	1	New
3754	Over-ride CS 5		1, blank	1	New
3755	Over-ride CS 6		1, blank	1	New
3756	Over-ride CS 7		1, blank	1	New
3757	Over-ride CS 8		1, blank	1	New
3758	Over-ride CS 9		1, blank	1	New
3759	Over-ride CS 10		1, blank	1	New
3760	Over-ride CS 11		1, blank	1	New
3761	Over-ride CS 12		1, blank	1	New
3762	Over-ride CS 13		1, blank	1	New
3763	Over-ride CS 14		1, blank	1	New
3764	Over-ride CS 15		1, blank	1	New
3765	Over-ride CS 16		1, blank	1	New
3766	Over-ride CS 17		1, blank	1	New
3767	Over-ride CS 18		1, blank	1	New
3768	Over-ride CS 19		1, blank	1	New
3769	Over-ride CS 20		1, blank	1	New
7010	Path Reporting Fac ID 1	Left justified, alphanumeric		25	
7011	Path Reporting Fac ID 2	Left justified, alphanumeric		25	
7012	Path Reporting Fac ID 3	Left justified, alphanumeric		25	
7013	Path Reporting Fac ID 4	Left justified, alphanumeric		25	
7014	Path Reporting Fac ID 5	Left justified, alphanumeric		25	
7090	Path Report Number 1	Left justified, alphanumeric		20	
7091	Path Report Number 2	Left justified, alphanumeric		20	
7092	Path Report Number 3	Left justified, alphanumeric		20	
7093	Path Report Number 4	Left justified, alphanumeric		20	
7094	Path Report Number 5	Left justified, alphanumeric		20	
7100	Path Order Phys Lic No 1	Left justified, alphanumeric, no embedded blanks		20	
7101	Path Order Phys Lic No 2	Left justified, alphanumeric, no embedded blanks		20	
7102	Path Order Phys Lic No 3	Left justified, alphanumeric, no embedded blanks		20	
7103	Path Order Phys Lic No 4	left justified, alphanumeric, no embedded blanks		20	
7104	Path Order Phys Lic No 5	left justified, alphanumeric, no embedded blanks		20	
7190	Path Ordering Fac No 1	Left justified, alphanumeric	blank	25	

Item #	Item Name	Format	Allowable Values	Length	Note
7191	Path Ordering Fac No 2	Left justified, alphanumeric	blank	25	
7192	Path Ordering Fac No 3	Left justified, alphanumeric	blank	25	
7193	Path Ordering Fac No 4	Left justified, alphanumeric	blank	25	
7194	Path Ordering Fac No 5	Left justified, alphanumeric	blank	25	
7320	Path Date Spec Collect 1	YYYYMMDD		14	
7321	Path Date Spec Collect 2	YYYYMMDD		14	
7322	Path Date Spec Collect 3	YYYYMMDD		14	
7323	Path Date Spec Collect 4	YYYYMMDD		14	
7324	Path Date Spec Collect 5	YYYYMMDD		14	
7480	Path Report Type 1	Right justified, zero filled	01-11, 98, 99	2	
7481	Path Report Type 2	Right justified, zero filled	01-11, 98, 99	2	
7482	Path Report Type 3	Right justified, zero filled	01-11, 98, 99	2	
7483	Path Report Type 4	Right justified, zero filled	01-11, 98, 99	2	
7484	Path Report Type 5	Right justified, zero filled	01-11, 98, 99	2	

CHAPTER X:

DATA DICTIONARY

In this chapter, data items are presented in alphabetical order by item names. For each item, a general description, specific codes and definitions are provided. For many items, the document provides a brief rationale for collecting the data item or for using the codes listed. The at-a-glance header for each data item has alternate name(s), item number, length, source of standard, and column numbers (for a discussion of NAACCR's standard naming conventions, see Chapter I).

Differences from Version 12 are marked "Revised" or "New" following the item name and item number. Black vertical lines in the outside margins highlight changes. Revised and new items are summarized in Appendix F.

Alternate names by which the same item is called under NAACCR's naming convention are listed alphabetically in Appendix D.

The Source of Standard designates the reference for detailed coding instructions for many of the data items. References can be found in Chapter VI. A list of reference manuals for Version 12.1 (and prior versions) is provided in Chapter II, Table 1. Websites for the standard setting organizations:

SEER: http://seer.cancer.gov/registrars/
CoC: http://www.facs.org/cancer/coc/fordsmanual.html
NPCR: http://www.cdc.gov/cancer/npcr/
Canadian Cancer Registry: http://www.statcan.gc.ca/bsolc/english/bsolc?catno=82-225-X&CHROPG=1

The Collaborative Staging website serves as the main repository for CS-related items including publications, software, educational activities, etc., for cancer registrars and cancer registry software vendors: http://www.cancerstaging.org/cstage/index.html.

The date format (YYYYMMDD) specifically addresses the NAACCR standard data transmission format; not how the data should be stored in an individual registry's database or viewed on the screen. Only valid portions of the date should be transmitted. Below are the common formats to handle the situation where only certain components of date are known.

YYYYMMDD – when complete date is known and valid
YYYYMM – when year and month are known and valid, and day is unknown
YYYY – when year is known and valid, and month and day are unknown
Blank – when no known date applies

The field is fixed-length and left-justified. Any missing component should be replaced by spaces. If there are no known date components, the fixed-length variable will be completely blank.

For unknown values and codes that have meanings other than dates the HL7 Flavors of Null Table (Appendix H) has been adopted for flagging each non-system-generated missing date as a way to eliminate the ambiguity of missing values. A date flag field, to serve as a flag or indicator, is used for each date field for which an "unknown" or "not applicable" value is appropriate. This item would be blank if a valid date is transmitted in its associated date item. The only date fields that would not have a flag are system-generated dates (e.g., Date Case Completed [2090]), for which "unknown" would never be a legitimate value.

ABSTRACTED BY

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

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

ACCESSION NUMBER--HOSP

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

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

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

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

ADDR AT DX--CITY

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

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

Codes (in addition to valid City)
UNKNOWN City at diagnosis unknown

ADDR AT DX--NO & STREET **Revised**

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

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

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

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

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

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

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

APT	apartment	N	north
BLDG	building	NE	northeast
FL	floor	NW	northwest
STE	suite	S	south
UNIT	unit	SE	southeast
RM	room	SW	southwest
DEPT	department	E	east
		W	west

Punctuation marks should be avoided, except when punctuation is necessary to convey the meaning. Punctuation normally is limited to periods when the period carries meaning (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 ½ MAIN ST), and hyphens when the hyphen carries meaning (e.g., 289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (e.g., 425 FLOWER BLVD # 72).

Codes (in addition to valid street address)

UNKNOWN	Patient's address is unknown

ADDR AT DX--POSTAL CODE

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

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

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

For Canadian residents, use the 6-character alphanumeric postal code. Blanks follow the 6-character code.

When available, enter the postal code for other countries.

Codes (in addition to known US and Canadian or other postal codes)

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

ADDR AT DX--STATE

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

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

Codes (in addition to USPS abbreviations)

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

ADDR AT DX--SUPPLEMENTL

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

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

Rationale
Sometimes the registry receives the name of a facility instead of a proper street address containing the street number, name, direction, and other elements necessary to locate an address on a street file for the purpose of geocoding. By having a second street address field to hold address information, the registry can look up and store the street address and not lose the facility name due to a shortage of space. The presence of a second street address field to hold additional address information also aids in follow-up.

ADDR CURRENT--CITY

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

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

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

ADDR CURRENT--NO & STREET **Revised**

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

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

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

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

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

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

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

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

APT	apartment	N	north
BLDG	building	NE	northeast
FL	floor	NW	northwest
STE	suite	S	south
UNIT	unit	SE	southeast
RM	room	SW	southwest
DEPT	department	E	east
		W	west

Punctuation marks should be avoided, except when punctuation is necessary to convey the meaning. Punctuation normally is limited to periods when the period carries meaning (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 ½ MAIN ST), and hyphens when the hyphen carries meaning (e.g., 289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (e.g., 425 FLOWER BLVD # 72).

ADDR CURRENT--POSTAL CODE

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

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

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

Codes (in addition to U.S., Canadian, and Foreign postal codes)

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

ADDR CURRENT--STATE

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

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

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

Codes (in addition to the U.S. and Canadian postal service abbreviations)

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

ADDR CURRENT--SUPPLEMENTL

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

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

Rationale
Sometimes the registry receives the name of a facility instead of a proper street address containing the street number, name, direction, and other elements necessary to locate an address on a street file for the purpose of geocoding. By having a second street address field to hold address information, the registry can look up and store the street address and not lose the facility name due to a shortage of space. The presence of a second street address field to hold additional address information also aids in follow-up.

AGE AT DIAGNOSIS

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

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

Codes

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

ALCOHOL HISTORY **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	350			

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

AMBIGUOUS TERMINOLOGY DX **Revised**

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

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

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

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

Codes (Refer to http://seer.cancer.gov/tools/mphrules/index.html for additional instructions.)
0 Conclusive term
1 Ambiguous term only
2 Ambiguous term followed by conclusive term
9 Unknown term

Note: Refer to Table 2, page 23 for a list of ambiguous terms.

ARCHIVE FIN

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

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

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

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

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

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

AUTOPSY

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

Description
Code indicating whether or not an autopsy was performed.

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

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

BEHAVIOR (73-91) ICD-O-1

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

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

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

BEHAVIOR (92-00) ICD-O-2

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

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

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

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

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

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

BEHAVIOR CODE ICD-O-3

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

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

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

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

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

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

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

BIRTHPLACE **Revised**

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

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

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

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

CANCER STATUS

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

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

Rationale
This item can be used to compute disease-free survival. By maintaining this data item, central registries can assist hospital registries by sharing this information with other hospital registries that serve the same patients, if the state's privacy laws so permit.

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

CASEFINDING SOURCE

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

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

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

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

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

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

Case first identified by source other than a reporting facility covered in the codes above:
30 Physician-Initiated Case
40 Consultation-only or Pathology-only Report (not abstracted by reporting hospital)
50 Independent (non-hospital) Pathology-Laboratory Report
60 Nursing Home-Initiated Case
70 Coroner's Office Records Review
75 Managed Care Organization (MCO) or Insurance Records
80 Death Certificate (case identified through death clearance)
85 Out-of-State Case Sharing
90 Other Non-Reporting Hospital Source
95 Quality Control Review (case initially identified through quality control activities such as casefinding audit of a regional or central registry)
99 Unknown

CAUSE OF DEATH

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

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

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

Special codes in addition to ICD-7, ICD-8, ICD-9, and ICD-10 (refer to *SEER Program Code Manual* for additional instructions)
0000 Patient alive at last contact
7777 State death certificate not available
7797 State death certificate available but underlying cause of death is not coded

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

CENSUSBLOCKGROUP 70/80/90

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

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

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

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

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

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

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

CENSUS BLOCK GROUP 2000

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

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

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

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

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

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

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

CENSUS BLOCK GROUP 2010 **New**

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

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

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

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

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

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

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

CENSUS COD SYS 1970/80/90 **Revised**

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

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

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

Codes

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

Clarification of NPCR Required Status

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

Census-2000 data items:
Census Tract 2000 [130]
Census Tr Certainty 2000 [365]

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

CENSUS TR CERT 1970/80/90 **Revised**

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

Description

Code indicating basis of assignment of census tract or block numbering area (BNA) for an individual record. Helpful in identifying cases tracted from incomplete information or P.O. Box. This item is not coded by the hospital. Central registry staff manually assign the code.

Codes

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

Clarification of NPCR Required Status

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

Census-2000 data items:
Census Tract 2000 [130]
Census Tr Certainty 2000 [365]

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

CENSUS TR CERTAINTY 2000 **Revised**

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

Description

Code indicating basis of assignment of census tract for an individual record. Helpful in identifying cases tracted from incomplete information or P.O. Box. This item is not coded by the hospital. Central registry staff assign the code.

Codes

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

Clarification of NPCR Required Status

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

Census-2000 data items:
Census Tract 2000 [130]
Census Tr Certainty 2000 [365]

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

CENSUS TR CERTAINTY 2010 **New**

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

Description
Code indicating basis of assignment of census tract for an individual record. Helpful in identifying cases tracted from incomplete information or P.O. Box. This item is not coded by the hospital. Central registry staff assign the code.

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

Clarification of NPCR Required Status

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

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

CENSUS TRACT 1970/80/90

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

Description
Code for the census tract or BNA of the patient's residence at the time of diagnosis. SEER used this field for tumors reported before 1998. If the patient has more than one tumor, the codes may be different for each tumor.

Codes are those used by the U.S. Census Bureau. Census Bureau codes for BNA also are entered in this field.

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

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

Codes

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

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

CENSUS TRACT 2000

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

Description
This field is provided for coding census tract of patient's residence at time of diagnosis. See Census Tract 1970/80/90 [110]. Codes are those used by the U.S. Census Bureau for the Year 2000 Census. Census tract codes have a 4-digit basic number and also may have a 2-digit suffix. Census tract numbers range from 0001.01 to 9999.98. See the Census Bureau's "Area Classifications" at the following website: http://www.census.gov/prod/cen2000/doc/sf1.pdf for further details.

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

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

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

Codes

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

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

CENSUS TRACT 2010 **New**

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

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

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

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

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

Codes

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

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

CENSUS TRACT COD SYS--ALT **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	140			

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

CHEMOTHERAPY FIELD 1 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1600			

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

CHEMOTHERAPY FIELD 2 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1610			

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

CHEMOTHERAPY FIELD 3 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1620			

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

CHEMOTHERAPY FIELD 4 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1630			

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

CLASS OF CASE **Revised**

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

Description

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

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

Rationale

Class of Case reflects the facility's role in managing the cancer, whether the cancer is required to be reported by CoC, and whether the case was diagnosed after the program's Reference Date.

Codes	Definition	
Analytic Classes of Case (Required by CoC to be abstracted by accredited cancer programs; refer to *FORDS* for additional instructions)		
INITIAL DIAGNOSIS AT REPORTING FACILITY		
00 *	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done ELSEWHERE	
10 *	Initial diagnosis at the reporting facility or in a staff physician's office AND PART OR ALL of first course treatment or a decision not to treat was at the reporting facility, NOS	
	11	Initial diagnosis in staff physician's office AND PART of first course treatment was done at the reporting facility
	12	Initial diagnosis in staff physician's office AND ALL first course treatment or a decision not to treat was done at the reporting facility
	13*	Initial diagnosis at the reporting facility AND PART of first course treatment was done at the reporting facility
	14*	Initial diagnosis at the reporting facility AND ALL first course treatment or a decision not to treat was done at the reporting facility
INITIAL DIAGNOSIS ELSEWHERE, FACILITY INVOLVED IN FIRST COURSE TREATMENT		
20 *	Initial diagnosis elsewhere AND PART OR ALL of first course treatment was done at the reporting facility, NOS	
	21 *	Initial diagnosis elsewhere AND PART of treatment was done at the reporting facility
	22 *	Initial diagnosis elsewhere AND ALL first course treatment was done at the reporting facility

Codes	Definition (continued)
Classes of Case not required by CoC to be abstracted (May be required by Cancer Committee, state or regional registry, or other entity)	
PATIENT APPEARS IN PERSON AT REPORTING FACILITY; BOTH INITIAL DIAGNOSIS AND TREATMENT ELSEWHERE	
30 *	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in DIAGNOSTIC WORKUP (for example, consult only, staging workup after initial diagnosis elsewhere)
31 *	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided IN-TRANSIT care
32 *	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease RECURRENCE OR PERSISTENCE
33 *	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease HISTORY ONLY
34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility
35	Case diagnosed before program's Reference Date AND initial diagnosis AND PART OR ALL of first course treatment by reporting facility
36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND part of all of first course treatment by reporting facility
37	Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
38*	Initial diagnosis established by AUTOPSY at the reporting facility, cancer not suspected prior to death
PATIENT DOES NOT APPEAR IN PERSON AT REPORTING FACILITY	
40	Diagnosis AND all first course treatment given at the same staff physician's office
41	Diagnosis and all first course treatment given in two or more different staff physician offices
42	Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43 *	PATHOLOGY or other lab specimens ONLY
49 *	DEATH CERTIFICATE ONLY
UNKNOWN RELATIONSHIP TO REPORTING FACILITY	
99*	Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases.); UNKNOWN

Note: This expanded list of coded values is effective with Version 12.

*Indicates Class of Case codes appropriate for abstracting cases from non-hospital sources such as physician offices, ambulatory surgery centers, freestanding pathology laboratories, radiation therapy centers. When applied to these types of facilities, the non-hospital source is the reporting facility. The codes are applied the same way as if the case were reported from a hospital.

By using Class of Case codes in this manner for non-hospital sources, the central cancer registry is able to retain information reflecting the facility's role in managing the cancer consistent with the way it is reported from hospitals. Using Class of Case in conjunction with Type of Reporting Source [500] which identifies the source documents used to abstract the cancer being reported, the central cancer registry has two distinct types of information to use in making consolidation decisions.

COC CODING SYS--CURRENT

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

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

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

COC CODING SYS--ORIGINAL **Revised**

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

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

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

CODING SYSTEM FOR EOD

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

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

Rationale
Used in data editing and analysis.

Codes
0 2-Digit Nonspecific Extent of Disease (1973-82)
1 2-Digit Site-Specific Extent of Disease (1973-82)
2 13-Digit (expanded) Site-Specific Extent of Disease (1973-1982)
3 4-Digit Extent of Disease (1983-87)
4 10-Digit Extent of Disease, 1988 (1988-2003)
Blank Cases diagnosed 2004+; or the item is not collected

COMORBID/COMPLICATION 1

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

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

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

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

00000 No secondary diagnoses documented

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

COMORBID/COMPLICATION 2

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

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

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

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

Leave blank if no further secondary diagnosis.

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

COMORBID/COMPLICATION 3

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

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

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

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

Leave blank if no further secondary diagnoses.

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

COMORBID/COMPLICATION 4

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

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

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

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

Leave blank if no further secondary diagnoses.

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

COMORBID/COMPLICATION 5

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

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

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

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

Leave blank if no further secondary diagnoses.

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

COMORBID/COMPLICATION 6

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

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

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

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

Leave blank if no further secondary diagnoses.

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

COMORBID/COMPLICATION 7

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

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

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

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

Leave blank if no further secondary diagnosis.

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

COMORBID/COMPLICATION 8

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

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

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

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

Leave blank if no further secondary diagnosis.

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

COMORBID/COMPLICATION 9

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

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

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

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

Leave blank if no further secondary diagnosis.

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

COMORBID/COMPLICATION 10

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

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

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

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

Leave blank if no further secondary diagnosis.

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

COMPUTED ETHNICITY

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

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

See also Computed Ethnicity Source [210].

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

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

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

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

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

COMPUTED ETHNICITY SOURCE

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

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

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

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

COUNTY AT DX

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

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

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

Note: See Appendix A for standard FIPS county codes. See EDITS Table BPLACE.DBF in Appendix B for geocodes used by CoC.

Note: SEER does not use code 998. CoC uses country geocodes for nonresidents of the United States (see Appendix B) and 998 for residents of other states.

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

COUNTY--CURRENT

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

Description
Code for county of patient's current residence. See Chapter V, Unresolved Issues, for further discussion.

Note: This item was used by CoC only. CoC recommended use of FIPS codes (see Appendix A). The *ROADS Manual* also provided for use of geocodes for countries of residence outside the United States and Canada to be used in the county fields.

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

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

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

CRC CHECKSUM

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

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

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

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

CS EXTENSION **Revised**

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

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

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

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

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

CS LYMPH NODES **Revised**

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

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

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

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

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

CS LYMPH NODES EVAL **Revised**

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

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

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

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

CS METS AT DX **Revised**

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

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

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

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

CS METS AT DX-BONE **Revised**

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

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

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

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

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

CS METS AT DX-BRAIN **Revised**

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

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

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

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

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

CS METS AT DX-LIVER **Revised**

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

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

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

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

Note: This includes only the liver.

CS METS AT DX-LUNG **Revised**

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

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

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

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

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

CS METS EVAL **Revised**

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

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

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

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

CS POSTRX EXTENSION **Revised**

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

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

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

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

CS POSTRX LYMPH NODES **Revised**

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

Description

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

Rationale

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

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

CS POSTRX METS AT DX **Revised**

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

Description

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

Rationale

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

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

CS POSTRX TUMOR SIZE **Revised**

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

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

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

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

CS PRERX EXTENSION **Revised**

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

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

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

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

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

CS PRERX LYMPH NODES **Revised**

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

Description

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

Rationale

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

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

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

CS PRERX METS AT DX **Revised**

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

Description

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

Rationale

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

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

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

CS PRERX METS EVAL **Revised**

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

Description

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

Rationale

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

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

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

CS PRERX REG NODES EVAL **Revised**

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

Description

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

Rationale

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

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

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

CS PRERX TUM SZ/EXT EVAL **Revised**

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

Description

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

Rationale

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

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

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

CS PRERX TUMOR SIZE **Revised**

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

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

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

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

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

CS SITE-SPECIFIC FACTOR 1 **Revised**

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

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

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

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

CS SITE-SPECIFIC FACTOR 2 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2890	3	AJCC	1006-1008

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

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

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

CS SITE-SPECIFIC FACTOR 3 **Revised**

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

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

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

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

CS SITE-SPECIFIC FACTOR 4 **Revised**

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

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

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

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

CS SITE-SPECIFIC FACTOR 5 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2920	3	AJCC	1015-1017

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

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

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

CS SITE-SPECIFIC FACTOR 6 **Revised**

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

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

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

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

CS SITE-SPECIFIC FACTOR 7 **Revised**

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

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

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

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

CS SITE-SPECIFIC FACTOR 8 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2862	3	AJCC	1024-1026

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

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

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

CS SITE-SPECIFIC FACTOR 9 **Revised**

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

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

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

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

CS SITE-SPECIFIC FACTOR10 **Revised**

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

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

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

Codes (The information recorded in CS Site-Specific Factor10 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR11 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2865	3	AJCC	1033-1035

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

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

Codes (The information recorded in CS Site-Specific Factor11 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR12 **Revised**

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

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

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

Codes (The information recorded in CS Site-Specific Factor12 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR13 **Revised**

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

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

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

Codes (The information recorded in CS Site-Specific Factor13 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR14 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2868	3	AJCC	1042-1044

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

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

Codes (The information recorded in CS Site-Specific Factor14 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR15 **Revised**

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

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

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

Codes (The information recorded in CS Site-Specific Factor15 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR16 **Revised**

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

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

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

Codes (The information recorded in CS Site-Specific Factor16 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR17 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2871	3	AJCC	1051-1053

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

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

Codes (The information recorded in CS Site-Specific Factor17 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR18 **Revised**

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

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

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

Codes (The information recorded in CS Site-Specific Factor18 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR19 **Revised**

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

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

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

Codes (The information recorded in CS Site-Specific Factor19 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR20 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2874	3	AJCC	1060-1062

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

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

Codes (The information recorded in CS Site-Specific Factor20 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR21 **Revised**

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

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

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

Codes (The information recorded in CS Site-Specific Factor21 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR22 **Revised**

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

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

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

Codes (The information recorded in CS Site-Specific Factor22 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR23 **Revised**

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

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

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

Codes (The information recorded in CS Site-Specific Factor23 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR24 **Revised**

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

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

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

Codes (The information recorded in CS Site-Specific Factor24 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS SITE-SPECIFIC FACTOR25 **Revised**

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

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

Rationale
CS Site-Specific Factor25 is used to discriminate between CS staging schema or between AJCC chapters where site and histology alone are insufficient to identify the tumor type or location to identify the applicable staging method.

Codes (The information recorded in CS Site-Specific Factor25 differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org),[13] for rules and site-specific codes and coding structures.)

CS TUMOR SIZE **Revised**

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

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

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

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

CS TUMOR SIZE/EXT EVAL **Revised**

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

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

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

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

CS VERSION DERIVED **Revised**

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

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

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

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

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

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

CS VERSION INPUT CURRENT **Revised**

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

Description
This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the AJCC Cancer Staging Manual, 6th and 7th editions. This item identifies the version after CS input fields have been updated or recoded. This data item is recorded the first time the CS input fields are entered and should be updated each time the CS input fields are modified. For cases originally coded under CSv1, upon conversion from CSv1 to CSv2, CS Version Input Current will be set to 020000, a special version number to reflect its conversion status.

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

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

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

CS VERSION INPUT ORIGINAL **Revised**

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

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

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

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

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

DATE CASE COMPLETED

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

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

DATE CASE COMPLETED--COC

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

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

DATE CASE INITIATED **Revised**

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

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

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

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

DATE CASE LAST CHANGED

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

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

DATE CASE REPORT EXPORTED **Revised**

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

Description
Date the reporting facility exports the electronic abstract to a file for transmission to the central registry. See page 97 for date format. Standard edits check that no dates are later than the current date.

DATE CASE REPORT LOADED **Revised**

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

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

DATE CASE REPORT RECEIVED **Revised**

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

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

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

DATE CONCLUSIVE DX FLAG **Revised**

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

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

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

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

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

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

DATE OF 1ST CONTACT **Revised**

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

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

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

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

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

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

DATE OF 1ST CONTACT FLAG **Revised**

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

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

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

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)
12 A proper value is applicable but not known (e.g., date of 1st contact is unknown)
Blank A valid date value is provided in item Date of 1st Contact [580], or the date was not expected to have been transmitted

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

DATE OF 1ST CRS RX FLAG

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

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

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

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)
10 No information whatsoever can be inferred from this exceptional value (e.g., unknown whether treatment was administered)
11 No proper value is applicable in this context (e.g., autopsy only case)
12 A proper value is applicable but not known (e.g., treatment administered but date is unknown)
Blank A valid date value is provided in item Date of 1st Crs RX [1270], or the date was not expected to have been transmitted

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

DATE OF 1ST CRS RX--COC

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

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

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

DATE OF 1ST POSITIVE BX **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1080			

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

DATE OF BIRTH

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

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

DATE OF BIRTH FLAG

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

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

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

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions. Use code 12 when date of birth is unknown.)
12 A proper value is applicable but not known (i.e., birth date is unknown)
Blank A valid date value is provided in item Date of Birth [240], or the date was not expected to have been transmitted

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

DATE OF CA CONFERENCE **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	660			

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

DATE OF CONCLUSIVE DX **Revised**

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

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

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

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

Codes (refer to http://seer.cancer.gov/tools/mphrules/index.html for additional instructions).

DATE OF DEATH--CANADA

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

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

DATE OF DEATH--CANADAFLAG

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

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

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

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

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

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

DATE OF DIAGNOSIS

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

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

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

DATE OF DIAGNOSIS FLAG

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

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

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

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)
12 A proper value is applicable but not known. (e.g., date of diagnosis is unknown)
Blank A valid date value is provided in item Date of Diagnosis [390], or the date was not expected to have been transmitted

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

DATE OF INITIAL RX FLAG

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

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

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

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)
10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if therapy was administered)
11 No proper value is applicable in this context (e.g., therapy was not administered)
12 A proper value is applicable but not known (e.g., therapy was administered and date is unknown)
Blank A valid date value is provided in item Date of Initial RX-SEER [1260], or the date was not expected to have been transmitted

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

DATE OF INITIAL RX--SEER

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

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

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

DATE OF INPATIENT ADM

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

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

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

DATE OF INPATIENT DISCH

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

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

Note: This item is not the same as the old NAACCR item, Date of Discharge, which has been deleted from the NAACCR layout.

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

DATE OF INPT ADM FLAG

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

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

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if patient was an inpatient).

11 No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., the patient was an inpatient but the date is unknown).

Blank A valid date value is provided in item Date of Inpatient Adm [590], or the date was not expected to have been transmitted.

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

DATE OF INPT DISCH FLAG

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

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

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if patient was an inpatient).
11 No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility).
12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., the patient was an inpatient but the date is unknown).
Blank A valid date value is provided in item Date of Inpatient Disch [600], or the date was not expected to have been transmitted.

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

DATE OF LAST CONTACT **Revised**

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

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

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

DATE OF LAST CONTACT FLAG

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

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

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

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

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., date of last contact is unknown).

Blank A valid date value is provided in item Date of Last Contact [1750], or the date was not expected to have been transmitted.

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

DATE OF MULT TUMORS FLAG

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

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

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

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

11 No proper value is applicable in this context (e.g., information on multiple tumors not collected/not applicable for this site).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., patient was diagnosed with multiple tumors and the date is unknown.

15 Information is not available at this time, but it is expected that it will be available later (e.g., single tumor).

Blank A valid date value is provided in item Date Multiple Tumors [445], or the date was not expected to have been transmitted.

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

DATE OF MULTIPLE TUMORS **Revised**

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

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

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

Codes (refer to http://seer.cancer.gov/tools/mphrules/index.html for additional instructions).

DATE TUMOR RECORD AVAILBL **Revised**

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

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

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

DC STATE **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	2370			

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

DC STATE FILE NUMBER

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

Description
Death certificate identification number as assigned by the vital statistics office in the place recorded in Place of Death [1940].

DERIVED AJCC-6 M **Revised**

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

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

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

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

DERIVED AJCC-6 M DESCRIPT **Revised**

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

Description

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

Rationale

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

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

DERIVED AJCC-6 N **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 6 N Storage Code Derived AJCC N	2960	2	AJCC	1106-1107

Description

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

Rationale

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

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

DERIVED AJCC-6 N DESCRIPT **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 6 N Descriptor Storage Code Derived AJCC N Descriptor	2970	1	AJCC	1108-1108

Description

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

Rationale

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

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

DERIVED AJCC-6 STAGE GRP **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 6 Stage Group Storage Group Derived AJCC Stage Group	3000	2	AJCC	1112-1113

Description

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

Rationale

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

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

DERIVED AJCC-6 T **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 6 T Storage Code Derived AJCC T	2940	2	AJCC	1103-1104

Description

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

Rationale

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

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

DERIVED AJCC-6 T DESCRIPT

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 6 T Descriptor Storage Code Derived AJCC T Descriptor	2950	1	AJCC	1105-1105

Description

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

Rationale

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

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

DERIVED AJCC-7 M **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 7 M Storage Code	3420	3	AJCC	1122-1124

Description
This item is the derived AJCC "T" staging element from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
Derived AJCC-7 T can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

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

DERIVED AJCC-7 M DESCRIPT **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 7 M Descript Storage Code	3422	1	AJCC	1125-1125

Description
This item is the derived AJCC "M Descriptor" from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
Derived AJCC-7 M Descript can be used in analysis to differentiate the timing of staging with respect to the treatment process.

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

DERIVED AJCC-7 N **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 7 N Storage Code	3410	3	AJCC	1118-1120

Description
This item is the derived AJCC "N" staging element from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
The CS *Derived AJCC-7 N* can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

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

DERIVED AJCC-7 N DESCRIPT **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 7 N Descript Storage Code	3412	1	AJCC	1121-1121

Description
This item is the derived AJCC "N Descriptor" from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
Derived AJCC-7 N Descript can be used in analysis to differentiate the timing of staging with respect to the treatment process.

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

DERIVED AJCC-7 STAGE GRP **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 7 Stage Grp Storage Code	3430	3	AJCC	1126-1128

Description
This item is the derived AJCC "Stage Group" from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
The CS *Derived AJCC-7 Stage Group* can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

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

DERIVED AJCC-7 T **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 7 T Storage Code	3400	3	AJCC	1114-1116

Description
This item is the derived AJCC "T" staging element from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
Derived AJCC-7 T can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

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

DERIVED AJCC-7 T DESCRIPT **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived 7 T Descript Storage Code	3402	1	AJCC	1117-1117

Description
This item is the derived AJCC "T Descriptor" from coded fields using the CS algorithm. Effective for cases diagnosed 2010+.

Rationale
Derived AJCC-7 T Descript can be used in analysis to differentiate the timing of staging with respect to the treatment process.

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

DERIVED AJCC--FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
AJCC Conversion Flag	3030	1	AJCC	1158-1158

Description
Flag to indicate whether the derived AJCC stage was derived from CS or EOD codes.

Codes
1 AJCC fields derived from Collaborative Stage
2 AJCC fields derived from EOD (prior to 2004)
Blank Not derived

DERIVED NEOADJUV RX FLAG **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	3600	1	AJCC	1157-1157

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. This field indicates whether the patient received neoadjuvant therapy (systemic therapy or radiation therapy prior to first course surgical treatment) as part of first course of treatment.

Rationale

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

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

0 Neoadjuvant therapy was not administered as part of the first course of therapy
1 Neoadjuvant therapy was administered as part of the first course of therapy
9 Unknown

This data item will record whether neoadjuvant therapy was administered. This will be a derived field based on RX SUMM--SYSTEMIC/SUR SEQ [1639] & RX SUMM--SURG/RAD SEQ [1380].

Comments:

1. This data field is used to record that neoadjuvant therapy was administered as part of the first course of treatment
2. This item is derived based on whether systemic therapy and/or radiation therapy was administered prior to surgical treatment
3. If the initial surgical therapy is not performed following the systemic therapy or radiation therapy, then this will be derived as 0, i.e., it is not considered neoadjuvant therapy

DERIVED POSTRX-7 M **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PostRX 7 M Storage Code	3490	2	AJCC	1150-1151

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the post-treatment AJCC 7th edition "M" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

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

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

DERIVED POSTRX-7 N **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PostRX 7 N Storage Code	3482	3	AJCC	1147-1149

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the post-treatment AJCC 7th edition "N" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

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

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

DERIVED POSTRX-7 STGE GRP **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PostRX 7 Stge Grp Storage Code	3492	3	AJCC	1152-1154

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the post-treatment AJCC 7th edition "Stage Group" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

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

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

DERIVED POSTRX-7 T **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PostRX 7 T Storage Code	3480	3	AJCC	1144-1146

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus the post-treatment AJCC 7th edition "T" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

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

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

DERIVED PRERX-7 M **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PreRX 7 M Storage Code	3460	3	AJCC	1137-1139

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition "M" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

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

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

DERIVED PRERX-7 M DESCRIP **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PreRX 7 M Descrip Storage Code	3462	1	AJCC	1140-1140

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for pre-treatment AJCC 7th edition "M Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

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

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

DERIVED PRERX-7 N **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PreRX 7 N Storage Code	3450	3	AJCC	1133-1135

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition "N" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

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

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

DERIVED PRERX-7 N DESCRIP **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PreRX 7 N Descrip Storage Code	3452	1	AJCC	1136-1136

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition "N Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

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

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

DERIVED PRERX-7 STAGE GRP **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PreRX 7 Stge Grp Storage Code	3470	3	AJCC	1141-1143

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition "Stage Group" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

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

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

DERIVED PRERX-7 T **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PreRX 7 T Storage Code	3440	3	AJCC	1129-1131

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition "T" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

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

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

DERIVED PRERX-7 T DESCRIP **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Derived PreRX 7 T Descrip Storage Code	3442	1	AJCC	1132-1132

Description

This data item belongs to the Collaborative Stage (CS) Data Collection System which is based on the *AJCC Cancer Staging Manual*, 6th and 7th editions. AJCC T, N, M plus descriptors and AJCC staging components are composed of combinations of characters, numbers, and/or special characters and can be of varying lengths. To more easily handle these components a numeric code was assigned to each unique category for each T, N, M plus descriptors and AJCC stage for 6th and 7th editions. This field contains the numeric representation for the pre-treatment AJCC 7th edition "T Descriptor" and is derived from CS coded fields using the CS algorithm. This numeric representation is referred to as the "storage" code and its associated label is referred to as the "display" code. Explanations of the "storage" codes and their corresponding "display" codes can be found in the most current version of the *Collaborative Stage Data Collection System* (http://cancerstaging.org/cstage/manuals.html).[13] The display code should be used for display on the screen and in reports. Effective for cases diagnosed 2012+.

Rationale

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

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

DERIVED SS1977

Alternate Name	Item #	Length	Source of Standard	Column #
Derived SEER Summary Stage 1977	3010	1	AJCC	1155-1155

Description
This item is the derived "SEER Summary Stage 1977" from the CS algorithm (or EOD codes) effective with 2004 diagnosis.

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

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

DERIVED SS1977--FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
SS1977 Conversion Flag	3040	1	AJCC	1159-1159

Description
Flag to indicate whether the derived SEER Summary Stage 1977 was derived from CS or EOD codes.

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

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

1 SS1977 derived from Collaborative Stage
2 SS1977 derived from EOD (prior to 2004)
Blank Not derived

DERIVED SS2000

Alternate Name	Item #	Length	Source of Standard	Column #
Derived SEER Summary Stage 2000	3020	1	AJCC	1156-1156

Description
This item is the derived "SEER Summary Stage 2000" from the CS algorithm (or EOD codes) effective with 2004 diagnosis.

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

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

DERIVED SS2000--FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
SS2000 Conversion Flag	3050	1	AJCC	1160-1160

Description
Flag to indicate whether the derived SEER Summary Stage 2000 was derived from CS or EOD codes.

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

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

1 SS2000 derived from Collaborative Stage
2 SS2000 derived from EOD (prior to 2004)
Blank Not derived

DIAGNOSTIC CONFIRMATION **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	490	1	SEER/CoC	562-562

Description
Code for the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history.

Rationale
Diagnostic confirmation is useful to calculate rates based on microscopically confirmed cancers. Full incidence calculations must also include tumors that are only confirmed clinically. The percentage of tumors that are not microscopically confirmed is an indication of whether case finding is including sources outside of pathology reports.

Codes
1 Positive histology
2 Positive cytology
3 Positive histology PLUS –
positive immunophenotyping AND/OR positive genetic studies
(Used only for hematopoietic and lymphoid neoplasms M-9590/3-9992/3)
4 Positive microscopic confirmation, method not specified
5 Positive laboratory test/marker study
6 Direct visualization without microscopic confirmation
7 Radiography and/or other imaging techniques without microscopic confirmation
8 Clinical diagnosis only (other than 5, 6, or 7)
9 Unknown whether or not microscopically confirmed; death certificate only

Note: Code 3 (used only for hematopoietic and lymphoid neoplasms M-9590/3-9992/3) was adopted for use effective with 2010 diagnoses.

DIAGNOSTIC PROC 73-87

Alternate Name	Item #	Length	Source of Standard	Column #
Diagnostic Procedures (1973-87 SEER)	2200	2	SEER	1949-1950

Description
Data item required by SEER for tumors of certain sites for the years 1973-87. This item is no longer collected. See Appendix D of the *SEER Program Code Manual* for details.

EOD--EXTENSION **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Extension (pre-96 SEER/CoC) Extension (SEER EOD) (96 CoC)	790	2	SEER	909-910

Description
Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from January 1, 1988, through December 31, 2003.

Codes were revised effective January 1, 1998, to reflect changes in the *AJCC Cancer Staging Manual*, Fifth Edition.

Rationale
Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See *Comparative Staging Guide for Cancer*[6].

Codes (See *SEER Extent of Disease, 1988: Codes and Coding Instructions*, Third Edition[8] for site-specific codes and coding rules for all EOD fields.)

EOD--EXTENSION PROST PATH **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	800	2	SEER	911-912

Description
Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from January 1, 1988, through December 31, 2003.

Codes were revised effective January 1, 1998, to reflect changes in the *AJCC Cancer Staging Manual*, Fifth Edition.

Rationale
Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See *Comparative Staging Guide for Cancer*.

EOD--Extension Prost Path is an additional field for prostate cancer only to reflect information from radical prostatectomy, effective for January 1, 1995, through December 31, 2003, diagnoses. The field is left blank for all other primaries.

Codes (See *SEER Extent of Disease, 1988: Codes and Coding Instructions*, Third Edition[8] for site-specific codes and coding rules for all EOD fields.)

EOD--LYMPH NODE INVOLV **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Lymph Nodes (pre 96-SEER/CoC) Lymph Nodes (SEER EOD) (96 CoC)	810	1	SEER	913-913

Description
Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from January 1, 1988, through December 31, 2003.

Codes were revised effective January 1, 1998, to reflect changes in the *AJCC Cancer Staging Manual*, Fifth Edition.

Rationale
Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See *Comparative Staging Guide for Cancer*.

Codes (See *SEER Extent of Disease, 1988: Codes and Coding Instructions*, Third Edition[8] for site-specific codes and coding rules for all EOD fields.)

EOD--OLD 13 DIGIT

Alternate Name	Item #	Length	Source of Standard	Column #
13-Digit (Expanded) Site-Specific Extent of Disease (SEER) SEER EEOD (SEER)	840	13	SEER	918-930

Description
Detailed site-specific codes for EOD used by SEER for selected sites of cancer for tumors diagnosed 1973-1982, except death-certificate-only cases.

Codes (See *Extent of Disease: Codes and Coding Instructions (SEER 1977)* [10] for codes.)

EOD--OLD 2 DIGIT

Alternate Name	Item #	Length	Source of Standard	Column #
2-Digit Nonspecific and 2-Digit Site-Specific Extent of Disease (1973-1982 SEER)	850	2	SEER	931-932

Description
Site-specific codes for EOD used by SEER for tumors diagnosed from January 1, 1973, to December 31, 1982, for cancer sites that did not have a 13-digit scheme see EOD--Old 13 Digit [840].

Codes (See *Extent of Disease: Codes and Coding Instructions (SEER 1977)*[10] for codes.)

EOD--OLD 4 DIGIT

Alternate Name	Item #	Length	Source of Standard	Column #
4-Digit Extent of Disease (1983-1987 SEER)	860	4	SEER	933-936

Description
Codes for site-specific EOD used by SEER for tumors diagnosed from January 1, 1983, to December 31, 1987, for all cancer sites.

Codes (See *SEER Extent of Disease: New 4-Digit Schemes: Codes and Coding Instructions*[9] for codes.)

EOD--TUMOR SIZE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Size of Primary Tumor (SEER) Size of Tumor (CoC)	780	3	SEER/CoC	906-908

Description
Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from January 1, 1988, through December 31, 2003.

This field was included in the CoC dataset, separate from EOD.

Codes were revised effective January 1, 1998, to reflect changes in the *AJCC Cancer Staging Manual*, Fifth Edition.

Rationale
Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See *Comparative Staging Guide for Cancer*.

Codes
See *SEER Extent of Disease, 1988: Codes and Coding Instructions*, Third Edition, for site-specific codes and coding rules for all EOD fields. The CoC codes for Tumor Size are in the *FORDS* manual.

Note: See Chapter V, Unresolved Issues, for a discussion of coding differences between CoC and SEER.

EXTENT OF DISEASE 10-DIG **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	779	12		906-917

Description
The name for a group of subfields that contain detailed site-specific codes for the anatomic EOD. SEER uses the subfields for tumors diagnosed from January 1, 1988, through December 31, 2003.

Group names appear only in the data dictionary and in Appendix E.

Subfields
EOD--Tumor Size [780]
EOD--Extension [790]
EOD--Extension Prost Path [800]
EOD--Lymph Node Involv [810]
Regional Nodes Positive [820]
Regional Nodes Examined [830]

FAMILY HISTORY OF CANCER **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	360			

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

FIN CODING SYSTEM

Alternate Name	Item #	Length	Source of Standard	Column #
	35	1	NAACCR	3-3

Description
The FIN Coding System is a generated code that identifies the coding system used by individual facilities (hospital, clinics, or other providers).

This field identifies the coding system used by facilities in the following seven fields of the NAACCR layout:

Registry ID [40] (when Registry Type [30] = 3)
Reporting Facility [540]
Institution Referred From [2410]
Institution Referred To [2420]
Last Follow-Up Hospital [2430] (this data item was retired in Version 11)
Following Registry [2440]
Archive FIN [3100]

Within a single NAACCR record, all of these fields listed above must be coded using the same FIN coding system.

Codes
1 CoC 7-digit codes (assigned by CoC until the end of 2000)
2 CoC FIN 10-digit codes (assigned 2001+)
9 Unknown

Note: Code 3, NPI 8-digit code, has been deleted. Code 4, 15-digit codes, has been deleted.

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

FIRST COURSE CALC METHOD **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	1500	1	NAACCR	1595-1595

Description
Code indicating the source of the standard for defining the first course of therapy.

Codes
1 CoC definitions
2 SEER definitions
9 Other, unknown

FOLLOWING REGISTRY **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2440	10	CoC	4295-4304

Description
Records the FIN of the registry responsible for following the patient.

Rationale
Each FIN is unique. The number is essential to NCDB for monitoring data submissions, ensuring the accuracy of data, and identifying areas for special studies.

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

For facilities with 7-digit FINs, consisting of a constant "6" followed by 6-digit facility-specific codes in the range of 6020009-6953290 that were assigned by CoC before January 1, 2001: Enter all FIN codes of this type as 3 zeroes, followed by the constant "6" and the 6-digit facility-specific codes.

For facilities with FINs greater than or equal to 10000000 that were assigned by CoC after January 1, 2001: Enter FIN codes of this type as 2 zeroes followed by the full 8-digit code. These sometimes are called CoC FIN 10 digit codes.

Codes (in addition to CoC assigned codes)
0000000000 Case not reported by a facility
0099999999 Case reported, but facility number is unknown

FOLLOW-UP CONTACT--CITY **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	1842	50	SEER	2208-2257

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

Rationale
Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

FOLLOW-UP CONTACT--NAME **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2394	60	SEER	3884-3943

Description
First and last name, in natural order, of a person, other than the patient or a physician, who can be contacted to obtain follow-up information for the patient. If the patient has multiple tumors, Follow-up Contact-Name should be the same for all tumors.

Rationale
Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

FOLLOW-UP CONTACT--NO&ST **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2392	60	SEER	3944-4003

Description
The number and street address or the rural mailing address of the follow-up contact's current usual residence. This can be used to generate a follow-up inquiry, and must correspond to the other fields in the follow-up contact address. If the patient has multiple tumors, Follow-Up Contact--No&St should be the same for all tumors.

U.S. addresses should conform to the USPS *Postal Addressing Standards*. These standards are referenced in USPS Pub. 28, November 2000, *Postal Addressing Standards*. The current USPS Pub. 28 may be found and downloaded from the following website: http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf.

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

Rationale
Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

Note: Prior to Version 5, Follow-Up Contact fields may have been used for patient current address in the NAACCR record layout.

FOLLOW-UP CONTACT--POSTAL **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	1846	9	SEER	2260-2268

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

Rationale
Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

Codes (in addition to U.S., Canadian, and foreign postal codes)

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

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

FOLLOW-UP CONTACT--STATE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	1844	2	SEER	2258-2259

Description
USPS abbreviation for the state (including U.S. territories, commonwealths, or possessions), or Canada Post abbreviation for the Canadian province/territory of the follow-up contact's current usual residence. If the patient has multiple tumors, the follow-up contact state should be the same for all tumors.

Rationale
Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

Codes (in addition to USPS and Canadian Postal Service abbreviations)

CD Resident of Canada, NOS (province/territory unknown)

US Resident of United States, NOS (state/commonwealth/territory/possession unknown)

XX Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known

YY Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown

ZZ Residence unknown

FOLLOW-UP CONTACT--SUPPL **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2393	60	SEER	4004-4063

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

Rationale
Sometimes registries carry out follow-up by contacting the patient and other contacts by a letter or phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting research studies.

FOLLOW-UP SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
Follow-Up Method (pre-96 CoC)	1790	1	CoC	2129-2129

Description
Records the source from which the latest follow-up information was obtained.

Rationale
For registries performing follow-up, this field helps evaluate the success rates of various methods of follow-up. It also can be used to report to institutions the source of follow-up information that is sent to them. When there is a conflict in follow-up information, knowing the source can help resolve the inconsistency.

Codes
0 Reported hospitalization
1 Readmission
2 Physician
3 Patient
4 Department of Motor Vehicles
5 Medicare/Medicaid file
7 Death certificate
8 Other
9 Unknown, not stated in patient record

FOLLOW-UP SOURCE CENTRAL **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	1791	2	NAACCR	2278-2279

Description
This field is created by the central registry. It records the source from which the consolidated information was obtained on a patient's vital status and date of last contact. Follow-up Source Central would be updated when new or more reliable information becomes available. However, when the existing date of last contact/vital status is deemed to be more reliable than newly obtained information, then neither the date of last contact/vital status nor the follow-up source central would be changed.

Rationale
For central registries performing follow-up, this field could help evaluate the success rates of various methods of follow-up. When new follow-up information conflicts with the existing information, knowing the follow-up source can help resolve any discrepancies.

Codes
00 Follow-up not performed for this patient
(01-29) File Linkages
01 Medicare/Medicaid File
02 Center for Medicare and Medicaid Services (CMS, formerly HCFA)
03 Department of Motor Vehicle Registration
04 National Death Index (NDI)
05 State Death Tape/Death Certificate File
06 County/Municipality Death Tape/ Death Certificate File
07 Social Security Administration Death Master File
08 Hospital Discharge Data
09 Health Maintenance Organization (HMO) file
10 Social Security Epidemiological Vital Status Data
11 Voter Registration File
12 Research/Study Related Linkage
29 Linkages, NOS
(30-39) Hospitals and Treatment Facilities
30 Hospital in-patient/outpatient
31 Casefinding
32 Hospital cancer registry
33 Radiation treatment center
34 Oncology clinic
35 Ambulatory surgical center
39 Clinic/facility, NOS

(40-49) Physicians
40 Attending physician
41 Medical oncologist
42 Radiation oncologist
43 Surgeon
48 Other specialist
49 Physician, NOS
(50-59) Patient
50 Patient contact
51 Relative contact
59 Patient, NOS
(60-98) Other
60 Central or Regional cancer registry
61 Internet sources
62 Hospice
63 Nursing homes
64 Obituary
65 Other research/study related sources
98 Other, NOS
99 Unknown source

FUTURE USE TIMELINESS 1 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	2114			

Description
Reserved for future use for storing date of a central registry processing milestone. No standards have been adopted for this item. The NAACCR UDSC retired this data item in Version 10.1, as of January 1, 2004.

FUTURE USE TIMELINESS 2 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	2115			

Description
Reserved for future use for storing date of a central registry processing milestone. No standards have been adopted for this item. The NAACCR UDSC retired this data item in Version 10.1, as of January 1, 2004.

GIS COORDINATE QUALITY **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	366	2	NAACCR	422-423

Description

Code indicating the basis of assignment of latitude and longitude coordinates for an individual record from an address. This data item is helpful in identifying cases that were assigned coordinates based on incomplete information, post office boxes, or rural routes. This item is coded at the central registry, not by the reporting facility. Most of the time, this information is provided by geocoding software. Alternatively, a central registry staff member manually assigns the code. Codes are hierarchical, with lower numbers having priority.

Rationale

Spatial analysis of cancer data often requires identifying data records with a high degree of geographic precision. Researchers can use this code as a basis for selecting records with a degree of precision that is appropriate to the study.

Codes

00 Coordinates derived from local government-maintained address points, which are based on property parcel locations, not interpolation over a street segment's address range
01 Coordinates assigned by Global Positioning System (GPS)
02 Coordinates are match of house number and street, and based on property parcel location
03 Coordinates are match of house number and street, interpolated over the matching street segment's address range
04 Coordinates are street intersections
05 Coordinates are at mid-point of street segment (missing or invalid building number)
06 Coordinates are address ZIP code+4 centroid
07 Coordinates are address ZIP code+2 centroid
08 Coordinates were obtained manually by looking up a location on a paper or electronic map
09 Coordinates are address 5-digit ZIP code centroid
10 Coordinates are point ZIP code of Post Office Box or Rural Route
11 Coordinates are centroid of address city (when address ZIP code is unknown or invalid, and there are multiple ZIP codes for the city)
12 Coordinates are centroid of county
98 Latitude and longitude are assigned, but coordinate quality is unknown
99 Latitude and longitude are not assigned, but geocoding was attempted; unable to assign coordinates based on available information
Blank GIS Coordinate Quality not coded

Instructions for Coding: Where multiple codes are applicable, use the lower code value.

Note: This data item is similar in function to Census Tract Certainty 1970/80/90 [364] and Census Tract Certainty 2000 [365]. The codes for this data item and the two census tract data items all describe how location information was assigned based on the patient's resident address at the time of diagnosis.

This data item must be populated if Latitude [2352] and Longitude [2354] are also populated.

GRADE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Grade, Differentiation, or Cell Lineage Indicator (SEER/CCCR) Grade/Differentiation (CoC)	440	1	SEER/CoC	555-555

Description
Code for the grade or degree of differentiation of the reportable tumor. For lymphomas and leukemias, field also is used to indicate T-, B-, Null-, or NK-cell origin.

Note: Code 8 was adopted for use with lymphoma cases diagnosed in 1995 and later.

Codes
See the grade tables on page 67 of ICD-O-3.[16] See also the most recent CoC *FORDS* manual and *SEER Program Code Manual*, for site specific coding rules and conversions.

1 Grade I
2 Grade II
3 Grade III
4 Grade IV
5 T-cell
6 B-cell
7 Null cell
8 NK (natural killer) cell
9 Grade/differentiation unknown, not stated, or not applicable

Comment: Use the most recent hematopoietic and lymphoid rules for assigning grades 5-8.

GRADE (73-91) ICD-O-1

Alternate Name	Item #	Length	Source of Standard	Column #
	1973	1	SEER	1918-1918

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

Codes
For cases diagnosed before 1992, contains the ICD-O-1 or field trial 1-digit grade code as originally coded, if available. [18, 19]

GRADE PATH SYSTEM **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	449	1	AJCC	557-557

Description
Indicates whether a two, three or four grade system is used.

Rationale
This item is used to show whether a two, three or four grade system is used. This is the grade system stated in the path report; it is not converted. This item is used in conjunction with Grade Path Value [441] and is abstracted in addition to Grade Differentiation [440].

Codes (Refer to the most recent version of *FORDS* for additional instructions.)
2 Two-Grade System
3 Three-Grade System
4 Four-Grade System
Blank Not a two, three or four grade system; unknown

GRADE PATH VALUE

Alternate Name	Item #	Length	Source of Standard	Column #
	441	1	AJCC	556-556

Description
Describes the actual grade according to the grading system in Grade Path System [449].

Rationale
This data item will record grade specified in Grade Path System. This does not replace Grade [440].

Codes (Refer to the most recent version of *FORDS* for additional instructions.)
1 Recorded as Grade I or 1
2 Recorded as Grade II or 2
3 Recorded as Grade III or 3
4 Recorded as Grade IV or 4
Blank No Two, Three or Four System Grade is available; unknown

HISTOLOGIC TYPE ICD-O-3 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
ICD-O-3 Histology (CCCR)	522	4	SEER/CoC	550-553

Description
Codes for the histologic type of the tumor being reported using ICD-O-3. NAACCR adopted ICD-O-3 as the standard coding system for tumors diagnosed in 2001 and later, and recommended that prior tumors be converted from ICD-O-2. Effective with 2010 diagnoses, this item also includes codes for new terms as per the 2008 WHO Hematopoietic/Lymphoid publication.[39]

Note: See Histology (92-00) ICD-O-2 [420] for ICD-O-2 codes.

Codes
See ICD-O-3,[14] Morphology Section and the SEER Hematopoietic database.

Clarification of Required Status
This data item is required by all standard-setting organizations for tumors diagnosed on or after January 1, 2001, and recommended (by conversion from ICD-O-2 codes when conversion algorithms and tables are available) for tumors diagnosed before 2001.

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

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

HISTOLOGY (73-91) ICD-O-1 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	1971	4	SEER	1913-1916

Description
Area for retaining the histology portion (4 digits) of the ICD-O-1 or field trial morphology codes entered before a conversion to ICD-O-2. See grouped data item Morph (73-91) ICD-O-1 [1970], in Appendix E. The item name includes years 1973-91. However, some states may have used the codes for cases before 1973.

Codes
For cases diagnosed before 1992, contains the ICD-O-1 or field trial 4-digit histology code as originally coded, if available. Blank for tumors coded directly into ICD-O-2 or ICD-O-3 (i.e., 1992 and later cases).

HISTOLOGY (92-00) ICD-O-2

Alternate Name	Item #	Length	Source of Standard	Column #
Histology (CoC) ICD-O-2 Histology (CCCR)	420	4	SEER/CoC	545-548

Description
Codes for the histologic type of the tumor being reported using ICD-O-2. NAACCR adopted ICD-O-2 as the standard coding system for tumors diagnosed in 1992 and later and recommended that prior cases be converted to ICD-O-2.

Note: See Histology (73-91) ICD-O-1 [1971] for ICD-O-1 and field trial codes.

Codes
See ICD-O-2,[15] Morphology Section.

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

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

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

ICD REVISION COMORBID

Alternate Name	Item #	Length	Source of Standard	Column #
ICD Revision Comorbidities	3165	1	CoC	1185-1185

Description
This item indicates the coding system in which the Comorbidities and Complications (secondary diagnoses) codes are provided.

Rationale
The CoC currently requires the collection and reporting of up to 10 ICD-9-CM codes describing secondary diagnoses for patients hospitalized for cancer treatment. Currently the use of ICD-10-CM is not mandatory in U.S. hospitals, though it may become so in the future. In the event this occurs cancer registries that maintain or collect this information will need to differentiate between ICD-9-CM and ICD-10-CM code use. The code values and definitions for this item would be expanded as necessary. Allowable codes reported in the Comorbidity and Complications items in *FORDS* would be re-assessed at the same time.

Codes
0 No comorbidities or complications recorded in patients record
1 ICD-10-CM
9 ICD-9-CM
Blank Comorbidities and Complications not collected

ICD REVISION NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
ICD Code Revision Used for Cause of Death (SEER)	1920	1	SEER	2273-2273

Description
Indicator for the coding scheme used to code the cause of death.

Codes
0 Patient alive at last follow-up
1 ICD-10
7 ICD-7
8 ICDA-8
9 ICD-9

ICD-O-2 CONVERSION FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
Review Flag for 1973-91 Cases (SEER)	1980	1	SEER	1919-1919

Description
Code specifying how the conversion of site and morphology codes from ICD-O-1 and the field trial editions to ICD-O-2 was accomplished. The item names include years 1973-91. However, some states may have used the codes for tumors before 1973. The code also covers morphology conversions from ICD-O-3 to ICD-O-2.

Codes
0 Primary site and morphology originally coded in ICD-O-2
1 Primary site and morphology converted without review
2 Primary site converted with review; morphology machine-converted without review
3 Primary site machine-converted without review, morphology converted with review
4 Primary site and morphology converted with review
5 Morphology converted from ICD-O-3 without review
6 Morphology converted from ICD-O-3 with review
Blank Not converted

ICD-O-3 CONVERSION FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	2116	1	SEER/CoC	2015-2015

Description
Code specifying how the conversion of site and morphology codes from ICD-O-2 to ICD-O-3 was accomplished.

Codes
0 Morphology (Morph--Type&Behav ICD-O-3 [521]) originally coded in ICD-O-3
1 Morphology (Morph--Type&Behav ICD-O-3 [521]) converted from (Morph--Type&Behav ICD-O-2 [419]) without review
3 Morphology (Morph--Type&Behav ICD-O-3 [521]) converted from (Morph--Type&Behav ICD-O-2 [419]) with review
Blank Not converted (clarification for cases diagnosed as of January 1, 2007: cases coded in prior ICD-O version and not converted to ICD-O-3)

IHS LINK

Alternate Name	Item #	Length	Source of Standard	Column #
Indian Health Service Linkage	192	1	NPCR	421-421

Description
This variable captures the results of the linkage of the registry database with the Indian Health Service patient registration database.

Rationale
The IHS linkage identifies cancer cases among American Indians who were misclassified as non-Indian in the registry database in order to improve the quality of cancer surveillance data on American Indians in individual registries and in all registries as a whole. The goal is to include cancer incidence data for American Indians in the United States Cancer Statistics by use of this variable as well as the race variable.

Codes
0 Record sent for linkage, no IHS match
1 Record sent for linkage, IHS match
Blank Record not sent for linkage or linkage result pending

INDUSTRY CODE--CENSUS

Alternate Name	Item #	Length	Source of Standard	Column #
	280	3	Census/NPCR	212-214

Description
Code for the patient's usual industry, using U.S. Census Bureau codes (2000 Census[26] is preferable) according to coding procedures recommended for death certificates.[25] This data item applies only to patients who are age 14 years or older at the time of diagnosis.

Note: Occupation/industry coding should NOT be performed by reporting facilities. This is a central cancer registry data item. Specially trained and qualified personnel should perform coding.

Note: 2000 Census codes for occupation and industry are recommended for tumors diagnosed on or after January 1, 2003.[26] The 1990 Census codes are recommended for tumors diagnosed before January 1, 2003.[24] For more information, see the U.S. Census Bureau website at: http://www.census.gov/hhes/www/ioindex/ioindex.html.

Rationale
Use of the Census Bureau classification system improves consistency of data collected from multiple sources. The Census Bureau industrial classification system is used for coding industry information from death certificates and from the U.S. Census of Population. The system includes specific coding rules.[22-27]

Codes
For the 1990 Census codes see Instructional Manual Part 19: *Industry and Occupation Coding for Death Certificates*, 1999[23] and related materials in the reference list, Chapter VI. A similar instruction manual for the 2000 Census codes has not been developed. Software for automated coding of occupation and industry is available from the Division of Safety Research, National Institute for Occupational Safety and Health, CDC. Contact Suzanne Marsh at (304) 285-6009 or at smm2@cdc.gov. As of press time, NIOSH was updating their automated coding software. The contact person for this software (which probably will not be available until after January 1, 2011) is Sue Nowlin, who can be contacted at sxn1@cdc.gov or (513) 841-4467.

INDUSTRY SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
	300	1	NPCR	216-216

Description
Code that best describes the source of industry information provided on this patient. This is a central cancer registry data item (i.e., codes should be applied by a central or regional registry rather than collected from reporting facilities).

Rationale
Industry information may come from a variety of sources. The most valid and reliable source of industry information for patients has not yet been determined.

Codes
0 Unknown industry/no industry available
1 Reporting facility records
2 Death certificate
3 Interview
7 Other source
8 Not applicable, patient less than 14 years of age at diagnosis
9 Unknown source
Blank Not collected

INPATIENT STATUS **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	605	1	NAACCR	775-775

Description
This data item records whether there was an inpatient admission for the most definitive therapy, or in the absence of therapy, for diagnostic evaluation. This data item was first available in Volume II Version 12 (effective January 2010).

Rationale
Before Version 12 (through 2009 diagnosis), date fields included information in addition to dates. This data item incorporates the non-date meanings for the Date of Inpatient Adm [590] and Date of Inpatient Disch [600] in order to retain the non-date information with the transition to interoperable dates.

Codes
0 Patient was never an inpatient
1 Patient was inpatient
9 Unknown if patient was an inpatient
Blank Not collected

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

INPATIENT/OUTPT STATUS **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	640			

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

INSTITUTION REFERRED FROM **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Facility Referred From	2410	10	CoC	4315-4324

Description
Identifies the facility that referred the patient to the reporting facility.

Rationale
Each facility's FIN is unique. This number is used to document and monitor referral patterns.

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

For facilities with 7-digit FINs, consisting of a constant "6" followed by 6-digit facility-specific codes in the range of 6020009-6953290 that were assigned by CoC before January 1, 2001: Enter all FIN codes of this type as 3 zeroes, followed by the constant "6" and the 6-digit facility-specific codes.

For facilities with FINs greater than or equal to 10000000 that were assigned by CoC after January 1, 2001: Enter FIN codes of this type as 2 zeroes followed by the full 8-digit code. These sometimes are called CoC FIN 10-digit codes.

Codes (in addition to CoC assigned codes)
0000000000 Case not referred from a facility
0099999999 Case referred from a facility, but facility number is unknown

INSTITUTION REFERRED TO **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Facility Referred To	2420	10	CoC	4335-4344

Description
Identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

Rationale
Each facility's FIN is unique. This number is used to document and monitor referral patterns.

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

For facilities with 7-digit FINs, consisting of a constant "6" followed by 6-digit facility-specific codes in the range of 6020009-6953290 that were assigned by CoC before January 1, 2001: Enter all FIN codes of this type as 3 zeroes, followed by the constant "6" and the 6-digit facility-specific codes.

For facilities with FINs greater than or equal to 10000000 that were assigned by CoC after January 1, 2001: Enter FIN codes of this type as 2 zeroes followed by the full 8-digit code. These sometimes are called CoC FIN 10-digit codes.

Codes (in addition to CoC assigned codes)
0000000000 Case not referred to a facility
0099999999 Case referred to a facility, but facility number is unknown

LAST FOLLOW-UP HOSPITAL **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	2430			

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

LATERALITY

Alternate Name	Item #	Length	Source of Standard	Column #
Laterality at Diagnosis (SEER)	410	1	SEER/CoC	544-544

Description
Code for the side of a paired organ, or the side of the body on which the reportable tumor originated. This applies to the primary site only.

Codes
0 Not a paired site
1 Right: origin of primary
2 Left: origin of primary
3 Only one side involved, right or left origin unspecified
4 Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5 Paired site: midline tumor
9 Paired site, but no information concerning laterality

LATITUDE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2352	10	NAACCR	4064-4073

Description
Paired with Longitude [2354], this represents the point location of the individual's residence on the earth's surface. It is typically determined by matching an address to a reference file or by identifying the residence using satellite imagery. This item is coded at the central registry, not by the reporting facility.

Rationale
Latitude and Longitude comprise the universal standard for designating location on the earth's surface. Geographic Information Systems software can be used to convert these values into projected coordinates for map display.

Allowable values and format
Latitude is a 10- digit numeric field, right justified, with up to six decimal places and an explicit decimal point. The format is x12.345678, where "x" is reserved for a negative sign for locations south of the equator. Latitude north of the equator is positive. The datum of the decimal degree data shall be North American Datum of 1983 (NAD 83).

Values are in decimal degrees, not degrees/minutes/seconds.

Correct: Latitude: 41. 890833

Not this: Latitude: 41 deg 53' 27"

LOC/REG/DISTANT STAGE **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	770			

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

LONGITUDE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2354	11	NAACCR	4074-4084

Description
Paired with Latitude [2352], this represents the point location of the individual's residence on the earth's surface. It is typically determined by matching an address to a reference file or by identifying the residence using satellite imagery. This item is coded at the central registry, not by the reporting facility.

Rationale
Latitude and Longitude comprise the universal standard for designating location on the earth's surface. Geographic Information Systems software can be used to convert these values into projected coordinates for map display.

Allowable values and format
Latitude is an 11 digit numeric field, right justified, with up to six decimal places and an explicit decimal point. The format is x123.456789, where "x" is reserved for a negative sign for locations west of the Prime Meridian (0 degrees) and east of 180 degrees. The datum of the decimal degree data shall be North American Datum of 1983 (NAD 83).

Values are in decimal degrees, not degrees/minutes/seconds.

Correct: Longitude: -123.128943

Not this: Longitude: -123 deg 7' 44"

LYMPH-VASCULAR INVASION **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	1182	1	AJCC	984-984

Description
Indicates whether lymphatic duct or blood vessel invasion (LVI) is identified in the pathology report.

Rationale
This data item will record the information as stated in the record. Presence or absence of cancer cells in the lymphatic ducts or blood vessels is useful for prognosis.

Codes
0 Lymph-vascular Invasion stated as Not Present
1 Lymph-vascular Invasion Present/Identified
8 Not Applicable
9 Unknown/Indeterminate/not mentioned in path report

MARITAL STATUS AT DX **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Marital Status at Diagnosis (SEER/CoC) Marital Status at Initial Diagnosis (pre-96 CoC)	150	1	SEER	176-176

Description
Code for the patient's marital status at the time of diagnosis for the reportable tumor. If the patient has multiple tumors, marital status may be different for each tumor.

Rationale
Incidence and survival with certain cancers vary by marital status. The item also helps in patient identification.

Codes
1 Single (never married)
2 Married (including common law)
3 Separated
4 Divorced
5 Widowed
6 Unmarried or Domestic Partner (same sex or opposite sex, registered or unregistered)
9 Unknown

MEDICAL RECORD NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	2300	11	CoC	3606-3616

Description
Records medical record number used by the facility to identify the patient. The CoC *FORDS* manual instructs registrars to record numbers assigned by the facility's Health Information Management (HIM) Department only, not department-specific numbers.

Rationale
This number identifies the patient in a facility. It can be used by a central registry to point back to the patient record, and it helps identify multiple reports on the same patient.

Codes (in addition to the medical record number)
UNK Medical record number unknown
RT Radiation therapy department patient without HIM number
SU 1-day surgery clinic patient without HIM number

Note: Other standard abbreviations may be used to indicate departments within the facility for patients without HIM numbers assigned.

MILITARY RECORD NO SUFFIX

Alternate Name	Item #	Length	Source of Standard	Column #
Military Medical Record Number Suffix (CoC)	2310	2	CoC	3617-3618

Description
Patient identifier used by military hospitals to record relationship of the patient to the sponsor.

Codes
01-19 Child
20 Sponsor
30-39 Spouse
40-44 Mother
45-49 Father
50-54 Mother-in-law
55-59 Father-in-law
60-69 Other eligible dependents
98 Civilian emergency (Air Force/Navy)
99 Not classified elsewhere/stillborn
Blank Not a military facility

MORPH (73-91) ICD-O-1

Alternate Name	Item #	Length	Source of Standard	Column #
	1970	6		1913-1918

Description
The name for a group of subfields describing the type and behavior of the tumor being reported using ICD-O-1 codes.

Group names appear only in the data dictionary and Appendix E.

Subfields
Histology (73-91) ICD-O-1 [1971]
Behavior (73-91) ICD-O-1 [1972]
Grade (73-91) ICD-O-1 [1973]

MORPH CODING SYS--CURRENT

Alternate Name	Item #	Length	Source of Standard	Column #
	470	1	NAACCR	560-560

Description
Code that best describes how morphology is currently coded. If converted, this field shows the system it is converted to.

Codes
1 ICD-O, First Edition
2 ICD-O, 1986 Field Trial
3 ICD-O, 1988 Field Trial
4 ICD-O, Second Edition
5 ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6 ICD-O, Second Edition, plus FAB codes effective 1/1/98
7 ICD-O, Third Edition
8 ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms effective 1/1/2010
9 Other

MORPH CODING SYS--ORIGINL

Alternate Name	Item #	Length	Source of Standard	Column #
	480	1	NAACCR	561-561

Description
Code that best describes how morphology was originally coded. If later converted, this field shows the original codes used.

Codes
1 ICD-O, First Edition
2 ICD-O, 1986 Field Trial
3 ICD-O, 1988 Field Trial
4 ICD-O, Second Edition
5 ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6 ICD-O, Second Edition, plus FAB codes effective 1/1/98
7 ICD-O, Third Edition
8 ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms effective 1/1/2010
9 Other

MORPH--TYPE&BEHAV ICD-O-2

Alternate Name	Item #	Length	Source of Standard	Column #
	419	5		545-549

Description
The name for a group of subfields describing the type and behavior of the tumor being reported using ICD-O-2 codes.

Group names appear only in the data dictionary and Appendix E.

Subfields
Histology (92-00) ICD-O-2 [420]
Behavior (92-00) ICD-O-2 [430]

MORPH--TYPE&BEHAV ICD-O-3

Alternate Name	Item #	Length	Source of Standard	Column #
	521	5		550-554

Description
The name for a group of subfields describing the type and behavior of the tumor being reported using ICD-O-3 codes.

Group names appear only in the data dictionary and Appendix E.

Subfields
Histologic Type ICD-O-3 [522]
Behavior Code ICD-O-3 [523]

MULT TUM RPT AS ONE PRIM **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Multiple Tumors Reported as Single Primary	444	2	SEER	577-578

Description

This data item is used to identify the type of multiple tumors in cases with multiple tumors that are abstracted and reported as a single primary using the SEER, IARC, or Canadian Cancer Registry multiple primary rules. Multiple tumors may individually exhibit *in situ*, invasive, or a combination of *in situ* and invasive behaviors. Multiple intracranial and central nervous system tumors may individually exhibit benign, borderline, malignant, or a combination of these behaviors. Multiple tumors found in the same organ or in a single primary site may occur at the time of initial diagnosis or later.

Rationale

Patients with multiple tumors that are currently reported as a single primary may have a worse prognosis or more extensive treatment than patients with a single tumor. This data item will make it possible to identify important information about these cases for data analysis, and to compare individually reported cancer cases with historical data if the rules are changed.

Codes (refer to http://seer.cancer.gov/tools/mphrules/index.html for additional instructions).

00 Single tumor
10 Multiple benign
11 Multiple borderline
12 Benign and borderline
20 Multiple *in situ*
30 *In situ* and invasive
31 Polyp and adenocarcinoma
32 FAP with carcinoma
40 Multiple invasive
80 Unknown *in situ* or invasive
88 NA
99 Unknown

MULTIPLICITY COUNTER **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	446	2	SEER	589-590

Description
This data item is used to count the number of tumors (multiplicity) that are reported as a single primary, when present at the time of diagnosis or occurring later.

Rationale
Patients with multiple tumors reported as a single primary for surveillance purposes may have a worse prognosis or more extensive treatment than patients with a single tumor. This data item will make it possible to identify important information about these cases for data analysis.

Codes (refer to http://seer.cancer.gov/tools/mphrules/index.html for additional instructions).
00 No primary tumor identified
01 One tumor only
02 Two tumors present; bilateral ovaries involved with cystic carcinoma
03 Three tumors present
..
..
88 Information on multiple tumors not collected/not applicable for this site
89 Multicentric, multifocal, number unknown
99 Unknown if multiple tumors; not documented
Blank Information not collected for this diagnosis date (e.g., all cases diagnosed prior to 2007)

Note: Codes 00 and 89 were added effective for 2011.

NAACCR RECORD VERSION **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	50	3	NAACCR	17-19

Description
This item applies only to record types I, C, A, and M. Code the NAACCR record version used to create the record. The correction record (U) has its own record version data item.

Rationale
The NAACCR Layout version is necessary to communicate to the recipient of data in NAACCR form where the various items are found and how they are coded. It should be added to the record when the record is created.

Codes
120 2010 Version 12
121 2011 Version 12.1

Historically (before 2010), this was a 1-character field with the following codes in column 19:

1 1992-1994 Version 2 and Version 3
4 1995 Version 4.0
5 1996 and 1997 Version 5.0 or Version 5.1
6 1998 Version 6
7 1999 Version 7
8 2000 Version 8
9 2001 and 2002 Version 9 and 9.1
A 2003, 2004, and 2005 Version 10, 10.1, and 10.2
B 2006, 2007, and 2008 Version 11, 11.1, 11.2, and 11.3
Blank September 1989 Version

Note: Code 4 was assigned to the 1995 Version to synchronize the document version and the layout version numbers. Layout document Versions 2 and 3 are coded as 1.

NAME--ALIAS **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Alias (CoC)	2280	40	CoC	3466-3505

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

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

NAME--FIRST

Alternate Name	Item #	Length	Source of Standard	Column #
First Name (CoC)	2240	40	CoC	3380-3419

Description
First name of the patient.

Note: The CoC *FORDS* manual allows this field to be blank. If facilities with CoC-approved cancer programs submit blanks to the central registry, it is suggested that the central registry devise procedures for completing the last and first name with text, such as UNKNOWN, after verifying with the hospital that the field was left intentionally blank.

NAME--LAST

Alternate Name	Item #	Length	Source of Standard	Column #
Last Name (CoC)	2230	40	CoC	3340-3379

Description
Last name of the patient.

Note: See the most recent *FORDS* for CoC allowable values.

NAME--MAIDEN **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Maiden Name (CoC)	2390	40	CoC	3506-3545

Description
Maiden name of female patients who are or have been married.

Rationale
This is used to link reports on a woman who changed her name between reports. It also is critical when using Spanish surname algorithms to categorize ethnicity.

The field should be left blank if the maiden name is not known or not applicable. Since a value in this field may be used by linkage software or other computer algorithms, only legitimate surnames are allowable, and any variation of "unknown" or "not applicable" is not allowable.

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

NAME--MIDDLE

Alternate Name	Item #	Length	Source of Standard	Column #
Middle Name (CoC) Middle Initial (pre-96 CoC)	2250	40	CoC	3420-3459

Description
Middle name or, if middle name is unavailable, middle initial of the patient.

NAME--PREFIX **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Name Prefix (CoC)	2260	3	CoC	3460-3462

Description
Abbreviated title that precedes name in a letter (e.g., "Rev," "Ms").

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

NAME--SPOUSE/PARENT

Alternate Name	Item #	Length	Source of Standard	Column #
	2290	60	NAACCR	3546-3605

Description
NAACCR has not adopted standards for this item. Use varies by area.

NAME--SUFFIX **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Name Suffix (CoC)	2270	3	CoC	3463-3465

Description
Title that follows a patient's last name, such as a generation order or credential status (e.g., "MD," "Jr.").

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

NEXT FOLLOW-UP SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
Next Follow-Up Method (pre-96 CoC)	1800	1	CoC	2130-2130

Description
Identifies the method planned for the next follow-up.

Codes
0 Chart requisition
1 Physician letter
2 Contact letter
3 Phone call
4 Other hospital contact
5 Other, NOS
8 Foreign residents (not followed)
9 Not followed, other cases for which follow-up is not required

NHIA DERIVED HISP ORIGIN

Alternate Name	Item #	Length	Source of Standard	Column #
	191	1	NAACCR	418-418

Description
The NAACCR Hispanic Identification Algorithm (NHIA) uses a combination of standard variables to directly or indirectly classify cases as Hispanic for analytic purposes. It is possible to separate Hispanic ancestral subgroups (e.g., Mexican) when indirect assignment results from birthplace information but not from surname match. The algorithm uses the following standard variables: Spanish/Hispanic Origin [190], Name--Last [2230], Name--Maiden [2390], Birthplace [250], Race 1 [160], IHS Link [192], and Sex [220].

Code 7 (Spanish surname only) of the Spanish/Hispanic Origin [190] data item became effective with 1994 diagnoses. It is recommended that NHIA should be run on 1995 and later diagnoses. However, a central registry may run it on their data for prior years. For greater detail, please refer to the technical documentation: http://www.naaccr.org/dat#NHIA.

Rationale
Sometimes despite best efforts to obtain complete information directly from the medical record, information is not available and is reported to the cancer registry as a missing data item. With regard to Hispanic ethnicity, some cancer registries have found it necessary to rely on indirect methods to populate this data element. Registries often have significant numbers or proportions of Hispanic populations in their jurisdiction.

Codes
0 Non-Hispanic
1 Mexican, by birthplace or other specific identifier
2 Puerto Rican, by birthplace or other specific identifier
3 Cuban, by birthplace or other specific identifier
4 South or Central American (except Brazil), by birthplace or other specific identifier
5 Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic), by birthplace or other specific identifier
6 Spanish, NOS; Hispanic, NOS; Latino, NOS
7 NHIA surname match only
8 Dominican Republic
Blank Algorithm has not been run

Note: Code 8 was added in Standards Volume II Version 10.2 effective January 2005.

NPI--ARCHIVE FIN

Alternate Name	Item #	Length	Source of Standard	Column #
	3105	10	CMS	711-720

Description
This field identifies the NPI number (National Provider Identifier) of the facility at the time it initially accessioned the tumor.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI-Archive FIN is the functional equivalent of Archive FIN [3100].

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

NPI--FOLLOWING REGISTRY

Alternate Name	Item #	Length	Source of Standard	Column #
	2445	10	CMS	4285-4294

Description
The NPI (National Provider Identifier) code that records the registry responsible for following the patient.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI equivalent of Following Registry [2440].

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

NPI--INST REFERRED FROM

Alternate Name	Item #	Length	Source of Standard	Column #
	2415	10	CMS	4305-4314

Description
The NPI (National Provider Identifier) code that identifies the facility that referred the patient to the reporting facility.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI equivalent of Institution Referred From [2410].

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]
Blank

NPI--INST REFERRED TO

Alternate Name	Item #	Length	Source of Standard	Column #
	2425	10	CMS	4325-4334

Description
The NPI (National Provider Identifier) code that identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI equivalent of Institution Referred To [2420].

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]
Blank

NPI--PHYSICIAN 3 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation Oncologist (CoC)	2495	10	CMS	4449-4458

Description
The NPI (National Provider Identifier) code for another physician involved in the care of the patient.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI equivalent of Physician 3 [2490].

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]
Blank

NPI--PHYSICIAN 4 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Medical Oncologist (CoC)	2505	10	CMS	4467-4476

Description
The NPI (National Provider Identifier) code for another physician involved in the care of the patient.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI equivalent of Physician 4 [2500].

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]
Blank

NPI--PHYSICIAN--FOLLOW-UP

Alternate Name	Item #	Length	Source of Standard	Column #
	2475	10	CMS	4413-4422

Description
The NPI (National Provider Identifier) code for the physician currently responsible for the patient's medical care.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI equivalent of Physician--Follow-Up [2470].

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]
Blank

NPI--PHYSICIAN--MANAGING

Alternate Name	Item #	Length	Source of Standard	Column #
	2465	10	CMS	4395-4404

Description
The NPI (National Provider Identifier) code that identifies the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI equivalent of Physician--Managing [2460].

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]
Blank

NPI--PHYSICIAN--PRIMARY SURG

Alternate Name	Item #	Length	Source of Standard	Column #
	2485	10	CMS	4431-4440

Description
The NPI (National Provider Identifier) code for the physician who performed the most definitive surgical procedure.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI equivalent of Physician--Primary Surg [2480].

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.]
Blank

NPI--REGISTRY ID

Alternate Name	Item #	Length	Source of Standard	Column #
	45	10	CMS	20-29

Description
The NPI (National Provider Identifier) code that represents the data transmission source. This item stores the NPI of the facility registry that transmits the record.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

If the transmission source is not a health care provider or a covered entity, this item will be blank and the item Registry ID [40] should be used to identify the transmission source.

Rationale
The NPI equivalent of Registry ID [40].

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

NPI--REPORTING FACILITY

Alternate Name	Item #	Length	Source of Standard	Column #
	545	10	CMS	691-700

Description
The NPI (National Provider Identifier) code for the facility submitting the data in the record.

NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Rationale
The NPI equivalent of Reporting Facility [540].

Codes [only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do]

NUMBER OF TUMORS/HIST **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	447		Retired	

Description
The NAACCR UDSC retired this data item in Version 11.2, effective January 1, 2008.

OCCUP/IND CODING SYSTEM

Alternate Name	Item #	Length	Source of Standard	Column #
	330	1	NPCR	417-417

Description
Code that identifies coding system used for occupation and industry. This is a central cancer registry data item (i.e., codes should be applied by a central or regional registry rather than collected from reporting facilities).

Codes
1 1970 Census
2 1980 Census
3 1990 Census
4 2000 Census
7 Other coding system
9 Unknown coding system
Blank Not collected

Note: 2000 Census codes for occupation and industry are recommended for tumors diagnosed on or after January 1, 2003.[26] The 1990 Census codes are recommended for tumors diagnosed before January 1, 2003.[24] For more information, see the U.S. Bureau of the Census website at: http://www.census.gov/hhes/www/ioindex/ioindex.html.

OCCUPATION CODE--CENSUS

Alternate Name	Item #	Length	Source of Standard	Column #
	270	3	Census/NPCR	209-211

Description
Code for the patient's usual occupation, using U.S. Census Bureau codes (2000 Census[26] is preferable) according to coding procedures recommended for death certificates.[25] This data item applies only to patients who are age 14 years or older at the time of diagnosis.

Note: Occupation/industry coding should NOT be performed by reporting facilities. This is a central registry data item. Specially trained and qualified personnel should perform coding.

Note: 2000 Census codes for occupation and industry are recommended for cancers diagnosed on or after January 1, 2003.[26] The 1990 Census codes are recommended for cancers diagnosed before January 1, 2003.[24] For more information, see the U.S. Bureau of the Census website at: http://www.census.gov/hhes/www/ioindex/ioindex.html.

Rationale
Use of the Census Bureau classification system improves consistency of data collected from multiple sources. The Census Bureau occupation classification system is used for coding occupation information from death certificates and from the U.S. Census of Population. The system includes specific coding rules. [22-27]

Codes
For the 1990 Census codes, see Instructional Manual Part 19: *Industry and Occupation Coding for Death Certificates*, 1999,[23] and related materials in the reference list, Chapter VI. A similar instruction manual for the 2000 Census codes has not been developed. Software for automated coding of occupation and industry is available from the Division of Safety Research, National Institute for Occupational Safety and Health, CDC. Contact Suzanne Marsh at (304) 285-6009 or at smm2@cdc.gov. As of press time, NIOSH was updating their automated coding software. The contact person for this software (which probably will not be available until after January 1, 2011) is Sue Nowlin, who can be contacted at sxn1@cdc.gov or (513) 841-4467.

OCCUPATION SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
	290	1	NPCR	215-215

Description
Code that best describes the source of occupation information provided on this patient. This is a central cancer registry data item (i.e., codes should be applied by a central or regional registry rather than collected from reporting facilities).

Rationale
Occupation information may come from a variety of sources. The most valid and reliable source of occupation information for patients has not yet been determined.

Codes

0	Unknown occupation/no occupation available
1	Reporting facility records
2	Death certificate
3	Interview
7	Other source
8	Not applicable, patient less than 14 years of age at diagnosis
9	Unknown source
Blank	Not collected

OTHER STAGING SYSTEM **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1070			

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

OVER-RIDE ACSN/CLASS/SEQ

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Accession/Class of Case/Sequence	1985	1	CoC	1891-1891

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software:
Accession Number, Class of Case, Seq Number (CoC).

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
The edit, Accession Number, Class of Case, Seq Number (CoC), checks the following:

1. If the case is the only case or the first of multiple cases diagnosed at the facility (Sequence Number--Hospital = 00, 01, 60, or 61, and Class of Case = 00, 10-14, or 40), then the first 4 characters of the Accession Number--Hosp must equal the year of the Date of 1st Contact.
2. If the case is first diagnosed at autopsy (Class of Case = 38) and the case is the only case or the first of multiple cases for a patient (Sequence Number--Hospital = 00, 01, 60, or 61), then the first 4 characters of the Accession Number--Hosp must equal the year of the Date of Last Contact AND must equal the year of the Date of 1st Contact.
3. If the case is first diagnosed at autopsy (Class of Case = 38) and the case is not the first case for a patient (Sequence Number--Hospital) greater than 01 or greater than 61), then the year of the Date of 1st Contact must equal the year of Date of Last Contact.

There are some exceptions to the above rules. Over-ride Acsn/Class/Seq may be used to override the edit when the circumstances fit the following situation or one similar to it:

The case may be the only or the first of multiple malignant cases for a patient (Sequence Number--Hospital = 00 or 01), but there is an earlier benign case (with an earlier year of the Date of 1st Contact) to which the Accession Number--Hosp applies.

Instructions for Coding

1. If edit generates an error or warning message, verify that the Accession Number--Hosp, Sequence Number--Hospital, and Class of Case are correct.
2. Leave blank if the program does not generate an error message for the edit Accession Number, Class of Case, Seq Number (CoC).
3. Leave blank and correct any errors for the case if an item is discovered to be incorrect.
4. Code 1 if review of accession number, sequence number and class of case verifies that they have been coded correctly and there is an unusual combination of these data items.

Codes

1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE AGE/SITE/MORPH

Alternate Name	Item #	Length	Source of Standard	Column #
Age/Site/Histology Interfield Review (Interfield Edit 15)	1990	1	SEER	1896-1896

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Age, Primary Site, Morphology ICDO2 (SEER IF15)
Age, Primary Site, Morphology ICDO3 (SEER IF15)
Age, Primary Site, Morph ICDO3--Adult (SEER)
Age, Primary Site, Morph ICDO3--Pediatric (NPCR)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Some cancers occur almost exclusively in certain age groups.

Edits of the type Age, Primary Site, Morphology require review if a site/morphology combination occurs in an age group for which it is extremely rare. The edit Age, Primary Site, Morph ICDO3--Adult (SEER) edits cases with an Age at Diagnosis of 15 and older. The edit Age, Primary Site, Morph ICDO3--Pediatric (NPCR) edits cases with an Age at Diagnosis of less than 15. The edits Age, Primary Site, Morphology ICDO2 (SEER IF15) and Age, Primary Site, Morphology ICDO3 (SEER IF15) contain logic for all ages.

Instructions for Coding
1. Leave blank if the program does not generate an error message (and if the case was not diagnosed *in utero*) for the edits of the type Age, Primary Site, Morphology.
2. Correct any errors for the case if an item is discovered to be incorrect.
3. Code 1 or 3 as indicated if review of items in the error or warning message confirms that all are correct.

Codes
1 Reviewed and confirmed that age/site/histology combination is correct as reported
2 Reviewed and confirmed that case was diagnosed *in utero*
3 Reviewed and confirmed that conditions 1 and 2 both apply
Blank Not reviewed or reviewed and corrected.

OVER-RIDE COC-SITE/TYPE

Alternate Name	Item #	Length	Source of Standard	Column #
	1987	1	CoC	1893-1893

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Primary Site, Morphology-Type ICDO2 (CoC)
Primary Site, Morphology-Type ICDO3 (CoC)
Primary Site, Morphology-Type, Behavior ICDO3 (CoC)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Multiple versions of edits of the type Primary Site, Morphology-Type check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus, uses a different over-ride flag. The CoC version of the edit will accept Over-ride CoC Site/Type or Over-ride Site/Type (the SEER edit) as equivalent.

> The Site/Histology validation list (available on the SEER web site) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not included. These edits require review of all combinations not listed.

Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if primary site is in the range C440-C449 (skin), and ICD-O-2 histology is in the range 8000-8004 (neoplasms, malignant, NOS), 8010-8045 (epithelial carcinomas), 8050-8082 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), or ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No over-ride is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether the combination is biologically plausible or whether cancer registry coding conventions would allow different codes for the diagnosis. Review of these rare combinations often results in a change to either the site or histology.

Instructions for Coding
1. Leave blank if the program does not generate an error message for the CoC edits of the type Primary Site, Morphology-Type.
2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.
3. Code 1 if review of all items in the error or warning message confirms they are correct and coded in conformance with coding rules.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 1 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3750	1	AJCC	2016-2016

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 2 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3751	1	AJCC	2017-2017

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 3 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3752	1	AJCC	2018-2018

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 4 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3753	1	AJCC	2019-2019

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 5 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3754	1	AJCC	2020-2020

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 6 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3755	1	AJCC	2021-2021

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 7 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3756	1	AJCC	2022-2022

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 8 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3757	1	AJCC	2023-2023

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 9 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3758	1	AJCC	2024-2024

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 10 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3759	1	AJCC	2025-2025

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 11 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3760	1	AJCC	2026-2026

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 12 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3761	1	AJCC	2027-2027

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 13 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3762	1	AJCC	2028-2028

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 14 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3763	1	AJCC	2029-2029

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 15 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3764	1	AJCC	2030-2030

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 16 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3765	1	AJCC	2031-2031

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 17 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3766	1	AJCC	2032-2032

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 18 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3767	1	AJCC	2033-2033

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 19 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3768	1	AJCC	2034-2034

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE CS 20 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	3769	1	AJCC	2035-2035

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE HISTOLOGY

Alternate Name	Item #	Length	Source of Standard	Column #
Histology/Behavior Interfield Review (Field Item Edit Morph)	2040	1	SEER	1901-1901

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Diagnostic Confirmation, Behavior ICDO2 (SEER IF31)
Diagnostic Confirmation, Behavior ICDO3 (SEER IF31)
Morph (1973-91) ICD-O-1 (SEER MORPH)
Morphology--Type/Behavior ICDO2 (SEER MORPH)
Morphology--Type/Behavior ICDO3 (SEER MORPH)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flags as Used in the EDITS Software Package
Edits of the type Diagnostic Confirmation, Behavior differ in the use of ICD-O-2 or ICD-O-3 and check that, for *in situ* cases (Behavior = 2), Diagnostic Confirmation specifies microscopic confirmation (1, 2, or 4).

The distinction between *in situ* and invasive is very important to a registry, since prognosis is so different. Since the determination that a neoplasm has not invaded surrounding tissues, i.e., *in situ*, is made microscopically, cases coded *in situ* in behavior should have a microscopic confirmation code. However, very rarely, a physician will designate a case noninvasive or *in situ* without microscopic evidence.

If an edit of the type, Diagnostic Confirmation, Behavior, gives an error message or warning, check that Behavior and Diagnostic Confirmation have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding.

Edits of the type, Morphology--Type/Behavior, perform the following check:

1. Codes listed in ICD-O-2 or ICD-O-3 with behavior codes of only 0 or 1 are considered valid, since the behavior matrix of ICD-O-2 and ICD-O-3 allows for the elevation of the behavior of such histologies when the tumor is *in situ* or malignant. This edit forces review of these rare cases to verify that they are indeed *in situ* or malignant.
2. The following histologies are generally not accepted as *in situ*: ICD-O-2 histologies 8000-8004, 8020, 8021, 8331, 8332, 8800-9054, 9062, 9082, 9083, 9110-9491, 9501-9989, ICD-O-3 histologies 8000-8005, 8020, 8021, 8331, 8332, 8800-9055, 9062, 9082, 9083, 9110-9493, 9501-9989. This edit forces review of these cases.
3. If a Morphology-Type/Behavior edit produces an error or warning message and the case is one in which the 4-digit morphology code is one that appears in ICD-O-2 or ICD-O-3 only with behavior codes of 0 or 1, or the case is one in which the 4-digit morphology code is not generally accepted with a behavior code of 2, verify the coding of morphology and that the behavior should be coded malignant or *in situ*. The registrar may need to consult a pathologist or medical advisor in problem cases.

Exceptions:
If year of Date of Diagnosis > 2000, then a behavior code of 1 is valid for the following ICD-O-2 histologies and no over-ride flag is needed: 8931, 9393, 9538, 9950, 9960-9962, 9980-9984, and 9989. Similarly, the following ICD-O-3 histologies are valid with a behavior code of 1: 8442, 8451, 8462, 8472, and 8473.

If year of Date of Diagnosis > 2003, the following ICD-O-3 benign histologies will pass without review: 8146, 8271, 8861, 8897, 9121, 9122, 9131, 9161, 9350, 9351, 9352, 9360, 9361, 9383, 9384, 9394, 9412, 9413, 9444, 9492, 9493, 9506, 9531, 9532, 9533, 9534, 9537, 9541, 9550, 9562, and 9570.

4. Grade 5-8 with histologies not in the range of 9590-9948 is impossible.
5. Some terms in ICD-O-2 and ICD-O-3 carry an implied statement of grade. These histologies must be reported with the correct grade as stated below. An error of this type cannot be over-ridden.

ICD-O-2
8020/34 Carcinoma, undifferentiated
8021/34 Carcinoma, anaplastic
8331/31 Follicular adenocarcinoma, well differentiated
8851/31 Liposarcoma, well differentiated
9062/34 Seminoma, anaplastic
9082/34 Malignant teratoma, undifferentiated
9083/32 Malignant teratoma, intermediate type
9401/34 Astrocytoma, anaplastic
9451/34 Oligodendroglioma, anaplastic
9511/31 Retinoblastoma, differentiated
9512/34 Retinoblastoma, undifferentiated

ICD-O-3
8020/34 Carcinoma, undifferentiated
8021/34 Carcinoma, anaplastic
8331/31 Follicular adenocarcinoma, well differentiated
9082/34 Malignant teratoma, undifferentiated
9083/32 Malignant teratoma, intermediate type
9401/34 Astrocytoma, anaplastic
9451/34 Oligodendroglioma, anaplastic
9511/31 Retinoblastoma, differentiated
9512/34 Retinoblastoma, undifferentiated

Instructions for Coding

1. Leave blank if the program does not generate an error message for the edits of the types, Diagnostic Confirmation, Behav Code or Morphology--Type/Behavior.
2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.
3. Code 1, 2, or 3 as indicated if review of all items in the error or warning message confirms that all are correct.

Codes

1 Reviewed and confirmed that the pathologist states the primary to be "*in situ*" or "malignant" although the behavior code of the histology is designated as "benign" or "uncertain" in ICD-O-2 or ICD-O-3
2 Reviewed and confirmed that the behavior code is "*in situ*," but the case is not microscopically confirmed
3 Reviewed and confirmed that conditions 1 and 2 both apply
Blank Not reviewed or reviewed and corrected

OVER-RIDE HOSPSEQ/DXCONF

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Hospital Sequence/Diagnostic Confirmation	1986	1	CoC	1892-1892

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software:
Diagnostic Confirm, Seq Num--Hosp (CoC)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
The edit, Diagnostic Confirm, Seq Num--Hosp (CoC), does the following:

1. If any case is one of multiple primaries and is not microscopically confirmed or lacks a positive lab test/marker study, i.e., Diagnostic Confirmation > 5 and Sequence Number--Hospital > 00 (more than one primary), review is required.
2. If Primary Site specifies an ill-defined or unknown primary (C760-C768, C809), no further checking is done.
3. If Sequence Number--Hospital is in the range of 60-88, this edit is skipped.

It is important to verify that the non-microscopically confirmed case is indeed a separate primary from any others that may have been reported. This edit forces review of multiple primary cancers when one of the primaries is coded to a site other than ill-defined or unknown and is not microscopically confirmed or confirmed by a positive lab test/marker study.

1. If the suspect case is confirmed accurate as coded and if the number of primaries is correct, set the Over-ride HospSeq/DxConf to 1. Do not set the over-ride flag on the patient's other primary cancers.
2. If it turns out that the non-microscopically confirmed cancer is considered a manifestation of one of the patient's other cancers, delete the non-microscopically confirmed case. Check the sequence numbers of remaining cases, correcting them if necessary. Also check for other data items on the remaining cases that may need to be changed as a result of the corrections, such as stage and treatment.

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Diagnostic Confirm, Seq Num--Hosp (CoC).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE HOSPSEQ/SITE

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Hospital Sequence/Site	1988	1	CoC	1894-1894

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Seq Num--Hosp, Primary Site, Morph ICDO2 (CoC)
Seq Num--Hosp, Primary Site, Morph ICDO3 (CoC)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Seq Num--Hosp, Primary Site, Morph differ in use of ICD-O-2 or ICD-O-3 morphology. They force review of multiple primary cancers when one of the primaries is coded to a site/morphology combination that could indicate a metastatic site rather than a primary site.

1. If Sequence Number--Hospital indicates the person has had more than one primary, then any case with one of the following site/histology combinations requires review:
   - C760-C768 (ill-defined sites) or C809 (unknown primary) and ICD-O-2 or ICD-O-3 histology < 9590. Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry, and should not be entered as a second primary.
   - C770-C779 (lymph nodes) and ICD-O-2 histology not in range 9590-9717 or ICD-O-3 histology not in the range 9590-9729; or C420-C424 and ICD-O-2 histology not in range 9590-9941 or ICD-O-3 histology not in the range 9590-9989. That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.
   - Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741 or ICD-O-3 histology in the range 9740-9758. Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.
2. If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

Instructions for Coding
- Leave blank if the program does not generate an error message for an edit of the type Seq Num--Hosp, Primary Site, Morph.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that hospital sequence number and site are both correct.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE ILL-DEFINE SITE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Sequence Number/Ill-defined Site Interfield Review (Interfield Edit 22)	2060	1	SEER	1903-1903

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Seq Num--Central, Prim Site, Morph ICDO2 (SEER IF22)
Seq Num--Central, Prim Site, Morph ICDO3 (SEER IF22)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Seq Num--Central, Primary Site, Morph differ in use of ICD-O-2 or ICD-O-3 morphology. They force review of multiple primary cancers when one of the primaries is coded to a site/morphology combination that could indicate a metastatic site rather than a primary site.

1. If Sequence Number-Central indicates the person has had more than one primary, then any case with one of the following site/histology combinations requires review:
   - C760-C768 (ill-defined sites) or C809 (unknown primary) and ICD-O-2 or ICD-O-3 histology < 9590. Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry, and should not be entered as a second primary.
   - C770-C779 (lymph nodes) and ICD-O-2 histology not in the range 9590-9717 or ICD-O-3 histology not in the range 9590-9729; or C420-C424 and ICD-O-2 histology not in the range 9590-9941 or ICD-O-3 histology not in the range 9590-9989. That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.
   - Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741 or ICD-O-3 histology in the range 9740-9758. Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.
2. If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

Instructions for Coding
- Code 1 can be used if a second or subsequent primary reporting with an ill-defined primary site has been reviewed and is indeed an independent primary.
- Leave blank and correct any errors for the caseif an item is discovered to be incorrect.

Codes
1 Reviewed and confirmed as reported: a second or subsequent primary reported with an ill-defined primary site (C76.0-C76.8, C80.9) has been reviewed and is an independent primary
Blank Not reviewed or reviewed and corrected

OVER-RIDE LEUK, LYMPHOMA

Alternate Name	Item #	Length	Source of Standard	Column #
Leukemia or Lymphoma/Diagnostic Confirmation Interfield Review (Interfield Edit 48)	2070	1	SEER	1904-1904

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Diagnostic Confirmation, Histology ICDO2 (SEER IF48)
Diagnostic Confirmation, Histology ICDO3 (SEER IF48)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Diagnostic Confirmation, Histology differ in use of ICD-O-2 or ICD-O-3 and check the following:

1. Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma that have diagnostic confirmation of direct visualization or clinical, and any leukemia with a diagnostic confirmation of direct visualization.
2. If histology = 9590-9717 for ICD-O-2 or 9590-9729 for ICD-O-3 (lymphoma) then Diagnostic Confirmation cannot be 6 (direct visualization) or 8 (clinical).
3. If histology = 9720-9941 for ICD-O-2 or 9731-9948 for ICD-O-3 (leukemia and other) then Diagnostic Confirmation cannot be 6 (direct visualization).

Instructions for Coding

- Leave blank if the program does not generate an error message for the edits of the type Diagnostic Confirmation, Histology.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- If the edit produces an error or warning message, verify that the ICD-O-2 or ICD-O-3 histology and diagnostic confirmation are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in Diagnostic Confirmation) for leukemia. Code 1 indicates that a review has taken place and histologic type and diagnostic confirmation are correctly coded.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE REPORT SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
Type of Reporting Source/Sequence Number Interfield Review (Interfield Edit 04)	2050	1	SEER	1902-1902

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Type of Rep Srce(DC),Seq Num--Cent, ICDO2 (SEER IF04)
Type of Rep Srce(DC),Seq Num--Cent, ICDO3 (SEER IF04)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Date Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type 'Type of Rep Srce(DC), Seq Num--Cent' checks that if the case is a death-certificate-only case and the histology is not a lymphoma, leukemia, immunoproliferative or myeloproliferative disease (ICD-O-2 or ICD-O-3 histology is less than 9590), then the tumor sequence number must specify one primary only (sequence '00').

Instructions for Coding
- Leave blank if the program does not generate an error message for the report source edit.
- Code 1 if review of type of reporting source, histologic type and tumor sequence number verified that a second or subsequent primary with a reporting source of death-certificate-only has been reviewed and is indeed an independent primary.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE SEQNO/DXCONF

Alternate Name	Item #	Length	Source of Standard	Column #
Sequence Number/Diagnostic Confirmation Interfield Review (Interfield Edit 23)	2000	1	SEER	1897-1897

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Diagnostic Confirm, Seq Num--Central (SEER IF23)

Rationale
Some edits check for code combinations that are impossible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
- The edit checks if the case is one of multiple primaries and is not microscopically confirmed or has only positive lab test/marker studies (i.e., Diagnostic Confirmation >5) and tumor sequence number >00 (more than one primary).
- The edit is skipped if the Sequence Number--Central is in the range of 60-99.

Instructions for Coding
- Leave blank if the program does not generate an error message for the Diagnostic Confirmation and Sequence Number Central edit.
- Code 1 if the cases have been reviewed and it is verified that there are multiple primaries of specific sites in which at least one diagnosis has not been microscopically confirmed.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE SITE/BEHAVIOR

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Flag for Site/Behavior (IF39)	2071	1	SEER	1905-1905

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Primary Site, Behavior Code ICDO2 (SEER IF39)
Primary Site, Behavior Code ICDO3 (SEER IF39)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type, Primary Site, Behavior Code, require review of the following primary sites with a behavior of *in situ* (ICD-O-2 or ICD-O-3 behavior = 2):

C269	Gastrointestinal tract, NOS
C399	Ill-defined sites within respiratory system
C559	Uterus, NOS
C579	Female genital tract, NOS
C639	Male genital organs, NOS
C689	Urinary system, NOS
C729	Nervous system, NOS
C759	Endocrine gland, NOS
C760-C768	Ill-defined sites
C809	Unknown primary site

Since the designation of *in situ* is very specific and almost always requires microscopic confirmation, ordinarily specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being *in situ* is reliable.

If an *in situ* diagnosis is stated, try to obtain a more specific primary site. A primary site within an organ system can sometimes be identified based on the diagnostic procedure or treatment given or on the histologic type. If no more specific site can be determined, it is usually preferable to code a behavior code of 3. In the exceedingly rare situation in which it is certain that the behavior is *in situ* and no more specific site code is applicable, set Over-ride Site/Behavior to 1.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Primary Site, Behavior Code ICDO2 (SEER IF39) and/or the edit Primary Site, Behavior Code ICDO3 (SEER IF39).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of site and behavior verifies that the patient has an *in situ* cancer of a nonspecific site and no further information about the primary site is available.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

Note: The IF 39 edit does not allow *in situ* cases of nonspecific sites, such as gastrointestinal tract, NOS; uterus, NOS; female genital tract, NOS; male genital organs, NOS; and others. The over-ride indicates that the conflict has been reviewed.

OVER-RIDE SITE/EOD/DX DT

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Flag for Site/EOD/Diagnosis Date (IF40) Over-ride Flag for Site/CS Extension/Diagnosis Date (IF176)	2072	1	SEER	1906-1906

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Primary Site, EOD, ICDO2 (SEER IF40)
Primary Site, EOD, ICDO3 (SEER IF40)
Primary Site, CS Extension (SEER IF 176)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of this type Primary Site, EOD do not allow "localized" disease with nonspecific sites, such as mouth, NOS; colon, NOS (except ICD-O-2 or ICD-O-3 histology 8210, 8220, 8261, or 8263); bone, NOS; female genital system, NOS; male genital organs, NOS; and others.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Primary Site, EOD, ICDO2 (SEER IF40) and/or the edit Primary Site, EOD, ICDO3 (SEER IF40).
- Code 1 if the case has been reviewed and it has been verified that the patient had "localized" disease with a nonspecific site and no further information about the primary site is available.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE SITE/LAT/EOD

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Flag for Site/Laterality/EOD (IF41) Over-ride Flag for Site/Laterality/CS Extension (IF177)	2073	1	SEER	1907-1907

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, Laterality, EOD, ICDO2 (SEER IF41)
Primary Site, Laterality, EOD, ICDO3 (SEER IF41)
Primary Site, Laterality, CS Extension (SEER IF177)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of this type Primary Site, Laterality, EOD apply to paired organs and do not allow EOD to be specified as *in situ*, localized, or regional by direct extension if laterality is coded as "bilateral, site unknown," or "laterality unknown."

Instructions for Coding

- Leave blank if the program does not generate an error message for the edit Primary Site, Laterality, EOD, ICDO2 (SEER IF41) and/or Primary Site, Laterality, EOD, ICDO3 (SEER IF41).
- Code 1 if the case has been reviewed and it has been verified that the patient had laterality coded nonspecifically and EOD coded specifically.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE SITE/LAT/MORPH

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Flag for Site/Laterality/Morphology (IF42)	2074	1	SEER	1908-1908

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Laterality, Primary Site, Morph ICDO2 (SEER IF42)
Laterality, Primary Site, Morph ICDO3 (SEER IF42)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type Laterality, Primary Site, Morph differ in use of ICD-O-2 or ICD-O-3 morphology and do the following:

1. If the Primary Site is a paired organ and ICD-O-2 or ICD-O-3 behavior is *in situ* (2), then laterality must be 1, 2, or 3.
2. If diagnosis year less than 1988 and ICD-O-2 or ICD-O-3 histology ≥ 9590, no further editing is performed.
3. If diagnosis year greater than 1987 and ICD-O-2 or ICD-O-3 histology = 9140, 9700, 9701, 9590-9980, no further editing is performed.

The intent of this edit is to force review of *in situ* cases for which laterality is coded 4 (bilateral) or 9 (unknown laterality) as to origin.

In rare instances when the tumor is truly midline (9) or the rare combination is otherwise confirmed correct, enter a code 1 for Override Site/Lat/Morph.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Laterality, Primary site, Morph ICDO2 (SEER IF 42) and/or the edit Laterality, Primary site, Morph ICDO3 (SEER IF42).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of site, laterality and morphology verifies that the case had behavior code of "*in situ*" and laterality is not stated as "right: origin of primary;" "left: origin of primary;" or "only one side involved, right or left origin not specified".

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE SITE/LAT/SEQNO

Alternate Name	Item #	Length	Source of Standard	Column #
Site/Histology/Laterality/Sequence Number Interrecord Review (Interrecord Edit 09)	2010	1	SEER	1898-1898

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following Interrecord Edit from the SEER Program:
Verify Same Primary Not Reported Twice for a Person (SEER IR09)

Presently, documentation on interrecord edits is not included in the EDITS software.

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Verify Same Primary Not Reported Twice for a Person (SEER IR09) applies to paired organs and does not allow two cases with the same primary site group, laterality and three digit histology code. This edit verifies that the same primary is not reported twice for a person.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Verify Same Primary Not Reported Twice for a Person (SEER IR09).
- Code 1 if the case has been reviewed and it has been verified that the patient had multiple primaries of the same histology (3 digit) in the same primary site group.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE SITE/TNM-STGGRP

Alternate Name	Item #	Length	Source of Standard	Column #
	1989	1	CoC	1895-1895

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software:
Primary Site, AJCC Stage Group -- Ed 6, ICDO3 (CoC)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
The edit, Primary Site, AJCC Stage Group -- Ed 6, ICDO3 (CoC), checks that the pathologic and clinical AJCC stage group codes are valid for the site and histology group according to the *AJCC Cancer Staging Manual Sixth Edition*, using the codes described for the items TNM Clin Stage Group [970] and TNM Path Stage Group [910]. Combinations of site and histology not represented in any AJCC schema must be coded 88. Unknown stage groups must be coded 99. Blanks are not permitted.

Since pediatric cancers whose sites and histologies have an AJCC scheme may be coded according to a pediatric scheme instead, Override Site/TNM-Stage Group is used to indicate pediatric cases not coded according to the AJCC manual. Pediatric Stage groups should not be recorded in the TNM Clin Stage Group or TNM Path Stage Group items. When neither clinical nor pathologic AJCC staging is used for pediatric cases, code all AJCC items 88. When any components of either is used to stage a pediatric case, follow the instructions for coding AJCC items and leave Override Site/TNM-Stage Group blank.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit, Primary Site, AJCC Stage Group -- Ed 6, ICDO3 (CoC).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case is confirmed to be a pediatric case that was coded using a pediatric coding system.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE SITE/TYPE

Alternate Name	Item #	Length	Source of Standard	Column #
Site/Type Interfield Review (Interfield Edit 25)	2030	1	SEER	1900-1900

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Primary Site, Morphology-Type ICDO2 (CoC)
Primary Site, Morphology-Type ICDO3 (CoC)
Primary Site, Morphology-Type ICDO2 (SEER IF25)
Primary Site, Morphology-Type ICDO3 (SEER IF25)
Primary Site, Morphology-Type, Behavior ICDO3 (SEER IF25)
Primary Site, Morphology-Type, Behavior ICDO3 (CoC)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Multiple versions of edits of the type Primary site, Morphology-Type check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different over-ride flag. The CoC version of the edit will accept Over-ride CoC-Site/Type or Over-ride Site/Type as equivalent.

1. The Site/Histology validation list (available on the SEER web site) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not included. These edits require review of all combinations not listed.
2. Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if Primary Site is in the range C440-C449 (skin), and ICD-O-2 histology is in the range 8000-8004 (neoplasms, malignant, NOS), 8010-8045 (epithelial carcinomas), 8050-8082 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), or ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No over-ride is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether a) the combination is biologically implausible, or b) there are cancer registry coding conventions that would dictate different codes for the diagnosis. Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.

Instructions for Coding

- Leave blank if the program does not generate an error message for the edits of the type Primary Site, Morphology-Type.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case has been reviewed and both the site and histology are correct.

Codes

1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE SS/DISMET1 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1984			

Description

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

OVER-RIDE SS/NODESPOS

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Summary Stage/Nodes Positive	1981	1	NAACCR	1888-1888

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Summary Stage 1977, Regional Nodes Pos (NAACCR)
Summary Stage 2000, Regional Nodes Pos (NAACCR)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error or warning message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
The edit Summary Stage 1977, Regional Nodes Pos (NAACCR) checks SEER Summary Stage 1977 against Regional Nodes Positive and generates an error or warning if there is an incompatibility between the two data items. The edit Summary Stage 2000, Regional Nodes Pos (NAACCR) checks SEER Summary Stage 2000 against Regional Nodes Positive and generates an error or warning if there is an incompatibility between the two data items.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Summary Stage 1977, Regional Nodes Pos (NAACCR) or the edit Summary Stage 2000, Regional Nodes Pos (NAACCR).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case has been reviewed and it has been verified that the case has both SEER Summary Stage 1977 and Nodes Positive coded correctly or SEER Summary Stage 2000 and Nodes Positive coded correctly.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE SS/TNM-M

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Summary Stage/TNM-M	1983	1	NAACCR	1890-1890

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Summary Stage 1977, TNM-M (NAACCR)
Summary Stage 2000, TNM-M (NAACCR)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error or warning message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
The edit Summary Stage 1977, TNM-M (NAACCR) checks the SEER Summary Stage 1977 against the TNM-M and generates a warning if the SEER Summary Stage 1977 is ‘distant’ and the TNM-M is ‘0’. (TNM-M is derived from TNM Path M and TNM Clin M, with TNM Path M having precedence.) It also checks if the SEER Summary Stage 1977 is not ‘distant’ and the TNM-M is greater than or equal to ‘1’ and generates an error or a warning. The edit Summary Stage 2000, TNM-M (NAACCR) checks the SEER Summary Stage 2000 against the TNM-M and generates a warning if the SEER Summary Stage 2000 is ‘distant’ and the TNM-M is ‘0’. It also checks if the SEER Summary Stage 2000 is not ‘distant’ and the TNM-M is greater than or equal to ‘1’ and generates an error or a warning.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Summary Stage 1977, TNM-M (NAACCR) or the edit Summary Stage 2000, TNM-M (NAACCR).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case has been reviewed and it has been verified that both SEER Summary Stage 1977 and TNM-M have been coded correctly or that SEER Summary Stage 2000 and TNM-M have been coded correctly.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE SS/TNM-N

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Summary Stage/TNM-N	1982	1	NAACCR	1889-1889

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
Summary Stage 1977, TNM-N (NAACCR)
Summary Stage 2000, TNM-N (NAACCR)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
The edit Summary Stage 1977, TNM-N (NAACCR) checks SEER Summary Stage 1977 against the TNM-N and generates an error if the SEER Summary Stage 1977 indicates regional nodal involvement and the TNM-N does not. (TNM-N is derived from TNM Path N and TNM Clin N, with TNM Path N having precedence.) It also generates an error if the SEER Summary Stage 1977 is '*in situ*' or 'localized' and the TNM-N is greater than or equal to '1'. The edit Summary Stage 2000, TNM-N (NAACCR) checks SEER Summary Stage 2000 against the TNM-N and generates an error if the SEER Summary Stage 2000 indicates regional nodal involvement and the TNM-N does not. It also generates an error if the SEER Summary Stage 2000 is '*in situ*' or 'localized' and the TNM-N is greater than or equal to '1'.

Instructions for Coding
- Leave blank if the program does not generate an error message for the edit Summary Stage 1977, TNM-N (NAACCR) or the edit Summary Stage 2000, TNM-N (NAACCR).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case has been reviewed and it has been verified that both SEER Summary Stage 1977 and TNM-N or both SEER Summary Stage 2000 and TNM-N have been coded correctly.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

OVER-RIDE SURG/DXCONF

Alternate Name	Item #	Length	Source of Standard	Column #
Surgery/Diagnostic Confirmation Interfield Review (Interfield Edit 46)	2020	1	SEER	1899-1899

Description
Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:
RX Summ--Surg Prim Site, Diag Conf (SEER IF76)
RX Summ--Surg Site 98-02, Diag Conf (SEER IF106)
RX Summ--Surgery Type, Diag Conf (SEER IF46)

Rationale
Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards.

Over-ride Flag as Used in the EDITS Software Package
Edits of the type RX Summ--Surg Prim Site, Diag Conf check that cases with a primary site surgical procedure coded 20-90 are histologically confirmed.

If the patient had a surgical procedure, most likely there was a microscopic examination of the cancer. Verify the surgery and diagnostic confirmation codes, and correct any errors. Sometimes there are valid reasons why no microscopic confirmation is achieved with the surgery; for example, the tissue removed may be inadequate for evaluation.

Instructions for Coding
- Leave blank if the program does not generate an error message for edits of the type, RX Summ--Surg Prim Site, Diag Conf.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review confirms that they are correct. The patient had surgery, but the tissue removed was not sufficient for microscopic confirmation.

Codes
1 Reviewed and confirmed as reported
Blank Not reviewed or reviewed and corrected

PAIN ASSESSMENT **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	3260			

Description
This data item was published in *FORDS* but later withdrawn by CoC and never implemented. The NAACCR UDSC retired this data item in Version 10.1, as on January 1, 2004.

PATH DATE SPEC COLLECT 1

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-7 Observation Date/Time #00241 (HL7) Path--Date Spec Collection	7320	14	HL7	4580-4593

Description
Records the date and time of the specimen collection for the cancer being reported, not the date read or date the report was typed.

Rationale
Describes the origin of the pathology report contributing to this cancer abstract. The date that the specimen was collected is likely to correspond to the procedure date at the facility where a specimen was obtained.

PATH DATE SPEC COLLECT 2

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-7 Observation Date/Time #00241 (HL7) Path--Date Spec Collection	7321	14	HL7	4686-4699

Description
Records the date and time of the specimen collection for the cancer being reported, not the date read or date the report was typed.

Rationale
Describes the origin of the pathology report contributing to this cancer abstract. The date that the specimen was collected is likely to correspond to the procedure date at the facility where a specimen was obtained.

PATH DATE SPEC COLLECT 3

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-7 Observation Date/Time #00241 (HL7) Path Date Spec Collect 2	7322	14	HL7	4792-4805

Description
Records the date and time of the specimen collection for the cancer being reported, not the date read or date the report was typed.

Rationale
Describes the origin of the pathology report contributing to this cancer abstract. The date that the specimen was collected is likely to correspond to the procedure date at the facility where a specimen was obtained.

PATH DATE SPEC COLLECT 4

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-7 Observation Date/Time #00241 (HL7) Path--Date Spec Collection	7323	14	HL7	4898-4911

Description
Records the date and time of the specimen collection for the cancer being reported, not the date read or date the report was typed.

Rationale
Describes the origin of the pathology report contributing to this cancer abstract. The date that the specimen was collected is likely to correspond to the procedure date at the facility where a specimen was obtained.

PATH DATE SPEC COLLECT 5

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-7 Observation Date/Time #00241 (HL7) Path Date Spec Collect 4	7324	14	HL7	5004-5017

Description
Records the date and time of the specimen collection for the cancer being reported, not the date read or date the report was typed.

Rationale
Describes the origin of the pathology report contributing to this cancer abstract. The date that the specimen was collected is likely to correspond to the procedure date at the facility where a specimen was obtained.

PATH ORDER PHYS LIC NO 1 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-16 Ordering Provider (License Number) #00226 Path Ordering Client/Phys--Lic No.	7100	20	HL7	4621-4640

Description
License number of physician submitting specimens for the first path report.

This data item accommodates only one path report. If additional reports were prepared, enter the license number of physician in Path Order Phys Lic No 2 through Path Order Phys Lic No 5 [7101-7104]. Information in this data item should refer to the path report described in data items 7010, 7090, 7190, and 7480.

Rationale
Describes the origin of the first pathology report contributing to this cancer abstract.

PATH ORDER PHYS LIC NO 2 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-16 Ordering Provider (License Number) #00226 Path Ordering Client/Phys--Lic No.	7101	20	HL7	4727-4746

Description
License number of physician submitting specimens for the second path report.

This data item accommodates only one path report; if additional path reports were prepared, enter the license number of physician in Path Order Phys Lic No 3 through Path Order Phys Lic No 5 [7102-7104]. Information in this data item should refer to the path report described in data items 7011, 7091, 7191, and 7481.

Rationale
Describes the origin of the second pathology report contributing to this cancer abstract.

PATH ORDER PHYS LIC NO 3 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-16 Ordering Provider (License Number) #00226 Path Ordering Client/Phys--Lic No.	7102	20	HL7	4833-4852

Description
License number of physician submitting specimens for the third path report.

This item accommodates only one path report; if additional path reports were prepared, enter the license number of physician in Path Order Phys Lic No 4 through Path Order Phys Lic No 5 [7103-7104]. Information in this data item should refer to the path report described in data items 7012, 7022, 7192, and 7482.

Rationale
Describes the origin of the third pathology report contributing to this cancer abstract.

PATH ORDER PHYS LIC NO 4 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-16 Ordering Provider (License Number) #00226 Path Ordering Client/Phys--Lic No.	7103	20	HL7	4939-4958

Description
License number of physician submitting specimens for the fourth path report.

This data item accommodates only one path report; if an additional path report was prepared, enter the license number of physician in Path Order Phys Lic No 5 [7104]. Information in this data item should refer to the path report described in data items 7013, 7023, 7193, and 7483.

Rationale
Describes the origin of the fourth pathology report contributing to this cancer abstract.

PATH ORDER PHYS LIC NO 5

Alternate Name	Item #	Length	Source of Standard	Column #
	7104	20	HL7	5045-5064

Description
License number of physician submitting specimens for the fifth path report.

Information in this data item should refer to the path report described in data items 7014, 7024, 7194, and 7484.

Rationale
Describes the origin of the fifth pathology report contributing to this cancer abstract.

PATH ORDERING FAC NO 1 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)	7190	25	HL7	4596-4620

Description
Facility ID number of the facility where the specimen described in the first path report was removed/collected.

Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).

This item accommodates only one path report; if additional path reports were prepared, enter the facility ID number(s) in Path Ordering Fac No 2 through Path Ordering Fac No 5 [7191-7194]. Information in this data item should refer to the path report described in data items 7010, 7090, 7100, and 7480.

Rationale
Describes the origin of the first pathology report contributing to this cancer abstract. The facility where the specimen was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

PATH ORDERING FAC NO 2 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)	7191	25	HL7	4702-4726

Description
Facility ID number of the facility where the specimen described in the second path report was removed/collected.

Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).

This item accommodates only one path report; if additional path reports were prepared, enter the facility ID number(s) in Path Ordering Fac No 3 through Path Ordering Fac No 5 [7192-7194]. Information in this data item should refer to the path report described in data items 7011, 7091, 7101, and 7481.

Rationale
Describes the origin of the second pathology report contributing to this cancer abstract. The facility where the specimen was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

PATH ORDERING FAC NO 3 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)	7192	25	HL7	4808-4832

Description
Facility ID number of the facility where the specimen described in the third path report was removed/collected.

Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).

This item accommodates only one path report; if additional path reports were prepared, enter the facility ID number(s) in Path Ordering Fac No 4 through Path Ordering Fac No 5 [7193-7194]. Information in this data item should refer to the path report described in data items 7012, 7092, 7102, and 7482.

Rationale
Describes the origin of the third pathology report contributing to this cancer abstract. The facility where the specimen was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

PATH ORDERING FAC NO 4 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)	7193	25	HL7	4914-4938

Description
Facility ID number of the facility where the specimen described in the fourth path report was removed/collected.

Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).

This item accommodates only one path report; if an additional path report was prepared, enter the facility ID number in Path Ordering Fac No 5 [7194]. Information in this data item should refer to the path report described in data items 7013, 7093, 7103, and 7483.

Rationale
Describes the origin of the fourth pathology report contributing to this cancer abstract. The facility where the specimen was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

PATH ORDERING FAC NO 5

Alternate Name	Item #	Length	Source of Standard	Column #
ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)	7194	25	HL7	5020-5044

Description
Facility ID number of the facility where the specimen described in the fifth path report was removed/collected.

Use the National Provider Identifier (NPI) if possible. Otherwise, use a number defined by the American Hospital Association (AHA), or some other standard-setting organization such as the American College of Surgeons (ACoS) or Clinical Laboratory Improvement Amendments (CLIA).

This item accommodates only one path report. Information in this data item should refer to the path report described in data items 7014, 7094, 7104, and 7484.

Rationale
Describes the origin of the fifth pathology report contributing to this cancer abstract. The facility where the specimen described in the fifth path report was obtained is most likely the location of the medical record for the patient as well as any residual tissue.

PATH REPORT NUMBER 1

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-3 Filler Order Number #00217 (HL7) Path Report Number	7090	20	HL7	4560-4579

Description
Unique sequential number assigned by a laboratory to the first report for this case.

This item accommodates only one path report. When information is available for more than one path report, enter the path report number(s) in Path Report No 2 through Path Report No 5 [7091-7094]. Information in this data item should refer to the path report described in data items 7010, 7100, 7190, and 7480.

Rationale
Describes the first pathology report contributing to this cancer abstract. The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow-back with the pathology facility.

PATH REPORT NUMBER 2

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-3 Filler Order Number #00217 (HL7) Path Report Number	7091	20	HL7	4666-4685

Description
Unique sequential number assigned by a laboratory to the second report for this case.

This item accommodates only one path report. When information is available for more than two path reports, enter the path report number(s) in Path Report No 3 through Path Report No 5 [7092-7094]. Information in this data item should refer to the path report described in data items 7011, 7101, 7191, and 7481.

Rationale
Describes the second pathology report contributing to this cancer abstract. The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow-back with the pathology facility.

PATH REPORT NUMBER 3

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-3 Filler Order Number #00217 (HL7) Path Report Number	7092	20	HL7	4772-4791

Description
Unique sequential number assigned by a laboratory to the third report for this case.

This item accommodates only one path report. When information is available for more than three path reports, enter the path report number(s) in Path Report No 4 through Path Report No 5 [7093-7094]. Information in this data item should refer to the path report described in data items 7012, 7102, 7192, and 7482.

Rationale
Describes the third pathology report contributing to this cancer abstract. The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow-back with the pathology facility.

PATH REPORT NUMBER 4

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-3 Filler Order Number #00217 (HL7) Path Report Number	7093	20	HL7	4878-4897

Description
Unique sequential number assigned by a laboratory to the fourth report for this case.

This item accommodates only one path report. When information is available for more than four path reports, enter the path report number in Path Report No 5 [7094]. Information in this data item should refer to the path report described in data items 7013, 7103, 7193, and 7483.

Rationale
Describes the fourth pathology report contributing to this cancer abstract. The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow-back with the pathology facility.

PATH REPORT NUMBER 5

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-3 Filler Order Number #00217 (HL7) Path Report Number	7094	20	HL7	4984-5003

Description
Unique sequential number assigned by a laboratory to the fifth report for this case.

This item accommodates only one path report. Information in this data item should refer to the path report described in data items 7014, 7104, 7194, and 7484.

Rationale
Describes the fifth pathology report contributing to this cancer abstract. The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow-back with the pathology facility.

PATH REPORT TYPE 1

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-4 Universal Service ID #00238 (HL7) Path--Report Type	7480	2	HL7	4594-4595

Description
This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the path report type(s) in Path Report Type 2 through Path Report Type 5 [7481-7484]. Information in this data item should refer to the path report described in data items 7010, 7100, 7090, and 7190.

Rationale
Describes the origin of the first pathology report contributing to this cancer abstract. This variable is primarily used for administrative purposes at the cancer registry.

Codes
01 Pathology
02 Cytology
03 Gyn Cytology
04 Bone Marrow (biopsy/aspirate)
05 Autopsy
06 Clinical Laboratory Blood Work, NOS
07 Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)
08 Cytogenetics
09 Immunohistochemical Stains
10 Molecular Studies
11 Flow Cytometry, Immunophenotype
98 Other
99 Unknown

PATH REPORT TYPE 2

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-4 Universal Service ID #00238 (HL7) Path--Report Type	7481	2	HL7	4700-4701

Description
This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the path report type(s) in Path Report Type 3 through Path Report Type 5 [7482-7484]. Information in this data item should refer to the path report described in data items 7011, 7101, 7091, and 7191.

Rationale
Describes the origin of the second pathology report contributing to this cancer abstract. This variable is primarily used for administrative purposes at the cancer registry.

Codes
01 Pathology
02 Cytology
03 Gyn Cytology
04 Bone Marrow (biopsy/aspirate)
05 Autopsy
06 Clinical Laboratory Blood Work, NOS
07 Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)
08 Cytogenetics
09 Immunohistochemical Stains
10 Molecular Studies
11 Flow Cytometry, Immunophenotype
98 Other
99 Unknown

PATH REPORT TYPE 3

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-4 Universal Service ID #00238 (HL7) Path--Report Type	7482	2	HL7	4806-4807

Description
This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the path report type(s) in Path Report Type 4 through Path Report Type 5 [7433-7484]. Information in this data item should refer to the path report described in data items 7012, 7102, 7092, and 7192.

Rationale
Describes the origin of the third pathology report contributing to this cancer abstract. This variable is primarily used for administrative purposes at the cancer registry.

Codes
01 Pathology
02 Cytology
03 Gyn Cytology
04 Bone Marrow (biopsy/aspirate)
05 Autopsy
06 Clinical Laboratory Blood Work, NOS
07 Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)
08 Cytogenetics
09 Immunohistochemical Stains
10 Molecular Studies
11 Flow Cytometry, Immunophenotype
98 Other
99 Unknown

PATH REPORT TYPE 4

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-4 Universal Service ID #00238 (HL7) Path--Report Type	7483	2	HL7	4912-4913

Description
This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. If an additional path report was prepared, enter the path report type in Path Report Path Report Type 5 [7484]. Information in this data item should refer to the path report described in data items 7013, 7103, 7093, and 7193.

Rationale
Describes the origin of the fourth pathology report contributing to this cancer abstract. This variable is primarily used for administrative purposes at the cancer registry.

Codes
01 Pathology
02 Cytology
03 Gyn Cytology
04 Bone Marrow (biopsy/aspirate)
05 Autopsy
06 Clinical Laboratory Blood Work, NOS
07 Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)
08 Cytogenetics
09 Immunohistochemical Stains
10 Molecular Studies
11 Flow Cytometry, Immunophenotype
98 Other
99 Unknown

PATH REPORT TYPE 5

Alternate Name	Item #	Length	Source of Standard	Column #
OBR-4 Universal Service ID #00238 (HL7) Path--Report Type	7484	2	HL7	5018-5019

Description
This field reflects the type of report transmitted to the cancer registry and may need to be classified at the central cancer registry.

This data item accommodates information for only one path report. Information in this data item should refer to the path report described in data items 7014, 7104, 7094, and 7194.

Rationale
Describes the origin of the fifth pathology report contributing to this cancer abstract. This variable is primarily used for administrative purposes at the cancer registry.

Codes
01 Pathology
02 Cytology
03 Gyn Cytology
04 Bone Marrow (biopsy/aspirate)
05 Autopsy
06 Clinical Laboratory Blood Work, NOS
07 Tumor Marker (p53, CD's Ki, CEA, Her2/Neu, etc.)
08 Cytogenetics
09 Immunohistochemical Stains
10 Molecular Studies
11 Flow Cytometry, Immunophenotype
98 Other
99 Unknown

PATH REPORTING FAC ID 1 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084	7010	25	HL7	4535-4559

Description
An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the first report of the case.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the identifying code of pathology facility sending the report in Path Reporting Fac ID 2 through Path Reporting Fac ID 5 [7011-7014]. Information in this data item should refer to the path report described in data items 7100, 7090, 7190, and 7480.

Rationale
Describes the origin of the first pathology report contributing to this cancer abstract. Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.

PATH REPORTING FAC ID 2 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084	7011	25	HL7	4641-4665

Description
An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the second report of the case.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the identifying code of pathology facility sending the report in Path Reporting Fac ID 3 through Path Reporting Fac ID 5 [7012-7014]. Information in this data item should refer to the path report described in data items 7101, 7091, 7191, and 7481.

Rationale
Describes the origin of the second pathology report contributing to this cancer abstract. Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.

PATH REPORTING FAC ID 3 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084	7012	25	HL7	4747-4771

Description
An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the third report of the case.

This data item accommodates information for only one path report. If additional path reports were prepared, enter the identifying code of pathology facility sending the report in Path Reporting Fac ID 4 through Path Reporting Fac ID 5 [7013-7014]. Information in this data item should refer to the path report described in data items 7102, 7092, 7192, and 7482.

Rationale
Describes the origin of the third pathology report contributing to this cancer abstract. Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.

PATH REPORTING FAC ID 4 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084	7013	25	HL7	4853-4877

Description
An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the fourth report of the case.

This data item accommodates information for only one path report. If an additional path report was prepared, enter the identifying code of pathology facility sending the report in Path Reporting Fac ID 5 [7014]. Information in this data item should refer to the path report described in data items 7103, 7093, 7193, and 7483.

Rationale
Describes the origin of the fourth pathology report contributing to this cancer abstract. Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.

PATH REPORTING FAC ID 5 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084	7014	25	HL7	4959-4983

Description
An identifying code (for example, a CLIA number) that uniquely identifies the pathology facility sending the fifth report of the case.

Information in this data item should refer to the path report described in data items 7104, 7094, 7194, and 7484.

Rationale
Describes the origin of the fifth pathology report contributing to this cancer abstract. Clinical Laboratory Improvement Act Identification Numbers (CLIAs) are used for laboratory reporting.

PATIENT ID NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	20	8	Reporting Registry	42-49

Description
Unique number assigned to an individual patient by the central registry. The central registry will assign this same number to all of the patient's subsequent tumors (records).

Patient ID Number will only differ when multiple central registries accession the same patient. Each central registry will assign their unique Patient ID Number.

NAACCR recommends that the registry should not reissue or reuse this number when a patient's record is deleted from the files.

In the transmit file (data exchange) this number will be the Patient ID Number assigned by the sending registry as defined in Registry ID [40].

Rationale
Provides the central registry with a unique identification number that will link all records (multiple tumors) for the same patient. The unique number also allows the central registry to identify the patient when there are multiple reports from different hospitals.

PATIENT SYSTEM ID-HOSP

Alternate Name	Item #	Length	Source of Standard	Column #
	21	8	NAACCR	50-57

Description
The unique, non-repeating number automatically assigned to patients by the hospital tumor registry software system. The same number is used for all the patient's subsequent tumors. This Patient System ID-Hosp number should not be reused when a patient is deleted.

This number is different from Accession Number-Hosp [550]. While Accession Number-Hosp [550] is subject to change, the Patient System ID-Hosp number is created and maintained by the hospital tumor registry's software system, and requires no key entry. Because the Patient System ID-Hosp number is unchanging, it affords an absolute linkage between a hospital patient record and a central registry's patient record.

Rationale
This provides a stable identifier to link back to all reported tumors for a patient. It also serves as a reliable linking identifier; useful when central registries send follow-up information back to hospitals. Other identifiers such as social security number and medical record number, while useful, are subject to change and are thus less useful for this type of record linkage.

PEDIATRIC STAGE

Alternate Name	Item #	Length	Source of Standard	Column #
	1120	2	CoC	976-977

Description
Code for stage of pediatric tumor in an AJCC stage scheme, a pediatric intergroup study scheme, or a pediatric cooperative group scheme.

Rationale
Staging of pediatric tumors requires very different schemes from those used to stage adult tumors.

Codes
See the *ROADS Manual* for allowable codes for this field.
Note: This data item is no longer supported by CoC (as of January 1, 2003).

PEDIATRIC STAGED BY

Alternate Name	Item #	Length	Source of Standard	Column #
Staged By (Pediatric Stage) (CoC)	1140	1	CoC	980-980

Description
Code for person who documented the pediatric staging system and stage.

Codes
0 Not staged
1 Managing physician
2 Pathologist
3 Other physician
4 Any combination of 1, 2, or 3
5 Registrar
6 Any combination of 5 with 1, 2, or 3
7 Other
8 Staged, individual not specified
9 Unknown if staged

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

PEDIATRIC STAGING SYSTEM

Alternate Name	Item #	Length	Source of Standard	Column #
Type of Staging System (Pediatric) (CoC)	1130	2	CoC	978-979

Description
Staging system used to assign the Pediatric Stage.

Rationale
Staging of pediatric tumors requires very different schemes from those used to stage adult tumors.

Codes
00 None
01 AJCC
02 Ann Arbor
03 Children's Cancer Group (CCG)
04 Evans
05 General Summary
06 Intergroup Ewings
07 Intergroup Hepatoblastoma
08 Intergroup Rhabdomyosarcoma
09 International System
10 Murphy
11 NCI (pediatric oncology)
12 National Wilms Tumor Study
13 Pediatric Oncology Group (POG)
14 Reese-Ellsworth
15 SEER Extent of Disease
88 Not applicable (not pediatric case)
97 Other
99 Unknown

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

PHYSICIAN 3

Alternate Name	Item #	Length	Source of Standard	Column #
Physician #3 (CoC) Other Physician (pre-96 CoC)	2490	8	CoC	4459-4466

Description
Code for another physician involved in the care of the patient. Registry may use physicians' medical license numbers or may create individual numbering systems. See the most recent *FORDS* manual for suggested use of this item and detailed instructions.

Codes in addition to medical license numbers or facility-generated codes
00000000 None, no additional physician
99999999 Physician is unknown or an identification number is not assigned

PHYSICIAN 4

Alternate Name	Item #	Length	Source of Standard	Column #
Physician #4 (CoC) Other Physician (pre-96 CoC)	2500	8	CoC	4477-4484

Description
Code for another physician involved in the care of the patient. Registry may use physicians' medical license numbers or may create individual numbering systems. See the most recent *FORDS* manual for suggested use of this item and detailed instructions.

Codes in addition to medical license numbers or facility-generated codes
00000000 None, no additional physician
99999999 Physician is unknown or an identification number is not assigned

PHYSICIAN--FOLLOW-UP

Alternate Name	Item #	Length	Source of Standard	Column #
Following Physician (CoC) Follow-Up Physician (pre-96 CoC)	2470	8	CoC	4423-4430

Description
Code for the physician currently responsible for the patient's medical care. Registry may use physicians' medical license numbers or may create individual numbering systems.

Codes in addition to medical license numbers or facility-generated codes
99999999 Follow-up physician unknown or ID number not assigned

PHYSICIAN--MANAGING

Alternate Name	Item #	Length	Source of Standard	Column #
Managing Physician (CoC) Attending Physician (pre-96 CoC)	2460	8	NAACCR	4405-4412

Description
Code for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer. Registry may use physicians' medical license numbers or may create individual numbering systems.

Codes in addition to medical license numbers or facility-generated codes
99999999 Managing physician unknown or ID number not assigned

PHYSICIAN--PRIMARY SURG

Alternate Name	Item #	Length	Source of Standard	Column #
Primary Surgeon (CoC)	2480	8	CoC	4441-4448

Description
Code for physician who performed the most definitive surgical procedure. Registry may use physician's medical license numbers or may create individual numbering systems.

Codes in addition to medical license numbers or facility-generated codes

00000000	Patient had no surgery and no surgical consultation
88888888	Physician who performed a surgical procedure was not a surgeon (i.e., radiation oncologist, diagnostic radiologist, or general practitioner)
99999999	Primary Surgeon unknown or ID number not assigned

PLACE OF DEATH

Alternate Name	Item #	Length	Source of Standard	Column #
	1940	3	NPCR	2275-2277

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

Rationale
This field also helps carry out death clearance. When a hospital reports a place of death, the information can help in death certificate matching. It can also signal an out-of-state death for which the death certificate is to be requested.

Codes in addition to geocodes

997	Not applicable, patient alive
999	Place of death unknown

Note: See Appendix B for geocodes.

PRESENTATION AT CA CONF **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	650			

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

PRIMARY PAYER AT DX

Alternate Name	Item #	Length	Source of Standard	Column #
Primary Payer at Diagnosis (CoC)	630	2	CoC	778-779

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

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

Codes
01 Not insured
02 Not insured, self-pay
10 Insurance, NOS
20 Private Insurance: Managed care, HMO, or PPO
21 Private Insurance: Fee-for-Service
31 Medicaid
35 Medicaid -- Administered through a Managed Care plan
60 Medicare/Medicare, NOS
61 Medicare with supplement, NOS
62 Medicare -- Administered through a Managed Care plan
63 Medicare with private supplement
64 Medicare with Medicaid eligibility
65 TRICARE
66 Military
67 Veterans Affairs
68 Indian/Public Health Service
99 Insurance status unknown

PRIMARY SITE

Alternate Name	Item #	Length	Source of Standard	Column #
IDC-O-2/3 Topography (CCCR)	400	4	SEER/CoC	540-543

Description
Code for the primary site of the tumor being reported using either ICD-O-2 or ICD-O-3. NAACCR adopted ICD-O-2 as the standard coding system for tumors diagnosed beginning January 1, 1992. In addition, NAACCR recommended that tumors diagnosed prior to 1992 be converted to ICD-O-2. The topography (primary site) codes did not change between ICD-O-2 and ICD-O-3.

Codes
See ICD-O-2,[14] or ICD-O-3,[13] Topography Section, for the codes for primary site.
Note: See data item Site (73-91) ICD-O-1 [1960] for ICD-O-1 cases.

PROTOCOL ELIGIBILITY STAT **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1470			

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

PROTOCOL PARTICIPATION **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1480			

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

QUALITY OF SURVIVAL

Alternate Name	Item #	Length	Source of Standard	Column #
	1780	1	CoC	2128-2128

Description
Records patient's ability to carry on the activities of daily living at the date of last contact.

Codes
0 Normal activity
1 Symptomatic and ambulatory
2 Ambulatory more than 50 percent of the time, occasionally needs assistance
3 Ambulatory less than 50 percent of the time, nursing care needed
4 Bedridden, may require hospitalization
8 Not applicable, dead
9 Unknown or unspecified

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

RACE 1

Alternate Name	Item #	Length	Source of Standard	Column #
Race	160	2	SEER/CoC	177-178

Description
Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current *SEER Program Coding and Staging Manual*.[3]

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf (Appendix G).

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Codes
01 White
02 Black
03 American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)
04 Chinese
05 Japanese
06 Filipino
07 Hawaiian
08 Korean
*
10 Vietnamese
11 Laotian
12 Hmong
13 Kampuchean (Cambodian)
14 Thai
15 Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16 Asian Indian
17 Pakistani
20 Micronesian, NOS
21 Chamorran
22 Guamanian, NOS
25 Polynesian, NOS
26 Tahitian
27 Samoan
28 Tongan
30 Melanesian, NOS
31 Fiji Islander
32 New Guinean

96 Other Asian, including Asian, NOS and Oriental, NOS
97 Pacific Islander, NOS
98 Other
99 Unknown
*****Code 09 was retired effective with Version 12. See codes 15-17.

RACE 2

Alternate Name	Item #	Length	Source of Standard	Column #
	161	2	SEER/CoC	179-180

Description
Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current *SEER Program Coding and Staging Manual.* [3]

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf (Appendix G).

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Codes
01 White
02 Black
03 American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)
04 Chinese
05 Japanese
06 Filipino
07 Hawaiian
08 Korean
*****
10 Vietnamese
11 Laotian
12 Hmong
13 Kampuchean (Cambodian)
14 Thai
15 Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16 Asian Indian
17 Pakistani
20 Micronesian, NOS
21 Chamorran

22 Guamanian, NOS
25 Polynesian, NOS
26 Tahitian
27 Samoan
28 Tongan
30 Melanesian, NOS
31 Fiji Islander
32 New Guinean
88 No further race documented
96 Other Asian, including Asian, NOS and Oriental, NOS
97 Pacific Islander, NOS
98 Other
99 Unknown
Blank Race 2-5 not coded
*****Code 09 was retired effective with Version 12. See codes 15-17.

Note: If diagnosed prior to 2000 and any race code (Race 2, 3, 4, or 5) is blank, all subsequent race codes must be blank. If diagnosed after 1999 and any race code (for Race 2, 3, 4, and 5) is 88 (no further race documented), then all subsequent race codes also must be 88. If any race equals 99, then all race codes (Race 1, 2, 3, 4, and 5) must be 99.

RACE 3

Alternate Name	Item #	Length	Source of Standard	Column #
	162	2	SEER/CoC	181-182

Description
Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current *SEER Program Coding and Staging Manual.* [3]

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf (Appendix G).

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Codes

01	White
02	Black
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
*	
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean (Cambodian)
14	Thai
15	Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16	Asian Indian
17	Pakistani
20	Micronesian, NOS
21	Chamorran
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	New Guinean
88	No further race documented
96	Other Asian, including Asian, NOS and Oriental, NOS
97	Pacific Islander, NOS
98	Other
99	Unknown
Blank	Race 2-5 not coded

*****Code 09 was retired effective with Version 12. See codes 15-17.

Note: If diagnosed prior to 2000 and any race code (Race 2, 3, 4, or 5) is blank, all subsequent race codes must be blank. If diagnosed after 1999 and any race code (for Race 2, 3, 4, and 5) is 88 (no further race documented), then all subsequent race codes also must be 88. If any race equals 99, then all race codes (Race 1, 2, 3, 4, and 5) must be 99.

RACE 4

Alternate Name	Item #	Length	Source of Standard	Column #
	163	2	SEER/CoC	183-184

Description
Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current *SEER Program Coding and Staging Manual*.[3]

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf (Appendix G).

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Codes
01 White
02 Black
03 American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere).
04 Chinese
05 Japanese
06 Filipino
07 Hawaiian
08 Korean
*
10 Vietnamese
11 Laotian
12 Hmong
13 Kampuchean (Cambodian)
14 Thai
15 Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16 Asian Indian
17 Pakistani
20 Micronesian, NOS
21 Chamorran
22 Guamanian, NOS
25 Polynesian, NOS
26 Tahitian
27 Samoan
28 Tongan

30 Fiji Islander
31 Fiji Islander
32 New Guinean
88 No further race documented
96 Other Asian, including Asian, NOS and Oriental, NOS
97 Pacific Islander, NOS
98 Other
99 Unknown
Blank Race 2-5 not coded
***** Code 09 was retired effective with Version 12. See codes 15-17.

Note: If diagnosed prior to 2000 and any race code (Race 2, 3, 4, or 5) is blank, all subsequent race codes must be blank. If diagnosed after 1999 and any race code (for Race 2, 3, 4, and 5) is 88 (no further race documented), then all subsequent race codes also must be 88. If any race equals 99, then all race codes (Race 1, 2, 3, 4, and 5) must be 99.

RACE 5

Alternate Name	Item #	Length	Source of Standard	Column #
	164	2	SEER/CoC	185-186

Description
Code the patient's race. Race is coded separately from Spanish/Hispanic Origin [190]. All tumors for the same patient should have the same race codes. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164]. For coding instructions and race code history see the current *SEER Program Coding and Staging Manual.*[3]

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf (Appendix G).

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Codes

01 White
02 Black
03 American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)
04 Chinese
05 Japanese
06 Filipino
07 Hawaiian
08 Korean
*****
10 Vietnamese
11 Laotian
12 Hmong
13 Kampuchean (Cambodian)
14 Thai
15 Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16 Asian Indian
17 Pakistani
20 Micronesian, NOS
21 Chamorran
22 Guamanian, NOS
25 Polynesian, NOS
26 Tahitian
27 Samoan
28 Tongan
30 Melanesian, NOS
31 Fiji Islander
32 New Guinean
88 No further race documented
96 Other Asian, including Asian, NOS and Oriental, NOS
97 Pacific Islander, NOS
98 Other
99 Unknown
Blank Race 2-5 not coded

*****Code 09 was retired effective with Version 12. See codes 15-17.

Note: If diagnosed prior to 2000 and any race code (Race 2, 3, 4, or 5) is blank, all subsequent race codes must be blank. If diagnosed after 1999 and any race code (for Race 2, 3, 4, and 5) is 88 (no further race documented), then all subsequent race codes also must be 88. If any race equals 99, then all race codes (Race 1, 2, 3, 4, and 5) must be 99.

RACE CODING SYS--CURRENT **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	170	1	NAACCR	187-187

Description
Code that best describes how Race [160] currently is coded. If the data have been converted, this field shows the system to which it has been converted.

Rationale
Race 1 - 5 codes [160 -- 164] have changed over time. To be able to accurately group and analyze the data, it is necessary to record the system used to record the race codes.

Codes
1 4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2 SEER < 1988 (1-digit)
3 1988-1990 SEER & CoC (2-digit)
4 1991-1993 SEER & CoC (added codes 20-97, additional Asian and Pacific Islander codes)
5 1994-1999 SEER & CoC (added code 14, Thai)
6 2000+ SEER & CoC (added code 88 for Race 2, 3, 4, and 5)
7 2010+ SEER & CoC (added codes 15, 16, and 17; removed 09)
9 Other

RACE CODING SYS--ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Column #
	180	1	NAACCR	188-188

Description
Code that best describes how Race [160] originally was coded. If data have been converted, this field identifies the coding system originally used to code the case.

Rationale
Race 1 - 5 codes [160 -- 164] have changed over time. Identifying both original and current coding systems used to code race promotes accurate data grouping and analysis.

Codes
1 4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2 SEER < 1988 (1-digit)
3 1988-1990 SEER & CoC (2-digit)
4 1991-1993 SEER & CoC (added codes 20-97, additional Asian and Pacific Islander codes)
5 1994-1999 SEER & CoC (added code 14, Thai)
6 2000+ SEER & CoC (added code 88 for Race 2, 3, 4, and 5)
7 2010+ SEER & CoC (added codes 15, 16, and 17; removed 09)
9 Other

RACE--NAPIIA(DERIVED API) **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Race--NAPIIA	193	2	NAACCR	419-420

Description
NAPIIA is an acronym for NAACCR Asian and Pacific Islander Identification Algorithm. Race--NAPIIA (derived API) recodes some single-race cases with a Race 1 [160] code of 96 to a more specific Asian race category, based on an algorithm that makes use of the birthplace and name fields (first, last, and maiden names). For single-race cases with a Race 1 code other than 96, it returns the Race 1 code. Multiple-race cases (those with information in Race 2 through Race 5, [161-164]) are handled variously; for greater detail please refer to the technical documentation: http://www.naaccr.org/filesystem/pdf/NAPIIA%20v1.1%2007032008.pdf

In Version 1.1 of the algorithm, birthplace can be used to indirectly assign a specific race to one of eight Asian race groups (Chinese, Japanese, Vietnamese, Korean, Asian Indian, Filipino, Thai, and Cambodian), and names can be used to indirectly assign a specific race to one of seven Asian groups (Chinese, Japanese, Vietnamese, Korean, Asian Indian, Filipino, and Hmong). Subsequent versions of NAPIIA may incorporate Pacific Islanders and may potentially incorporate name lists for Thai, Cambodian, and Laotians.

Rationale
The use of more specific Asian and Pacific Islander codes will enhance surveillance and research activities focused on specific API subgroups.

Codes
01 White
02 Black
03 American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western Hemisphere)
04 Chinese
05 Japanese
06 Filipino
07 Hawaiian
08 Korean
*
10 Vietnamese
11 Laotian
12 Hmong
13 Kampuchean (Cambodian)
14 Thai
15 Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16 Asian Indian
17 Pakistani
20 Micronesian, NOS
21 Chamorran
22 Guamanian, NOS
25 Polynesian, NOS
26 Tahitian
27 Samoan
28 Tongan

30 Melanesian, NOS
31 Fiji Islander
32 New Guinean
96 Other Asian, including Asian, NOS and Oriental, NOS
97 Pacific Islander, NOS
98 Other
99 Unknown
Blank Algorithm was not run

* Code 09 was retired effective with Version 12. See codes 15-17.

RAD--BOOST DOSE CGY

Alternate Name	Item #	Length	Source of Standard	Column #
Boost Radiation Dose: cGY	3210	5	CoC	1611-1615

Description
Records the additional dose delivered to that part of the treatment volume encompassed by the boost fields or devices. The unit of measure is centiGray (cGy).

Rationale
To evaluate patterns of radiation oncology care, it is necessary to describe the boost radiation dose. A boost dose is administered to a volume within the regional volume. As in chemotherapy, outcomes are strongly related to the dose delivered.

Codes (in addition to value dose)
(Fill blanks) Record the actual boost dose delivered
00000 Boost radiation therapy was not administered
88888 Not applicable, brachytherapy or radioisotopes administered to the patient
99999 Boost radiation therapy administered, boost dose unknown

RAD--BOOST RX MODALITY

Alternate Name	Item #	Length	Source of Standard	Column #
Boost Radiation Treatment Modality	3200	2	CoC	1609-1610

Description
Records the dominant modality of radiation therapy used to deliver the most clinically significant boost dose to the primary volume of interest during the first course of treatment. This is accomplished with external beam fields of reduced size (relative to the regional treatment fields), implants, stereotactic radiosurgery, conformal therapy, or intensity-modulated radiation therapy. External beam boosts may consist of two or more successive phases with progressively smaller fields, and they are generally coded as a single entity. This field is used with Rad--Regional RX Modality [1570].

Rationale
Radiation treatment frequently is delivered in two or more phases that can be summarized as regional and boost treatments. A boost dose is administered to a volume within the regional volume. For outcomes analysis, the modalities used for each of these phases can be very important

Codes
00 No boost treatment
20 External beam, NOS
21 Orthovoltage
22 Cobalt-60, Cesium-137
23 Photons (2-5 MV)
24 Photons (6-10 MV)
25 Photons (11-19 MV)
26 Photons (> 19 MV)
27 Photons (mixed energies)
28 Electrons
29 Photons and electrons mixed
30 Neutrons, with or without photons/electrons
31 IMRT
32 Conformal or 3-D therapy
40 Protons
41 Stereotactic radiosurgery, NOS
42 Linac radiosurgery
43 Gamma Knife
50 Brachytherapy, NOS
51 Brachytherapy, Intracavitary, LDR
52 Brachytherapy, Intracavitary, HDR
53 Brachytherapy, Interstitial, LDR
54 Brachytherapy, Interstitial, HDR
55 Radium
60 Radio-isotopes, NOS
61 Strontium -- 89
62 Strontium -- 90
98 Other, NOS
99 Unknown

RAD--ELAPSED RX DAYS **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1530			

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

RAD--INTENT OF TREATMENT **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1560			

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

RAD--LOCAL CONTROL STATUS **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1590			

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

RAD--LOCATION OF RX

Alternate Name	Item #	Length	Source of Standard	Column #
Location of Radiation Treatment (CoC)	1550	1	CoC	1606-1606

Description
Identifies the location of the facility where radiation treatment was administered during first course of treatment. See also RX Summ--Radiation [1360].

Codes
0 No radiation treatment
1 All radiation treatment at this facility
2 Regional treatment at this facility, boost elsewhere
3 Boost radiation at this facility, regional elsewhere
4 All radiation treatment elsewhere
8 Other, NOS
9 Unknown

RAD--NO OF TREATMENT VOL **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Number of Treatments to this Volume (CoC)	1520	3	CoC	1601-1603

Description

Records the total number of treatment sessions (fractions) administered during the first course of therapy. See also RX-- Treatment Volume [1540].

Codes

000	None
001-998	Number of treatments
999	Unknown

RAD--REGIONAL DOSE: CGY

Alternate Name	Item #	Length	Source of Standard	Column #
Regional Dose: cGy (CoC)	1510	5	CoC	1596-1600

Description

The dominant or most clinically significant total dose of regional radiation therapy delivered to the patient during the first course of treatment. The unit of measure is centiGray (cGy). See also Rad--Regional RX Modality [1570].

Codes (in addition to actual doses)

(Fill spaces)	Record the actual regional dose delivered
00000	Radiation therapy was not administered
88888	Not applicable, brachytherapy or radioisotopes administered to the patient
99999	Regional radiation therapy was administered, but the dose is unknown

RAD--REGIONAL RX MODALITY

Alternate Name	Item #	Length	Source of Standard	Column #
Regional Treatment Modality (CoC)	1570	2	CoC	1607-1608

Description
Records the dominant modality of radiation therapy used to deliver the clinically most significant regional dose to the primary volume of interest during the first course of treatment.

Rationale
Radiation treatment frequently is delivered in two or more phases that can be summarized as regional and boost treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Codes
00 No radiation treatment
20 External beam, NOS
21 Orthovoltage
22 Cobalt-60, Cesium-137
23 Photons (2-5 MV)
24 Photons (6-10 MV)
25 Photons (11-19 MV)
26 Photons (> 19 MV)
27 Photons (mixed energies)
28 Electrons
29 Photons and electrons mixed
30 Neutrons, with or without photons/electrons
31 IMRT
32 Conformal or 3-D therapy
40 Protons
41 Stereotactic radiosurgery, NOS
42 Linac radiosurgery
43 Gamma Knife
50 Brachytherapy, NOS
51 Brachytherapy, Intracavitary, Low Dose Rate (LDR)
52 Brachytherapy, Intracavitary, High Dose Rate (HDR)
53 Brachytherapy, Interstitial, Low Dose Rate (LDR)
54 Brachytherapy, Interstitial, High Dose Rate (HDR)
55 Radium

60 Radio-isotopes, NOS
61 Strontium -- 89
62 Strontium -- 90
80* Combination modality, specified
85* Combination modality, NOS
98 Other, NOS
99 Unknown

Note: For tumors diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation administered to the patient as part or all of the first course of therapy.

*Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to *Volume II ROADS*, and *DAM* rules and should only be used to record regional radiation for tumors diagnosed prior to January 1, 2003.

RAD--RX COMPLETION STATUS **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1580			

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

RAD--TREATMENT VOLUME

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation Treatment Volume (CoC)	1540	2	CoC	1604-1605

Description
Identifies the volume or anatomic target of the most clinically significant regional radiation therapy delivered to the patient during the first course of therapy. See also Rad--Regional RX Modality [1570].

Codes
00 No radiation therapy, not applicable
01 Eye/orbit
02 Pituitary
03 Brain (NOS)
04 Brain (limited)
05 Head and neck (NOS)
06 Head and neck (limited)
07 Glottis
08 Sinuses
09 Parotid
10 Chest/lung (NOS)
11 Lung (limited)
12 Esophagus
13 Stomach
14 Liver

15	Pancreas
16	Kidney
17	Abdomen (NOS)
18	Breast
19	Breast/lymph nodes
20	Chest wall
21	Chest wall/lymph nodes
22	Mantle, mini-mantle
23	Lower extended field
24	Spine
25	Skull
26	Ribs
27	Hip
28	Pelvic bones
29	Pelvis (NOS)
30	Skin
31	Soft tissue
32	Hemibody
33	Whole body
34	Bladder and pelvis
35	Prostate and pelvis
36	Uterus and Cervix
37	Shoulder
38	Extremities bone, NOS
39	Inverted Y
40	Spinal cord
41	Prostate
50	Thyroid
60	Lymph node region, NOS
98	Other
99	Unknown

READM SAME HOSP 30 DAYS

Alternate Name	Item #	Length	Source of Standard	Column #
Readmission to the Same Hospital Within 30 Days of Surgical Discharge	3190	1	CoC	1619-1619

Description
Records a readmission to the same hospital within 30 days of discharge following hospitalization for surgical resection of the primary site for the same illness.

Rationale
This data item provides information related to the quality of care. A patient may have a readmission related to the primary diagnosis on discharge if the length of stay was too short, and then needed to return due to problems or complications. A patient may also need to be readmitted if discharge planning and/or follow-up instructions were ineffective. It is important to distinguish a planned from an unplanned readmission, since a planned readmission is not an indicator of quality of care problems.

Codes

0 No surgical procedure of the primary site was performed. Patient not readmitted to the same hospital within 30 days of discharge.
1 Patient was surgically treated and was then readmitted to the same hospital within 30 days of being discharged. This readmission was unplanned.
2 Patient was surgically treated and was then readmitted to the same hospital within 30 days of being discharged. This readmission was planned (chemotherapy port insertion, revision of colostomy, etc.).
3 Patient was surgically treated and, within 30 days of being discharged, had both a planned and an unplanned readmission to the same hospital.
9 It is unknown whether surgery of the primary site was recommended or performed. It is unknown whether the patient was readmitted to the same hospital within 30 days of discharge. Death certificate only.

REASON FOR NO CHEMO **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1440			

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

REASON FOR NO HORMONE **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1450			

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

REASON FOR NO RADIATION

Alternate Name	Item #	Length	Source of Standard	Column #
Reason for No Regional Radiation Therapy	1430	1	CoC	1592-1592

Description
Code the reason the patient did not receive radiation treatment as part of first course of therapy. See also RX--Regional RX Modality [1570].

Codes
0 Radiation therapy was administered.
1 Radiation therapy was not administered because it was not part of the planned first-course treatment.
2 Radiation therapy was not administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc).
5 Radiation therapy was not administered because the patient died prior to planned or recommended treatment.
6 Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of the first-course therapy. No reason was noted in the patient's record.
7 Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8 Radiation therapy was recommended, but it is unknown if it was administered.
9 It is unknown if radiation therapy was recommended or administered. Death-certificate-only and autopsy-only cases.

REASON FOR NO SURGERY

Alternate Name	Item #	Length	Source of Standard	Column #
Reason for No Cancer-Directed Surgery (SEER) Reason for No CA Dir Surgery (CoC) Reason for No Surgery to Primary Site	1340	1	SEER/CoC	1576-1576

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

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

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

RECORD TYPE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	10	1	NAACCR	1-1

Description
Generated field that identifies which of the seven NAACCR data exchange record types is being used in a file of data exchange records. A file should have records of only one type.

Codes

I **I**ncidence-only record type (nonconfidential coded data)
Length = 3339

C **C**onfidential record type (incidence record plus confidential data)
Length = 5564

A Full case **A**bstract record type (incidence and confidential data plus text summaries; used for reporting to central registries)
Length = 22824

U Correction/**U**pdate record type (short format record used to submit corrections to data already submitted)
Length = 1543

M Record **M**odified since previous submission to central registry (identical in format to the "A" record type)
Length = 22824

L Pathology **L**aboratory

RECURRENCE DATE--1ST

Alternate Name	Item #	Length	Source of Standard	Column #
Date of First Recurrence (CoC)	1860	8	CoC	2196-2203

Description
The date of the first recurrence of this tumor. See page 97 for date format.

RECURRENCE DATE--1ST FLAG **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	1861	2	NAACCR	2204-2205

Description
This flag explains why no appropriate value is in the field, Recurrence Date--1st [1860]. This data item was first available in Volume II Version 12 (effective January 2010).

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if the patient had a first recurrence)
11 No proper value is applicable in this context (e.g., patient became disease-free after treatment; never had a recurrence; or patient was never disease-free; autopsy only case)
12 A proper value is applicable but not known (i.e., there was a recurrence, but the date is unknown)
Blank A valid date value is provided in item Recurrence Date--1st [1860], or the date was not expected to have been transmitted

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

RECURRENCE DISTANT SITE 1 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1871			

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

RECURRENCE DISTANT SITE 2 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1872			

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

RECURRENCE DISTANT SITE 3 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1873			

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

RECURRENCE DISTANT SITES **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1870			

Description
The NAACCR UDSC retired this data item in Version 9.1, as of January 1, 2002.

RECURRENCE TYPE--1ST

Alternate Name	Item #	Length	Source of Standard	Column #
Type of First Recurrence (CoC)	1880	2	CoC	2206-2207

Description
Code for the type of first recurrence after a period of documented disease free intermission or remission.

Codes
00 Patient became disease-free after treatment and has not had a recurrence; leukemia in remission.
04 *In situ* recurrence of an invasive tumor.
06 *In situ* recurrence of an *in situ* tumor.
10 Local recurrence and there is insufficient information available to code to 13-17. Recurrence is confined to the remnant of the organ of origin; to the organ of origin; to the anastomosis; or to scar tissue where the organ previously existed.
13 Local recurrence of an invasive tumor.
14 Trocar recurrence of an invasive tumor. Includes recurrence in the trocar path or entrance site following prior surgery.
15 Both local and trocar recurrence of an invasive tumor (both 13 and 14)
16 Local recurrence of an *in situ* tumor.
17 Both local and trocar recurrence of an *in situ* tumor.
20 Regional recurrence, and there is insufficient information available to code to 21-27.
21 Recurrence of an invasive tumor in adjacent tissue or organ(s) only.
22 Recurrence of an invasive tumor in regional lymph nodes only.
25 Recurrence of an invasive tumor in adjacent tissue or organ(s) and in regional lymph nodes (both 21 and 22) at the same time.
26 Regional recurrence of an *in situ* tumor, NOS.
27 Recurrence of an *in situ* tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time.
30 Both regional recurrence of an invasive tumor in adjacent tissue or organ(s) and/or regional lymph nodes (20-25) and local and/or trocar recurrence (10, 13, 14, or 15).
36 Both regional recurrence of an *in situ* tumor in adjacent tissue or organ(s) and/or regional lymph nodes (26 or 27) and local and/or trocar recurrence (16 or 17).
40 Distant recurrence and there is insufficient information available to code to 46-62.
46 Distant recurrence of an *in situ* tumor.
51 Distant recurrence of an invasive tumor in the peritoneum only. Peritoneum includes peritoneal surfaces of all structures within the abdominal cavity and/or positive 317scetic fluid.
52 Distant recurrence of an invasive tumor in the lung only. Lung includes the visceral pleura.
53 Distant recurrence of an invasive tumor in the pleura only. Pleura includes the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
54 Distant recurrence of an invasive tumor in the liver only.
55 Distant recurrence of an invasive tumor in bone only. This includes bones other than the primary site.
56 Distant recurrence of an invasive tumor in the CNS only. This includes the brain and spinal cord, but not the external eye.

57 Distant recurrence of an invasive tumor in the skin only. This includes skin other than the primary site.
58 Distant recurrence of an invasive tumor in lymph node only. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site.
59 Distant systemic recurrence of an invasive tumor only. This includes leukemia, bone marrow metastasis, carcinomatosis, and generalized disease.
60 Distant recurrence of an invasive tumor in a single distant site (51-58) and local, trocar, and/or regional recurrence (10-15, 20-25, or 30).
62 Distant recurrence of an invasive tumor in multiple sites (recurrences that can be coded to more than one category 51-59).
70 Since diagnosis, patient has never been disease-free. This includes cases with distant metastasis at diagnosis, systemic disease, unknown primary, or minimal disease that is not treated.
88 Disease has recurred, but the type of recurrence is unknown.
99 It is unknown whether the disease has recurred or if the patient was ever disease-free.

RECURRENCE TYPE--1ST--OTH **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1890			

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

REFERRAL TO SUPPORT SERV **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1490			

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

REGIONAL NODES EXAMINED

Alternate Name	Item #	Length	Source of Standard	Column #
Number of Regional Lymph Nodes Examined (SEER) Pathologic Review of Regional Lymph Nodes (SEER) Regional Lymph Nodes Examined	830	2	SEER/CoC	916-917

Description
Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system.

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

Codes

00	No nodes were examined
01-89	1-89 nodes were examined (code the exact number of regional lymph nodes examined)
90	90 or more nodes were examined
95	No regional nodes were removed, but aspiration of regional nodes was performed
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown
99	It is unknown whether nodes were examined; not applicable or negative; not stated in patient record

REGIONAL NODES POSITIVE

Alternate Name	Item #	Length	Source of Standard	Column #
Number of Positive Regional Lymph Nodes (SEER) Pathologic Review of Regional Lymph Nodes (SEER) Regional Lymph Nodes Positive	820	2	SEER/CoC	914-915

Description
Records the exact number of regional nodes examined by the pathologist and found to contain metastases. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system. For tumors diagnosed from 1988 through 2003, this item was part of the 10-digit EOD [779], detailed site-specific codes for anatomic EOD.

Rationale
This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient.

Codes
00 All nodes examined are negative
01-89 1-89 nodes are positive (code exact number of nodes positive)
90 90 or more nodes are positive
95 Positive aspiration of lymph node(s) was performed
97 Positive nodes are documented, but the number is unspecified
98 No nodes were examined
99 It is unknown whether nodes are positive; not applicable; not stated in patient record

Note: See Chapter V, Unresolved Issues, for a discussion of coding differences between CoC and SEER.

REGISTRY ID

Alternate Name	Item #	Length	Source of Standard	Column #
	40	10	NAACCR	30-39

Description
A unique code that represents the data transmission source. This item should be used for central registries and non-US health care providers. Refer to Registry ID table in Appendix B.

For cases diagnosed on or after 2008, this item may be blank if NPI--Registry ID (item 45) is used to represent the data transmission source.

Rationale
Used to track data submission flow and to resolve transmission issues.

Codes (in addition to CoC assigned codes or NAACCR assigned codes)
0000000000 Case not reported by a facility
0099999999 Case reported, but facility number is unknown

Note: Prior to 2008, this field may contain data from reporting facilities.

REGISTRY TYPE

Alternate Name	Item #	Length	Source of Standard	Column #
	30	1	NAACCR	2-2

Description
A computer-generated code that best describes the type of registry generating the record; used when cases are pooled from multiple registries (a hospital-based registry reporting to a state should have a "3" in this field).

Rationale
Facilitates tracking of data sources when data from multiple registries are pooled.

Codes
1 Central registry (population-based)
2 Central registry or hospital consortium (not population-based)
3 Single hospital/freestanding center

RELIGION **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	260			

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

REPORTING FACILITY **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Institution ID Number (CoC) Facility Identification Number (CoC) Reporting Hospital	540	10	CoC	701-710

Description
CoC code for the facility whose data are described in the record.

Rationale
The Reporting Facility identification number or FIN is used to identify a reporting facility in the central registry database and is useful for monitoring data submission, ensuring the accuracy of data and identifying areas for special studies.

Codes (in addition to CoC assigned codes)
0000000000 Case not reported by a facility
0099999999 Case reported, but facility number is unknown

A listing of valid FINs can be found at http://www.facs.org/cancer/coc/fin.html.

Note: When this special code is being used, the length in 9s should correspond to the length indicated by the code in FIN coding system [35]. The 9s must be right justified in the field, and the remaining spaces should be filled with leading zeroes to a total length of 10.

REPORTING HOSPITAL FAN **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	538			

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

RESERVED 00

Alternate Name	Item #	Length	Source of Standard	Column #
	37	13		4-16

RESERVED 01

Alternate Name	Item #	Length	Source of Standard	Column #
	370	37		58-94

RESERVED 02 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	530	92		436-527

RESERVED 03

Alternate Name	Item #	Length	Source of Standard	Column #
	680	100		591-690

RESERVED 04

Alternate Name	Item #	Length	Source of Standard	Column #
	750	100		804-903

RESERVED 05

Alternate Name	Item #	Length	Source of Standard	Column #
	1180	200		1236-1435

RESERVED 06

Alternate Name	Item #	Length	Source of Standard	Column #
	1190	100		1624-1723

RESERVED 07

Alternate Name	Item #	Length	Source of Standard	Column #
	1300	100		1788-1887

RESERVED 08 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	1650	80		2036-2115

RESERVED 09

Alternate Name	Item #	Length	Source of Standard	Column #
	1740	50		2290-2339

RESERVED 10

Alternate Name	Item #	Length	Source of Standard	Column #
	1835	200		4085-4284

RESERVED 11

Alternate Name	Item #	Length	Source of Standard	Column #
	1900	50		4345-4394

RESERVED 12

Alternate Name	Item #	Length	Source of Standard	Column #
	2510	50		4485-4534

RESERVED 13

Alternate Name	Item #	Length	Source of Standard	Column #
	2080	500		5065-5564

RESERVED 14

Alternate Name	Item #	Length	Source of Standard	Column #
	2210	2000		20825-22824

RESERVED 15

Alternate Name	Item #	Length	Source of Standard	Column #
	2400	1		780-780

RESERVED 16

Alternate Name	Item #	Length	Source of Standard	Column #
	2450	1		788-788

RURALURBAN CONTINUUM 1993

Alternate Name	Item #	Length	Source of Standard	Column #
Beale Code	3300	2	NAACCR	424-425

Description
The RuralUrban Continuum (1993) codes (usually known as the Beale Codes) separate counties into four metropolitan and six non-metropolitan categories, based on the size their populations and form a classification scheme that distinguishes metropolitan counties by size and nonmetropolitan counties by degree of urbanization and proximity to metro areas.

These codes can be derived electronically, using patients' state and county at diagnosis, so registrars do not need to provide them. FIPS state and county code mappings to Beale Codes can be obtained in an Excel file at http://www.ers.usda.gov/Data/RuralUrbanContinuumCodes.

The code is a 10-point continuum, transmitted in standard NAACCR record form with a leading 0, (00-09). Abstractors do not enter these codes.

Areas that are not included in the Rural-Urban Continuum code table, such as Canadian provinces/territories and U.S. territories (other than Puerto Rico) will be coded 98. Records for non-residents of the state of the reporting institution (County at DX = 998) also will be coded 98. If Addr at DX--State is XX, YY or ZZ, or if County at DX = 999, the Rural-Urban Continuum will be coded 99.

Rationale
Categorizing counties by population size helps researchers investigate geographic correlates of the burden of cancer in the area of interest.

Codes
Metropolitan Counties (00-03)
00 Central counties of metropolitan areas of 1 million population or more
01 Fringe counties of metropolitan areas of 1 million population or more
02 Counties in metropolitan areas of 250,000-1,000,000 population
03 Counties in metropolitan areas of less than 250,000 population

Nonmetropolitan Counties (04-09)
04 Urban population of 20,000 or more, adjacent to a metropolitan area
05 Urban population of 20,000 or more, not adjacent to a metropolitan area
06 Urban population of 2,500-19,999, adjacent to a metropolitan area
07 Urban population of 2,500-19,999, not adjacent to a metropolitan area
08 Completely rural (no places with a population of 2,500 or more) adjacent to a metropolitan area
09 Completely rural (no places with a population of 2,500 or more) not adjacent to a metropolitan area
98 Program run, but: (1) area is not included in Rural-Urban Continuum code table, or (2) record is for resident outside of state of reporting institution
99 Unknown
Blank Program not run; record not coded

RURALURBAN CONTINUUM 2003

Alternate Name	Item #	Length	Source of Standard	Column #
Beale Code RuralUrban Continuum 2000	3310	2	NAACCR	426-427

Description
The RuralUrban Continuum (2003) codes (usually known as the Beale Codes) separate counties into four metropolitan and six non-metropolitan categories, based on the size their populations and form a classification scheme that distinguishes metropolitan counties by size and nonmetropolitan counties by degree of urbanization and proximity to metro areas.

These codes can be derived electronically, using patients' state and county at diagnosis, so registrars do not need to provide them. FIPS state and county code mappings to Beale Codes can be obtained in an Excel file at http://www.ers.usda.gov/Data/RuralUrbanContinuumCodes.

The code is a 9-point continuum, transmitted in standard NAACCR record form with a leading 0, (01-09). Abstractors do not enter these codes.

Areas that are not included in the Rural-Urban Continuum code table, such as Canadian provinces/territories and U.S. territories (other than Puerto Rico) will be coded 98. Records for non-residents of the state of the reporting institution (County at DX = 998) also will be coded 98. If Addr at DX--State is XX, YY or ZZ, or if County at DX = 999, the Rural-Urban Continuum will be coded 99.

Rationale
Categorizing counties by population size helps researchers investigate geographic correlates of the burden of cancer in the area of interest.

Codes
Metropolitan Counties (01-03)
01 Counties in metro areas of 1 million population or more
02 Counties in metro areas of 250,000 to 1 million population
03 Counties in metro areas of fewer than 250,000 population

Nonmetropolitan Counties (04-09)
04 Urban population of 20,000 or more, adjacent to a metro area
05 Urban population of 20,000 or more, not adjacent to a metro area
06 Urban population of 2,500 to 19,999, adjacent to a metro area
07 Urban population of 2,500 to 19,999, not adjacent to a metro area
08 Completely rural or less than 2,500 urban population, adjacent to a metro area
09 Completely rural or less than 2,500 urban population, not adjacent to a metro area
98 Program run, but: (1) area is not included in Rural-Urban Continuum code table, or (2) record is for resident outside of state of reporting institution
99 Unknown
Blank Program not run; record not coded

RX CODING SYSTEM--CURRENT

Alternate Name	Item #	Length	Source of Standard	Column #
	1460	2	NAACCR	1593-1594

Description
Code describing how treatment for this tumor now is coded.

Codes
00 Treatment data not coded/transmitted (i.e., all treatment fields [items 1200-1450 and 1500-1645] blank)
01 Treatment data coded using 1-digit surgery codes (obsolete)
02 Treatment data coded according to 1983-1992 SEER manuals and 1983-1995 CoC manuals
03 Treatment data coded according to 1996 *ROADS Manual*
04 Treatment data coded according to 1998 *ROADS* Supplement
05 Treatment data coded according to 1998 *SEER Manual*
06 Treatment data coded according to *FORDS* manual
07 Treatment data coded according to 2010 *SEER Manual*
99 Other coding, including partial or nonstandard coding

RX DATE MST DEFN SRG FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	3171	2	NAACCR	1474-1475

Description
This flag explains why no appropriate value is in the field, RX Date--Most Defin Surg [3170]. This data item was first available in Volume II Version 12 (effective January 2010).

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

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)
10 No information whatsoever can be inferred from this exceptional value. (e.g., unknown if any surgical procedure of the primary site was performed).
11 No proper value is applicable in this context (e.g., no surgical resection of the primary site was performed and for cases diagnosed at autopsy).
12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., surgical procedure of the primary site was performed but the date is unknown).
Blank A valid date value is provided in item RX Date--Most Defin Surg [3170], or the date was not expected to have been transmitted.

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

RX DATE RAD ENDED FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	3221	2	NAACCR	1504-1505

Description
This flag explains why no appropriate value is in the field, RX Date--Radiation Ended [3220]. This data item was first available in Volume II Version 12 (effective January 2010).

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if radiation therapy administered).
11 No proper value is applicable in this context (e.g., radiation therapy was not administered; diagnosed at autopsy).
12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., date radiation ended is unknown).
15 Information is not available at this time, but it is expected that it will be available later (e.g., radiation was administered and was ongoing at the time of most recent follow-up).
Blank A valid date value is provided in item RX Date-Radiation Ended [3220], or the date was not expected to have been transmitted.

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

RX DATE SURG DISCH FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	3181	2	NAACCR	1484-1485

Description
This flag explains why no appropriate value is in the field, RX Date--Surgical Disch [3180]. This data item was first available in Volume II Version 12 (effective January 2010).

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown whether surgical treatment was performed).

11 No proper value is applicable in this context (e.g., no surgical treatment of the primary site was performed; autopsy only case).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., surgical treatment performed but the date of discharge is unknown).

Blank A valid date value is provided in item RX Date-Surgical Disch [3180], or the date was not expected to have been transmitted.

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

RX DATE SYSTEMIC FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	3231	2	NAACCR	1514-1515

Description
This flag explains why no appropriate value is in the field, RX Date--Systemic [3230]. This data item was first available in Volume II Version 12 (effective January 2010).

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if systemic therapy was administered).
11 No proper value is applicable in this context (e.g., no systemic therapy was administered; autopsy only case).
12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., systemic therapy administered but date is unknown).
15 Information is not available at this time, but it is expected that it will be available later (e.g., systemic therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank A valid date value is provided in item RX Date--Systemic [3230], or the date was not expected to have been transmitted.

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

RX DATE--BRM

Alternate Name	Item #	Length	Source of Standard	Column #
Date Immunotherapy Started (CoC)	1240	8	CoC	1536-1543

Description
Date of initiation for immunotherapy (a.k.a. biological response modifier) that is part of the first course of treatment. See also RX Summ--BRM [1410]. See page 97 for date format.

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

Note: CoC discontinued support of this item from 2003 through 2009.

RX DATE--BRM FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1241	2	NAACCR	1544-1545

Description
This flag explains why no appropriate value is in the field, RX Date--BRM [1240]. This data item was first available in Volume II Version 12 (effective January 2010).

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if immunotherapy administered).
11 No proper value is applicable in this context (e.g., no immunotherapy administered; autopsy only case).
12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., immunotherapy administered but date is unknown).
15 Information is not available at this time, but it is expected that it will be available later (e.g., immune therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank A valid date value is provided in item RX Date BRM [1240], or the date was not expected to have been transmitted.

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

RX DATE--CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
Date Chemotherapy Started (CoC)	1220	8	CoC	1516-1523

Description
Date of initiation of chemotherapy that is part of the first course of treatment. See also RX Summ--Chemo [1390]. See page 97 for date format.

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

Note: CoC discontinued support of this item from 2003 through 2009.

RX DATE--CHEMO FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1221	2	NAACCR	1524-1525

Description
This flag explains why no appropriate value is in the field, RX Date--Chemo [1220]. This data item was first available in Volume II Version 12 (effective January 2010).

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if chemotherapy administered).
11 No proper value is applicable in this context (e.g., no chemotherapy administered; autopsy only case).
12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15 Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank A valid date value is provided in item RX Date--Chemo [1220], or the date was not expected to have been transmitted.

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

RX DATE--DX/STG PROC

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Non Cancer-Directed Surgery (CoC) Date of Diagnostic, Staging or Palliative Procedures (1996-2002) Date of Surgical Diagnostic and Staging Procedure (CoC) RX Date--DX/Stg/Pall Proc	1280	8	CoC	1556-1563

Description
Records the date on which the surgical diagnostic and/or staging procedure was performed. See Surgical and Diagnostic Staging Procedure [1350]. See page 97 for date format.

Note: This is a CoC item and for tumors diagnosed from January 1, 1996, through December 31, 2002, this may have been the date on which diagnostic, staging, and palliative procedures were performed. Beginning with tumors diagnosed on or after January 1, 2003, palliative procedures are collected in RX Summ--Palliative Proc [3270] and RX Hosp--Palliative Proc [3280].

RX DATE--DX/STG PROC FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1281	2	NAACCR	1564-1565

Description
This flag explains why no appropriate value is in the field, RX Date--DX/Stg Proc [1280]. This data item was first available in Volume II Version 12 (effective January 2010).

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if any diagnostic or staging procedure performed).
11 No proper value is applicable in this context (e.g., no diagnostic or staging procedure performed; autopsy only case).
12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., diagnostic or staging procedure performed but date is unknown).
Blank A valid date value is provided in item RX Date-DX/Stg Proc [1280], or the date was not expected to have been transmitted.

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

RX DATE--HORMONE

Alternate Name	Item #	Length	Source of Standard	Column #
Date Hormone Therapy Started (CoC)	1230	8	CoC	1526-1533

Description
Date of initiation for hormone therapy that is part of the first course of treatment. See also RX Summ--Hormone [1400]. See page 97 for date format.

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

Note: CoC discontinued support of this item from 2003 through 2009.

RX DATE--HORMONE FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1231	2	NAACCR	1534-1535

Description
This flag explains why no appropriate value is in the field, RX Date--Hormone [1230]. This data item was first available in Volume II Version 12 (effective January 2010).

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if any hormone therapy administered).
11 No proper value is applicable in this context (e.g., no hormone therapy administered; autopsy only cases).
12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., hormone therapy administered but date is unknown).
15 Information is not available at this time, but it is expected that it will be available later (e.g., hormone therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank A valid date value is provided in item RX Date-Hormone [1230], or the date was not expected to have been transmitted.

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

RX DATE--MOST DEFIN SURG

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Most Definitive Surgical Resection of the Primary Site	3170	8	CoC	1466-1473

Description
Date of most definitive surgical resection of the primary site performed as part of the first course of treatment. See page 97 for date format.

Rationale
This item is used to measure lag time between diagnosis and the most definitive surgery of the primary site or survival following the procedure. It also is used in conjunction with Date of Surgical Discharge [3180] to calculate the duration of hospitalization following the most definitive primary site surgical procedure to evaluate treatment efficacy.

RX DATE--OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
Date Other Treatment Started (CoC)	1250	8	CoC	1546-1553

Description
Date of initiation for other treatment that is part of the first course of treatment at any facility. See RX Summ--Other [1420]. See page 97 for date format.

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

RX DATE--OTHER FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1251	2	NAACCR	1554-1555

Description
This flag explains why no appropriate value is in the field, RX Date--Other [1250]. This data item was first available in Volume II Version 12 (effective January 2010).

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if other therapy administered).
11 No proper value is applicable in this context (e.g., no other treatment administered; autopsy only case).
12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., other therapy administered but the date is unknown).
Blank A valid date value is provided in item RX Date-Other [1250], or the date was not expected to have been transmitted.

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

RX DATE--RADIATION

Alternate Name	Item #	Length	Source of Standard	Column #
Date Radiation Started (CoC)	1210	8	CoC	1486-1493

Description
Records the date on which radiation therapy began at any facility that is part of the first course of treatment. See page 97 for date format.

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

RX DATE--RADIATION ENDED

Alternate Name	Item #	Length	Source of Standard	Column #
Date Radiation Ended	3220	8	CoC	1496-1503

Description
The date on which the patient completes or receives the last radiation treatment at any facility. See page 97 for date format.

Rationale
The length of time over which radiation therapy is administered to a patient is a factor in tumor control and treatment morbidity. It is useful in evaluating the quality-of-care and the success of patient support programs designed to maintain continuity of treatment.

RX DATE--RADIATION FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1211	2	NAACCR	1494-1495

Description
This flag explains why no appropriate value is in the field, RX Date--Radiation [1210]. This data item was first available in Volume II Version 12 (effective January 2010).

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown whether any radiation therapy administered).
11 No proper value is applicable in this context (e.g., no radiation therapy administered; autopsy only case).
12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., radiation therapy administered but date is unknown).
15 Information is not available at this time, but it is expected that it will be available later (e.g., radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
Blank A valid date value is provided in item RX Date--Radiation [1210], or the date was not expected to have been transmitted.

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

RX DATE--SURGERY

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Cancer-Directed Surgery (CoC) Date of Surgery Date of First Surgical Procedure (CoC)	1200	8	CoC	1456-1463

Description
Date the first surgery of the type described under Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes was performed. See also RX Summ--Surg Prim Site [1290], RX Summ--Scope Reg LN Sur [1292], and RX Summ--Surg Oth Reg/Dis [1294]. See page 97 for date format.

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

RX DATE--SURGERY FLAG **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	1201	2	NAACCR	1464-1465

Description
This flag explains why no appropriate value is in the field, RX Date--Surgery [1200]. This data item was first available in Volume II Version 12 (effective January 2010).

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if any surgical procedure was performed).
11 No proper value is applicable in this context (e.g., no surgical procedure was performed; autopsy only case).
12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., surgery was performed but the date is unknown).
Blank A valid date value is provided in item Date-Surgery [1200], or the date was not expected to have been transmitted.

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

RX DATE--SURGICAL DISCH **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Surgical Discharge	3180	8	CoC	1476-1483

Description
Records the date the patient was discharged following primary site surgery. The date corresponds to the event recorded in Date of Most Definitive Surgical Resection [3170]. See page 97 for date format.

Rationale
Length of stay is an important quality-of-care and financial measure among hospital administrations, those who fund public and private health care, and public health users. This date, in conjunction with the data item “Date of Most Definitive Surgical Resection” [3170], will allow for the calculation of a patient’s length of hospitalization associated with primary site surgery.

RX DATE--SYSTEMIC

Alternate Name	Item #	Length	Source of Standard	Column #
Date Systemic Therapy Started	3230	8	CoC	1506-1513

Description
Date of initiation of systemic therapy that is part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormone agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy. See page 97 for date format.

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

RX HOSP--ASA CLASS **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	665			

Description
This data item was proposed for inclusion in Version 12 but the request was withdrawn prior to implementation of the standard. The data item was retired in Version 12.1, as of January 1, 2011.

RX HOSP--BRM **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Immunotherapy at this Facility (CoC)	720	2	CoC	794-795

Description
Records whether immunotherapeutic agents (biologic response modifiers) were administered as first-course treatment at this facility or the reason they were not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

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

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes (Refer to the most recent *FORDS* and SEER Rx for complete coding instructions.)

00 None, immunotherapy was not part of the planned first-course of therapy; not customary therapy for this cancer.
01 Immunotherapy administered as first course therapy.
82 Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.) or there was progression of disease prior to administration.
85 Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86 Immunotherapy was not administered. It was recommended by the patient's physician but was not administered as part of the first-course of therapy. No reason was noted in the patient record.
87 Immunotherapy was not administered. It was recommended by the patient's physician but was refused by the patient or the patient's family or guardian. The refusal was noted in the patient record.
88 Immunotherapy was recommended, but it is unknown if it was administered.
99 It is unknown if immunotherapy was recommended or administered because it was not stated in the patient record. Death certificate-only case.

Note: For tumors diagnosed on or after January 1, 2003, information on bone marrow transplants and stem cell transplants should be coded in the new field RX SUMM--Transplnt/Endocr [3250]. Codes 02-06 should not be used for tumors diagnosed on or after January 1, 2003.

RX HOSP--CHEMO **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Chemotherapy at this Facility (CoC)	700	2	CoC	790-791

Description
Records the type of chemotherapy administered at the reporting facility as a part of first course therapy or the reason chemotherapy was not given.

Rationale
Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of chemotherapeutic agents given as part of the first course of therapy. Furthermore, it is useful to know the reason chemotherapy was not administered when evaluating quality of care.

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes (Refer to the most recent *FORDS* and SEER RX for additional complete coding directions.)

00 None, chemotherapy was not part of the first course of therapy or there was progression of disease prior to administration; Not customary therapy for this cancer. Diagnosed at autopsy.
01 Chemotherapy was administered, but type and number of agents is not documented in patient record.
02 Chemotherapy, single agent.
03 Chemotherapy, multiple agents.
82 Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age) or there was progression of disease prior to planned administration.
85 Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86 Chemotherapy was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87 Chemotherapy was not administered. It was recommended by the patient's physician, but was refused by the patient, or the patient's family or guardian. The refusal was noted in the patient record.
88 Chemotherapy was recommended, but it is unknown if it was administered.
99 It is unknown whether chemotherapy was recommended or administered because it is not stated in patient record. Death certificate-only case

RX HOSP--DX/STG PROC **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Non Cancer-Directed Surgery at this Facility (CoC) Surgical Diagnostic & Staging Procedure at this Facility (1996-2002) RX Hosp--DX/Stg/Pall Proc	740	2	CoC	797-798

Description
Identifies the surgical procedure(s) performed in an effort to diagnose and/or stage disease at this facility.

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

If central registries wish to study the procedures performed at particular facilities, the facility-level fields must be used. The summary fields, conversely, combine information for all facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and diagnostic/staging procedures by type of healthcare setting. Knowing what part of the diagnostic or staging process was performed at a particular facility also helps resolve consolidation issues.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)
00 No surgical diagnostic or staging procedure was performed.
01 A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02 A biopsy (incisional, needle, or aspiration) was done of the primary site.
03 A surgical exploratory only. The patient was not biopsied or treated during the procedure.
04 A surgical procedure with a bypass was performed, but no biopsy was done.
05 An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06 A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07 A procedure was done, but the type of procedure is unknown.
09 No information about whether a diagnostic or staging procedure was performed.

Note: This item has been used for tumors diagnosed in 1996 and later. For cases diagnosed before 1996, this item may have been converted from the *DAM*, and cases with surgery would have been converted to 09 in this field. For cases diagnosed between 1996 and 2002, this field may have described palliative care according to coding rules in *ROADS*. For tumors diagnosed on or after January 1, 2003, palliative care is coded in a new field RX Hosp--Palliative Proc [3280].

RX HOSP--HORMONE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Hormone Therapy at this Facility (CoC)	710	2	CoC	792-793

Description
Records whether systemic hormonal agents were administered as first-course treatment at this facility or the reason they were not given. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Rationale
Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of hormonal agents given as part of the first course of therapy. Furthermore, it is useful to know the reason hormone therapy was not administered when evaluating quality of care for certain tumors.

If central registries wish to study the treatment given at particular facilities, the facility -level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes (Refer to the most recent version of *FORDS* and SEER Rx for additional instructions.)

00 None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01 Hormone therapy was administered as first course therapy.
82 Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age), or there was progression of disease prior to administration.
85 Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86 Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87 Hormone therapy was not administered. It was recommended by the patient's physician, but was refused by the patient, or the patient's family member or guardian. The refusal was noted in the patient record.
88 Hormone therapy was recommended, but it is unknown if it was administered.
99 It is unknown whether hormone therapy was recommended or administered because it is not stated in the patient record. Death certificate-only cases.

Note: Codes 02-03 entered under the *ROADS* rules for tumors diagnosed prior to January 1, 2003, should have been converted to the appropriate code in the new field RX SUMM--Transplnt/Endocr [3250] implemented with *FORDS*. Endocrine surgery and endocrine radiation therapy are no longer coded as Hormone Therapy for tumors diagnosed on or after January 1, 2003.

RX HOSP--OTHER **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Other Treatment at this Facility (CoC)	730	1	CoC	796-796

Description
Identifies treatment given at this facility that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment modifies, controls, removes, or destroys proliferating cancer tissue. Supportive care such as phlebotomy, transfusions, or aspirin may be recorded for hematopoietic diseases ONLY.

Rationale
Information on other therapy is used to describe treatment practices and evaluate quality of care. If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes
0 None; all cancer treatment was coded in other treatment fields. Patient received no cancer treatment. Diagnosed at autopsy.
1 Cancer treatment that cannot be assigned to specified treatment data items.
2 Other-Experimental; this code is not defined. It may be used to record participation in institution-based clinical trials.
3 Patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6 Other unproven; Cancer treatments administered by nonmedical personnel.
7 Refusal; other treatment was not administered. Treatment listed in code 1, 2 or 3 was recommended by the patient's physician but was refused by the patient or the patient's family or guardian. The refusal was noted in the patient record.
8 Recommended, unknown if administered; other treatment was recommended, but it is unknown whether it was administered.
9 It is unknown whether other treatment was recommended or administered because it is not stated in the patient record. Death certificate only case.

RX HOSP--PALLIATIVE PROC **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Palliative Procedure at this Facility Palliative Care at this Facility	3280	1	CoC	799-799

Description
Identifies care provided at the reporting facility in an effort to palliate or alleviate symptoms. Palliative procedures may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or pain management.

Rationale
This data item allows reporting facilities to track care that is considered palliative rather than diagnostic or curative in intent. If central registries wish to study types of palliative care given at particular facilities, the facility-level fields must be used. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what palliative procedures and care was performed at a particular facility also helps resolve consolidation issues.

Codes
0 No palliative care provided. Diagnosed at autopsy.
1 Surgery (which may involve a bypass procedure) performed to alleviate symptoms, but no attempt to diagnose, stage, or treat the tumor is made.
2 Radiation therapy given to alleviate symptoms, but no attempt to produce cure is made.
3 Chemotherapy, hormone therapy, or other systemic drugs given to alleviate symptoms without curative intent.
4 Patient received or was referred for pain management only.
5 Any combination of codes 1, 2, and/or 3 <u>without</u> code 4.
6 Any combination of codes 1, 2, and/or 3 <u>with</u> code 4.
7 Palliative care was performed or recommended, but no information on the type of procedure is available in the patient record.
9 Unknown if palliative care was performed or recommended. Not stated in patient record.

RX HOSP--RADIATION **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation at this Facility (CoC)	690	1	SEER	789-789

Description
Defines the type of radiation therapy the patient received at the reporting facility as a part of the first course of treatment.

Rationale
If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all facilities that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes
0 None
1 Beam radiation
2 Radioactive implants
3 Radioisotopes
4 Combination of 1 with 2 or 3
5 Radiation, NOS--method or source not specified
9 Unknown if radiation therapy administered

Note: CoC no longer requires this item effective January 1, 2002. SEER continues to support it as a historically collected and currently transmitted data item.

RX HOSP--REG LN REMOVED **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Number of Regional Lymph Nodes Examined at This Facility (CoC) RX Hosp--Reg LN Examined	676	2	CoC	786-787

Description

Describes number of regional lymph nodes removed at the reporting facility as part of the first course of treatment.

Rationale

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing the extent of treatment given at a particular facility also helps resolve consolidation issues.

Codes (Refer to *ROADS* for additional coding instructions.)

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as a dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed, but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate-only

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

RX HOSP--SCOPE REG 98-02 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Scope of Regional Lymph Node Surgery at this Facility (CoC)	747	1	CoC	802-802

Description
Describes the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at the reporting facility. This field is to be used for *ROADS* codes after the *ROADS* to *FORDS* conversion. It is also to be used to code Scope of Regional Lymph Node Surgery at the reporting facility for all tumors diagnosed before January 1, 2003.

Rationale
In evaluating quality of care and treatment practices it is important to identify the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

If central registries wish to study the treatment given at particular hospitals, the hospital-level treatment fields must be used. The summary treatment fields, conversely, combine information across all hospitals that provide first course of treatment for the tumor. Hospital-specific fields allow studies of detailed referral patterns and treatment by type of hospital. Knowing the extent of treatment given at a particular hospital also helps resolve coding issues.

Codes (See the CoC *ROADS Manual* 1998 Supplement and the *SEER Program Code Manual* for site-specific codes.)

RX HOSP--SCOPE REG LN SUR **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Scope of Regional Lymph Node Surgery at this Facility (CoC)	672	1	CoC	784-784

Description

Describes the removal, biopsy, or aspiration of regional lymph node(s) performed at the reporting facility for diagnosis and/or staging or as a part of the first course of therapy.

Rationale

In evaluating quality of care and treatment practices it is important to identify the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.
If central registries wish to study the treatment given at particular hospitals, the hospital-level treatment fields must be used. The summary treatment fields, conversely, combine information across all hospitals that provide first course of treatment for the tumor. Hospital-specific fields allow studies of detailed referral patterns and treatment by type of hospital. Knowing the extent of treatment given at a particular hospital also helps resolve coding issues.

Codes (Refer to the most recent *FORDS* for additional instructions.)

0 No regional lymph nodes removed. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1 Biopsy or aspiration of regional lymph node, NOS.
2 Sentinel lymph node biopsy.
3 Regional lymph node(s) removed and the number of nodes removed is unknown or not stated; the procedure is not specified as sentinel node biopsy. Regional lymph nodes removed, NOS.
4 1 to 3 regional lymph nodes removed.
5 4 or more regional lymph nodes removed.
6 Sentinel node biopsy and code 3, 4, or 5 at same time or timing not stated.
7 Sentinel node biopsy and code 3, 4, or 5 at different times.
9 Unknown or not applicable. It is unknown whether regional lymph node surgery was performed. Death certificate only case; unknown or ill-defined primary site; hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease.

Note: One important use of registry data is the tracking of treatment patterns over time. To compare contemporary treatment to previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is very important to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than 4 nodes was not reflected in surgery codes. It is not intended to reflect clinical significance when applied to a particular surgical procedure. It is important to avoid inferring, by data presentation or other methods, that one category is preferable to another within the intent of these items.

RX HOSP--SCREEN/BX PROC1 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	742			

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

RX HOSP--SCREEN/BX PROC2 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	743			

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

RX HOSP--SCREEN/BX PROC3 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	744			

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

RX HOSP--SCREEN/BX PROC4 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	745			

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

RX HOSP--SURG APP 2010 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	668	1	CoC	781-781

Description
This item is used to describe the method of surgical approach used for patients undergoing surgery of the primary site at the reporting facility. If the patient has multiple surgeries to the primary site, this item describes the approach used for the most invasive, definitive surgery.

Rationale
This item is used to monitor patterns and trends in the adoption and use of minimally-invasive surgical techniques.

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing the extent of treatment given at a particular facility also helps resolve consolidation issues.

Codes
0 No surgical procedure of primary site at this facility. Diagnosed at autopsy.
1 Robotic assisted.
2 Robotic converted to open.
3 Laparoscopic.
4 Laparoscopic converted to open.
5 Open. Approach not specified.
9 Unknown whether surgery was performed; Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

RX HOSP--SURG OTH 98-02 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) at this Facility (CoC) Surgical Procedure/Other Site at this Facility	748	1	CoC	803-803

Description
Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site at this facility. This field is to be used for *ROADS* codes after the *ROADS* to *FORDS* conversion. It is also to be used to code Surgery Other Regional/Distant Sites at the reporting facility for all tumors diagnosed before January 1, 2003.

Rationale
The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes (See the CoC *ROADS Manual* 1998 Supplement and the *SEER Program Code Manual* for site-specific codes.)

RX HOSP--SURG OTH REG/DIS **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) at this Facility (CoC) Surgical Procedure/Other Site at this Facility	674	1	CoC	785-785

Description

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

Rationale

The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement. If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes (Refer to the most recent *FORDS* for additional instructions.)

0 None; no non-primary site resection was performed. Diagnosed at autopsy.
1 Non-primary surgical procedure performed, unknown if whether site is regional or distant.
2 Non-primary surgical procedure to other regional sites.
3 Non-primary surgical procedure to *distant lymph node(s).*
4 Non-primary surgical procedure to distant site.
5 Any combination of codes 2, 3, or 4.
9 Unknown; it is unknown whether any surgical procedure of a non-primary site was performed. Death certificate only.

RX HOSP--SURG PRIM SITE

Alternate Name	Item #	Length	Source of Standard	Column #
Cancer-Directed Surgery at This Facility (pre-96 CoC) RX Hosp--CA Dir Surgery (pre-96 NAACCR) Surgical Procedure of Primary Site	670	2	CoC	782-783

Description
Describes surgical procedures used to treat the primary site of the reportable tumor. This item records that portion of the first course of treatment given at the reporting facility. See Chapter V, Unresolved Issues, for a discussion of differences in treatment coding among groups and over time.

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

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes in addition to the site-specific codes (refer to the most recent *FORDS* for additional instructions).

00 None. No surgical procedure of primary site. Diagnosed at autopsy.
10-19 Site-specific codes; tumor destruction; No pathologic specimen produced.
20-80 Site-specific codes. Resection. Path specimen produced.
90 Surgery, NOS; surgical treatment of the primary site was done, but no information on the type of procedure is provided.
98 Site specific codes; special.
99 Unknown. Patient record does not state whether surgical treatment of the primary site was performed, and no information is available. Death certificate-only.

RX HOSP--SURG SITE 98-02 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Cancer-Directed Surgery at this Facility (pre-96 CoC) RX Hosp--CA Dir Surgery (pre-96 NAACCR) Surgical Procedure of Primary Site	746	2	CoC	800-801

Description
Describes surgical procedures used to treat the primary site of the reportable tumor. This item records that portion of the first course of treatment given at the reporting facility. This field is to be used for *ROADS* codes after the *ROADS* to *FORDS* conversion. It is also to be used to code Surgery Primary Site at the reporting facility for all tumors diagnosed before January 1, 2003. See Chapter V, Unresolved Issues, for a discussion of differences in treatment coding among groups and over time.

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

If central registries wish to study the treatment given at particular facilities, the facility-level treatment fields must be used. The summary treatment fields, conversely, combine information for all hospitals that provide first course of treatment for the tumor. Facility-specific fields allow studies of detailed referral patterns and treatment by type of healthcare setting. Knowing what part of the treatment was given at a particular facility also helps resolve consolidation issues.

Codes (in addition to the site-specific codes)
00 No surgery performed
99 Unknown if surgery performed

Note: See the CoC *ROADS Manual* 1998 Supplement and the *SEER Program Code Manual* for site-specific codes.

RX HOSP--SURG TIMING **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	678			

Description
This data item was proposed for inclusion in Version 12 but the request was withdrawn prior to implementation of the standard. The data item was retired in Version 12.1, as of January 1, 2011.

RX SUMM--BRM

Alternate Name	Item #	Length	Source of Standard	Column #
Immunotherapy (SEER/CoC) Biological Response Modifiers (pre-96 SEER)	1410	2	SEER/CoC	1589-1590

Description
Records whether immunotherapeutic (biologic response modifiers) agents were administered as first-course treatment at all facilities or the reason they were not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

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

Codes (Refer to the most recent *FORDS* and the *SEER Program Code Manual* for additional instructions.)

00 None, immunotherapy was not part of the planned first course of therapy.
01 Immunotherapy administered as first course therapy.
82 Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85 Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86 Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87 Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88 Immunotherapy was recommended, but it is unknown if it was administered.
99 It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record; death certificate-only cases.

Note: For tumors diagnosed on or after January 1, 2003, information on bone marrow transplants and stem cell transplants should be coded in the new field, RX SUMM--Transplnt/Endocr [3250]. The CoC standards for hospitals do not allow use of codes 02-06 in tumors diagnosed on or after January 1, 2003.

RX SUMM--CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
Chemotherapy (SEER/CoC)	1390	2	SEER/CoC	1585-1586

Description
Codes for chemotherapy given as part of the first course of treatment or the reason chemotherapy was not given. Includes treatment given at all facilities as part of the first course.

Codes (Refer to the most recent version of *FORDS* for additional instructions.)

00 None, chemotherapy was not part of the planned first course of therapy.
01 Chemotherapy, NOS.
02 Chemotherapy, single agent.
03 Chemotherapy, multiple agents.
82 Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85 Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86 Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87 Chemotherapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88 Chemotherapy was recommended, but it is unknown if it was administered.
99 It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record; death certificate-only cases.

RX SUMM--DX/STG PROC

Alternate Name	Item #	Length	Source of Standard	Column #
Non Cancer-Directed Surgery (CoC) Surgical Diagnostic and Staging Procedure (1996-2002) RX Summ--DX/Stg/Pall Proc	1350	2	CoC	1577-1578

Description
Identifies the surgical procedure(s) performed in an effort to diagnose and/or stage disease.

Codes (Refer to the most recent *FORDS* for additional instructions.)
00 No surgical diagnostic or staging procedure was performed.
01 A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02 A biopsy (incisional, needle, or aspiration) was done of the primary site.
03 A surgical exploratory only. The patient was not biopsied or treated.
04 A surgical procedure with a bypass was performed, but no biopsy was done.
05 An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06 A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07 A procedure was done, but the type of procedure is unknown.
09 No information about whether a diagnostic or staging procedure was performed.

Note: CoC recommends this item for tumors diagnosed 1996 and forward. For tumors diagnosed before 1996, this item may have been converted, and tumors with surgery would have been converted to 09 in this field. See also RX Summ--Surg Prim Site [1290] and RX Summ--Reconstruct 1st [1330]. For SEER and pre-1996 CoC, see RX Summ--Surgery Type [1640]. For tumors diagnosed between 1996 and 2002 this field may have described palliative care. For tumors diagnosed on or after January 1, 2003, palliative care is coded in a new field RX Summ--Palliative Proc [3270].

RX SUMM--HORMONE

Alternate Name	Item #	Length	Source of Standard	Column #
Hormone Therapy (SEER/CoC) Endocrine (Hormone/Steroid) Therapy (pre-96 SEER)	1400	2	SEER/CoC	1587-1588

Description
Records whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

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

Codes (Refer to the most recent *FORDS* and the *SEER Program Code Manual* for additional instructions.)

00 None, hormone therapy was not part of the planned first course of therapy.
01 Hormone therapy administered as first course therapy.
82 Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85 Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86 Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87 Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88 Hormone therapy was recommended, but it is unknown if it was administered.
99 It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in the patient record. Death certificate-only cases.

Note: For tumors diagnosed on or after January 1, 2003, information on endocrine surgery and/or endocrine radiation should be coded in the new field, RX Summ--Transplnt/Endocr [3250]. The CoC standards for hospitals do not allow use of codes 02-03 in tumors diagnosed on or after January 1, 2003.

RX SUMM--OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
Other Treatment (CoC) Other Cancer-Directed Therapy (SEER/pre-96 CoC)	1420	1	SEER/CoC	1591-1591

Description
Identifies other treatment given at all facilities that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment modifies, controls, removes, or destroys proliferating cancer tissue. Such treatments include phlebotomy, transfusions, and aspirin.

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

Codes (Refer to the most recent *FORDS* for additional coding instructions.)
0 None
1 Other
2 Other Experimental
3 Other-Double Blind
6 Other-Unproven
7 Refusal
8 Recommended
9 Unknown; unknown if administered

RX SUMM--PALLIATIVE PROC

Alternate Name	Item #	Length	Source of Standard	Column #
Palliative Procedure Palliative Care	3270	1	CoC	1579-1579

Description
Identifies any care provided in an effort to palliate or alleviate symptoms. Palliative care is performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or pain management therapy.

Rationale
This data item allows reporting facilities to track care that is considered palliative rather than diagnostic or curative intent.

Codes
0 No palliative care provided; diagnosed at autopsy
1 Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made
2 Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made
3 Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made
4 Patient received or was referred for pain management therapy with no other palliative care
5 Any combination of codes 1, 2, and/or 3 without code 4
6 Any combination of codes 1, 2, and/or 3 with code 4
7 Palliative care was performed or referred, but no information on the type of procedure is available in the patient record
9 Unknown if palliative care was performed or referred; not stated in patient record

RX SUMM--RAD TO CNS

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation Therapy to CNS (CoC) Radiation to the Brain and/or Central Nervous System (SEER)	1370	1	SEER/CoC	1581-1581

Description
For lung and leukemia cases only, codes for radiation given to the brain or central nervous system. Includes treatment given at all facilities as part of the first course. See Chapter V, Unresolved Issues, for more information.

Note: SEER does not collect this data item beginning with 1998 cases. They retain the codes for older cases in this field, and they have also recoded radiation coded here as radiation in RX Summ--Radiation [1360]. CoC does not collect this data item beginning with 1996 cases.

Codes
For Lung and Leukemia Cases only:
0 No radiation to the brain and/or central nervous system
1 Radiation
7 Patient or patient's guardian refused
8 Radiation recommended, unknown if administered
9 Unknown

For all other cases (primaries other than lung or leukemia):
9 Not applicable

RX SUMM--RADIATION

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation (SEER/CoC) Radiation Therapy (pre-96 CoC)	1360	1	SEER	1580-1580

Description
Codes for the type of radiation therapy performed as part of the first course of treatment.

Note: Radiation to brain and central nervous system for leukemia and lung cases is coded as radiation in this field.

Codes
0 None
1 Beam radiation
2 Radioactive implants
3 Radioisotopes
4 Combination of 1 with 2 or 3
5 Radiation, NOS--method or source not specified
6 Currently allowable for historic cases only; see note below
7 Patient or patient's guardian refused*
8 Radiation recommended, unknown if administered*
9 Unknown if radiation administered

Note: CoC discontinued collection of this item in 2003 when *FORDS* was implemented. For CoC, codes 7 and 8 were used for tumors diagnosed before 1996, but should have been converted to 0 in this field and to the appropriate code in the new field Reason for No Radiation [1430]. SEER continues to use codes 7 and 8 for all years. See Chapter V, Unresolved Issues, for further discussion.

In the SEER program, a code 2 for other radiation was used between 1973 and 1987. When the radiation codes were expanded to add codes '2' radioactive implants and '3' radioisotopes, all cases with a code '2' and diagnosed in 1973-1987 were converted to a code '6' radiation other than beam radiation.

RX SUMM--RECONSTRUCT 1ST

Alternate Name	Item #	Length	Source of Standard	Column #
Reconstruction--First Course (SEER) Reconstruction/Restoration-First Course (CoC)	1330	1	SEER	1575-1575

Description
Codes for surgical procedures done to reconstruct, restore, or improve the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or therapies. Reconstructive/restorative procedures are coded here when started during the first course of therapy.

CoC introduced site-specific codes for this item in the CoC *ROADS Manual* 1998 Supplement. RX Coding System--Current [1460] identifies which coding system applies.

SEER collects reconstructive procedures for breast cancer tumors only.

For reconstructive/restorative procedures performed later, see Subseq RX--Reconstruct Del [1741]. See also RX Summ--Surgery Type [1640].

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

RX SUMM--REG LN EXAMINED

Alternate Name	Item #	Length	Source of Standard	Column #
Number of Regional Lymph Nodes Examined (SEER/CoC) Number of Regional Lymph Nodes Removed (CoC)	1296	2	SEER/CoC	1571-1572

Description
Codes for the number of regional lymph nodes examined in conjunction with surgery performed as part of the first-course treatment. This includes treatment given at all facilities as part of the first course of treatment. See also RX Summ--Scope Reg LN Sur [1292].

Codes
00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
..
90 90 or more regional lymph nodes examined
..
95 No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as sampling, and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as a dissection, and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed, but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate-only

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

RX SUMM--SCOPE REG 98-02

Alternate Name	Item #	Length	Source of Standard	Column #
Scope of Regional Lymph Node Surgery (SEER/CoC)	1647	1	SEER/CoC	1622-1622

Description
Describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at all facilities. This field is to be used for *ROADS* codes after the *ROADS* to *FORDS* conversion. It is also to be used to code Scope of Regional Lymph Node Surgery at all facilities for all tumors diagnosed before January 1, 2003.

Rationale
In evaluating quality of care and treatment practices it is important to identify the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

Codes (See the CoC *ROADS Manual* 1998 Supplement and the *SEER Program Code Manual* for site-specific codes.)

RX SUMM--SCOPE REG LN SUR

Alternate Name	Item #	Length	Source of Standard	Column #
Scope of Regional Lymph Node Surgery (SEER/CoC)	1292	1	SEER/CoC	1569-1569

Description
Describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at all facilities.

Rationale
In evaluating quality-of-care and treatment practices it is important to identify the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

Codes (Refer to the most recent *FORDS* and *SEER Program Code Manual* for additional instructions.)

0 None
1 Biopsy or aspiration of regional lymph node, NOS
2 Sentinel lymph node biopsy
3 Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS
4 1 to 3 regional lymph nodes removed
5 4 or more regional lymph nodes removed
6 Sentinel node biopsy and code 3, 4, or 5 at same time or timing not noted
7 Sentinel node biopsy and code 3, 4, or 5 at different times
9 Unknown or not applicable

Note: One important use of registry data is the tracking of treatment patterns over time. To compare contemporary treatment to previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is very important to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than 4 nodes was not reflected in surgery codes. It is not intended to reflect clinical significance when applied to a particular surgical procedure. It is important to avoid inferring, by data presentation or other methods, that one category is preferable to another within the intent of these items.

RX SUMM--SCREEN/BX PROC1 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1642			

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

RX SUMM--SCREEN/BX PROC2 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1643			

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

RX SUMM--SCREEN/BX PROC3 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1644			

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

RX SUMM--SCREEN/BX PROC4 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1645			

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

RX SUMM--SURG OTH 98-02

Alternate Name	Item #	Length	Source of Standard	Column #
Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes (SEER/CoC) Surgical Procedure/Other Site	1648	1	SEER/CoC	1623-1623

Description
Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site given at all facilities as part of the first course of treatment. This field is to be used for *ROADS* codes after the *ROADS* to *FORDS* conversion. It is also to be used to code Surgery Regional/Distant Sites at all facilities for all tumors diagnosed before January 1, 2003.

Rationale
The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Codes (See the CoC *ROADS Manual* 1998 Supplement and the *SEER Program Code Manual* for site-specific codes.)

RX SUMM--SURG OTH REG/DIS

Alternate Name	Item #	Length	Source of Standard	Column #
Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes (SEER/CoC) Surgical Procedure/Other Site	1294	1	SEER/CoC	1570-1570

Description
Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

Rationale
The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Codes (Refer to the most recent *FORDS* and *SEER Program Code Manual* for additional instructions.)
0 None; diagnosed at autopsy
1 Non-primary surgical procedure performed
2 Non-primary surgical procedure to other regional sites
3 Non-primary surgical procedure to distant lymph node(s)
4 Non-primary surgical procedure to distant site
5 Any combination of codes 2, 3, or 4
9 Unknown; death certificate only

RX SUMM--SURG PRIM SITE

Alternate Name	Item #	Length	Source of Standard	Column #
Cancer-Directed Surgery (pre-96 CoC) Surgery of Primary Site (SEER/CoC)	1290	2	SEER/CoC	1567-1568

Description
Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment. This includes treatment given at all facilities as part of the first course of treatment.

Codes (In addition to the site-specific codes; refer to the most recent *FORDS* and SEER Program Code manual for additional instructions.)
00 None
10-19 Site-specific code; tumor destruction
20-80 Site-specific codes; resection
90 Surgery, NOS
98 Site specific codes; special
99 Unknown

RX SUMM--SURG SITE 98-02

Alternate Name	Item #	Length	Source of Standard	Column #
Cancer-Directed Surgery (pre-96 CoC) Surgery of Primary Site (SEER/CoC)	1646	2	SEER/CoC	1620-1621

Description
Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment. This includes treatment given at all facilities as part of the first course of treatment. This field is to be used for *ROADS* codes after the *ROADS* to *FORDS* conversion. It is also to be used to code Surgery Primary Site at all facilities for all tumors diagnosed before January 1, 2003.

Rationale
If central registries wish to study the treatment given at particular hospitals, the hospital-level treatment fields must be used.

Codes (in addition to the site-specific codes)
00 No primary site surgery performed
99 Unknown if primary site surgery performed

Note: See the CoC *ROADS Manual*, 1998 Supplement, CoC Coding System [2140] code 7, and the *SEER Program Code Manual*, RX Coding System [1460] code 5, 1998 for site-specific codes.

RX SUMM--SURG/RAD SEQ

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation Sequence with Surgery (pre-96 SEER/CoC) Radiation/Surgery Sequence (CoC)	1380	1	SEER/CoC	1582-1582

Description
Codes for the sequencing of radiation and surgery given as part of the first course of treatment. See also RX Summ--Surg Prim Site [1290], RX Summ--Scope LN Surg [1292], RX Summ--Surg Oth Reg/Dis [1294], and RX Summ--Radiation [1360].

Codes
0 No radiation and/or no surgery; unknown if surgery and/or radiation given
2 Radiation before surgery
3 Radiation after surgery
4 Radiation both before and after surgery
5 Intraoperative radiation
6 Intraoperative radiation with other radiation given before or after surgery
9 Sequence unknown, but both surgery and radiation were given

RX SUMM--SURGERY TYPE

Alternate Name	Item #	Length	Source of Standard	Column #
Site--Specific Surgery (pre-98 SEER)	1640	2	SEER	1617-1618

Description
Field for pre-1996 surgery codes for CoC and pre-1998 surgery codes for SEER. Surgery codes used 1998 and later can be backward converted into the older codes and the converted value can be stored in this field. See Chapter V, Unresolved Issues, for discussion of CoC/SEER differences in coding treatment.

RX SUMM--SURGICAL APPROCH **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Surgical Approach (CoC)	1310	1	CoC	1573-1573

Description
Codes for method used to approach the surgical field for the primary site.

Codes
See the CoC *ROADS Manual*, 1998 Supplement, for site-specific codes.
Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained. This former item should not be confused with NAACCR item [668] RX HOSP--SURG APP 2010 .

RX SUMM--SURGICAL MARGINS

Alternate Name	Item #	Length	Source of Standard	Column #
Surgical Margins (CoC) Residual Primary Tumor Following Cancer-Directed Surgery (pre-96 CoC)	1320	1	CoC	1574-1574

Description
Codes describe the final status of surgical margins after resection of the primary tumor. See also RX Summ--Surg Prim Site [1290].

Rationale
This item serves as a quality measure for pathology reports, is used for staging, and may be a prognostic factor in recurrence. This item is not limited to cases that have been staged. It applies to all cases that have a surgical procedure of the primary site.

Codes (Refer to the most recent *FORDS* for additional instructions.)
0 No residual tumor
1 Residual tumor, NOS
2 Microscopic residual tumor
3 Macroscopic residual tumor
7 Margins not evaluable
8 No primary site surgery
9 Unknown or not applicable

Note: Codes were site specific (1998-2002), and have been changed to be generic across all disease sites.

RX SUMM--SYSTEMIC/SUR SEQ **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Systemic/Surgery Sequence	1639	1	CoC	1616-1616

Description
Records the sequencing of systemic therapy (RX Summ-Chemo [1390], RX Summ-Hormone [1400], RX Summ-BRM [1410], and RX Summ-Transplnt/Endocr [3250]) and surgical procedures given as part of the first course of treatment. See also RX Summ--Surg Prim Site [1290], RX Summ--Scope LN Surg [1292], and RX Summ--Surg Oth Reg/Dis [1294].

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

Codes
0 No systemic therapy and/or surgical procedures; unknown if surgery and/or systemic therapy given
2 Systemic therapy before surgery
3 Systemic therapy after surgery
4 Systemic therapy both before and after surgery
5 Intraoperative systemic therapy
6 Intraoperative systemic therapy with other therapy administered before or after surgery
9 Sequence unknown, but both surgery and systemic therapy given

RX SUMM--TRANSPLNT/ENDOCR

Alternate Name	Item #	Length	Source of Standard	Column #
Hematologic Transplant and Endocrine Procedures	3250	2	CoC	1583-1584

Description
Identifies systemic therapeutic procedures administered as part of the first course of treatment at this and all other facilities. If none of these procedures were administered then this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

Rationale
This data item allows the evaluation of patterns of treatment, which involve the alteration of the immune system or change the patient's response to tumor cells but do not involve the administration of antineoplastic agents.

Codes (Refer to the most recent *FORDS* for additional instructions.)

00 No transplant procedure or endocrine therapy was administered as part of first course therapy; diagnosed at autopsy.
10 Bone marrow transplant procedure was administered, but the type was not specified.
11 Bone marrow transplant--autologous.
12 Bone marrow transplant--allogeneic.
20 Stem cell harvest and infusion.
30 Endocrine surgery and/or endocrine radiation therapy.
40 Combination of endocrine surgery and/or radiation with a transplant procedure. (combination of codes 30 and 10, 11, 12 or 20).
82 Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85 Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.
86 Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was stated in the patient record.
87 Hematologic transplant and/or endocrine surgery/radiation was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian; refusal noted in patient record.
88 Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99 It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record; death certificate-only cases.

RX SUMM--TREATMENT STATUS

Alternate Name	Item #	Length	Source of Standard	Column #
	1285	1	SEER/CoC	1566-1566

Description
This data item is a summary of the status for all treatment modalities. It is used in conjunction with Date of Initial RX-SEER [1260] and/or Date of 1st Crs RX--CoC [1270] and each modality of treatment with their respective date field to document whether treatment was given or not given, whether it is unknown if treatment was given, or whether treatment was given on an unknown date. Also indicates active surveillance (watchful waiting). This data item is effective for January 2010+ diagnoses.

Rationale
This field will document active surveillance (watchful waiting) and eliminate searching each treatment modality to determine whether treatment was given.

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

RX TEXT--BRM

Alternate Name	Item #	Length	Source of Standard	Column #
	2660	1000	NPCR	17765-18764

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

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

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

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

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

Suggestions for text:

- Date treatment began
- Where treatment was given, e.g., at this facility, at another facility
- Type of BRM agent, e.g., Interferon, BCG
- BRM procedures, e.g., bone marrow transplant, stem cell transplant
- Other treatment information, e.g., treatment cycle incomplete; unknown if BRM was given

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Initial RX--SEER	1260
Date of 1st Crs RX--CoC	1270
RX Hosp--BRM	720
RX Date Systemic	3230
RX Summ--Tranplnt/Endocr	3250
RX Summ--BRM	1410
RX Date--BRM	1240
RX Summ--Systemic/Sur Seq	1639

RX TEXT--CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
	2640	1000	NPCR	15765-16764

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

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

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

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

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

Suggestions for text:
- Date chemotherapy began
- Where treatment was given, e.g., at this facility, at another facility
- Type of chemotherapy, e.g., name of agent(s) or protocol
- Other treatment information, e.g., treatment cycle incomplete, unknown if chemotherapy was given

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Initial RX--SEER	1260
Date of 1st Crs RX--CoC	1270
RX Summ--Chemo	1390
RX Hosp--Chemo	700
RX Date--Systemic	3230
RX Date--Chemo	1220
RX Summ--Systemic/Sur Seq	1639

RX TEXT--HORMONE

Alternate Name	Item #	Length	Source of Standard	Column #
	2650	1000	NPCR	16765-17764

Description
Text area for information about hormonal treatment.

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

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

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

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

Suggestions for text:
- Date treatment was started
- Where treatment was given, e.g., at this facility, at another facility
- Type of hormone or antihormone, e.g., Tamoxifen
- Type of endocrine surgery or radiation, e.g., orchiectomy
- Other treatment information, e.g., treatment cycle incomplete; unknown if hormones were given

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Initial RX--SEER	1260
Date of 1st Crs RX--CoC	1270
RX Summ--Hormone	1400
RX Hosp--Hormone	710
RX Date--Systemic	3230
RX Date--Hormone	1230
RX Summ--Systemic/Sur Seq	1639

RX TEXT--OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
	2670	1000	NPCR	18765-19764

Description
Text area for manual documentation of information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field.

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

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

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

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

Suggestions for text:
- Date treatment was started
- Where treatment was given, e.g., at this facility, at another facility
- Type of other treatment, e.g., blinded clinical trial, hyperthermia
- Other treatment information, e.g., treatment cycle incomplete; unknown if other treatment was given

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Initial RX--SEER	1260
Date of 1st Crs RX--CoC	1270
RX Summ--Other	1420
RX Date--Other	1250
RX Hosp--Other	730

RX TEXT--RADIATION (BEAM)

Alternate Name	Item #	Length	Source of Standard	Column #
	2620	1000	NPCR	13765-14764

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

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

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

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

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

Suggestions for text:
- Date radiation treatment began
- Where treatment was given, e.g., at this facility, at another facility
- Type(s) of beam radiation, e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities
- Other treatment information, e.g., patient discontinued after 5 treatments; unknown if radiation was given

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Initial RX--SEER	1260
Date of 1st Crs RX--CoC	1270
RX Summ--Radiation	1360
RX Summ--Surg/Rad Seq	1380
Reason For No Radiation	1430
RX Date-Radiation	1210
Rad Regional RX Modality	1570
RX Hosp-Radiation	690
RX Date Radiation Ended	3220
RX Summ-Rad to CNS	1370
Rad-No of Treatment Vol	1520
Rad-Regional Dose cGy	1510
Rad Treatment Volume	1540
Rad Location of RX	1550
Rad Boost RX Modality	3200
Rad Boost Dose cGy	3210

RX TEXT--RADIATION OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
	2630	1000	NPCR	14765-15764

Description
Text area for manual documentation of information regarding treatment of the tumor being reported with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy.

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

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

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

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

Suggestions for text:

- Date treatment was started
- Where treatment was given, e.g., at this facility, at another facility
- Type(s) of nonbeam radiation, e.g., High Dose rate brachytherapy, seed implant, Radioisotopes (I-131)
- Other treatment information, e.g., unknown if radiation was given

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Initial RX--SEER	1260
Date of 1st Crs RX--CoC	1270
RX Summ--Radiation	1360
RX Summ--Surg/Rad Seq	1380
Reason For No Radiation	1430
RX Date-Radiation	1210
Rad Regional RX Modality	1570
RX Hosp--Radiation	690
RX Date Radiation Ended	3220
RX Summ--Rad to CNS	1370
Rad--No of Treatment Vol	1520
Rad--Regional Dose cGy	1510
Rad Treatment Volume	1540
Rad Location of RX	1550
Rad Boost RX Modality	3200
Rad Boost Dose cGy	3210

RX TEXT--SURGERY

Alternate Name	Item #	Length	Source of Standard	Column #
	2610	1000	NPCR	12765-13764

Description
Text area for information describing all surgical procedures performed as part of treatment.

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

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

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

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

Suggestions for text:
- Date of each procedure.
- Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites.
- Lymph nodes removed.
- Regional tissues removed.
- Metastatic sites.
- Facility where each procedure was performed.
- Record positive and negative findings. Record positive findings first.
- Other treatment information, e.g., planned procedure aborted; unknown if surgery performed.

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Initial RX--SEER	1260
Date of 1st Crs RX--CoC	1270
RX Date Surgery	1200
RX Summ--Surg Prim Site	1290
RX Hosp--Surg Prim Site	670
RX Summ--Scope Reg LN Sur	1292
RX Hosp--Scope Reg LN Sur	672
RX Summ--Surg Oth Reg/Dis	1294
RX Hosp--Surg Oth Reg/Dis	674
Reason for No Surgery	1340
RX Summ--Surgical Margins	1320
RX Hosp--Palliative Proc	3280
RX Summ--Palliative Proc	3270
Text-Place of Diagnosis	2690
RX Summ--Surg/Rad Seq	1380
RX Summ--Systemic/Sur Seq	1639

SCREENING DATE **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	510			

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

SCREENING RESULT **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	520			

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

SEER CODING SYS--CURRENT **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2120	1	NAACCR	1930-1930

Description
This shows the SEER coding system best describing the majority of SEER items as they are in the record (after conversion).

Rationale
Change the allowable values to alpha-numeric in order to accommodate SEER Program Manual editions.

Codes
0 No SEER coding
1 Pre-1988 *SEER Coding Manuals*
2 1988 SEER *Coding Manual*
3 *1989 SEER Coding Manual*
4 *1992 SEER Coding Manual*
5 *1998 SEER Coding Manual*
6 *2003 SEER Coding Manual*
7 *2004 SEER Coding Manual*
8 *2007 SEER Coding Manual*
9 *January 2008 SEER Coding Manual*
A *January 2010 SEER Coding Manual*

SEER CODING SYS--ORIGINAL **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2130	1	NAACCR	1931-1931

Description
This shows the SEER coding system best describing the way the majority of SEER items in the record were originally coded.

Rationale
Change the allowable values to alpha-numeric in order to accommodate SEER Program Manual editions.

Codes
0 No SEER coding
1 Pre-1988 *SEER Coding Manuals*
2 *1988 SEER Coding Manual*
3 *1989 SEER Coding Manual*
4 *1992 SEER Coding Manual*
5 *1998 SEER Coding Manual*
6 *2003 SEER Coding Manual*
7 *2004 SEER Coding Manual*
8 *2007 SEER Coding Manual*
9 *January 2008 SEER Coding Manual*
A *January 2010 SEER Coding Manual*

SEER RECORD NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
Record Number (SEER)	2190	2	SEER	1947-1948

Description
A unique sequential number assigned by the SEER participant to each record for the person for each submission. The number may change from submission to submission. See also Tumor Record Number [60].

Codes
01 One or first of more than one record for person
02 Second record for person
..
..
nn Last of nn records for person

SEER SITE-SPECIFIC FACT 1

Alternate Name	Item #	Length	Source of Standard	Column #
	3700	1	SEER	1179-1179

Description
A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale
This field is a place holder when site-specific information is needed for SEER.

Codes (To be determined for each site where needed. Refer to the most current version of the *SEER Program Coding and Staging Manual,*[3] for details.)
Blank Field not coded

SEER SITE-SPECIFIC FACT 2 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	3702	1	SEER	1180-1180

Description
A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale
This field is a place holder when site-specific information is needed for SEER.

Codes (To be determined for each site where needed. Refer to the most current version of the *SEER Program Coding and Staging Manual,*[3] for details.)
Blank Field not coded.

SEER SITE-SPECIFIC FACT 3 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	3704	1	SEER	1181-1181

Description
A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale
This field is a place holder when site-specific information is needed for SEER.

Codes (To be determined for each site where needed. Refer to the most current version of the *SEER Program Coding and Staging Manual,*[3] for details.)
Blank Field not coded.

SEER SITE-SPECIFIC FACT 4 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	3706	1	SEER	1182-1182

Description
A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale
This field is a place holder when site-specific information is needed for SEER.

Codes (To be determined for each site where needed. Refer to the most current version of the *SEER Program Coding and Staging Manual*,[3] for details.)
Blank Field not coded

SEER SITE-SPECIFIC FACT 5 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	3708	1	SEER	1183-1183

Description
A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale
This field is a place holder when site-specific information is needed for SEER.

Codes (To be determined for each site where needed. Refer to the most current version of the *SEER Program Coding and Staging Manual*,[3] for details.)
Blank Field not coded

SEER SITE-SPECIFIC FACT 6 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	3710	1	SEER	1184-1184

Description
A one character field to be used when information for a particular primary site needs to be collected by SEER.

Rationale
This field is a place holder when site-specific information is needed for SEER.

Codes (To be determined for each site where needed. Refer to the most current version of the *SEER Program Coding and Staging Manual*,[3] for details.)
Blank Field not coded

SEER SUMMARY STAGE 1977

Alternate Name	Item #	Length	Source of Standard	Column #
General Summary Stage (SEER/CoC)	760	1	SEER	905-905

Description
Code for summary stage at the initial diagnosis or treatment of the reportable tumor. This has traditionally been used by central registries to monitor time trends. For hospital registries, CoC requires its use in the absence of a defined AJCC classification. For site-specific definitions of categories, see the SEER Summary Staging Guide.

SEER Summary Stage 1977 is limited to information available within 2 months of the date of diagnosis. NAACCR approved extension of this time period to 4 months for prostate tumors diagnosed beginning January 1, 1995.

Rationale
Stage information is important when evaluating the effects of cancer control programs. It is crucial for understanding whether changes over time in incidence rates or outcomes are due to earlier detection of the cancers. In addition, cancer treatment cannot be studied without knowing the stage at diagnosis.

To study historical trends in stage, the coding system must be relatively unchanged (stable) over time. AJCC's TNM system is updated periodically to maintain clinical relevance with changes in diagnosis and treatment. The surveillance registries often rely on the Summary Stage, which they consider to be more "stable." Summary Stage has been in widespread use, either as the primary staging scheme or a secondary scheme, in most central and hospital registries since 1977.

Codes
0 *In situ*
1 Localized
2 Regional, direct extension only
3 Regional, regional lymph nodes only
4 Regional, direct extension and regional lymph nodes
5 Regional, NOS
7 Distant
8 Not applicable
9 Unstaged

Note: Code 8 has been added in Version 10.1 to be used when there is not an applicable code to reflect stage (e.g., benign brain, borderline ovarian).

Note: See also the item Derived SS1977 [3010] for the value of SEER Summary Stage 1977 as generated by the Collaborative Staging algorithm.

Clarification of NAACCR and NPCR Required Status
Summary stage is required. The correct data item to use (and corresponding code manual) is determined by the year in which the cancer was diagnosed. Tumors diagnosed on or after January 1, 2004, should be assigned a summary stage based upon the Collaborative Stage data item algorithms and retained in Derived SS2000 [3020]. Tumors diagnosed on or after January 1, 2001, should be assigned a summary stage according to the SEER *Summary Staging Manual 2000*, and the code should be reported in SEER Summary Stage 2000 [759]. Tumors diagnosed before January 1, 2001, should be assigned a summary stage according to *SEER Summary Stage Guide 1977*, and the code should be reported in SEER Summary Stage 1977 [760].

SEER SUMMARY STAGE 2000

Alternate Name	Item #	Length	Source of Standard	Column #
	759	1	SEER	904-904

Description
Code for summary stage at the initial diagnosis or treatment of the reportable tumor. For hospital registries, CoC requires its use in the absence of a defined AJCC classification. For site-specific definitions of categories, see SEER *Summary Staging Manual 2000*.

Summary stage should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Rationale
Stage information is important when evaluating the effects of cancer control programs. It is crucial in understanding whether changes over time in incidence rates or outcomes are due to earlier detection of the cancers. In addition, cancer treatment cannot be studied without knowing the stage at diagnosis.

Codes
0 *In situ*
1 Localized
2 Regional, direct extension only
3 Regional, regional lymph nodes only
4 Regional, direct extension and regional lymph nodes
5 Regional, NOS
7 Distant
8 Not applicable
9 Unstaged

Note: Code 8 has been added in Version 10.1 to be used when there is not an applicable code to reflect stage (e.g., benign brain, borderline ovarian).

Note: See also the item Derived SS2000 [3020] for the value of SEER Summary Stage 2000 as generated by the collaborative Staging algorithm.

Clarification of NAACCR and NPCR Required Status
Summary stage is required. The correct data item to use (and corresponding code manual) is determined by the year in which the cancer was diagnosed. Tumors diagnosed on or after January 1, 2004, should be assigned a summary stage based upon the Collaborative Stage data item algorithms and retained in Derived SS2000 [3020]. Tumors diagnosed on or after January 1, 2001, should be assigned a summary stage according to the SEER *Summary Staging Manual 2000*, and the code should be reported in SEER Summary Stage 2000 [759]. Tumors diagnosed before January 1, 2001, should be assigned a summary stage according to *SEER Summary Stage Guide 1977*, and the code should be reported in SEER Summary Stage 1977 [760].

SEER TYPE OF FOLLOW-UP

Alternate Name	Item #	Length	Source of Standard	Column #
Type of Follow-Up (SEER)	2180	1	SEER	1946-1946

Description
Codes for the type of follow-up expected for a SEER case.

Codes
1 "Autopsy-Only" or "Death Certificate-Only" case
2 Active follow-up case
3 *In situ* cancer of the cervix uteri only
4 Case not originally in active follow-up, but in active follow-up now (San Francisco-Oakland only)

SEQUENCE NUMBER--CENTRAL **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Sequence Number (pre-96 SEER)	380	2	SEER	528-529

Description
Code indicates the sequence of all reportable neoplasms over the lifetime of the person. This data item differs from Sequence Number-Hospital [560], because the definitions of reportable neoplasms often vary between a hospital and a central registry. Each neoplasm is assigned a different number. Sequence Number 00 indicates that the person has had only one *in situ* or one malignant neoplasm as defined by the Federal reportable list (regardless of central registry reference date). Sequence Number 01 indicates the first of two or more reportable neoplasms, but 02 indicates the second of two or more reportable neoplasms, and so on. Because the time period of Sequence Number is a person's lifetime, reportable neoplasms not included in the central registry (those that occur outside the registry catchment area or before the reference date) also are allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm preceded the central registry's reference date.

Reporting Requirements: Federally Required and State/Province Defined
The Federal or SEER/NPCR standard defining the reportable neoplasms is described in Chapter III, Standards For Tumor Inclusion and Reportability. It is assumed that this shared standard is the "minimum" definition of reportability. Individual central cancer registries may define additional neoplasms as reportable.

Numeric codes in the 00-59 range indicate the sequence of neoplasms of *in situ* or malignant behavior (2 or 3) at the time of diagnosis, which SEER/NPCR standards require to be reported. Codes 60 to 87 indicate the sequence of non-malignant tumors (as defined in Chapter III) and any other neoplasms that the central registry has defined as reportable. Neoplasms required by SEER/NPCR with an *in situ* or malignant behavior at the time of diagnosis are sequenced completely independently of this higher-numbered category. Sequence Number-Hospital does not affect Sequence Number-Central. The two notational systems are independent but central registries should take Sequence Number-Hospital [560] into account when coding Sequence Number Central.

Rationale
The purpose of sequencing based on the patient's lifetime is to truly identify the 00s, the people who only had one malignant primary in their lifetimes for survival analysis. If a central registry sequences by just what is reported to them, then it will be unclear whether 00 means the person only had one malignant primary in his lifetime or the person had one malignant primary since the central registry started collecting data. The Federally required reportable list has changed throughout the years, so the registry must use the appropriate reportable list for the year of diagnosis. The central registry reference date will not affect Sequence Number-Central.

Codes

In Situ/Malignant as Federally Required based on Diagnosis Year:

00 One primary in the patient's lifetime
01 First of two or more primaries
02 Second of two or more primaries
..
..
59 Fifty-ninth or higher of fifty-nine or more primaries
99 Unspecified or unknown sequence number of Federally required *in situ* or malignant tumors. Sequence number 99 can be used if there is a malignant tumor and its sequence number is unknown. If there is known to be more than one malignant tumor, then the tumors must be sequenced.

Non-malignant Tumor as Federally Required based on Diagnosis Year or State/Province Defined:

60 One non-malignant tumor or central registry-defined neoplasm
61 First of two or more non-malignant tumor or central registry-defined neoplasms
62 Second of two or more non-malignant tumor or central registry-defined neoplasms
.. ..
88 Unspecified or unknown sequence number for non-malignant tumor or central registry-defined neoplasms. (Sequence number 88 can be used if there is a non-malignant tumor and its sequence number is unknown. If there is known to be more than one non-malignant
98 Cervix carcinoma *in situ* (CIS)/CIN III, Diagnosis Years 1996-2002.

The table that follows shows which sequence number series to use by type of neoplasm.

Neoplasm	**SeqNum-Central**
***In Situ*/Malignant as Federally Required based on Diagnosis Year**	**(Numeric Series)**
In Situ (behavior code = 2) (Cervix CIS/CIN III, Diagnosis Year before 1996) (includes VIN III, VAIN III, AIN III)	00 -- 59
Malignant (behavior code = 3)	00 -- 59
Juvenile Astrocytoma, Diagnosis Year 2001+ (*)	00 -- 59
Invasive following *In Situ*--New primary as defined by CoC	00 -- 59
Invasive following *In Situ*--New primary as defined by SEER	00 -- 59
Unspecified Federally Required Sequence Number or Unknown	99
Non-malignant Tumor as Federally Required based on Diagnosis Year or State/Province Registry-Defined	
Examples:	
Non-malignant Tumor/Benign Brain	60 -- 87
Borderline Ovarian, Diagnosis Year 2001+	60 -- 87
Other Borderline/Benign	60 -- 87
Skin SCC/BCC	60 -- 87
PIN III	60 -- 87
Cervix CIS/CIN III, Diagnosis Year 2003+	60 -- 87
Unspecified Non-malignant Tumor or Central Registry-Defined Sequence Number	88
Cervix CIS/CIN III, Diagnosis Year 1996-2002	98

*Juvenile astrocytomas should be reported as 9421/3.

Note: See the section on Sequence Number--Central in The *SEER Program Code Manual*.

Note: Conversion Guidance: The sequence numbers for neoplasms whose histologies were associated with behavior codes that changed from *in situ*/malignant to benign/borderline or vice versa during the conversion from ICD-O-2 to ICD-O-3 should not be re-sequenced.

SEQUENCE NUMBER--HOSPITAL **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Sequence Number (CoC)	560	2	CoC	740-741

Description
Item indicates the sequence of all malignant and non-malignant neoplasms over the lifetime of the patient. The code may differ from the Sequence Number--Central [380] because the definitions of reportable neoplasms often vary between a hospital and a central registry. The two items also handle some types of tumors differently. Each neoplasm is assigned a different number. Sequence Number 00 indicates that the person has only one malignant neoplasm in his lifetime (regardless of hospital registry reference date). Sequence Number 01 indicates the first of two or more malignant neoplasms, while 02 indicates the second of two or more malignant neoplasms, and so on. Because the time period of Sequence Number is a person's lifetime, reportable neoplasms not included in the hospital registry are also allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the hospital registry's reference date. Similarly, Sequence Number 60 indicates the patient has only one non-malignant neoplasm, and Sequence Number 61 represents the first of multiple non-malignant neoplasms.

Sequence numbers should be reassigned if the facility subsequently learns of an unaccessioned tumor that affects sequencing. Sequence Number-Central [380] does not affect Sequence Number-Hospital. The two notational systems are independent.

Timing Rule
If two or more malignant tumors are diagnosed at the same time, the lowest sequence number will be assigned to the diagnosis with the worst prognosis. Likewise, if two or more non-malignant tumors are diagnosed at the same time, the lowest sequence number is assigned to the diagnosis with the worse prognosis. If no difference in prognosis is evident, the decision is arbitrary.

Codes
***In situ*/Malignant Tumors:**
00 One malignant primary only in the patient's lifetime
01 First of two or more malignant primaries
02 Second of two or more malignant primaries
..
.. (Actual number of this malignant primary)
..
59 Fifty-ninth or higher of fifty-nine or more malignant primaries
99 Unspecified sequence number of a primary malignant tumor or unknown (When a patient has multiple tumors with unspecified/unknown sequence numbers code 99 should only be used once.)

Nonmalignant Tumors
60 Only one non-malignant tumor in the patient's lifetime
61 First of two or more non-malignant tumors
62 Second of two or more non-malignant tumors
..
88 Unspecified number of non-malignant tumors (When a patient has multiple unspecified neoplasms in this category code 88 should only be used once.)

The table that follows shows which sequence number series to use by type of neoplasm

Neoplasm	**SeqNum-Hospital**
***In situ*/Malignant**	**(code range)**
One *in situ* (behavior code = 2) or malignant (behavior code =3) primary tumor only in the patient's lifetime	00
First of multiple *in situ* or malignant primary tumors in the patient's lifetime	01
Actual sequence of two or more *in situ* or malignant primary tumors	02 -- 59
Unspecified malignant sequence number or unknown	99
Non-Malignant	
One benign (behavior code = 0) or borderline (behavior code = 1) primary tumor only in the patient's lifetime	60
First of two or more benign or borderline primary tumors in the patient's lifetime	61
Actual sequence of two or more non-malignant primary tumors	62 -- 87
Unspecified non-malignant sequence number or unknown	88

*Juvenile astrocytomas should be reported as 9421/3.

Note: See the section on Sequence Number in CoC (*FORDS*) manual.

SEX

Alternate Name	Item #	Length	Source of Standard	Column #
	220	1	SEER/CoC	192-192

Description
Code for the sex of the patient.

Codes
1 Male
2 Female
3 Other (hermaphrodite)
4 Transsexual
9 Not stated/Unknown

SITE (73-91) ICD-O-1

Alternate Name	Item #	Length	Source of Standard	Column #
Primary Site (1973-91) (SEER)	1960	4	SEER	1909-1912

Description
Area for retaining the ICD-O-1 primary site code entered before conversion to ICD-0-2. The item name includes years 1973-91. However, some states may have used the codes for cases before 1973.

Codes
For tumors diagnosed before 1992, contains the ICD-O-1 site code as originally coded, if available. Blank for tumors coded directly into ICD-O-2 (i.e., 1992 and later tumors).

SITE CODING SYS--CURRENT

Alternate Name	Item #	Length	Source of Standard	Column #
	450	1	NAACCR	558-558

Description
Code that best describes how the primary site currently is coded. If converted, this field shows the system to which it is converted.

Codes
1 ICD-8 and MOTNAC
2 ICD-9
3 ICD-O, First Edition
4 ICD-O, Second Edition
5 ICD-O, Third Edition
6 ICD-10
9 Other

SITE CODING SYS--ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Column #
	460	1	NAACCR	559-559

Description
Code that best describes how primary site was originally coded. If converted, this field shows the original coding system used.

Codes
1 ICD-8 and MOTNAC
2 ICD-9
3 ICD-O, First Edition
4 ICD-O, Second Edition
5 ICD-O, Third Edition
6 ICD-10
9 Other

SITE OF DISTANT MET 1 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1090			

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

SITE OF DISTANT MET 2 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
Site of Distant Metastasis #2 (CoC)	1100			

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

SITE OF DISTANT MET 3 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1110			

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

SOCIAL SECURITY NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	2320	9	CoC	3619-3627

Description
Records patient's social security number. The number is entered without dashes and without any letter suffix. This is not always identical to the Medicare claim number.

Codes (in addition to social security number)
999999999 Unknown

SPANISH/HISPANIC ORIGIN

Alternate Name	Item #	Length	Source of Standard	Column #
Spanish Origin--All Sources (96 CoC) Spanish Surname or Origin (SEER)	190	1	SEER/CoC	189-189

Description
Code identifying persons of Spanish or Hispanic origin. This code is used by hospital and central registries to show the "best guess" as to whether or not the person should be classified as Hispanic for purposes of calculating cancer rates. If the patient has multiple tumors, all records should have the same code.

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf
All information resources should be used to determine the correct code, including:

- Stated ethnicity in the medical record
- Stated Hispanic origin on the death certificate
- Birthplace
- Information about life history and/or language spoken found during the abstracting process
- Patient's last name [2230] or maiden name [2390] found on a list of Hispanic names

Some registries code the information from the medical record, others code ethnicity based on Spanish names, and others use a combination of methods.

Persons of Spanish or Hispanic origin may be of any race, but these categories generally are not used for Native Americans, Filipinos, etc., who may have Spanish names. If a patient has an Hispanic name, but there is reason to believe they are not Hispanic (e.g., the patient is Filipino, or the patient is a woman known to be non-Hispanic who has a Hispanic married name), the code in this field should be 0 (non-Spanish, non-Hispanic). The code in item Computed Ethnicity [200], however, would reflect the Hispanic name.

Assign code 7 if Hispanic ethnicity is based strictly on a computer list or algorithm (unless contrary evidence is available) and also code in Computed Ethnicity [200].

See also Computed Ethnicity [200].

Note: NAACCR recognizes that available definitions and abstracting instructions for Name--Last [2230] and Name--Maiden [2390] may be inadequate for describing names used in some cultures, including Hispanic cultures. Explicit instructions have not been provided for entering compound names, with or without hyphens or "De." Order of names, use of maternal and paternal names, and use of hyphens can vary across cultures. It is likely that abstracting and coding practice for these items varies across registries. Limitations inherent in these definitions should be kept in mind when using the data.

Rationale
See the rationales for the Race 1-5 [160-164] and Computed Ethnicity [200]. Ethnic origin has a significant association with cancer rates and outcomes. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the "white" category of Race [160].

Codes
0 Non-Spanish; non-Hispanic
1 Mexican (includes Chicano)
2 Puerto Rican
3 Cuban
4 South or Central American (except Brazil)
5 Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6 Spanish, NOS
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 other categories 1-5.
7 Spanish surname only (Code 7 is ordinarily for central registry use only, hospital registrars may use code 7 if using a list of Hispanic surnames provided by their central registry; otherwise, code 9 'unknown whether Spanish or not' should be used.)
The only evidence of the person's Hispanic origin is the surname or maiden name and there is no contrary evidence that the person is not Hispanic.
8 Dominican Republic
9 Unknown whether Spanish or not

Note: Code 7 was adopted for use effective with 1994 diagnosis and modified December 1994.

Note: Code 8 was added in Standards Volume II Version 10.2, effective January 2005, however, abstractors may assign code 8 to tumors diagnosed prior to 2005.

STATE/REQUESTOR ITEMS **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2220	1000	Varies	2340-3339

Description
Reserved for use by individual states or central registries, or for use by special studies.

SUBSQ REPORT FOR PRIMARY **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	2160			

Description
The NAACCR UDSC retired this data item in Version 6, effective January 1, 1998.

SUBSQ RX 2ND COURSE BRM

Alternate Name	Item #	Length	Source of Standard	Column #
	1675	1	CoC	1743-1743

Description
Codes for the type of biological response modifier therapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Immunotherapy, *1998 ROADS Manual*, p. 243. See also First Course Calc Method [1500].

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

SUBSQ RX 2ND COURSE CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
	1673	1	CoC	1741-1741

Description
Codes for the type of chemotherapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Chemotherapy, *1998 ROADS Manual*, p. 228. See also First Course Calc Method [1500].

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

SUBSQ RX 2ND COURSE CODES

Alternate Name	Item #	Length	Source of Standard	Column #
	1670	11		1734-1744

Description
The name for a group of subfields that describe the second course or set of subsequent therapy. As of January 1, 2003, CoC no longer supports Subsequent Therapy data items.

Group names appear only in the data dictionary and Appendix E.

Subfields

Subsq RX 2nd Course Surg [1671]
Subsq RX 2nd Course Rad [1672]
Subsq RX 2nd Course Chemo [1673]
Subsq RX 2nd Course Horm [1674]
Subsq RX 2nd Course BRM [1675]
Subsq RX 2nd Course Oth [1676]

SUBSQ RX 2ND COURSE DATE

Alternate Name	Item #	Length	Source of Standard	Column #
Second Course of Therapy-Date Started (pre-96 CoC)	1660	8	CoC	1724-1731

Description
Date of initiation of second-course treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. See page 97 for date format.

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

SUBSQ RX 2ND COURSE HORM

Alternate Name	Item #	Length	Source of Standard	Column #
	1674	1	CoC	1742-1742

Description
Codes for the type of hormonal therapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Hormone Therapy, *1998 ROADS Manual*, p. 238. See also First Course Calc Method [1500].

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

SUBSQ RX 2ND COURSE OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1676	1	CoC	1744-1744

Description
Codes for the type of other treatment given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Other Treatment, *1998 ROADS Manual*, p. 246. See also First Course Calc Method [1500].

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

SUBSQ RX 2ND COURSE RAD

Alternate Name	Item #	Length	Source of Standard	Column #
	1672	1	CoC	1740-1740

Description
Codes for the type of radiation given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Radiation, *1998 ROADS Manual*, p. 199. See also First Course Calc Method [1500].

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

SUBSQ RX 2ND COURSE SURG

Alternate Name	Item #	Length	Source of Standard	Column #
	1671	2	CoC	1734-1735

Description
Codes for the type of primary site surgery given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Surgery of Primary Site, *1998 ROADS Manual*, p. 187. See also First Course Calc Method [1500].

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

SUBSQ RX 2NDCRS DATE FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1661	2	NAACCR	1732-1733

Description
This flag explains why no appropriate value is in the field, Subsq RX 2nd Course Date [1660]. This data item was first available in Volume II Version 12 (effective January 2010).

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if any subsequent therapy)
11 No proper value is applicable in this context (e.g., no subsequent therapy)
Blank A valid date value is provided in item Subsq RX 2nd Course Date [1660], or the date was not expected to have been transmitted

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

SUBSQ RX 2ND--REG LN REM

Alternate Name	Item #	Length	Source of Standard	Column #
	1679	2	CoC	1738-1739

Description
Codes for the number of regional lymph nodes removed as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Number of Regional Lymph Nodes Removed, *1998 ROADS Manual*, p. 193. See also First Course Calc Method [1500].

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

SUBSQ RX 2ND--SCOPE LN SU

Alternate Name	Item #	Length	Source of Standard	Column #
	1677	1	CoC	1736-1736

Description
Codes for the type of surgery performed to remove regional lymph nodes as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Scope of Regional Lymph Node Surgery, *1998 ROADS Manual*, p. 192. See also First Course Calc Method [1500].

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

SUBSQ RX 2ND--SURG OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1678	1	CoC	1737-1737

Description
Codes for the type of surgery performed on tissue or organs other than the primary site and regional lymph nodes as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s), *1998 ROADS Manual*, p. 194. See also First Course Calc Method [1500].

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

SUBSQ RX 3RD COURSE BRM

Alternate Name	Item #	Length	Source of Standard	Column #
	1695	1	CoC	1764-1764

Description
Codes for the type of biological response modifier therapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Immunotherapy, *1998 ROADS Manual*, p. 243

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

SUBSQ RX 3RD COURSE CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
	1693	1	CoC	1762-1762

Description
Codes for the type of chemotherapy given as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Chemotherapy, *1998 ROADS Manual*, p. 228.

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

SUBSQ RX 3RD COURSE CODES

Alternate Name	Item #	Length	Source of Standard	Column #
	1690	11		1755-1765

Description
The name for a group of subfields that describe the third course or set of subsequent therapy. As of January 1, 2003, CoC no longer supports Subsequent Therapy data items.

Group names appear only in the data dictionary and Appendix E.

Subfields
Subsq RX 3rd Course Surg [1691]
Subsq RX 3rd Course Rad [1692]
Subsq RX 3rd Course Chemo [1693]
Subsq RX 3rd Course Horm [1694]
Subsq RX 3rd Course BRM [1695]
Subsq RX 3rd Course Oth [1696]

SUBSQ RX 3RD COURSE DATE

Alternate Name	Item #	Length	Source of Standard	Column #
	1680	8	CoC	1745-1752

Description
Date of initiation of third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. See page 97 for date format.

SUBSQ RX 3RD COURSE HORM

Alternate Name	Item #	Length	Source of Standard	Column #
	1694	1	CoC	1763-1763

Description
Codes for the type of hormonal therapy given as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Hormone Therapy, *1998 ROADS Manual*, p. 238.

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

SUBSQ RX 3RD COURSE OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1696	1	CoC	1765-1765

Description
Codes for the type of other treatment given as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Other Treatment, *1998 ROADS Manual*, p. 246.

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

SUBSQ RX 3RD COURSE RAD

Alternate Name	Item #	Length	Source of Standard	Column #
	1692	1	CoC	1761-1761

Description
Codes for the type of radiation given as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Radiation, *1998 ROADS Manual*, p. 199.

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

SUBSQ RX 3RD COURSE SURG

Alternate Name	Item #	Length	Source of Standard	Column #
	1691	2	CoC	1755-1756

Description
Codes for the type of primary site surgery given as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Surgery of Primary Site, *1998 ROADS Manual*, p. 187.

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

SUBSQ RX 3RDCRS DATE FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1681	2	NAACCR	1753-1754

Description
This flag explains why no appropriate value is in the field, Subsq RX 3rd Course Date [1680]. This data item was first available in Volume II Version 12 (effective January 2010).

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if any subsequent therapy)
11 No proper value is applicable in this context (e.g., no subsequent therapy)
Blank A valid date value is provided in item Subsq RX 3rd Course Date [1680], or the date was not expected to have been transmitted

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

SUBSQ RX 3RD--REG LN REM

Alternate Name	Item #	Length	Source of Standard	Column #
	1699	2	CoC	1759-1760

Description
Codes for the number of regional lymph nodes removed as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Number of Regional Lymph Nodes Removed, *1998 ROADS Manual*, p. 193.

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

SUBSQ RX 3RD--SCOPE LN SU

Alternate Name	Item #	Length	Source of Standard	Column #
	1697	1	CoC	1757-1757

Description
Codes for the type of surgery performed to remove regional lymph nodes as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Scope of Regional Lymph Node Surgery, *1998 ROADS Manual*, p. 192.

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

SUBSQ RX 3RD--SURG OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1698	1	CoC	1758-1758

Description
Codes for the type of surgery performed on tissue or organs other than the primary site and regional lymph nodes as part of the third course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s), *1998 ROADS Manual*, p. 194.

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

SUBSQ RX 4TH COURSE BRM

Alternate Name	Item #	Length	Source of Standard	Column #
	1715	1	CoC	1785-1785

Description
Codes for the type of biological response modifier therapy given as part of the second course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Immunotherapy, *1998 ROADS Manual*, p. 243

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

SUBSQ RX 4TH COURSE CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
	1713	1	CoC	1783-1783

Description
Codes for the type of chemotherapy given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Chemotherapy, *1998 ROADS Manual*, p. 228.

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

SUBSQ RX 4TH COURSE CODES

Alternate Name	Item #	Length	Source of Standard	Column #
	1710	11		1776-1786

Description
The name for a group of subfields that describe the fourth course or set of subsequent therapy. As of January 1, 2003, CoC no longer support Subsequent Therapy data items.

Group names appear only in the data dictionary and Appendix E.

Subfields
Subsq RX 4th Course Surg [1711]
Subsq RX 4th Course Rad [1712]
Subsq RX 4th Course Chemo [1713]
Subsq RX 4th Course Horm [1714]
Subsq RX 4th Course BRM [1715]
Subsq RX 4th Course Oth [1716]

SUBSQ RX 4TH COURSE DATE

Alternate Name	Item #	Length	Source of Standard	Column #
	1700	8	CoC	1766-1773

Description
Date of initiation of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. See page 97 for date format.

SUBSQ RX 4TH COURSE HORM

Alternate Name	Item #	Length	Source of Standard	Column #
	1714	1	CoC	1784-1784

Description
Codes for the type of hormonal therapy given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Hormone Therapy, *1998 ROADS Manual*, p. 238.

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

SUBSQ RX 4TH COURSE OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1716	1	CoC	1786-1786

Description
Codes for the type of other treatment given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Other Treatment, *1998 ROADS Manual*, p. 246.

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

SUBSQ RX 4TH COURSE RAD

Alternate Name	Item #	Length	Source of Standard	Column #
	1712	1	CoC	1782-1782

Description
Codes for the type of radiation given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Radiation, *1998 ROADS Manual*, p. 199.

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

SUBSQ RX 4TH COURSE SURG

Alternate Name	Item #	Length	Source of Standard	Column #
	1711	2	CoC	1776-1777

Description
Codes for the type of primary site surgery given as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Surgery of Primary Site, *1998 ROADS Manual*, p. 187.

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

SUBSQ RX 4THCRS DATE FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
	1701	2	NAACCR	1774-1775

Description
This flag explains why no appropriate value is in the field, Subsq RX 4th Course Date [1700]. This data item was first available in Volume II Version 12 (effective January 2010).

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

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

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if any subsequent therapy)
11 No proper value is applicable in this context (e.g., no subsequent therapy)
Blank A valid date value is provided in item Subsq RX 4th Course Date [1700], or the date was not expected to have been transmitted

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

SUBSQ RX 4TH--REG LN REM

Alternate Name	Item #	Length	Source of Standard	Column #
	1719	2	CoC	1780-1781

Description
Codes for the number of regional lymph nodes removed as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Number of Regional Lymph Nodes Removed, *1998 ROADS Manual*, p. 193.

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

SUBSQ RX 4TH--SCOPE LN SU

Alternate Name	Item #	Length	Source of Standard	Column #
	1717	1	CoC	1778-1778

Description
Codes for the type of surgery performed to remove regional lymph nodes as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Scope of Regional Lymph Node Surgery, *1998 ROADS Manual*, p. 192.

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

SUBSQ RX 4TH--SURG OTH

Alternate Name	Item #	Length	Source of Standard	Column #
	1718	1	CoC	1779-1779

Description
Codes for the type of surgery performed on tissue or organs other than the primary site and regional lymph nodes as part of the fourth course of treatment. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. The codes are the same as those for Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s), *1998 ROADS Manual*, p. 194.

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

SUBSQ RX 5TH COURSE BRM **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1735			

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

SUBSQ RX 5TH COURSE CHEMO **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1733			

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

SUBSQ RX 5TH COURSE CODES **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1730			

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

SUBSQ RX 5TH COURSE DATE **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1720			

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

SUBSQ RX 5TH COURSE HORM **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1734			

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

SUBSQ RX 5TH COURSE OTH **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1736			

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

SUBSQ RX 5TH COURSE RAD **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1732			

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

SUBSQ RX 5TH COURSE SURG **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1731			

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

SUBSQ RX 5TH--REG LN REM **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1739			

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

SUBSQ RX 5TH--SCOPE LN SU **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1737			

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

SUBSQ RX 5TH--SURG OTH **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1738			

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

SUBSQ RX--RECONSTRUCT DEL

Alternate Name	Item #	Length	Source of Standard	Column #
Reconstruction/Restoration--Delayed (CoC)	1741	1	CoC	1787-1787

Description
Code for surgical procedure done to reconstruct, restore, or improve shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or therapies. Reconstructive/restorative procedures are coded here when started after the first course of therapy. Central registries currently collecting this data item should follow the *1998 ROADS Manual* coding instructions. For reconstructive/restorative procedures started during the first course of therapy, see RX Summ--Reconstruct 1st [1330]. See also RX Summ--Surgery Type [1640].

Codes
See the CoC *ROADS Manual*, 1998 Supplement, for site-specific codes.
Note: This data item is no longer supported by CoC (as of January 1, 2003).

TELEPHONE

Alternate Name	Item #	Length	Source of Standard	Column #
	2360	10	CoC	3868-3877

Description
Current telephone number with area code for the patient. Number is entered without dashes.

Codes (in addition to valid telephone number)

4..	Patient does not have a telephone
9999999999	Telephone number unavailable or unknown

Note: Prior to Version 5, Follow-Up Contact fields may have been used for patient current telephone in the NAACCR record layout.

TEXT--DX PROC--LAB TESTS

Alternate Name	Item #	Length	Source of Standard	Column #
	2550	1000	NPCR	8565-9564

Description
Text area for manual documentation of information from laboratory examinations other than cytology or histopathology.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values.**

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Type of lab test/tissue specimen(s)
- Record both positive and negative findings. Record positive test results first.
- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Date(s) of lab test(s)
- Tumor markers included, but are not limited to:
  - Breast Cancer – Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu
  - Prostate Cancer – Prostatic Specific Antigen (PSA)
  - Testicular Cancer – Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH)

Data Item(s) to be verified/validated using the text entered in this field:
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Primary Site	400
Grade	440
Diagnostic Confirmation	490
Collaborative Stage variables	2800-2930
Date of Diagnosis	390

TEXT--DX PROC--OP

Alternate Name	Item #	Length	Source of Standard	Column #
	2560	1000	NPCR	9565-10564

Description
Text area for manual documentation of all surgical procedures that provide information for staging.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values.**

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived
- Number of lymph nodes removed
- Size of tumor removed
- Documentation of residual tumor
- Evidence of invasion of surrounding areas
- Reason primary site surgery could not be completed

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Diagnosis	390
RX Summ--Dx/Stg Proc	1350
Diagnostic Confirmation	490
Primary Site	400
RX Hosp--Dx/Stg Proc	740
RX Summ--Surg Prim Site	1290
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759
Reason for No Surgery	1340

TEXT--DX PROC--PATH

Alternate Name	Item #	Length	Source of Standard	Column #
	2570	1000	NPCR	10565-11564

Description
Text area for manual documentation of information from cytology and histopathology reports.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values.**

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date(s) of procedure(s)
- Anatomic source of specimen
- Type of tissue specimen(s)
- Tumor type and grade (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.)
- Gross tumor size
- Extent of tumor spread
- Involvement of resection margins
- Number of lymph nodes involved and examined
- Record both positive and negative findings. Record positive test results first.
- Note if pathology report is a slide review or a second opinion from an outside source, i.e., AFIP, Mayo, etc.
- Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Diagnosis	390
Primary Site	400
Laterality	410
Histologic Type ICD-O-3	522
Grade	440
Collaborative Stage variables	2800-2930
Diagnostic confirmation	490
RX Hosp--Surg Prim Site	670
RX Hosp--Scope Reg LN Sur	672
RX Hosp--Surg Oth Rg/Dis	674
RX Summ--Surg Prim Site	1290
RX Summ--Scope Reg LN Sur	1292
RX Summ--Surg Oth Reg/Dis	1294
SEER Summary Stage 2000	759
SEER Summary Stage 1977	760
Regional Nodes Positive	820
Regional Nodes Examined	830
RX Date--Surgery	1200
Reason for No Surgery	1340
RX Summ--Surg/Rad Seq	1380
RX Summ--Systemic/Sur Seq	1639

TEXT--DX PROC--PE

Alternate Name	Item #	Length	Source of Standard	Column #
	2520	1000	NPCR	5565-6564

Description
Text area for manual documentation from the history and physical examination about the history of the current tumor and the clinical description of the tumor.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values.**

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- Date of physical exam
- Age, sex, race/ethnicity
- History that relates to cancer diagnosis
- Primary site
- Histology (if diagnosis prior to this admission)
- Tumor location
- Tumor size
- Palpable lymph nodes
- Record positive and negative clinical findings. Record positive results first
- Impression (when stated and pertains to cancer diagnosis)
- Treatment plan

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of 1st Contact	580
Date of Diagnosis	390
Age at Diagnosis	230
Race 1 - 5	160-164
Spanish Hispanic Origin	190
Sex	220
Primary Site	400
Laterality	410
Histology ICD-O-3	522
Sequence Number--Hospital	560
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759

TEXT--DX PROC--SCOPES

Alternate Name	Item #	Length	Source of Standard	Column #
	2540	1000	NPCR	7565-8564

Description
Text area for manual documentation from endoscopic examinations that provide information for staging and treatment.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values.**

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date(s) of endoscopic exam(s).
- Primary site.
- Histology (if given).
- Tumor location.
- Tumor size.
- Record site and type of endoscopic biopsy.
- Record positive and negative clinical findings. Record positive results first.

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Diagnosis	390
RX Summ--Dx/Stg Proc	1350
Diagnostic Confirmation	490
Primary Site	400
Laterality	410
Histology (92-00) ICD-O-2	420
Histology ICD-O-3	522
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759
RX Hosp--Surg Prim Site	670
RX Date--Surgery	1200

TEXT--DX PROC--X-RAY/SCAN

Alternate Name	Item #	Length	Source of Standard	Column #
	2530	1000	NPCR	6565-7564

Description
Text area for manual documentation from all X-rays, scan, and/or other imaging examinations that provide information about staging.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values.**

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- Date(s) and type(s) of X-ray/Scan(s).
- Primary site.
- Histology (if given).
- Tumor location.
- Tumor size.
- Lymph nodes.
- Record positive and negative clinical findings. Record positive results first.
- Distant disease or metastasis.

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Diagnosis	390
RxSumm--Dx/Stg Proc	1350
Primary Site	400
Laterality	410
Histology (92-00) ICD-O-2	420
Histology ICD-O-3	522
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759

TEXT--HISTOLOGY TITLE

Alternate Name	Item #	Length	Source of Standard	Column #
	2590	100	NPCR	11665-11764

Description
Text area for manual documentation of information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values.**

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Information on histologic type and behavior
- Information on differentiation from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc.

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Histology (92-00) ICD-O-2	420
Behavior (92-00) ICD-O-2	430
Histologic Type ICD-O-3	522
Behavior Code ICD-O-3	523
Grade	440

TEXT--PLACE OF DIAGNOSIS

Alternate Name	Item #	Length	Source of Standard	Column #
Place of Diagnosis	2690	60	NPCR	20765-20824

Description

Text area for manual documentation of the facility, physician office, city, state, or county where the diagnosis was made.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions

- Prioritize entered information in the order of the fields listed below.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- The complete name of the hospital or the physician office where diagnosis occurred. The initials of a hospital are not adequate.
- For out-of-state residents and facilities, include the city and the state where the medical facility is located.

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item Number
Reporting Facility	540
RX Hosp--DX/Stg Proc	740
RX Hosp--Surg Prim Site	670
Type of Reporting Source	500
Class of Case	610
Institution Referred From	2410
Institution Referred To	2420

TEXT--PRIMARY SITE TITLE

Alternate Name	Item #	Length	Source of Standard	Column #
	2580	100	NPCR	11565-11664

Description
Text area for manual documentation of information regarding the primary site and laterality of the tumor being reported.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values.**

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- State the specific location of the primary site, including subsite.
- Include available information on tumor laterality

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Primary site	400
Laterality	410

TEXT--REMARKS

Alternate Name	Item #	Length	Source of Standard	Column #
	2680	1000	NPCR	19765-20764

Description
Text area for information that is given only in coded form elsewhere or for which the abstract provides no other place. Overflow data can also be placed here. Problematic coding issues can also be discussed in this section.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments from other text fields can be continued in the Remarks field. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- Smoking history
- Family and personal history of cancer
- Comorbidities
- Information on sequence numbers if a person was diagnosed with another primary out-of-state or before the registry's reference date
- Place of birth
- Justification of over-ride flags
- Information clarifying anything unusual such as reason for reporting a case seemingly not reportable for that facility or reason for coding numerous fields as "unknown."

TEXT--STAGING

Alternate Name	Item #	Length	Source of Standard	Column #
	2600	1000	NPCR	11765-12764

Description
Additional text area for staging information not already entered in other Text fields.

Rationale
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values.**

Instructions
- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (see Appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:
- Date(s) of procedure(s), including clinical procedures, that provided information for assigning stage
- Organs involved by direct extension
- Size of tumor
- Status of margins
- Number and sites of positive lymph nodes
- Site(s) of distant metastasis
- Physician’s specialty and comments

Data Item(s) to be verified/validated using the text entered in this field
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
RX Date--DX/Stg Proc	1280
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759
Regional Nodes Positive	820
Regional Nodes Examined	830
RX Hosp--Surg Prim Site	670
RX Summ--Surg Prim Site	1290
RX Hosp--Scope Reg LN Sur	672
RX Summ--Scope Reg LN Sur	1292
RX Hosp--Surg Oth Reg/Dis	674
RX Summ--Surg Oth Reg/Dis	1294
Mult Tum Rpt as One Prim	444
Laterality	410

TEXT--USUAL INDUSTRY

Alternate Name	Item #	Length	Source of Standard	Column #
	320	100	NPCR	317-416

Description
Text area for information about the patient's usual industry, also known as usual kind of business/industry.

Rationale
Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

The data item "usual industry" is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death.[25] See related materials in reference list, Chapter VII.

Abstracting Instructions
Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that performs more than one of these components.

If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient for facility registrars to record the name of the company (with city or town) in which the patient performed his/her usual industry. In these situations, if resources permit, a central or regional registry may be able to use the employer name and city/town to determine the type of activity conducted at that location.

As noted in the Text--Usual Occupation [310] section, in those situations where the usual occupation is not available or is unknown, the patient's current or most recent occupation is recorded, if available. The information for industry should be based upon the information in occupation. Therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient's current or most recent business/industry.

If later documentation in the patient's record provides an industry that is more likely to be the usual industry than what was originally recorded, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with industry information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

There should be an entry for Text--Usual Industry if any occupation is recorded. If no information is available regarding the industry in which the reported occupation was carried out, record "unknown." If the patient was not a student or homemaker and had never worked, record "never worked" as the usual industry. This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

TEXT--USUAL OCCUPATION

Alternate Name	Item #	Length	Source of Standard	Column #
	310	100	NPCR	217-316

Description
Text area for information about the patient's usual occupation, also known as usual type of job or work.

Rationale
Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies occupational groups in which cancer screening or prevention activities may be beneficial.

The data item "usual occupation" is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death.[25] See related materials in reference list, Chapter VII.

Abstracting Instructions
Record the patient's usual occupation (i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor). Do not record "retired." If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation.

If later documentation in the patient's record provides an occupation that is more likely to be the usual occupation than what was originally recorded, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with occupation information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

If the patient was a homemaker and also worked outside the home during most of his/her adult life, record the usual occupation outside the home; if the patient was a homemaker and did not work outside the home for most of his/her adult life, record "homemaker." If the patient was not a student or homemaker and had never worked, record "never worked" as the usual occupation.

If no information is available, record "unknown."

This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

TNM CLIN DESCRIPTOR **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Clinical Stage (Prefix/Suffix) Descriptor (CoC)	980	1	CoC	974-974

Description
Identifies the AJCC clinical stage (prefix/suffix) descriptor as recorded by the physician. AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout. CoC defines a descriptor and "Staged By" item for each of these three areas.

Rationale
CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes

0	None
1	E (Extranodal, lymphomas only)
2	S (Spleen, lymphomas only)
3	M (Multiple primary tumors in a single site)
5	E & S (Extranodal and spleen, lymphomas only)
9	Unknown, not stated in patient record

TNM CLIN M

Alternate Name	Item #	Length	Source of Standard	Column #
Clinical M (CoC)	960	4	AJCC	966-969

Description
Detailed site-specific codes for the clinical metastases (M) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale
CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the *AJCC Cancer Staging Manual*)
88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
This field is left blank if no information at all is available to code this item.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the most recent *FORDS* manual for specifications for codes and data entry rules.

TNM CLIN N

Alternate Name	Item #	Length	Source of Standard	Column #
Clinical N (CoC)	950	4	AJCC	962-965

Description
Detailed site-specific codes for the clinical nodes (N) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale
CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the *AJCC Cancer Staging Manual*)
88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
This field is left blank if no information at all is available to code this item.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the most recent *FORDS* manual for specifications for codes and data entry rules.

TNM CLIN STAGE GROUP

Alternate Name	Item #	Length	Source of Standard	Column #
Clinical Stage Group (CoC)	970	4	AJCC	970-973

Description
Detailed site-specific codes for the clinical stage group as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale
CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the *AJCC Cancer Staging Manual*)
88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
99 Unknown, not staged

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the most recent *FORDS* manual for specifications for codes and data entry rules.

TNM CLIN STAGED BY

Alternate Name	Item #	Length	Source of Standard	Column #
Staged By (Clinical Stage) (CoC)	990	1	CoC	975-975

Description
Identifies the person who recorded the clinical AJCC staging elements and the stage group in the patient's medical record.

Rationale
Data captured in this field can be used to evaluate the source of clinical staging and form the basis for quality management and improvement studies. This item can be used to monitor application of the CoC Staging Standard.

Codes (Refer to the most recent *FORDS* for additional instructions.)
0 Not staged
1 Managing physician
2 Pathologist
3 Pathologist and managing physician
4 Cancer Committee chair, cancer liaison physician, or registry physician advisor
5 Cancer registrar
6 Cancer registrar and physician
7 Staging assigned at another facility
8 Case is not eligible for staging
9 Unknown; not stated in patient record

TNM CLIN T

Alternate Name	Item #	Length	Source of Standard	Column #
Clinical T (CoC)	940	4	AJCC	958-961

Description
Detailed site-specific codes for the clinical tumor (T) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale
CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the *AJCC Cancer Staging Manual*)
88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
This field is left blank if no information at all is available to code this item.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the most recent *FORDS* manual for specifications for codes and data entry rules.

TNM EDITION NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	1060	2	CoC	938-939

Description
A code that indicates the edition of the AJCC manual used to stage the case. This applies to the manually coded AJCC fields. It does not apply to the Derived AJCC T, N, M and AJCC Stage Group fields [2940, 2960, 2980, and 3000].

Rationale
TNM codes have changed over time and conversion is not always simple. Therefore, a case-specific indicator is needed to allow grouping of cases for comparison.

Codes
00 Not staged (cases that have AJCC staging scheme and staging was not done)
01 First Edition
02 Second Edition (published 1983)
03 Third Edition (published 1988)
04 Fourth Edition (published 1992), recommended for use for cases diagnosed 1993-1997
05 Fifth Edition (published 1997), recommended for use for cases diagnosed 1998-2002
06 Sixth Edition (published 2002), recommended for use for cases diagnosed 2003-2009
07 Seventh Edition (published 2009), recommended for use with cases diagnosed 2010+
88 Not applicable (cases that do not have an AJCC staging scheme)
99 Edition Unknown

TNM OTHER DESCRIPTOR **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1050			

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

TNM OTHER M **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1020			

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

TNM OTHER N **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1010			

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

TNM OTHER STAGE GROUP **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1030			

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

TNM OTHER STAGED BY **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1040			

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

TNM OTHER T **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1000			

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

TNM PATH DESCRIPTOR

Alternate Name	Item #	Length	Source of Standard	Column #
Pathologic Stage (Prefix/Suffix) Descriptor (CoC)	920	1	CoC	956-956

Description
Identified the AJCC pathologic stage (prefix/suffix) descriptor as recorded by the physician. AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout. CoC defines a descriptor and "Staged By" item for each of these three areas.

Rationale
CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes
0 None
1 E (Extranodal, lymphomas only)
2 S (Spleen, lymphomas only)
3 M (Multiple primary tumors in a single site)
4 Y (Classification during or after initial multimodality therapy)--pathologic staging only
5 E & S (Extranodal and spleen, lymphomas only)
6 M & Y (Multiple primary tumors and initial multimodality therapy)
9 Unknown, not stated in patient record

TNM PATH M

Alternate Name	Item #	Length	Source of Standard	Column #
Pathologic M (CoC)	900	4	AJCC	948-951

Description
Detailed site-specific codes for the pathologic metastases (M) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale
CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the *AJCC Cancer Staging Manual*)
88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
This field is left blank if no information at all is available to code this item.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the most recent *FORDS* manual for specifications for codes and data entry rules.

TNM PATH N

Alternate Name	Item #	Length	Source of Standard	Column #
Pathologic N (CoC)	890	4	AJCC	944-947

Description
Detailed site-specific codes for the pathologic nodes (N) as defined by AJCC and recorded by physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale
CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the *AJCC Cancer Staging Manual*)
88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
This field is left blank if no information at all is available to code this item.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the most recent *FORDS* manual for specifications for codes and data entry rules.

TNM PATH STAGE GROUP

Alternate Name	Item #	Length	Source of Standard	Column #
Pathologic Stage Group (CoC)	910	4	AJCC	952-955

Description
Detailed site-specific codes for the pathologic stage group as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale
CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the *AJCC Cancer Staging Manual*)
88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
99 Unknown, unstaged

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the most recent *FORDS* manual for specifications for codes and data entry rules.

TNM PATH STAGED BY

Alternate Name	Item #	Length	Source of Standard	Column #
Staged By (Pathologic Stage) (CoC)	930	1	CoC	957-957

Description
Identifies the person who recorded the pathologic AJCC staging elements and the stage group in the patient's medical record.

Rationale
Data captured in this field can be used to evaluate the source of pathologic staging and form the basis for quality management and improvement studies.

Codes (Refer to the most recent *FORDS* for additional instructions.)
0 Not staged
1 Managing physician
2 Pathologist
3 Pathologist and managing physician
4 Cancer Committee chair, cancer liaison physician, or registry physician advisor
5 Cancer registrar
6 Cancer registrar and physician
7 Staging assigned at another facility
8 Case is not eligible for staging
9 Unknown; not stated in patient record

TNM PATH T

Alternate Name	Item #	Length	Source of Standard	Column #
Pathologic T (CoC)	880	4	AJCC	940-943

Description
Detailed site-specific codes for the pathologic tumor (T) as defined by AJCC and recorded by the physician.

Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

Rationale
CoC requires that AJCC TNM staging be used in its approved cancer programs. AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.

Codes (in addition to those published in the *AJCC Cancer Staging Manual*)
88 Not applicable, no code assigned for this case in the current AJCC Staging Manual.
This field is left blank if no information at all is available to code this item.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the most recent *FORDS* manual for specifications for codes and data entry rules.

TOBACCO HISTORY **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	340			

Description
The NAACCR UDSC retired this data item in Version 12, as of January 1, 2010.

TUMOR MARKER 1

Alternate Name	Item #	Length	Source of Standard	Column #
Tumor Marker One (CoC)	1150	1	SEER	981-981

Description
Records prognostic indicators for specific sites or histologies. CoC offered these items for optional use for cases diagnosed 1996 and forward. See the CoC *ROADS Manual*, 1998 Supplement, for a list of specific sites and histologies.

For SEER requirements for the specific sites, histologies, and diagnosis years for which this item is coded, see the 1998 *SEER Program Code Manual*.

Codes
0 None done (SX)
1 Positive/elevated
2 Negative/normal; within normal limits (S0)
3 Borderline; undetermined whether positive/elevated or negative/normal

Three-tiered system:
4 Range 1 (S1)
5 Range 2 (S2)
6 Range 3 (S3)
8 Ordered, but results not in chart
9 Unknown or no information

For sites for which Tumor Marker 1 is not collected:
9 Not applicable

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

TUMOR MARKER 2

Alternate Name	Item #	Length	Source of Standard	Column #
Tumor Marker Two (CoC)	1160	1	SEER	982-982

Description
Records prognostic indicators for specific sites or histologies. CoC offered these items for optional use for cases diagnosed 1996 and forward. See the CoC *ROADS Manual*, 1998 Supplement, for a list of specific sites and histologies.

For SEER requirements for the specific sites, histologies, and diagnosis years for which this item is coded, see the 1998 *SEER Program Code Manual*.

Codes
0 None done (SX)
1 Positive/elevated
2 Negative/normal; within normal limits (S0)
3 Borderline; undetermined whether positive/elevated or negative/normal

Three-tiered system:
4 Range 1 (S1)
5 Range 2 (S2)
6 Range 3 (S3)
8 Ordered, but results not in chart
9 Unknown or no information

For sites for which Tumor Marker 2 is not collected:
9 Not applicable

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

TUMOR MARKER 3

Alternate Name	Item #	Length	Source of Standard	Column #
Tumor Marker Three (CoC)	1170	1	SEER	983-983

Description
Records prognostic indicators for specific sites or histologies. CoC offered these items for optional use for cases diagnosed 1996 and forward. See the CoC *ROADS Manual*, 1998 Supplement, for a list of specific sites and histologies.

For SEER requirements for the specific sites, histologies, and diagnosis years for which this item is coded, see the 1998 *SEER Program Code Manual*.

Codes
0 None done (SX)
1 Positive/elevated
2 Negative/normal; within normal limits (S0)
3 Borderline; undetermined whether positive/elevated or negative/normal

Three-tiered system:
4 Range 1 (S1)
5 Range 2 (S2)
6 Range 3 (S3)
8 Ordered, but results not in chart
9 Unknown or no information

For sites for which Tumor Marker 3 is not collected:
9 Not applicable

Note: As of January 1, 2003, this data item is no longer required or recommended by CoC. However, the item was collected in the past and it is recommended that historic data be retained.

TUMOR RECORD NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	60	2	NAACCR	40-41

Description
A system-generated number assigned to each tumor. The number should never change even if the tumor sequence is changed or a record (tumor) is deleted.

Rationale
This is a unique number that identifies a specific tumor so data can be linked. “Sequence Number” cannot be used as a link because the number is changed if a report identifies an earlier tumor or if a tumor record is deleted.

TYPE OF REPORTING SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
	500	1	SEER	563-563

Description
This variable codes the source documents used to abstract the majority of information on the tumor being reported. This may not be the source of original case finding (for example, if a case is identified through a pathology laboratory report review and all source documents used to abstract the case are from the physician's office, code this item 4).

Rationale
The code in this field can be used to explain why information may be incomplete on a tumor. For example, death certificate only cases have unknown values for many data items, so one may want to exclude them from some analyses. The field also is used to monitor the success of non-hospital case reporting and follow-back mechanisms. All population-based registries should have some death certificate-only cases where no hospital admission was involved, but too high a percentage can imply both shortcomings in case-finding and that follow-back to uncover missed hospital reports was not complete.

Coding Instructions
Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. This is a change to reflect the addition of codes 2 and 8 and to prioritize laboratory reports over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.

This data item is intended to indicate the completeness of information available to the abstractor. Reports from health plans (e.g., Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally and is available to the abstractor are expected to be at least as complete as reports for hospital inpatients, which is why these sources are grouped with inpatients and given the code with the highest priority.

Sources coded with '2' usually have complete information on the cancer diagnosis, staging, and treatment.

Sources coded with '8' would include, but would not be limited to, outpatient surgery and nuclear medicine services. A physician's office that calls itself a surgery center should be coded as a physician's office. Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. If a physician's office calls itself a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

Codes
1 Hospital inpatient; Managed health plans with comprehensive, unified medical records
2 Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
3 Laboratory only (hospital-affiliated or independent)
4 Physician's office/private medical practitioner (LMD)
5 Nursing/convalescent home/hospice
6 Autopsy only
7 Death certificate only
8 Other hospital outpatient units/surgery centers

UNUSUAL FOLLOW-UP METHOD

Alternate Name	Item #	Length	Source of Standard	Column #
	1850	1	CoC	2195-2195

Description
User-defined numeric codes used to flag cases that need unusual follow-up methods.

Codes
User-defined
Note: This data item is no longer supported by CoC (as of January 1, 2003).

VENDOR NAME

Alternate Name	Item #	Length	Source of Standard	Column #
	2170	10	NAACCR	1936-1945

Description
System-generated. Name of the computer services vendor who programmed the system submitting the data. Abbreviate as necessary and keep a consistent name throughout all submissions. Include software version number where available. Code is self-assigned by vendor.

Rationale
This is used to track which vendor and which software version submitted the case. It helps define the source and extent of a problem discovered in data submitted by a software provider.

VITAL STATUS

Alternate Name	Item #	Length	Source of Standard	Column #
	1760	1	SEER/CoC	2126-2126

Description
Vital status of the patient as of the date entered in Date of Last Contact [1750]. If the patient has multiple tumors, vital status should be the same for all tumors.

Codes
0 Dead (CoC)
1 Alive
4 Dead (SEER)

YEAR FIRST SEEN THIS CA **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	620			

Description
The NAACCR UDSC retired this data item in Version 11, as of January 1, 2006.

APPENDIX A:

FIPS CODES FOR COUNTIES AND EQUIVALENT ENTITIES

[Ed. Note: The information in this table is from FIPS Publication Number 6-4, "Counties and Equivalent Entities of the United States, its Possessions, and Associated Areas," as reissued December 21, 1992, and made available electronically on the National Institute of Standards and Technology Website (http://www.itl.nist.gov). We compared two versions of the file against printed lists to reconcile apparent errors and discrepancies.]

STATE NAME: ALABAMA
ALPHABETIC CODE: AL
NUMERIC CODE: 01

CODE	COUNTY NAME
001	Auatauga
003	Baldwin
005	Barbour
007	Bibb
009	Blount
011	Bullock
013	Butler
015	Calhoun
017	Chambers
019	Cherokee
021	Chilton
023	Choctaw
025	Clarke
027	Clay
029	Cleburne
031	Coffee
033	Colbert
035	Conecuh
037	Coosa
039	Covington
041	Crenshaw
043	Cullman
045	Dale
047	Dallas
049	DeKalb
051	Elmore
053	Escambia
055	Etowah
057	Fayette
059	Franklin
061	Geneva
063	Greene
065	Hale
067	Henry
069	Houston
071	Jackson
073	Jefferson
075	Lamar
077	Lauderdale
079	Lawrence
081	Lee
083	Limestone
085	Lowndes
087	Macon
089	Madison
091	Marengo
093	Marion
095	Marshall
097	Mobile
099	Monroe
101	Montgomery
103	Morgan
105	Perry
107	Pickens
109	Pike
111	Randolph
113	Russell
115	St. Clair
117	Shelby
119	Sumter
121	Talladega
123	Tallapoosa
125	Tuscaloosa
127	Walker
129	Washington
131	Wilcox
133	Winston

STATE NAME: ALASKA
ALPHABETIC CODE: AK
NUMERIC CODE: 02

Note: The following is a complete list of all current Alaska county equivalents where (B) identifies a borough and (C) identifies a census area per FIPS Publication Change Notice (Reissue 12/21/92).

CODE	BOROUGH/ CENSUS AREA
013	Aleutians East (B)
016	Aleutians West I
020	Anchorage (B)
050	Bethel I
060	Bristol Bay (B)
068	Denali (B)
070	Dillingham I
090	Fairbanks North Star (B)
100	Haines (B)
110	Juneau (B)
122	Kenai Peninsula (B)
130	Ketchikan Gateway (B)
150	Kodiak Island (B)
164	Lake and Peninsula (B)
170	Matanuska-Susitna (B)
180	Nome I
185	North Slope (B)
188	Northwest Arctic (B)
201	Prince of Wales-Outer Ketchikan I
220	Sitka (B)
232	Skagway-Hoonah-Angoon I
240	Southeast Fairbanks I
261	Valdez-Cordova I
270	Wade Hampton I
280	Wrangell-Petersburg I
282	Yakutat (B)
290	Yukon-Koyukuk I

STATE NAME: ARIZONA
ALPHABETIC CODE: AZ
NUMERIC CODE: 04

CODE	COUNTY NAME
001	Apache
003	Cochise
005	Coconino
007	Gila
009	Graham
011	Greenlee
012	LaPaz
013	Maricopa
015	Mohave
017	Navajo
019	Pima
021	Pinal
023	Santa Cruz
025	Yavapai
027	Yuma

La Paz was established from part of Yuma (1/1/83).

STATE NAME: ARKANSAS
ALPHABETIC CODE: AR
NUMERIC CODE: 05

CODE	COUNTY NAME
001	Arkansas
003	Ashley
005	Baxter
007	Benton
009	Boone
011	Bradley
013	Calhoun
015	Carroll
017	Chicot
019	Clark
021	Clay
023	Cleburne
025	Cleveland
027	Columbia
029	Conway
031	Craighead
033	Crawford
035	Crittenden
037	Cross
039	Dallas
041	Desha
043	Drew
045	Faulkner
047	Franklin
049	Fulton
051	Garland
053	Grant
055	Greene
057	Hempstead
059	Hot Spring
061	Howard
063	Independence
065	Izard
067	Jackson
069	Jefferson
071	Johnson
073	Lafayette
075	Lawrence
077	Lee
079	Lincoln
081	Little River
083	Logan
085	Lonoke
087	Madison
089	Marion
091	Miller
093	Mississippi
095	Monroe
097	Montgomery
099	Nevada
101	Newton
103	Ouachita
105	Perry
107	Phillips
109	Pike
111	Poinsett
113	Polk
115	Pope
117	Prairie
119	Pulaski
121	Randolph
123	St. Francis
125	Saline
127	Scott
129	Searcy

131	Sebastian
133	Sevier
135	Sharp
137	Stone
139	Union
141	Van Buren
143	Washington
145	White
147	Woodruff
149	Yell

STATE NAME: CALIFORNIA
ALPHABETIC CODE: CA
NUMERIC CODE: 06

CODE	COUNTY NAME
001	Alameda
003	Alpine
005	Amador
007	Butte
009	Calaveras
011	Colusa
013	Contra Costa
015	Del Norte
017	El Dorado
019	Fresno
021	Glenn
023	Humboldt
025	Imperial
027	Inyo
029	Kern
031	Kings
033	Lake
035	Lassen
037	Los Angeles
039	Madera
041	Marin
043	Mariposa
045	Mendocino
047	Merced
049	Modoc
051	Mono
053	Monterey
055	Napa
057	Nevada
059	Orange
061	Placer
063	Plumas
065	Riverside
067	Sacramento
069	San Benito
071	San Bernardino
073	San Diego
075	San Francisco
077	San Joaquin
079	San Luis Obispo
081	San Mateo
083	Santa Barbara
085	Santa Clara
087	Santa Cruz
089	Shasta
091	Sierra
093	Siskiyou
095	Solano
097	Sonoma
099	Stanislaus
101	Sutter
103	Tehama
105	Trinity
107	Tulare
109	Tuolomne
111	Ventura
113	Yolo
115	Yuba

STATE NAME: COLORADO
ALPHABETIC CODE: CO
NUMERIC CODE: 08

CODE	COUNTY NAME
001	Adams
003	Alamosa
005	Arapahoe
007	Archuleta
009	Baca
011	Bent
013	Boulder
014	Broomfield
015	Chaffee
017	Cheyenne
019	Clear Creek
021	Conejos
023	Costilla
025	Crowley
027	Custer
029	Delta
031	Denver
033	Dolores
035	Douglas
037	Eagle
039	Elbert
041	El Paso
043	Fremont
045	Garfield
047	Gilpin
049	Grand
051	Gunnison
053	Hinsdale
055	Huerfano
057	Jackson
059	Jefferson
061	Kiowa
063	Kit Carson
065	Lake
067	La Plata
069	Larimer
071	Las Animas
073	Lincoln
075	Logan
077	Mesa
079	Mineral
081	Moffat
083	Montezuma
085	Montrose
087	Morgan
089	Otero
091	Ouray
093	Park
095	Phillips
097	Pitkin
099	Prowers
101	Pueblo
103	Rio Blanco
105	Rio Grande
107	Routt
109	Saguache
111	San Juan
113	San Miguel
115	Sedgwick
117	Summit
119	Teller
121	Washington
123	Weld
125	Yuma

Broomfield County, Colorado, has been created from parts of Adams (001), Boulder (013), Jefferson (059) and Weld (123) counties effective November 15, 2001. The boundaries of Broomfield County reflect the boundaries of Broomfield city legally in effect on November 15, 2001. To maintain alphanumeric sequences of counties, Broomfield County will have a code of 014 for FIPS 6-4.

STATE NAME: CONNECTICUT
ALPHABETIC CODE: CT
NUMERIC CODE: 09

CODE	COUNTY NAME
001	Fairfield
003	Hartford
005	Litchfield
007	Middlesex
009	New Haven
011	New London
013	Tolland
015	Windham

STATE NAME: DELAWARE
ALPHABETIC CODE: DE
NUMERIC CODE: 10

CODE	COUNTY NAME
001	Kent
003	New Castle
005	Sussex

STATE NAME: DISTRICT OF COLUMBIA
ALPHABETIC CODE: DC
NUMERIC CODE: 11

CODE	SUBDIVISION NAME
4..	District of Columbia

Name was reported incorrectly as "Washington" in FIPS PUB 6-3. The District has no first-order subdivisions, and therefore "District of Columbia" also serves as the county-equivalent entity.

STATE NAME: FLORIDA
ALPHABETIC CODE: FL
NUMERIC CODE: 12

CODE	COUNTY NAME
001	Alachua
003	Baker
005	Bay
007	Bradford
009	Brevard
011	Broward
013	Calhoun
015	Charlotte
017	Citrus
019	Clay
021	Collier
023	Columbia
027	DeSoto
029	Dixie
031	Duval
033	Escambia
035	Flagler
037	Franklin
039	Gadsden
041	Gilchrist
043	Glades
045	Gulf
047	Hamilton
049	Hardee
051	Hendry
053	Hernando
055	Highlands
057	Hillsborough
059	Holmes
061	Indian River
063	Jackson
065	Jefferson
067	Lafayette
069	Lake
071	Lee
073	Leon
075	Levy
077	Liberty
079	Madison
081	Manatee
083	Marion
085	Martin
086	Miami-Dade
087	Monroe
089	Nassau
091	Okaloosa
093	Okeechobee
095	Orange
097	Osceola
099	Palm Beach
101	Pasco
103	Pinellas
105	Polk
107	Putnam
109	St. Johns
111	St. Lucie
113	Santa Rosa
115	Sarasota
117	Seminole
119	Sumter

121	Suwannee
123	Taylor
125	Union
127	Volusia
129	Wakulla
131	Walton
133	Washington

Convert Dade County 025 to Miami-Dade County 086. Edits should only allow for code 086.

STATE NAME: GEORGIA
ALPHABETIC CODE: GA
NUMERIC CODE: 13

CODE	COUNTY NAME
001	Appling
003	Atkinson
005	Bacon
007	Baker
009	Baldwin
011	Banks
013	Barrow
015	Bartow
017	Ben Hill
019	Berrien
021	Bibb
023	Bleckley
025	Brantley
027	Brooks
029	Bryan
031	Bulloch
033	Burke
035	Butts
037	Calhoun
039	Camden
043	Candler
045	Carroll
047	Catoosa
049	Charlton
051	Chatham
053	Chattahoochee
055	Chattooga
057	Cherokee
059	Clarke
061	Clay
063	Clayton
065	Clinch
067	Cobb
069	Coffee
071	Colquitt
073	Columbia
075	Cook
077	Coweta
079	Crawford
081	Crisp
083	Dade
085	Dawson
087	Decatur
089	DeKalb
091	Dodge
093	Dooly
095	Dougherty
097	Douglas
099	Early
101	Echols
103	Effingam
105	Elbert
107	Emanuel
109	Evans
111	Fannin
113	Fayette
115	Floyd
117	Forsyth
119	Franklin
121	Fulton
123	Gilmer
125	Glascock
127	Glynn
129	Gordon
131	Grady
133	Greene
135	Gwinnett
137	Habersham
139	Hall
141	Hancock
143	Haralson
145	Harris
147	Hart
149	Heard
151	Henry
153	Houston
155	Irwin
157	Jackson
159	Jasper
161	Jeff Davis
163	Jefferson
165	Jenkins
167	Johnson
169	Jones
171	Lamar
173	Lanier
175	Laurens
177	Lee
179	Liberty
181	Lincoln
183	Long
185	Lowndes
187	Lumpkin
189	McDuffie
191	McIntosh
193	Macon
195	Madison
197	Marion
199	Meriwether
201	Miller
205	Mitchell
207	Monroe
209	Montgomery
211	Morgan
213	Murray
215	Muscogee
217	Newton
219	Oconee
221	Oglethorpe
223	Paulding
225	Peach
227	Pickens
229	Pierce
231	Pike
233	Polk
235	Pulaski
237	Putnam
239	Quitman
241	Rabun
243	Randolph
245	Richmond
247	Rockdale
249	Schley
251	Screven
253	Seminole
255	Spalding
257	Stephens
259	Stewart
261	Sumter
263	Talbot
265	Taliaferro
267	Tattnall
269	Taylor
271	Telfair
273	Terrell
275	Thomas
277	Tift
279	Toombs
281	Towns
283	Treutlen
285	Troup
287	Turner
289	Twiggs
291	Union
293	Upson
295	Walker
297	Walton
299	Ware
301	Warren
303	Washington
305	Wayne
307	Webster
309	Wheeler
311	White
313	Whitfield
315	Wilcox
317	Wilkes
319	Wilkinson
321	Worth

Muscogee was reported incorrectly as "Columbus (consolidated government)" (510) in FIPS PUB6-3.

STATE NAME: HAWAII
ALPHABETIC CODE: HI
NUMERIC CODE: 15

CODE	COUNTY NAME
001	Hawaii
003	Honolulu
005	Kalawao
007	Kauai
009	Maui

Kalawao does not have its own local government; it is administered by the State of Hawaii. It may be included with Maui for statistical purposes.

STATE NAME: IDAHO
ALPHABETIC CODE: ID
NUMERIC CODE: 16

CODE	COUNTY NAME
001	Ada
003	Adams
005	Bannock
007	Bear Lake
009	Benewah
011	Bingham
013	Blaine
015	Boise
017	Bonner
019	Bonneville
021	Boundary
023	Butte
025	Camas
027	Canyon
029	Caribou
031	Cassia
033	Clark
035	Clearwater
037	Custer
039	Elmore
041	Franklin
043	Fremont
045	Gem
047	Gooding
049	Idaho
051	Jefferson
053	Jerome
055	Kootenai
057	Latah
059	Lemhi
061	Lewis
063	Lincoln
065	Madison
067	Minidoka
069	Nez Perce
071	Oneida
073	Owyhee
075	Payette
077	Power
079	Shoshone
081	Teton
083	Twin Falls
085	Valley
087	Washington

STATE NAME: ILLINOIS
ALPHABETIC CODE: IL
NUMERIC CODE: 17

CODE	COUNTY NAME
001	Adams
003	Alexander
005	Bond
007	Boone
009	Brown
011	Bureau
013	Calhoun
015	Carroll
017	Cass
019	Champaign
021	Christian
023	Clark
025	Clay
027	Clinton
029	Coles
031	Cook
033	Crawford
035	Cumberland
037	DeKalb
039	De Witt
041	Douglas

043	DuPage
045	Edgar
047	Edwards
049	Effingham
051	Fayette
053	Ford
055	Franklin
057	Fulton
059	Gallatin
061	Greene
063	Grundy
065	Hamilton
067	Hancock
069	Hardin
071	Henderson
073	Henry
075	Iroquois
077	Jackson
079	Jasper
081	Jefferson
083	Jersey
085	Jo Daviess
087	Johnson
089	Kane
091	Kankakee
093	Kendall
095	Knox
097	Lake
099	La Salle
101	Lawrence
103	Lee
105	Livingston
107	Logan
109	McDonough
111	McHenry
113	McLean
115	Macon
117	Macoupin
119	Madison
121	Marion
123	Marshall
125	Mason
127	Massac
129	Menard
131	Mercer
133	Monroe
135	Montgomery
137	Morgan
139	Moultrie
141	Ogle
143	Peoria
145	Perry
147	Piatt
149	Pike
151	Pope
153	Pulaski
155	Putnam
157	Randolph
159	Richland
161	Rock Island
163	St. Clair
165	Saline
167	Sangamon
169	Schuyler
171	Scott
173	Shelby
175	Stark
177	Stephenson
179	Tazewell
181	Union
183	Vermilion
185	Wabash
187	Warren
189	Washington
191	Wayne
193	White
195	Whiteside
197	Will
199	Williamson
201	Winnebago
203	Woodford

STATE NAME: INDIANA
ALPHABETIC CODE: IN
NUMERIC CODE: 18

CODE	**COUNTY NAME**
001	Adams
003	Allen
005	Bartholomew
007	Benton
009	Blackford
011	Boone
013	Brown
015	Carroll
017	Cass
019	Clark
021	Clay
023	Clinton
025	Crawford
027	Daviess
029	Dearborn
031	Decatur
033	DeKalb
035	Delaware
037	Dubois
039	Elkhart
041	Fayette
043	Floyd
045	Fountain
047	Franklin
049	Fulton
051	Gibson
053	Grant
055	Greene
057	Hamilton
059	Hancock
061	Harrison
063	Hendricks
065	Henry
067	Howard
069	Huntington
071	Jackson
073	Jasper
075	Jay
077	Jefferson
079	Jennings
081	Johnson
083	Knox
085	Kosciusko
087	Lagrange
089	Lake
091	LaPorte
093	Lawrence
095	Madison
097	Marion
099	Marshall
101	Martin
103	Miami
105	Monroe
107	Montgomery
109	Morgan
111	Newton
113	Noble
115	Ohio
117	Orange
119	Owen
121	Parke
123	Perry
125	Pike
127	Porter
129	Posey
131	Pulaski
133	Putnam
135	Randolph
137	Ripley
139	Rush
141	St. Joseph
143	Scott
145	Shelby
147	Spencer
149	Starke
151	Steuben
153	Sullivan
155	Switzerland
157	Tippecanoe
159	Tipton
161	Union
163	Vanderburgh
165	Vermillion
167	Vigo
169	Wabash
171	Warren
173	Warrick
175	Washington
177	Wayne
179	Wells
181	White
183	Whitley

STATE NAME: IOWA
ALPHABETIC CODE: IA
NUMERIC CODE: 19

CODE	**COUNTY NAME**
001	Adair
003	Adams
005	Allamakee
007	Appanoose
009	Audubon
011	Benton
013	Black Hawk
015	Boone
017	Bremer
019	Buchanan
021	Buena Vista
023	Butler
025	Calhoun
027	Carroll
029	Cass
031	Cedar
033	Cerro Gordo
035	Cherokee
037	Chickasaw
039	Clarke
041	Clay
043	Clayton
045	Clinton
047	Crawford
049	Dallas
051	Davis
053	Decatur
055	Delaware
057	Des Moines
059	Dickinson
061	Dubuque
063	Emmet
065	Fayette
067	Floyd
069	Franklin
071	Fremont
073	Greene
075	Grundy
077	Guthrie
079	Hamilton
081	Hancock
083	Hardin
085	Harrison
087	Henry
089	Howard
091	Humboldt
093	Ida
095	Iowa
097	Jackson
099	Jasper
101	Jefferson
103	Johnson
105	Jones
107	Keokuk
109	Kossuth
111	Lee
113	Linn
115	Louisa
117	Lucas
119	Lyon
121	Madison
123	Mahaska
125	Marion
127	Marshall
129	Mills
131	Mitchell
133	Monona
135	Monroe
137	Montgomery
139	Muscatine
141	O'Brien
143	Osceola
145	Page
147	Palo Alto
149	Plymouth
151	Pocahontas
153	Polk
155	Pottawattamie
157	Poweshiek
159	Ringgold
161	Sac
163	Scott
165	Shelby
167	Sioux
169	Story
171	Tama
173	Taylor
175	Union
177	Van Buren
179	Wapello
181	Warren
183	Washington
185	Wayne

187	Webster
189	Winnebago
191	Winneshiek
193	Woodbury
195	Worth
197	Wright

STATE NAME: KANSAS
ALPHABETIC CODE: KS
NUMERIC CODE: 20

CODE	COUNTY NAME
001	Allen
003	Anderson
005	Atchison
007	Barber
009	Barton
011	Bourbon
013	Brown
015	Butler
017	Chase
019	Chautauqua
021	Cherokee
023	Cheyenne
025	Clark
027	Clay
029	Cloud
031	Coffey
033	Comanche
035	Cowley
037	Crawford
039	Decatur
041	Dickinson
043	Doniphan
045	Douglas
047	Edwards
049	Elk
051	Ellis
053	Ellsworth
055	Finney
057	Ford
059	Franklin
061	Geary
063	Gove
065	Graham
067	Grant
069	Gray
071	Greeley
073	Greenwood
075	Hamilton
077	Harper
079	Harvey
081	Haskell
083	Hodgeman
085	Jackson
087	Jefferson
089	Jewell
091	Johnson
093	Kearny
095	Kingman
097	Kiowa
099	Labette
101	Lane
103	Leavenworth
105	Lincoln
107	Linn
109	Logan
111	Lyon
113	McPherson
115	Marion
117	Marshall
119	Meade
121	Miami
123	Mitchell
125	Montgomery
127	Morris
129	Morton
131	Nemaha
133	Neosho
135	Ness
137	Norton
139	Osage
141	Osborne
143	Ottawa
145	Pawnee
147	Phillips
149	Pottawatomie
151	Pratt
153	Rawlins
155	Reno
157	Republic
159	Rice
161	Riley
163	Rooks
165	Rush
167	Russell
169	Saline
171	Scott
173	Sedgwick
175	Seward
177	Shawnee
179	Sheridan
181	Sherman
183	Smith
185	Stafford
187	Stanton
189	Stevens
191	Sumner
193	Thomas
195	Trego
197	Wabaunsee
199	Wallace
201	Washington
203	Wichita
205	Wilson
207	Woodson
209	Wyandotte

STATE NAME: KENTUCKY
ALPHABETIC CODE: KY
NUMERIC CODE: 21

CODE	COUNTY NAME
001	Adair
003	Allen
005	Anderson
007	Ballard
009	Barren
011	Bath
013	Bell
015	Boone
017	Bourbon
019	Boyd
021	Boyle
023	Bracken
025	Breathitt
027	Breckinridge
029	Bullitt
031	Butler
033	Caldwell
035	Calloway
037	Campbell
039	Carlisle
041	Carroll
043	Carter
045	Casey
047	Christian
049	Clark
051	Clay
053	Clinton
055	Crittenden
057	Cumberland
059	Daviess
061	Edmonson
063	Elliott
065	Estill
067	Fayette
069	Fleming
071	Floyd
073	Franklin
075	Fulton
077	Gallatin
079	Garrard
081	Grant
083	Graves
085	Grayson
087	Green
089	Greenup
091	Hancock
093	Hardin
095	Harlan
097	Harrison
099	Hart
101	Henderson
103	Henry
105	Hickman
107	Hopkins
109	Jackson
111	Jefferson
113	Jessamine
115	Johnson
117	Kenton
119	Knott
121	Knox
123	Larue
125	Laurel
127	Lawrence
129	Lee
131	Leslie
133	Letcher
135	Lewis
137	Lincoln
139	Livingston
141	Logan
143	Lyon
145	McCracken
147	McCreary
149	McLean
151	Madison
153	Magoffin
155	Marion
157	Marshall
159	Martin
161	Mason
163	Meade
165	Menifee
167	Mercer
169	Metcalfe
171	Monroe
173	Montgomery
175	Morgan
177	Muhlenberg
179	Nelson
181	Nicholas
183	Ohio
185	Oldham
187	Owen
189	Owsley
191	Pendleton
193	Perry
195	Pike
197	Powell
199	Pulaski
201	Roberston
203	Rockcastle
205	Rowan
207	Russell
209	Scott
211	Shelby
213	Simpson
215	Spencer
217	Taylor
219	Todd
221	Trigg
223	Trimble
225	Union
227	Warren
229	Washington
231	Wayne
233	Webster
235	Whitley
237	Wolfe
239	Woodford

STATE NAME: LOUISIANA
ALPHABETIC CODE: LA
NUMERIC CODE: 22

CODE	COUNTY NAME
001	Acadia
003	Allen
005	Ascension
007	Assumption
009	Avoylelles
011	Beauregard
013	Bienville
015	Bossier
017	Caddo
019	Calcasieu
021	Caldwell
023	Cameron
025	Catahoula
027	Claiborne
029	Concordia
031	DeSoto
033	East Baton Rouge
035	East Carroll
037	East Feliciana
039	Evangeline
041	Franklin
043	Grant
045	Iberia
047	Iberville
049	Jackson
051	Jefferson

053	Jefferson Davis
055	Lafayette
057	Lafourche
059	La Salle
061	Lincoln
063	Livingston
065	Madison
067	Morehouse
069	Natchitoches
071	Orleans
073	Ouachita
075	Plaquemines
077	Pointe Coupee
079	Rapides
081	Red River
083	Richland
085	Sabine
087	St. Bernard
089	St. Charles
091	St. Helena
093	St. James
095	St. John the Baptist
097	St. Landry
099	St. Martin
101	St. Mary
103	St. Tammany
105	Tangipahoa
107	Tensas
109	Terrebonne
111	Union
113	Vermilion
115	Vernon
117	Washington
119	Webster
121	West Baton Rouge
123	West Carroll
125	West Feliciana
127	Winn

STATE NAME: MAINE
ALPHABETIC CODE: ME
NUMERIC CODE: 23

CODE	COUNTY NAME
001	Androscoggin
003	Aroostook
005	Cumberland
007	Franklin
009	Hancock
011	Kennebec
013	Knox
015	Lincoln
017	Oxford
019	Penobscot
021	Piscataquis
023	Sagadahoc
025	Somerset
027	Waldo
029	Washington
031	York

STATE NAME: MARYLAND
ALPHABETIC CODE: MD
NUMERIC CODE: 24

CODE	COUNTY NAME
001	Allegany
003	Anne Arundel
005	Baltimore
009	Calvert
011	Caroline
013	Carroll
015	Cecil
017	Charles
019	Dorchester
021	Frederick
023	Garrett
025	Harford
027	Howard
029	Kent
031	Montgomery
033	Prince George's
035	Queen Anne's
037	St. Mary's
039	Somerset
041	Talbot
043	Washington
045	Wicomico
047	Worcester

CODE	INDEPENDENT CITY
510	Baltimore (City)

STATE NAME: MASSACHUSETTS
ALPHABETIC CODE: MA
NUMERIC CODE: 25

CODE	COUNTY NAME
001	Barnstable
003	Berkshire
005	Bristol
007	Dukes
009	Essex
011	Franklin
013	Hampden
015	Hampshire
017	Middlesex
019	Nantucket
021	Norfolk
023	Plymouth
025	Suffolk
027	Worcester

STATE NAME: MICHIGAN
ALPHABETIC CODE: MI
NUMERIC CODE: 26

CODE	COUNTY NAME
001	Alcona
003	Alger
005	Allegan
007	Alpena
009	Antrim
011	Arenac
013	Baraga
015	Barry
017	Bay
019	Benzie
021	Berrien
023	Branch
025	Calhoun
027	Cass
029	Charlevoix
031	Cheboygan
033	Chippewa
035	Clare
037	Clinton
039	Crawford
041	Delta
043	Dickinson
045	Eaton
047	Emmet
049	Genesee
051	Gladwin
053	Gogebic
055	Grand Traverse
057	Gratiot
059	Hillsdale
061	Houghton
063	Huron
065	Ingham
067	Ionia
069	Iosco
071	Iron
073	Isabella
075	Jackson
077	Kalamazoo
079	Kalkaska
081	Kent
083	Keweenaw
085	Lake
087	Lapeer
089	Leelanau
091	Lenawee
093	Livingston
095	Luce
097	Mackinac
099	Macomb
101	Manistee
103	Marquette
105	Mason
107	Mecosta
109	Menominee
111	Midland
113	Missaukee
115	Monroe
117	Montcalm
119	Montmorency
121	Muskegon
123	Newaygo
125	Oakland
127	Oceana
129	Ogemaw
131	Ontonagon
133	Osceola
135	Oscoda
137	Otsego
139	Ottawa
141	Presque Isle
143	Roscommon
145	Saginaw
147	St. Clair
149	St. Joseph
151	Sanilac
153	Schoolcraft
155	Shiawassee
157	Tuscola
159	Van Buren
161	Washtenaw
163	Wayne
165	Wexford

STATE NAME: MINNESOTA
ALPHABETIC CODE: MN
NUMERIC CODE: 27

CODE	COUNTY NAME
001	Aitkin
003	Anoka
005	Becker
007	Beltrami
009	Benton
011	Big Stone
013	Blue Earth
015	Brown
017	Carlton
019	Carver
021	Cass
023	Chippewa
025	Chisago
027	Clay
029	Clearwater
031	Cook
033	Cottonwood
035	Crow Wing
037	Dakota
039	Dodge
041	Douglas
043	Faribault
045	Fillmore
047	Freeborn
049	Goodhue
051	Grant
053	Hennepin
055	Houston
057	Hubbard
059	Isanti
061	Itasca
063	Jackson
065	Kanabec
067	Kandiyohi
069	Kittson
071	Koochiching
073	Lac qui Parle
075	Lake
077	Lake of the Woods
079	Le Sueur
081	Lincoln
083	Lyon
085	McLeod
087	Mahnomen
089	Marshall
091	Martin
093	Meeker
095	Mille Lacs
097	Morrison
099	Mower
101	Murray
103	Nicollet
105	Nobles
107	Norman
109	Olmsted
111	Otter Tail
113	Pennington
115	Pine
117	Pipestone
119	Polk
121	Pope
123	Ramsey
125	Red Lake

127	Redwood
129	Renville
131	Rice
133	Rock
135	Roseau
137	St. Louis
139	Scott
141	Sherburne
143	Sibley
145	Stearns
147	Steele
149	Stevens
151	Swift
153	Todd
155	Traverse
157	Wabasha
159	Wadena
161	Waseca
163	Washington
165	Watonwan
167	Wilkin
169	Winona
171	Wright
173	Yellow Medicine

STATE NAME: MISSISSIPPI
ALPHABETIC CODE: MS
NUMERIC CODE: 28

CODE	COUNTY NAME
001	Adams
003	Alcorn
005	Amite
007	Attala
009	Benton
011	Bolivar
013	Calhoun
015	Carroll
017	Chickasaw
019	Choctaw
021	Claiborne
023	Clarke
025	Clay
027	Coahoma
029	Copiah
031	Covington
033	DeSoto
035	Forrest
037	Franklin
039	George
041	Greene
043	Grenada
045	Hancock
047	Harrison
049	Hinds
051	Holmes
053	Humphreys
055	Issaquena
057	Itawamba
059	Jackson
061	Jasper
063	Jefferson
065	Jefferson Davis
067	Jones
069	Kemper
071	Lafayette
073	Lamar
075	Lauderdale
077	Lawrence
079	Leake
081	Lee
083	Leflore
085	Lincoln
087	Lowndes
089	Madison
091	Marion
093	Marshall
095	Monroe
097	Montgomery
099	Neshoba
101	Newton
103	Noxubee
105	Oktibbeha
107	Panola
109	Pearl River
111	Perry
113	Pike
115	Pontotoc
117	Prentiss
119	Quitman
121	Rankin
123	Scott
125	Sharkey
127	Simpson
129	Smith
131	Stone
133	Sunflower
135	Tallahatchie
137	Tate
139	Tippah
141	Tishomingo
143	Tunica
145	Union
147	Walthall
149	Warren
151	Washington
153	Wayne
155	Webster
157	Wilkinson
159	Winston
161	Yalobusha
163	Yazoo

NAME: MISSOURI
ALPHABETIC CODE: MO
NUMERIC CODE: 29

CODE	COUNTY NAME
001	Adair
003	Andrew
005	Atchison
007	Audrain
009	Barry
011	Barton
013	Bates
015	Benton
017	Bollinger
019	Boone
021	Buchanan
023	Butler
025	Caldwell
027	Callaway
029	Camden
031	Cape Girardeau
033	Carroll
035	Carter
037	Cass
039	Cedar
041	Chariton
043	Christian
045	Clark
047	Clay
049	Clinton
051	Cole
053	Cooper
055	Crawford
057	Dade
059	Dallas
061	Daviess
063	DeKalb
065	Dent
067	Douglas
069	Dunklin
071	Franklin
073	Gasconade
075	Gentry
077	Greene
079	Grundy
081	Harrison
083	Henry
085	Hickory
087	Holt
089	Howard
091	Howell
093	Iron
095	Jackson
097	Jasper
099	Jefferson
101	Johnson
103	Knox
105	Laclede
107	Lafayette
109	Lawrence
111	Lewis
113	Lincoln
115	Linn
117	Livingston
119	McDonald
121	Macon
123	Madison
125	Maries
127	Marion
129	Mercer
131	Miller
133	Mississippi
135	Moniteau
137	Monroe
139	Montgomery
141	Morgan
143	New Madrid
145	Newton
147	Nodaway
149	Oregon
151	Osage
153	Ozark
155	Pemiscot
157	Perry
159	Pettis
161	Phelps
163	Pike
165	Platte
167	Polk
169	Pulaski
171	Putnam
173	Ralls
175	Randolph
177	Ray
179	Reynolds
181	Ripley
183	St. Charles
185	St. Clair
186	Ste. Genevieve
187	St. Francois
189	St. Louis County
195	Saline
197	Schuyler
199	Scotland
201	Scott
203	Shannon
205	Shelby
207	Stoddard
209	Stone
211	Sullivan
213	Taney
215	Texas
217	Vernon
219	Warren
221	Washington
223	Wayne
225	Webster
227	Worth
229	Wright

CODE INDEPENDENT CITY

510	St. Louis City

STATE NAME: MONTANA
ALPHABETIC CODE: MT
NUMERIC CODE: 30

CODE	COUNTY NAME
001	Beaverhead
003	Big Horn
005	Blaine
007	Broadwater
009	Carbon
011	Carter
013	Cascade
015	Chouteau
017	Custer
019	Daniels
021	Dawson
023	Deer Lodge
025	Fallon
027	Fergus
029	Flathead
031	Gallatin
033	Garfield
035	Glacier
037	Golden Valley
039	Granite
041	Hill
043	Jefferson
045	Judith Basin
047	Lake
049	Lewis and Clark
051	Liberty
053	Lincoln
055	McCone
057	Madison
059	Meagher
061	Mineral
063	Missoula
065	Musselshell

067	Park
069	Petroleum
071	Phillips
073	Pondera
075	Powder River
077	Powell
079	Prairie
081	Ravalli
083	Richland
085	Roosevelt
087	Rosebud
089	Sanders
091	Sheridan
093	Silver Bow
095	Stillwater
097	Sweet Grass
099	Teton
101	Tooke
103	Treasure
105	Valley
107	Wheatland
109	Wibaux
111	Yellowstone

NIST has been notified by the Bureau of Census that Yellowstone National Park, MT, is legally part of Gallatin County and Park County. This eliminates Yellowstone National Park (FIPS Code 113) as a county equivalent.

STATE NAME: NEBRASKA
ALPHABETIC CODE: NE
NUMERIC CODE: 31

CODE	COUNTY NAME
001	Adams
003	Antelope
005	Arthur
007	Banner
009	Blaine
011	Boone
013	Box Butte
015	Boyd
017	Brown
019	Buffalo
021	Burt
023	Butler
025	Cass
027	Cedar
029	Chase
031	Cherry
033	Cheyenne
035	Clay
037	Colfax
039	Cuming
041	Custer
043	Dakota
045	Dawes
047	Dawson
049	Deuel
051	Dixon
053	Dodge
055	Douglas
057	Dundy
059	Fillmore
061	Franklin
063	Frontier
065	Furnas
067	Gage
069	Garden
071	Garfield
073	Gosper
075	Grant
077	Greeley
079	Hall
081	Hamilton
083	Harlan
085	Hayes
087	Hitchcock
089	Holt
091	Hooker
093	Howard
095	Jefferson
097	Johnson
099	Kearney
101	Keith
103	Keya Paha
105	Kimball
107	Knox
109	Lancaster
111	Lincoln
113	Logan
115	Loup
117	McPherson
119	Madison
121	Merrick
123	Morrill
125	Nance
127	Nemaha
129	Nuckolls
131	Otoe
133	Pawnee
135	Perkins
137	Phelps
139	Pierce
141	Platte
143	Polk
145	Red Willow
147	Richardson
149	Rock
151	Saline
153	Sarpy
155	Saunders
157	Scotts Bluff
159	Seward
161	Sheridan
163	Sherman
165	Sioux
167	Stanton
169	Thayer
171	Thomas
173	Thurston
175	Valley
177	Washington
179	Wayne
181	Webster
183	Wheeler
185	York

STATE NAME: NEVADA
ALPHABETIC CODE: NV
NUMERIC CODE: 32

CODE	COUNTY NAME
001	Churchill
003	Clark
005	Doulgas
007	Elko
009	Esmeralda
011	Eureka
013	Humboldt
015	Lander
017	Lincoln
019	Lyon
021	Mineral
023	Nye
027	Pershing
029	Storey
031	Washoe
033	White Pine

CODE	INDEPENDENT CITY
510	Carson City

Carson City does not include a legal designation (such as "city").

STATE NAME:
NEW HAMPSHIRE
ALPHABETIC CODE: NH
NUMERIC CODE: 33

CODE	COUNTY NAME
001	Belknap
003	Carroll
005	Cheshire
007	Coos
009	Grafton
011	Hillsborough
013	Merrimack
015	Rockingham
017	Strafford
019	Sullivan

STATE NAME:
NEW JERSEY
ALPHABETIC CODE: NJ
NUMERIC CODE: 34

CODE	COUNTY NAME
001	Atlantic
003	Bergen
005	Burlington
007	Camden
009	Cape May
011	Cumberland
013	Essex
015	Gloucester
017	Hudson
019	Hunterdon
021	Mercer
023	Middlesex
025	Monmouth
027	Morris
029	Ocean
031	Passaic
033	Salem
035	Somerset
037	Sussex
039	Union
041	Warren

STATE NAME:
NEW MEXICO
ALPHABETIC CODE: NM
NUMERIC CODE: 35

CODE	COUNTY NAME
001	Bernalillo
003	Catron
005	Chaves
006	Cibola
007	Colfax
009	Curry
011	DeBaca
013	Dona Ana
015	Eddy
017	Grant
019	Guadalupe
021	Harding
023	Hidalgo
025	Lea
027	Lincoln
028	Los Alamos
029	Luna
031	McKinley
033	Mora
035	Otero
037	Quay
039	Rio Arriba
041	Roosevelt
043	Sandoval
045	San Juan
047	San Miguel
049	Santa Fe
051	Sierra
053	Socorro
055	Taos
057	Torrance
059	Union
061	Valencia

Cibola was established from part of Valencia (6/19/81).

STATE NAME:
NEW YORK
ALPHABETIC CODE: NY
NUMERIC CODE: 36

CODE	COUNTY NAME
001	Albany
003	Allegany
005	Bronx
007	Broome
009	Cattaraugus
011	Cayuga
013	Chautauqua
015	Chemung
017	Chenango
019	Clinton
021	Columbia
023	Cortland
025	Delaware
027	Dutchess
029	Erie
031	Essex
033	Franklin
035	Fulton
037	Genesee

039	Greene
041	Hamilton
043	Herkimer
045	Jefferson
047	Kings
049	Lewis
051	Livingston
053	Madison
055	Monroe
057	Montgomery
059	Nassau
061	New York
063	Niagara
065	Oneida
067	Onondaga
069	Ontario
071	Orange
073	Orleans
075	Oswego
077	Otsego
079	Putnam
081	Queens
083	Rensselaer
085	Richmond
087	Rockland
089	St. Lawrence
091	Saratoga
093	Schenectady
095	Schoharie
097	Schuyler
099	Seneca
101	Steuben
103	Suffolk
105	Sullivan
107	Tioga
109	Tompkins
111	Ulster
113	Warren
115	Washington
117	Wayne
119	Westchester
121	Wyoming
123	Yates

STATE NAME: NORTH CAROLINA
ALPHABETIC CODE: NC
NUMERIC CODE: 37

CODE	COUNTY NAME
001	Alamance
003	Alexander
005	Alleghany
007	Anson
009	Ashe
011	Avery
013	Beaufort
015	Bertie
017	Bladen
019	Brunswick
021	Buncombe
023	Burke
025	Cabarrus
027	Caldwell
029	Camden
031	Carteret
033	Caswell
035	Catawba
037	Chatham
039	Cherokee
041	Chowan
043	Clay
045	Cleveland
047	Columbus
049	Craven
051	Cumberland
053	Currituck
055	Dare
057	Davidson
059	Davie
061	Duplin
063	Durham
065	Edgecombe
067	Forsyth
069	Franklin
071	Gaston
073	Gates
075	Graham
077	Granville
079	Greene
081	Guilford
083	Halifax
085	Harnett
087	Haywood
089	Henderson
091	Hertford
093	Hoke
095	Hyde
097	Iredell
099	Jackson
101	Johnston
103	Jones
105	Lee
107	Lenoir
109	Lincoln
111	McDowell
113	Macon
115	Madison
117	Martin
119	Mecklenburg
121	Mitchell
123	Montgomery
125	Moore
127	Nash
129	New Hanover
131	Northampton
133	Onslow
135	Orange
137	Pamlico
139	Pasquotank
141	Pender
143	Perquimans
145	Person
147	Pitt
149	Polk
151	Randolph
153	Richmond
155	Robeson
157	Rockingham
159	Rowan
161	Rutherford
163	Sampson
165	Scotland
167	Stanly
169	Stokes
171	Surry
173	Swain
175	Transylvania
177	Tyrrell
179	Union
181	Vance
183	Wake
185	Warren
187	Washington
189	Watauga
191	Wayne
193	Wilkes
195	Wilson
197	Yadkin
199	Yancey

STATE NAME: NORTH DAKOTA
ALPHABETIC CODE: ND
NUMERIC CODE: 38

CODE	COUNTY NAME
001	Adams
003	Barnes
005	Benson
007	Billings
009	Bottineau
011	Bowman
013	Burke
015	Burleigh
017	Cass
019	Cavalier
021	Dickey
023	Divide
025	Dunn
027	Eddy
029	Emmons
031	Foster
033	Golden Valley
035	Grand Forks
037	Grant
039	Griggs
041	Hettinger
043	Kidder
045	LaMoure
047	Logan
049	McHenry
051	McIntosh
053	McKenzie
055	McLean
057	Mercer
059	Morton
061	Mountrail
063	Nelson
065	Oliver
067	Pembina
069	Pierce
071	Ramsey
073	Ransom
075	Renville
077	Richland
079	Rolette
081	Sargent
083	Sheridan
085	Sioux
087	Slope
089	Stark
091	Steele
093	Stutsman
095	Towner
097	Traill
099	Walsh
101	Ward
103	Wells
105	Williams

STATE NAME: OHIO
ALPHABETIC CODE: OH
NUMERIC CODE: 39

CODE	COUNTY NAME
001	Adams
003	Allen
005	Ashland
007	Ashtabula
009	Athens
011	Auglaize
013	Belmont
015	Brown
017	Butler
019	Carroll
021	Champaign
023	Clark
025	Clermont
027	Clinton
029	Columbiana
031	Coshocton
033	Crawford
035	Cuyahoga
037	Darke
039	Defiance
041	Delaware
043	Erie
045	Fairfield
047	Fayette
049	Franklin
051	Fulton
053	Gallia
055	Geauga
057	Greene
059	Guernsey
061	Hamilton
063	Hancock
065	Hardin
067	Harrison
069	Henry
071	Highland
073	Hocking
075	Holmes
077	Huron
079	Jackson
081	Jefferson
083	Knox
085	Lake
087	Lawrence
089	Licking
091	Logan
093	Lorain
095	Lucas
097	Madison
099	Mahoning
101	Marion
103	Medina
105	Meigs
107	Mercer
109	Miami
111	Monroe
113	Montgomery
115	Morgan
117	Morrow
119	Muskingum
121	Noble

123	Ottawa
125	Paulding
127	Perry
129	Pickaway
131	Pike
133	Portage
135	Preble
137	Putnam
139	Richland
141	Ross
143	Sandusky
145	Scioto
147	Seneca
149	Shelby
151	Stark
153	Summit
155	Trumbull
157	Tuscarawas
159	Union
161	VanWert
163	Vinton
165	Warren
167	Washington
169	Wayne
171	Williams
173	Wood
175	Wyandot

STATE NAME: OKLAHOMA
ALPHABETIC CODE: OK
NUMERIC CODE: 40

CODE	COUNTY NAME
001	Adair
003	Alfalfa
005	Atoka
007	Beaver
009	Beckham
011	Blaine
013	Bryan
015	Caddo
017	Canadian
019	Carter
021	Cherokee
023	Choctaw
025	Cimarron
027	Cleveland
029	Coal
031	Comanche
033	Cotton
035	Craig
037	Creek
039	Custer
041	Delaware
043	Dewey
045	Ellis
047	Garfield
049	Garvin
051	Grady
053	Grant
055	Greer
057	Harmon
059	Harper
061	Haskell
063	Hughes
065	Jackson
067	Jefferson
069	Johnston
071	Kay
073	Kingfisher
075	Kiowa
077	Latimer
079	Le Flore
081	Lincoln
083	Logan
085	Love
087	McClain
089	McCurtain
091	McIntosh
093	Major
095	Marshall
097	Mayes
099	Murray
101	Muskogee
103	Noble
105	Nowata
107	Okfushee
109	Oklahoma
111	Okmulgee
113	Osage
115	Ottawa
117	Pawnee
119	Payne
121	Pittsburg
123	Pontotoc
125	Pottawatomie
127	Pushmataha
129	Roger Mills
131	Rogers
133	Seminole
135	Sequoyah
137	Stephens
139	Texas
141	Tillman
143	Tulsa
145	Wagoneer
147	Washington
149	Washita
151	Woods
153	Woodward

STATE NAME: OREGON
ALPHABETIC CODE: OR
NUMERIC CODE: 41

CODE	COUNTY NAME
001	Baker
003	Benton
005	Clackamas
007	Clatsop
009	Columbia
011	Coos
013	Crook
015	Curry
017	Deschutes
019	Douglas
021	Gilliam
023	Grant
025	Harney
027	Hood River
029	Jackson
031	Jefferson
033	Josephine
035	Klamath
037	Lake
039	Lane
041	Lincoln
043	Linn
045	Malheur
047	Marion
049	Morrow
051	Multnomah
053	Polk
055	Sherman
057	Tillamook
059	Umatilla
061	Union
063	Wallowa
065	Wasco
067	Washington
069	Wheeler
071	Yamhill

STATE NAME: PENNSYLVANIA
ALPHABETIC CODE: PA
NUMERIC CODE: 42

CODE	COUNTY NAME
001	Adams
003	Allegheny
005	Armstrong
007	Beaver
009	Bedford
011	Berks
013	Blair
015	Bradford
017	Bucks
019	Butler
021	Cambria
023	Cameron
025	Carbon
027	Centre
029	Chester
031	Clarion
033	Clearfield
035	Clinton
037	Columbia
039	Crawford
041	Cumberland
043	Dauphin
045	Delaware
047	Elk
049	Erie
051	Fayette
053	Forest
055	Franklin
057	Fulton
059	Greene
061	Huntingdon
063	Indiana
065	Jefferson
067	Juniata
069	Lackawanna
071	Lancaster
073	Lawrence
075	Lebanon
077	Lehigh
079	Luzerne
081	Lycoming
083	McKean
085	Mercer
087	Mifflin
089	Monroe
091	Montgomery
093	Montour
095	Northampton
097	Northumberland
099	Perry
101	Philadelphia
103	Pike
105	Potter
107	Schuylkill
109	Snyder
111	Somerset
113	Sullivan
115	Susquehanna
117	Tioga
119	Union
121	Venango
123	Warren
125	Washington
127	Wayne
129	Westmoreland
131	Wyoming
133	York

STATE NAME: RHODE ISLAND
ALPHABETIC CODE: RI
NUMERIC CODE: 44

CODE	COUNTY NAME
001	Bristol
003	Kent
005	Newport
007	Providence
009	Washington

STATE NAME: SOUTH CAROLINA
ALPHABETIC CODE: SC
NUMERIC CODE: 45

CODE	COUNTY NAME
001	Abbeviille
003	Aiken
005	Allendale
007	Anderson
009	Bamberg
011	Barnwell
013	Beaufort
015	Berkeley
017	Calhoun
019	Charleston
021	Cherokee
023	Chester
025	Chesterfield
027	Clarendon
029	Colleton
031	Darlington
033	Dillon
035	Dorchester
037	Edgefield
039	Fairfield
041	Florence
043	Georgetown
045	Greenville
047	Greenwood
049	Hampton
051	Horry
053	Jasper
055	Kershaw
057	Lancaster

059	Laurens
061	Lee
063	Lexington
065	McCormick
067	Marion
069	Marlboro
071	Newberry
073	Oconee
075	Orangeburg
077	Pickens
079	Richland
081	Saluda
083	Spartanburg
085	Sumter
087	Union
089	Williamsburg
091	York

STATE NAME: SOUTH DAKOTA
ALPHABETIC CODE: SD
NUMERIC CODE: 46

CODE	COUNTY NAME
003	Aurora
005	Beadle
007	Bennett
009	Bon Homme
011	Brookings
013	Brown
015	Brule
017	Buffalo
019	Butte
021	Campbell
023	Charles Mix
025	Clark
027	Clay
029	Codington
031	Corson
033	Custer
035	Davison
037	Day
039	Deuel
041	Dewey
043	Douglas
045	Edmunds
047	Fall River
049	Faulk
051	Grant
053	Gregory
055	Haakon
057	Hamlin
059	Hand
061	Hanson
063	Harding
065	Hughes
067	Hutchinson
069	Hyde
071	Jackson
073	Jerauld
075	Jones
077	Kingsbury
079	Lake
081	Lawrence
083	Lincoln
085	Lyman
087	McCook
089	McPherson
091	Marshall
093	Meade
095	Mellette
097	Miner
099	Minnehaha
101	Moody
103	Pennington
105	Perkins
107	Potter
109	Roberts
111	Sanborn
113	Shannon
115	Spink
117	Stanley
119	Sully
121	Todd
123	Tripp
125	Turner
127	Union
129	Walworth
135	Yankton
137	Ziebach

STATE NAME: TENNESSEE
ALPHABETIC CODE: TN
NUMERIC CODE: 47

CODE	COUNTY NAME
001	Anderson
003	Bedford
005	Benton
007	Bledsoe
009	Blount
011	Bradley
013	Campbell
015	Cannon
017	Carroll
019	Carter
021	Cheatham
023	Chester
025	Claiborne
027	Clay
029	Cocke
031	Coffee
033	Crockett
035	Cumberland
037	Davidson
039	Decatur
041	DeKalb
043	Dickson
045	Dyer
047	Fayette
049	Fentress
051	Franklin
053	Gibson
055	Giles
057	Grainger
059	Greene
061	Grundy
063	Hamblen
065	Hamilton
067	Hancock
069	Hardeman
071	Hardin
073	Hawkins
075	Haywood
077	Henderson
079	Henry
081	Hickman
083	Houston
085	Humphreys
087	Jackson
089	Jefferson
091	Johnson
093	Knox
095	Lake
097	Lauderdale
099	Lawrence
101	Lewis
103	Lincoln
105	Loudon
107	McMinn
109	McNairy
111	Macon
113	Madison
115	Marion
117	Marshall
119	Maury
121	Meigs
123	Monroe
125	Montgomery
127	Moore
129	Morgan
131	Obion
133	Overton
135	Perry
137	Pickett
139	Polk
141	Putnam
143	Rhea
145	Roane
147	Robertson
149	Rutherford
151	Scott
153	Sequatchie
155	Sevier
157	Shelby
159	Smith
161	Stewart
163	Sullivan
165	Sumner
167	Tipton
169	Trousdale
171	Unicoi
173	Union
175	Van Buren
177	Warren
179	Washington
181	Wayne
183	Weakley
185	White
187	Williamson
189	Wilson

STATE NAME: TEXAS
ALPHABETIC CODE: TX
NUMERIC CODE: 48

CODE	COUNTY NAME
001	Anderson
003	Andrews
005	Angelina
007	Aransas
009	Archer
011	Armstrong
013	Atascosa
015	Austin
017	Bailey
019	Bandera
021	Bastrop
023	Baylor
025	Bee
027	Bell
029	Bexar
031	Blanco
033	Borden
035	Bosque
037	Bowie
039	Brazoria
041	Brazos
043	Brewster
045	Briscoe
047	Brooks
049	Brown
051	Burleson
053	Burnet
055	Caldwell
057	Calhoun
059	Callahan
061	Cameron
063	Camp
065	Carson
067	Cass
069	Castro
071	Chambers
073	Cherokee
075	Childress
077	Clay
079	Cochran
081	Coke
083	Coleman
085	Collin
087	Collingsworth
089	Colorado
091	Comal
093	Comanche
095	Concho
097	Cooke
099	Coryell
101	Cottle
103	Crane
105	Crockett
107	Crosby
109	Culberson
111	Dallam
113	Dallas
115	Dawson
117	Deaf Smith
119	Delta
121	Denton
123	DeWitt
125	Dickens
127	Dimmit
129	Donley
131	Duval
133	Eastland
135	Ector
137	Edwards
139	Ellis
141	El Paso
143	Erath
145	Falls
147	Fannin
149	Fayette
151	Fisher
153	Floyd
155	Foard

157	Fort Bend
159	Franklin
161	Freestone
163	Frio
165	Gaines
167	Galveston
169	Garza
171	Gillespie
173	Glasscock
175	Goliad
177	Gonzales
179	Gray
181	Grayson
183	Gregg
185	Grimes
187	Guadalupe
189	Hale
191	Hall
193	Hamilton
195	Hansford
197	Hardeman
199	Hardin
201	Harris
203	Harrison
205	Hartley
207	Haskell
209	Hays
211	Hemphill
213	Henderson
215	Hidalgo
217	Hill
219	Hockley
221	Hood
223	Hopkins
225	Houston
227	Howard
229	Hudspeth
231	Hunt
233	Hutchinson
235	Irion
237	Jack
239	Jackson
241	Jasper
243	Jeff Davis
245	Jefferson
247	Jim Hogg
249	Jim Wells
251	Johnson
253	Jones
255	Karnes
257	Kaufman
259	Kendall
261	Kenedy
263	Kent
265	Kerr
267	Kimble
269	King
271	Kinney
273	Kleberg
275	Knox
277	Lamar
279	Lamb
281	Lampasas
283	La Salle
285	Lavaca
287	Lee
289	Leon
291	Liberty
293	Limestone
295	Lipscomb
297	Live Oak
299	Llano
301	Loving
303	Lubbock
305	Lynn
307	McCulloch
309	McLennan
311	McMullen
313	Madison
315	Marion
317	Martin
319	Mason
321	Matagorda
323	Maverick
325	Medina
327	Menard
329	Midland
331	Milam
333	Mills
335	Mitchell
337	Montague
339	Montgomery
341	Moore
343	Morris
345	Motley
347	Nacogdoches
349	Navarro
351	Newton
353	Nolan
355	Nueces
357	Ochiltree
359	Oldham
361	Orange
363	Palo Pinto
365	Panola
367	Parker
369	Parmer
371	Pecos
373	Polk
375	Potter
377	Presidio
379	Rains
381	Randall
383	Reagan
385	Real
387	Red River
389	Reeves
391	Refugio
393	Roberts
395	Robertson
397	Rockwall
399	Runnels
401	Rusk
403	Sabine
405	San Augustine
407	San Jacinto
409	San Patricio
411	San Saba
413	Schleicher
415	Scurry
417	Shackleford
419	Shelby
421	Sherman
423	Smith
425	Somervell
427	Starr
429	Stephens
431	Sterling
433	Stonewall
435	Sutton
437	Swisher
439	Tarrant
441	Taylor
443	Terrell
445	Terry
447	Throckmorton
449	Titus
451.	Tom Green
453	Travis
455	Trinity
457	Tyler
459	Upshur
461	Upton
463	Uvalde
465	Val Verde
467	Van Zandt
469	Victoria
471	Walker
473	Waller
475	Ward
477	Washington
479	Webb
481	Wharton
483	Wheeler
485	Wichita
487	Wilbarger
489	Willacy
491	Williamson
493	Wilson
495	Winkler
497	Wise
499	Wood
501	Yoakum
503	Young
505	Zapata
507	Zavala

STATE NAME: UTAH
ALPHABETIC CODE: UT
NUMERIC CODE: 49

CODE	COUNTY NAME
001	Beaver
003	Box Elder
005	Cache
007	Carbon
009	Daggett
011	Davis
013	Duchesne
015	Emery
017	Garfield
019	Grand
021	Iron
023	Juab
025	Kane
027	Millard
029	Morgan
031	Piute
033	Rich
035	Salt Lake
037	San Juan
039	Sanpete
041	Sevier
043	Summit
045	Tooele
047	Uintah
049	Utah
051	Wasatch
053	Washington
055	Wayne
057	Weber

STATE NAME: VERMONT
ALPHABETIC CODE: VT
NUMERIC CODE: 50

CODE	COUNTY NAME
001	Addison
003	Bennington
005	Caldedonia
007	Chittenden
009	Essex
011	Franklin
013	Grand Isle
015	Lamoille
017	Orange
019	Orleans
021	Rutland
023	Washington
025	Windham
027	Windsor

STATE NAME: VIRGINIA
ALPHABETIC CODE: VA
NUMERIC CODE: 51

CODE	COUNTY NAME
001	Accomack
003	Albermarle
005	Alleghany
007	Amelia
009	Amherst
011	Appomattox
013	Arlington
015	Augusta
017	Bath
019	Bedford
021	Bland
023	Botetourt
025	Brunswick
027	Buchanan
029	Buckingham
031	Campbell
033	Caroline
035	Carroll
036	Charles City
037	Charlotte
041	Chesterfield
043	Clarke
045	Craig
047	Culpeper
049	Cumberland
051	Dickenson
053	Dinwiddie
057	Essex
059	Fairfax
061	Fauquier
063	Floyd
065	Fluvanna
067	Franklin
069	Frederick
071	Giles
073	Gloucester
075	Goochland
077	Grayson
079	Greene

081	Greensville
083	Halifax
085	Hanover
087	Henrico
089	Henry
091	Highland
093	Isle of Wight
095	James City
097	King And Queen
099	King George
101	King William
103	Lancaster
105	Lee
107	Loudoun
109	Louisa
111	Lunenburg
113	Madison
115	Mathews
117	Mecklenburg
119	Middlesex
121	Montgomery
125	Nelson
127	New Kent
131	Northampton
133	Northumberland
135	Nottoway
137	Orange
139	Page
141	Patrick
143	Pittsylvania
145	Powhatan
147	Prince Edward
149	Prince George
153	Prince William
155	Pulaski
157	Rappahannock
159	Richmond
161	Roanoke
163	Rockbridge
165	Rockingham
167	Russell
169	Scott
171	Shenandoah
173	Smyth
175	Southampton
177	Spotsylvania
179	Stafford
181	Surry
183	Sussex
185	Tazewell
187	Warren
191	Washington
193	Westmoreland
195	Wise
197	Wythe
199	York

CODE	**INDEPENDENT CITY**
510	Alexandria (city)
515	Bedford (city)
520	Bristol (city)
530	Buena Vista (city)
540	Charlottsville (city)
550	Chesapeake (city)
570	Colonial Heights (city)
580	Covington (city)
590	Danville (city)
595	Emporia (city)
600	Fairfax (city)
610	Falls Church (city)
620	Franklin (city)
630	Fredericksburg (city)
640	Galax (city)
650	Hampton (city)
660	Harrisonburg (city)
670	Hopewell (city)
678	Lexington (city)
680	Lynchburg (city)
683	Manassas (city)
685	Manassas Park (city)
690	Martinsville (city)
700	Newport News (city)
710	Norfolk (city)
720	Norton (city)
730	Petersburg (city)
735	Poquoson (city)
740	Portsmouth (city)
750	Radford (city)
760	Richmond (city)
770	Roanoke (city)
775	Salem (city)
790	Staunton (city)
800	Suffolk (city)
810	Virginia Beach (city)
820	Waynesboro (city)
830	Williamsburg (city)
840	Winchester (city)

The codes for Charles City and Charlotte Counties, reported respectively as 037 and 039 in FIPS PUB 6-3, have been corrected. The Bureau of Economic Analysis, U.S. Department of Commerce has defined codes in the 900 series to represent county/independent city combination in Virginia.

The FIPS county code of 780 for South Boston, VA, is deleted. South Boston will be incorporated within Halifax County rather than a separate county-equivalent surrounded by Halifax County.

The independent city (county-equivalent) of Clifton Forge has reverted to town status, effective July 1, 2001. Clifton Forge is now an incorporated place within Alleghany County, rather than a separate county-equivalent surrounded by Alleghany County. The FIPS county code of 560 for Clifton Forge is deleted.

STATE NAME: WASHINGTON
ALPHABETIC CODE: WA
NUMERIC CODE: 53

CODE	**COUNTY NAME**
001	Adams
003	Asotin
005	Benton
007	Chelan
009	Clallam
011	Clark
013	Columbia
015	Cowlitz
017	Douglas
019	Ferry
021	Franklin
023	Garfield
025	Grant
027	Grays Harbor
029	Island
031	Jefferson
033	King
035	Kitsap
037	Kittitas
039	Klickitat
041	Lewis
043	Lincoln
045	Mason
047	Okanogan
049	Pacific
051	Pend Oreille
053	Pierce
055	San Juan
057	Skagit
059	Skamania
061	Snohomish
063	Spokane
065	Stevens
067	Thurston
069	Wahkiakum
071	Walla Walla
073	Whatcom
075	Whitman
077	Yakima

STATE NAME: WEST VIRGINIA
ALPHABETIC CODE: WV
NUMERIC CODE: 54

CODE	**COUNTY NAME**
001	Barbour
003	Berkeley
005	Boone
007	Braxton
009	Brooke
011	Cabell
013	Calhoun
015	Clay
017	Doddridge
019	Fayette
021	Gilmer
023	Grant
025	Greenbrier
027	Hampshire
029	Hancock
031	Hardy
033	Harrison
035	Jackson
037	Jefferson
039	Kanawha
041	Lewis
043	Lincoln
045	Logan
047	McDowell
049	Marion
051	Marshall
053	Mason
055	Mercer
057	Mineral
059	Mingo
061	Monongalia
063	Monroe
065	Morgan
067	Nicholas
069	Ohio
071	Pendleton
073	Pleasants
075	Pocahontas
077	Preston
079	Putnam
081	Raleigh
083	Randolph
085	Ritchie
087	Roane
089	Summers
091	Taylor
093	Tucker
095	Tyler
097	Upshur
099	Wayne
101	Webster
103	Wetzel
105	Wirt
107	Wood
109	Wyoming

STATE NAME: WISCONSIN
ALPHABETIC CODE: WI
NUMERIC CODE: 55

CODE	**COUNTY NAME**
001	Adams
003	Ashland
005	Barron
007	Bayfield
009	Brown
011	Buffalo
013	Burnett
015	Calumet
017	Chippewa
019	Clark
021	Columbia
023	Crawford
025	Dane
027	Dodge
029	Door
031	Douglas
033	Dunn
035	Eau Claire
037	Florence
039	Fond du Lac
041	Forest
043	Grant
045	Green
047	Green Lake
049	Iowa
051	Iron
053	Jackson
055	Jefferson
057	Juneau
059	Kenosha
061	Kewaunee
063	La Crosse
065	Lafayette

067	Langlade
069	Lincoln
071	Manitowoc
073	Marathon
075	Marinette
077	Marquette
078	Menominee
079	Milwaukee
081	Monroe
083	Oconto
085	Oneida
087	Outagamie
089	Ozaukee
091	Pepin
093	Pierce
095	Polk
097	Portage
099	Price
101	Racine
103	Richland
105	Rock
107	Rusk
109	St. Croix
111	Sauk
113	Sawyer
115	Shawano
117	Sheboygan
119	Taylor
121	Trempealeau
123	Vernon
125	Vilas
127	Walworth
129	Washburn
131	Washington
133	Waukesha
135	Waupaca
137	Waushara
139	Winnebago
141	Wood

STATE NAME: WYOMING
ALPHABETIC CODE: WY
NUMERIC CODE: 56

CODE	COUNTY NAME
001	Albany
003	Big Horn
005	Campbell
007	Carbon
009	Converse
011	Crook
013	Fremont
015	Goshen
017	Hot Springs
019	Johnson
021	Laramie
023	Lincoln
025	Natrona
027	Niobrara
029	Park
031	Platte
033	Sheridan
035	Sublette
037	Sweetwater
039	Teton
041	Uinta
043	Washakie
045	Weston

AREA NAME: AMERICAN SAMOA
ALPHABETIC CODE: AS
NUMERIC CODE: 60

CODE	DISTRICT/ISLAND NAME
010	Eastern (District)
020	Manu'a (District)
030	Rose Island
040	Swains Island
050	Western (District)

"Island" is part of the name of Rose Island and Swains Island. The entities called "counties" in American Samoa are subdivisions of the districts, and therefore are second-order subdivisions of American Samoa.

AREA NAME: GUAM
ALPHABETIC CODE: GU
NUMERIC CODE: 66

CODE	SUBDIVISION NAME
010	Guam

Guam has no first-order subdivisions, and therefore "Guam" also serves as the county-equivalent entity.

AREA NAME: NORTHERN MARINA ISLANDS
ALPHABETIC CODE: MP
NUMERIC CODE: 69

CODE	MUNICIPALITY NAME
085	Northern Islands
100	Rota
110	Saipan
120	Tinian

AREA NAME: PALAU
ALPHABETIC CODE: PW
NUMERIC CODE: 70

CODE	STATE NAME
002	Aimeliik
004	Airai
010	Angaur
050	Hatoboheit
100	Kayangel
150	Koror
212	Melekeok
214	Ngaraard
218	Ngarchelong
222	Ngardmau
224	Ngatpang
226	Ngchesar
227	Ngernmlengui
228	Ngiwal
350	Peleliu
370	Sonsorol

Palau also is known as Beau, and may be referred to as the Republic of..." Changes since recognition of Palau in Change Notice No. 9 to FIPS PUB 6-3. The first-order subdivisions of Palau have been revised from municipalities to states; the name of Melekeiok has been revised to Melekeok; the name and code for Ngaremlengui (223) have been revised to Ngeremlengui (227); the name and code for Tobi (380) have been revised to Hatobohei (050); the Palau Islands (unorganized territory) (300) is no longer included because that area is part of Koror and Peleliu.

AREA NAME: PUERTO RICO
ALPHABETIC CODE: PR
NUMERIC CODE: 72

CODE	MUNICIPALITY NAME
001	Adjuntas
003	Aguada
005	Aguadilla
007	Aguas Buenas
009	Aibonito
011	Anasco
013	Arecibo
015	Arroyo
017	Barceloneta
019	Barranquitas
021	Bayamo'n
023	Cabo Rojo
025	Caguas
027	Camuy
029	Canovanas
031	Carolina
033	Catano
035	Cayey
037	Ceiba
039	Ciales
041	Cidra
043	Coamo
045	Comerio
047	Corozal
049	Culebra
051	Dorado
053	Fajardo
054	Florida
057	Guayama
059	Guayanilla
061	Guaynabo
063	Gurabo
065	Hatillo
067	Hormigueros
069	Humacao
071	Isabela
073	Jayuya
075	Juana Diaz
077	Juncos
079	Lajas
081	Lares
083	Las Marias
085	Las Piedras
087	Loiza
089	Luquillo
091	Manati
093	Maricao
095	Maunabo
097	Mayaguez
099	Moca
101	Morovis
103	Naguabo
105	Naranjito
107	Orocovis
109	Patillas
111	Penuelas
113	Ponce
115	Quebradillas
117	Rincon
119	Rio Grande
121	Sabana Grande
123	Salinas
125	San German
127	San Juan
129	San Lorenzo
131	San Sebastian
133	Santa Isabel
135	Toa Alta
137	Toa Baja
139	Trujillo Alto
141	Utuado
143	Vega Alta
145	Vega Baja
147	Vieques
149	Villalba
151	Yabucoa
153	Yauco

AREA NAME: U.S. OUTLYING ISLANDS
ALPHABETIC CODE: UM
NUMERIC CODE: 74

CODE	ISLAND NAME
050	Baker Island
100	Howland Island
150	Jarvis Island
200	Johnston Island
250	Kingman Reef
300	Midway Islands
350	Navassa Island
400	Palmyra Atoll
450	Wake Island

An FIPS State numeric code is available for each area; FIPS PUB 5-2 identifies the codes and explains their usage. The State codes can be used in combination with the "county" codes listed here.

AREA NAME: VIRGIN ISLANDS OF THE UNITED STATES
ALPHABETIC CODE: VI
NUMERIC CODE: 78

CODE	ISLAND NAME
010	St. Croix
020	St. John
030	St. Thomas
30	

AREA NAME: FEDERATED STATES OF MICRONESIA
ALPHABETIC CODE: FM
NUMERIC CODE: 64

CODE	STATE NAME
002	Chuuk
005	Kosrae
040	Pohnpeit
060	Yap

The Federated States of Micronesia (FSM) became a freely associated state on 11/3/86. Its first-order subdivisions are called states. Changes since recognition of the FSM in Change Notice No. 9 to FIPS PUB 6-3. Ponape was renamed Pohnpei (11/8/84), and retained code 040; Truk (050) was renamed Chuuk (10/1/89).

AREA NAME: MARSHALL ISLANDS
ALPHABETIC CODE: MH
NUMERIC CODE: 68

CODE	MUNICIPALITY NAME
007	Ailinginaie
010	Ailinglaplap
030	Ailuk
040	Arno
050	Aur
060	Bikar
070	Bikini
073	Bokak
080	Ebon
090	Enewetak
100	Erikub
110	Jabat
120	Jaluit
130	Jemo
140	Kili
150	Kwajalein
160	Lae
170	Lib
180	Likiep
190	Majuro
300	Maloelap
310	Mejit
320	Mili
330	Namorik
340	Namu
350	Rongelap
360	Rongrik
385	Toke
390	Ujae
400	Ujelang
410	Utrik
420	Wotho
430	Wotle

The Marshall Islands became a freely associated state on 11/3/86. Its first-order subdivisions also may be referred to as “islands” and “atolls.” Since the recognition of the Marshall Islands in Change Notice No. 9, Jemo has been revised from Jemo Island to a municipality. Toke also may be spelled “Taka.”

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 (Kimgman Reef, Palmyra Atoll, Jarvis Island, Baker Island, Howland Island)

NORTH AND SOUTH AMERICA, EXCLUSIVE OF THE UNITED STATES AND ITS POSSESSIONS

210	Greenland
220	Canada
221	Labrador
	Maritime provinces
	New Brunswick
	Newfoundland and Labrador
	Nova Scotia
	Prince Edward Island
222	Quebec
223	Ontario
224	Prairie provinces
	Alberta
	Manitoba
	Saskatchewan
225	Northwest Territories
	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
	Carribean, 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
300	South America, NOS
311	Colombia
321	Venezuela
331	Guyana (British Guiana)
332	Suriname (Dutch Guiana)
333	French Guiana
341	Brazil
345	Ecuador
351	Peru
355	Bolivia
361	Chile
365	Argentina
371	Paraguay
375	Uruguay
380	South American Islands
381	Falkland Islands

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
	Azores
	Cape Verde Islands
	Madeira Islands
447	Italy
	San Marino
	Sardinia
	Sicily
	Vatican City (Holy See)
449	Romania
450	Slavic countries
451	Poland
452	(former) Czechoslovakia region
	Bohemia
	Czech Republic
	Moravia
	Slovak Republic
	Slovakia
453	(former) Yugoslavia region
	Bosnia-Herzogovina
	Croatia
	Dalmatia
	Montenegro
	Macedonia
	Serbia
	Slavonia
	Slovenia
454	Bulgaria
455	Russia
	Russian Federation
	(former) U.S.S.R.
	Russia, NOS
	(Russian S.F.S.R.)
456	Ukraine and Moldova
	(Bessarabia)
	Moldavia
	(Moldavian S.S.R.)
	(Ukranian S.S.R.)
457	Belarus
	(Byelorussian S.S.R.)
	(White Russia)
458	Estonia (Estonian S.S.R.)
459	Latvia (Latvian S.S.R.)
461	Lithuania
	(Lithuanian S.S.R.)
463	Baltic Republic(s), NOS
	(Baltic States, NOS)
470	Other mainland Europe
471	Greece
475	Hungary
481	Albania
485	Gibraltar
490	Other Mediterranean islands
491	Malta
495	Cyprus
499	Europe, NOS*
	Central Europe, NOS
	Eastern Europe, NOS
	Northern Europe, NOS
	Southern Europe, NOS
	Western Europe, NOS

** Effective tumors diagnosed 1/1/92.*

AFRICA

500	Africa, NOS
	Central Africa, NOS
	Equatorial Africa, NOS
510	North Africa, NOS
511	Morocco
513	Algeria
515	Tunisia
517	Libya
	(Cyrenaica)
	(Tripoli)
	(Tripolitania)
519	Egypt (United Arab Republic)
520	Sudanese countries
	Burkina Faso (Upper Volta)
	Chad
	Mali
	Mauritania
	Niger
	Sudan (Anglo-Egyptian Sudan)
	Western (Spanish) Sahara
530	West Africa, NOS
	French West Africa, NOS
531	Nigeria
539	Other West African Countries
	Benin (Dahomey)
	Cameroon (Kameroon)
	Central African Republic (French Equatorial Africa)
	Cote d-Ivoire (Ivory Coast)
	Congo (Congo-Brazzaville, French Congo)
	Equatorial Guinea (Spanish Guinea) (Bioko [Fernando Poo], Rio Muni)
	Gambia
	Gabon
	Ghana
	Guinea
	Guinea Bissau (Portuguese Guinea)
	Liberia
	Senegal
	Sierra Leone
	Togo
540	South Africa, NOS
541	Zaire (Congo-Leopoldville, Belgian Congo, Congo/Kinshasa)
543	Angola (Sao Tome, Principe, Cabinda)
545	Republic of South Africa
	(Bophuthatswana, Cape Colony, Ciskei, Natal, Free State [Orange Free State], Transkei, Transvaal, Venda)
	Botswana (Bechuanaland)
	Lesotho (Basutoland)
	Namibia (South West Africa)
	Swaziland
547	Zimbabwe (Rhodesia, Southern Rhodesia)
549	Zambia (Northern Rhodesia)
551	Malawi (Nyasaland)
553	Mozambique
555	Madagascar (Malagasy Republic)
570	East Africa
571	Tanzania (Tanganyika, Tanzanyika, Zanzibar)
573	Uganda
575	Kenya
577	Rwanda (Ruanda)
579	Burundi (Urundi)
581	Somalia (Somali Republic, Somaliland)

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
629	Aden
583	Afars and Issas
638	Afghanistan
500	Africa
570	Africa, East
510	Africa, North
540	Africa, South
545	Africa, South West
530	Africa, West
580	African Coastal Islands (previously included in 540)
037	Alabama
091	Alaska
481	Albania
224	Alberta
513	Algeria
250	America, Central
260	America, North (see also North America)
300	America, South
121	American Samoa
611	Anatolia
641	Andaman Islands
443	Andorra
543	Angola
245	Anguilla
665	Annam
750	Antarctica
245	Antigua
245	Antilles, NOS
245	Antilles, Netherlands
625	Arab Palestine
629	Arabia, Saudi
629	Arabian Peninsula
365	Argentina
087	Arizona
071	Arkansas
633	Armenia (U.S.S.R.)
611	Armenia (Turkey)
750	Antarctica
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	Azerbaizhan S.S.R.
445	Azores

B

247	Bahamas
629	Bahrain
443	Balearic islands
463	Baltic Republic, NOS
463	Baltic States, NOS
645	Bangladesh
245	Barbados
245	Barbuda
431	Bavaria
545	Basutoland
545	Bechuanaland
457	Belarus
541	Belgian Congo
433	Belgium
252	Belize
539	Benin
246	Bermuda
456	Bessarabia
643	Bhutan
539	Bioko (Fernando Poo)
452	Bohemia
355	Bolivia
545	Bophuthatswana
673	Borneo
453	Bosnia-Herzogovina
545	Botswana
341	Brazil
226	British Columbia
331	British Guiana
252	British Honduras
245	British Virgin Islands
245	British West Indies, NOS
671	Brunei
454	Bulgaria
520	Burkina Faso (Upper Volta)
649	Burma (see Myanmar)
579	Burundi
457	Byelorussian S.S.R.

C

543	Cabinda
245	Caicos Islands
097	California
663	Cambodia
539	Cameroon
220	Canada
110	Canal Zone
443	Canary islands
122	Canton islands
545	Cape Colony
445	Cape Verde islands
245	Caribbean, NOS
245	Caribbean islands, other
123	Caroline Islands
711	Cartier Islands
633	Caucasian Republics of the former U.S.S.R.
245	Cayman Islands
500	Central Africa, NOS
539	Central African Republic
250	Central America
499	Central Europe, NOS
060	Central Midwest States
647	Ceylon
520	Chad
401	Channel Islands (British)
361	Chile
681	China (not otherwise specified)
665	China, Cochin
682	China, People's Republic of
684	China, Republic of
723	Christmas Island
545	Ciskel
665	Cochin China
711	Cocos (Keeling) Islands
311	Colombia
083	Colorado
580	Comoros
226	Columbia, British
022	Columbia, District of
539	Congo-Brazzaville
541	Congo-Leopoldville
541	Congo, Belgian
539	Congo, French
541	Congo Kinshasa
007	Connecticut
124	Cook Islands
441	Corsica
256	Costa Rica
539	Cote d'Ivoire (Ivory Coast)
471	Crete
453	Croatia
241	Cuba
245	Curacao
495	Cyprus
517	Cyrenaica
452	Czechoslovakia
452	Czech Republic

D

539	Dahomey
453	Dalmatia
017	Delaware
425	Denmark
022	District of Columbia
583	Djibouti
449	Dobruja
245	Dominica
243	Dominican Republic
673	Dutch East Indies
332	Dutch Guiana

E

570	East Africa
680	East Asia
431	East Germany
673	East Indies, Dutch
645	East Pakistan
499	Eastern Europe, NOS
345	Ecuador
519	Egypt
410	Eire
254	El Salvador
125	Ellice Islands
122	Enderbury Islands
401	England
500	Equatorial Africa, NOS
539	Equatorial Guinea (Spanish Guinea)
585	Eritrea
458	Estonia
458	Estonian S.S.R. (Estonia)
585	Ethiopia

499	Europe, NOS*
470	Europe, other mainland

F

425	Faroe (Faeroe) Islands
381	Falkland Islands
431	Federal Republic of Germany
539	Fernando Poo
721	Fiji
429	Finland
035	Florida
684	Formosa
721	Fotuna
441	France
545	Free State (Orange Free State)
539	French Congo
333	French Guiana
725	French Polynesia
583	French Somaliland
530	French West Africa, NOS
245	French West Indies

G

539	Gabon
345	Galapagos Islands
539	Gambia
631	Gaza Strip
033	Georgia (U.S.A.)
633	Georgia (U.S.S.R.)
430	Germanic countries
431	German Democratic Republic
431	Germany
431	Germany, East
431	Germany, Federal Republic of
431	Germany, West
539	Ghana
485	Gibraltar
122	Gilbert Islands
471	Greece
210	Greenland
245	Grenada
245	Grenadines, The
245	Guadaloupe
126	Guam
251	Guatamala
401	Guernsey
331	Guiana, British
332	Guiana, Dutch
333	Guiana, French
539	Guinea
539	Guinea-Bissau (Portuguese Guinea)
539	Guinea, Equatorial
—	Guinea, New (see New Guinea)
539	Guinea, Portuguese
331	Guyana

H

242	Haiti
099	Hawaii
432	Holland
253	Honduras
252	Honduras, British
683	Hong Kong
475	Hungary

I

421	Iceland
081	Idaho
061	Illinois
641	India
045	Indiana
673	Indies, Dutch East
660	Indochina
673	Indonesia
053	Iowa
637	Iran
627	Iraq
620	Iraq-Saudi Arabian Neutral Zone
410	Ireland (Eire)
404	Ireland, Northern
410	Ireland, NOS
410	Ireland, Republic of
401	Isle of Man
631	Israel
583	Issas
447	Italy
539	Ivory Coast

J

423	Jan Mayen
244	Jamaica
693	Japan
673	Java
401	Jersey
631	Jewish Palestine
127	Johnston Atoll
625	Jordan
453	Jugoslavia

K

539	Kameroon
663	Kampuchea
065	Kansas
634	Kazakh S.S.R.
634	Kazakhstan
047	Kentucky
575	Kenya
634	Kirghiz S.S.R.
122	Kiribati
695	Korea
695	Korea, North
695	Korea, South
629	Kuwait
634	Kyrgystan
634	Kyrgyz

L

221	Labrador
661	Laos
265	Latin America, NOS
420	Lapland, NOS
459	Latvia
459	Latvian S.S.R. (Latvia)
623	Lebanon
245	Leeward Islands, NOS
545	Lesotho
539	Liberia
517	Libya
437	Liechtenstein
122	Line Islands, Southern
461	Lithuania
461	Lithuanian S.S.R. (Lithuania)
073	Louisiana
434	Luxembourg

M

686	Macao
686	Macau
453	Macedonia
555	Madagascar
445	Madeira islands
002	Maine
555	Malagasy Republic
551	Malawi
671	Malay Peninsula
671	Malaysia
640	Maldives
520	Mali
491	Malta
224	Manitoba
129	Mariana Islands
221	Maritime provinces, Canada
131	Marshall Islands
245	Martinique
021	Maryland
005	Massachusetts
520	Mauritania
580	Mauritius
580	Mayotte
490	Mediterranean Islands, Other
721	Melanesian islands
610	Mesopotamia, NOS
230	Mexico
041	Michigan
123	Micronesian islands
640	Mid-East Asia
132	Midway Islands
052	Minnesota
249	Miquelon
039	Mississippi
063	Missouri
456	Moldavia
456	Moldavian S.S.R.
456	Moldova
441	Monaco
691	Mongolia
056	Montana
453	Montenegro
245	Montserrat
452	Moravia
511	Morocco
080	Mountain States
553	Mozambique
629	Muscat
649	Myanmar (See Burma)

N

545	Namibia
133	Nampo-shoto, Southern
545	Natal
723	Nauru
610	Near-East Asia
067	Nebraska
643	Nepal
432	Netherlands
245	Netherlands Antilles
332	Netherlands Guiana
085	Nevada

245	Nevis
221	New Brunswick
725	New Caledonia
001	New England
673	New Guinea, except Australian and North East
711	New Guinea, Australian
711	New Guinea, North East
003	New Hampshire
721	New Hebrides
008	New Jersey
086	New Mexico
011	New York
715	New Zealand
221	Newfoundland
255	Nicaragua
520	Niger
531	Nigeria
715	Niue
711	Norfolk Island
671	North Borneo (Malaysia)
510	North Africa, NOS
260	North America, NOS (use more specific term if possible)
240	North American islands
025	North Carolina
040	North Central States
054	North Dakota
711	North East New Guinea
695	North Korea
010	North Mid-Atlantic States
499	Northern Europe, NOS
404	Northern Ireland
129	Northern Mariana Islands
050	Northern Midwest States
549	Northern Rhodesia
225	Northwest Territories (Canada)
423	Norway
998	Not United States, NOS
221	Nova Scotia
227	Nunavut
551	Nyasaland
	O
043	Ohio
075	Oklahoma
629	Oman
223	Ontario
545	Orange Free State
095	Oregon
403	Orkney Islands
	P
120	Pacific area, U.S. possessions
720	Pacific islands
123	Pacific Islands, Trust Territory of the (code to specific islands if possible)
090	Pacific Coast States
639	Pakistan
645	Pakistan, East
639	Pakistan, West
139	Palau (Trust Territory of the Pacific Islands)
625	Palestine, Arab
631	Palestine, Jewish
631	Palestine, NOS
631	Palestinian National Authority (PNA)
257	Panama
711	Papua New Guinea
371	Paraguay
014	Pennsylvania
629	People's Democratic Republic of Yemen
682	People's Republic of China
637	Persia
629	Persian Gulf States, NOS
351	Peru
675	Philippine Islands
675	Philippines
725	Pitcairn
451	Poland
725	Polynesian islands
445	Portugal
539	Portuguese Guinea
224	Prairie Provinces, Canada
221	Prince Edward Island
543	Principe
101	Puerto Rico
	Q
629	Qatar
222	Quebec
	R
684	Republic of China
545	Republic of South Africa
580	Reunion
006	Rhode Island
547	Rhodesia
549	Rhodesia, Northern
547	Rhodesia, Southern
539	Rio Muni
440	Romance-language countries
449	Romania
449	Roumania
577	Ruanda
449	Rumania
455	Russia, NOS
457	Russia, White
455	Russian Federation (former U.S.S.R.)
455	Russian S.F.S.R.
577	Rwanda
134	Ryukyu Islands
	S
520	Sahara, Western
121	Samoa, American
725	Samoa, Western
245	St. Christopher-Nevis
580	St. Helena
245	St. Kitts (see St. Christopher-Nevis)
245	St. Lucia
249	St. Pierre
245	St. Vincent
447	San Marino
543	Sao Tome
447	Sardinia
224	Saskatchewan
629	Saudi Arabia
420	Scandinavia
403	Scotland
539	Senegal
453	Serbia
580	Seychelles
403	Shetland Islands
651	Siam
447	Sicily
539	Sierra Leone
643	Sikkim
671	Singapore
450	Slavic countries
453	Slavonia
452	Slovak Republic
452	Slovakia
453	Slovenia
721	Solomon Islands
581	Somali Republic
581	Somalia
581	Somaliland
583	Somaliland, French
540	South Africa
545	South Africa, Republic of
545	South Africa, Union of
300	South America
380	South American islands
026	South Carolina
055	South Dakota
695	South Korea
020	South Mid-Atlantic States
545	South West Africa
650	Southeast Asia
030	Southeastern States
499	Southern Europe, NOS
122	Southern Line Islands
070	Southern Midwest States
133	Southern Nampo-shoto
547	Southern Rhodesia
629	Southern Yemen
—	Soviet Union (see individual republics)
443	Spain
520	Spanish Sahara
647	Sri Lanka
520	Sudan (Anglo-Egyptian Sudan)
520	Sudanese countries
673	Sumatra
332	Suriname
423	Svalbard
135	Swan Islands
545	Swaziland
427	Sweden
435	Switzerland
621	Syria
	T
634	Tadzhik S.S.R.
684	Taiwan
634	Tajikistan
571	Tanzania
571	Tanganyika
571	Tanzanyika
031	Tennessee
077	Texas
651	Thailand (Siam)
685	Tibet
245	Tobago
539	Togo
136	Tokelau Islands

725	Tonga
665	Tonkin
625	Trans-Jordan
545	Transkei
545	Transvaal
449	Transylvania
245	Trinidad
517	Tripoli
517	Tripolitania
629	Trucial States
515	Tunisia
611	Turkey
634	Turkmen S.S.R.
634	Turkmenistan
245	Turks Islands
125	Tuvalu
	U
573	Uganda
456	Ukraine
456	Ukranian S.S.R.
404	Ulster
545	Union of South Africa
—	Union of Soviet Socialist Republics (U.S.S.R.) (see individual republics)
629	United Arab Emirates
519	United Arab Republic
400	United Kingdom
000	United States
102	U.S. Virgin Islands
999	Unknown
520	Upper Volta
375	Uruguay
579	Urundi
084	Utah
634	Uzbekistan
634	Uzbek S.S.R.
	V
721	Vanuatu
447	Vatican City
545	Venda
321	Venezuela
004	Vermont
665	Vietnam
102	Virgin Islands (U.S.)
245	Virgin Islands (British)
023	Virginia
	W
137	Wake Island
402	Wales
721	Wallis
449	Wallachia
093	Washington (state)
022	Washington D.C.
530	West Africa, NOS
539	West African countries, other
631	West Bank
431	West Germany
245	West Indies, NOS (see also individual islands)
639	West Pakistan
024	West Virginia
499	Western Europe, NOS
520	Western Sahara
725	Western Samoa
457	White Russia
245	Windward islands
051	Wisconsin
082	Wyoming
	Y
629	Yemen
629	Yemen, People's Democratic Republic of
453	Yugoslavia (former Yugoslavia region)
225	Yukon Territory
	Z
541	Zaire
549	Zambia
571	Zanzibar
547	Zimbabwe

Table Name: REGID.DBF

0000000200 Maine Cancer Incidence Registry
0000000300 New Hampshire State Cancer Registry
0000000400 Vermont Cancer Registry
0000000500 Massachusetts Cancer Registry
0000000580 Southeast Massachusetts Cancer Registry
0000000581 Greater Lowell Cancer Program
0000000600 Rhode Island Cancer Registry
0000000700 Connecticut Tumor Registry
0000000800 New Jersey State Cancer Registry
0000001100 New York State Cancer Registry
0000001180 Rochester Regional Tumor Registry
0000001400 Pennsylvania Cancer Registry
0000001480 Pennsylvania-Northeast Regional Cancer Ctr.
0000001480 Northeast Regional Cancer Center
0000001500 National Cancer Institute SEER Program
0000001500 SEER Program, National Cancer Institute
0000001501 SEER San Francisco-Oakland SMSA
0000001502 SEER Connecticut
0000001520 SEER Metropolitan Detroit
0000001521 SEER Hawaii
0000001522 SEER Iowa
0000001523 SEER New Mexico
0000001525 SEER Seattle-Puget Sound
0000001526 SEER Utah
0000001527 SEER Metropolitan Atlanta
0000001529 SEER Alaska Native
0000001531 SEER San Jose-Monterey
0000001533 SEER Arizona Indians
0000001535 SEER Los Angeles
0000001537 SEER Rural Georgia
0000001541 SEER California except LA, SF-Oak, and San Jose/Monterey
0000001542 SEER Kentucky
0000001543 SEER Louisiana
0000001544 SEER New Jersey
0000001551 Cherokee Nation-Oklahoma (NCI funded)
0000001680 National Cancer Data Base
0000001700 Delaware State Cancer Registry
0000001801 Central Brain Tumor Registry of the U.S.
0000001900 U.S. Army Central Registry (ACTUR)
0000001900 Automated Central Tumor Registry (ACTUR)
0000002100 Maryland Cancer Registry
0000002200 District of Columbia Central Cancer Registry
0000002300 Virginia Cancer Registry
0000002400 West Virginia Cancer Registry
0000002500 North Carolina Central Cancer Registry
0000002600 South Carolina Central Cancer Registry
0000002601 Savannah River Region Cancer Registry in SC
0000002601 South Carolina -- Savannah River Region in SC
0000003100 Tennessee Cancer Reporting System
0000003300 Georgia Center for Cancer Statistics
0000003300 Georgia Cancer Registry
0000003301 Georgia-Metropolitan Atlanta Cancer Registry
0000003301 Metropolitan Atlanta Cancer Registry
0000003302 Georgia-Rural Georgia Cancer Registry
0000003302 Rural Georgia Cancer Registry
0000003303 Georgia-Savannah River Region Cancer Registry
0000003303 Savannah River Region Cancer Registry in GA
0000003500 Florida Cancer Data System
0000003700 Alabama State Cancer Registry
0000003900 Mississippi State Cancer Registry
0000004100 Michigan Cancer Surveillance System
0000004101 Michigan Cancer Foundation, CA Surveillance Detroit Metropolitan Area
0000004101 Detroit Metropolitan
0000004300 Ohio Bureau of Chronic Disease
0000004301 Cancer Data System, Inc.
0000004301 Ohio-Cancer Data System, Inc.
0000004500 Indiana State Cancer Registry
0000004700 Kentucky Cancer Registry
0000005100 Wisconsin Cancer Reporting System
0000005200 Minnesota Cancer Surveillance System
0000005300 Iowa State Health Registry
0000005300 State Health Registry of Iowa
0000005400 North Dakota Cancer Registry
0000005500 South Dakota Cancer Registry
0000005600 Montana Central Tumor Registry
0000006100 Illinois State Cancer Registry
0000006300 Missouri Cancer Registry
0000006500 Kansas-Cancer Data Service
0000006500 Cancer Data Service
0000006700 Nebraska Cancer Registry
0000007100 Arkansas CART I
0000007300 Louisiana Tumor Registry
0000007301 New Orleans Regional Cancer Registry
0000007301 Louisiana Region I
0000007302 Baton Rouge Regional Tumor Registry
0000007302 Louisiana Region II
0000007303 Southeast Louisiana Regional Cancer Registry
0000007303 Louisiana Region III
0000007304 Acadiana Tumor Registry
0000007304 Louisiana Region IV
0000007305 Southwest Louisiana Regional Tumor Registry
0000007305 Louisiana Region V
0000007306 Central Louisiana Regional Tumor Registry
0000007306 Louisiana Region VI
0000007307 Northwest Louisiana Regional Tumor Registry
0000007307 Louisiana Region VII
0000007308 Northeast Louisiana Regional Tumor Registry
0000007308 Louisiana Region VIII
0000007309 New Orleans/Southeast Louisiana Reg. CA RegLouisiana's regions I and III combined
0000007310 North Louisiana Regional Tumor Registry; Louisiana's regions VI, VII, and VIII
0000007500 Oklahoma State Department of Health
0000007501 Cherokee Nation Cancer Registry
0000007700 Texas Cancer Incidence Reporting System
0000008100 Cancer Data Registry of Idaho
0000008100 Idaho Cancer Data Registry
0000008200 Wyoming Central Tumor Registry
0000008300 Colorado Central Cancer Registry
0000008400 Utah Cancer Registry
0000008500 Nevada Statewide Cancer Registry
0000008600 New Mexico Tumor Registry
0000008601 Arizona Indians; data collected by New Mexico Tumor Reg.
0000008700 Arizona Cancer Registry
0000009100 Alaska State Cancer Registry
0000009101 Alaska Area Native Health Service
0000009300 Washington State Cancer Registry
0000009301 Cancer Surveillance System Fred Hutchinson; Seattle Puget Sound area, 13 counties
0000009301 Washington-Seattle-Puget Sound
0000009302 Eastern Washington State Cancer Registry
0000009302 Washington -- Eastern State Cancer Registry
0000009380 Spokane Central Tumor Registry (multihospital)
0000009380 Washington -- Spokane Central Tumor Registry (multihospital)
0000009500 Oregon State Cancer Registry
0000009580 Sisters of Providence Cancer Registry
0000009580 Oregon-Sisters of Providence Cancer Reg.
0000009700 California Cancer Registry
0000009701 California Region 1
0000009701 San Jose-Monterey
0000009701 Greater Bay Area Cancer Registry (Region 1)
0000009702 California Region 2

0000009702 Cancer Registry of Central California
0000009703 California Region 3
0000009703 Cancer Surveillance Program, Region 3
0000009704 California Region 4
0000009704 Tri-Counties Regional Cancer Registry
0000009705 California Region 5
0000009705 Cancer Surveillance Program, Region 5
0000009706 California Region 6
0000009706 Cancer Registry of Northern California
0000009707 California Region 7
0000009707 San Diego/Imperial Org. for Cancer Control
0000009708 California Region 8
0000009708 San Francisco-Oakland SMSA
0000009708 Greater Bay Area Cancer Registry (Region 8)
0000009709 California Region 9
0000009709 Cancer Surveillance Program of Los Angeles
0000009709 Los Angeles
0000009710 California Region 10
0000009710 Cancer Surveillance Program of Orange County
0000009711 Greater Bay Area Cancer Registry; California's Regions 1 and 8 combined
0000009711 California Greater Bay Area Cancer Registry
0000009712 California CSPOC and SANDIOCC; California's Regions 7 and 10 combined
0000009900 Hawaii Tumor Registry
0010100000 Puerto Rico Central Cancer Registry
0012000000 Pacific Region Central Cancer Registry
0012100000 American Samoa Cancer Registry
0012900000 CNMI Cancer Registry
0012300000 FSM National Cancer Registry
0012300001 Yap Cancer Registry
0012300002 Chuuk Cancer Registry
0012300003 Kosrae Cancer Registry
0012300004 Pohnpei Cancer Registry
0012600000 Guam Cancer Registry
0013100000 Marshall Islands Cancer Registry
0013900000 Palau Cancer Registry
0022000000 Canadian Cancer Registry
0022001000 Newfoundland Cancer Treatment & Research Fnd.
0022001100 Prince Edward Island Cancer Registry
0022001200 Nova Scotia Cancer Registry
0022001300 New Brunswick Provincial Cancer Registry
0022002400 Fichier Des Tumeurs Du Quebec
0022002400 Quebec Cancer Registry
0022003500 Ontario Cancer Registry
0022004600 Manitoba Cancer Registry
0022004700 Saskatchewan Cancer Foundation
0022004800 Alberta Cancer Registry
0022005900 British Columbia Cancer Registry
0022006000 Yukon Bureau of Statistics
0022006100 Northwest Territories Department of Health
0022006200 Nunavut Cancer Registry
0088820020 Veterans Health Administration

Table Name: STATE.DBF

AB	Alberta
AK	Alaska
AL	Alabama
AR	Arkansas
AS	American Samoa
AZ	Arizona
BC	British Columbia
CA	California
CD	Resident of Canada, NOS
CO	Colorado
CT	Connecticut
DC	District of Columbia
DE	Delaware
FL	Florida
FM	Federated States of Micronesia
GA	Georgia
GU	Guam
HI	Hawaii
IA	Iowa
ID	Idaho
IL	Illinois
IN	Indiana
KS	Kansas
KY	Kentucky
LA	Louisiana
MA	Massachusetts
MB	Manitoba
MD	Maryland
ME	Maine
MH	Marshall Islands
MI	Michigan
MN	Minnesota
MO	Missouri
MP	Northern Mariana Islands
MS	Mississippi
MT	Montana
NB	New Brunswick
NC	North Carolina
ND	North Dakota
NE	Nebraska
NL	Newfoundland and Labrador
NH	New Hampshire
NJ	New Jersey
NM	New Mexico
NS	Nova Scotia
NT	Northwest Territories
NU	Nunavut
NV	Nevada
NY	New York
OH	Ohio
OK	Oklahoma
ON	Ontario
OR	Oregon
PA	Pennsylvania
PE	Prince Edward Island
PR	Puerto Rico
PW	Palau
QC	Quebec
RI	Rhode Island
SC	South Carolina
SD	South Dakota
SK	Saskatchewan
TN	Tennessee
TT	Trust Territories
TX	Texas
UM	US Minor Outlying Islands
US	Resident of United States, NOS
UT	Utah
VA	Virginia
VI	Virgin Islands
VT	Vermont
WA	Washington
WI	Wisconsin
WV	West Virginia
WY	Wyoming
XX	Country Known, Not U.S., Not Canada
YT	Yukon Territories
YY	Country Unknown, Not U.S., Not Canada
ZZ	Country Unknown
AA	APO/FPO for Armed Services America
AE	APO/FPO for Armed Services Europe
AP	APO/FPO for Armed Services Pacific

APPENDIX C:

ABBREVIATIONS AND ACRONYMS USED

AACCR	American Association of Central Cancer Registries
ACoS	American College of Surgeons
ACS	American Cancer Society
AJCC	American Joint Committee on Cancer
BNA	Block Numbering Area
CCCR	Canadian Council of Cancer Registries
CDC	Centers for Disease Control and Prevention
CIN	Cervical intraepithelial neoplasia
CIS	Carcinoma *in situ*
CLIA	Clinical Laboratory Improvement Act
CoC	Commission on Cancer (of ACoS)
CPT	Current Procedural Terminology (codes)
CRC	Cyclic redundancy code
CS	Collaborative Staging
CTR	Certified Tumor Registrar
DAM	*Data Acquisition Manual* (of ACoS)
DCO	Death Certificate Only
EOD	Extent of Disease
FIPS	Federal Information Processing Standards
FORDS	*Facility Oncology Registry Data Standards* (manual of ACoS)
FTRO	*Fundamental Tumor Registry Operations Program* (of ACoS)
GenEDITS	Generic EDITS Driver Program
GIS	Geographic Information System
HCFA	Health Care Finance Administration
HIM	Health Information Management
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
NAPIIA	NAACCR Asian/Pacific Islander Identification Algorithm
NCCCS	National Coordinating Council for Cancer Surveillance
NCDB	National Cancer Data Base
NCI	National Cancer Institute
NCRA	National Cancer Registrars Association
N.d.	No date (bibliographic term: no ascertainable place of publication)
NHIA	NAACCR Hispanic Identification Algorithm
NPCR	National Program of Cancer Registries
NPI	National Provider Identifier
PIN	Prostatic intraepithelial neoplasia
ROADS	*Registry Operations and Data Standards* (manual of ACoS)
SEER	Surveillance, Epidemiology, and End Results Program of NCI
SIL	Squamous intraepithelial lesion

SS	Summary Stage
TNM	Tumor, Nodes and Metastasis: staging system of AJCC and UICC
UDSC	Uniform Data Standards Committee of NAACCR
UICC	Union Internationale Contre le Cancer (in English, International Union Against Cancer)
USPS	United States Postal Service
WHO	World Health Organization

APPENDIX D:

ALTERNATE NAMES

Following the item name are other names by which the same item is called, including the name used by the standard setter for the item. All other names are followed by the source of each name indicated with the following labels:

CoC	Preferred name in the CoC *FORDS/ROADS* manual and supplements
CoC pre-96	Previously used name appearing in the CoC *ROADS* manual
CoC pre-98	Previously used name appearing in the CoC *ROADS* manual before 1998
NAACCR pre-98	Previously used name appearing in NAACCR standards before 1998
SEER	Name in the *SEER Program Code Manual*
SEER pre-98	Previously used name appearing in SEER Manual before 1998

Item #	Item Name	Alternate Names
70	Addr at DX--City	City or Town (pre-96 CoC) City/Town at Diagnosis (CoC)
80	Addr at DX--State	State (pre-96 CoC) State at Diagnosis (CoC)
90	County at DX	County (pre-96 SEER/CoC) County at Diagnosis (CoC)
100	Addr at DX--Postal Code	Postal Code at Diagnosis (CoC) Zip Code (pre-CoC) Postal Code (CCCR)
110	Census Tract 1970/80/90	Census Tract/Block Numbering Area (BNA) (SEER) Census Tract
120	Census Cod Sys 1970/80/90	Census Coding System (CoC) Coding System for Census Tract (pre-96 SEER/CoC)
130	Census Tract 2000	Census Tract--Alternate (pre-2003)
150	Marital Status at DX	Marital Status at Diagnosis (SEER/CoC) Marital Status at Initial Diagnosis (pre-96 CoC)
160	Race 1	Race
190	Spanish/Hispanic Origin	Spanish Origin--All Sources (96 CoC) Spanish Surname or Origin (SEER)
192	IHS Link	Indian Health Service Linkage
193	Race--NAPIIA(derived API)	Race--NAPIIA
240	Date of Birth	Birth Date(SEER/CoC/CCCR)
250	Birthplace	Place of Birth (SEER/CoC)
362	Census Block Group 2000	Census Tract Block Group
364	Census Tr Cert 1970/80/90	Census Tract Certainty

Item #	Item Name	Alternate Names
380	Sequence Number--Central	Sequence Number (pre-96 SEER)
390	Date of Diagnosis	Date of Initial Diagnosis (CoC)
400	Primary Site	IDC-O-2/3 Topography (CCCR)
410	Laterality	Laterality at Diagnosis (SEER)
420	Histology (92-00) ICD-O-2	Histology (CoC) ICD-O-2 Histology (CCCR)
430	Behavior (92-00) ICD-O-2	ICD-O-2 Behaviour (CCCR)
440	Grade	Grade, Differentiation, or Cell Lineage Indicator (SEER/CCCR) Grade/Differentiation (CoC)
442	Ambiguous Terminology DX	Ambiguous Terminology as Basis for Diagnosis
443	Date of Conclusive DX	Date of Conclusive Diagnosis
444	Mult Tum Rpt as One Prim	Multiple Tumors Reported as Single Primary
522	Histologic Type ICD-O-3	ICD-O-3 Histology (CCCR)
523	Behavior Code ICD-O-3	Behavior Code (CoC) ICD-O-3 Behaviour (CCCR)
540	Reporting Facility	Institution ID Number (CoC) Facility Identification Number (CoC) Reporting Hospital
550	Accession Number--Hosp	Accession Number (CoC)
560	Sequence Number--Hospital	Sequence Number (CoC)
580	Date of 1st Contact	Date of Adm/First Contact
581	Date of 1st Contact Flag	Date of First Contact Flag
590	Date of Inpatient Adm	Date of Inpatient Admission (CoC)
600	Date of Inpatient Disch	Date of Inpatient Discharge (CoC)
630	Primary Payer at DX	Primary Payer at Diagnosis (CoC)
670	RX Hosp--Surg Prim Site	Cancer-Directed Surgery at This Facility (pre-96 CoC) RX Hosp--CA Dir Surgery (pre-96 NAACCR) Surgical Procedure of Primary Site
672	RX Hosp--Scope Reg LN Sur	Scope of Regional Lymph Node Surgery at this Facility (CoC)
674	RX Hosp--Surg Oth Reg/Dis	Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) at this Facility (CoC) Surgical Procedure/Other Site at this Facility
676	RX Hosp--Reg LN Removed	Number of Regional Lymph Nodes Examined at This Facility (CoC) RX Hosp--Reg LN Examined
690	RX Hosp--Radiation	Radiation at this Facility (CoC)

Item #	Item Name	Alternate Names
700	RX Hosp--Chemo	Chemotherapy at this Facility (CoC)
710	RX Hosp--Hormone	Hormone Therapy at this Facility (CoC)
720	RX Hosp--BRM	Immunotherapy at this Facility (CoC)
730	RX Hosp--Other	Other Treatment at this Facility (CoC)
740	RX Hosp--DX/Stg Proc	Non Cancer-Directed Surgery at this Facility (CoC) Surgical Diagnostic & Staging Procedure at this Facility (1996-2002) RX Hosp--DX/Stg/Pall Proc
746	RX Hosp--Surg Site 98-02	Cancer-Directed Surgery at this Facility (pre-96 CoC) RX Hosp--CA Dir Surgery (pre-96 NAACCR) Surgical Procedure of Primary Site
747	RX Hosp--Scope Reg 98-02	Scope of Regional Lymph Node Surgery at this Facility (CoC)
748	RX Hosp--Surg Oth 98-02	Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) at this Facility (CoC) Surgical Procedure/Other Site at this Facility
760	SEER Summary Stage 1977	General Summary Stage (SEER/CoC)
780	EOD--Tumor Size	Size of Primary Tumor (SEER) Size of Tumor (CoC)
790	EOD--Extension	Extension (pre-96 SEER/CoC) Extension (SEER EOD) (96 CoC)
810	EOD--Lymph Node Involv	Lymph Nodes (pre 96-SEER/CoC) Lymph Nodes (SEER EOD) (96 CoC)
820	Regional Nodes Positive	Number of Positive Regional Lymph Nodes (SEER) Pathologic Review of Regional Lymph Nodes (SEER) Regional Lymph Nodes Positive
830	Regional Nodes Examined	Number of Regional Lymph Nodes Examined (SEER) Pathologic Review of Regional Lymph Nodes (SEER) Regional Lymph Nodes Examined
840	EOD--Old 13 Digit	13-Digit (Expanded) Site-Specific Extent of Disease (SEER) SEER EEOD (SEER)
850	EOD--Old 2 Digit	2-Digit Nonspecific and 2-Digit Site-Specific Extent of Disease (1973-1982 SEER)
860	EOD--Old 4 Digit	4-Digit Extent of Disease (1983-1987 SEER)
870	Coding System for EOD	Coding System for Extent of Disease (SEER)
880	TNM Path T	Pathologic T (CoC)
890	TNM Path N	Pathologic N (CoC)
900	TNM Path M	Pathologic M (CoC)
910	TNM Path Stage Group	Pathologic Stage Group (CoC)
920	TNM Path Descriptor	Pathologic Stage (Prefix/Suffix) Descriptor (CoC)
930	TNM Path Staged By	Staged By (Pathologic Stage) (CoC)
940	TNM Clin T	Clinical T (CoC)

Item #	Item Name	Alternate Names
950	TNM Clin N	Clinical N (CoC)
960	TNM Clin M	Clinical M (CoC)
970	TNM Clin Stage Group	Clinical Stage Group (CoC)
980	TNM Clin Descriptor	Clinical Stage (Prefix/Suffix) Descriptor (CoC)
990	TNM Clin Staged By	Staged By (Clinical Stage) (CoC)
1130	Pediatric Staging System	Type of Staging System (Pediatric) (CoC)
1140	Pediatric Staged By	Staged By (Pediatric Stage) (CoC)
1150	Tumor Marker 1	Tumor Marker One (CoC)
1160	Tumor Marker 2	Tumor Marker Two (CoC)
1170	Tumor Marker 3	Tumor Marker Three (CoC)
1200	RX Date--Surgery	Date of Cancer-Directed Surgery (CoC) Date of Surgery Date of First Surgical Procedure (CoC)
1210	RX Date--Radiation	Date Radiation Started (CoC)
1220	RX Date--Chemo	Date Chemotherapy Started (CoC)
1230	RX Date--Hormone	Date Hormone Therapy Started (CoC)
1240	RX Date--BRM	Date Immunotherapy Started (CoC)
1250	RX Date--Other	Date Other Treatment Started (CoC)
1260	Date of Initial RX--SEER	Date Therapy Initiated (SEER) Date Started (SEER)
1270	Date of 1st Crs RX--CoC	Date of First Course Treatment (CoC) Date Started (pre 96 CoC)
1280	RX Date--DX/Stg Proc	Date of Non Cancer-Directed Surgery (CoC) Date of Diagnostic, Staging or Palliative Procedures (1996-2002) Date of Surgical Diagnostic and Staging Procedure (CoC) RX Date--DX/Stg/Pall Proc
1290	RX Summ--Surg Prim Site	Cancer-Directed Surgery (pre-96 CoC) Surgery of Primary Site (SEER/CoC)
1292	RX Summ--Scope Reg LN Sur	Scope of Regional Lymph Node Surgery (SEER/CoC)
1294	RX Summ--Surg Oth Reg/Dis	Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes (SEER/CoC) Surgical Procedure/Other Site
1296	RX Summ--Reg LN Examined	Number of Regional Lymph Nodes Examined (SEER/CoC) Number of Regional Lymph Nodes Removed (CoC)
1310	RX Summ--Surgical Approch	Surgical Approach (CoC)
1320	RX Summ--Surgical Margins	Surgical Margins (CoC) Residual Primary Tumor Following Cancer-Directed Surgery (pre-96 CoC)

Item #	Item Name	Alternate Names
1330	RX Summ--Reconstruct 1st	Reconstruction--First Course (SEER) Reconstruction/Restoration-First Course (CoC)
1340	Reason for No Surgery	Reason for No Cancer-Directed Surgery (SEER) Reason for No CA Dir Surgery (CoC) Reason for No Surgery to Primary Site
1350	RX Summ--DX/Stg Proc	Non Cancer-Directed Surgery (CoC) Surgical Diagnostic and Staging Procedure (1996-2002) RX Summ--DX/Stg/Pall Proc
1360	RX Summ--Radiation	Radiation (SEER/CoC) Radiation Therapy (pre-96 CoC)
1370	RX Summ--Rad to CNS	Radiation Therapy to CNS (CoC) Radiation to the Brain and/or Central Nervous System (SEER)
1380	RX Summ--Surg/Rad Seq	Radiation Sequence with Surgery (pre-96 SEER/CoC) Radiation/Surgery Sequence (CoC)
1390	RX Summ--Chemo	Chemotherapy (SEER/CoC)
1400	RX Summ--Hormone	Hormone Therapy (SEER/CoC) Endocrine (Hormone/Steroid) Therapy (pre-96 SEER)
1410	RX Summ--BRM	Immunotherapy (SEER/CoC) Biological Response Modifiers (pre-96 SEER)
1420	RX Summ--Other	Other Treatment (CoC) Other Cancer-Directed Therapy (SEER/pre-96 CoC)
1430	Reason for No Radiation	Reason for No Regional Radiation Therapy
1510	Rad--Regional Dose: CGY	Regional Dose: cGy (CoC)
1520	Rad--No of Treatment Vol	Number of Treatments to this Volume (CoC)
1540	Rad--Treatment Volume	Radiation Treatment Volume (CoC)
1550	Rad--Location of RX	Location of Radiation Treatment (CoC)
1570	Rad--Regional RX Modality	Regional Treatment Modality (CoC)
1639	RX Summ--Systemic/Sur Seq	Systemic/Surgery Sequence
1640	RX Summ--Surgery Type	Site--Specific Surgery (pre-98 SEER)
1646	RX Summ--Surg Site 98-02	Cancer-Directed Surgery (pre-96 CoC) Surgery of Primary Site (SEER/CoC)
1647	RX Summ--Scope Reg 98-02	Scope of Regional Lymph Node Surgery (SEER/CoC)
1648	RX Summ--Surg Oth 98-02	Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes (SEER/CoC) Surgical Procedure/Other Site
1660	Subsq RX 2nd Course Date	Second Course of Therapy-Date Started (pre-96 CoC)
1741	Subsq RX--Reconstruct Del	Reconstruction/Restoration--Delayed (CoC)
1750	Date of Last Contact	Date of Last Contact or Death (CoC) Date of Last Follow-Up or of Death (SEER)
1790	Follow-Up Source	Follow-Up Method (pre-96 CoC)

Item #	Item Name	Alternate Names
1800	Next Follow-Up Source	Next Follow-Up Method (pre-96 CoC)
1810	Addr Current--City	City/Town--Current (CoC)
1820	Addr Current--State	State--Current (CoC)
1830	Addr Current--Postal Code	Postal Code--Current (CoC)
1860	Recurrence Date--1st	Date of First Recurrence (CoC)
1880	Recurrence Type--1st	Type of First Recurrence (CoC)
1910	Cause of Death	Underlying Cause of Death (SEER) Underlying Cause of Death (ICD Code) (pre-96 CoC)
1920	ICD Revision Number	ICD Code Revision Used for Cause of Death (SEER)
1960	Site (73-91) ICD-O-1	Primary Site (1973-91) (SEER)
1980	ICD-O-2 Conversion Flag	Review Flag for 1973-91 Cases (SEER)
1981	Over-ride SS/NodesPos	Over-ride Summary Stage/Nodes Positive
1982	Over-ride SS/TNM-N	Over-ride Summary Stage/TNM-N
1983	Over-ride SS/TNM-M	Over-ride Summary Stage/TNM-M
1985	Over-ride Acsn/Class/Seq	Over-ride Accession/Class of Case/Sequence
1986	Over-ride HospSeq/DxConf	Over-ride Hospital Sequence/Diagnostic Confirmation
1988	Over-ride HospSeq/Site	Over-ride Hospital Sequence/Site
1990	Over-ride Age/Site/Morph	Age/Site/Histology Interfield Review (Interfield Edit 15)
2000	Over-ride SeqNo/DxConf	Sequence Number/Diagnostic Confirmation Interfield Review (Interfield Edit 23)
2010	Over-ride Site/Lat/SeqNo	Site/Histology/Laterality/Sequence Number Interrecord Review (Interrecord Edit 09)
2020	Over-ride Surg/DxConf	Surgery/Diagnostic Confirmation Interfield Review (Interfield Edit 46)
2030	Over-ride Site/Type	Site/Type Interfield Review (Interfield Edit 25)
2040	Over-ride Histology	Histology/Behavior Interfield Review (Field Item Edit Morph)
2050	Over-ride Report Source	Type of Reporting Source/Sequence Number Interfield Review (Interfield Edit 04)
2060	Over-ride Ill-define Site	Sequence Number/Ill-defined Site Interfield Review (Interfield Edit 22)
2070	Over-ride Leuk, Lymphoma	Leukemia or Lymphoma/Diagnostic Confirmation Interfield Review (Interfield Edit 48)
2071	Over-ride Site/Behavior	Over-ride Flag for Site/Behavior (IF39)

Item #	Item Name	Alternate Names
2072	Over-ride Site/EOD/DX Dt	Over-ride Flag for Site/EOD/Diagnosis Date (IF40) Over-ride Flag for Site/CS Extension/Diagnosis Date (IF176)
2073	Over-ride Site/Lat/EOD	Over-ride Flag for Site/Laterality/EOD (IF41) Over-ride Flag for Site/Laterality/CS Extension (IF177)
2074	Over-ride Site/Lat/Morph	Over-ride Flag for Site/Laterality/Morphology (IF42)
2110	Date Case Report Exported	Date Case Transmitted (pre-98 NAACCR)
2140	CoC Coding Sys--Current	Commission on Cancer Coding System-Current (CoC)
2180	SEER Type of Follow-Up	Type of Follow-Up (SEER)
2190	SEER Record Number	Record Number (SEER)
2200	Diagnostic Proc 73-87	Diagnostic Procedures (1973-87 SEER)
2230	Name--Last	Last Name (CoC)
2240	Name--First	First Name (CoC)
2250	Name--Middle	Middle Name (CoC) Middle Initial (pre-96 CoC)
2260	Name--Prefix	Name Prefix (CoC)
2270	Name--Suffix	Name Suffix (CoC)
2280	Name--Alias	Alias (CoC)
2310	Military Record No Suffix	Military Medical Record Number Suffix (CoC)
2330	Addr at DX--No & Street	Patient Address (Number and Street) at Diagnosis (CoC) Number and Street (pre-96 CoC)
2335	Addr at DX--Supplementl	Patient Address (Number and Street) at Diagnosis--Supplemental (CoC)
2350	Addr Current--No & Street	Patient Address (Number and Street)-Current (CoC)
2355	Addr Current--Supplementl	Patient Address (Number and Street) Current--Supplemental (CoC)
2390	Name--Maiden	Maiden Name (CoC)
2410	Institution Referred From	Facility Referred From
2420	Institution Referred To	Facility Referred To
2460	Physician--Managing	Managing Physician (CoC) Attending Physician (pre-96 CoC)
2470	Physician--Follow-Up	Following Physician (CoC) Follow-Up Physician (pre-96 CoC)
2480	Physician--Primary Surg	Primary Surgeon (CoC)
2490	Physician 3	Physician #3 (CoC) Other Physician (pre-96 CoC)

Item #	Item Name	Alternate Names
2495	NPI--Physician 3	Radiation Oncologist (CoC)
2500	Physician 4	Physician #4 (CoC) Other Physician (pre-96 CoC)
2505	NPI--Physician 4	Medical Oncologist (CoC)
2690	Text--Place of Diagnosis	Place of Diagnosis
2820	CS Tumor Size/Ext Eval	CS Tumor Size/Extension Evaluation CS TS/Ext-Eval
2830	CS Lymph Nodes	CS Lymph Nodes (SEER EOD)
2840	CS Lymph Nodes Eval	CS Regional Nodes Evaluation CS Reg Nodes Eval
2850	CS Mets at DX	CS Metastasis at Diagnosis
2860	CS Mets Eval	CS Metastasis Evaluation
2935	CS Version Input Original	CS Version 1ST
2936	CS Version Derived	CS Version Latest
2940	Derived AJCC-6 T	Derived 6 T Storage Code Derived AJCC T
2950	Derived AJCC-6 T Descript	Derived 6 T Descriptor Storage Code Derived AJCC T Descriptor
2960	Derived AJCC-6 N	Derived 6 N Storage Code Derived AJCC N
2970	Derived AJCC-6 N Descript	Derived 6 N Descriptor Storage Code Derived AJCC N Descriptor
2980	Derived AJCC-6 M	Derived 6 M Storage Code Derived AJCC M
2990	Derived AJCC-6 M Descript	Derived 6 M Descriptor Storage Code Derived AJCC M Descriptor
3000	Derived AJCC-6 Stage Grp	Derived 6 Stage Group Storage Code Derived AJCC Stage Group
3010	Derived SS1977	Derived SEER Summary Stage 1977
3020	Derived SS2000	Derived SEER Summary Stage 2000
3030	Derived AJCC--Flag	AJCC Conversion Flag
3040	Derived SS1977--Flag	SS1977 Conversion Flag
3050	Derived SS2000--Flag	SS2000 Conversion Flag
3110	Comorbid/Complication 1	Comorbidities and Complications #1 Secondary Diagnoses
3120	Comorbid/Complication 2	Comorbidities and Complications #2 Secondary Diagnoses
3130	Comorbid/Complication 3	Comorbidities and Complications #3 Secondary Diagnoses

Item #	Item Name	Alternate Names
3140	Comorbid/Complication 4	Comorbidities and Complications #4 Secondary Diagnoses
3150	Comorbid/Complication 5	Comorbidities and Complications #5 Secondary Diagnoses
3160	Comorbid/Complication 6	Comorbidities and Complications #6 Secondary Diagnoses
3161	Comorbid/Complication 7	Comorbidities and Complications #7 Secondary Diagnoses
3162	Comorbid/Complication 8	Comorbidities and Complications #8 Secondary Diagnoses
3163	Comorbid/Complication 9	Comorbidities and Complications #9 Secondary Diagnoses
3164	Comorbid/Complication 10	Comorbidities and Complications #10 Secondary Diagnoses
3165	ICD Revision Comorbid	ICD Revision Comorbidities
3170	RX Date--Most Defin Surg	Date of Most Definitive Surgical Resection of the Primary Site
3180	RX Date--Surgical Disch	Date of Surgical Discharge
3190	Readm Same Hosp 30 Days	Readmission to the Same Hospital Within 30 Days of Surgical Discharge
3200	Rad--Boost RX Modality	Boost Radiation Treatment Modality
3210	Rad--Boost Dose cGy	Boost Radiation Dose: cGY
3220	RX Date--Radiation Ended	Date Radiation Ended
3230	RX Date--Systemic	Date Systemic Therapy Started
3250	RX Summ--Transplnt/Endocr	Hematologic Transplant and Endocrine Procedures
3270	RX Summ--Palliative Proc	Palliative Procedure Palliative Care
3280	RX Hosp--Palliative Proc	Palliative Procedure at this Facility Palliative Care at this Facility
3300	RuralUrban Continuum 1993	Beale Code
3310	RuralUrban Continuum 2003	Beale Code RuralUrban Continuum 2000
3400	Derived AJCC-7 T	Derived 7 T Storage Code
3402	Derived AJCC-7 T Descript	Derived 7 N Descript Storage Code
3410	Derived AJCC-7 N	Derived 7 N Storage Code
3412	Derived AJCC-7 N Descript	Derived 7 N Descript Storage Code
3420	Derived AJCC-7 M	Derived 7 M Storage Code
3422	Derived AJCC-7 M Descript	Derived 7 M Descript Storage Code

Item #	Item Name	Alternate Names
3430	Derived AJCC-7 Stage Group	Derived 7 Stage Grp Storage Code
3440	Derived PreRX-7 T	Derived PreRX 7 T Storage Code
3442	Derived PreRX-7 T Descrip	Derived PreRX 7 T Descrip Storage Code
3450	Derived PreRX-7 N	Derived PreRX 7 N Storage Code
3452	Derived PreRX-7 N Descrip	Derived PreRX 7 N Descrip Storage Code
3460	Derived PreRX-7 M	Derived PreRX 7 M Storage Code
3462	Derived PreRX-7 M Descrip	Derived PreRX 7 M Descrip Storage Code
3470	Derived PreRX-7 Stage Grp	Derived PreRX 7 Stge Grp Storage Code
3480	Derived PostRX-7 T	Derived PostRX 7 T Storage Code
3482	Derived PostRX-7 N	Derived PostRX 7 N Storage Code
3490	Derived PostRX-7 M	Derived PostRX 7 M Storage Code
3492	Derived PostRX-7 Stge Grp	Derived PostRX 7 Stge Grp Storage Code
7010	Path Reporting Fac ID 1	MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084
7011	Path Reporting Fac ID 2	MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084
7012	Path Reporting Fac ID 3	MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084
7013	Path Reporting Fac ID 4	MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084
7014	Path Reporting Fac ID 5	MSH-4 Sending Facility (Name) #00004 (HL7) BHS-4 Batch Sending Facility #0084
7090	Path Report Number 1	OBR-3 Filler Order Number #00217 (HL7) Path Report Number
7091	Path Report Number 2	OBR-3 Filler Order Number #00217 (HL7) Path Report Number
7092	Path Report Number 3	OBR-3 Filler Order Number #00217 (HL7) Path Report Number
7093	Path Report Number 4	OBR-3 Filler Order Number #00217 (HL7) Path Report Number
7094	Path Report Number 5	OBR-3 Filler Order Number #00217 (HL7) Path Report Number
7100	Path Order Phys Lic No 1	OBR-16 Ordering Provider (License Number) #00226 Path Ordering Client/Phys--Lic No.
7101	Path Order Phys Lic No 2	OBR-16 Ordering Provider (License Number) #00226 Path Ordering Client/Phys--Lic No.
7102	Path Order Phys Lic No 3	OBR-16 Ordering Provider (License Number) #00226 Path Ordering Client/Phys--Lic No.
7103	Path Order Phys Lic No 4	OBR-16 Ordering Provider (License Number) #00226 Path Ordering Client/Phys--Lic No.

Item #	Item Name	Alternate Names
7190	Path Ordering Fac No 1	ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)
7191	Path Ordering Fac No 2	ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)
7192	Path Ordering Fac No 3	ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)
7193	Path Ordering Fac No 4	ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)
7194	Path Ordering Fac No 5	ORC-21 Ordering Facility Name #01311 (HL7) Path Ordering Facility Number (AHA Number)
7320	Path Date Spec Collect 1	OBR-7 Observation Date/Time #00241 (HL7) Path--Date Spec Collection
7321	Path Date Spec Collect 2	OBR-7 Observation Date/Time #00241 (HL7) Path--Date Spec Collection
7322	Path Date Spec Collect 3	OBR-7 Observation Date/Time #00241 (HL7) Path Date Spec Collect 2
7323	Path Date Spec Collect 4	OBR-7 Observation Date/Time #00241 (HL7) Path--Date Spec Collection
7324	Path Date Spec Collect 5	OBR-7 Observation Date/Time #00241 (HL7) Path Date Spec Collect 4
7480	Path Report Type 1	OBR-4 Universal Service ID #00238 (HL7) Path--Report Type
7481	Path Report Type 2	OBR-4 Universal Service ID #00238 (HL7) Path--Report Type
7482	Path Report Type 3	OBR-4 Universal Service ID #00238 (HL7) Path--Report Type
7483	Path Report Type 4	OBR-4 Universal Service ID #00238 (HL7) Path--Report Type
7484	Path Report Type 5	OBR-4 Universal Service ID #00238 (HL7) Path--Report Type

APPENDIX E:

GROUPED DATA ITEMS

Item Name [Item#]	Length	Column #
Extent of Disease 10-Dig [779]	12	906-917
Subfields:		
EOD--Tumor Size [780]	3	906-908
EOD--Extension [790]	2	909-910
EOD--Extension Prost Path [800]	2	911-912
EOD--Lymph Node Involv [810]	1	913-913
Regional Nodes Positive [820]	2	914-915
Regional Nodes Examined [830]	2	916-917
Morph (73-91) ICD-O-1 [1970]	6	1913-1918
Subfields:		
Histology (73-91) ICD-O-1 [1971]	4	1913-1916
Behavior (73-91) ICD-O-1 [1972]	1	1917-1917
Grade (73-91) ICD-O-1 [1973]	1	1918-1918
Morph--Type&Behav ICD-O-2 [419]	5	545-549
Subfields:		
Histology (92-00) ICD-O-2 [420]	4	545-548
Behavior (92-00) ICD-O-2 [430]	1	549-549
Morph--Type&Behav ICD-O-3 [521]	5	550-554
Subfields:		
Histologic Type ICD-O-3 [522]	4	550-553
Behavior Type ICD-O-3 [523]	1	554-554
Subsq RX 2nd Course Codes [1670]	11	1734-1744
Subsq RX 2nd Course Surg [1671]	2	1734-1735
Subsq RX 2nd--Scope LN SU [1677]	1	1736-1736
Subsq RX 2nd--Surg Oth [1678]	1	1737-1737
Subsq RX 2nd--Reg LN Rem [1679]	2	1738-1739
Subsq RX 2nd Course Rad [1672]	1	1740-1740
Subsq RX 2nd Course Chemo [1673]	1	1741-1741
Subsq RX 2nd Course Horm [1674]	1	1742-1742
Subsq RX 2nd Course BRM [1675]	1	1743-1743
Subsq RX 2nd Course Oth [1676]	1	1744-1744

Item Name [Item#]	Length	Column #
Subsq RX 3rd Course Codes [1690]	11	1755-1765
Subsq RX 3rd Course Surg [1691]	2	1755-1756
Subsq RX 3rd--Scope LN SU [1697]	1	1757-1757
Subsq RX 3rd--Surg Oth [1698]	1	1758-1758
Subsq RX 3rd--Reg LN Rem [1699]	2	1759-1760
Subsq RX 3rd Course Rad [1692]	1	1761-1761
Subsq RX 3rd Course Chemo [1693]	1	1762-1762
Subsq RX 3rd Course Horm [1694]	1	1763-1763
Subsq RX 3rd Course BRM [1695]	1	1764-1764
Subsq RX 3rd Course Oth [1696]	1	1765-1765
Subsq RX 4th Course Codes [1710]	11	1776-1786
Subsq RX 4th Course Surg [1711]	2	1176-1777
Subsq RX 4th--Scope LN Su [1717]	1	1778-1778
Subsq RX 4th--Surg Oth [1718]	1	1789-1789
Subsq RX 4th--Reg LN Rem [1719]	2	1780-1781
Subsq RX 4th Course Rad [1712]	1	1782-1782
Subsq RX 4th Course Chemo [1713]	1	1783-1783
Subsq RX 4th Course Horm [1714]	1	1784-1784
Subsq RX 4th Course BRM [1715]	1	1785-1785
Subsq RX 4th Course Oth [1716]	1	1786-1786

APPENDIX F:

TABLES AND DATA DICTIONARY REVISIONS

Item #	Item Name	Record Layout Note	Required Status Note	Data Descriptor Note	Data Dictionary Description	Data Dictionary Rationale	Data Dictionary Codes
10	Record Type						Revised
50	NAACCR Record Version			Revised		Revised	Revised
135	Census Tract 2010	New	New	New	New	New	New
150	Marital Status at DX			Revised			Revised
170	Race Coding Sys--Current				Revised		
250	Birthplace						Revised
270	Occupation Code--Census						Revised
280	Industry Code--Census						Revised
363	Census Block Group 2010	New	New	New	New	New	New
364	Census Tr Cert 1970/80/90				Revised		Revised
365	Census Tr Certainty 2000				Revised		Revised
366	GIS Coordinate Quality				Revised	Revised	
367	Census Tr Certainty 2010	New	New	New	New	New	New
380	Sequence Number--Central						Revised
440	Grade				Revised		Revised
442	Ambiguous Terminology DX						Revised
443	Date of Conclusive DX				Revised		Revised
444	Mult Tum Rpt as One Prim				Revised		
445	Date of Multiple Tumors						Revised
446	Multiplicity Counter			Revised			Revised
448	Date Conclusive DX Flag					Revised	Revised
449	Grade Path System					Revised	
490	Diagnostic Confirmation				Revised	Revised	Revised
522	Histologic Type ICD-O-3				Revised		Revised
530	Reserved 02	Revised		Revised			
540	Reporting Facility						Revised
560	Sequence Number--Hospital				Revised		
580	Date of 1st Contact				Revised		
581	Date of 1st Contact Flag				Revised		
605	Inpatient Status			Revised			Revised
610	Class of Case				Revised		Revised
668	RX Hosp--Surg App 2010					Revised	Revised
670	RX Hosp--Surg Prim Site					Revised	Revised
672	RX Hosp--Scope Reg LN Sur				Revised	Revised	Revised
674	RX Hosp--Surg Oth Reg/Dis				Revised	Revised	Revised
676	RX Hosp--Reg LN Removed				Revised	Revised	
690	RX Hosp--Radiation			Revised	Revised	Revised	Revised
700	RX Hosp--Chemo				Revised	Revised	Revised
710	RX Hosp--Hormone					Revised	Revised
720	RX Hosp--BRM					Revised	Revised
730	RX Hosp--Other				Revised	Revised	Revised
740	RX Hosp--DX/Stg Proc					Revised	Revised
746	RX Hosp--Surg Site 98-02					Revised	Revised

Item #	Item Name	Record Layout Note	Required Status Note	Data Descriptor Note	Data Dictionary Description	Data Dictionary Rationale	Data Dictionary Codes
747	RX Hosp--Scope Reg 98-02						Revised
748	RX Hosp--Surg Oth 98-02					Revised	Revised
779	Extent of Disease 10-Dig	Group			Revised		
780	EOD--Tumor Size				Revised		
790	EOD--Extension				Revised		
800	EOD--Extension Prost Path				Revised	Revised	
810	EOD--Lymph Node Involv				Revised		
980	TNM Clin Descriptor			Revised			Revised
1182	Lymph-vascular Invasion				Revised	Revised	Revised
1201	RX Date--Surgery Flag						Revised
1310	RX Summ--Surgical Approch					Revised	
1500	First Course Calc Method				Revised		
1520	Rad--No of Treatment Vol				Revised		
1639	RX Summ--Systemic/Sur Seq				Revised		Revised
1650	Reserved 08	Revised		Revised			
1750	Date of Last Contact					Revised	
1791	Follow-up Source Central					Revised	
1842	Follow-Up Contact--City					Revised	
1844	Follow-Up Contact--State					Revised	
1846	Follow-Up Contact--Postal					Revised	
1861	Recurrence Date--1st Flag						Revised
1971	Histology (73-91) ICD-O-1						Revised
2060	Over-ride Ill-define Site					Revised	
2085	Date Case Initiated				Revised	Revised	
2110	Date Case Report Exported				Revised		
2111	Date Case Report Received				Revised	Revised	
2112	Date Case Report Loaded				Revised		
2113	Date Tumor Record Availbl					Revised	Revised
2120	SEER Coding Sys--Current			Revised		Revised	Revised
2130	SEER Coding Sys--Original			Revised		Revised	Revised
2150	CoC Coding Sys--Original						Revised
2220	State/Requestor Items				Revised		
2260	Name--Prefix				Revised		
2270	Name--Suffix				Revised		
2280	Name--Alias				Revised		
2330	Addr at DX--No & Street				Revised	Revised	
2350	Addr Current--No & Street						Revised
2352	Latitude				Revised	Revised	Revised
2354	Longitude				Revised	Revised	Revised
2390	Name--Maiden					Revised	
2392	Follow-Up Contact--No&St				Revised	Revised	
2393	Follow-Up Contact--Suppl					Revised	
2394	Follow-Up Contact--Name					Revised	
2410	Institution Referred From						Revised
2420	Institution Referred To						Revised
2440	Following Registry						Revised
2495	NPI--Physician 3				Revised		
2505	NPI--Physician 4				Revised		

Item #	Item Name	Record Layout Note	Required Status Note	Data Descriptor Note	Data Dictionary Description	Data Dictionary Rationale	Data Dictionary Codes
2730	CS PreRx Tumor Size				Revised	Revised	
2735	CS PreRx Extension				Revised	Revised	
2740	CS PreRx Tum Sz/Ext Eval				Revised	Revised	
2750	CS PreRx Lymph Nodes				Revised	Revised	
2755	CS PreRx Reg Nodes Eval				Revised	Revised	
2760	CS PreRx Mets at DX				Revised	Revised	
2765	CS PreRx Mets Eval				Revised	Revised	
2770	CS PostRx Tumor Size				Revised	Revised	
2775	CS PostRx Extension					Revised	
2780	CS PostRx Lymph Nodes				Revised	Revised	
2785	CS PostRx Mets at DX				Revised	Revised	
2800	CS Tumor Size				Revised	Revised	
2810	CS Extension				Revised	Revised	
2820	CS Tumor Size/Ext Eval				Revised	Revised	
2830	CS Lymph Nodes				Revised	Revised	Revised
2840	CS Lymph Nodes Eval				Revised	Revised	
2850	CS Mets at DX				Revised	Revised	
2851	CS Mets at Dx-Bone				Revised	Revised	
2852	CS Mets at Dx-Brain				Revised	Revised	
2853	CS Mets at Dx-Liver				Revised	Revised	
2854	CS Mets at Dx-Lung				Revised	Revised	
2860	CS Mets Eval				Revised	Revised	
2861	CS Site-Specific Factor 7				Revised	Revised	
2862	CS Site-Specific Factor 8				Revised	Revised	
2863	CS Site-Specific Factor 9				Revised	Revised	
2864	CS Site-Specific Factor10				Revised	Revised	
2865	CS Site-Specific Factor11				Revised	Revised	
2866	CS Site-Specific Factor12				Revised	Revised	
2867	CS Site-Specific Factor13				Revised	Revised	
2868	CS Site-Specific Factor14				Revised	Revised	
2869	CS Site-Specific Factor15				Revised	Revised	
2870	CS Site-Specific Factor16				Revised	Revised	
2871	CS Site-Specific Factor17				Revised	Revised	
2872	CS Site-Specific Factor18				Revised	Revised	
2873	CS Site-Specific Factor19				Revised	Revised	
2874	CS Site-Specific Factor20				Revised	Revised	
2875	CS Site-Specific Factor21				Revised	Revised	
2876	CS Site-Specific Factor22				Revised	Revised	
2877	CS Site-Specific Factor23				Revised	Revised	
2878	CS Site-Specific Factor24				Revised	Revised	
2879	CS Site-Specific Factor25				Revised	Revised	
2880	CS Site-Specific Factor 1				Revised	Revised	
2890	CS Site-Specific Factor 2				Revised	Revised	
2900	CS Site-Specific Factor 3				Revised	Revised	
2910	CS Site-Specific Factor 4				Revised	Revised	
2920	CS Site-Specific Factor 5				Revised	Revised	
2930	CS Site-Specific Factor 6				Revised	Revised	
2935	CS Version Input Original				Revised	Revised	
2936	CS Version Derived				Revised	Revised	

Item #	Item Name	Record Layout Note	Required Status Note	Data Descriptor Note	Data Dictionary Description	Data Dictionary Rationale	Data Dictionary Codes
2937	CS Version Input Current				Revised	Revised	
2940	Derived AJCC-6 T				Revised		
2950	Derived AJCC-6 T Descript				Revised		
2960	Derived AJCC-6 N				Revised		
2970	Derived AJCC-6 N Descript				Revised		
2980	Derived AJCC-6 M				Revised		
2990	Derived AJCC-6 M Descript				Revised		
3000	Derived AJCC-6 Stage Grp				Revised		
3180	RX Date--Surgical Disch				Revised		
3280	RX Hosp--Palliative Proc				Revised	Revised	Revised
3400	Derived AJCC-7 T				Revised	Revised	
3402	Derived AJCC-7 T Descript				Revised	Revised	
3410	Derived AJCC-7 N				Revised	Revised	
3412	Derived AJCC-7 N Descript				Revised	Revised	
3420	Derived AJCC-7 M				Revised	Revised	
3422	Derived AJCC-7 M Descript				Revised	Revised	
3430	Derived AJCC-7 Stage Grp				Revised	Revised	
3440	Derived PreRx-7 T				Revised		
3442	Derived PreRx-7 T Descrip				Revised		
3450	Derived PreRx-7 N				Revised		
3452	Derived PreRx-7 N Descrip				Revised		
3460	Derived PreRx-7 M				Revised		
3462	Derived PreRx-7 M Descrip				Revised		
3470	Derived PreRx-7 Stage Grp					Revised	
3480	Derived PostRx-7 T					Revised	
3482	Derived PostRx-7 N				Revised		
3490	Derived PostRx-7 M				Revised		
3492	Derived PostRx-7 Stge Grp					Revised	
3600	Derived Neoadjuv Rx Flag				Revised		
3702	SEER Site-Specific Fact 2				Revised		
3704	SEER Site-Specific Fact 3				Revised		
3706	SEER Site-Specific Fact 4				Revised		
3708	SEER Site-Specific Fact 5				Revised		
3710	SEER Site-Specific Fact 6				Revised		
3750	Over-ride CS 1	New	New	New	New	New	New
3751	Over-ride CS 2	New	New	New	New	New	New
3752	Over-ride CS 3	New	New	New	New	New	New
3753	Over-ride CS 4	New	New	New	New	New	New
3754	Over-ride CS 5	New	New	New	New	New	New
3755	Over-ride CS 6	New	New	New	New	New	New
3756	Over-ride CS 7	New	New	New	New	New	New
3757	Over-ride CS 8	New	New	New	New	New	New
3758	Over-ride CS 9	New	New	New	New	New	New
3759	Over-ride CS 10	New	New	New	New	New	New
3760	Over-ride CS 11	New	New	New	New	New	New
3761	Over-ride CS 12	New	New	New	New	New	New
3762	Over-ride CS 13	New	New	New	New	New	New
3763	Over-ride CS 14	New	New	New	New	New	New

Item #	Item Name	Record Layout Note	Required Status Note	Data Descriptor Note	Data Dictionary Description	Data Dictionary Rationale	Data Dictionary Codes
3764	Over-ride CS 15	New	New	New	New	New	New
3765	Over-ride CS 16	New	New	New	New	New	New
3766	Over-ride CS 17	New	New	New	New	New	New
3767	Over-ride CS 18	New	New	New	New	New	New
3768	Over-ride CS 19	New	New	New	New	New	New
3769	Over-ride CS 20	New	New	New	New	New	New
7010	Path Reporting Fac ID 1				Revised		
7011	Path Reporting Fac ID 2				Revised		
7012	Path Reporting Fac ID 3				Revised		
7013	Path Reporting Fac ID 4				Revised		
7014	Path Reporting Fac ID 5				Revised		
7100	Path Order Phys Lic No 1				Revised		
7101	Path Order Phys Lic No 2				Revised		
7102	Path Order Phys Lic No 3				Revised		
7103	Path Order Phys Lic No 4				Revised		
7190	Path Ordering Fac No 1				Revised		
7191	Path Ordering Fac No 2				Revised		
7192	Path Ordering Fac No 3				Revised		
7193	Path Ordering Fac No 4				Revised		

APPENDIX G:

RECOMMENDED ABBREVIATIONS FOR ABSTRACTORS

The use of abbreviations in cancer abstraction is becoming more commonplace as the demands on abstractors increase. Abbreviations often are used by cancer abstractors to shorten the written narratives entered into text fields to facilitate the electronic storage and transmission of the information. However, abbreviations can generate confusion, because abbreviations may vary among different institutions and even between different specialties within the same institution. To be useful, an abbreviation must be clearly understood by any individual who encounters it. Consequently, the use of abbreviations is a useful abstracting practice only if universally recognized and understood abbreviations are used.

The NAACCR Recommended Abbreviations Listings were developed for utilization by cancer report abstractors and the agencies to which they submit their data. These lists were compiled to reduce some of the confusion that can result from the use of common and not-so-common abbreviations when abstracting reports of cancer from the medical record. Although the lists may shed some light on abbreviations used in the medical record, please note that these lists are intended to be used as a primary reference by the cancer abstractor, to help abstract necessary information into a limited number of text fields for storage and transmission of cancer information.

The NAACCR Recommended Abbreviations Listings consist of two main lists of almost 500 word/terms and their recommended abbreviations/symbols, as well as a special table delineating context-sensitive abbreviations. The first main listing is ordered by word/term to enable the look-up of a recommended abbreviation for a particular word or term, and the second main listing is ordered by abbreviation/symbol to enable the look-up of the word or term for a particular abbreviation or symbol. The context-sensitive abbreviations list consists of a subset of the abbreviations from the main lists where a different context for the same abbreviation conveys a different meaning (for example, CA may mean calcium or carcinoma/ML may mean milliliter or middle lobe). For these context-sensitive abbreviations, the meaning of the abbreviation should be readily apparent from the context in which it is used.

The listings were compiled from abbreviation lists from SEER Book 3, the NAACCR Pathology Committee, the Veterans Administration, Dr. Jay Piccirillo's comorbid conditions training materials, the Florida Cancer Data System, and the California Cancer Registry. Terms included in the lists are limited to those that are commonly utilized when abstracting cancer information. The listings are not exhaustive, but many of the most commonly used terms were included. Abbreviations for chemotherapy drugs and/or regimens are not included. Please note that although abbreviations are presented in uppercase, either upper- or lowercase may be utilized when entering abbreviations within abstraction software. When abstracting into text fields, the use of abbreviations should be limited to those that appear on these lists whenever practical. Abbreviations and symbols should be used carefully. Any questions or suggestions for new/modified abbreviations may be emailed to either of the current Chairpersons of the NAACCR Registry Operations Committee.

NAACCR RECOMMENDED ABBREVIATION LIST
ORDERED BY WORD/TERM(S)

WORD/TERM(S)	ABBREVIATION/SYMBOL
Abdomen (abdominal)	ABD
Abdominal perineal	AP
Abnormal	ABN
Above	^
Above knee (amputation)	AK(A)
Absent/Absence	ABS
Abstract/Abstracted	ABST
Achilles tendon reflex	ATR
Acid phosphatase	ACID PHOS
Acquired Immune Deficiency Syndrome	AIDS
Activities of daily living	ADL
Acute granulocytic leukemia	AGL
Acute lymphocytic leukemia	ALL
Acute myelogenous leukemia	AML
Acute myocardial infarction	AMI
Acute Respiratory Distress (Disease) Syndrome	ARDS
Acute tubular necrosis	ATN
Acute renal failure	ARF
Adenocarcinoma	ADENOCA
Adenosine triphosphate	ATP
Adjacent	ADJ
Adult-onset Diabetes Mellitus	AODM
Admission/Admit	ADM
Adrenal cortical hormone	ACH
Adrenal cortex	AC
Adrenocorticotrophic hormone	ACTH
Affirmative	AFF
Against medical advice	AMA
AIDS-related condition (complex)	ARC
AIDS-related disease	ARD
Air contrast barium enema	ACBE
Albumin	ALB
Alcohol	ETOH
Alkaline phosphatase	ALK PHOS
Alpha-fetoprotein	AFP
Also known as	AKA
Ambulatory	AMB
Amount	AMT
Amputation	AMP
Amyotrophic lateral sclerosis	ALS
Anal intraepithelial neoplasia, grade III	AIN III
Anaplastic	ANAP

WORD/TERM(S)	ABBREVIATION/SYMBOL
And	&
Angiography/Angiogram	ANGIO
Anterior	ANT
Anteroposterior	AP
Antidiuretic hormone	ADH
Antigen	AG
Aortic stenosis	A-STEN
Appendix	APP
Apparently	APPL'Y
Approximately	APPROX
Arrhythmia	ARRHY
Arterial blood gases	ABG
Arteriosclerotic cardiovascular disease	ASCVD
Arteriosclerotic heart disease	ASHD
Arteriosclerotic Peripheral Vascular Disease	ASPVD
Arteriosclerosis/Arteriosclerotic	AS
Arteriovenous	AV
Arteriovenous malformation	AVM
Artery (ial)	ART
Ascending colon	A-COLON
Aspiration	ASP
Aspirin, Acetylsalicylic acid	ASA
As soon as possible	ASAP
At	@
Atrial fibrillation	A FIB
Atrial flutter	A FLUTTER
Atrial stenosis/insufficiency/incompetence	AI
Atrial premature complexes	APC
Auscultation & percussion	A&P
Autonomic nervous system	ANS
Autopsy	AUT
Autoimmune hemolytic anemia	AIHA
Average	AVG
Axilla(ry)	AX
Bacillus Calmette-Guerin	BCG
Barium	BA
Barium enema	BE
Bartholin's, Urethral & Skene's	BUS
Basal cell carcinoma	BCC
Before noon	AM
Below knee (amputation)	BK(A)
Benign prostatic hypertrophy/hyperplasia	BPH
Bilateral	BIL
Bilateral salpingo-oophorectomy	BSO
Bile duct	BD

WORD/TERM(S)	ABBREVIATION/SYMBOL
Biological response modifier	BRM
Biopsy	BX
Bipolar affective disorder	BAD
Black female	B/F
Black male	B/M
Bladder tumor	BT
Blood pressure	BP
Blood urea nitrogen	BUN
Blood volume	BV
Bone marrow	BM
Bone marrow transplant	BMT
Bowel movement	BM
Brother	BRO
Calcium	CA
Capsule (s)	CAP(S)
Carcinoembryonic antigen	CEA
Carcinoma	CA
Carcinoma *in situ*	CIS
Cardiovascular disease	CVD
CAT/CT scan/Computerized axial tomography	CT
Centimeter	CM
Central nervous system	CNS
Cerebrospinal fluid	CSF
Cerebrovascular accident	CVA
Cervical intraepithelial neoplasia	CIN
Cervical intraepithelial neoplasia, grade III	CIN III
Cervical vertebrae	C1-C7
Cervical spine	C-SPINE
Change	CHG
Chemotherapy	CHEMO
Chest X-ray	CXR
Chronic	CHR
Chronic granulocytic leukemia	CGL
Chronic lymphocytic leukemia	CLL
Chronic myeloid (myelocytic) leukemia	CML
Chronic obstructive lung disease	COLD
Chronic obstructive pulmonary disease	COPD
Chronic renal failure	CRF
Chronic ulcerative colitis	CUC
Cigarettes	CIG
Clear	CLR
Cobalt 60	CO60
Collaborative stage	CS
Colon, Ascending	A-COLON
Colon, Descending	D-COLON

WORD/TERM(S)	ABBREVIATION/SYMBOL
Colon, Sigmoid	SIG COLON
Colon, Transverse	TRANS-COLON
Colony-stimulating factor	C-SF
Complaint (-ning) of	C/O
Complete blood count	CBC
Congenital heart disease	CHD
Congestive heart failure	CHF
Consistent with	C/W
Continue/continuous	CONT
Contralateral	CONTRA
Coronary artery bypass graft	CABG
Coronary artery disease	CAD
Coronary care unit	CCU
Cubic centimeter	CC
Cystoscopy	CYSTO
Cytology	CYTO
Cystic fibrosis	CF
Date of birth	DOB
Date of death	DOD
Dead on arrival	DOA
Decrease(d)	DECR
Deep tendon reflex	DTR
Deep vein thrombosis	DVT
Deoxyribonucleic acid	DNA
Descending colon	D-COLON
Dermatology	DERM
Diabetes mellitus	DM
Diagnosis	DX
Diameter	DIAM
Diethylstilbestrol	DES
Differentiated/differential	DIFF
Digital rectal examination	DRE
Dilatation and curettage	D&C
Discharge	DISCH
Discontinue(d)	DC
Disease	DZ
Disseminated intravascular coagulopathy	DIC
Ductal carcinoma *in situ*	DCIS
Dyspnea on exertion	DOE
Ears, nose, and throat	ENT
Electrocardiogram	ECG/EKG
Electroencephalogram	EEG
Electromyogram	EMG
Emergency room	ER

WORD/TERM(S)	ABBREVIATION/SYMBOL
Endoscopic retrograde cholangiopancreatography	ERCP
End stage renal disease	ESRD
Enlarged	ENLGD
Equal(s)	=
Esophagogastro-duodenoscopy	EGD
Estrogen receptor (assay)	ER, ERA
Evaluation	EVAL
Every	Q
Every day	QD
Examination	EXAM
Excision/excised	EXC(D)
Expired	EXP
Exploratory	EXPL
Exploratory laparotomy	EXPL LAP
Extend/extension	EXT
Fever of unknown origin	FUO
Fine needle aspiration	FNA
Fine needle aspiration biopsy	FNAB
Floor of mouth	FOM
Fluid	FL
Fluoroscopy	FLURO
Follow-up	FU
For example	E.G.
Fracture	FX
Frequent/Frequency	FREQ
Frozen section	FS
Full thickness skin graft	FTSG
Gallbladder	GB
Gastroesophageal	GE
Gastroesophageal reflux disease	GERD
Gastrointestinal	GI
General/Generalized	GEN
Genitourinary	GU
Grade	GR
Greater/Greater than	>
Gynecology	GYN
Hematocrit	HCT
Hemoglobin	HGB
Hepatitis A (virus)	HAV
Hepatitis B (virus)	HBV
Hepatitis C (virus)	HCV
Hepatitis D (virus)	HDV
Hepatosplenomegaly	HSM

WORD/TERM(S)	ABBREVIATION/SYMBOL
History	HX
History and physical	H&P
History of	H/O
Hormone	HORM
Hospital	HOSP
Hour/Hours	HR(S)
Human chorionic gonadotropin	HCG
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymphotrophic Virus, (Type III)	HTLV
Hypertension	HTN
Hypertensive cardiovascular disease	HCVD
Hypertensive vascular disease	HVD
Hysterectomy	HYST
Idiopathic hypertrophic subaortic stenosis	IHSS
Idiopathic thrombocytopenia	ITP
Immunoglobulin	IG
Immunohistochemical	IHC
Impression	IMP
Incision & drainage	I&D
Includes/Including	INCL
Increase(d)	INCR
Inferior	INF
Inferior vena cava	IVC
Infiltrating	INFILT
Inflammatory bowel disease	IBD
Inpatient	IP
Insulin-dependent diabetes mellitus	IDDM
Intensive care unit	ICU
Intercostal margin	ICM
Intercostal space	ICS
Intermittent positive pressure breathing	IPPB
Internal	INT
Interstitial lung disease	ILD
Intramuscular	IM
Intrathecal	IT
Intravenous	IV
Intravenous cholangiogram	IVCA
Intravenous pyelogram	IVP
Invade(s)/invading/invasion	INV
Involve(s)/involvement/involving	INVL
Ipsilateral	IPSI
Irregular	IRREG

WORD/TERM(S)	ABBREVIATION/SYMBOL
Jugular venous distention	JVD
Juvenile rheumatic arthritis	JRA
Kaposi sarcoma	KS
Kidneys, ureters, bladder	KUB
Kilogram	KG
Kilovolt	KV
Laboratory	LAB
Lactic dehydrogenase	LDH
Laparotomy	LAP
Large	LRG
Last menstrual period	LMP
Lateral	LAT
Left	LT
Left bundle branch block	LBBB
Left costal margin	LCM
Left lower extremity	LLE
Left lower lobe	LLL
Left lower quadrant	LLQ
Left salpingo-oophorectomy	LSO
Left upper extremity	LUE
Left upper lobe	LUL
Left upper quadrant	LUQ
Left upper outer quadrant	LUOQ
Less/Less than	<
Licensed practical nurse	LPN
Linear accelerator	LINAC
Liver/spleen scan	LS SCAN
Lower extremity	LE
Lower inner quadrant	LIQ
Lower outer quadrant	LOQ
Lumbar vertebra	L1-L5
Lumbar spine	L-SPINE
Lumbosacral	LS
Lymphadenopathy-associated virus	LAV
Lymph node(s)	LN(S)
Lymph node dissection	LND
Lupus erythematosus	LUP ERYTH
Macrophage colony-stimulating factor	M-CSF
Magnetic resonance imaging	MRI
Magnetic resonance cholangiopancreatography	MRCP
Main stem bronchus	MSB
Malignant	MALIG
Mandible/mandibular	MAND

WORD/TERM(S)	ABBREVIATION/SYMBOL
Maximum	MAX
Medical center	MC
Medication	MED
Metastatic/Metastasis	METS
Methicillin Resistant Staphylococcus Aureus	MRSA
Microgram	MCG
Microscopic	MICRO
Middle lobe	ML
Millicurie (hours)	MC(H)
Milligram (hours)	MG(H)
Milliliter	ML
Millimeter	MM
Million electron volts	MEV
Minimum	MIN
Minus	-
Minute	MIN
Mitral valve prolapse	MVP
Mixed combined immunodeficiency	MCID
Mixed connective tissue disease	MCTD
Moderate (ly)	MOD
Moderately differentiated	MD, MOD DIFF
Modified radical mastectomy	MRM
More/More than	>
Multifocal arterial tachycardia	MAT
Multifocal premature ventricular contraction	MPVC
Multiple	MULT
Multiple sclerosis	MS
Multiple myeloma	MM
Myasthenia gravis	MG
Myocardial infarction	MI
Neck vein distention	NVD
Negative	NEG
Negative	-
Neoplasm	NEOPL
Neurology	NEURO
No evidence of disease	NED
No significant findings	NSF
Non-Hodgkins lymphoma	NHL
Normal	NL
Non small cell carcinoma	NSCCA
Not applicable	NA
Not otherwise specified	NOS
Not recorded	NR
Number	#
Nursing home	NH

WORD/TERM(S)	ABBREVIATION/SYMBOL
Obstetrics	OB
Obstructed (-ing, -ion)	OBST
Operating room	OR
Operative report	OP RPT
Organic brain syndrome	OBS
Orthopedics	ORTHO
Otology	OTO
Ounce	OZ
Outpatient	OP
Packs per day	PPD
Palpated (-able)	PALP
Papanicolaou smear	PAP
Papillary	PAP
Past/personal (medical) history	PMH
Pathology	PATH
Patient	PT
Pediatrics	PEDS
Pelvic inflammatory disease	PID
Peptic ulcer disease	PUD
Percutaneous	PERC
Percutaneous transhepatic cholecystogram	PTC
Peripheral vascular disease	PVD
Prescription	RX
Primary medical physician	PMP
Phosphorus 32	P32
Physical examination	PE
Physiotherapy/Physical therapy	PT
Platelets	PLT
Plus	+
Poorly differentiated	PD, POOR DIFF
Positive	POS
Positive	+
Positron emission tomography	PET
Possible	POSS
Posterior	POST
Postoperative (-ly)	POST OP
Pound(s)	LB(S)
Pound(s)	#
Premature atrial contraction	PAC
Preoperative (-ly)	PRE OP
Previous	PREV
Prior to admission	PTA
Probable (-ly)	PROB
Proctoscopy	PROCTO
Progesterone receptor (assay)	PR, PRA

WORD/TERM(S)	ABBREVIATION/SYMBOL
Prostatic intraepithelial neoplasia, grade III	PIN III
Prostatic specific antigen	PSA
Pulmonary	PULM
Quadrant	QUAD
Radiation absorbed dose	RAD
Radiation therapy	RT
Radioimmunoassay	RIA
Received	REC'D
Red blood cells (count)	RBC
Regarding	RE
Regional medical center	RMC
Regular	REG
Regular sinus rhythm	RSR
Resection (ed)	RESEC
Review of outside films	ROF
Review of outside slides	ROS
Rheumatoid arthritis	RA
Rheumatic heart disease	RHD
Right	RT
Right bundle branch block	RBBB
Right costal margin	RCM
Right inner quadrant	RIQ
Right lower extremity	RLE
Right lower lobe	RLL
Right lower quadrant	RLQ
Right middle lobe	RML
Right outer quadrant	ROQ
Right salpingo-oophorectomy	RSO
Right upper extremity	RUE
Right upper lobe	RUL
Right upper quadrant	RUQ
Rule out	R/O
Sacral spine	S-SPINE
Sacral vertebra	S1-S5
Salpingo-oophorectomy	SO
Satisfactory	SATIS
Serum glutamic oxaloacetic transaminase	SGOT
Serum glutamic pyruvic transaminase	SGPT
Severe combined immunodeficiency syndrome	SCID
Short(ness) of breath	SOB
Sick sinus syndrome	SSS
Sigmoid colon	SIG COLON
Small	SM

WORD/TERM(S)	ABBREVIATION/SYMBOL
Small bowel	SB
Specimen	SPEC
Spine, Cervical	C-SPINE
Spine, Lumbar	L-SPINE
Spine, Sacral	S-SPINE
Spine, Thoracic	T-SPINE
Split thickness skin graft	STSG
Squamous	SQ
Squamous cell carcinoma	SCC
Status post	S/P
Subcutaneous	SUBCU
Summary stage	SS
Superior vena cava	SVC
Surgery/Surgical	SURG
Suspicious/suspected	SUSP
Symptoms	SX
Syndrome of inappropriate ADH	SIADH
Systemic lupus erythematosus	SLE
Thoracic spine	T-SPINE
Thrombotic thrombocytopenia purpura	TTP
Times	X
Total abdominal hysterectomy	TAH
Total abdominal hysterectomy- bilateral salpingo-oophorectomy	TAH-BSO
Total vaginal hysterectomy	TVH
Transient ischemic attack	TIA
Transitional cell carcinoma	TCC
Transurethral resection	TUR
Transurethral resection bladder	TURB
Transurethral resection prostate	TURP
Transverse colon	TRANS-COLON
Treatment	TX
True vocal cord	TVC
Tuberculosis	TB
Twice a day (daily)	BID
Ultrasound	US
Undifferentiated	UNDIFF
Unknown	UNK
Upper extremity	UE
Upper gastrointestinal (series)	UGI
Upper inner quadrant	UIQ
Upper outer quadrant	UOQ
Upper respiratory infection	URI
Urinary tract infection	UTI

WORD/TERM(S)	ABBREVIATION/SYMBOL
Vagina/Vaginal	VAG
Vaginal hysterectomy	VAG HYST
Vaginal intraepithelial neoplasia (grade III)	VAIN III
Vulvar intraepithelial neoplasia (grade III)	VIN III
Well differentiated	WD, WELL DIFF
White blood cells (count)	WBC
White female	W/F
White male	W/M
With	W/
Within normal limits	WNL
Without	W/O
Wolff-Parkinson-White syndrome	WPW
Work-up	W/U
Xray	XR
Year	YR

NAACCR RECOMMENDED ABBREVIATION LIST
ORDERED BY ABBREVIATION/SYMBOL

ABBREVIATION/SYMBOL	WORD/TERM(S)
^	above
@	at
&	and
<	less, less than
=	equals
>	greater than, more, more than
-	negative, minus
#	number, pound(s)
+	plus, positive
X	times
A-COLON	Ascending colon
A FIB	Atrial fibrillation
A FLUTTER	Atrial flutter
A-STEN	Aortic stenosis
A&P	Auscultation & percussion
ABD	Abdomen (abdominal)
ABG	Arterial blood gases
ABN	Abnormal
ABS	Absent/Absence
ABST	Abstract/Abstracted
AC	Adrenal cortex
ACBE	Air contrast barium enema
ACH	Adrenal cortical hormone
ACID PHOS	Acid phosphatase
ACTH	Adrenocorticotrophic hormone
ADENOCA	Adenocarcinoma
ADH	Antidiuretic hormone
ADJ	Adjacent
ADL	Activities of daily living
ADM	Admission/Admit
AFF	Affirmative
AFP	Alpha-fetoprotein
AG	Antigen
AGL	Acute granulocytic leukemia
AI	Atrial stenosis/insufficiency/incompetence
AIDS	Acquired Immune Deficiency Syndrome
AIHA	Autoimmune hemolytic anemia
AIN III	Anal intraepithelial neoplasia, grade III
AK(A)	Above knee (amputation)
AKA	Also known as
ALB	Albumin
ALK PHOS	Alkaline phosphatase

ABBREVIATION/SYMBOL	WORD/TERM(S)
ALL	Acute lymphocytic leukemia
ALS	Amyotrophic lateral sclerosis
AM	Before noon
AMA	Against medical advice
AMB	Ambulatory
AMI	Acute myocardial infarction
AML	Acute myelogenous leukemia
AMP	Amputation
AMT	Amount
ANAP	Anaplastic
ANGIO	Angiography/Angiogram
ANS	Autonomic nervous system
ANT	Anterior
AODM	Adult-onset Diabetes Mellitus
AP	Abdominal perineal
AP	Anteroposterior
APC	Atrial premature complexes
APP	Appendix
APPL'Y	Apparently
APPROX	Approximately
ARC	AIDS-related condition (complex)
ARD	AIDS-related disease
ARDS	Acute Respiratory Distress (Disease) Syndrome
ARF	Acute renal failure
ARRHY	Arrhythmia
ART	Artery (ial)
AS	Arteriosclerosis/Arteriosclerotic
ASA	Aspirin, Acetylsalicylic acid
ASAP	As soon as possible
ASCVD	Arteriosclerotic cardiovascular disease
ASHD	Arteriosclerotic heart disease
ASP	Aspiration
ASPVD	Arteriosclerotic Peripheral Vascular Disease
ATN	Acute tubular necrosis
ATP	Adenosine triphosphate
ATR	Achilles tendon reflex
AUT	Autopsy
AV	Arteriovenous
AVG	Average
AVM	Arteriovenous malformation
AX	Axilla(ry)
B/F	Black female
B/M	Black male
BA	Barium
BAD	Bipolar affective disorder

ABBREVIATION/SYMBOL	WORD/TERM(S)
BCC	Basal cell carcinoma
BCG	Bacillus Calmette-Guerin
BD	Bile duct
BE	Barium enema
BID	Twice a day (daily)
BIL	Bilateral
BK(A)	Below knee (amputation)
BM	Bone marrow
BM	Bowel movement
BMT	Bone marrow transplant
BP	Blood pressure
BPH	Benign prostatic hypertrophy/hyperplasia
BRM	Biological response modifier
BRO	Brother
BSO	Bilateral salpingo-oophorectomy
BT	Bladder tumor
BUN	Blood urea nitrogen
BUS	Bartholin's, Urethral & Skene's
BV	Blood volume
BX	Biopsy
C/O	Complaint (-ning) of
C/W	Consistent with
C1-C7	Cervical vertebrae
CA	Calcium
CA	Carcinoma
CABG	Coronary artery bypass graft
CAD	Coronary artery disease
CAP(S)	Capsule (s)
CBC	Complete blood count
CC	Cubic centimeter
CCU	Coronary care unit
CEA	Carcinoembryonic antigen
CF	Cystic fibrosis
CGL	Chronic granulocytic leukemia
CHD	Congenital heart disease
CHEMO	Chemotherapy
CHF	Congestive heart failure
CHG	Change
CHR	Chronic
CIG	Cigarettes
CIN	Cervical intraepithelial neoplasia
CIN III	Cervical intraepithelial neoplasia, grade III
CIS	Carcinoma *in situ*
CLL	Chronic lymphocytic leukemia
CLR	Clear

ABBREVIATION/SYMBOL	WORD/TERM(S)
CM	Centimeter
CML	Chronic myeloid (myelocytic) leukemia
CNS	Central nervous system
CO60	Cobalt 60
COLD	Chronic obstructive lung disease
CONT	Continue/continuous
CONTRA	Contralateral
COPD	Chronic obstructive pulmonary disease
CRF	Chronic renal failure
CS	Collaborative stage
CSF	Cerebrospinal fluid
C-SF	Colony stimulating factor
C-SPINE	Cervical spine
CT	CAT/CT scan/Computerized axial tomography
CUC	Chronic ulcerative colitis
CVA	Cerebrovascular accident
CVD	Cardiovascular disease
CXR	Chest X-ray
CYSTO	Cystoscopy
CYTO	Cytology
D-COLON	Descending colon
D&C	Dilatation and curettage
DC	Discontinue(d)
DCIS	Ductal carcinoma *in situ*
DECR	Decrease(d)
DERM	Dermatology
DES	Diethylstilbestrol
DIAM	Diameter
DIC	Disseminated intravascular coagulopathy
DIFF	Differentiated/differential
DISCH	Discharge
DM	Diabetes mellitus
DNA	Deoxyribonucleic acid
DOA	Dead on arrival
DOB	Date of birth
DOD	Date of death
DOE	Dyspnea on exertion
DRE	Digital rectal examination
DTR	Deep tendon reflex
DVT	Deep vein thrombosis
DX	Diagnosis
DZ	Disease
E.G.	For example
ECG/EKG	Electrocardiogram
EEG	Electroencephalogram

ABBREVIATION/SYMBOL	WORD/TERM(S)
EGD	Esophagogastro-duodenoscopy
EMG	Electromyogram
ENLGD	Enlarged
ENT	Ears, nose, and throat
ER	Emergency room
ER, ERA	Estrogen receptor (assay)
ERCP	Endoscopic retrograde cholangiopancreatography
ESRD	End stage renal disease
ETOH	Alcohol
EVAL	Evaluation
EXAM	Examination
EXC(D)	Excision/excised
EXP	Expired
EXPL	Exploratory
EXPL LAP	Exploratory laparotomy
EXT	Extend/extension
FL	Fluid
FLURO	Fluoroscopy
FNA	Fine needle aspiration
FNAB	Fine needle aspiration biopsy
FOM	Floor of mouth
FREQ	Frequent/Frequency
FS	Frozen section
FTSG	Full thickness skin graft
FU	Follow-up
FUO	Fever of unknown origin
FX	Fracture
GB	Gallbladder
GE	Gastroesophageal
GEN	General/Generalized
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GR	Grade
GU	Genitourinary
GYN	Gynecology
H&P	History and physical
H/O	History of
HAV	Hepatitis A (virus)
HBV	Hepatitis B (virus)
HCG	Human chorionic gonadotropin
HCT	Hematocrit
HCV	Hepatitis C (virus)
HCVD	Hypertensive cardiovascular disease

ABBREVIATION/SYMBOL	WORD/TERM(S)
HDV	Hepatitis D (virus)
HGB	Hemoglobin
HIV	Human Immunodeficiency Virus
HORM	Hormone
HOSP	Hospital
HPV	Human Papilloma Virus
HR(S)	Hour/Hours
HSM	Hepatosplenomegaly
HTLV	Human T-Lymphotrophic Virus, (Type III)
HTN	Hypertension
HVD	Hypertensive vascular disease
HX	History
HYST	Hysterectomy
I&D	Incision & drainage
IBD	Inflammatory bowel disease
ICM	Intercostal margin
ICS	Intercostal space
ICU	Intensive care unit
IDDM	Insulin-dependent diabetes mellitus
IG	Immunoglobulin
IHC	Immunohistochemical
IHSS	Idiopathic hypertrophic subaortic stenosis
ILD	Interstitial lung disease
IM	Intramuscular
IMP	Impression
INCL	Includes/Including
INCR	Increase(d)
INF	Inferior
INFILT	Infiltrating
INT	Internal
INV	Invade(s)/invading/invasion
INVL	Involve(s)/involvement/involving
IP	Inpatient
IPPB	Intermittent positive pressure breathing
IPSI	Ipsilateral
IRREG	Irregular
IT	Intrathecal
ITP	Idiopathic thrombocytopenia
IV	Intravenous
IVC	Inferior vena cava
IVCA	Intravenous cholangiogram
IVP	Intravenous pyelogram
JRA	Juvenile rheumatic arthritis
JVD	Jugular venous distention

ABBREVIATION/SYMBOL	WORD/TERM(S)
KG	Kilogram
KS	Kaposi sarcoma
KUB	Kidneys, ureters, bladder
KV	Kilovolt
L-SPINE	Lumbar spine
L1-L5	Lumbar vertebra
LAB	laboratory
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-associated virus
LB	Pound
LBBB	Left bundle branch block
LCM	Left costal margin
LDH	Lactic dehydrogenase
LE	Lower extremity
LINAC	Linear accelerator
LIQ	Lower inner quadrant
LLE	Left lower extremity
LLL	Left lower lobe
LLQ	Left lower quadrant
LMP	Last menstrual period
LN(S)	Lymph node(s)
LND	Lymph node dissection
LOQ	Lower outer quadrant
LPN	Licensed practical nurse
LRG	Large
LS	Lumbosacral
LS SCAN	Liver/spleen scan
LSO	Left salpingo-oophorectomy
LT	Left
LUE	Left upper extremity
LUL	Left upper lobe
LUOQ	Left upper outer quadrant
LUP ERYTH	Lupus erythematosus
LUQ	Left upper quadrant
M-CSF	Macrophage colony-stimulating factor
MALIG	Malignant
MAND	Mandible/mandibular
MAT	Multifocal arterial tachycardia
MAX	Maximum
MC	Medical center
MC(H)	Millicurie (hours)
MCG	Microgram
MCID	Mixed combined immunodeficiency

ABBREVIATION/SYMBOL	WORD/TERM(S)
MCTD	Mixed connective tissue disease
MD	Moderately differentiated
MED	Medication
METS	Metastatic/Metastasis
MEV	Million electron volts
MG	Myasthenia gravis
MG(H)	Milligram (hours)
MI	Myocardial infarction
MICRO	Microscopic
MIN	Minimum
MIN	Minute
ML	Middle lobe
ML	Milliliter
MM	Millimeter
MM	Multiple myeloma
MOD	Moderate (ly)
MOD DIFF	Moderately differentiated
MPVC	Multifocal premature ventricular contraction
MRCP	Magnetic resonance cholangiopancreatography
MRI	Magnetic resonance imaging
MRM	Modified radical mastectomy
MRSA	Methicillin Resistant Staphylococcus Aureus
MS	Multiple sclerosis
MSB	Main stem bronchus
MULT	Multiple
MVP	Mitral valve prolapse
NA	Not applicable
NED	No evidence of disease
NEG	Negative
NEOPL	Neoplasm
NEURO	Neurology
NH	Nursing home
NHL	Non-Hodgkins lymphoma
NL	Normal
NOS	Not otherwise specified
NR	Not recorded
NSCCA	Non small cell carcinoma
NSF	No significant findings
NVD	Neck vein distention
OB	Obstetrics
OBS	Organic brain syndrome
OBST	Obstructed (-ing, -ion)
OP	Outpatient
OP RPT	Operative report

ABBREVIATION/SYMBOL	WORD/TERM(S)
OR	Operating room
ORTHO	Orthopedics
OTO	Otology
OZ	Ounce
P32	Phosphorus 32
PAC	Premature atrial contraction
PALP	Palpated (-able)
PAP	Papanicolaou smear
PAP	Papillary
PATH	Pathology
PD	Poorly differentiated
PE	Physical examination
PEDS	Pediatrics
PERC	Percutaneous
PET	Positron emission tomography
PID	Pelvic inflammatory disease
PIN III	Prostatic intraepithelial neoplasia, grade III
PLT	Platelets
PMH	Past/personal (medical) history
PMP	Primary medical physician
POOR DIFF	Poorly differentiated
POS	Positive
POSS	Possible
POST	Posterior
POST OP	Postoperative (-ly)
PPD	Packs per day
PR, PRA	Progesterone receptor (assay)
PRE OP	Preoperative (-ly)
PREV	Previous
PROB	Probable (-ly)
PROCTO	Proctoscopy
PSA	Prostatic specific antigen
PT	Patient
PT	Physiotherapy/Physical therapy
PTA	Prior to admission
PTC	Percutaneous transhepatic cholecystogram
PUD	Peptic ulcer disease
PULM	Pulmonary
PVD	Peripheral vascular disease
Q	Every
QD	Every day
QUAD	Quadrant
R/O	Rule out
RA	Rheumatoid arthritis

ABBREVIATION/SYMBOL	WORD/TERM(S)
RAD	Radiation absorbed dose
RBBB	Right bundle branch block
RBC	Red blood cells (count)
RCM	Right costal margin
RE	Regarding
REC'D	Received
REG	Regular
RESEC	Resection (ed)
RHD	Rheumatic heart disease
RIA	Radioimmunoassay
RIQ	Right inner quadrant
RLE	Right lower extremity
RLL	Right lower lobe
RLQ	Right lower quadrant
RMC	Regional medical center
RML	Right middle lobe
ROF	Review of outside films
ROQ	Right outer quadrant
ROS	Review of outside slides
RSO	Right salpingo-oophorectomy
RSR	Regular sinus rhythm
RT	Radiation therapy
RT	Right
RUE	Right upper extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
RX	Prescription
S/P	Status post
S1-S5	Sacral vertebra
S-SPINE	Sacral spine
SATIS	Satisfactory
SB	Small bowel
SCC	Squamous cell carcinoma
SCID	Severe combined immunodeficiency syndrome
SGOT	Serum glutamic oxaloacetic transaminase
SGPT	Serum glutamic pyruvic transaminase
SIADH	Syndrome of inappropriate ADH
SIG COLON	Sigmoid colon
SLE	Systemic lupus erythematosus
SM	Small
SO	Salpingo-oophorectomy
SOB	Short(ness) of breath
SPEC	Specimen
SQ	Squamous
SS	Summary stage

ABBREVIATION/SYMBOL	WORD/TERM(S)
SSS	Sick sinus syndrome
STSG	Split thickness skin graft
SUBCU	Subcutaneous
SURG	Surgery/Surgical
SUSP	Suspicious/suspected
SVC	Superior vena cava
SX	Symptoms
T-SPINE	Thoracic spine
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy- bilateral
TB	Tuberculosis
TCC	Transitional cell carcinoma
TIA	Transient ischemic attack
TRANS-COLON	Transverse colon
TTP	Thromboticthrombocytopenia purpura
TUR	Transurethral resection
TURB	Transurethral resection bladder
TURP	Transurethral resection prostate
TVC	True vocal cord
TVH	Total vaginal hysterectomy
TX	Treatment
UE	Upper extremity
UGI	Upper gastrointestinal (series)
UIQ	Upper inner quadrant
UNDIFF	Undifferentiated
UNK	Unknown
UOQ	Upper outer quadrant
URI	Upper respiratory infection
US	Ultrasound
UTI	Urinary tract infection
VAG	Vagina/Vaginal
VAG HYST	Vaginal hysterectomy
VAIN III	Vaginal intraepithelial neoplasia (grade III)
VIN III	Vulvar intraepithelial neoplasia (grade III)
W/	With
W/F	White female
W/M	White male
W/O	Without
W/U	Work-up
WBC	White blood cells (count)
WD	Well differentiated
WELL DIFF	Well differentiated

ABBREVIATION/SYMBOL	WORD/TERM(S)
WNL	Within normal limits
WPW	Wolff-Parkinson-White syndrome
XR	Xray
YR	Year

NAACCR RECOMMENDED ABBREVIATION LIST
CONTEXT-SENSITIVE ABBREVIATIONS

ABBREVIATION/SYMBOL	WORD/TERM(S)
AP	Anteroposterior
AP	Abdominal perineal
BM	Bone marrow
BM	Bowel movement
CA	Calcium
CA	Carcinoma
MIN	Minimum
MIN	Minute
ML	Milliliter
ML	Middle lobe
MM	Millimeter
MM	Multiple myeloma
PAP	Papillary
PAP	Papanicolaou smear
PT	Patient
PT	Physiotherapy/Physical therapy
RT	Right
RT	Radiation therapy

APPENDIX H:

HL7 FLAVORS OF NULL TABLE

Definition: If a value is an exceptional value (NULL-value), this specifies in what way and why proper information is missing.

NAACCR Code	HL7 Code	Name	Definition
10	NI	no information	No information whatsoever can be inferred from this exceptional value. This is the most general exceptional value. It is also the default exceptional value. It is unknown whether this event occurred (e.g., radiation treatment).
11	NA	not applicable	No proper value is applicable in this context (e.g., last menstrual period for a male).
12	UNK	unknown	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., birth date).
13	NASK	not asked	This information has not been sought (i.e., patient was not asked).
14	ASKU	asked but unknown	Information was sought but not found (i.e., patient was asked but did not know).
15	NAV	temporarily unavailable	Information is not available at this time, but it is expected that it will be available later.
16	OTH*	other*	The actual value is not an element in the value domain of a variable (e.g., concept not provided by required code system).
17	PINF	positive infinity	Positive infinity of numbers.
18	NINF	negative infinity	Negative infinity of numbers.
19	MSK	masked	Information on this item is available, but it has not been provided by the sender due to security, privacy, or other reasons. An alternate mechanism for gaining access to this information may be available. Note: Using this null flavor does provide information that may be a breach of confidentiality. Its primary purpose is for those circumstances where it is necessary to inform the receiver that the information does exist.
20	NP	not present	Value is not present in a message. This is only defined in messages, never in application data! All values not present in the message must be replaced by the applicable default or No-Information (NI) as the default of all defaults.

The null flavors are a general domain extension of all normal data types. Note the distinction between value domain of any data type and the vocabulary domain of coded data types. A vocabulary domain is a value domain for coded values, but not all value domains are vocabulary domains.

* The null flavor Other is used whenever the actual value is not in the required value domain. This may be, for example, when the value exceeds some constraints that are defined too restrictively (e.g., age < 100 years).

Note: Null flavors are applicable to any property of a data value or a higher-level object attribute. Where the difference of null flavors is not significant, ITs are not required to represent them. If nothing else is noted in this specification, ITs need not represent general NULL flavors for data-value property.

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