North American Association of Central Cancer Registries

Standards for Cancer Registries Volume II

Data Standards and Data Dictionary

Twelfth Edition
Record Layout Version 11.2

Edited By
Jim Hofferkamp, CTR
Lori A Havener, CTR

April 2007

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Edited By
Jim Hofferkamp, CTR
NAACCR, Inc.

Lori A Havener, CTR
Program Manager of Standards, NAACCR, Inc.

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, and Management of Data***

Intended for central registries, this provides detailed standards for many aspects of the operation of a population-based cancer registry.

- **Volume IV, *Standard Data Edits***

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- **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. For additional paper copies, write to the NAACCR Executive Office at: 2121 W. White Oaks Drive, Suite B, Springfield, IL, 62704-6495.

Suggested citation

Hofferkamp J, Havener L, editors, Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Twelfth Edition, Version 11.2. Springfield, IL: North American Association of Central Cancer Registries, April 2007.

Acknowledgment

We are very grateful to the NAACCR Volume II subcommittee of the Uniform Data Standards Committee for their dedication and many hours to prepare this document.

This project has been funded in part with Federal funds from the National Cancer Institute, National Institutes of Health, Department of Health & Human Services under Contract No. HHSN26120044401C and ADB No. N02-PC-44401. Production and distribution of this Volume was provided in part by Cooperative Agreement Number U75/CCU523346 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC. The NAACCR Board of Directors adopted these standards in April 2007.

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NAACCR BOARD OF DIRECTORS
2006-2007

President:
Betsy A. Kohler, MPH, CTR 2005-07
New Jersey State Cancer Registry
Cancer Epidemiology Services
New Jersey Department of Health & Senior Services
Telephone: (609) 588-3500
E-mail: betsy.kohler@doh.state.nj.us

President Elect:
Susan T. Gershman, MS, MPH, PhD, CTR 2006-07
Massachusetts Cancer Registry
Department of Public Health
Telephone: (617) 624-5646
E-mail: susan.gershman@state.ma.us

Treasurer:
Lilia C. O'Connor, MBA, RHIT, CTR 2003-07
California Cancer Registry
California Department of Health Services
Telephone: (916) 779-0355
E-mail: lilia@ccr.ca.gov

Executive Director:
Holly L Howe, PhD
NAACCR, Inc.
Telephone: (217) 698-0800 ext 2
E-mail: hhowe@naaccr.org

Representative, Sponsoring Member Organization:
Elizabeth Ward, PhD 2006-08
American Cancer Society
Telephone: (404) 327-6552
E-mail: eward@cancer.org

Members at Large:
Susan Bolick-Aldrich, MSPH, CTR 2005-07
South Carolina Central Cancer Registry
Public Health Statistics & Information Services
South Carolina Department of Health & Environmental Control
Telephone: (803) 898-3626
E-mail: bolicks@dhec.sc.gov

Mignon Dryden, CTR 2006-08
Cancer Registry of Northern California
Telephone: (530) 345-2483
E-mail: mdryden@healthcollaborative.org

Eric S. Holowaty, MD, FRCPC, MSc 2005-07
Ontario Cancer Registry
Cancer Care Ontario
Telephone: (416) 971-9800
E-mail: eric.holowaty@cancercare.on.ca

Karen Knight, MS 2006-08
North Carolina Central Cancer Registry
Telephone: (919) 715-4556
E-mail: karen.knight@ncmail.net

Maureen MacIntyre, BSN, MHSA 2006-08
Surveillence and Epidmiology Unit
Cancer Care Nova Scotia
Telephone: (902) 473-6084
E-mail: maureen.macintyre@ccns.nshealth.ca

Frances E. Ross, CTR 2005-07
Kentucky Cancer Registry
Telephone: (859) 219-0773
E-mail: fer@kcr.uky.edu

UNIFORM DATA STANDARDS COMMITTEE
2006-2007

Andrew Stewart, MA Chair*
American College of Surgeons
Commission on Cancer
Telephone: (312) 202-5285
E-mail: astewart@facs.org

Jim Hofferkamp, CTR
NAACCR Staff
NAACCR, Inc
Phone (217)698-0800 x 5
E-mail jhofferkamp@naaccr.org

Sally Bushhouse, DVM, PhD*
Minnesota Cancer Surveillance System
Minnesota Department of Health
Telephone: (651) 201-5374
E-mail:
sally.bushhouse@state.mn.us

Susan Capron *
Telephone: (773) 278-6207
E-mail: scapron@mindspring.com

Dianne Cleveland, RHIA, CTR*
Onco, Inc.
Telephone: (817) 497-3209
E-mail: dcleveland@oncolog.com

Susan T. Gershman, MS, MPH, PhD, CTR
Massachusetts Cancer Registry
Telephone: (617) 624-5646
Email: susan.gershman@state.ma.us

Barry Gordon, PhD*
C/NET Solutions
Telephone: (510) 540-0778
E-mail: barryg@askcnet.org

Maria Halama, MD, CTR*
New Jersey State Cancer Registry
Telephone: (609) 588-3500
E-mail: maria.halama@doh.state.nj.us

Elaine Hamlyn, CTR, CCHRA(A)*
Canadian Council of Cancer Registries
Telephone: (709) 364-9229
Email: hamlyn@nl.rogers.com

Megsys Casuso Herna, CTR*
Florida Cancer Data System
University of Miami School of Medicine
Telephone: (305) 243-2625
E-mail: MHerna@med.miami.edu

Dianne Hultstrom, RHIT, CTR*
IMPAC Medical Systems, Inc.
Telephone: (978) 897-5330
E-mail: dhultstrom@impac.com

Amy Kahn, MS, CTR*
New York State Cancer Registry
Telephone: (518) 474-2255
E-mail: ark02@health.state.ny.us

Gary Levin, CTR
Florida Cancer Data System
Telephone: (305 243-4600
Fax: (305) 243-4871
E-mail: glevin@med.miami.edu

Mary Lewis, CTR*
Center for Disease Control & Prevention
Phone (770) 488-4827
Fax (770) 488-4759
E-mail: bkf5@cdc.gov

Maureen MacIntyre, BSN, MHSA*
Cancer Care Nova Scotia
Telephone: (902) 473-6084
Email:
maureen.macintyre@ccns.nshealth.ca

David O'Brien, PhD*
Alaska Cancer Registry
Section of Epidemiology, Department of Health
Telephone: (907) 269-8047
E-mail: david_obrien@health.state.ak.us

Lynn Ries, MS*
Cancer Statistics Branch
Surveillance Epidemiology and End Results Program
Division of Cancer Control and Population Sciences
National Cancer Institute
National Institutes of Health
Telephone: (301) 402-5259
E-mail: lr44c@nih.gov

Cathy Rimmer, CTR*
NCRA Liason
Forsyth Medical Center
Phone: (336) 718-8462
Fax: (301) 496-9949
E-mail ccrimmer@novanthealth

Nancy Schlag, BS, CTR*
California Cancer Registry
Telephone: (916) 779-0310
E-mail: nschlag@ccr.ca.gov

Jan Snodgrass, CTR*
Illinois State Cancer Registry
Telephone: (217) 785-7132
E-mail: jan.snodgrass@illinois.gov

*Voting Member

VOLUME II SUBCOMMITTEE
2006-2007

Andrew Stewart, MA, Chair
American College of Surgeons
Telephone: (312) 202-5285
E-mail: astewart@facs.org

Jim Hofferkamp, CTR
NAACCR, Inc
Telephone: (217) 698-0800 ext 5
E-mail: jhofferkamp@naaccr.org

Peggy Adamo, RHIT, CTR
National Cancer Institute
Phone: (301) 435-4971
E-mail: adamom@mail.nih.gov

Patricia Andrews, MPH, CTR
Louisiana Tumor Registry
Telephone: (504) 568-4795
E-mail: pandre@lsuhsc.edu

Sally Bushhouse, DVM, PhD
Minnesota Cancer Surveillance System
Minnesota Department of Health
Telephone: (651) 201-5374
E-mail: sally.bushhouse@state.mn.us

Gayle Clutter, CTR
CDC/NPCR
Telephone: (770) 488-4570
E-mail: gcc6@cdc.gov

Elaine Hamlyn, CTR, CCHRA (A)
Canadian Council of Cancer Registries
Telephone: (709) 364-9229
Email: hamlyn@nl.rogers.com

Coreen Hildebrand, CTR, HIT
Manitoba Cancer Registry
Telephone: (204) 787-2103
E-mail: coreen.hildebrand@cancercare.mb.ca

Dianne Hultstrom, RHIT, CTR
IMPAC Medical Systems, Inc.
Telephone: (978) 897-5330
E-mail: dhultstrom@impac.com

Amy Kahn, MS, CTR
New York State Cancer Registry
Telephone: (518) 474-2255
E-mail: ark02@health.state.ny.us

David O'Brien, PhD
Alaska Cancer Registry
EPI-Cancer
Division of Public Health
Department of Health and Social Services
Telephone: (907) 269-8047
E-mail: david_obrien@health.state.ak.us

Judy Paradies, CTR
Nebraska Cancer Registry
Health and Human Services
Telephone: (402) 354-3393
E-mail: judy.paradies@nmhs.org

Jerri Linn Phillips, MA, CTR
American College of Surgeons
National Cancer Data Base
Telephone: (312) 202-5514
E-mail: jphillips@facs.org

Lynn Ries, MS
Cancer Statistics Branch
Surveillance Epidemiology and End Results Program
Division of Cancer Control and Population Sciences
National Cancer Institute
National Institutes of Health
Telephone: (301) 402-5259
E-mail: lr44c@nih.gov

Sue Vest, CTR
Missouri Cancer Registry
Missouri Department of Health
Telephone: (573) 884-9655
E-mail: vests@health.missouri.edu

STANDARD SETTING ORGANIZATIONS

American College of Surgeons (ACoS**)**
633 N. Saint Clair Street
Chicago, IL 60611-3211
Telephone: (312) 202-5000
Fax: (312) 202-5001
E-mail: postmaster@facs.org
Website: www.facs.org

American Joint Committee on Cancer (AJCC)
633 N. Saint Clair Street
Chicago, IL 60611-3211
Telephone: (312) 202-5290
E-mail: sburkhardt@facs.org
Website: cancerstaging.org

Centers for Disease Control and Prevention (CDC)
National Program of Cancer Registries (NPCR)
Division of Cancer Prevention and Control
National Center for Chronic Disease
Prevention and Health Promotion
4770 Buford Hwy, NE
MS K53
Atlanta, GA 30341-3717
Telephone: (770) 488-4783
Fax: (770) 488-4759
Website: www.cdc.gov/cancer/npcr

Canadian Council of Cancer Registries
c/o Statistics Canada
Canadian Cancer Registry
Health Statistics Section
Health Statistics Division
Main Building, Room 2200, Section F
120 Parkdale Avenue
Ottawa, ON K1A 0T6
Telephone: (613) 951-1630
Fax: (613) 951-0792
Website: www.statcan.ca

Commission on Cancer (CoC)
633 N. Saint Clair Street
Chicago, IL 60611-3211
Telephone: (312) 202-5085
E-mail: CoC@facs.org
Website: www.facs.org

National Cancer Institute SEER Program
Cancer Surveillance Research Program
Division of Cancer Control and Population Sciences
6116 Executive Blvd. - MSC 8316
Suite 504
Bethesda, MD 20892-8316
Telephone: (301) 496-8510
Fax: (301) 496-9949
E-mail: cancer.gov_staff@mail.nih.gov
Website: www.seer.cancer.gov

National Cancer Registrars Association (NCRA**)**
1340 Braddock Place #203
Alexandria, VA 22314
Telephone: (703) 299-6640
Fax: (703) 299-6620
E-mail: info@ncra-usa.org
Website: www.ncra-usa.org

North American Association of
Central Cancer Registries, Inc. (NAACCR)
2121 West White Oaks Drive
Springfield, IL 62704-6495
Telephone: (217) 698-0800
Fax: (217) 698-0188
E-mail: info@naaccr.org
Website: www.naaccr.org

PREFACE TO THE TWELFTH EDITION

NAACCR continues its strong commitment to all its members in North America to maintain standardization of cancer registry data, as evidenced in the publication of the Twelfth Edition of NAACCR Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary*. Standardization of cancer registry data is a core component of cancer registration and surveillance and provides the foundation for developing comparable data among registries that can then be combined for the compilation of national or regional rates. Standardization also allows data from different registries to be used for comparison of variations in cancer rates among different populations and across geographic boundaries.

I believe that these revisions will assist our members in achieving the NAACCR mission, namely, providing current, high-quality, and useful data for the cancer surveillance community and cancer control researchers with the ultimate goal of reducing cancer morbidity and mortality in North America.

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

NAACCR and the Canadian Council of Cancer Registries (CCCR) have been working in a collaborative effort to resolve discrepancies among standards. Through this collaborative effort the CCCR requirements and recommendations for collection of data items are included in Chapter VIII, Required Status Table. In addition to several minor revisions, this version also includes clarification of the NPI data items and the addition of one new data item (CensusBlockGroup70/80/90, data item #368).

A special thanks to Andrew Stewart, Chair of the Volume II Subcommittee and Chair of the Uniform Data Standards Committee, for his leadership, dedication, and hard work in bringing this document to completion.

Lori A. Havener, CTR
Program Manager of Standards
NAACCR, Inc.

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 for different purposes drew attention to problems encountered as a result of insufficient data standardization. It became clear to the cancer registry community that the lack of standardization had a substantial cost and limited more widespread use of valuable data. Three examples follow:

Electronic Submission of Hospital Registry Data to State or Other Central Registries
Central registries recognized that data quality and collection efficiency could be improved with electronic data reporting by means of a diskette, modem, or the Internet. Many registries have established systems for receiving electronic data from multiple sources. Often, these data were collected using different software, different data variables, different codes, and different coding rules. Central registries experienced the frustration of mapping submission files into their own data systems. Software providers were frustrated at the need to prepare submissions for multiple state registries that differed from each other and followed different models of electronic data collection.

North American Association of Central Cancer Registries Data Evaluation and Publications Committee Activities
The North American Association of Central Cancer Registries (NAACCR) requested statistical analysis files from its member registries in the standard NAACCR Data Exchange Record Layout[1] to prepare descriptive epidemiological data about the participating areas. However, data sets submitted by the participants differed; the original codes, data formats, edits, and coding rules varied; and a significant amount of work was required to produce comparable summary statistics.

National Cancer Data Base
The National Cancer Data Base (NCDB) is a joint project of the American College of Surgeons' (ACoS) Commission on Cancer (CoC) and the American Cancer Society (ACS) that pools data submitted by participating hospitals to address questions of clinical interest. Discrepancies in codes, format, and data sets, however, required effort and interpretation before the data could successfully be pooled.

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. Other problems encountered in pooling data included the lack of standardization regarding the use of blanks in fields and the inconsistent use of blanks, dashes, and defined codes for "unknown" data. More substantial discrepancies were less easy to detect and correct. Hospitals were faced with conflicting standards when they were both reporting to a central registry and maintaining a database consistent with CoC standards, and the requirements were not the same.

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 NCDB and the NAACCR Data Exchange Committee, and the task fell to a subcommittee of NAACCR's Uniform Data Standards Committee. At the same time, CDC entered into an agreement with NAACCR—one of the projects to be accomplished under that agreement was the preparation of broader standards for population-based cancer registries. The two efforts were complementary, producing separate but related documents that together specified NAACCR standards. The continued support from 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 L ed. Standards for Cancer Registries Volume I: Data Exchange Standards and Record Descriptions, Version 11.1. Springfield, IL: North American Association of Central Cancer Registries, June 2006.

Havener L, Abe T, Bushhouse S, Gordon B, Hamlyn E, Hill K, Hurlbut A, Menck H, editors. Standards for Cancer Registries Volume I: Data Exchange and Record Descriptions, Version 11. Springfield, IL: North American Association of Central Cancer Registries, November 2004.

Havener L, Abe T, Bushhouse S, Gordon B, Hill K, Hurlbut A, Seiffert J, editors. Standards for Cancer Registries Volume I: Data Exchange and Record Descriptions, Version 10.1. Springfield, IL: North American Association of Central Cancer Registries, July 2003.

Abe T and Seiffert J, editors. North American Association of Center Cancer Registries, Standards for Cancer Registries, Volume I, Data Exchange Standards and Record Description. Version 9. Springfield, IL: 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 (CA): 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 (CA): North American Association of Central Cancer Registries; March 20, 1998.

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

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

NAACCR Standards Volume II:

Havener L, Hultstrom D, editors. Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Eleventh Edition. Version 11.1. Springfield (IL): North American Association of Central Cancer Registries; April 2006.

Havener L, Hultstrom D, editors. Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Tenth Edition. Version 11. Springfield (IL): North American Association of Central Cancer Registries; October 2004.

Havener L, Hultstrom D, editors. Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Ninth Edition. Version 10.2. Springfield (IL): North American Association of Central Cancer Registries; March 2004.

Hultstrom D, Havener L, editors. Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Eighth Edition. Version 10.1. Springfield (IL): North American Association of Central Cancer Registries; March 2003.

Hultstrom D, editor. Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Seventh Edition. Version 10. Springfield (IL): North American Association of Central Cancer Registries; March 2002.

Hultstrom D, editor. Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Sixth Edition. Version 9.1. Springfield (IL): North American Association of Central Cancer Registries; March 4, 2001.

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

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

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

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

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

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

NAACCR Standards Volume III:
Havener L, editor. Standards for Cancer Registries Volume III: Standards for Completeness, Quality, Analysis, and Management of Data, Springfield, IL: North American Association of Central Cancer Registries, October 2004.

North American Association of Central Cancer Registries. Standards for Completeness, Quality, Analysis, and Management of Data, Volume III. Springfield (IL): North American Association of Central Cancer Registries; September 2000.

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

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

NAACCR Standards Volume V:
Havener L (Ed). Standards for Cancer Registries Volume V: Pathology Laboratory Electronic Reporting. Springfield (IL): North American Association of Central Cancer Registries, Inc., November 2005.

[Updated annually and available on the NAACCR website www.naaccr.org.]

GOAL OF THIS DOCUMENT

The goal of this document, which describes and publishes continuing, modified, and new data items and codes as well as the specification for transmission of data in record layout Version 11.2, is to define the NAACCR data standards for cancer registration for use by central registries, hospital-based registries, and other groups in North America as of January 1, 2008. Although the new and modified codes and the layout are available for use on that date, some registries may continue to use compatible earlier versions of the NAACCR record layout.

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
- Encourage the adoption of these standards by all parties.

This document will be used by new and existing facility-based and central cancer registries to ensure that the definitions and codes used within their programs are standard and 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 ACoS, CDC, NAACCR, NCI and CCCR also will benefit.

The present document 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 are provided, but the different items are kept separate or another data field is used to indicate which coding standard was used.

The NAACCR data exchange layout incorporates several record types that are combinations of standard components, such as demographic information, patient confidential information, and text. Thus, the different purposes and constraints of data exchange can be accommodated without the requirement for separate formats (see Standards Volume I[1] for specifics).

SCOPE OF THIS DOCUMENT: WHAT STANDARDS ARE INCLUDED?

A variety of standards for cancer registries can be specified. Some standards apply to the data themselves, and other standards record activities in the registration process, such as death clearance procedures, follow-up methods, or quality control. Yet another standard might address the completeness of coverage of a population-based central registry, and still another the qualifications and adequacy of staffing.

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 specifies the rules for which tumors are to be included in the registry (see Chapter III).

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

Data items or elements consist of required or recommended data items that a registry should collect and include in its database. Chapter VIII contains standards for data set items.

Example: "Sex" is a standard data element on the list in Chapter VIII.

- **Standardized Item Numbers and Item Names**

For ease and consistency of reference, all items are assigned both item 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 have been deleted the item numbers are retired; item numbers will never be reused for a different data item. Data item numbers were not assigned consecutively to allow 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.
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 ACoS 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.

The NAACCR data item names are assigned to meet the needs of NAACCR and its data standards publications. 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 can be identical in this data standards volume and the NAACCR Metafile.

- **Consistency**
  Consistency was attempted 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. Also, see Volume I[1] in this series for information on the data exchange and other NAACCR standard layouts.

Example: "Sex" is in character position 118 in the NAACCR Data Exchange Record Layout Version 11.2.

❖ Codes

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

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 would accurately collapse into the categories represented by the standard codes. This approach permits diversity without compromising inter-registry comparability or meta-analyses.

❖ Coding Rules

Coding rules are the rules and interpretations for deciding the correct code for a given tumor. Coding rules 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 of 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* 2004,[27] which presents standards for the full range of cancer program activities, including the registry.

- *Facility Oncology Registry Data Standards (FORDS): Revised for 2004*,[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 facilities, software providers, and the general cancer registry community. Hospitals in the Approvals 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 Sixth Edition as well as the *Collaborative Staging Manual and Coding Instructions.*[13]

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. A college-level cancer registry methods textbook also was published (*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) successfully have 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 biannually 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 45 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 continue 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 2006 the fifth edition of this joint publication was released. This edition contained 2003 incidence data from 47 states (37 NPCR-, 4 NPCR/SEER-, and 9 SEER-funded registries). In total the cancer registries whose data are included in this report cover 96% 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 25 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, oversample 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 allows 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 45 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. It also must be realized that standardization is not always desirable or feasible.

For example, although the NAACCR standard for entry of dates is MMDDCCYY, SEER collects only month and year of birth date and date of death. SEER does not want to receive date of birth or death because of potential compromises to patient confidentiality, although individual SEER registries may collect this information.

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. Coding rules and rule interpretations sometimes are determined informally and documented marginally. 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 will 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 (i.e., then 2009, 2012, 2015, etc.). These changes require the publication of a new Version of the NAACCR Volume II Data Dictionary and Data Standards (e.g., from Version 10.x to Version 11.0). **Minor** changes will be implemented on an annual cycle. These changes will be published in an update of the current Version of the NAACCR Volume II Data Dictionary and Data Standards (e.g., Version 10.1 [*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 ensure coordination in the development and implementation of major data items, standards, and procedures related to cancer registration. Its purpose is to provide regular communication among leaders of NAACCR and its sponsoring member organizations to facilitate coordination and promote consensus. The committee members include all sponsoring member organizations; the NAACCR President, Executive Director, and Program Manager of Standards; and, the Chairs of the Uniform Data Standards Committee and the Registry Operations Committee.

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.

Record Layouts:
Fourteen versions of the NAACCR layout have been released. All registries should begin using Version 11.2 in January 2008:

- Version 11.2 (dated April 2007)
- Version 11.1 (dated April 2006)
- Version 11 (dated November 2004)
- Version 10.2 (dated March 2004)
- Version 10.1 (dated March 2003)
- Version 10 (dated March 2002)
- Version 9.1 (dated March 2001)
- Version 9 (dated May 2000)
- Version 8 (dated April 1999)
- Version 7 (dated April 13, 1998)
- Version 6 (dated January 23, 1998, and as slightly revised, dated March 20, 1998)
- Version 5.1 (dated March 12, 1997)
- Version 5 (dated April 10, 1996)
- Version 4 (dated 1994).

Please refer to Table 1 on the following page for more detail.

Standards for Tumor Inclusions, Reportability, and Multiple Primary Rules are in Chapter III.

Table 1. Record Layout Table With References.

NAACCR	Release Date	Effective Date*	Reference Manuals Accommodated	NAACCR Metafile Version
Version 4	02/14/1994	01/01/1994	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
Version 5	04/10/1996	01/01/1996	**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 5.1	03/12/1997	01/01/1997	Same as Version 5	Metafile Version 5
Version 6	01/23/1998 Rev 3/20/1998	01/01/1998	**CoC/*ROADS*, 1996, Rev. 1998** **SEER Program Code Manual, 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 7	04/13/1998	01/01/1999	Same as Version 6	Metafile Version 7
Version 8	03/30/1999	01/01/2000	Same as Versions 6 and 7	Metafile Version 8
Version 9	05/15/2000	01/01/2001	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 9.1	03/21/2001	01/01/2002	Same as Version 9	Metafile Version 9
Version 10	03/20/2002	01/01/2003	**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 10.1	03/2003	01/01/2004	**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 1.0 (implementation 01/01/2004)**	Metafile Version 10
Version 10.2	03/2004	01/01/2005	**Same as Version 10.1 (most recent)**	Metafile Version 10

Version 11	10/2004	01/01/2006	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 11.1	04/2006	01/01/2007	**CoC FORDS Revised for 2007** **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 01.03.00**	Metafile Version 11.1
Version 11.2	04/2007	01/01/2008	**Same as Version 11.1**	Metafile Version 11.2

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 tumors that are reportable and are to be included in the registry; however, some differences 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 CCR 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.

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 *CCR 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).

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 tumor 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 (CCR 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 Sixth 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 Sixth Edition but localized in SEER Summary Stage 2000.

Whether a tumor diagnosis is *in situ* or invasive is important because it affects how the tumor will be reported in published statistics. Some tumors staged by central cancer registries using SEER Summary Stage or SEER EOD codes as "localized" can be classified as Tis or Stage 0 when coded according to AJCC or when EOD codes are converted to AJCC. Some tumors classified as invasive in the behavior code can be classified as Tis or Stage 0 when coded according to AJCC Sixth Edition or when EOD codes are converted to AJCC Sixth Edition. These differences should be considered when data are being compared. For more information on differences in staging classifications and current activities toward improving the situation, see Chapter V.

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 CCR database between 1992 and 2006. See the CCR System Guide for details[5]. 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 mulitple primaries, CCR 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 (IARC).[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 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 Canada's CCR 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 CCR 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 11: Comparison of Reportable Cancers: CoC, SEER, and NPCR.

	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] 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; error messages; EDITS system help; and EDITS language reference.

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 current 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, 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 13 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 written in IBM COBOL,[31] which it applied 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.

As more and more computer processing moved away from the mainframe environment, the SEER Program decided to reprogram their edits in C++. 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 field, inter-field, and inter-record edits in the COBOL edits plus new and revised edits needed because of the introduction of ICD-O-3. The SEER*Edits package replaces the COBOL edits and the COBOL edits are no longer being maintained. 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 are input into the stand-alone version of SEER*Edits in NAACCR format. The SEER*Edits package also includes report-generating functions including manipulation of errors to facilitate data correction, a follow-up report, and a surveillance report. Any changes made to the SEER*Edits package also are made 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
- patient names
- occupation and industry
- sequence numbers
- staging descriptors
- timing of first course treatment
- treatment descriptors
- 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 a NAACCR approach to Hispanic identification, an algorithm which uses a combination of NAACCR variables to directly or indirectly assign ethnicity, the NAACCR Hispanic Identification Algorithm (NHIA).

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].

Name--Last [2230]
The CoC *FORDS Manual* allows embedded spaces, hyphens, apostrophes, and punctuation in the last name field. NAACCR standards allow no embedded spaces or punctuation, except hyphens. For CoC and other registries that perform follow-up, the field is used for direct communication with patients and for follow-up with family members or other medical providers, where the patient's representation of the last name is important. At the central registry level, as reflected in the NAACCR standard, last names may be used in matching routines that do not necessarily accept embedded spaces or punctuation. Central registries can, if they choose, strip submitted spaces and apostrophes from Name-Last when the field is stored or when it is passed to a matching routine. Neither CoC nor NAACCR standards allow the last name field to be blank.

Name--Maiden [2390]
This data item is not in the CoC *FORDS* Manual. For tumors diagnosed prior to 2003, however, the CoC *ROADS Manual* allowed embedded spaces, hyphens, apostrophes, and other special characters and punctuation in the maiden name field. SEER became the Source of Standard for this item in 2003 when its use was discontinued by CoC, but SEER has not published specifications for allowable values. NAACCR standards allow no embedded spaces or punctuation, except hyphens. At the central registry level, as reflected in the NAACCR standard, maiden names may be used in matching routines that do not necessarily accept embedded spaces or punctuation. Central registries can, if they choose, strip submitted spaces and apostrophes from Name-Maiden when the field is stored or when it is passed to a matching routine. Both SEER and NAACCR standards allow the maiden name field to be blank.

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 collection of occupation or industry data to the extent available in the medical record by central registries funded by NPCR.[33] In response to this mandate, CDC sponsored a meeting of experts in occupational health and cancer epidemiology in 1995. Recommendations from the meeting resulted in the adoption of data items and codes by the NAACCR UDSC in August 1995.[24] These standards were included in Versions 6 and later of NAACCR's data standards.

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 United States registries are required to use the Collaborative Staging System for cases diagnosed January 1, 2004 and after.

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. 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)**
  In its Sixth Edition, the *AJCC Cancer Staging Manual* includes a clinically 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. CoC standards for approved cancer programs require that the registry data contain the clinical and pathologic T, N, and M components as they are recorded by the managing physician in the patient record. If the physician does not also provide the stage group, the registrar must provide it.

- **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**
  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 three systems for which staging currently can be derived include AJCC TNM 6th Edition, SEER Summary Stage 1977, and SEER Summary Stage 2000. CoC requires registrars to code all Collaborative Stage components. SEER and NPCR require a subset of the Collaborative Stage components 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 is recorded as zeros.

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 11.2 of the NAACCR record layout. The table has column number, length, item number, item name, section, and note fields. Differences from Version 11.1 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	
2-9	8	20	Patient ID Number	Record ID	
10-10	1	30	Registry Type	Record ID	
11-11	1	35	FIN Coding System	Record ID	
12-18	7	37	Reserved 00	Record ID	
19-19	1	50	NAACCR Record Version	Record ID	
20-29	10	40	Registry ID	Record ID	
30-31	2	60	Tumor Record Number	Record ID	
32-39	8	21	Patient System ID-Hosp	Record ID	
40-49	10	45	NPI--Registry ID	Record ID	
50-51	2	370	Reserved 01	Record ID	
52-71	20	70	Addr at DX--City	Demographic	
72-73	2	80	Addr at DX--State	Demographic	
74-82	9	100	Addr at DX--Postal Code	Demographic	
83-85	3	90	County at DX	Demographic	
86-91	6	110	Census Tract 1970/80/90	Demographic	
92-92	1	120	Census Cod Sys 1970/80/90	Demographic	
93-98	6	130	Census Tract 2000	Demographic	
99-99	1	362	Census Block Group 2000	Demographic	
100-100	1	364	Census Tr Cert 1970/80/90	Demographic	
101-101	1	365	Census Tr Certainty 2000	Demographic	
102-102	1	150	Marital Status at DX	Demographic	
103-104	2	160	Race 1	Demographic	
105-106	2	161	Race 2	Demographic	
107-108	2	162	Race 3	Demographic	
109-110	2	163	Race 4	Demographic	
111-112	2	164	Race 5	Demographic	
113-113	1	170	Race Coding Sys--Current	Demographic	
114-114	1	180	Race Coding Sys--Original	Demographic	
115-115	1	190	Spanish/Hispanic Origin	Demographic	
116-116	1	200	Computed Ethnicity	Demographic	
117-117	1	210	Computed Ethnicity Source	Demographic	
118-118	1	220	Sex	Demographic	
119-121	3	230	Age at Diagnosis	Demographic	
122-129	8	240	Birth Date	Demographic	
130-132	3	250	Birthplace	Demographic	

Column #	Length	Item #	Item Name	Section	Note
133-134	2	260	Religion	Demographic	
135-137	3	270	Occupation Code--Census	Demographic	
138-140	3	280	Industry Code--Census	Demographic	
141-141	1	290	Occupation Source	Demographic	
142-142	1	300	Industry Source	Demographic	
143-182	40	310	Text--Usual Occupation	Demographic	
183-222	40	320	Text--Usual Industry	Demographic	
223-223	1	330	Occup/Ind Coding System	Demographic	
224-224	1	340	Tobacco History	Demographic	
225-225	1	350	Alcohol History	Demographic	
226-226	1	360	Family History of Cancer	Demographic	
227-228	2	3300	RuralUrban Continuum 1993	Demographic	
229-230	2	3310	RuralUrban Continuum 2003	Demographic	
231-231	1	191	NHIA Derived Hisp Origin	Demographic	
232-232	1	192	IHS Link	Demographic	
233-234	2	366	GIS Coordinate Quality	Demographic	
235-235	1	368	CensusBlockGroup 70/80/90	Demographic	New
236-280	45	530	Reserved 02	Demographic	Revised
281-282	2	380	Sequence Number--Central	Cancer Identification	
283-290	8	390	Date of Diagnosis	Cancer Identification	
291-294	4	400	Primary Site	Cancer Identification	
295-295	1	410	Laterality	Cancer Identification	
296-300	5	419	Morph--Type&Behav ICD-O-2	Cancer Identification	Group
296-299	4	420	Histology (92-00) ICD-O-2	Cancer Identification	Subfield
300-300	1	430	Behavior (92-00) ICD-O-2	Cancer Identification	Subfield
301-305	5	521	Morph--Type&Behav ICD-O-3	Cancer Identification	Group
301-304	4	522	Histologic Type ICD-O-3	Cancer Identification	Subfield
305-305	1	523	Behavior Code ICD-O-3	Cancer Identification	Subfield
306-306	1	440	Grade	Cancer Identification	
307-307	1	450	Site Coding Sys--Current	Cancer Identification	
308-308	1	460	Site Coding Sys--Original	Cancer Identification	
309-309	1	470	Morph Coding Sys--Current	Cancer Identification	
310-310	1	480	Morph Coding Sys--Originl	Cancer Identification	
311-311	1	490	Diagnostic Confirmation	Cancer Identification	
312-312	1	500	Type of Reporting Source	Cancer Identification	
313-320	8	510	Screening Date	Cancer Identification	

Column #	Length	Item #	Item Name	Section	Note
321-321	1	520	Screening Result	Cancer Identification	
322-323	2	501	Casefinding Source	Cancer Identification	
324-324	1	442	Ambiguous Terminology DX	Cancer Identification	
325-332	8	443	Date of Conclusive DX	Cancer Identification	
333-334	2	444	Mult Tum Rpt as One Prim	Cancer Identification	
335-342	8	445	Date of Multiple Tumors	Cancer Identification	
343-344	2	446	Multiplicity Counter	Cancer Identification	
345-371	26	680	Reserved 03	Cancer Identification	Revised
372-381	10	545	NPI--Reporting Facility	Hospital-Specific	
382-391	10	540	Reporting Facility	Hospital-Specific	
392-401	10	3100	Archive FIN	Hospital-Specific	
402-410	9	550	Accession Number--Hosp	Hospital-Specific	
411-412	2	560	Sequence Number--Hospital	Hospital-Specific	
413-415	3	570	Abstracted By	Hospital-Specific	
416-423	8	580	Date of 1st Contact	Hospital-Specific	
424-431	8	590	Date of Inpatient Adm	Hospital-Specific	
432-439	8	600	Date of Inpatient Disch	Hospital-Specific	
440-440	1	610	Class of Case	Hospital-Specific	
441-444	4	615	Reserved 26	Hospital-Specific	
445-446	2	630	Primary Payer at DX	Hospital-Specific	
447-456	10	3105	NPI--Archive FIN	Hospital-Specific	
457-458	2	670	RX Hosp--Surg Prim Site	Hospital-Specific	
459-459	1	672	RX Hosp--Scope Reg LN Sur	Hospital-Specific	
460-460	1	674	RX Hosp--Surg Oth Reg/Dis	Hospital-Specific	
461-462	2	676	RX Hosp--Reg LN Removed	Hospital-Specific	
463-463	1	690	RX Hosp—Radiation	Hospital-Specific	
464-465	2	700	RX Hosp—Chemo	Hospital-Specific	
466-467	2	710	RX Hosp—Hormone	Hospital-Specific	
468-469	2	720	RX Hosp—BRM	Hospital-Specific	
470-470	1	730	RX Hosp—Other	Hospital-Specific	
471-472	2	740	RX Hosp--DX/Stg Proc	Hospital-Specific	
473-473	1	3280	RX Hosp--Palliative Proc	Hospital-Specific	
474-477	4	741	Reserved 28	Hospital-Specific	
478-479	2	746	RX Hosp--Surg Site 98-02	Hospital-Specific	
480-480	1	747	RX Hosp--Scope Reg 98-02	Hospital-Specific	
481-481	1	748	RX Hosp--Surg Oth 98-02	Hospital-Specific	

Column #	Length	Item #	Item Name	Section	Note
482-527	46	750	Reserved 04	Hospital-Specific	
528-528	1	759	SEER Summary Stage 2000	Stage/Prognostic Factors	
529-529	1	760	SEER Summary Stage 1977	Stage/Prognostic Factors	
530-530	1	765	Reserved 29	Stage/Prognostic Factors	
531-542	12	779	Extent of Disease 10-Dig	Stage/Prognostic Factors	Group
531-533	3	780	EOD--Tumor Size	Stage/Prognostic Factors	Subfield
534-535	2	790	EOD—Extension	Stage/Prognostic Factors	Subfield
536-537	2	800	EOD--Extension Prost Path	Stage/Prognostic Factors	Subfield
538-538	1	810	EOD--Lymph Node Involv	Stage/Prognostic Factors	Subfield
539-540	2	820	Regional Nodes Positive	Stage/Prognostic Factors	Subfield
541-542	2	830	Regional Nodes Examined	Stage/Prognostic Factors	Subfield
543-555	13	840	EOD--Old 13 Digit	Stage/Prognostic Factors	
556-557	2	850	EOD--Old 2 Digit	Stage/Prognostic Factors	
558-561	4	860	EOD--Old 4 Digit	Stage/Prognostic Factors	
562-562	1	870	Coding System for EOD	Stage/Prognostic Factors	
563-564	2	880	TNM Path T	Stage/Prognostic Factors	
565-566	2	890	TNM Path N	Stage/Prognostic Factors	
567-568	2	900	TNM Path M	Stage/Prognostic Factors	
569-570	2	910	TNM Path Stage Group	Stage/Prognostic Factors	
571-571	1	920	TNM Path Descriptor	Stage/Prognostic Factors	
572-572	1	930	TNM Path Staged By	Stage/Prognostic Factors	
573-574	2	940	TNM Clin T	Stage/Prognostic Factors	
575-576	2	950	TNM Clin N	Stage/Prognostic Factors	
577-578	2	960	TNM Clin M	Stage/Prognostic Factors	
579-580	2	970	TNM Clin Stage Group	Stage/Prognostic Factors	
581-581	1	980	TNM Clin Descriptor	Stage/Prognostic Factors	
582-582	1	990	TNM Clin Staged By	Stage/Prognostic Factors	
583-592	10	995	Reserved 30	Stage/Prognostic Factors	
593-594	2	1060	TNM Edition Number	Stage/Prognostic Factors	
595-609	15	1065	Reserved 31	Stage/Prognostic Factors	
610-617	8	1080	Date of 1st Positive BX	Stage/Prognostic Factors	
618-618	1	1090	Site of Distant Met 1	Stage/Prognostic Factors	
619-619	1	1100	Site of Distant Met 2	Stage/Prognostic Factors	
620-620	1	1110	Site of Distant Met 3	Stage/Prognostic Factors	
621-622	2	1120	Pediatric Stage	Stage/Prognostic Factors	
623-624	2	1130	Pediatric Staging System	Stage/Prognostic Factors	

Column #	Length	Item #	Item Name	Section	Note
625-625	1	1140	Pediatric Staged By	Stage/Prognostic Factors	
626-626	1	1150	Tumor Marker 1	Stage/Prognostic Factors	
627-627	1	1160	Tumor Marker 2	Stage/Prognostic Factors	
628-628	1	1170	Tumor Marker 3	Stage/Prognostic Factors	
629-631	3	2800	CS Tumor Size	Stage/Prognostic Factors	
632-633	2	2810	CS Extension	Stage/Prognostic Factors	
634-634	1	2820	CS Tumor Size/Ext Eval	Stage/Prognostic Factors	
635-636	2	2830	CS Lymph Nodes	Stage/Prognostic Factors	
637-637	1	2840	CS Reg Node Eval	Stage/Prognostic Factors	
638-639	2	2850	CS Mets at DX	Stage/Prognostic Factors	
640-640	1	2860	CS Mets Eval	Stage/Prognostic Factors	
641-643	3	2880	CS Site-Specific Factor 1	Stage/Prognostic Factors	
644-646	3	2890	CS Site-Specific Factor 2	Stage/Prognostic Factors	
647-649	3	2900	CS Site-Specific Factor 3	Stage/Prognostic Factors	
650-652	3	2910	CS Site-Specific Factor 4	Stage/Prognostic Factors	
653-655	3	2920	CS Site-Specific Factor 5	Stage/Prognostic Factors	
656-658	3	2930	CS Site-Specific Factor 6	Stage/Prognostic Factors	
659-660	2	2940	Derived AJCC T	Stage/Prognostic Factors	
661-661	1	2950	Derived AJCC T Descriptor	Stage/Prognostic Factors	
662-663	2	2960	Derived AJCC N	Stage/Prognostic Factors	
664-664	1	2970	Derived AJCC N Descriptor	Stage/Prognostic Factors	
665-666	2	2980	Derived AJCC M	Stage/Prognostic Factors	
667-667	1	2990	Derived AJCC M Descriptor	Stage/Prognostic Factors	
668-669	2	3000	Derived AJCC Stage Group	Stage/Prognostic Factors	
670-670	1	3010	Derived SS1977	Stage/Prognostic Factors	
671-671	1	3020	Derived SS2000	Stage/Prognostic Factors	
672-672	1	3030	Derived AJCC--Flag	Stage/Prognostic Factors	
673-673	1	3040	Derived SS1977--Flag	Stage/Prognostic Factors	
674-674	1	3050	Derived SS2000--Flag	Stage/Prognostic Factors	
675-679	5	3110	Comorbid/Complication 1	Stage/Prognostic Factors	
680-684	5	3120	Comorbid/Complication 2	Stage/Prognostic Factors	
685-689	5	3130	Comorbid/Complication 3	Stage/Prognostic Factors	
690-694	5	3140	Comorbid/Complication 4	Stage/Prognostic Factors	
695-699	5	3150	Comorbid/Complication 5	Stage/Prognostic Factors	
700-704	5	3160	Comorbid/Complication 6	Stage/Prognostic Factors	
705-710	6	2935	CS Version 1st	Stage/Prognostic Factors	

Column #	Length	Item #	Item Name	Section	Note
711-716	6	2936	CS Version Latest	Stage/Prognostic Factors	
717-721	5	3161	Comorbid/Complication 7	Stage/Prognostic Factors	
722-726	5	3162	Comorbid/Complication 8	Stage/Prognostic Factors	
727-731	5	3163	Comorbid/Complication 9	Stage/Prognostic Factors	
732-736	5	3164	Comorbid/Complication 10	Stage/Prognostic Factors	
737-737	1	3165	ICD Revision Comorbid	Stage/Prognostic Factors	
738-754	17	1180	Reserved 05	Stage/Prognostic Factors	
755-762	8	1200	RX Date--Surgery	Treatment-1st Course	
763-770	8	3170	RX Date--Most Defin Surg	Treatment-1st Course	
771-778	8	3180	RX Date--Surgical Disch	Treatment-1st Course	
779-786	8	1210	RX Date--Radiation	Treatment-1st Course	
787-794	8	3220	RX Date--Radiation Ended	Treatment-1st Course	
795-802	8	3230	RX Date--Systemic	Treatment-1st Course	
803-810	8	1220	RX Date--Chemo	Treatment-1st Course	
811-818	8	1230	RX Date--Hormone	Treatment-1st Course	
819-826	8	1240	RX Date--BRM	Treatment-1st Course	
827-834	8	1250	RX Date--Other	Treatment-1st Course	
835-842	8	1260	Date of Initial RX--SEER	Treatment-1st Course	
843-850	8	1270	Date of 1st Crs RX--CoC	Treatment-1st Course	
851-858	8	1280	RX Date--DX/Stg Proc	Treatment-1st Course	
859-860	2	1290	RX Summ--Surg Prim Site	Treatment-1st Course	
861-861	1	1292	RX Summ--Scope Reg LN Sur	Treatment-1st Course	
862-862	1	1294	RX Summ--Surg Oth Reg/Dis	Treatment-1st Course	
863-864	2	1296	RX Summ--Reg LN Examined	Treatment-1st Course	
865-865	1	1310	RX Summ--Surgical Approch	Treatment-1st Course	
866-866	1	1320	RX Summ--Surgical Margins	Treatment-1st Course	
867-867	1	1330	RX Summ--Reconstruct 1st	Treatment-1st Course	
868-868	1	1340	Reason for No Surgery	Treatment-1st Course	
869-870	2	1350	RX Summ--DX/Stg Proc	Treatment-1st Course	
871-871	1	3270	RX Summ--Palliative Proc	Treatment-1st Course	
872-872	1	1355	Reserved 22	Treatment-1st Course	
873-873	1	1360	RX Summ--Radiation	Treatment-1st Course	
874-874	1	1370	RX Summ--Rad to CNS	Treatment-1st Course	
875-875	1	1380	RX Summ--Surg/Rad Seq	Treatment-1st Course	
876-877	2	3250	RX Summ--Transplnt/Endocr	Treatment-1st Course	
878-879	2	1390	RX Summ--Chemo	Treatment-1st Course	

Column #	Length	Item #	Item Name	Section	Note
880-881	2	1400	RX Summ--Hormone	Treatment-1st Course	
882-883	2	1410	RX Summ--BRM	Treatment-1st Course	
884-884	1	1420	RX Summ--Other	Treatment-1st Course	
885-885	1	1430	Reason for No Radiation	Treatment-1st Course	
886-887	2	1435	Reserved 32	Treatment-1st Course	
888-889	2	1460	RX Coding System--Current	Treatment-1st Course	
890-893	4	1465	Reserved 33	Treatment-1st Course	
894-894	1	1500	First Course Calc Method	Treatment-1st Course	
895-899	5	1510	Rad--Regional Dose: CGY	Treatment-1st Course	
900-901	2	1520	Rad--No of Treatment Vol	Treatment-1st Course	
902-904	3	1535	Reserved 34	Treatment-1st Course	
905-906	2	1540	Rad--Treatment Volume	Treatment-1st Course	
907-907	1	1550	Rad--Location of RX	Treatment-1st Course	
908-908	1	1555	Reserved 35	Treatment-1st Course	
909-910	2	1570	Rad--Regional RX Modality	Treatment-1st Course	
911-912	2	3200	Rad--Boost RX Modality	Treatment-1st Course	
913-917	5	3210	Rad--Boost Dose cGy	Treatment-1st Course	
918-930	13	1635	Reserved 23	Treatment-1st Course	
931-931	1	1639	RX Summ--Systemic/Sur Seq	Treatment-1st Course	
932-933	2	1640	RX Summ--Surgery Type	Treatment-1st Course	
934-937	4	1641	Reserved 36	Treatment-1st Course	
938-938	1	3190	Readm Same Hosp 30 Days	Treatment-1st Course	
939-940	2	1646	RX Summ--Surg Site 98-02	Treatment-1st Course	
941-941	1	1647	RX Summ--Scope Reg 98-02	Treatment-1st Course	
942-942	1	1648	RX Summ--Surg Oth 98-02	Treatment-1st Course	
943-987	45	1190	Reserved 06	Treatment-1st Course	
988-995	8	1660	Subsq RX 2nd Course Date	Treatment-Subsequent & Other	
996-1002	7	1670	Subsq RX 2nd Course Codes	Treatment-Subsequent & Other	Group
996-997	2	1671	Subsq RX 2nd Course Surg	Treatment-Subsequent & Other	Subfield
998-998	1	1672	Subsq RX 2nd Course Rad	Treatment-Subsequent & Other	Subfield
999-999	1	1673	Subsq RX 2nd Course Chemo	Treatment-Subsequent & Other	Subfield
1000-1000	1	1674	Subsq RX 2nd Course Horm	Treatment-Subsequent & Other	Subfield
1001-1001	1	1675	Subsq RX 2nd Course BRM	Treatment-Subsequent & Other	Subfield
1002-1002	1	1676	Subsq RX 2nd Course Oth	Treatment-Subsequent & Other	Subfield
1003-1010	8	1680	Subsq RX 3rd Course Date	Treatment-Subsequent & Other	
1011-1017	7	1690	Subsq RX 3rd Course Codes	Treatment-Subsequent & Other	Group

Column #	Length	Item #	Item Name	Section	Note
1011-1012	2	1691	Subsq RX 3rd Course Surg	Treatment-Subsequent & Other	Subfield
1013-1013	1	1692	Subsq RX 3rd Course Rad	Treatment-Subsequent & Other	Subfield
1014-1014	1	1693	Subsq RX 3rd Course Chemo	Treatment-Subsequent & Other	Subfield
1015-1015	1	1694	Subsq RX 3rd Course Horm	Treatment-Subsequent & Other	Subfield
1016-1016	1	1695	Subsq RX 3rd Course BRM	Treatment-Subsequent & Other	Subfield
1017-1017	1	1696	Subsq RX 3rd Course Oth	Treatment-Subsequent & Other	Subfield
1018-1025	8	1700	Subsq RX 4th Course Date	Treatment-Subsequent & Other	
1026-1032	7	1710	Subsq RX 4th Course Codes	Treatment-Subsequent & Other	Group
1026-1027	2	1711	Subsq RX 4th Course Surg	Treatment-Subsequent & Other	Subfield
1028-1028	1	1712	Subsq RX 4th Course Rad	Treatment-Subsequent & Other	Subfield
1029-1029	1	1713	Subsq RX 4th Course Chemo	Treatment-Subsequent & Other	Subfield
1030-1030	1	1714	Subsq RX 4th Course Horm	Treatment-Subsequent & Other	Subfield
1031-1031	1	1715	Subsq RX 4th Course BRM	Treatment-Subsequent & Other	Subfield
1032-1032	1	1716	Subsq RX 4th Course Oth	Treatment-Subsequent & Other	Subfield
1033-1047	15	1725	Reserved 37	Treatment-Subsequent & Other	
1048-1048	1	1677	Subsq RX 2nd--Scope LN SU	Treatment-Subsequent & Other	
1049-1049	1	1678	Subsq RX 2nd--Surg Oth	Treatment-Subsequent & Other	
1050-1051	2	1679	Subsq RX 2nd--Reg LN Rem	Treatment-Subsequent & Other	
1052-1052	1	1697	Subsq RX 3rd--Scope LN Su	Treatment-Subsequent & Other	
1053-1053	1	1698	Subsq RX 3rd--Surg Oth	Treatment-Subsequent & Other	
1054-1055	2	1699	Subsq RX 3rd--Reg LN Rem	Treatment-Subsequent & Other	
1056-1056	1	1717	Subsq RX 4th--Scope LN Su	Treatment-Subsequent & Other	
1057-1057	1	1718	Subsq RX 4th--Surg Oth	Treatment-Subsequent & Other	
1058-1059	2	1719	Subsq RX 4th--Reg LN Rem	Treatment-Subsequent & Other	
1060-1063	4	1726	Reserved 38	Treatment-Subsequent & Other	
1064-1064	1	1741	Subsq RX--Reconstruct Del	Treatment-Subsequent & Other	
1065-1114	50	1300	Reserved 07	Treatment-Subsequent & Other	
1115-1115	1	1981	Over-ride SS/NodesPos	Edit Overrides/Conversion History/System Admin	
1116-1116	1	1982	Over-ride SS/TNM-N	Edit Overrides/Conversion History/System Admin	
1117-1117	1	1983	Over-ride SS/TNM-M	Edit Overrides/Conversion History/System Admin	
1118-1118	1	1984	Over-ride SS/DisMet1	Edit Overrides/Conversion History/System Admin	
1119-1119	1	1985	Over-ride Acsn/Class/Seq	Edit Overrides/Conversion History/System Admin	
1120-1120	1	1986	Over-ride HospSeq/DxConf	Edit Overrides/Conversion History/System Admin	

Column #	Length	Item #	Item Name	Section	Note
1121-1121	1	1987	Over-ride CoC-Site/Type	Edit Overrides/Conversion History/System Admin	
1122-1122	1	1988	Over-ride HospSeq/Site	Edit Overrides/Conversion History/System Admin	
1123-1123	1	1989	Over-ride Site/TNM-StgGrp	Edit Overrides/Conversion History/System Admin	
1124-1124	1	1990	Over-ride Age/Site/Morph	Edit Overrides/Conversion History/System Admin	
1125-1125	1	2000	Over-ride SeqNo/DxConf	Edit Overrides/Conversion History/System Admin	
1126-1126	1	2010	Over-ride Site/Lat/SeqNo	Edit Overrides/Conversion History/System Admin	
1127-1127	1	2020	Over-ride Surg/DxConf	Edit Overrides/Conversion History/System Admin	
1128-1128	1	2030	Over-ride Site/Type	Edit Overrides/Conversion History/System Admin	
1129-1129	1	2040	Over-ride Histology	Edit Overrides/Conversion History/System Admin	
1130-1130	1	2050	Over-ride Report Source	Edit Overrides/Conversion History/System Admin	
1131-1131	1	2060	Over-ride Ill-define Site	Edit Overrides/Conversion History/System Admin	
1132-1132	1	2070	Over-ride Leuk- Lymphoma	Edit Overrides/Conversion History/System Admin	
1133-1133	1	2071	Over-ride Site/Behavior	Edit Overrides/Conversion History/System Admin	
1134-1134	1	2072	Over-ride Site/EOD/DX Dt	Edit Overrides/Conversion History/System Admin	
1135-1135	1	2073	Over-ride Site/Lat/EOD	Edit Overrides/Conversion History/System Admin	
1136-1136	1	2074	Over-ride Site/Lat/Morph	Edit Overrides/Conversion History/System Admin	
1137-1140	4	1960	Site (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	
1141-1146	6	1970	Morph (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	Group
1141-1144	4	1971	Histology (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	Subfield
1145-1145	1	1972	Behavior (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	Subfield
1146-1146	1	1973	Grade (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	Subfield
1147-1147	1	1980	ICD-O-2 Conversion Flag	Edit Overrides/Conversion History/System Admin	
1148-1163	16	2082	Reserved 24	Edit Overrides/Conversion History/System Admin	
1164-1173	10	2081	CRC CHECKSUM	Edit Overrides/Conversion History/System Admin	
1174-1181	8	2090	Date Case Completed	Edit Overrides/Conversion History/System Admin	
1182-1189	8	2100	Date Case Last Changed	Edit Overrides/Conversion History/System Admin	

Column #	Length	Item #	Item Name	Section	Note
1190-1197	8	2110	Date Case Report Exported	Edit Overrides/Conversion History/System Admin	
1198-1198	1	2120	SEER Coding Sys--Current	Edit Overrides/Conversion History/System Admin	
1199-1199	1	2130	SEER Coding Sys--Original	Edit Overrides/Conversion History/System Admin	
1200-1201	2	2140	CoC Coding Sys--Current	Edit Overrides/Conversion History/System Admin	
1202-1203	2	2150	CoC Coding Sys--Original	Edit Overrides/Conversion History/System Admin	
1204-1213	10	2170	Vendor Name	Edit Overrides/Conversion History/System Admin	
1214-1214	1	2180	SEER Type of Follow-Up	Edit Overrides/Conversion History/System Admin	
1215-1216	2	2190	SEER Record Number	Edit Overrides/Conversion History/System Admin	
1217-1218	2	2200	Diagnostic Proc 73-87	Edit Overrides/Conversion History/System Admin	
1219-1226	8	2111	Date Case Report Received	Edit Overrides/Conversion History/System Admin	
1227-1234	8	2112	Date Case Report Loaded	Edit Overrides/Conversion History/System Admin	
1235-1242	8	2113	Date Tumor Record Availbl	Edit Overrides/Conversion History/System Admin	
1243-1243	1	2116	ICD-O-3 Conversion Flag	Edit Overrides/Conversion History/System Admin	
1244-1293	50	1650	Reserved 08	Edit Overrides/Conversion History/System Admin	
1294-1301	8	1750	Date of Last Contact	Follow-up/Recurrence/Death	
1302-1302	1	1760	Vital Status	Follow-up/Recurrence/Death	
1303-1303	1	1770	Cancer Status	Follow-up/Recurrence/Death	
1304-1304	1	1780	Quality of Survival	Follow-up/Recurrence/Death	
1305-1305	1	1790	Follow-Up Source	Follow-up/Recurrence/Death	
1306-1306	1	1800	Next Follow-Up Source	Follow-up/Recurrence/Death	
1307-1326	20	1810	Addr Current--City	Follow-up/Recurrence/Death	
1327-1328	2	1820	Addr Current--State	Follow-up/Recurrence/Death	
1329-1337	9	1830	Addr Current--Postal Code	Follow-up/Recurrence/Death	
1338-1340	3	1840	County--Current	Follow-up/Recurrence/Death	
1341-1341	1	1850	Unusual Follow-Up Method	Follow-up/Recurrence/Death	
1342-1349	8	1860	Recurrence Date--1st	Follow-up/Recurrence/Death	
1350-1350	1	1871	Recurrence Distant Site 1	Follow-up/Recurrence/Death	
1351-1351	1	1872	Recurrence Distant Site 2	Follow-up/Recurrence/Death	
1352-1352	1	1873	Recurrence Distant Site 3	Follow-up/Recurrence/Death	
1353-1354	2	1880	Recurrence Type--1st	Follow-up/Recurrence/Death	

Column #	Length	Item #	Item Name	Section	Note
1355-1356	2	1895	Reserved 39	Follow-up/Recurrence/Death	
1357-1376	20	1842	Follow-Up Contact--City	Follow-up/Recurrence/Death	
1377-1378	2	1844	Follow-Up Contact--State	Follow-up/Recurrence/Death	
1379-1387	9	1846	Follow-Up Contact--Postal	Follow-up/Recurrence/Death	
1388-1391	4	1910	Cause of Death	Follow-up/Recurrence/Death	
1392-1392	1	1920	ICD Revision Number	Follow-up/Recurrence/Death	
1393-1393	1	1930	Autopsy	Follow-up/Recurrence/Death	
1394-1396	3	1940	Place of Death	Follow-up/Recurrence/Death	
1397-1398	2	1791	Follow-up Source Central	Follow-up/Recurrence/Death	
1399-1446	48	1740	Reserved 09	Follow-up/Recurrence/Death	
1447-1946	500	2220	State/Requestor Items	Special Use	
1947-1971	25	2230	Name--Last	Patient-Confidential	
1972-1985	14	2240	Name--First	Patient-Confidential	
1986-1999	14	2250	Name--Middle	Patient-Confidential	
2000-2002	3	2260	Name--Prefix	Patient-Confidential	
2003-2005	3	2270	Name--Suffix	Patient-Confidential	
2006-2020	15	2280	Name--Alias	Patient-Confidential	
2021-2035	15	2390	Name--Maiden	Patient-Confidential	
2036-2085	50	2290	Name--Spouse/Parent	Patient-Confidential	
2086-2096	11	2300	Medical Record Number	Patient-Confidential	
2097-2098	2	2310	Military Record No Suffix	Patient-Confidential	
2099-2107	9	2320	Social Security Number	Patient-Confidential	
2108-2147	40	2330	Addr at DX--No & Street	Patient-Confidential	
2148-2187	40	2335	Addr at DX--Supplementl	Patient-Confidential	
2188-2227	40	2350	Addr Current--No & Street	Patient-Confidential	
2228-2267	40	2355	Addr Current--Supplementl	Patient-Confidential	
2268-2277	10	2360	Telephone	Patient-Confidential	
2278-2283	6	2380	DC State File Number	Patient-Confidential	
2284-2313	30	2394	Follow-Up Contact--Name	Patient-Confidential	
2314-2353	40	2392	Follow-Up Contact--No&St	Patient-Confidential	
2354-2393	40	2393	Follow-Up Contact--Suppl	Patient-Confidential	
2394-2403	10	2352	Latitude	Patient-Confidential	
2404-2414	11	2354	Longitude	Patient-Confidential	
2415-2464	50	1835	Reserved 10	Patient-Confidential	
2465-2474	10	2435	Reserved 40	Hospital-Confidential	
2475-2484	10	2440	Following Registry	Hospital-Confidential	

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

CHAPTER VIII

REQUIRED STATUS TABLE (ITEM # ORDER)

The following table presents Version 11.2 of the NAACCR required status summarizing the requirements and recommendations for collection of each item by standard-setting groups. Differences from Version 11.1 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 CCCR Refers to requirements of Canadian Council of Cancer Registries. Provincial/Territorial Cancer Registries should refer to the *CCR 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 (CCR). 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 cases diagnosed before 2004 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	.	.	T	T	NAACCR	
20	Patient ID Number	R	.	.	R	R	.	.	.	T	Reporting Registry	
21	Patient System ID-Hosp	.	.	.	.	.	.	.	T	.	NAACCR	
30	Registry Type	.	.	.	.	.	.	.	.	T	NAACCR	
35	FIN Coding System	.	.	.	.	.	.	.	.	.	NAACCR	
37	Reserved 00	.	.	.	.	.	.	.	.	.		
40	Registry ID	R	.	.	R	R	.	.	T	T	NAACCR	Revised
45	NPI--Registry ID	.	.	.	R*	.	.	.	.	.	NAACCR	
50	NAACCR Record Version	.	.	R	.	.	.	.	T	T	NAACCR	
60	Tumor Record Number	.	.	.	S	S	.	.	T	T	NAACCR	
70	Addr at DX--City	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	
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	

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 – cases diagnosed before 2004, transmit data if available in exchange record. 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
191	NHIA Derived Hisp Origin	D	.	.	D	R	.	.	.	.	NAACCR	
192	IHS Link	R*	.	.	.	R	.	.	.	.	NPCR	
200	Computed Ethnicity	R	.	.	D	R	.	.	.	.	SEER	
210	Computed Ethnicity Source	R	.	.	R	R	.	.	.	.	SEER	
220	Sex	R	R	R	R	R	.	.	T	T	SEER/CoC	
230	Age at Diagnosis	R	R	R	R	R	.	.	.	.	SEER/CoC	
240	Birth Date	R	R	R	R	R	R	R	T	T	SEER/CoC	
250	Birthplace	R*	R	R	R	R	.	.	T*	T	SEER/CoC	
260	Religion	.	.	.	.	.	.	.	.	.	Varies	
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	.	.	.	.	.	.	.	.	.	Varies	
350	Alcohol History	.	.	.	.	.	.	.	.	.	Varies	
360	Family History of Cancer	.	.	.	.	.	.	.	.	.	Varies	
362	Census Block Group 2000	.	.	.	S	.	.	.	.	.	Census	Revised
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	
368	CensusBlockGroup 70/80/90	.	.	.	S	.	.	.	.	.	Census	New
370	Reserved 01	.	.	.	.	.	.	.	.	.		
380	Sequence Number--Central	R	.	.	R	R	.	.	.	T	SEER	
390	Date of Diagnosis	R	R	R	R	R	.	.	T	T	SEER/CoC	
400	Primary Site	R	R	R	R	R	.	.	T	T	SEER/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
410	Laterality	R	R	R	R	R	.	.	T	T	SEER/CoC	
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	
440	Grade	R	R	R	R	R	R	R	T	T	SEER/CoC	
442	Ambiguous Terminology DX	.	R	R	R	R	.	.	.	.	SEER	
443	Date of Conclusive DX	.	R	R	R	R	.	.	.	.	SEER	
444	Mult Tum Rpt as One Prim	.	R	R	R	R	.	.	.	.	SEER	
445	Date of Multiple Tumors	.	R	R	R	R	.	.	.	.	SEER	
446	Multiplicity Counter	.	R	R	R	R	.	.	.	.	SEER	
447	Number of Tumors/Hist											Retired
450	Site Coding Sys--Current	R	R	R	.	.	.	.	T	T	NAACCR	
460	Site Coding Sys--Original	.	R	R	.	.	.	.	T	T	NAACCR	
470	Morph Coding Sys --Current	R	R	R	.	.	.	.	T	T	NAACCR	
480	Morph Coding Sys --Originl	.	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	.	.	.	R	R	.	.	T*	T*	NAACCR	
510	Screening Date	.	.	.	.	.	.	.	.	.	NAACCR	
520	Screening Result	.	.	.	.	.	.	.	.	.	NAACCR	
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	.	.	.	.	.	.	.	.	.		
535	Reserved 25	.	.	.	.	.	.	.	.	.		
538	Reporting Hospital FAN											Retired
540	Reporting Facility	R	R	R	R	.	.	.	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
545	NPI --Reporting Facility	R*	R*	R*	R*	.	.	.	.	.	NAACCR	
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	
590	Date of Inpatient Adm	.	.	.	.	.	.	.	.	.	NAACCR	
600	Date of Inpatient Disch	.	.	.	.	.	.	.	.	.	NAACCR	
610	Class of Case	R	R	R	RC	.	.	.	T	.	CoC	
615	Reserved 26	.	.	.	.	.	.	.	.	.		
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
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	.	.	.	.	T*	.	CoC	
680	Reserved 03	.	.	.	.	.	.	.	.	.		
690	RX Hosp -- Radiation	.	.	.	RH	.	.	.	TH*	.	SEER/CoC	
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	
741	Reserved 28	.	.	.	.	.	.	.	.	.		
742	RX Hosp -- Screen/BX Proc1											Retired
743	RX Hosp -- Screen/BX Proc2											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
744	RX Hosp -- Screen/BX Proc3											Retired
745	RX Hosp -- Screen/BX Proc4											Retired
746	RX Hosp -- Surg Site 98-02	.	.	RH	RH	.	.	.	TH*	.	CoC	
747	RX Hosp -- Scope Reg 98-02	.	.	RH	RH	.	.	.	TH*	.	CoC	
748	RX Hosp -- Surg Oth 98-02	.	.	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	
765	Reserved 29	.	.	.	.	.	.	.	.	.		
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*	T*	T*	SEER/CoC	
830	Regional Nodes Examined	.	R	R	R	R	R*	R*	T*	T*	SEER/CoC	
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	

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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
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	
980	TNM Clin Descriptor	.	R	R	.	.	.	.	T*	T*	CoC	
990	TNM Clin Staged By	.	R	R	.	.	.	.	T*	T*	CoC	
995	Reserved 30	.	.	.	.	.	.	.	.	.		
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	
1065	Reserved 31	.	.	.	.	.	.	.	.	.		
1070	Other Staging System											Retired
1080	Date of 1st Positive BX	.	.	.	.	.	.	.	.	.	NAACCR	
1090	Site of Distant Met 1	.	.	RH	.	.	.	.	.	.	CoC	
1100	Site of Distant Met 2	.	.	RH	.	.	.	.	.	.	CoC	
1110	Site of Distant Met 3	.	.	RH	.	.	.	.	.	.	CoC	
1120	Pediatric Stage	.	.	.	.	.	.	.	.	.	CoC	
1130	Pediatric Staging System	.	.	.	.	.	.	.	.	.	CoC	
1140	Pediatric Staged By	.	.	.	.	.	.	.	.	.	CoC	
1150	Tumor Marker 1	.	.	RH	RH	RH	.	.	TH*	TH*	SEER	
1160	Tumor Marker 2	.	.	RH	RH	RH	.	.	TH*	TH*	SEER	
1170	Tumor Marker 3	.	.	RH	RH	RH	.	.	TH*	TH*	SEER	
1180	Reserved 05	.	.	.	.	.	.	.	.	.		
1190	Reserved 06	.	.	.	.	.	.	.	.	.		

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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
1200	RX Date--Surgery	.	R	R	S	.	.	.	T*	T*	CoC	
1210	RX Date--Radiation	.	R	R	S	.	.	.	T*	T*	CoC	
1220	RX Date--Chemo	.	.	.	.	.	.	.	TH*	TH*	NAACCR	
1230	RX Date--Hormone	.	.	.	.	.	.	.	TH*	TH*	NAACCR	
1240	RX Date--BRM	.	.	.	S	.	.	.	TH*	TH*	NAACCR	
1250	RX Date--Other	.	R	R	S	.	.	.	T*	T*	CoC	
1260	Date of Initial RX--SEER	R#	.	.	R	R	.	.	T*	T*	SEER	
1270	Date of 1st Crs RXcCoC	R#	R	R	.	.	.	.	T*	T*	CoC	
1280	RX Date--DX/Stg Proc	.	R	R	.	.	.	.	.	.	CoC	
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	.	.	TH*	TH*	SEER/CoC	
1300	Reserved 07	.	.	.	.	.	.	.	.	.		
1310	RX Summ--Surgical Approch	.	.	RH	.	.	.	.	.	.	CoC	
1320	RX Summ--Surgical Margins	.	R	R	.	.	.	.	.	.	CoC	
1330	RX Summ--Reconstruct 1st	.	.	.	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	
1355	Reserved 22	.	.	.	.	.	.	.	.	.		
1360	RX Summ--Radiation	.	.	.	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	

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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
1430	Reason for No Radiation	.	R	R	.	.	.	.	.	.	CoC	
1435	Reserved 32	.	.	.	.	.	.	.	.	.		
1440	Reason for No Chemo											Retired
1450	Reason for No Hormone											Retired
1460	RX Coding System--Current	R	R	R	.	RH	.	.	T*	T*	NAACCR	
1465	Reserved 33	.	.	.	.	.	.	.	.	.		
1470	Protocol Eligibility Stat											Retired
1480	Protocol Participation											Retired
1490	Referral to Support Serv											Retired
1500	First Course Calc Method	.	.	.	.	.	.	.	.	.	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
1535	Reserved 34	.	.	.	.	.	.	.	.	.		
1540	Rad--Treatment Volume	.	R	R	.	.	.	.	T	.	CoC	
1550	Rad--Location of RX	.	R	R	.	.	.	.	T	.	CoC	
1555	Reserved 35	.	.	.	.	.	.	.	.	.		
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
1635	Reserved 23	.	.	.	.	.	.	.	.	.		
1639	RX Summ--Systemic/Sur Seq	R	R	R	R	R	.	.	T	T	CoC	
1640	RX Summ--Surgery Type	.	.	.	RH	RH	.	.	TH*	TH*	SEER	

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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
1641	Reserved 36	.	.	.	.	.	.	.	.	.		
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	
1670	Subsq RX 2nd Course Codes											
1671	Subsq RX 2nd Course Surg	.	.	.	.	.	.	.	.	.	CoC	
1672	Subsq RX 2nd Course Rad	.	.	.	.	.	.	.	.	.	CoC	
1673	Subsq RX 2nd Course Chemo	.	.	.	.	.	.	.	.	.	CoC	
1674	Subsq RX 2nd Course Horm	.	.	.	.	.	.	.	.	.	CoC	
1675	Subsq RX 2nd Course BRM	.	.	.	.	.	.	.	.	.	CoC	
1676	Subsq RX 2nd Course Oth	.	.	.	.	.	.	.	.	.	CoC	
1677	Subsq RX 2nd --Scope LN SU	.	.	.	.	.	.	.	.	.	CoC	
1678	Subsq RX 2nd --Surg Oth	.	.	.	.	.	.	.	.	.	CoC	
1679	Subsq RX 2nd --Reg LN Rem	.	.	.	.	.	.	.	.	.	CoC	
1680	Subsq RX 3rd Course Date	.	.	.	.	.	.	.	.	.	CoC	
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	

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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
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	
1710	Subsq RX 4th Course Codes											
1711	Subsq RX 4th Course Surg	.	.	.	.	.	.	.	.	.	CoC	
1712	Subsq RX 4th Course Rad	.	.	.	.	.	.	.	.	.	CoC	
1713	Subsq RX 4th Course Chemo	.	.	.	.	.	.	.	.	.	CoC	
1714	Subsq RX 4th Course Horm	.	.	.	.	.	.	.	.	.	CoC	
1715	Subsq RX 4th Course BRM	.	.	.	.	.	.	.	.	.	CoC	
1716	Subsq RX 4th Course Oth	.	.	.	.	.	.	.	.	.	CoC	
1717	Subsq RX 4th--Scope LN Su	.	.	.	.	.	.	.	.	.	CoC	
1718	Subsq RX 4th--Surg Oth	.	.	.	.	.	.	.	.	.	CoC	
1719	Subsq RX 4th--Reg LN Rem	.	.	.	.	.	.	.	.	.	CoC	
1720	Subsq RX 5th Course Date											Retired
1725	Reserved 37	.	.	.	.	.	.	.	.	.		
1726	Reserved 38	.	.	.	.	.	.	.	.	.		
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

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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
1740	Reserved 09	.	.	.	.	.	.	.	.	.		
1741	Subsq RX--Reconstruct Del	.	.	.	.	.	.	.	.	.	CoC	
1750	Date of Last Contact	R	R	R	R	R	.	.	T	T	SEER/CoC	
1760	Vital Status	R	R	R	R	R	.	.	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	
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	
1870	Recurrence Distant Sites											Retired
1871	Recurrence Distant Site 1	.	.	.	.	.	.	.	.	.	NAACCR	
1872	Recurrence Distant Site 2	.	.	.	.	.	.	.	.	.	NAACCR	
1873	Recurrence Distant Site 3	.	.	.	.	.	.	.	.	.	NAACCR	
1880	Recurrence Type --1st	.	R	R	RC	.	.	.	T*	.	CoC	
1890	Recurrence Type --1st--Oth											Retired
1895	Reserved 39	.	.	.	.	.	.	.	.	.		
1900	Reserved 11	.	.	.	.	.	.	.	.	.		

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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
1910	Cause of Death	R	.	.	R	R	.	.	.	T	SEER	
1920	ICD Revision Number	R	.	.	R	R	.	.	.	T	SEER	
1930	Autopsy	.	.	.	.	.	.	.	.	.	NAACCR	
1940	Place of Death	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	.	R	R	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	.	.	.	.	.	.	.	T*	T*	NAACCR	
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	
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	

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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
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											Retired
2081	CRC CHECKSUM	.	.	.	S	S	.	.	.	.	NAACCR	
2082	Reserved 24	.	.	.	.	.	.	.	.	.		
2090	Date Case Completed	.	.	.	.	.	.	.	.	.	NAACCR	
2100	Date Case Last Changed	.	.	.	.	.	.	.	.	.	NAACCR	
2110	Date Case Report Exported	R	.	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	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
2161	Reserved 20											Retired
2170	Vendor Name	.	.	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											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
2220	State/Requestor Items	.	.	.	.	.	.	.	.	.	Varies	
2230	Name--Last	R	R	.	R	.	.	.	T	T	NAACCR	
2240	Name--First	R	R	.	R	.	.	.	T	T	NAACCR	
2250	Name--Middle	R	R	.	R	.	.	.	T*	T*	CoC	
2260	Name--Prefix	.	.	.	.	.	.	.	.	.	SEER	
2270	Name--Suffix	.	.	.	R	.	.	.	T*	T*	SEER	
2280	Name--Alias	R	.	.	R	.	.	.	T*	T*	SEER	
2290	Name--Spouse/Parent	.	.	.	.	.	.	.	.	.	NAACCR	
2300	Medical Record Number	R	R	.	R	.	.	.	T	.	CoC	
2310	Military Record No Suffix	.	R	.	.	.	.	.	.	.	CoC	
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
2371	Reserved 21											Retired
2380	DC State File Number	R	.	.	R*	.	.	.	.	T*	State	
2390	Name--Maiden	R	.	.	R	.	.	.	T*	T*	SEER	
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											Retired
2410	Institution Referred From	.	R	.	.	.	.	.	T*	.	CoC	
2415	NPI--Inst Referred From	.	R*	.	.	.	.	.	.	.	NAACCR	

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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
2420	Institution Referred To	.	R	.	.	.	.	.	T*	.	CoC	
2425	NPI--Inst Referred To	.	R*	.	.	.	.	.	.	.	NAACCR	
2430	Last Follow-Up Hospital											Retired
2435	Reserved 40	.	.	.	.	.	.	.	.	.		
2440	Following Registry	.	R	.	R	.	.	.	.	.	CoC	
2445	NPI --Following Registry	.	.	.	R*	.	.	.	.	.	NAACCR	
2450	Reserved 17											Retired
2460	Physician--Managing	.	.	.	.	.	.	.	.	.	NAACCR	
2465	NPI --Physician--Managing	.	R	.	.	.	.	.	.	.	NAACCR	Revised
2470	Physician--Follow-Up	.	R	.	R	.	.	.	T*	T*	CoC	
2475	NPI--Physician--Follow-Up	.	R*	R*	R*	.	.	.	.	.	NAACCR	
2480	Physician--Primary Surg	.	R	.	.	.	.	.	.	.	CoC	
2485	NPI --Physician--Primary Surg	.	R*	R*	.	.	.	.	.	.	NAACCR	
2490	Physician 3	.	R	.	.	.	.	.	.	.	CoC	
2495	NPI--Physician 3	.	R*	R*	.	.	.	.	.	.	NAACCR	
2500	Physician 4	.	R	.	.	.	.	.	.	.	CoC	
2505	NPI--Physician 4	.	R*	R*	.	.	.	.	.	.	NAACCR	
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	

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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
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	
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	
2700	Reserved 19	.	.	.	.	.			.	.		
2800	CS Tumor Size	R	R	R	R	R	R*	R*	T	T	AJCC	Revised
2810	CS Extension	R	R	R	R	R	R*	R*	T	T	AJCC	
2820	CS Tumor Size/Ext Eval	R	R	R	.	.	R*	R*	T*	T*	AJCC	Revised
2830	CS Lymph Nodes	R	R	R	R	R	R*	R*	T	T	AJCC	
2840	CS Reg Node Eval	.	R	R	.	.	R*	R*	T*	T*	AJCC	
2850	CS Mets at DX	R	R	R	R	R	R*	R*	T	T	AJCC	
2860	CS Mets Eval	.	R	R	.	.	R*	R*	T*	T*	AJCC	
2880	CS Site-Specific Factor 1	RS	R	R	R	R	R*	R*	T	T	AJCC	
2890	CS Site-Specific Factor 2	.	R	R	R	R	R*	R*	T	T	AJCC	
2900	CS Site-Specific Factor 3	RS	R	R	R	R	R*	R*	T	T	AJCC	
2910	CS Site-Specific Factor 4	.	R	R	R	R	R*	R*	T	T	AJCC	
2920	CS Site-Specific Factor 5	.	R	R	R	R	R*	R*	T	T	AJCC	
2930	CS Site-Specific Factor 6	.	R	R	R	R	R*	R*	T	T	AJCC	
2935	CS Version 1st	R	R	R	R	R	R*	R*	.	.	AJCC	
2936	CS Version Latest	R	R	R	R	R	R*	R*	.	.	AJCC	
2940	Derived AJCC T	.	D	D	D	D	R*	R*	T*	T*	AJCC	
2950	Derived AJCC T Descriptor	.	D	D	.	.	R*	R*	T*	T*	AJCC	
2960	Derived AJCC N	.	D	D	D	D	R*	R*	T*	T*	AJCC	
2970	Derived AJCC N Descriptor	.	D	D	.	.	R*	R*	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
2980	Derived AJCC M	.	D	D	D	D	R*	R*	T*	T*	AJCC	
2990	Derived AJCC M Descriptor	.	D	D	.	.	R*	R*	T*	T*	AJCC	
3000	Derived AJCC Stage Group	.	D	D	D	D	R*	R*	T*	T*	AJCC	
3010	Derived SS1977	.	D	D	D	D	R*	R*	T*	T*	AJCC	
3020	Derived SS2000	D	D	D	D	D	R*	R*	T*	T*	AJCC	
3030	Derived AJCC --Flag	.	R	R	D	D	R*	R*	T*	T*	AJCC	
3040	Derived SS1977 --Flag	.	R	R	D	D	R*	R*	T*	T*	AJCC	
3050	Derived SS2000 --Flag	D	R	R	D	D	R*	R*	T*	T*	AJCC	
3100	Archive FIN	.	R	R	.	.	.	.	.	.	CoC	
3105	NPI--Archive FIN	.	R*	R*	.	.	.	.	.	.	NAACCR	
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	
3180	RX Date--Surgical Disch	.	R	R	.	.	.	.	.	.	CoC	
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	

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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
3230	RX Date--Systemic	.	R	R	S	.	.	.	T*	T*	CoC	
3250	RX Summ--Transplnt/Endocr	R	R	R	R	R	.	.	T*	T*	CoC	
3260	Pain Assessment											Retired
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	

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CHAPTER IX

DATA DESCRIPTOR TABLE (ITEM # ORDER)

The following table presents Version 11.2 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 11.1 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 11.2 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.

Example: You are submitting data in NAACCR 11.2 format, and you collect information on surgery date. However, in some cases the date is not there because your program stores it as a date-time variable and either no surgery was given, it is unknown whether surgery was given, or it was an autopsy or death certificate-only (DCO) case. Those columns in the file you generate must contain no blanks; instead, the columns should contain "99999999" when it is unknown whether or not surgery was given or when the case was DCO, and "00000000" when no surgery was given or autopsy-only.

Exception: You are submitting in the NAACCR 11.2 format, and cases diagnosed in the years 1997-2001 are included. The Morph--Type&Behavior ICD-O-2 fields should contain the original ICD-O-2 codes for cases diagnosed in or before 2000, but the fields should be blank for cases diagnosed in 2001 (unless you have back-translated the ICD-O-3 morphology codes).

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 month, day, year format (MMDDCCYY), with 99 for unknown day or month and 9999 for unknown year. For example:

- 00000000 No date
- 99999999 Unknown date
- 01992003 Example of date when the month and year are known but the day is unknown
- 99992003 Example of date when the year is known but the month and day are unknown

Item #	Item Name	Format	Allowable Values	Length	Note
10	Record Type		I, C, A, U, R, 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			7	
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		Blank, 1, 4-9, A, B	1	
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	20	
80	Addr at DX--State	Upper case	Refer to EDITS table STATE.DBF in Appendix B	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	
140	Census Tract Cod Sys--Alt				Retired
150	Marital Status at DX		1-5, 9	1	
160	Race 1	Right justified, zero filled	01-14, 20-22, 25-28, 30-32, 96-99	2	
161	Race 2	Right justified, zero filled	01-14, 20-22, 25-28, 30-32, 88, 96-99, blank	2	
162	Race 3	Right justified, zero filled	01-14, 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	01-14, 20-22, 25-28, 30-32, 88, 96-99, blank	2	
164	Race 5	Right justified, zero filled	01-14, 20-22, 25-28, 30-32, 88, 96-99, blank	2	
170	Race Coding Sys--Current		1-6, 9	1	
180	Race Coding Sys--Original		1-6, 9	1	
190	Spanish/Hispanic Origin		0-8, 9	1	
191	NHIA Derived Hisp Origin		0-8, blank	1	
192	IHS Link		0, 1, 8	1	
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	Birth Date	MMDDCCYY	Valid date or 99999999	8	
250	Birthplace	Right justified, zero filled	Reference to EDITS table BPLACE.DBF in Appendix B	3	
260	Religion	No standard	Any	2	
270	Occupation Code--Census		Reference Industry and Occupation Coding for Death Certificates	3	
280	Industry Code--Census		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	40	
320	Text--Usual Industry	Free text	Neither carriage return nor line feed characters allowed	40	
330	Occup/Ind Coding System		1-4, 7, 9, blank	1	
340	Tobacco History	No standard	Any	1	
350	Alcohol History	No standard	Any	1	
360	Family History of Cancer	No standard	Any	1	
362	Census Block Group 2000		0-9, blank	1	Revised
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		01-12, 98, 99, blank	2	
368	CensusBlockGroup 70/80/90		0-9, blank	1	New
370	Reserved 01			2	
380	Sequence Number--Central	Right justified, zero filled	00-35, 60-87, 88, 98, 99	2	
390	Date of Diagnosis	MMDDCCYY	Valid date or 99999999	8	
400	Primary Site	C followed by 3 digits, no special characters, no embedded blanks	Refer to ICD-O-3 (decimals are dropped)	4	
410	Laterality		0-4, 9	1	
419	Morph--Type&Behav ICD-O-2		Reference to ICD-0-2	5	
420	Histology (92-00) ICD-O-2		Refer to ICD-0-2	4	
430	Behavior (92-00) ICD-O-2		0-3, Refer to ICD-0-2	1	

Item #	Item Name	Format	Allowable Values	Length	Note
440	Grade		1-9	1	
442	Ambiguous Terminology DX		0-2, 9	1	
443	Date of Conclusive DX		Valid date, 00000000, 88888888, 99999999	8	
444	Mult Tum Rpt as One Prim		00, 10-12, 20, 30-32, 40, 80, 88, 99	2	
445	Date of Multiple Tumors		Valid date, 00000000, 88888888, 99999999	8	
446	Multiplicity Counter		01-88, 99	2	
447	Number of Tumors/Hist				Retired
450	Site Coding Sys--Current		1-6, 9	1	
460	Site Coding Sys--Original		1-6, 9	1	
470	Morph Coding Sys--Current		1-7, 9	1	
480	Morph Coding Sys--Originl		1-7, 9	1	
490	Diagnostic Confirmation		1, 2, 4-9	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	MMDDCCYY	Valid date, 00000000, 99999999	8	
520	Screening Result		0-4, 8, 9	1	
521	Morph--Type&Behav ICD-O-3		Reference to ICD-O-3	5	
522	Histologic Type ICD-O-3		Refer to ICD-O-3	4	
523	Behavior Code ICD-O-3		0-3, Refer to ICD-O-3	1	
530	Reserved 02			45	Revised
535	Reserved 25				
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	00-35, 60-87, 88, 99	2	
570	Abstracted By	No special characters	Letters and numbers	3	
580	Date of 1st Contact	MMDDCCYY	Valid dates or 99999999	8	
590	Date of Inpatient Adm	MMDDCCYY	Valid dates, 00000000, 99999999	8	
600	Date of Inpatient Disch	MMDDCCYY	Valid dates, 00000000, 99999999	8	
610	Class of Case		0-9	1	
615	Reserved 26			4	
620	Year First Seen This CA				Retired
630	Primary Payer at DX	Right justified, zero filled	01, 02, 10, 20, 31, 35, 60-68, 99	2	
635	Reserved 27				Retired
640	Inpatient/Outpt Status				Retired
650	Presentation at CA Conf				Retired

Item #	Item Name	Format	Allowable Values	Length	Note
660	Date of CA Conference				Retired
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	
680	Reserved 03			27	Revised
690	RX Hosp--Radiation		0-5, 9	1	
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	
741	Reserved 28			4	
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)	2	
747	RX Hosp--Scope Reg 98-02		0-9 (site specific)	1	
748	RX Hosp--Surg Oth 98-02		0-9 (site specific)	1	
750	Reserved 04			46	
759	SEER Summary Stage 2000		0-5, 7, 8, 9	1	
760	SEER Summary Stage 1977		0-5, 7, 8, 9	1	
765	Reserved 29			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	See respective source references	2	
830	Regional Nodes Examined	Right justified, zero filled	See respective source references	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	1	
880	TNM Path T	Upper case, alphanumeric, left justified, blank filled	See *AJCC Cancer Staging Manual* and *FORDS Manual*; also 88, blank	2	

Item #	Item Name	Format	Allowable Values	Length	Note
890	TNM Path N	Upper case, alphanumeric, left justified, blank filled	See *AJCC Cancer Staging Manual* and *FORDS Manual*; also 88, blank	2	
900	TNM Path M	Upper case, alphanumeric, left justified, blank filled	See *AJCC Cancer Staging Manual* and *FORDS Manual*; also 88, blank	2	
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, blank	2	
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	2	
950	TNM Clin N	Upper case, alphanumeric, left justified, blank filled	See *AJCC Cancer Staging Manual* and *FORDS Manual*; also 88, blank	2	
960	TNM Clin M	Upper case, alphanumeric, left justified, blank filled	See *AJCC Cancer Staging Manual* and *FORDS Manual*; also 88, blank	2	
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	2	
980	TNM Clin Descriptor		0-6, 9	1	
990	TNM Clin Staged By		0-9	1	
995	Reserved 30			10	
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	00-06, 88, 99	2	
1065	Reserved 31			15	
1070	Other Staging System				Retired
1080	Date of 1st Positive BX	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1090	Site of Distant Met 1		0-9	1	
1100	Site of Distant Met 2		0-9	1	
1110	Site of Distant Met 3		0-9	1	
1120	Pediatric Stage		Reference to EDITS table PEDSTAGE.DBF.CODE in Appendix B	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			17	

Item #	Item Name	Format	Allowable Values	Length	Note
1190	Reserved 06			45	
1200	RX Date--Surgery	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1210	RX Date--Radiation	MMDDCCYY	Valid dates, 00000000, 88888888, 99999999	8	
1220	RX Date--Chemo	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1230	RX Date--Hormone	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1240	RX Date--BRM	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1250	RX Date--Other	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1260	Date of Initial RX--SEER	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1270	Date of 1st Crs RX--CoC	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1280	RX Date--DX/Stg Proc	MMDDCCYY	Valid dates, 00000000, 99999999	8	
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			50	
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	
1355	Reserved 22			1	
1360	RX Summ--Radiation		0-5, 7-9	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	
1435	Reserved 32			2	
1440	Reason for No Chemo				Retired
1450	Reason for No Hormone				Retired
1460	RX Coding System--Current	Right justified, zero filled	00-06, 99	2	
1465	Reserved 33			4	
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	

Item #	Item Name	Format	Allowable Values	Length	Note
1520	Rad--No of Treatment Vol	Right justified, zero filled	00-99	2	
1530	Rad--Elapsed RX Days				Retired
1535	Reserved 34			3	
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	
1555	Reserved 35			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
1635	Reserved 23			13	
1639	RX Summ--Systemic/Sur Seq		0, 2-6, 9	1	
1640	RX Summ--Surgery Type	Right justified, zero filled	00-99 (site-specific)	2	
1641	Reserved 36			4	
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)	2	
1647	RX Summ--Scope Reg 98-02		0-9 (site specific)	1	
1648	RX Summ--Surg Oth 98-02		0-9 (site specific)	1	
1650	Reserved 08			50	
1660	Subsq RX 2nd Course Date	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1670	Subsq RX 2nd Course Codes			7	
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	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1690	Subsq RX 3rd Course Codes			7	
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	

Item #	Item Name	Format	Allowable Values	Length	Note
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	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1710	Subsq RX 4th Course Codes			7	
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
1725	Reserved 37			15	
1726	Reserved 38			4	
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			48	
1741	Subsq RX--Reconstruct Del		Site-specific	1	
1750	Date of Last Contact	MMDDCCYY	Valid dates or 99999999	8	
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	20	
1820	Addr Current--State	Upper case	See EDITS table STATE.DBF in Appendix B	2	

Item #	Item Name	Format	Allowable Values	Length	Note
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			50	
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	20	
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	
1860	Recurrence Date--1st	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1870	Recurrence Distant Sites				Retired
1871	Recurrence Distant Site 1		0-9	1	
1872	Recurrence Distant Site 2		0-9	1	
1873	Recurrence Distant Site 3		0-9	1	
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
1895	Reserved 39			2	
1900	Reserved 11			20	
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	
1950	Reserved 12				Retired

Item #	Item Name	Format	Allowable Values	Length	Note
1960	Site (73-91) ICD-O-1	Four digits, first digit equals 1	Reference ICD-O-1 for valid entries	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	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	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		1 or blank	1	
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		1or 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				Retired
2081	CRC CHECKSUM		Calculated or blank	10	
2082	Reserved 24			16	
2090	Date Case Completed	MMDDCCYY		8	
2100	Date Case Last Changed	MMDDCCYY		8	
2110	Date Case Report Exported	MMDDCCYY		8	
2111	Date Case Report Received	MMDDCCYY		8	
2112	Date Case Report Loaded	MMDDCCYY		8	
2113	Date Tumor Record Availbl	MMDDCCYY		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		0-7	1	
2130	SEER Coding Sys--Original		0-7	1	

Item #	Item Name	Format	Allowable Values	Length	Note
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
2161	Reserved 20				Retired
2170	Vendor Name	Embedded spaces allowed		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				Retired
2220	State/Requestor Items			500	
2230	Name--Last	Mixed case, no embedded spaces, left justified, blank filled. Embedded hyphen allowed, but no other special characters		25	
2240	Name--First	Mixed case, no embedded spaces, no special characters, left justified, blank filled		14	
2250	Name--Middle	Mixed case, no embedded spaces, no special characters, left justified, blank filled		14	
2260	Name--Prefix	Mixed case, no special characters		3	
2270	Name--Suffix	Mixed case, no special characters		3	
2280	Name--Alias	Left justified, blank filled		15	
2290	Name--Spouse/Parent	No standard		50	
2300	Medical Record Number	Leading spaces, right justified		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		40	
2335	Addr at DX--Supplementl	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		40	
2350	Addr Current--No & Street	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		40	
2352	Latitude	Right justified	See Data Dictionary	10	
2354	Longitude	Right justified	See Data Dictionary	11	
2355	Addr Current--Supplementl	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		40	
2360	Telephone	10-digit number	Any 10-digit number	10	
2370	DC State				Retired
2371	Reserved 21				Retired
2380	DC State File Number		Any characters or blank	6	
2390	Name--Maiden	Mixed case, no embedded spaces, left justified, blank filled, embedded hyphen allowed, no other special characters		15	
2392	Follow-Up Contact--No&St	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		40	

Item #	Item Name	Format	Allowable Values	Length	Note
2393	Follow-Up Contact--Suppl	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		40	
2394	Follow-Up Contact--Name	Mixed case, embedded spaces, no special characters, left justified, blank fill		30	
2400	Reserved 16				Retired
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
2435	Reserved 40			10	
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				Retired
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	
2520	Text--DX Proc--PE	Free text	Neither carriage return nor line feed characters allowed	200	
2530	Text--DX Proc--X-ray/Scan	Free text	Neither carriage return nor line feed characters allowed	250	
2540	Text--DX Proc--Scopes	Free text	Neither carriage return nor line feed characters allowed	250	
2550	Text--DX Proc--Lab Tests	Free text	Neither carriage return nor line feed characters allowed	250	

Item #	Item Name	Format	Allowable Values	Length	Note
2560	Text--DX Proc--Op	Free text	Neither carriage return nor line feed characters allowed	250	
2570	Text--DX Proc--Path	Free text	Neither carriage return nor line feed characters allowed	250	
2580	Text--Primary Site Title	Free text	Neither carriage return nor line feed characters allowed	40	
2590	Text--Histology Title	Free text	Neither carriage return nor line feed characters allowed	40	
2600	Text--Staging	Free text	Neither carriage return nor line feed characters allowed	300	
2610	RX Text--Surgery	Free text	Neither carriage return nor line feed characters allowed	150	
2620	RX Text--Radiation (Beam)	Free text	Neither carriage return nor line feed characters allowed	150	
2630	RX Text--Radiation Other	Free text	Neither carriage return nor line feed characters allowed	150	
2640	RX Text--Chemo	Free text	Neither carriage return nor line feed characters allowed	200	
2650	RX Text--Hormone	Free text	Neither carriage return nor line feed characters allowed	200	
2660	RX Text--BRM	Free text	Neither carriage return nor line feed characters allowed	100	
2670	RX Text--Other	Free text	Neither carriage return nor line feed characters allowed	100	
2680	Text--Remarks	Free text	Neither carriage return nor line feed characters allowed	350	
2690	Text--Place of Diagnosis	Free text	Neither carriage return nor line feed characters allowed	50	
2700	Reserved 19			770	
2800	CS Tumor Size	Right justified, zero filled	000-999 (site specific)	3	
2810	CS Extension	Right justified, zero filled	00-99 (site specific)	2	
2820	CS Tumor Size/Ext Eval		0-9 (site specific)	1	
2830	CS Lymph Nodes	Right justified, zero filled	00-99 (site specific)	2	
2840	CS Reg Node Eval		0-9(site specific)	1	
2850	CS Mets at DX	Right justified, zero filled	00-99 (site specific)	2	
2860	CS Mets Eval		0-9 (site specific)	1	
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	

Item #	Item Name	Format	Allowable Values	Length	Note
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 1st	6-digit number	Any 6-digit number	6	
2936	CS Version Latest	6-digit number	Any 6-digit number	6	
2940	Derived AJCC T		Site specific (derived from Collaborative Stage fields), blank	2	
2950	Derived AJCC T Descriptor		c, p, a, y, N, and blank (derived from Collaborative Stage fields)	1	
2960	Derived AJCC N		Site specific (derived from Collaborative Stage fields), blank	2	
2970	Derived AJCC N Descriptor		c, p, a, y, N, and blank (derived from Collaborative Stage fields)	1	
2980	Derived AJCC M		Site specific (derived from Collaborative Stage fields), blank	2	
2990	Derived AJCC M Descriptor		c, p, a, y, N, and blank (derived from Collaborative Stage fields)	1	
3000	Derived AJCC Stage Group		Site specific (derived from Collaborative Stage fields)	2	
3010	Derived SS1977		0-5, 7, 8, 9 (derived from Collaborative Stage fields)	1	
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	

Item #	Item Name	Format	Allowable Values	Length	Note
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	
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		1, 9, blank	1	

Item #	Item Name	Format	Allowable Values	Length	Note
3170	RX Date--Most Defin Surg	MMDDCCYY	Valid dates, 00000000, 99999999	8	
3180	RX Date--Surgical Disch	MMDDCCYY	Valid dates, 00000000, 99999999	8	
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	MMDDCCYY	Valid dates, 00000000, 88888888, 99999999	8	
3230	RX Date--Systemic	MMDDCCYY	Valid dates, 00000000, 88888888, 99999999	8	
3250	RX Summ--Transplnt/Endocr	Right justified, zero filled	00, 10-12, 20, 30, 40, 82, 85-88, 99	2	
3260	Pain Assessment				
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, (calculated); blank	2	
3310	RuralUrban Continuum 2003	Right justified, zero filled	01-09, 98, 99, (calculated); blank	2	Revised

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 meanings are given. 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 11.1 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 in Appendix D.

The Source of Standard implies the reference for detailed coding instructions for many of the data items. A list of references can be found in Chapter VI. Chapter II, Table 1 provides a list of reference manuals for Version 11.2 (and prior versions).

Date fields are recorded in the month, day, year format (MMDDCCYY), with 99 for unknown day or month and 9999 for unknown year. For example:

- 00000000 No date
- 99999999 Unknown date
- 01992003 Example of date when the month and year are known but the day is unknown
- 99992003 Example of date when the year is known but the month and day are unknown

ABSTRACTED BY

Alternate Name	Item #	Length	Source of Standard	Column #
	570	3	CoC	413-415

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	402-410

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	20	CoC	52-71

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 their mailing address. If the patient has multiple primaries, the city of residence may be different for each primary.

Codes (in addition to valid street address)
UNKNOWN Patient's address is unknown

ADDR AT DX--NO & STREET

Alternate Name	Item #	Length	Source of Standard	Column #
Patient Address (Number and Street) at Diagnosis (CoC) Number and Street (pre-96 CoC)	2330	40	CoC	2108-2147

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, 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/personal/tools/pg/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, November 2000). 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 1/2 MAIN ST), and hyphens when the hyphen carries meaning (e.g., 289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (e.g., 425 FLOWER BLVD # 72).

Codes (in addition to valid street address)

UNKNOWN Patient's address is unknown

ADDR AT DX--POSTAL CODE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Postal Code at Diagnosis (CoC) Zip Code (pre-CoC)	100	9	CoC	74-82

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, then the corresponding characters of an unknown value may be blank.

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 US and Canadian 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 unknown

ADDR AT DX--STATE

Alternate Name	Item #	Length	Source of Standard	Column #
State (pre-96 CoC) State at Diagnosis (CoC)	80	2	CoC	72-73

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	40	CoC	2148-2187

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. Additional address information such as number and street should be entered in 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	20	CoC	1307-1326

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.

Note: Prior to Version 5, Follow-Up Contact fields may have been used for patient current address in the NAACCR record layout.

ADDR CURRENT--NO & STREET

Alternate Name	Item #	Length	Source of Standard	Column #
Patient Address (Number and Street)-Current (CoC)	2350	40	CoC	2188-2227

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, 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/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, November 2000). 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 1/2 MAIN ST), and hyphens when the hyphen carries meaning (e.g., 289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (e.g., 425 FLOWER BLVD # 72).

Note: Prior to Version 5, Follow-Up Contact fields may have been used for patient current address in the NAACCR record layout.

ADDR CURRENT--POSTAL CODE **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Postal Code--Current (CoC)	1830	9	CoC	1329-1337

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.) or Canada, and postal code Unknown
999999 Resident of Canada and postal code unknown

Note: Prior to Version 5, Follow-Up Contact fields may have been used for patient current address in the NAACCR record layout.

ADDR CURRENT--STATE

Alternate Name	Item #	Length	Source of Standard	Column #
State--Current (CoC)	1820	2	CoC	1327-1328

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

Note: Prior to Version 5, Follow-Up Contact fields may have been used for patient current address in the NAACCR record layout.

ADDR CURRENT--SUPPLEMENTL

Alternate Name	Item #	Length	Source of Standard	Column #
Patient Address (Number and Street) Current--Supplemental (CoC)	2355	40	CoC	2228-2267

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.

Note: Prior to Version 5, Follow-Up Contact fields may have been used for patient current address in the NAACCR record layout.

AGE AT DIAGNOSIS

Alternate Name	Item #	Length	Source of Standard	Column #
	230	3	SEER/CoC	119-121

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
001 1 year old, but less than 2 years
002 2 years old
… (show actual age in completed years)
101 101 years old
…
120 120 years old
999 Unknown age

ALCOHOL HISTORY

Alternate Name	Item #	Length	Source of Standard	Column #
	350	1	Varies	225-225

Description
NAACCR has not adopted standards for this item.

AMBIGUOUS TERMINOLOGY DX **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Ambiguous Terminology Ambiguous Terminology as Basis for Diagnosis	442	1	SEER	324-324

Definition

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.

Cases with a code 1 in this data item should be excluded from case selection in research studies and from annual contact (i.e., follow-up) by registrars. Direct patient contact is not recommended for these cases.

Ambiguous terms that are reportable

Apparent(ly)
Appears (effective with cases diagnosed 1/1/1998 and later)
Comparable with (effective with cases diagnosed 1/1/1998 and later)
Compatible with (effective with cases diagnosed 1/1/1998 and later)
Consistent with
Favor(s)
Malignant appearing (effective with cases diagnosed 1/1/1998 and later)
Most likely
Presumed
Probable
Suspect(ed)
Suspicious (for)
Typical (of)

Follow-back to a physician or subsequent readmission (following the initial two month diagnosis period) may eventually confirm a cancer diagnosis (conclusive cancer diagnosis greater than two months after date of initial diagnosis that was based on ambiguous terminology).

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. It will also allow these cases to be identified and excluded from patient contact studies.

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

ARCHIVE FIN **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	3100	10	CoC	392-401

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

NPI, a unique identification number for US health care providers, is scheduled for 2007 implementation by the Centers for Medicare and Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For cases accessioned after the facility has its NPI code assigned, this information should be transmitted in the data item NPI—Archive FIN [3105].

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	1393-1393

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	1145-1145

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[18,19].. Blank for tumors coded directly into ICD-O-2 (i.e., 1992 and later tumors).

BEHAVIOR (92-00) ICD-O-2

Alternate Name	Item #	Length	Source of Standard	Column #
	430	1	SEER/CoC	300-300

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-0-2[17] page 22, for behavior codes and definitions.

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 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)	523	1	SEER/CoC	305-305

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].

BIRTH DATE

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Birth (SEER/CoC)	240	8	SEER/CoC	122-129

Description
Date of birth of the patient. See page 95 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. Month and day would be coded as unknown (99). Estimate date of birth when information is not available. It is better to estimate than to code as an unknown value.

BIRTHPLACE

Alternate Name	Item #	Length	Source of Standard	Column #
Place of Birth (SEER/CoC)	250	3	SEER/CoC	130-132

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.

Code
See Appendix B (also Appendix B of the *SEER Program Code Manual*) for numeric and alphabetic lists of places and codes.

CANCER STATUS

Alternate Name	Item #	Length	Source of Standard	Column #
	1770	1	CoC	1303-1303

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
Hospitals use this field to compute survival analysis (disease-free intervals). 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	322-323

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, code 23; includes nuclear medicine
27 Tumor Board
28 Hospital Rehabilitation Service or Clinic
29 Other Hospital Source (including clinic, NOS or outpatient department, NOS)

Case 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	1388-1391

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 **New**

Alternate Name	Item #	Length	Source of Standard	Column #
	368	1	Census	235-235

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 such areas, 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.

Allowable values and format

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 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Census Tract Block Group	362	1	Census	99-99

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 COD SYS 1970/80/90

Alternate Name	Item #	Length	Source of Standard	Column #
Census Coding System (CoC) Coding System for Census Tract (pre-96 SEER/CoC)	120	1	SEER	92-92

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

Alternate Name	Item #	Length	Source of Standard	Column #
Census Tract Certainty	364	1	SEER	100-100

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

Note: Codes 1-5 and 9 are usually assigned by a geocoding vendor, while code 6 is usually assigned through a special effort by the central registry.

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 Unable to assign census tract or BNA based on available information
Blank Not applicable (e.g., census tracting not attempted); Census Tract Certainty information for 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]

CENSUS TR CERTAINTY 2000

Alternate Name	Item #	Length	Source of Standard	Column #
	365	1	NAACCR	101-101

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

Note: Codes 1-5 and 9 are usually assigned by a geocoding vendor, while code 6 is usually assigned through a special effort by the central registry.

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 Unable to assign census tract or bloc numbering based on available information
Blank Not applicable (e.g., census tracting not attempted); Census Tract Certainty information for 2000 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 TRACT 1970/80/90

Alternate Name	Item #	Length	Source of Standard	Column #
Census Tract/Block Numbering Area (BNA) (SEER) Census Tract	110	6	SEER	86-91

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"[32] 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	93-98

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 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 approved to retire this data item in Version 10.1.

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 approved to retire this data item in Version 10.1.

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 approved to retire this data item in Version 10.1.

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 approved to retire this data item in Version 10.1.

CLASS OF CASE

Alternate Name	Item #	Length	Source of Standard	Column #
	610	1	CoC	440-440

Description
For a hospital registry, divides cases into two groups: analytic cases are those included in reports on patient treatment and outcomes; nonanalytic cases are those not included in such reports. Class of Case codes 0-2 identify cases that are analytic (i.e., cases that were first diagnosed and/or received all or part of their first course of treatment or had treatment planned at the reporting hospital). Class of Case codes 3-5, 7, 8, and 9 identify cases that are considered nonanalytic (i.e., were first diagnosed and received all of their first course of treatment at a facility other than the reporting institution, or were diagnosed at autopsy or by death certificate only). Class of Case 6 identifies cases that were first diagnosed and received their entire first course of

treatment in the same staff physician's office. These cases were considered analytic for diagnosis dates January 1, 1998, through December 31, 1999. For diagnosis dates on or after January 1, 2000, these cases are considered nonanalytic.

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.

Codes

0 Diagnosis at the reporting facility and all of the first course of treatment was performed elsewhere or the decision not to treat was made at another facility.
1 Diagnosis at the reporting facility, and all or part of the first course of treatment was performed at the reporting facility.
2 Diagnosis elsewhere, and all or part of the first course of treatment was performed at the reporting facility.
3 Diagnosis and all of the first course of treatment was performed elsewhere. Presents at your facility with recurrence or persistent disease.
4 Diagnosis and/or first course of treatment were performed at the reporting facility prior to the reference date of the registry.
5 Diagnosed at autopsy
6 Diagnosis and all of the first course of treatment were completed by the same staff physician in an office setting. "Staff physician" is any medical staff with admitting privileges at the reporting facility.
7 Pathology report only. Patient does not enter the reporting facility at any time for diagnosis or treatment. This category excludes tumors diagnosed at autopsy.
8 Diagnosis was established by death certificate only. Used by central registries only.
9 Unknown. Sufficient detail for determining Class of Case is not stated in patient record. Used by central registries only.

COC CODING SYS--CURRENT

Alternate Name	Item #	Length	Source of Standard	Column #
Commission on Cancer Coding System-Current (CoC)	2140	2	CoC	1200-1201

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* 2003/2004 (effective with cases diagnosed 2003 and forward)
99 Unknown coding system

COC CODING SYS--ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Column #
	2150	2	CoC	1202-1203

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* 2003/2004 (effective with cases diagnosed 2003 and forward)
99 Unknown coding system

CODING SYSTEM FOR EOD

Alternate Name	Item #	Length	Source of Standard	Column #
Coding System for Extent of Disease (SEER)	870	1	SEER	562-562

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	675-679

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 *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	680-684

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 *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	685-689

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 *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	690-694

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 *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	695-699

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 *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	700-704

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 *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	717-721

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 *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	722-726

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 *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	727-731

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 *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	732-736

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 *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	116-116

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	117-117

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	83-85

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: The standard of using FIPS codes for this item has not been adopted by all states. Some states use their own codes for this data item. See Chapter V, Unresolved Issues, for further information.

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	1338-1340

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	1164-1173

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

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

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

CS EXTENSION

Alternate Name	Item #	Length	Source of Standard	Column #
	2810	2	AJCC	632-633

Description
This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. It is based on and replaces EOD--Extension (790) and EOD--Extension Prost Path (800). This modification for CS is collapsible into AJCC T code according to the sixth edition of *AJCC Cancer Staging Manual*. "CS Extension" identifies the primary tumor growth within the organ of origin or its extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in the CS Extension field.

Site-specific codes provide extensive detail describing disease extent. "CS Extension" is used to derive the Derived AJCC T [2940], Derived AJCC Stage Group [3000], Derived SS1977 [3010], and Derived SS2000 [3020] codes.

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/ stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions*[13], for site-specific codes and coding rules.

CS LYMPH NODES

Alternate Name	Item #	Length	Source of Standard	Column #
CS Lymph Nodes (SEER EOD)	2830	2	AJCC	635-636

Description
This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. It is based on and replaces EOD--Lymph Node Involv [810]. This modification for CS is collapsible into AJCC N code according to the sixth edition of *AJCC Cancer Staging Manual*. "CS Lymph Nodes" is site-specific and identifies the regional lymph nodes involved with cancer at the time of diagnosis.

Site-specific codes provide extensive detail describing disease extent. "CS Lymph Nodes" is used to derive the Derived AJCC N [2960], Derived AJCC Stage Group [3000], Derived SS1977 [3010], and Derived SS2000 [3020] codes.

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/ stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage

1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions*[13], for site-specific codes and coding rules.

CS METS AT DX

Alternate Name	Item #	Length	Source of Standard	Column #
CS Metastasis at Diagnosis	2850	2	AJCC	638-639

Description
This belongs to the set of Collaborative Staging (CS) data items and is part of the detailed site-specific codes for anatomic EOD effective with 2004 diagnosis. It replaces data items 1090, 1100, and 1110 (Site of Distant Met 1-3). This modification for CS is collapsible into AJCC M code according to the sixth edition of *AJCC Cancer Staging Manual*. “CS Metastasis at Diagnosis” identifies the site(s) of metastatic involvement at time of diagnosis.

Site-specific codes provide extensive detail describing disease extent. "CS Mets at DX" is used to derive the Derived AJCC M [2980], Derived AJCC Stage Group [3000], Derived SS1977 [3010], and Derived SS2000 [3020] codes.

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/ stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions*[13], for site-specific codes and coding rules.

CS METS EVAL

Alternate Name	Item #	Length	Source of Standard	Column #
CS Metastasis Evaluation	2860	1	AJCC	640-640

Description
This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. "CS Mets Eval" records how the code for item “CS Mets at DX” [2850] was determined based on the diagnostic methods employed.

This data item is used in CS to identify whether the M (of AJCC TNM) was clinically or pathologically diagnosed and by what methods, "CS Mets Eval" is used to derive the Derived AJCC M Descriptor [2990].

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/ stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions*[13], for site-specific codes and coding rules.

CS REG NODE EVAL

Alternate Name	Item #	Length	Source of Standard	Column #
CS Regional Nodes Evaluation	2840	1	AJCC	637-637

Description
This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. “CS Reg Node Eval” records how the code for the item “CS Lymph Nodes” [2830] was determined based on the diagnostic methods employed.

This data item is used in CS to identify whether the N (of AJCC TNM) was clinically or pathologically diagnosed and by what method "CS Reg Nodes Eval" is used to derive the Derived AJCC N Descriptor [2970].

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/ stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

Codes
See the most current version of the Collaborative Staging Manual and Coding Instructions[13], for site-specific codes and coding rules.

CS SITE-SPECIFIC FACTOR 1

Alternate Name	Item #	Length	Source of Standard	Column #
	2880	3	AJCC	641-643

Description
This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. The "CS Site-Specific Factor" items (1-6) are used to code additional site-specific information needed to derive TNM or AJCC stage, or to code prognostic factors that have an effect on stage or survival. Some site-specific information that was formerly recorded in "EOD-- Tumor Size" [780] (Breslow's Thickness for melanoma; HIV/AIDS status for lymphoma) is now also in "CS Site-Specific Factor" items. Many site-specific schemas do not use any of the Site-Specific Factors; other schemas use from 1 to all 6 of the factors.

Rationale
CS Site Specific Factors provide an optional area for coding information needed for stage. CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

Codes
See the most current version of the Collaborative Staging Manual and Coding Instructions[13], for site-specific codes and coding rules.

CS SITE-SPECIFIC FACTOR 2

Alternate Name	Item #	Length	Source of Standard	Column #
	2890	3	AJCC	644-646

Description
This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. The "CS Site-Specific Factor" items (1-6) are used to code additional site-specific information needed to derive TNM or AJCC stage, or to code prognostic factors that have an effect on stage or survival. Some site-specific information that was formerly recorded in "EOD--Tumor Size" [780] (Breslow's Thickness for melanoma; HIV/AIDS status for lymphoma) is now also in "CS Site-Specific Factor" items. Many site-specific schemas do not use any of the Site-Specific Factors; other schemas use from 1 to all 6 of the factors.

Rationale
CS Site Specific Factors provide an optional area for coding information needed for stage. CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR records for these outputs.

Codes
See the most current version of the Collaborative Staging Manual and Coding Instructions[13], for site-specific codes and coding rules.

CS SITE-SPECIFIC FACTOR 3

Alternate Name	Item #	Length	Source of Standard	Column #
	2900	3	AJCC	647-649

Description
This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. The "CS Site-Specific Factor" items (1-6) are used to code additional site-specific information needed to derive TNM or AJCC stage, or to code prognostic factors that have an effect on stage or survival. Some site-specific information that was formerly recorded in "EOD--Tumor Size" [780] (Breslow's Thickness for melanoma; HIV/AIDS status for lymphoma) is now also in "CS Site-Specific Factor" items. Many site-specific schemas do not use any of the Site-Specific Factors; other schemas use from 1 to all 6 of the factors.

Rationale
CS Site Specific Factors provide an optional area for coding information needed for stage. CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR records for these outputs.

Codes
See the most current version of the Collaborative Staging Manual and Coding Instructions[13], for site-specific codes and coding rules.

CS SITE-SPECIFIC FACTOR 4

Alternate Name	Item #	Length	Source of Standard	Column #
	2910	3	AJCC	650-652

Description
This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. The "CS Site-Specific Factor" items (1-6) are used to code additional site-specific information needed to derive TNM or AJCC stage, or to code prognostic factors that have an effect on stage or survival. Some site-specific information that was formerly recorded in "EOD--Tumor Size" [780] (Breslow's Thickness for melanoma; HIV/AIDS status for lymphoma) is now also in "CS Site-Specific Factor" items. Many site-specific schemas do not use any of the Site-Specific Factors; other schemas use from 1 to all 6 of the factors.

Rationale
CS Site Specific Factors provide an optional area for coding information needed for stage. CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR records for these outputs.

Codes
See the most current versions of the *Collaborative Staging Manual and Coding Instructions*[13], for site-specific codes and coding rules.

CS SITE-SPECIFIC FACTOR 5

Alternate Name	Item #	Length	Source of Standard	Column #
	2920	3	AJCC	653-655

Description
This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. The "CS Site-Specific Factor" items (1-6) are used to code additional site-specific information needed to derive TNM or AJCC stage, or to code prognostic factors that have an effect on stage or survival. Some site-specific information that was formerly recorded in "EOD--Tumor Size" [780] (Breslow's Thickness for melanoma; HIV/AIDS status for lymphoma) is now also in "CS Site-Specific Factor" items. Many site-specific schemas do not use any of the Site-Specific Factors; other schemas use from 1 to all 6 of the factors.

Rationale
CS Site Specific Factors provide an optional area for coding information needed for stage. CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR records for these outputs.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions*[13], for site-specific codes and coding rules.

CS SITE-SPECIFIC FACTOR 6

Alternate Name	Item #	Length	Source of Standard	Column #
	2930	3	AJCC	656-658

Description
This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. The "CS Site-Specific Factor" items (1-6) are used to code additional site-specific information needed to derive TNM or AJCC stage, or to code prognostic factors that have an effect on stage or survival. Some site-specific information that was formerly recorded in "EOD--Tumor Size" [780] (Breslow's Thickness for melanoma; HIV/AIDS status for lymphoma) is now also in "CS Site-Specific Factor" items. Many site-specific schemas do not use any of the Site-Specific Factors; other schemas use from 1 to all 6 of the factors.

Rationale
CS Site Specific Factors provide an optional area for coding information needed for stage. CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR records for these outputs.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions*[13], for site-specific codes and coding rules.

CS TUMOR SIZE

Alternate Name	Item #	Length	Source of Standard	Column #
	2800	3	AJCC	629-631

Description
This item belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. It is based on and replaces EOD--Tumor size [780]. For most sites, CS Tumor Size is used to record the largest dimension, or the diameter of the primary tumor in millimeters (for example: 1 mm = 001, 1 cm = 010). See the CS schemes for site-specific variants. For many sites, the CS algorithm uses this data item to derive the Derived AJCC T [2940] according to the sixth edition of *AJCC Cancer Staging Manual*.

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/ stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions*[13], for site-specific codes and coding rules.

CS TUMOR SIZE/EXT EVAL

Alternate Name	Item #	Length	Source of Standard	Column #
CS Tumor Size/Extension Evaluation	2820	1	AJCC	634-634

Description
This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. “CS Tumor Size/Ext Eval” records how the codes for "CS Tumor Size” [2800] and “CS Extension” [2810] were determined based on the diagnostic methods employed. This data item is used in CS to identify whether the T (of AJCC TNM) was clinically or pathologically diagnosed and by what method, "CS Tumor Size/Ext Eval" is used to derive the Derived AJCC T Descriptor [2950].

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/ stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

Codes
See the most current version of the *Collaborative Staging Manual and Coding Instructions*[13], for site-specific codes and coding rules.

CS VERSION 1ST

Alternate Name	Item #	Length	Source of Standard	Column #
	2935	6	AJCC	705-710

Description
This item indicates the number of the version used to initially code CS fields. The CS version number is returned as part of the output of the CS algorithm. As long as the CS algorithm is run and the output values stored at the time of initial abstracting, the returned values from the program should be automatically stored as CS Version 1st. This item may be blank if the CS algorithm has not been run or if this field has not been implemented. When it is implemented, this data item should be entered at the time the CS fields are first coded and the algorithm first applied. If the calculation algorithm is not called at the time of the initial abstracting, the CS Version 1st could also be entered manually by the abstractor.

It is not expected that this field would be updated every time a coded value is changed. However, the field should be available for future updating if, for example, the CS fields for certain records were to be systematically recoded for a special study using a later version, the CS Version 1st could be appropriately updated with the new version. The meaning and interpretation of CS Version 1st will be dependent on vendor implementation and local practices. This field should be interpreted with caution in a dataset where the actual coding procedures are unknown.

Codes
CS Version 1st is a 6-digit code. 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 (e.g., 010100).

CS VERSION LATEST

Alternate Name	Item #	Length	Source of Standard	Column #
	2936	6	AJCC	711-716

Description
This item indicates the number of the version of the CS used most recently to derive the CS output fields. 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 re-computed. The CS version number is returned as part of the output of the CS algorithm. The returned value from the program should be automatically stored as CS Version Latest. This item should not be updated manually.

Codes
CS Version Latest is a 6-digit code. 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 (e.g., 010100).

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

DATE CASE COMPLETED

Alternate Name	Item #	Length	Source of Standard	Column #
	2090	8	NAACCR	1174-1181

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 is a local use field. See page 95 for date format. Standard edits check that no dates are later than the current date.

DATE CASE LAST CHANGED

Alternate Name	Item #	Length	Source of Standard	Column #
	2100	8	NAACCR	1182-1189

Description
Date the case was last changed or updated. See page 95 for date format. Standard edits check that no dates are later than the current date. Definitions may vary among areas.

DATE CASE REPORT EXPORTED

Alternate Name	Item #	Length	Source of Standard	Column #
Date Case Transmitted (pre-98 NAACCR)	2110	8	NPCR	1190-1197

Description
Date the reporting facility exports the electronic abstract to a file for transmission to the central registry via diskette or other electronic medium. See page 95 for date format. Standard edits check that no dates are later than the current date.

Definitions may vary among registries and software providers. This item is not yet well defined for use when a central registry is creating a transmission record for a consolidated tumor record from multiple source records.

DATE CASE REPORT LOADED

Alternate Name	Item #	Length	Source of Standard	Column #
	2112	8	NPCR	1227-1234

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 95 for date format.

This item is not yet well defined for use when a central registry is creating a transmission record for a consolidated tumor record from multiple source records.

DATE CASE REPORT RECEIVED

Alternate Name	Item #	Length	Source of Standard	Column #
	2111	8	NPCR	1219-1226

Description
Date the electronic or paper 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 95 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 and consequently, timeliness standards have been established. 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 by individual reporting facilities to central cancer registries. 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 OF 1ST CONTACT

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Adm/1st Contact	580	8	CoC	416-423

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 95 for date format.

When Pathology Specimen Only (Class of Case 7, Type of Reporting Source 3) tumors are collected, the Path--Date of Specimen Collection [7320] from the pathology report should be used for the Date of 1st Contact. If a pathology-specimen-only case is followed by a patient contact with the facility for the diagnosis and/or treatment of the respective tumor, the Date of 1st Contact is not changed. The date of the initial pathology laboratory specimen collection remains the Date of 1st Contact.

When Death Certificate Only (Class of Case 8, 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 5, Type of Reporting Source 6) tumors are collected, the date of death should be used as the Date of 1st Contact.

Rationale
Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations. Date of 1st Contact is one of several data items that can be used to measure timeliness of reporting by individual facilities to central cancer registries. For tumors that are not diagnosed at the reporting facility (Class of Case 2, 3, or 4), 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. To accurately measure the timeliness of data collection and submission of abstracts that are first diagnosed at autopsy (Class of Case 5, 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 8, 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 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	843-850

Description
Date of initiation of the first therapy for the cancer being reported, using the CoC definition of first course. The date of first treatment includes the date a decision was made not to treat the patient. See *FORDS* for details. See Chapter V, Unresolved Issues for further discussion of the difference between SEER and CoC items. See page 95 for date format.

Codes (in addition to valid dates)
00000000 Diagnosed at autopsy.
99999999 When it is unknown whether any treatment was administered to the patient, the date is unknown or the case was identified by death certificate-only.

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

Alternate Name	Item #	Length	Source of Standard	Column #
Date of First Positive Biopsy (CoC)	1080	8	NAACCR	610-617

Description
Date of first positive tissue biopsy/positive histology. See page 95 for date format.

Codes (in addition to valid dates)
00000000 Positive biopsy never obtained

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

DATE OF CA CONFERENCE **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	660			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

DATE OF CONCLUSIVE DX **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Conclusive Terminology Date of Conclusive Diagnosis	443	8	SEER	325-332

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. The date of the conclusive diagnosis must be greater than 60 days following the initial (ambiguous terminology only) diagnosis. See page 95 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 conclusive terminology.

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

00000000	Accessioned based on ambiguous terminology only (Code 1 in data item Ambiguous Terminology DX)
88888888	Not applicable, initial diagnosis made by unambiguous terminology (Code 0 in data item Ambiguous Terminology DX)
99999999	Unknown date, unknown if diagnosis based on ambiguous terminology (Code 9 in data item Ambiguous Terminology DX)

DATE OF DIAGNOSIS

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Initial Diagnosis (CoC)	390	8	SEER/CoC	283-290

Description
Date of initial diagnosis by a recognized medical practitioner for the tumor being reported whether clinically or microscopically confirmed. See page 95 for date format.

For more discussion on determining date of diagnosis, consult the *SEER Program Manual* or CoC *FORDS Manual*.

DATE OF INITIAL RX--SEER

Alternate Name	Item #	Length	Source of Standard	Column #
Date Therapy Initiated (SEER) Date Started (SEER)	1260	8	SEER	835-842

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 95 for date format.

Codes (in addition to valid dates)
00000000 No therapy
99999999 Unknown date/Unknown if therapy was administered

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	424-431

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 95 for date format.

Codes (in addition to valid dates)
00000000 Patient was never an inpatient at the reporting facility
99999999 Unknown

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	432-439

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 95 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.

Special Codes (in addition to a valid date

00000000	Patient was never an inpatient at the reporting hospital
99999999	Unknown

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

DATE OF LAST CONTACT

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Last Contact or Death (CoC) Date of Last Follow-Up or of Death (SEER)	1750	8	SEER/CoC	1294-1301

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 95 for date format.

Rationale

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

DATE OF MULTIPLE TUMORS **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	445	8	SEER	335-342

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 95 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

00000000	Single tumor
88888888	Information on multiple tumors not collected/not applicable for this site
99999999	Unknown date

DATE TUMOR RECORD AVAILBL

Alternate Name	Item #	Length	Source of Standard	Column #
	2113	8	NPCR	1235-1242

Description
Date the demographic and tumor identification information on a single 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 95 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 and consequently, timeliness standards have been established. 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 approved to retire this data item in Version 6. See Place of Death [1940].

DC STATE FILE NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	2380	6	State	2278-2283

Description
Death certificate identification number as assigned by the vital statistics office in the place recorded in Place of Death [1940].

DERIVED AJCC M

Alternate Name	Item #	Length	Source of Standard	Column #
Derived M	2980	2	AJCC	665-666

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

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/ stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form and adds several additional fields. When CS data items are

coded, a computer algorithm provided by the Task Force allows generation of AJCC Sixth Edition TNM stage, Summary Stage 1977, and Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

The Storage Code column is the value to be stored in the NAACCR record. The 2-character numeric Storage Codes are designed for analysis purposes. The Display String is the corresponding label that should be displayed on the screen or in a report. The meaning of these strings is explained for each site in the AJCC Manual.

Codes

M Storage Code	Display String	Comments
99	MX	MX
00	M0	M0
10	M1	M1
11	M1a	M1a
12	M1b	M1b
13	M1c	M1c
19	M1NOS	M1 NOS
88	NA	Not applicable

DERIVED AJCC M DESCRIPTOR

Alternate Name	Item #	Length	Source of Standard	Column #
Derived M Descriptor	2990	1	AJCC	667-667

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

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/ stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

This derived output records a “c,” “p,” “a,” “y,” or "N" for “clinical,” “pathological,” “autopsy only,” “y prefix,” or "not applicable," respectively. For those tumors in which staging classification is performed during or following initial multimodality therapy, the category is identified by a “y prefix” to be derived from the computerized algorithm.

Codes

c	Clinical stage
p	Pathologic stage
a	Autopsy stage
y	Pathologic examination of metastatic tissue performed after presurgical systemic treatment or radiation, and extension based on pathologic evidence
N	Not applicable
blank	Not derived

DERIVED AJCC N

Alternate Name	Item #	Length	Source of Standard	Column #
Derived N	2960	2	AJCC	662-663

Description
This is the AJCC "N" component that is derived from coded fields, using the CS algorithm, effective with 2004 diagnosis.

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/ stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

The Storage Code column is the value to be stored in the NAACCR record. The 2-character numeric Storage Codes are designed for analysis purposes. The Display String is the corresponding label that should be displayed on the screen or in a report. The meaning of these strings is explained for each site in the AJCC Manual.

Codes

N Storage Codes	Display String	Comments
99	NX	NX
00	N0	N0
09	N0NOS	N0 NOS
01	N0(i-)	N0(i-)
02	N0(i+)	N0(i+)
03	N0(mol-)	N0(mol-)
04	N0(mol+)	N0(mol+)
10	N1	N1
19	N1NOS	N1 NOS
11	N1a	N1a
12	N1b	N1b
13	N1c	N1c
18	N1mi	N1mi
20	N2	N2
29	N2NOS	N2 NOS
21	N2a	N2a
22	N2b	N2b
23	N2c	N2c
30	N3	N3
39	N3NOS	N3 NOS
31	N3a	N3a
32	N3b	N3b
33	N3c	N3c
88	NA	Not applicable

DERIVED AJCC N DESCRIPTOR

Alternate Name	Item #	Length	Source of Standard	Column #
Derived N Descriptor	2970	1	AJCC	664-664

Description
This is the AJCC "N Descriptor" component that is derived from coded fields using the CS algorithm, effective with 2004 diagnosis.

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

This derived output records a "c," "p," "a," "y," or "N" for "clinical," "pathological," "autopsy only," "y prefix," or "not applicable," respectively. For those tumors in which AJCC TNM staging classification is performed during or following initial multimodality therapy, the category is identified by a "y prefix" to be derived from the computerized algorithm.

Codes

c	Clinical stage
p	Pathologic stage
a	Autopsy stage
y	Lymph nodes removed for examination after presurgical systemic treatment or radiation, and lymph node evaluation based on pathologic evidence
N	Not applicable
blank	Not derived

DERIVED AJCC STAGE GROUP

Alternate Name	Item #	Length	Source of Standard	Column #
Derived Stage Group	3000	2	AJCC	668-669

Description
This is the AJCC "Stage Group" component that is derived from the CS detailed site-specific codes, using the CS from the CS algorithm effective with 2004 diagnosis.

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/ stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

Codes

AJCC Storage Code	Display String	Comments
00	0	Stage 0
01	0a	Stage 0a
02	0is	Stage 0is
10	I	Stage I
11	INOS	Stage I NOS
12	IA	Stage IA
13	IA1	Stage IA1
14	IA2	Stage IA2
15	IB	Stage IB
16	IB1	Stage IB1
17	IB2	Stage IB2
18	IC	Stage IC
19	IS	Stage IS
23	ISA	Stage ISA (lymphoma only)
24	ISB	Stage ISB (lymphoma only)
20	IEA	Stage IEA (lymphoma only)
21	IEB	Stage IEB (lymphoma only)
22	IE	Stage IE (lymphoma only)
30	II	Stage II
31	IINOS	Stage II NOS
32	IIA	Stage IIA
33	IIB	Stage IIB
34	IIC	Stage IIC
35	IIEA	Stage IIEA (lymphoma only)
36	IIEB	Stage IIEB (lymphoma only)
37	IIE	Stage IIE (lymphoma only)
38	IISA	Stage IISA (lymphoma only)
39	IISB	Stage IISB (lymphoma only)
40	IIS	Stage IIS (lymphoma only)
41	IIESA	Stage IIESA (lymphoma only)
42	IIESB	Stage IIESB (lymphoma only)
43	IIES	Stage IIES (lymphoma only)
50	III	Stage III
51	IIINOS	Stage III NOS
52	IIIA	Stage IIIA
53	IIIB	Stage IIIB
54	IIIC	Stage IIIC
55	IIIEA	Stage IIIEA (lymphoma only)
56	IIIEB	Stage IIIEB (lymphoma only)
57	IIIE	Stage IIIE (lymphoma only)
58	IIISA	Stage IIISA (lymphoma only)
59	IIISB	Stage IIISB (lymphoma only)
60	IIIS	Stage IIIS (lymphoma only)
61	IIIESA	Stage IIIESA (lymphoma only)

62	IIIESB	Stage IIIESB (lymphoma only)
63	IIIES	Stage IIIES (lymphoma only)
70	IV	Stage IV
71	IVNOS	Stage IV NOS
72	IVA	Stage IVA
73	IVB	Stage IVB
74	IVC	Stage IVC
88	NA	Not applicable
90	OCCULT	Stage Occult
99	UNK	Stage Unknown

DERIVED AJCC T

Alternate Name	Item #	Length	Source of Standard	Column #
Derived T	2940	2	AJCC	659-660

Description
This is the AJCC "T" component that is derived from CS coded fields, using the CS algorithm, effective with 2004 diagnosis.

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/ stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

The Storage Code column is the value to be stored in the NAACCR record. The 2-character numeric Storage Codes are designed for analysis purposes. The Display String is the corresponding label that should be displayed on the screen or in a report. The meaning of these strings is explained for each site in the AJCC Manual.

Codes

T Storage Code	Display String	Comments
99	TX	TX
00	T0	T0
01	Ta	Ta
05	Tis	Tis
06	Tispu	Tispu (urethra only)
07	Tispd	Tispd (urethra only)
10	T1	T1
11	T1mic	T1mic
19	T1NOS	T1 NOS
12	T1a	T1a
13	T1a1	T1a1
14	T1a2	T1a2

15	T1b	T1b
16	T1b1	T1b1
17	T1b2	T1b2
18	T1c	T1c
20	T2	T2
29	T2NOS	T2NOS
21	T2a	T2a
22	T2b	T2b
23	T2c	T2c
30	T3	T3
39	T3NOS	T3 NOS
31	T3a	T3a
32	T3b	T3b
33	T3c	T3c
40	T4	T4
49	T4NOS	T4 NOS
41	T4a	T4a
42	T4b	T4b
43	T4c	T4c
44	T4d	T4d
88	NA	Not applicable

DERIVED AJCC T DESCRIPTOR

Alternate Name	Item #	Length	Source of Standard	Column #
Derived T Descriptor	2950	1	AJCC	661-661

Description
This is the AJCC "T Descriptor" component that is derived from CS coded fields, using the CS algorithm, effective with 2004 diagnosis.

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

This derived output records a "c," "p," "a," "y," or "N" for "clinical," "pathological," "autopsy only," "y prefix," or "not applicable," respectively. For those cases in which staging classification is performed during or following initial multimodality therapy, the category is identified by a "y prefix" to be derived from the computerized algorithm.

Codes
c Clinical stage
p Pathologic stage
a Autopsy stage

y Surgical resection performed after presurgical systemic treatment or radiation; tumor size/extension based on pathologic evidence
N Not applicable
blank Not derived

DERIVED AJCC--FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
AJCC Conversion Flag	3030	1	AJCC	672-672

Description
Flag to indicate whether the derived AJCC stage was derived from CS or EOD codes.

Codes
1 AJCC Sixth Edition derived from *Collaborative Staging Manual and Coding Instructions,* Version 1.0
2 AJCC Sixth Edition derived from EOD (prior to 2004)
Blank Not derived

DERIVED SS1977

Alternate Name	Item #	Length	Source of Standard	Column #
Derived SEER Summary Stage 1977	3010	1	AJCC	670-670

Description
This item is the derived "SEER Summary Stage 1977" from the CS algorithm (or EOD codes) effective with 2004 diagnosis.

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/ stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

Codes

Storage Code	Display String	Comments
	ERROR	Processing error (no storage code needed)
	NONE	None (internal use only, no storage code needed)
0	IS	*In situ*
1	L	Localized
2	RE	Regional, direct extension
3	RN	Regional, lymph nodes only
4	RE+RN	Regional, extension and nodes
5	RNOS	Regional, NOS
7	D	Distant
8	NA	Not applicable
9	U	Unknown/Unstaged

DERIVED SS1977--FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
SS1977 Conversion Flag	3040	1	AJCC	673-673

Description
Flag to indicate whether the derived SEER Summary Stage 1977 was derived from CS or EOD codes.

Codes
1 SS1977 derived from *Collaborative Staging Manual and Coding Instructions,* Version 1.0
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	671-671

Description
This item is the derived "SEER Summary Stage 2000" from the CS algorithm (or EOD codes) effective with 2004 diagnosis.

Rationale
CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/ stage information to meet the needs of all of the participating standard setters. CS incorporates all of the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR record for these outputs.

Codes

Storage Code	Display String	Comments
	ERROR	Processing error (no storage code needed)
	NONE	None (internal use only, no storage code needed)
0	IS	*In situ*
1	L	Localized
2	RE	Regional, direct extension
3	RN	Regional, lymph nodes only
4	RE+RN	Regional, extension and nodes
5	RNOS	Regional, NOS
7	D	Distant
8	NA	Not applicable
9	U	Unknown/Unstaged

DERIVED SS2000--FLAG

Alternate Name	Item #	Length	Source of Standard	Column #
SS2000 Conversion Flag	3050	1	AJCC	674-674

Description
Flag to indicate whether the derived SEER Summary Stage 2000 was derived from CS or EOD codes.

Codes
1 SS2000 derived from *Collaborative Staging Manual and Coding Instructions,* Version 1.0
2 SS2000 derived from EOD (prior to 2004)
Blank Not derived

DIAGNOSTIC CONFIRMATION

Alternate Name	Item #	Length	Source of Standard	Column #
	490	1	SEER/CoC	311-311

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 clinically diagnosed only is an indication of whether case finding is including sources outside of pathology reports.

Codes
1 Positive histology
2 Positive cytology, no positive histology
4 Positive microscopic confirmation, method not specified
5 Positive laboratory test/marker study
6 Direct visualization without microscopic confirmation
7 Radiography and other imaging techniques without microscopic confirmation
8 Clinical diagnosis only (other than 5, 6, or 7)
9 Unknown whether or not microscopically confirmed

DIAGNOSTIC PROC 73-87

Alternate Name	Item #	Length	Source of Standard	Column #
Diagnostic Procedures (1973-87 SEER)	2200	2	SEER	1217-1218

Description
Data item required by SEER for tumors of certain sites for the years 1973-87. This item is no longer collected. See Appendix D of the *SEER Program Code Manual* for details.

EOD--EXTENSION

Alternate Name	Item #	Length	Source of Standard	Column #
Extension (pre-96 SEER/CoC) Extension (SEER EOD) (96 CoC)	790	2	SEER	534-535

Description
Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from 1988 forward.

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 for site-specific codes and coding rules for all EOD fields.

EOD--EXTENSION PROST PATH

Alternate Name	Item #	Length	Source of Standard	Column #
	800	2	SEER	536-537

Description
Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from 1988 forward.

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 with 1995 diagnoses. The field is left blank for all other primaries.

Codes
See *SEER Extent of Disease, 1988: Codes and Coding Instructions*, Third Edition, for site-specific codes and coding rules for all EOD fields.

EOD--LYMPH NODE INVOLV

Alternate Name	Item #	Length	Source of Standard	Column #
Lymph Nodes (pre 96-SEER/CoC) Lymph Nodes (SEER EOD) (96 CoC)	810	1	SEER	538-538

Description
Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from 1988 forward.

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.

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	556-557

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	558-561

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--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	543-555

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--TUMOR SIZE

Alternate Name	Item #	Length	Source of Standard	Column #
Size of Primary Tumor (SEER) Size of Tumor (CoC)	780	3	SEER/CoC	531-533

Description
Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from 1988 forward.

This field is 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

Alternate Name	Item #	Length	Source of Standard	Column #
	779	12		531-542

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 1988 forward.

Group names appear only in the data dictionary and in Appendix E.

Subfields
EOD--Tumor Size [780]
EOD--Extension [790]
EOD--Extension Prost Path [800]
EOD--Lymph Node Involv [810]
Regional Nodes Positive [820]
Regional Nodes Examined [830]

FAMILY HISTORY OF CANCER

Alternate Name	Item #	Length	Source of Standard	Column #
	360	1	Varies	226-226

Description
NAACCR has not adopted standards for this item.

FIN CODING SYSTEM

Alternate Name	Item #	Length	Source of Standard	Column #
	35	1	NAACCR	11-11

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.

NPI, a unique identification number for US health care providers, is scheduled for 2007 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). When a facility starts to use the NPI codes, they should be transmitted in the NPI-specific data items, not in a FIN data item.

Rationale
FIN and NPI codes should not be stored in the same Coding System field, as they are reported in distinctly different fields within the NAACCR layout.

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.

FIRST COURSE CALC METHOD

Alternate Name	Item #	Length	Source of Standard	Column #
	1500	1	NAACCR	894-894

Description
Codes indicating the time interval for defining the first course of therapy.

Codes
1 CoC definitions
2 SEER definitions
9 Other, unknown

FOLLOWING REGISTRY

Alternate Name	Item #	Length	Source of Standard	Column #
	2440	10	CoC	2475-2484

Description
Records the FIN of the registry responsible for following the patient.

NPI, a unique identification number for US health care providers, is scheduled for 2007 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). When a facility starts to use the NPI codes, that information should be transmitted in the data item NPI--Following Registry [2445]. During the transition period to NPIs, Facility Identification Numbers must be provided.

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

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.

FOLLOW-UP CONTACT--CITY

Alternate Name	Item #	Length	Source of Standard	Column #
	1842	20	SEER	1357-1376

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 epidemiological or research studies.

FOLLOW-UP CONTACT--NAME

Alternate Name	Item #	Length	Source of Standard	Column #
	2394	30	SEER	2284-2313

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 epidemiological or research studies.

FOLLOW-UP CONTACT--NO&ST

Alternate Name	Item #	Length	Source of Standard	Column #
	2392	40	SEER	2314-2353

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/personal/tools/pg/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 epidemiological or research studies.

Note: Prior to Version 5, Follow-Up Contact fields may have been used for patient current address in the NAACCR record layout.

FOLLOW-UP CONTACT--POSTAL

Alternate Name	Item #	Length	Source of Standard	Column #
	1846	9	SEER	1379-1387

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 epidemiological or 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

Alternate Name	Item #	Length	Source of Standard	Column #
	1844	2	SEER	1377-1378

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 epidemiological or research studies.

Codes (in addition to USPS and Canadian Postal Service abbreviations)

CD Resident of Canada, NOS (province/territory unknown)

US Resident of United States, NOS (state/commonwealth/territory/possession unknown)

XX Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known

YY Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown

ZZ Residence unknown

FOLLOW-UP CONTACT--SUPPL

Alternate Name	Item #	Length	Source of Standard	Column #
	2393	40	SEER	2354-2393

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 epidemiological or research studies.

FOLLOW-UP SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
Follow-Up Method (pre-96 CoC)	1790	1	CoC	1305-1305

Description
Records the source from which the latest follow-up information was obtained.

Rationale
For registries performing follow-up, this field helps evaluate the success rates of various methods of follow-up. It also can be used to report to institutions the source of follow-up information that is sent to them. When there is a conflict in follow-up information, knowing the source can help resolve the inconsistency.

Codes
0 Reported hospitalization
1 Readmission
2 Physician
3 Patient
4 Department of Motor Vehicles
5 Medicare/Medicaid file
7 Death certificate
8 Other
9 Unknown, not stated in patient record

FOLLOW-UP SOURCE CENTRAL

Alternate Name	Item #	Length	Source of Standard	Column #
	1791	2	NAACCR	1397-1398

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. Because follow-up information includes follow-up address and cancer status as well as date of last contact/vital status, and may come from different sources, it is important to note that Follow-up Source Central refers to the two fields, date of last contact and vital status.

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 approved to retire this data item in Version 10.1.

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 approved to retire this data item in Version 10.1.

GIS COORDINATE QUALITY **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	366	2	NAACCR	233-234

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

Rationale
Spatial analysis of cancer data often requires identifying data records with a high degree of locational 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 exact match of house number and street, and based on property parcel location
03	Coordinates are exact 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 centroids of address city (where 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

Alternate Name	Item #	Length	Source of Standard	Column #
Grade, Differentiation, or Cell Indicator (SEER) Grade/Differentiation (CoC)	440	1	SEER/CoC	306-306

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 current *CoC FORDS Manual* and *SEER Program Code Manual*, for site specific coding rules and conversions.

1	Grade I
2	Grade II
3	Grade III
4	Grade IV
5	T-cell
6	B-cell
7	Null cell
8	NK (natural killer) cell
9	Grade/differentiation unknown, not stated, or not applicable

GRADE (73-91) ICD-O-1

Alternate Name	Item #	Length	Source of Standard	Column #
	1973	1	SEER	1146-1146

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].

HISTOLOGIC TYPE ICD-O-3

Alternate Name	Item #	Length	Source of Standard	Column #
	522	4	SEER/CoC	301-304

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.

Note: See Histology (92-00) ICD-O-2 [420] for ICD-O-2 codes.

Codes
See ICD-O-3,[16] Morphology Section.

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

Alternate Name	Item #	Length	Source of Standard	Column #
	1971	4	SEER	1141-1144

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 [18,19] as originally coded, if available. Blank for tumors coded directly into ICD-O-2 (i.e., 1992 and later cases).

HISTOLOGY (92-00) ICD-O-2

Alternate Name	Item #	Length	Source of Standard	Column #
Histology (CoC)	420	4	SEER/CoC	296-299

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-0-1 and field trial codes.

Codes
See ICD-O-2,[17] 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	737-737

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 may become so in the future. In the event this occurs cancer registries that maintain or collect this information will need to differentiate between ICD-9-CM and ICD-10-CM code use. The code values and definitions for this item would be expanded as necessary. Allowable codes reported in the Comorbidity and Complications items in FORDS would be re-assessed at the same time.

Codes
0 No comorbidities or complications recorded in patient's record
1 ICD-10-CM
9 ICD-9-CM
Blank Comorbidities and Complications not collected

ICD REVISION NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
ICD Code Revision Used for Cause of Death (SEER)	1920	1	SEER	1392-1392

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	1147-1147

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	1243-1243

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	232-232

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 both the 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	138-140

Description
Code for the patient's usual industry, using U.S. Census Bureau codes (2000 Census[25] is preferable) according to coding procedures recommended for death certificates.[24] 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.[25] The 1990 Census codes are recommended for tumors diagnosed before January 1, 2003.[23] For more information, see the U.S. Census Bureau website at: http://www.census.gov/hhes/www/ioindex/overview.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.[21-26]

Codes
For the 1990 Census codes see Instructional Manual Part 19: *Industry and Occupation Coding for Death Certificates*, 1999[22] 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.

INDUSTRY SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
	300	1	NPCR	142-142

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/OUTPT STATUS **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	640			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

INSTITUTION REFERRED FROM

Alternate Name	Item #	Length	Source of Standard	Column #
Facility Referred From	2410	10	CoC	2485-2494

Description
Identifies the facility that referred the patient to the reporting facility.

NPI, a unique identification number for US health care providers, is scheduled for 2007 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). When a facility starts to use the NPI codes, that information should be transmitted in the data item NPI--Inst Referred From [2415]. During the transition period to NPIs, Facility Identification Numbers must be provided.

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

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.

INSTITUTION REFERRED TO

Alternate Name	Item #	Length	Source of Standard	Column #
Facility Referred To	2420	10	CoC	2495-2504

Description
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, is scheduled for 2007 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). When a facility starts to use the NPI codes, that information should be transmitted in the data item NPI--Inst Referred To [2425]. During the transition period to NPIs, Facility Identification Numbers must be provided.

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

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.

LAST FOLLOW-UP HOSPITAL **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	2430			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

LATERALITY

Alternate Name	Item #	Length	Source of Standard	Column #
Laterality at Diagnosis (SEER)	410	1	SEER/CoC	295-295

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, lateral origin unknown; stated to be single primary; including both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms' tumors
9 Paired site, but no information concerning laterality, midline tumor

LATITUDE

Alternate Name	Item #	Length	Source of Standard	Column #
	2352	10	NAACCR	2394-2403

Description
Cancer Registry spatial data for a tumor record represents the point location of the individual's residence on the Earth's surface. The point location is expressed as a coordinate pair of latitude and longitude values determined by any one of several methods: for example, geocoding, address matching, global positioning satellite (GPS) readings, and interpolation from paper or electronic maps. Most of the time this information is provided by a geocoding vendor service. Alternatively, a central registry staff manually assigns the code. This item is not coded by the hospital.

Rationale
Decimal degree coordinate data can be thought of as the universal "currency" of exchange for spatial data to be used (projected or not projected) in GIS. Data in this format can be used by any GIS software and projected for the appropriate area of interest, and would be consistent with formats of data obtained from other sources. Users may not necessarily need to project their data unless they need to preserve properties of area, shape, distance, or direction. Different projections provide one or more of these properties. Some projections are used simply for presentation purposes because they make the map "look" better. Displaying a large area such as a state or province/territory using an unprojected rectangular latitude/longitude decimal degree grid may make the area appear distorted, especially in far northern latitudes.

Allowable values and format
Projection and Units -- Spatial data will be exchanged in "unprojected" latitude and longitude coordinates. The data units will be in decimal degrees (and not in degrees, minutes, seconds).

Correct: Latitude: 41. 890833
Longitude: -123.128943

Not this: Latitude: 41 deg 53' 27"
Longitude: -71 deg 7' 44"

The latitude field is a 10-byte numeric field, right justified. This coordinate may be carried out to 6 decimal places with an explicit decimal point. It has the following format: x12.345678, where "x" is reserved for a negative sign if the coordinate represents a location south of the equator.

Codes
Latitude and longitude data shall always be stored and exchanged as numeric values. Latitude north of the equator is positive. Longitude west of 0 degrees (the Prime Meridian) and east of 180 degrees (approximately the International Date Line) is negative—this applies to the entire North American continent with the exception of the tip of the Aleutian Islands in Alaska.

Note: The datum of the decimal degree data shall be North American Datum of 1983 (NAD 83). Data in NAD 27 shall be converted to NAD 83 prior to data exchange.

LOC/REG/DISTANT STAGE **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	770			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

LONGITUDE

Alternate Name	Item #	Length	Source of Standard	Column #
	2354	11	NAACCR	2404-2414

Description
Cancer Registry spatial data for a tumor record represents the point location of the individual's residence on the Earth's surface. The point location is expressed as a coordinate pair of latitude and longitude values determined by any one of several methods: for example, geocoding, address matching, GPS readings, and interpolation from paper or electronic maps. Most of the time this information is provided by a geocoding vendor service. Alternatively, a central registry staff manually assigns the code. This item is not coded by the hospital.

Rationale
Decimal degree coordinate data can be thought of as the universal "currency" of exchange for spatial data to be used (projected or not projected) in GIS. Data in this format can be used by any GIS software and projected for the appropriate area of interest, and would be consistent with formats of data obtained from other sources. Users may not necessarily need to project their data unless they need to preserve properties of area, shape, distance, or direction. Different projections provide one or more of these properties. Some projections are used simply for presentation purposes because they make the map "look" better. Displaying a large area such as a state or province/territory using an unprojected rectangular latitude/longitude decimal degree grid may make the area appear distorted, especially in far northern latitudes.

Allowable values and format
Projection and Units -- Spatial data are exchanged in "unprojected" latitude and longitude coordinates. The data units are in decimal degrees (and not in degrees, minutes, seconds).

Correct: Latitude: 41.890833
Longitude: -123.128943

Not this: Latitude: 41 deg 53' 27"
Longitude: -123 deg 7' 44"

The longitude field is an 11-byte numeric field, right justified. This coordinate may be carried out to 6 decimal places with an explicit decimal point. It has the following format: x123.456789, where "x" is reserved for a negative sign if the coordinate represents a location west of 0 degrees (Prime Meridian) and east of 180 degrees.

Codes
Latitude and longitude data are stored and exchanged as numeric values. Latitude north of the equator is positive. Longitude west of 0 degrees (the Prime Meridian) and east of 180 degrees (approximately the International Date Line) is negative—this applies to the entire North American continent with the exception of the tip of the Aleutian Islands in Alaska.

Note: The datum of the decimal degree data is NAD 83. Data in NAD 27 are converted to NAD 83 prior to data exchange.

MARITAL STATUS AT DX

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	102-102

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
9 Unknown

MEDICAL RECORD NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	2300	11	CoC	2086-2096

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	2097-2098

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		1141-1146

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 of version 11.2.

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	309-309

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
9 Other

MORPH CODING SYS—ORIGINL

Alternate Name	Item #	Length	Source of Standard	Column #
	480	1	NAACCR	310-310

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
9 Other

MORPH--TYPE&BEHAV ICD-O-2

Alternate Name	Item #	Length	Source of Standard	Column #
	419	5		296-300

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		301-305

Description
Group names appear only in the 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 #
Type of Multiple Tumors Reported as One Primary Multiple Tumors Reported as Single Primary	444	2	SEER	333-334

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, 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
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 Unk in situ or invasive
88 NA
99 Unknown

MULTIPLICITY COUNTER **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	446	2	SEER	343-344

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.

Data collected under this item will be used to assess the number of reportable tumors currently abstracted as a single primary using the 2007, IARC, or Canadian Cancer Registry rules for determining multiple primary cancers and the impact of these cases on cancer case counts and incidence rates. In addition, it will serve as a basis for measuring the impact and feasibility of future modifications to the multiple primary rules, and to compare individually reported cancer cases with historical data if the rules are changed.

Codes

01 One tumor only
02 Two tumors present
03 Three tumors present
..
..
88 Information on multiple tumors not collected/not applicable for this site
99 Multiple tumors present, unknown how many

NAACCR RECORD VERSION **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	50	1	NAACCR	19-19

Description

This item applies only to record types I, C, A and M. Code the NAACCR record version used to create the record.

Note: The correction record (U) has its own record version data item.

Codes

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, and 11.2
Blank September 1989 Version

Note: Code 4 was assigned to the 1995 Version to synchronize the document version and the layout version numbers. Layout document Versions 2 and 3 are coded as 1.

NAME--ALIAS

Alternate Name	Item #	Length	Source of Standard	Column #
Alias (CoC)	2280	15	SEER	2006-2020

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].

NAME--FIRST

Alternate Name	Item #	Length	Source of Standard	Column #
First Name (CoC)	2240	14	NAACCR	1972-1985

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	25	NAACCR	1947-1971

Description
Last name of the patient.

Note: See *FORDS Manual 2004* for CoC allowable values (see Chapter V Unresolved Issues for differences between CoC and NAACCR).

NAME--MAIDEN

Alternate Name	Item #	Length	Source of Standard	Column #
Maiden Name (CoC)	2390	15	SEER	2021-2035

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: See Chapter V, Unresolved Issues, for discussion of hyphenated maiden name.

NAME--MIDDLE

Alternate Name	Item #	Length	Source of Standard	Column #
Middle Name (CoC) Middle Initial (pre-96 CoC)	2250	14	CoC	1986-1999

Description
Middle name or, if middle name is unavailable, middle initial of the patient.

NAME--PREFIX

Alternate Name	Item #	Length	Source of Standard	Column #
Name Prefix (CoC)	2260	3	SEER	2000-2002

Description
Abbreviated title that precedes name in a letter (e.g., "Rev.," "Ms.").

NAME--SPOUSE/PARENT

Alternate Name	Item #	Length	Source of Standard	Column #
	2290	50	NAACCR	2036-2085

Description
NAACCR has not adopted standards for this item. Use varies by area.

NAME--SUFFIX

Alternate Name	Item #	Length	Source of Standard	Column #
Name Suffix (CoC)	2270	3	SEER	2003-2005

Description
Title that follows a patient's last name, such as a generation order or credential status (e.g., "MD," "Jr.").

NEXT FOLLOW-UP SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
Next Follow-Up Method (pre-96 CoC)	1800	1	CoC	1306-1306

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	231-231

Description
The NAACCR Hispanic Identification Algorithm (NHIA) uses a combination of NAACCR 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 NAACCR standard variables: Spanish/Hispanic Origin [190], Name-Last [2230], Name-Maiden [2390], Birthplace [250], Race 1 [160], and Sex [220].

Code 7 (Spanish surname only) of the Spanish/Hispanic Origin [190] data item became effective with 1994 diagnosis. It is recommended that NHIA should be run on 1995 and forward diagnoses. However, a central registry may run it on their data for prior years.

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. The 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 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	3105	10	NAACCR	447-456

Description
This field identifies the NPI (National Provider Identifier) number of the facility at the time it initially accessioned the tumor.

NPI, a unique identification number for US health care providers, is 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 will be required to use NPI codes by May 2007; small health plans will be required to use NPI codes by May 2008. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items.

Rationale
The NPI equivalent of Archive FIN [3100].

Codes
NPI assigned to institutions start with the value "2". Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at:
,http://new.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIcheckdigit.pdf

NPI--FOLLOWING REGISTRY **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2445	10	NAACCR	2525-2534

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, is 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 will be required to use NPI codes by May 2007; small health plans will be required to use NPI codes by May 2008. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items.

Rationale
The NPI equivalent of Following Registry [2440].

Codes
NPI assigned to institutions start with the value "2". Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at:
http://new.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIcheckdigit.pdf

NPI--INST REFERRED FROM **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2415	10	NAACCR	2505-2514

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, is 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 will be required to use NPI codes by May 2007; small health plans will be required to use NPI codes by May 2008. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items.

Rationale
The NPI equivalent of Institution Referred From [2410].

Codes
NPI assigned to institutions start with the value "2". Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at:
http://new.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIcheckdigit.pdf

NPI--INST REFERRED TO **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2425	10	NAACCR	2515-2524

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, is 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 will be required to use NPI codes by May 2007; small health plans will be required to use NPI codes by May 2008. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items.

Rationale
The NPI equivalent of Institution Referred To [2420].

Codes
NPI assigned to institutions start with the value "2". Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at:
http://new.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIcheckdigit.pdf

NPI--PHYSICIAN 3 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Medical Oncologist (CoC)	2495	10	NAACCR	2625-2634

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, is 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 will be required to use NPI codes by May 2007; small health plans will be required to use NPI codes by May 2008. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items.

Codes
NPI assigned to individuals start with the value "1". Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at:
http://new.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIcheckdigit.pdf

NPI--PHYSICIAN 4 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation Oncologist (CoC)	2505	10	NAACCR	2635-2644

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, is 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 will be required to use NPI codes by May 2007; small health plans will be required to use NPI codes by May 2008. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items.

Codes
NPI assigned to individuals start with the value "1". Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at:
http://new.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIcheckdigit.pdf

NPI--PHYSICIAN--FOLLOW-UP **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2475	10	NAACCR	2605-2614

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, is 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 will be required to use NPI codes by May 2007; small health plans will be required to use NPI codes by May 2008. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items.

Rationale
The NPI equivalent of Physician—Follow-Up [2470].

Codes
NPI assigned to individuals start with the value "1".Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at:
http://new.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIcheckdigit.pdf

NPI--PHYSICIAN--MANAGING **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2465	10	NAACCR	2595-2604

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, is 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 will be required to use NPI codes by May 2007; small health plans will be required to use NPI codes by May 2008. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items.

Rationale
The NPI equivalent of Physician—Managing [2460].

Codes
NPI assigned to individuals start with the value "1". Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at:
http://new.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIcheckdigit.pdf

NPI--PHYSICIAN--PRIMARY SURG **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	2485	10	NAACCR	2615-2624

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, is 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 will be required to use NPI codes by May 2007; small health plans will be required to use NPI codes by May 2008. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items.

Rationale
The NPI equivalent of Physician--Primary Surg [2480].

Codes
NPI assigned to individuals start with the value "1". Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at:
http://new.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIcheckdigit.pdf .

NPI--REGISTRY ID **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	45	10	NAACCR	40-49

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, is 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 will be required to use NPI codes by May 2007; small health plans will be required to use NPI codes by May 2008. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items.

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
NPI assigned to individuals start with the value "1", and facilities start with the value "2".
Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at: http://new.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIcheckdigit.pdf.

NPI--REPORTING FACILITY **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	545	10	NAACCR	372-381

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, is 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 will be required to use NPI codes by May 2007; small health plans will be required to use NPI codes by May 2008. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items.

Rationale
The NPI equivalent of Reporting Facility [540].

Codes
NPI assigned to institutions start with the value "2". Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at:
http://new.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIcheckdigit.pdf

NUMBER OF TUMORS/HIST **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	447			

Description
The NAACCR UDSC approved to retire this data item in Version 11.2

OCCUP/IND CODING SYSTEM

Alternate Name	Item #	Length	Source of Standard	Column #
	330	1	NPCR	223-223

Description
Code that identifies coding system used for occupation and industry. This is a central cancer registry data item (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.[25] The 1990 Census codes are recommended for tumors diagnosed before January 1, 2003.[23] For more information, see the U.S. Bureau of the Census website at: http://www.census.gov/hhes/www/ioindex /overview.html.

OCCUPATION CODE--CENSUS

Alternate Name	Item #	Length	Source of Standard	Column #
	270	3	Census/NPCR	135-137

Description
Code for the patient's usual occupation, using U.S. Census Bureau codes (2000 Census[25] is preferable) according to coding procedures recommended for death certificates.[24] 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.[25] The 1990 Census codes are recommended for cancers diagnosed before January 1, 2003.[23] For more information, see the U.S. Bureau of the Census website at: http://www.census.gov/hhes/www/ioindex/overview.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.[22-26]

Codes
For the 1990 Census codes, see Instructional Manual Part 19: *Industry and Occupation Coding for Death Certificates*, 1999,[22] 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.

OCCUPATION SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
	290	1	NPCR	141-141

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 approved to retire this data item in Version 11.

OVER-RIDE ACSN/CLASS/SEQ

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Accession/Class of Case/Sequence	1985	1	CoC	1119-1119

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 = 0, 1, or 6), 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 = 5) 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 = 5) and the case is not the first case for a patient (Sequence Number--Hospital not equal to 00, 01, 60, or 61), then the year of the Date of 1st Contact must equal the year of Date of Last Contact.

There are some exceptions to the above rules. Over-ride Acsn/Class/Seq may be used to override the edit when the circumstances fit the following situation or one similar to it:

1. The case may be the only or the first of multiple malignant cases for a patient (Sequence Number--Hospital = 00 or 01), but there is an earlier benign case (with an earlier year of the Date of 1st Contact) to which the Accession Number--Hosp applies.

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 Class of Case 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
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	1124-1124

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 for the edits of the type Age, Primary Site, Morphology.
2. Leave blank and correct any errors for the case if an item is discovered to be incorrect.
3. Code 1 as indicated if review of items in the error or warning message confirms that all are correct.

Codes

1 Reviewed: An unusual occurrence of a particular age/site/histology combination for a given age group has been reviewed.
Blank Not reviewed or reviewed and corrected.

OVER-RIDE COC-SITE/TYPE

Alternate Name	Item #	Length	Source of Standard	Column #
	1987	1	CoC	1121-1121

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)

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, 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.

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.

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 (epithielial 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
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	1129-1129

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.

1. 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 appears in ICD-O-2 or ICD-O-3 only with behavior codes of 0 or 1, or 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 items in the error or warning message confirms all are correct.

Codes

1 Reviewed: The behavior code of the histology is designated as "benign" or "uncertain" in ICD-O-2 or ICD-O-3, and the pathologist states the primary to be "*in situ*" or "malignant"
Reviewed: The behavior code of the histology is generally not "*in situ*" in ICD-O-2 or ICD-O-3 and the pathologist states the primary to be "*in situ*"

2 Reviewed: The behavior code is "*in situ*," but the case is not microscopically confirmed (flag for a "Diagnostic Confirmation, Behavior" edit)

3 Reviewed: Conditions 1 and 2 above 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	1120-1120

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
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	1122-1122

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 form 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
Blank Not reviewed or reviewed and corrected

OVER-RIDE ILL-DEFINE SITE

Alternate Name	Item #	Length	Source of Standard	Column #
Sequence Number/Ill-defined Site Interfield Review (Interfield Edit 22)	2060	1	SEER	1131-1131

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.

Codes

1 Reviewed: 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	1132-1132

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
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	1130-1130

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 check 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
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	1125-1125

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 special sites in which at least one diagnosis has not been microscopically confirmed.

Codes
1 Reviewed
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	1133-1133

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.

1. 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
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)	2072	1	SEER	1134-1134

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)

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
Blank Not reviewed or reviewed and corrected

OVER-RIDE SITE/LAT/EOD

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Flag for Site/Laterality/EOD (IF41)	2073	1	SEER	1135-1135

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)

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, Laterality, EOD apply to paired organs and identifies EOD 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).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
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	1136-1136

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.

1. 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
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	1126-1126

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
Blank Not reviewed or reviewed and corrected

OVER-RIDE SITE/TNM-STGGRP

Alternate Name	Item #	Length	Source of Standard	Column #
	1989	1	CoC	1123-1123

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 codes 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
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	1128-1128

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)

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
Blank Not reviewed or reviewed and corrected

OVER-RIDE SS/DISMET1

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Summary Stage/Distant Metastasis 1	1984	1	NAACCR	1118-1118

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, Site Dist Met 1 (NAACCR)
Summary Stage 2000, Site Dist Met 1 (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, Site Dist Met 1 (NAACCR) checks SEER Summary Stage 1977against the Distant Metastatic Site 1 and generates an error or warning if there is an incompatibility between the two data items. The edit Summary Stage 2000, Site Dist Met 1 (NAACCR) checks SEER Summary Stage 2000 against the Site Distant Met 1 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, Site Dist Met 1 (NAACCR) or the edit Summary Stage 2000, Site Dist Met 1 (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 SEER Summary Stage 1977 and Site Distant Met 1 have been coded correctly or SEER Summary Stage 2000 and Site Distant Met 1 have been coded correctly.

Codes

1 Reviewed
Blank Not reviewed or reviewed and corrected

OVER-RIDE SS/NODESPOS

Alternate Name	Item #	Length	Source of Standard	Column #
Over-ride Summary Stage/Nodes Positive	1981	1	NAACCR	1115-1115

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
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	1117-1117

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
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	1116-1116

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
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	1127-1127

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.

1. 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
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 approved to retire this data item in Version 10.1.

PATIENT ID NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	20	8	Reporting Registry	2-9

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	32-39

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	621-622

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	625-625

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	623-624

Description
Staging system used to assign the Pediatric Stage.

Rationale
Staging of pediatric tumors requires very different schemes from those used to stage adult tumors.

Codes
00 None
01 AJCC
02 Ann Arbor
03 Children's Cancer Group (CCG)
04 Evans
05 General Summary
06 Intergroup Ewings
07 Intergroup Hepatoblastoma
08 Intergroup Rhabdomyosarcoma
09 International System
10 Murphy
11 NCI (pediatric oncology)
12 National Wilms's Tumor Study
13 Pediatric Oncology Group (POG)
14 Reese-Ellsworth
15 SEER Extent of Disease
88 Not applicable (not pediatric case)
97 Other
99 Unknown

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

PHYSICIAN 3

Alternate Name	Item #	Length	Source of Standard	Column #
Physician #3 (CoC) Other Physician (pre-96 CoC)	2490	8	CoC	2579-2586

Description
Code for another physician involved in the care of the patient. Registry may use physicians' medical license numbers or may create individual numbering systems. See *FORDS Manual* for suggested use of this item and detailed instructions.

NPI, a unique identification number for US health care providers, is scheduled for 2007 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). When a physician starts to use the NPI codes, that information should be transmitted in the data item NPI--Physician 3 [2495].

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	2587-2594

Description
Code for another physician involved in the care of the patient. Registry may use physicians' medical license numbers or may create individual numbering systems. See *FORDS Manual* for suggested use of this item and detailed instructions.

NPI, a unique identification number for US health care providers, is scheduled for 2007 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). When a physician starts to use the NPI codes, that information should be transmitted in the data item NPI--Physician 4 [2505].

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	2563-2570

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.

NPI, a unique identification number for US health care providers, is scheduled for 2007 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). When a physician starts to use the NPI codes, that information should be transmitted in the data item NPI--Physician--Follow-Up [2475].

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	2555-2562

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.

NPI, a unique identification number for US health care providers, is scheduled for 2007 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). When a physician starts to use the NPI codes, that information should be transmitted in the data item NPI--Physician--Managing [2465].

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	2571-2578

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.

NPI, a unique identification number for US health care providers, is scheduled for 2007 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). When a physician starts to use the NPI codes, that information should be transmitted in the data item NPI--Physician--Primary Surg [2485].

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	1394-1396

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 approved to retire this data item in Version 11.

PRIMARY PAYER AT DX

Alternate Name	Item #	Length	Source of Standard	Column #
Primary Payer at Diagnosis (CoC)	630	2	CoC	445-446

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 #
	400	4	SEER/CoC	291-294

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 have not changed between ICD-O-2 and ICD-O-3.

Codes
See ICD-O-2,[17] or ICD-O-3,[16] Topography Section, for the codes for primary site.

Note: See 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 approved to retire this data item in Version 11.

PROTOCOL PARTICIPATION **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1480			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

QUALITY OF SURVIVAL

Alternate Name	Item #	Length	Source of Standard	Column #
	1780	1	CoC	1304-1304

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	103-104

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 code. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164].

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis 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 (for for additional instructions see the current SEER Program Coding and Staging Manual)
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
09 Asian Indian, Pakistani

10 Vietnamese
11 Laotian
12 Hmong
13 Kampuchean
14 Thai
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

Note: Codes 20-97 were adopted for use effective with 1991 diagnoses. Code 14 was adopted for use effective with 1994 diagnoses.

RACE 2

Alternate Name	Item #	Length	Source of Standard	Column #
	161	2	SEER/CoC	105-106

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 code. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164].

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis 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 (for additional instructions see the current SEER Program Coding and Staging Manual)
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
09 Asian Indian, Pakistani
10 Vietnamese
11 Laotian
12 Hmong
13 Kampuchean
14 Thai
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

Note: Codes 20-97 were adopted for use effective with 1991 diagnoses. Code 14 was adopted for use effective with 1994 diagnoses. Code 88 was adopted for use effective with 2000 diagnoses.

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	107-108

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 code. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164].

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis 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 (for additional instructions see the current SEER Program Coding and Staging Manual)

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
09 Asian Indian, Pakistani
10 Vietnamese
11 Laotian
12 Hmong
13 Kampuchean
14 Thai
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

Note: Codes 20-97 were adopted for use effective with 1991 diagnoses. Code 14 was adopted for use effective with 1994 diagnoses. Code 88 was adopted for use effective with 2000 diagnoses.

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	109-110

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 code. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164].

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis 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 (for additional instructions see the current SEER Program Coding and Staging Manual)

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
09	Asian Indian, Pakistani
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean
14	Thai
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

Note: Codes 20-97 were adopted for use effective with 1991 diagnoses. Code 14 was adopted for use effective with 1994 diagnoses. Code 88 was adopted for use effective with 2000 diagnoses.

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	111-112

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 code. If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164].

Reference to Census 2000 definitions for ethnicity and race: http://www.census.gov/prod/cen2000/doc/sf2.pdf

Rationale
Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis 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 (for additional instructions see the current SEER Program Coding and Staging Manual)
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
09 Asian Indian, Pakistani
10 Vietnamese
11 Laotian
12 Hmong
13 Kampuchean
14 Thai
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,
97 Pacific Islander, NOS
98 Other
99 Unknown

Note: Codes 20-97 were adopted for use effective with 1991 diagnoses. Code 14 was adopted for use effective with 1994 diagnoses. Code 88 was adopted for use effective with 2000 diagnoses.

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

Alternate Name	Item #	Length	Source of Standard	Column #
	170	1	NAACCR	113-113

Description
Code describes how race 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)
9 Other

RACE CODING SYS--ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Column #
	180	1	NAACCR	114-114

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)
9 Other

RAD--BOOST DOSE CGY **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Boost Radiation Dose: cGY	3210	5	CoC	913-917

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 prescribed 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 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Boost Radiation Treatment Modality	3200	2	CoC	911-912

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 approved to retire this data item in Version 11.

RAD--INTENT OF TREATMENT **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1560			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

RAD--LOCAL CONTROL STATUS **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1590			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

RAD--LOCATION OF RX

Alternate Name	Item #	Length	Source of Standard	Column #
Location of Radiation Treatment (CoC)	1550	1	CoC	907-907

Description
Identifies the location of the facility where radiation treatment was administered during first course of treatment. See also RX Summ--Radiation [1360].

Codes
0 No radiation treatment
1 All radiation treatment at this facility
2 Regional treatment at this facility, boost elsewhere
3 Boost radiation at this facility, regional elsewhere
4 All radiation treatment elsewhere
8 Other, NOS
9 Unknown

RAD--NO OF TREATMENT VOL

Alternate Name	Item #	Length	Source of Standard	Column #
Number of Treatments to this Volume (CoC)	1520	2	CoC	900-901

Description
Records the total number of treatment sessions (fractions) administered during the first course of therapy. See also RX Summ--Radiation [1360].

Codes
00 None
01-98 Number of treatments
99 Unknown

RAD--REGIONAL DOSE: CGY

Alternate Name	Item #	Length	Source of Standard	Column #
Regional Dose: cGy (CoC)	1510	5	CoC	895-899

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	909-910

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 approved to retire this data item in Version 11.

RAD--TREATMENT VOLUME

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation Treatment Volume (CoC)	1540	2	CoC	905-906

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	938-938

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 approved to retire this data item in Version 11.

REASON FOR NO HORMONE **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1450			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

REASON FOR NO RADIATION

Alternate Name	Item #	Length	Source of Standard	Column #
Reason for No Regional Radiation Therapy	1430	1	CoC	885-885

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	868-868

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

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 = 1946
C **C**onfidential record type (incidence record plus confidential data)
Length = 2644
A Full case **A**bstract record type (incidence and confidential data plus text summaries; used for reporting to central registries)
Length = 6694

U Correction/**U**pdate record type (short format record used to submit corrections to data already submitted)
Length = 850

R Analysis/**R**esearch record type (incidence record plus appended error flags and recoded values)
Length = 2215

M Record **M**odified since previous submission to central registry (identical in format to the "A" record type)
Length = 6694

L Pathology **L**aboratory

RECURRENCE DATE--1ST

Alternate Name	Item #	Length	Source of Standard	Column #
Date of First Recurrence (CoC)	1860	8	CoC	1342-1349

Description
The date of the first recurrence of this tumor. See page 95 for date format.

Codes

00000000 Patient became disease-free after treatment, never had a recurrence, or patient was never disease-free. Diagnosed at autopsy.

99999999 Unknown if the patient had a first recurrence or the tumor was identified by DCO.

RECURRENCE DISTANT SITE 1

Alternate Name	Item #	Length	Source of Standard	Column #
	1871	1	NAACCR	1350-1350

Description
Code for the distant site or sites in which the tumor has recurred.

Codes

0 None or none known
1 Peritoneum
2 Lung
3 Pleura
4 Liver
5 Bone
6 Central nervous system
7 Skin
8 Lymph nodes (distant)
9 Other, generalized, NOS, carcinomatosis

Note: When carcinomatosis is present, all three fields—Recurrence Distant Site 1, 2, and 3—are coded 9.

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

RECURRENCE DISTANT SITE 2

Alternate Name	Item #	Length	Source of Standard	Column #
	1872	1	NAACCR	1351-1351

Description
Code for the distant site or sites in which the tumor has recurred.

Codes
0 None or none known
1 Peritoneum
2 Lung
3 Pleura
4 Liver
5 Bone
6 Central nervous system
7 Skin
8 Lymph nodes (distant)
9 Other, generalized, NOS, carcinomatosis

Note: When carcinomatosis is present, all three fields—Recurrence Distant Site 1, 2, and 3—are coded 9. If Recurrence Distant Site 1 [1871] is coded to 0, then this field also must be coded to 0.

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

RECURRENCE DISTANT SITE 3

Alternate Name	Item #	Length	Source of Standard	Column #
	1873	1	NAACCR	1352-1352

Description
Code for the distant site or sites in which the tumor has recurred.

Codes
0 None or none known
1 Peritoneum
2 Lung
3 Pleura
4 Liver
5 Bone
6 Central nervous system
7 Skin
8 Lymph nodes (distant)
9 Other, generalized, NOS, carcinomatosis

Note: When carcinomatosis is present, all three fields—Recurrence Distant Site 1, 2, and 3—are coded 9. If Recurrence Distant Site 1 [1871] is coded to 0, then this field also must be coded to 0.

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

RECURRENCE DISTANT SITES **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1870			

Description
The NAACCR UDSC approved to retire this data item in Version 9.1. The subfields are not retired.

Subfields
Recurrence Distant Site 1 [1871]
Recurrence Distant Site 2 [1872]
Recurrence Distant Site 3 [1873]

RECURRENCE TYPE--1ST

Alternate Name	Item #	Length	Source of Standard	Column #
Type of First Recurrence (CoC)	1880	2	CoC	1353-1354

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's that are in remission.
04 *In situ* recurrence of an invasive tumor.
06 *In situ* recurrence of an *in situ* tumor.
10 Local recurrence and there is insufficient information available to code to 13-17. Recurrence is confined to the remnant of the organ of origin; to the organ of origin; to the anastomosis; or to scar tissue where the organ previously existed.
13 Local recurrence of an invasive tumor.
14 Trocar recurrence of an invasive tumor. Includes recurrence in the trocar path or entrance site following prior surgery.
15 Both local and trocar recurrence of an invasive tumor (both 13 and 14)
16 Local recurrence of an *in situ* tumor.
17 Both local and trocar recurrence of an *in situ* tumor.
20 Regional recurrence, and there is insufficient information available to code to 21-27.
21 Recurrence of an invasive tumor in adjacent tissue or organ(s) only.
22 Recurrence of an invasive tumor in regional lymph nodes only.
25 Recurrence of an invasive tumor in adjacent tissue or organ(s)) and in regional lymph nodes (both 21 and 22) at the same time.
26 Regional recurrence of an *in situ* tumor, NOS.
27 Recurrence of an *in situ* tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time.
30 Both regional recurrence of an invasive tumor in adjacent tissue or organ(s) and/or regional lymph nodes (20-25) and local and/or trocar recurrence (10, 13, 14, or 15).
36 Both regional recurrence of an *in situ* tumor in adjacent tissue or organ(s) and/or regional lymph nodes (26 or 27) and local and/or trocar recurrence (16 or 17).
40 Distant recurrence and there is insufficient information available to code to 46-62.
46 Distant recurrence of an *in situ* tumor.

51 Distant recurrence of an invasive tumor in the peritoneum only. Peritoneum includes peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
52 Distant recurrence of an invasive tumor in the lung only. Lung includes the visceral pleura.
53 Distant recurrence of an invasive tumor in the pleura only. Pleura includes the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
54 Distant recurrence of an invasive tumor in the liver only.
55 Distant recurrence of an invasive tumor in bone only. This includes bones other than the primary site.
56 Distant recurrence of an invasive tumor in the CNS only. This includes the brain and spinal cord, but not the external eye.
57 Distant recurrence of an invasive tumor in the skin only. This includes skin other than the primary site.
58 Distant recurrence of an invasive tumor in lymph node only. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site.
59 Distant systemic recurrence of an invasive tumor only. This includes leukemia, bone marrow metastasis, carcinomatosis, and generalized disease.
60 Distant recurrence of an invasive tumor in a single distant site (51-58) and local, trocar, and/or regional recurrence (10-15, 20-25, or 30).
62 Distant recurrence of an invasive tumor in multiple sites (recurrences that can be coded to more than one category 51-59).
70 Since diagnosis, patient has never been disease-free. This includes cases with distant metastasis at diagnosis, systemic disease, unknown primary, or minimal disease that is not treated.
88 Disease has recurred, but the type of recurrence is unknown.
99 It is unknown whether the disease has recurred or if the patient was ever disease-free.

RECURRENCE TYPE--1ST--OTH **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1890			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

REFERRAL TO SUPPORT SERV **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1490			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

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	541-542

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. Tumors diagnosed from 1988 through 2003, this item is a part of the 10-digit EOD [779], detailed site-specific codes for anatomic EOD.

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

Note: See Chapter V, Unresolved Issues, for a discussion of coding differences between CoC and SEER.

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	539-540

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. Tumors diagnosed from 1988 through 2003,this item is 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 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	40	10	NAACCR	20-29

Description
A unique code that represents the data transmission source. This item may not be blank for central registries and non-US health care providers.

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: 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.

REGISTRY TYPE

Alternate Name	Item #	Length	Source of Standard	Column #
	30	1	NAACCR	10-10

Description
A computer-generated code that best describes the type of registry generating the record; used when cases are pooled from multiple registries (a hospital-based registry reporting to a state should have a "3" in this field).

Rationale
Facilitates tracking of data sources when data from multiple registries are pooled.

Codes
1 Central registry (population-based)
2 Central registry or hospital consortium (not population-based)
3 Single hospital/freestanding center

RELIGION

Alternate Name	Item #	Length	Source of Standard	Column #
	260	2	Varies	133-134

Description
NAACCR has not adopted standards for this item.

REPORTING FACILITY

Alternate Name	Item #	Length	Source of Standard	Column #
Institution ID Number (CoC) Facility Identification Number (CoC) Reporting Hospital	540	10	CoC	382-391

Description
CoC code for the facility whose data are described in the record.

NPI, a unique identification number for US health care providers, is scheduled for 2007 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). When a facility starts to use the NPI codes, that information should be transmitted in the data item NPI--Reporting Facility [545]. During the transition period to NPIs, Facility Identification Numbers must be provided.

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

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 approved to retire this data item in Version 11.

RESERVED 00

Alternate Name	Item #	Length	Source of Standard	Column #
	37	7		12-18

RESERVED 01

Alternate Name	Item #	Length	Source of Standard	Column #
	370	2		50-51

RESERVED 02 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	530	45		236-280

RESERVED 03 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
	680	27		345-371

RESERVED 04

Alternate Name	Item #	Length	Source of Standard	Column #
	750	46		482-527

RESERVED 05

Alternate Name	Item #	Length	Source of Standard	Column #
	1180	17		738-754

RESERVED 06

Alternate Name	Item #	Length	Source of Standard	Column #
	1190	45		943-987

RESERVED 07

Alternate Name	Item #	Length	Source of Standard	Column #
	1300	50		1065-1114

RESERVED 08

Alternate Name	Item #	Length	Source of Standard	Column #
	1650	50		1244-1293

RESERVED 09

Alternate Name	Item #	Length	Source of Standard	Column #
	1740	48		1399-1446

RESERVED 10

Alternate Name	Item #	Length	Source of Standard	Column #
	1835	50		2415-2464

RESERVED 11

Alternate Name	Item #	Length	Source of Standard	Column #
	1900	20		2535-2554

RESERVED 12 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1950			

RESERVED 13 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	2080			

RESERVED 14 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	2210			

RESERVED 16 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	2400			

RESERVED 17 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	2450			

RESERVED 19

Alternate Name	Item #	Length	Source of Standard	Column #
	2700	770		5925-6694

RESERVED 20 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	2161			

RESERVED 21 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	2371			

RESERVED 22

Alternate Name	Item #	Length	Source of Standard	Column #
	1355	1		872-872

RESERVED 23

Alternate Name	Item #	Length	Source of Standard	Column #
	1635	13		918-930

RESERVED 24

Alternate Name	Item #	Length	Source of Standard	Column #
	2082	16		1148-1163

RESERVED 25 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	535			

RESERVED 26

Alternate Name	Item #	Length	Source of Standard	Column #
	615	4		441-444

RESERVED 27 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	635			

RESERVED 28

Alternate Name	Item #	Length	Source of Standard	Column #
	741	4		474-477

RESERVED 29

Alternate Name	Item #	Length	Source of Standard	Column #
	765	1		530-530

RESERVED 30

Alternate Name	Item #	Length	Source of Standard	Column #
	995	10		583-592

RESERVED 31

Alternate Name	Item #	Length	Source of Standard	Column #
	1065	15		595-609

RESERVED 32

Alternate Name	Item #	Length	Source of Standard	Column #
	1435	2		886-887

RESERVED 33

Alternate Name	Item #	Length	Source of Standard	Column #
	1465	4		890-893

RESERVED 34

Alternate Name	Item #	Length	Source of Standard	Column #
	1535	3		902-904

RESERVED 35

Alternate Name	Item #	Length	Source of Standard	Column #
	1555	1		908-908

RESERVED 36

Alternate Name	Item #	Length	Source of Standard	Column #
	1641	4		934-937

RESERVED 37

Alternate Name	Item #	Length	Source of Standard	Column #
	1725	15		1033-1047

RESERVED 38

Alternate Name	Item #	Length	Source of Standard	Column #
	1726	4		1060-1063

RESERVED 39

Alternate Name	Item #	Length	Source of Standard	Column #
	1895	2		1355-1356

RESERVED 40

Alternate Name	Item #	Length	Source of Standard	Column #
	2435	10		2465-2474

RURALURBAN CONTINUUM 1993 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Beale Code	3300	2	NAACCR	227-228

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 assigned programmatically, 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 RuralUrban 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 RuralUrban 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 **Revised**

Alternate Name	Item #	Length	Source of Standard	Column #
Beale Code RuralUrban Continuum 2000	3310	2	NAACCR	229-230

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 assigned programmatically, 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 RuralUrban 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 RuralUrban 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	888-889

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*
99 Other coding, including partial or nonstandard coding

RX DATE--BRM

Alternate Name	Item #	Length	Source of Standard	Column #
Date Immunotherapy Started (CoC)	1240	8	NAACCR	819-826

Description
Date of initiation for immunotherapy that is part of the first course of treatment. See also RX Summ--BRM [1410]. See page 95 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.

Codes (in addition to valid dates)
00000000 No immunotherapy administered; autopsy-only case
99999999 Unknown if any immunotherapy administered; date unknown, or death certificate-only case

Note: Beginning January 1, 2003, the CoC will no longer support this data item.

RX DATE--CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
Date Chemotherapy Started (CoC)	1220	8	NAACCR	803-810

Description
Date of initiation of chemotherapy that is part of the first course of treatment. See also RX Summ--Chemo [1390]. See page 95 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.

Codes (in addition to valid dates)
00000000 No chemotherapy administered; autopsy-only case
99999999 Unknown if any chemotherapy administered; date unknown, or death certificate only-case.

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

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	851-858

Description
Records the date on which the surgical diagnostic and/or staging procedure was performed. See Surgical and Diagnostic Staging Procedure [1350]. See page 95 for date format.

Codes (in addition to valid dates)
00000000 No diagnostic or staging procedure performed; autopsy-only case
99999999 Unknown if any diagnostic or staging procedure performed; date unknown, or death certificate-only case

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--HORMONE

Alternate Name	Item #	Length	Source of Standard	Column #
Date Hormone Therapy Started (CoC)	1230	8	NAACCR	811-818

Description
Date of initiation for hormone therapy that is part of the first course of treatment. See also RX Summ--Hormone [1400]. See page 95 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.

Codes (in addition to valid dates)
00000000 No hormone therapy administered; autopsy-only case
99999999 Unknown if any hormone therapy administered; date unknown, or death certificate-only case

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

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	763-770

Description
Date of most definitive surgical resection of the primary site performed as part of the first course of treatment. See page 95 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.

Special Codes (in addition to valid dates)

00000000 When no surgical resection of the primary site is performed and for cases diagnosed at autopsy.

99999999 When it is unknown if any surgical procedure of the primary site was performed, the date is unknown or the case was identified by death certificate-only.

RX DATE--OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
Date Other Treatment Started (CoC)	1250	8	CoC	827-834

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 95 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.

Codes (in addition to valid dates)

00000000 No other treatment administered; autopsy-only case

99999999 Unknown if any other treatment administered; date unknown, or death certificate-only case

RX DATE--RADIATION

Alternate Name	Item #	Length	Source of Standard	Column #
Date Radiation Started (CoC)	1210	8	CoC	779-786

Description
Records the date on which radiation therapy began at any facility that is part of the first course of treatment. See page 95 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.

Codes (in addition to valid dates)

00000000 No radiation therapy administered; autopsy-only case.

88888888 When 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. The date should be revised at the next follow-up.

99999999 When it is unknown whether any radiation therapy was administered; the date is unknown, or the case was identified by death certificate-only.

RX DATE--RADIATION ENDED

Alternate Name	Item #	Length	Source of Standard	Column #
Date Radiation Ended	3220	8	CoC	787-794

Description
The date on which the patient completes or receives the last radiation treatment at any facility. See page 95 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.

Codes (in addition to valid dates)

00000000 Radiation therapy was not administered or case diagnosed at autopsy

88888888 Radiation was administered and was ongoing at the time of most recent follow-up. The date should be revised at the next follow-up.

99999999 Unknown if radiation therapy was administered, or the date radiation ended is unknown. Death certificate-only cases.

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	755-762

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 95 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.

Codes (in addition to valid dates)
00000000 No surgical procedure was performed; autopsy-only case
99999999 When it is unknown if any surgical procedure of the primary site was performed, the date is unknown or the case was identified by death certificate-only

RX DATE--SURGICAL DISCH

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Surgical Discharge	3180	8	CoC	771-778

Description
Records the date the patient was discharged following primary site surgery. The date corresponds to the event recorded in Surgical Procedure of Primary Site [1290], and Date of Most Definitive Surgical Resection [3170]. See page 95 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.

Special Codes (in addition to valid dates)
00000000 When no surgical treatment of the primary site was performed. Diagnosed at autopsy.
99999999 When it is unknown whether surgical treatment was performed, the date is unknown or the case was identified by death certificate only.

RX DATE--SYSTEMIC

Alternate Name	Item #	Length	Source of Standard	Column #
Date Systemic Therapy Started	3230	8	CoC	795-802

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 95 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.

Codes (in addition to valid dates)

00000000 When no systemic therapy was administered or the case was diagnosed at autopsy.

88888888 When 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. The date should be revised at the next follow-up.

99999999 When it is unknown if any systemic therapy was administered, the date is unknown, or the case was identified by death certificate-only.

RX HOSP--BRM

Alternate Name	Item #	Length	Source of Standard	Column #
Immunotherapy at this Facility (CoC)	720	2	CoC	468-469

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 the administration of immunotherapeutic agents as part of the first course of therapy.

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 what part of the treatment was given at a particular hospital also helps resolve coding issues.

Codes (refer to *FORDS* for additional instructions)

00 None, immunotherapy was not part of the first course of therapy; not customary therapy for this cancer.

01 Immunotherapy

82 Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.).

85 Immunotherapy was not administered because the patient died prior to planned or recommended therapy.

86 Immunotherapy was not administered; it was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was noted 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 if immunotherapy was recommended or administered; 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]. Codes 02-06 should not be used for tumors diagnosed on or after January 1, 2003.

RX HOSP--CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
Chemotherapy at this Facility (CoC)	700	2	CoC	464-465

Description
Defines the type of chemotherapy the patient received as a part of the initial treatment for the reportable tumor at the reporting facility or the reason chemotherapy was not given.

Rationale
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 what part of the treatment was given at a particular hospital also helps resolve coding issues.

Codes (refer to *FORDS* for additional instructions)
00 None, chemotherapy was not part of the first course of therapy; not customary therapy for this cancer.
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 HOSP--DX/STG PROC

Alternate Name	Item #	Length	Source of Standard	Column #
Non Cancer-Directed Surgery at this Facility (CoC) Surgical Diagnostic & Staging Procedure at this Facility (1996-2002) RX Hosp--DX/Stg/Pall Proc	740	2	CoC	471-472

Description
Identifies the surgical procedure(s) performed in an effort to diagnose and/or stage disease at this facility. Used for cases diagnosed in 1996 and later. Earlier data may be converted into this field. See also RX Hosp--Surg Prim Site [670].

Rationale
If central registries wish to study the procedures given at particular hospitals, the hospital-level fields must be used. The summary fields, conversely, combine information across all hospitals that provide for the tumor. Hospital-specific fields allow studies of detailed referral patterns and treatment by type of hospital. Knowing what part of the treatment was given at a particular hospital also helps resolve coding issues.

Codes (refer to *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: This item has been used for tumors diagnosed in 1996 and later. For cases diagnosed before 1996, this item may have been converted, 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. For tumors diagnosed on or after January 1, 2003 palliative care is coded in a new field RX Hosp--Palliative Proc [3280].

RX HOSP--HORMONE

Alternate Name	Item #	Length	Source of Standard	Column #
Hormone Therapy at this Facility (CoC)	710	2	CoC	466-467

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 the administration of hormonal agents as part of the first course of therapy. 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 what part of the treatment was given at a particular hospital also helps resolve coding issues.

Codes (refer to *FORDS* for additional instructions)
00 None, hormone therapy was not part of the 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: Any therapy codes 02-03 should have been converted to the appropriate code in the new field RX SUMM--Transplnt/Endocr [3250]. Codes 02-03 should not be used for tumors diagnosed on or after January 1, 2003.

RX HOSP--OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
Other Treatment at this Facility (CoC)	730	1	CoC	470-470

Description
Identifies other 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. 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. 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 what part of the treatment was given at a particular hospital also helps resolve coding issues.

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

Note: Aspirin (also known as acetylsalicylic acid [ASA] or by a brand name) is used as a treatment for essential thrombocythemia. Record ONLY aspirin therapy to thin the blood for symptomatic control of thrombocythemia. To determine whether aspirin is administered for pain, cardiovascular protection, or thinning of platelets in the blood, use the following general guideline:

- Pain control is approximately 325-1,000mg every 3-4 hours.
- Cardiovascular protection starts at about 160 mg/day.
- Aspirin treatment for essential thrombocythemia is low dose, approximately 70-100 mg/day.

Phlebotomy may be called blood removal, bloodletting, or venisection. Transfusions may include whole blood, red blood cells, platelets, plateletpheresis, fresh frozen plasma, plasmapheresis, and cryoprecipitate.

RX HOSP--PALLIATIVE PROC

Alternate Name	Item #	Length	Source of Standard	Column #
Palliative Procedure at this Facility Palliative Care at this Facility	3280	1	CoC	473-473

Description
Identifies care provided at this facility in an effort to palliate or alleviate symptoms. Palliative procedures are 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) performed to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made
2 Radiation therapy given to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made
3 Chemotherapy, hormone therapy, or other systemic drugs given 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 HOSP--RADIATION

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation at this Facility (CoC)	690	1	SEER/CoC	463-463

Description
Defines the type of radiation therapy the patient received as a part of the initial treatment for the reportable tumor at the reporting facility.

Rationale
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 what part of the treatment was given at a particular hospital also helps resolve coding 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: This data item is no longer supported by CoC (as of January 1, 2003).

RX HOSP--REG LN REMOVED

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	461-462

Description
Describes number of regional lymph nodes removed as part of the first course of treatment. This item reflects that portion of the first course of treatment given at the reporting facility.

Rationale
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
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

Alternate Name	Item #	Length	Source of Standard	Column #
Scope of Regional Lymph Node Surgery at this Facility (CoC)	747	1	CoC	480-480

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
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 HOSP--SCOPE REG LN SUR

Alternate Name	Item #	Length	Source of Standard	Column #
Scope of Regional Lymph Node Surgery at this Facility (CoC)	672	1	CoC	459-459

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.

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 *FORDS* for additional instructions)

0 No regional lymph nodes removed
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 stated
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 HOSP--SCREEN/BX PROC1 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	742			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

RX HOSP--SCREEN/BX PROC2 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	743			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

RX HOSP--SCREEN/BX PROC3 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	744			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

RX HOSP--SCREEN/BX PROC4 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	745			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

RX HOSP--SURG OTH 98-02

Alternate Name	Item #	Length	Source of Standard	Column #
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) at this Facility (CoC) Surgical Procedure/Other Site at this Facility	748	1	CoC	481-481

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 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 what part of the treatment was given at a particular hospital also helps resolve coding issues.

Codes
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 HOSP--SURG OTH REG/DIS

Alternate Name	Item #	Length	Source of Standard	Column #
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) at this Facility (CoC) Surgical Procedure/Other Site at this Facility	674	1	CoC	460-460

Description
Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site at this facility.

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 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 what part of the treatment was given at a particular hospital also helps resolve coding issues.

Codes (refer to *FORDS* for additional instructions)
0 None
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

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	457-458

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
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 what part of the treatment was given at a particular hospital also helps resolve coding issues.

Codes in addition to the site-specific codes (refer to *FORDS* for additional instructions)
00 None. No surgical procedure of primary site. Autopsy only.
10-19 Site-specific codes. Tumor destruction; no pathologic specimen produced.
20-80 Site-specific codes. Resection. Path specimen produced.
90 Surgery, NOS
98 Site specific codes; special
99 Unknown. Death certificate-only.

RX HOSP--SURG SITE 98-02

Alternate Name	Item #	Length	Source of Standard	Column #
Cancer-Directed Surgery at this Facility (pre-96 CoC) RX Hosp--CA Dir Surgery (pre-96 NAACCR) Surgical Procedure of Primary Site	746	2	CoC	478-479

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
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 what part of the treatment was given at a particular hospital also helps resolve coding 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, 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--BRM

Alternate Name	Item #	Length	Source of Standard	Column #
Immunotherapy (SEER/CoC) Biological Response Modifiers (pre-96 SEER)	1410	2	SEER/CoC	882-883

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 *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.

Instructions for Storing/Converting Historical Codes
SEER recommends that the 1-digit historical codes be stored in the second character position preceded by a zero. CoC recommends that the historic codes be converted to the current codes, using the algorithm it has developed.

Historically (before 2003), this was a 1-character field with the following codes:
0 None
1 Biological response modifier
2 Bone marrow transplant--autologous
3 Bone marrow transplant--allogeneic
4 Bone marrow transplant, NOS
5 Stem cell transplant
6 Combination of 1 and any 2, 3, 4 or 5
7 Patient or patient's guardian refused
8 Biological response modifier recommended, unknown if administered
9 Unknown if immunotherapy given

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	878-879

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 *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	869-870

Description

Identifies the surgical procedure(s) performed in an effort to diagnose and/or stage disease. 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].

Codes (refer to *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: This item has been used for tumors diagnosed in 1996 and later. For tumors diagnosed before 1996, tumors with surgery would have been converted to 09 in this field. 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	880-881

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 *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 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 Hormone [1450]. The CoC standards for hospitals do not allow use of codes 7 and 8 in 1996 and later. SEER continues to use codes 7 and 8 for all years. See Chapter V, Unresolved Issues, for further discussion.

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	884-884

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 *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	871-871

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	874-874

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	873-873

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:* 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]. The CoC standards for hospitals do not allow use of codes 7 and 8 in 1996 and later. SEER continues to use codes 7 and 8 for all years. See Chapter V, Unresolved Issues, for further discussion.

Note: 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	867-867

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	863-864

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	941-941

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.

If central registries wish to study the treatment given at particular hospitals, the hospital-level treatment fields must be used. The summary 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
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--SCOPE REG LN SUR

Alternate Name	Item #	Length	Source of Standard	Column #
Scope of Regional Lymph Node Surgery (SEER/CoC)	1292	1	SEER/CoC	861-861

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 *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 approved to retire this data item in Version 11.

RX SUMM--SCREEN/BX PROC2 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1643			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

RX SUMM--SCREEN/BX PROC3 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1644			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

RX SUMM--SCREEN/BX PROC4 **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1645			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

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	942-942

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. 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 what part of the treatment was given at a particular hospital also helps resolve coding issues.

Codes
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 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	862-862

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 *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	859-860

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 *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	939-940

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. 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 what part of the treatment was given at a particular hospital also helps resolve coding issues.

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	875-875

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
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	932-933

Description
Field for pre-1996 surgery codes for CoC and pre-1998 surgery codes for SEER. Surgery codes used 1998 and later can be backward converted into the older codes and the converted value can be stored in this field. See Chapter V, Unresolved Issues, for discussion of CoC/SEER differences in coding treatment.

RX SUMM--SURGICAL APPROCH

Alternate Name	Item #	Length	Source of Standard	Column #
Surgical Approach (CoC)	1310	1	CoC	865-865

Description
Codes for method used to approach the surgical field for the primary site. CoC requires coding for tumors diagnosed 1996 and forward. CoC introduced site-specific codes for this item in the CoC *ROADS Manual* 1998 Supplement. See also item RX Summ--Surg Prim Site [1290].

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.

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	866-866

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 *FORDS* for additional instructions)
0 No residual tumor
1 Residual tumor, NOS
2 Microscopic residual tumor
3 Macroscopic residual tumor
7 Margins not evaluable.
8 No primary site surgery.
9 Unknown or not applicable.

Note: Codes were site specific (1998-2002), and have been changed to be generic across all disease sites.

RX SUMM--SYSTEMIC/SUR SEQ

Alternate Name	Item #	Length	Source of Standard	Column #
Systemic/Surgery Sequence	1639	1	CoC	931-931

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.

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
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

RX SUMM--TRANSPLNT/ENDOCR

Alternate Name	Item #	Length	Source of Standard	Column #
Hematologic Transplant and Endocrine Procedures	3250	2	CoC	876-877

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 *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 TEXT--BRM

Alternate Name	Item #	Length	Source of Standard	Column #
	2660	100	NPCR	5325-5424

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
- Date treatment was started.
- 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:

- When treatment was given, e.g., at this facility; at another facility
- Type of BRM agent, e.g., Interferon, BCG
- BRM procedures, e.g., bone marrow transplant, stem cell transplant
- Other treatment information, e.g., treatment cycle incomplete; unknown if BRM was given

Data Item(s) to be verified/validated using the text entered in this field

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 TEXT--CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
	2640	200	NPCR	4925-5124

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 when 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
Reason for No Chemo	1440 (Retired in Version 11)

RX TEXT--HORMONE

Alternate Name	Item #	Length	Source of Standard	Column #
	2650	200	NPCR	5125-5324

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
Reason For No Hormone	1450 (Retired in Version 11)

RX TEXT--OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
	2670	100	NPCR	5425-5524

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	150	NPCR	4625-4774

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 when 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 Elapsed RX Days	1530 (Retired in Version 11)
Rad Treatment Volume	1540
Rad Location of RX	1550
Rad Intent of Treatment	1560 (Retired in Version 11)
Rad Boost RX Modality	3200
Rad Boost Dose cGy	3210
Rad RX Completion Status	1580 (Retired in Version 11)
Rad Local Control Status	1590 (Retired in Version 11)

RX TEXT--RADIATION OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
	2630	150	NPCR	4775-4924

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 Elapsed Days	1530 (Retired in Version 11)
Rad Treatment Volume	1540
Rad Location of RX	1550
Rad Intent of Treatment	1560 (Retired in Version 11)
Rad Boost RX Modality	3200
Rad Boost Dose cGy	3210
Rad RX Completion Status	1580 (Retired in Version 11)
Rad Local Control Status	1590 (Retired in Version 11)

RX TEXT—SURGERY

Alternate Name	Item #	Length	Source of Standard	Column #
	2610	150	NPCR	4475-4624

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

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 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
Date of Initial RX--SEER	1260
Date of 1st Crs RX__CoC	1270
EOD-Extension	790
Site of Distant Met 1-3	1090-1110
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

SCREENING DATE

Alternate Name	Item #	Length	Source of Standard	Column #
	510	8	NAACCR	313-320

Description
Most recent date on which the patient participated in a screening program related to this primary cancer. See page 95 for date format.

Codes (in addition to appropriate dates)

00000000	Patient did not participate in screening program related to this primary cancer
99999999	Patient participated in screening program related to this primary cancer; date is unknown

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

SCREENING RESULT

Alternate Name	Item #	Length	Source of Standard	Column #
	520	1	NAACCR	321-321

Description
Code the findings from screening recorded in Screening Date [510].

Codes
0 Within normal limits
1 Abnormal/not suggestive of cancer
2 Abnormal/suggestive of cancer
3 Equivocal/no follow-up necessary
4 Equivocal/evaluation recommended
8 Not applicable
9 Unknown, result not specified

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

SEER CODING SYS--CURRENT

Alternate Name	Item #	Length	Source of Standard	Column #
	2120	1	NAACCR	1198-1198

Description
This shows the SEER coding system best describing the majority of SEER items as they are in the record (after conversion).

Codes
0 No SEER coding
1 Pre-1988 SEER Coding Manuals
2 May 1988 SEER Coding Manual
3 January 1989 SEER Coding Manual
4 January 1992 SEER Coding Manual
5 January 1998 SEER Coding Manual
6 January 2003 SEER Coding Manual
7 January 2004 SEER Coding Manual
8 January 2007 SEER Coding Manual

SEER CODING SYS--ORIGINAL

Alternate Name	Item #	Length	Source of Standard	Column #
	2130	1	NAACCR	1199-1199

Description
This shows the SEER coding system best describing the way the majority of SEER items in the record were originally coded.

Codes
0 No SEER coding
1 Pre-1988 SEER Coding Manuals
2 May 1988 SEER Coding Manual
3 January 1989 SEER Coding Manual
4 January 1992 SEER Coding Manual
5 January 1998 SEER Coding Manual
6 January 2003 SEER Coding Manual
7 January 2004 SEER Coding Manual
8 January 2007 SEER Coding Manual

SEER RECORD NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
Record Number (SEER)	2190	2	SEER	1215-1216

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 SUMMARY STAGE 1977

Alternate Name	Item #	Length	Source of Standard	Column #
General Summary Stage (SEER/CoC)	760	1	SEER	529-529

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	528-528

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	1214-1214

Description
Codes for the type of follow-up expected for a SEER case.

Codes
1 “Autopsy-Only” or “Death Certificate-Only” case
2 Active follow-up case
3 *In situ* cancer of the cervix uteri only
4 Case not originally in active follow-up, but in active follow-up now (San Francisco-Oakland only)

SEQUENCE NUMBER--CENTRAL

Alternate Name	Item #	Length	Source of Standard	Column #
Sequence Number (pre-96 SEER)	380	2	SEER	281-282

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.

Timing Rule
The sequence number may change over the lifetime of the patient. If an individual previously diagnosed with a single reportable malignant neoplasm is subsequently diagnosed with a second reportable malignant neoplasm, the sequence code for the first neoplasm changes from 00 to 01. A central registry might also discover that an individual with one or more known neoplasms had an earlier reportable neoplasm that had been unknown to the registry. Typically, a re-evaluation of all related sequence numbers is required whenever an additional neoplasm is identified.

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

If a registry collects any central registry-defined neoplasms, the codes 60-87 should be used. The codes 60-87 also should be used for non-malignant tumor diagnosed on or after January 1, 2004. Timing rules for sequencing these neoplasms are the same as timing rules for sequencing of required *in situ* or invasive neoplasms.

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 more than one non-malignant tumor, then the tumors must be sequenced.)
98 Cervix carcinoma *in situ* (CIS)/CIN III, Diagnosis Years 1996-2002.

The table that follows shows which sequence number series to use by type of neoplasm

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	411-412

Description
Code indicates the sequence of all malignant and non-malignant neoplasms over the lifetime of the patient. This item differs from the Sequence Number--Central [380] 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 only one malignant neoplasm in his lifetime (regardless of hospital registry reference date). Sequence Number 01 indicates the first of two or more malignant neoplasms, while 02 indicates the second of two or more malignant neoplasms, and so on. Because the time period of Sequence Number is a person's lifetime, reportable neoplasms not included in the hospital registry are also allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the hospital registry's reference date. Similarly, Sequence Number 60 indicates the patient has only one non-malignant neoplasm, and Sequence Number 61 represents the first of multiple non-malignant neoplasms.

Sequence numbers should be reassigned if the facility subsequently learns of an unaccessioned tumor that affects sequencing. Sequence Number-Central [380] does not affect Sequence Number-Hospital. The two notational systems are independent.

Timing Rule
If two or more malignant tumors are diagnosed at the same time, the lowest sequence number will be assigned to the diagnosis with the worst prognosis. Likewise, if two or more non-malignant tumors are diagnosed at the same time, the lowest sequence number is assigned to the diagnosis with the worse prognosis. If no difference in prognosis is evident, the decision is arbitrary.

Codes
In situ and Malignant Tumors:
00 One malignant primary only in the patient's lifetime
01 First of two or more malignant primaries
02 Second of two or more malignant primaries
.. (Actual number of this malignant primary)

..
59 Fifty-ninth or higher of fifty-nine or more 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 below shows which sequence number series to use by type of neoplasm

Neoplasm	**SeqNum-Hospital**
***In situ* and Malignant**	**(code range)**
One *in situ* (behavior code = 2) or malignant (behavior code =3) primary tumor only in the patient's lifetime	00
First of multiple *in situ* or malignant primary tumors in the patient's lifetime	01
Actual sequence of two or more *in situ* or malignant primary tumors	02 – 59
Unspecified malignant sequence number or unknown	99
Non-Malignant	
One benign (behavior code = 0) or borderline (behavior code = 1) primary tumor only in the patient's lifetime	60
First of two or more benign or borderline primary tumors in the patient's lifetime	61
Actual sequence of two or more non-malignant primary tumors	62 – 87
Unspecified non-malignant sequence number or unknown	88

*Juvenile astrocytomas should be reported as 9421/3

Note: See the section on Sequence Number in CoC (FORDS) Manual.

SEX

Alternate Name	Item #	Length	Source of Standard	Column #
	220	1	SEER/CoC	118-118

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	1137-1140

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	307-307

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	308-308

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

Alternate Name	Item #	Length	Source of Standard	Column #
Site of Distant Metastasis #1 (CoC)	1090	1	CoC	618-618

Description
Codes for a site of distant metastasis at initial diagnosis. There are three individual fields, each with a 1-digit code for a site of metastasis.

Codes
0 None
1 Peritoneum
2 Lung
3 Pleura
4 Liver
5 Bone
6 Central nervous system
7 Skin
8 Lymph nodes (distant)
9 Other, generalized, carcinomatosis, disseminated, not specified, unknown

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.

SITE OF DISTANT MET 2

Alternate Name	Item #	Length	Source of Standard	Column #
Site of Distant Metastasis #2 (CoC)	1100	1	CoC	619-619

Description
Codes for a site of distant metastasis at initial diagnosis. There are three individual fields, each with a 1-digit code for a site of metastasis.

Codes
0 None
1 Peritoneum
2 Lung
3 Pleura
4 Liver
5 Bone
6 Central nervous system
7 Skin
8 Lymph nodes (distant)
9 Other, generalized, carcinomatosis, disseminated, not specified, unknown

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.

SITE OF DISTANT MET 3

Alternate Name	Item #	Length	Source of Standard	Column #
Site of Distant Metastasis #3 (CoC)	1110	1	CoC	620-620

Description
Codes for a site of distant metastasis at initial diagnosis. There are three individual fields, each with a 1-digit code for a site of metastasis.

Codes
0 None
1 Peritoneum
2 Lung
3 Pleura
4 Liver
5 Bone
6 Central nervous system
7 Skin
8 Lymph nodes (distant)
9 Other, generalized, carcinomatosis, disseminated, not specified, unknown

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.

SOCIAL SECURITY NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	2320	9	CoC	2099-2107

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	115-115

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 categories 1-5.
7 Spanish surname only (Code 7 is ordinarily for central registry use only, hospital registrars may use code 7 if using a list of Hispanic surnames provided by their central registry; otherwise, code 9 'unknown whether Spanish or not' should be used.)
The only evidence of the person's Hispanic origin is the surname or maiden name and there is no contrary evidence that the patient is not Hispanic.

8 Dominican Republic
9 Unknown whether Spanish or not

Note: 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

Alternate Name	Item #	Length	Source of Standard	Column #
	2220	500	Varies	1447-1946

Description
Old fields, Site-Specific Studies, and State-Specific Items were combined into this area and renamed. The area also was expanded. Reserved for use by special studies, or for items defined in individual states or central registries. CoC uses this area for Patient Care Evaluation Studies.

SUBSQ REPORT FOR PRIMARY **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	2160			

Description
The NAACCR UDSC approved to retire this data item in Version 6.

SUBSQ RX 2ND COURSE BRM

Alternate Name	Item #	Length	Source of Standard	Column #
	1675	1	CoC	1001-1001

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	999-999

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	7		996-1002

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	988-995

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 95 for date format.

Codes (in addition to valid dates)
00000000 No subsequent therapy
99999999 Unknown if any subsequent therapy

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	1000-1000

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	1002-1002

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	998-998

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	996-997

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 2ND--REG LN REM

Alternate Name	Item #	Length	Source of Standard	Column #
	1679	2	CoC	1050-1051

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	1048-1048

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	1049-1049

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	1016-1016

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	1014-1014

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	7		1011-1017

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	1003-1010

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 95 for date format.
Codes
00000000 No subsequent therapy
99999999 Unknown if any subsequent therapy

SUBSQ RX 3RD COURSE HORM

Alternate Name	Item #	Length	Source of Standard	Column #
	1694	1	CoC	1015-1015

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	1017-1017

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	1013-1013

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	1011-1012

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 3RD--REG LN REM

Alternate Name	Item #	Length	Source of Standard	Column #
	1699	2	CoC	1054-1055

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	1052-1052

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	1053-1053

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	1031-1031

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	1029-1029

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	7		1026-1032

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	1018-1025

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 95 for date format.

Codes (in addition to valid dates)
00000000 No subsequent therapy
99999999 Unknown if any subsequent therapy

SUBSQ RX 4TH COURSE HORM

Alternate Name	Item #	Length	Source of Standard	Column #
	1714	1	CoC	1030-1030

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	1032-1032

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	1028-1028

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	1026-1027

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 4TH--REG LN REM

Alternate Name	Item #	Length	Source of Standard	Column #
	1719	2	CoC	1058-1059

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	1056-1056

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	1057-1057

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 approved to retire this data item in Version 11.

SUBSQ RX 5TH COURSE CHEMO **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1733			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

SUBSQ RX 5TH COURSE CODES **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1730			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

SUBSQ RX 5TH COURSE DATE **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1720			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

SUBSQ RX 5TH COURSE HORM **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1734			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

SUBSQ RX 5TH COURSE OTH **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1736			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

SUBSQ RX 5TH COURSE RAD **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1732			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

SUBSQ RX 5TH COURSE SURG **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1731			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

SUBSQ RX 5TH--REG LN REM **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1739			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

SUBSQ RX 5TH--SCOPE LN SU **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1737			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

SUBSQ RX 5TH--SURG OTH **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1738			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

SUBSQ RX--RECONSTRUCT DEL

Alternate Name	Item #	Length	Source of Standard	Column #
Reconstruction/Restoration--Delayed (CoC)	1741	1	CoC	1064-1064

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	2268-2277

Description
Current telephone number with area code for the patient. Number is entered without dashes.

Codes (in addition to valid telephone number)
0000000000 Patient does not have a telephone
9999999999 Telephone number unavailable or unknown

Note: Prior to Version 5, Follow-Up Contact fields may have been used for patient current telephone in the NAACCR record layout.

TEXT--DX PROC--LAB TESTS

Alternate Name	Item #	Length	Source of Standard	Column #
	2550	250	NPCR	3345-3594

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
Laterality	410
Collaborative Stage variables	2800-2930
Date of Diagnosis	390

TEXT--DX PROC--OP

Alternate Name	Item #	Length	Source of Standard	Column #
	2560	250	NPCR	3595-3844

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

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 Positive Bx	1080
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

TEXT--DX PROC--PATH

Alternate Name	Item #	Length	Source of Standard	Column #
	2570	250	NPCR	3845-4094

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)
- 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
Histology (92-00) ICD-O-2	420
Grade	440
Collaborative Stage variables	2800-2930
Diagnostic confirmation	490

TEXT--DX PROC--PE

Alternate Name	Item #	Length	Source of Standard	Column #
	2520	200	NPCR	2645-2844

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 (92-00) ICD-O-2	420
Histology ICD-O-3	522
Sequence Number-Central	380

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	250	NPCR	3095-3344

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
- Lymph nodes
- 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
Date of 1st Positive Bx	1080
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

TEXT--DX PROC--X-RAY/SCAN

Alternate Name	Item #	Length	Source of Standard	Column #
	2530	250	NPCR	2845-3094

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) of X-ray/Scan(s)
- Age, sex, race/ethnicity (when given)
- 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
Sex	220
Birth Date	240
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	40	NPCR	4135-4174

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	50	NPCR	5875-5924

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.

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:
- 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	40	NPCR	4095-4134

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:
- Include information on the location of the primary site of the tumor
- 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	350	NPCR	5525-5874

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.

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:
- Smoking history
- Family and personal history of cancer
- Comorbidities
- Information on sequence numbers if a person was diagnosed with another cancer out-of-state or before the registry's reference date
- Place of birth
- Justification of over-ride flags

TEXT--STAGING

Alternate Name	Item #	Length	Source of Standard	Column #
	2600	300	NPCR	4175-4474

Description
Additional text area for staging information not already entered in the Text--DX Proc areas.

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
EOD--Tumor Size	780
EOD--Lymph Node Involv	810
Regional Nodes Positive	820
Regional Nodes Examined	830
Behavior Code ICD-O-3	523
Behavior (92-00) ICD-O-2	430
Site of Distant Met 1-3	1090-1110

TEXT--USUAL INDUSTRY

Alternate Name	Item #	Length	Source of Standard	Column #
	320	40	NPCR	183-222

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.[24] 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 housewife 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	40	NPCR	143-182

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.[24] 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 househusband/housewife 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 househusband/housewife and did not work outside the home for most of his/her adult life, record "househusband" or "housewife." If the patient was not a student or housewife and had never worked, record "never worked" as the usual occupation.

If no information is available, record "unknown."

This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

TNM CLIN DESCRIPTOR

Alternate Name	Item #	Length	Source of Standard	Column #
Clinical Stage (Prefix/Suffix) Descriptor (CoC)	980	1	CoC	581-581

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, clinical, and other 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 CLIN M

Alternate Name	Item #	Length	Source of Standard	Column #
Clinical M (CoC)	960	2	AJCC	577-578

Description
Detailed site-specific codes for the clinical metastases (M) as defined by AJCC and recorded by the physician.

Pathologic, clinical, and other 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
This field can be left blank if a physician did not record the stage element.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the *FORDS Manual* for specifications for codes and data entry rules.

TNM CLIN N

Alternate Name	Item #	Length	Source of Standard	Column #
Clinical N (CoC)	950	2	AJCC	575-576

Description
Detailed site-specific codes for the clinical nodes (N) as defined by AJCC and recorded by the physician.

Pathologic, clinical, and other 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
This field can be left blank if a physician did not record the stage element.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the *FORDS Manual* for specifications for codes and data entry rules.

TNM CLIN STAGE GROUP

Alternate Name	Item #	Length	Source of Standard	Column #
Clinical Stage Group (CoC)	970	2	AJCC	579-580

Description
Detailed site-specific codes for the clinical stage group as defined by AJCC and recorded by the physician.

Pathologic, clinical, and other 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
99 Unknown, not staged

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the *FORDS Manual* for specifications for codes and data entry rules.

TNM CLIN STAGED BY

Alternate Name	Item #	Length	Source of Standard	Column #
Staged By (Clinical Stage) (CoC)	990	1	CoC	582-582

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 accuracy and completeness of physician staging and form the basis for quality management and improvement studies. This item is used to monitor compliance with the CoC Staging Standard. The medical record contains the AJCC stage assigned/initialed by the managing physician.

Codes (refer to *FORDS* for additional coding 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	2	AJCC	573-574

Description
Detailed site-specific codes for the clinical tumor (T) as defined by AJCC and recorded by the physician.

Pathologic, clinical, and other 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
This field can be left blank if a physician did not record the stage element.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the *FORDS Manual* for specifications for codes and data entry rules.

TNM EDITION NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	1060	2	CoC	593-594

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+
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 approved to retire this data item in Version 11.

TNM OTHER M **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1020			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

TNM OTHER N **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1010			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

TNM OTHER STAGE GROUP **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1030			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

TNM OTHER STAGED BY **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1040			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

TNM OTHER T **Retired**

Alternate Name	Item #	Length	Source of Standard	Column #
	1000			

Description
The NAACCR UDSC approved to retire this data item in Version 11.

TNM PATH DESCRIPTOR

Alternate Name	Item #	Length	Source of Standard	Column #
Pathologic Stage (Prefix/Suffix) Descriptor (CoC)	920	1	CoC	571-571

Description
Identified 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, clinical, and other 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	2	AJCC	567-568

Description
Detailed site-specific codes for the pathologic metastases (M) as defined by AJCC and recorded by the physician.

Pathologic, clinical, and other 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
This field can be left blank if a physician did not record the stage element.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the *FORDS Manual* for specifications for codes and data entry rules.

TNM PATH N

Alternate Name	Item #	Length	Source of Standard	Column #
Pathologic N (CoC)	890	2	AJCC	565-566

Description
Detailed site-specific codes for the pathologic nodes (N) as defined by AJCC and recorded by physician.

Pathologic, clinical, and other 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
This field can be left blank if a physician did not record the stage element.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the *FORDS Manual* for specifications for codes and data entry rules.

TNM PATH STAGE GROUP

Alternate Name	Item #	Length	Source of Standard	Column #
Pathologic Stage Group (CoC)	910	2	AJCC	569-570

Description
Detailed site-specific codes for the pathologic stage group as defined by AJCC and recorded by the physician.

Pathologic, clinical, and other 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
99 Unknown, unstaged

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the *FORDS Manual* for specifications for codes and data entry rules.

TNM PATH STAGED BY

Alternate Name	Item #	Length	Source of Standard	Column #
Staged By (Pathologic Stage) (CoC)	930	1	CoC	572-572

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 accuracy and completeness of physician staging and form the basis for quality management and improvement studies. This item is used to monitor compliance with the CoC Staging Standard. The medical record contains the AJCC stage assigned/initialed by the managing physician.

Codes (refer to *FORDS* for additional coding 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	2	AJCC	563-564

Description
Detailed site-specific codes for the pathologic tumor (T) as defined by AJCC and recorded by the physician.

Pathologic, clinical, and other 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

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups. See the *FORDS Manual* for specifications for codes and data entry rules.

TOBACCO HISTORY

Alternate Name	Item #	Length	Source of Standard	Column #
	340	1	Varies	224-224

Description
NAACCR has not adopted standards for this item.

TUMOR MARKER 1

Alternate Name	Item #	Length	Source of Standard	Column #
Tumor Marker One (CoC)	1150	1	SEER	626-626

Description
Records prognostic indicators for specific sites or histologies. CoC uses these codes for cases diagnosed 1996 and forward. See the CoC *ROADS Manual*, 1998 Supplement, for a list of specific sites and histologies. For tumors diagnosed before January 1, 1996, Tumor Marker 1 is coded only for estrogen receptor status of breast cancers.

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	627-627

Description
Records prognostic indicators for specific sites or histologies. CoC uses these codes for cases diagnosed 1996 and forward. See the CoC *ROADS Manual*, 1998 Supplement, for a list of specific sites and histologies. For tumors diagnosed before January 1, 1996, Tumor Marker 2 is coded only for progesterone receptor status of breast cancers.

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	628-628

Description
Records prognostic indicators for specific sites or histologies. CoC uses these codes for tumors diagnosed 1998 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	30-31

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	312-312

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	1341-1341

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	1204-1213

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	1302-1302

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
NAACCR UDSC approved to retire this data item in Version 11.

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 (C)
020	Anchorage (B)
050	Bethel (C)
060	Bristol Bay (B)
068	Denali (B)
070	Dillingham (C)
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 (C)
185	North Slope (B)
188	Northwest Arctic (B)
201	Prince of Wales-Outer Ketchikan (C)
220	Sitka (B)
232	Skagway-Hoonah-Angoon (C)
240	Southeast Fairbanks (C)
261	Valdez-Cordova (C)
270	Wade Hampton (C)
280	Wrangell-Petersburg (C)
282	Yakutat (B)
290	Yukon-Koyukuk (C)

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
001	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	Garrettt
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	Shebly
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

APPENDIX A

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

APPENDIX B

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

110 Canal Zone

120 Pacific Area
121 American Samoa
122 Kiribati (Canton and Enderbury Islands, Gilbert Islands, Southern 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 Mariana Islands (Trust Territory of Pacific Islands)
131 Marshall Islands (Trust Territory Pacific Islands)
132 Midway Islands

133 Nampo-Shoto, Southern
134 Ryukyu Islands (Japan)
135 Swan Islands
136 Tokelau Islands (New Zealand)
137 Wake Island
139 Palau (Trust Territory of Pacific Islands)

NORTH AND SOUTH AMERICA, EXCLUSIVE OF THE UNITED STATES AND 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 island, 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
0000007580 Eastern Oklahoma Regional Registry
0000007580 Oklahoma-Eastern Regional 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
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
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
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 Registrars
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
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
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)
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
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
240	Birth Date	Date of Birth (SEER/CoC)
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
380	Sequence Number--Central	Sequence Number (pre-96 SEER)
390	Date of Diagnosis	Date of Initial Diagnosis (CoC)

Item #	Item Name	Alternate Names
410	Laterality	Laterality at Diagnosis (SEER)
420	Histology (92-00) ICD-O-2	Histology (CoC)
440	Grade	Grade, Differentiation, or Cell Indicator (SEER) Grade/Differentiation (CoC)
442	Ambiguous Terminology DX	Ambiguous Terminology Ambiguous Terminology as Basis for Diagnosis
443	Date of Conclusive DX	Date of Conclusive Terminology Date of Conclusive Diagnosis
444	Mult Tum Rpt as One Prim	Type of Multiple Tumors Reported as One Primary Multiple Tumors Reported as Single Primary
523	Behavior Code ICD-O-3	Behavior Code (CoC)
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/1st Contact
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)
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)

Item #	Item Name	Alternate Names
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)
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)
1080	Date of 1st Positive BX	Date of First Positive Biopsy (CoC)
1090	Site of Distant Met 1	Site of Distant Metastasis #1 (CoC)
1100	Site of Distant Met 2	Site of Distant Metastasis #2 (CoC)
1110	Site of Distant Met 3	Site of Distant Metastasis #3 (CoC)

Item #	Item Name	Alternate Names
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)
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 of the 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)

Item #	Item Name	Alternate Names
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)
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)

Item #	Item Name	Alternate Names
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
1984	Over-ride SS/DisMet1	Over-ride Summary Stage/Distant Metastasis 1
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)
2072	Over-ride Site/EOD/DX Dt	Over-ride Flag for Site/EOD/Diagnosis Date (IF40)
2073	Over-ride Site/Lat/EOD	Over-ride Flag for Site/Laterality/EOD (IF41)
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)

Item #	Item Name	Alternate Names
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)
2495	NPI—Phyiscian 3	Medical Oncologist (COC)
2500	Physician 4	Physician #4 (CoC) Other Physician (pre-96 CoC)
2505	NPI—Physician 4	Radiation Oncologist (CoC)
2690	Text--Place of Diagnosis	Place of Diagnosis
2820	CS Tumor Size/Ext Eval	CS Tumor Size/Extension Evaluation
2830	CS Lymph Nodes	CS Lymph Nodes (SEER EOD)
2840	CS Reg Nodes Eval	CS Regional Nodes Evaluation
2850	CS Mets at DX	CS Metastasis at Diagnosis
2860	CS Mets Eval	CS Metastasis Evaluation
2940	Derived AJCC T	Derived T

Item #	Item Name	Alternate Names
2950	Derived AJCC T Descriptor	Derived T Descriptor
2960	Derived AJCC N	Derived N
2970	Derived AJCC N Descriptor	Derived N Descriptor
2980	Derived AJCC M	Derived M
2990	Derived AJCC M Descriptor	Derived M Descriptor
3000	Derived AJCC Stage Group	Derived 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	SS 1977 Conversion Flag
3050	Derived SS2000--Flag	SS 2000 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
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

Item #	Item Name	Alternate Names
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 2000	Beale Code

APPENDIX E

GROUPED DATA ITEMS

Item Name [Item#]	Length	Column #
Extent of Disease 10-Dig [779]	12	531-542
Subfields:		
EOD--Tumor Size [780]	3	531-533
EOD--Extension [790]	2	534-535
EOD--Extension Prost Path [800]	2	536-537
EOD--Lymph Node Involv [810]	1	538-538
Regional Nodes Positive [820]	2	539-540
Regional Nodes Examined [830]	2	541-542
Morph (73-91) ICD-O-1 [1970]	6	1141-1146
Subfields:		
Histology (73-91) ICD-O-1 [1971]	4	1141-1144
Behavior (73-91) ICD-O-1 [1972]	1	1145-1145
Grade (73-91) ICD-O-1 [1973]	1	1146-1146
Morph--Type&Behav ICD-O-2 [419]	5	296-300
Subfields:		
Histology (92-00) ICD-O-2 [420]	4	296-299
Behavior (92-00) ICD-O-2 [430]	1	300-300
Morph--Type&Behav ICD-O-3 [521]	5	301-305
Subfields:		
Histologic Type ICD-O-3 [522]	4	301-304
Behavior Type ICD-O-3 [523]	1	305-305
Subsq RX 2nd Course Codes [1670]	7	996-1002
Subsq RX 2nd Course Surg [1671]	2	996-997
Subsq RX 2nd Course Rad [1672]	1	998-998
Subsq RX 2nd Course Chemo [1673]	1	999-999
Subsq RX 2nd Course Horm [1674]	1	1000-1000
Subsq RX 2nd Course BRM [1675]	1	1001-1001
Subsq RX 2nd Course Oth [1676]	1	1002-1002
Subsq RX 3rd Course Codes [1690]	7	1011-1017
Subsq RX 3rd Course Surg [1691]	2	1011-1012
Subsq RX 3rd Course Rad [1692]	1	1013-1013
Subsq RX 3rd Course Chemo [1693]	1	1014-1014
Subsq RX 3rd Course Horm [1694]	1	1015-1015
Subsq RX 3rd Course BRM [1695]	1	1016-1016
Subsq RX 3rd Course Oth [1696]	1	1017-1017

Item Name [Item#]	Length	Column #
Subsq RX 4th Course Codes [1710]	7	1026-1032
Subsq RX 4th Course Surg [1711]	2	1026-1027
Subsq RX 4th Course Rad [1712]	1	1028-1028
Subsq RX 4th Course Chemo [1713]	1	1029-1029
Subsq RX 4th Course Horm [1714]	1	1030-1030
Subsq RX 4th Course BRM [1715]	1	1031-1031
Subsq RX 4th Course Oth [1716]	1	1032-1032

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
40	Registry ID		Revised		Revised		
45	NPI--Registry ID				Revised		Revised
50	NAACCR Record Version			Revised			Revised
100	Addr at DX--Postal Code						Revised
362	Census Block Group 2000		Revised	Revised	Revised	Revised	Revised
366	GIS Coordinate Quality						Revised
368	CensusBlockGroup 70/80/90	New	New	New	New	New	New
395	NPI—Archive FIN				Revised		Revised
442	Ambiguous Terminology Dx				Revised	Revised	Revised
443	Date of Conclusive DX				Revised	Revised	Revised
444	Mult Tum Rpt As One Prim				Revised	Revised	Revised
445	Date Of Multiple Tumors				Revised	Revised	
446	Multiplicity Counter				Revised	Revised	
530	Reserved 02	Revised					
545	NPI--Reporting Facility				Revised		Revised
560	Sequence Number Hospital				Revised	Revised	
680	Reserved 03	Revised		Revised			
1830	Addr Current--Postal Code						Revised
2415	NPI--Inst Referred From				Revised		Revised
2425	NPI--Inst Referred To				Revised		Revised
2445	NPI--Following Registry				Revised		Revised
2465	NPI--Physician--Managing		Revised		Revised		Revised
2475	NPI--Physician--Follow-Up				Revised		Revised
2485	NPI--Physician--Primary Surg				Revised		Revised
2495	NPI--Physician 3				Revised		Revised
2505	NPI--Physician 4				Revised		Revised
2800	CS Tumor Size		Revised				
2820	CS Tumor Size/Ext Eval		Revised				
3100	Archive FIN				Revised	Revised	
3105	NPI--Archive FIN				Revised		Revised
3200	Rad--Boost RX Modality				Revised	Revised	
3210	Rad--Boost Dose cGy					Revised	
3300	RuralUrban Continuum 1993				Revised	Revised	Revised
3310	RuralUrban Continuum 2003			Revised	Revised	Revised	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 e-mailed 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/SYMBO
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/SYMBO
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

WORD/TERM(S)	ABBREVIATION/SYMBO
Bile duct	BD
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

WORD/TERM(S)	ABBREVIATION/SYMBO
Colon, Ascending	A-COLON
Colon, Descending	D-COLON
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

WORD/TERM(S)	ABBREVIATION/SYMBO
Electroencephalogram	EEG
Electromyogram	EMG
Emergency room	ER
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

WORD/TERM(S)	ABBREVIATION/SYMBO
Hepatitis B (virus)	HBV
Hepatitis C (virus)	HCV
Hepatitis D (virus)	HDV
Hepatosplenomegaly	HSM
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

WORD/TERM(S)	ABBREVIATION/SYMBO
Involve(s)/involvement/involving	INVL
Ipsilateral	IPSI
Irregular	IRREG
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

WORD/TERM(S)	ABBREVIATION/SYMBO
Magnetic resonance imaging	MRI
Magnetic resonance cholangiopancreatography	MRCP
Main stem bronchus	MSB
Malignant	MALIG
Mandible/mandibular	MAND
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

WORD/TERM(S)	ABBREVIATION/SYMBO
Non small cell carcinoma	NSCCA
Not applicable	NA
Not otherwise specified	NOS
Not recorded	NR
Number	#
Nursing home	NH
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)

WORD/TERM(S)	ABBREVIATION/SYMBO
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
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

WORD/TERM(S)	ABBREVIATION/SYMBO
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
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

WORD/TERM(S)	ABBREVIATION/SYMBO
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
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

ABBREVIATION/SYMBOL	WORD/TERM(S)
BAD	Bipolar affective disorder
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*

ABBREVIATION/SYMBOL	WORD/TERM(S)
CLL	Chronic lymphocytic leukemia
CLR	Clear
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

ABBREVIATION/SYMBOL	WORD/TERM(S)
E.G.	For example
ECG/EKG	Electrocardiogram
EEG	Electroencephalogram
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)

ABBREVIATION/SYMBOL	WORD/TERM(S)
HBV	Hepatitis B (virus)
HCG	Human chorionic gonadotropin
HCT	Hematocrit
HCV	Hepatitis C (virus)
HCVD	Hypertensive cardiovascular disease
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

ABBREVIATION/SYMBOL	WORD/TERM(S)
IVC	Inferior vena cava
IVCA	Intravenous cholangiogram
IVP	Intravenous pyelogram
JRA	Juvenile rheumatic arthritis
JVD	Jugular venous distention
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

ABBREVIATION/SYMBOL	WORD/TERM(S)
MALIG	Malignant
MAND	Mandible/mandibular
MAT	Multifocal arterial tachycardia
MAX	Maximum
MC	Medical center
MC(H)	Millicurie (hours)
MCG	Microgram
MCID	Mixed combined immunodeficiency
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

ABBREVIATION/SYMBOL	WORD/TERM(S)
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
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

ABBREVIATION/SYMBOL	WORD/TERM(S)
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
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

ABBREVIATION/SYMBOL	WORD/TERM(S)
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
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	Thrombotic thrombocytopenia 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

ABBREVIATION/SYMBOL	WORD/TERM(S)
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
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

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