

**NAACCR 2003 Implementation  
Workgroup Guidelines**

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## Introduction

Consensus standards developed through the North American Association of Central Cancer Registries (NAACCR) involve all standard-setting organizations and representatives, including the National Cancer Registrars Association (NCRA). Data transmission standards should be consistently maintained among all hospital and central registries, and should be implemented in a planned and timely manner. As with the introduction of any new set of standards and its potential consequences, implementation must be evaluated by each national program, central cancer registry (CCR), and reporting facility during the planning process. NAACCR's 2003 Implementation Workgroup has been working with the American College of Surgeons' (ACoS) Commission on Cancer (CoC), the National Cancer Institute's (NCI) Surveillance Epidemiology and End Results (SEER) Program, the National Program of Cancer Registries (NPCR), NCRA, CCRs, and cancer registry software vendors to develop an implementation plan to assist cancer registries and help ease the transition from Version 9.1 to Version 10 of the NAACCR Data Exchange and Record Layout standards.

Version 10 of the NAACCR Data Exchange and Record Layout was developed primarily in response to broad changes introduced by CoC's revisions to its data collection and reporting requirements for registries in approved cancer programs, known as the *Facility Oncology Registry Data Standards Manual* (FORDS). Several new data items of interest to other standard-setters were introduced in Version 10, including Latitude, Longitude, two Rural/Urban Continuum fields, and the new Census Tract Certainty 2000 data item. In addition, Version 10 accommodates the data elements necessary to support the Collaborative Stage (CS) schema. Note, however, that the delayed implementation of CS, withheld until January 1, 2004, does not, in and of itself, delay the utilization of Version 10. Between FORDS, CS, and other new data items introduced for 2003, the NAACCR data exchange record absorbed a total of 60 new items and 62 modifications of existing items. Both the CoC requirement revisions and Version 10 of the NAACCR Data Exchange and Record Layout are effective for cases diagnosed on or after January 1, 2003.

A number of items introduced with the publication of FORDS will require the utilization of Version 10 for the transmission of data. This has consequences for the design and application of EDITS as well as data management schemes for hospitals, central registries, standard-setters, and vendors. Reporting facilities should prioritize the abstraction of cases diagnosed on or before December 31, 2002, so that as many as possible are abstracted and entered into their registry before converting their data and/or beginning to use FORDS-compatible software. Completion, or near completion, of all 2002 cases and subsequent conversion should occur as soon as possible for all reporting facilities in 2003. Delays in implementation, including adoption of the Version 10 Data Exchange and Record Layout, forward converting treatment data, and making accommodations for new data items, may result in inconsistent data collection practice, and in some cases, the loss of valuable treatment information.

Revisions to data collection and data system design require close attention to facilitate transition to NAACCR Version 10 in a timely and efficient manner. Recommendations for forward conversions of treatment data items should be reviewed carefully. Refer to individual program and central registry requirements for additional information and guidance.

Information system design modifications and data conversions will be necessary for all data systems to meet the 2003 requirements. NAACCR Record Layout Version 10 and the data collection, data conversion, and file maintenance issues must be addressed by hospital registries and CCRs in addition to vendors who support these registries.

The implementation guidelines in this report describe the NAACCR consensus with specific program implications for registries and vendors working with CoC hospitals as well as the SEER and NPCR Programs. In the future, more explicit input will be sought from the Canadian cancer registries to address other potential needs for additional guidelines.

## Overview

**Section 1** provides guidance for the forward conversion of cases that were collected under coding rules prior to the implementation of CoC's *FORDS Manual*.

**Section 2** provides guidance for how to abstract and store information on tumors that were diagnosed on or before December 31, 2002, but are not abstracted and coded until after a reporting facility's registry data have been converted to be consistent with FORDS data item and code definitions.

**Section 3** contains policy statements from the three U.S. standard-setting organizations (CoC, SEER, and NPCR).

**Appendix A** provides additional information about the revised standard for the item *Sequence Number--Central* (#380). Note that alphabetic (e.g., AA) sequence numbers will no longer be accepted as valid codes with records that are reported using the Version 10 layout.

**Appendix B** is a review of the use of override flags and case administration items. Careful attention to the data items that indicate what rules were used when abstracting and coding cases becomes more important with every subsequent change in data item and code definitions.

**Appendix C** contains three summaries of the guidelines, specifically aimed at the three main audiences who must implement these changes: (1) central cancer registries, (2) software vendors/developers, and (3) reporting facilities.

**Appendix D** presents errata pages for "Standards for Cancer Registries, Volume II, Data Standards and Data Dictionary, Seventh Edition, Record Layout Version 10." Replacement pages for Chapters VIII, IX, and X, as well as supplemental pages for Chapter XI, are included.

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## Section 1: Forward Code Conversion

The NAACCR 2003 Implementation Workgroup recognizes that preserving the analytic use of data is of utmost importance. Furthermore, the standard-setters are sensitive to the fact that forward conversion may not be appropriate for all convertible items if the longitudinal descriptive power of reported data is to be maintained. To avoid the degradation of data interpretation as a result of conversions made to existing data items, the Workgroup recommends that hospital registries use CoC's *Registry Operations and Data Standards Manual* (ROADS) definitions for data items describing the surgical treatment of patients diagnosed on or before December 31, 2002.

In addition, vendors are advised not to install their FORDS product release until their respective hospital registry clients have completed, or almost completed, their 2002 abstracting and these cases have been entered into the local registry. This will minimize double-coding specific surgery treatment items.

Among the modifications made to the CoC data collection requirements were a number of changes to the items that describe surgical procedures. The forward conversion of cases coded according to pre-2003 rules, from ROADS (pre-2003) to FORDS (2003 and later) standards, will result in the loss of information for the following specified surgery treatment items:

- *RX Summ/Hosp--Surg Prim Site* (#1290 and #670)  
Some pre-2003 codes were not carried over into the 2003+ coding schema. The conversion rules for these site-specific descriptions of surgery of the primary site require that they be combined or collapsed when they are mapped to the 2003+ schema.
- *RX Summ/Hosp--Scope Reg LN Sur* (#1292 and #672)  
The 2003+ coding schema for this item reused pre-2003 codes and associated new descriptions to these codes. The pre-2003 schema was site-specific; therefore, codes were sensitive to the regional nodes associated with particular primary sites. By definition, the forward conversion rules call for many-to-one mapping for this item.
- *RX Summ/Hosp--Reg LN Examined/Removed* (#1296 and #676)  
This item is no longer required to be collected by CoC, but will be collected by SEER for cases coded using the *SEER Program Code Manual, Third Edition*. The conversion rules applied to pre-2003 cases for *RX Summ/Hosp--Scope Reg LN Sur* depend on the availability of information in this item.
- *RX Summ/Hosp--Surg Oth Reg/Dis* (#1294 and #674)  
The 2003+ coding schema for this item reused pre-2003 codes and associated new descriptions to these codes. The pre-2003 schema was site-specific; therefore, codes were sensitive to the regional and distant sites and distant lymph nodes associated with particular primary sites. By definition, the forward conversion rules call for many-to-one mapping for this item.

- *RX Summ--Reconstruct 1st* (#1330)

This item is no longer required by CoC for cases diagnosed on or after January 1, 2003. However, both CoC and SEER will continue to collect this item for historical cases (those diagnosed on or before December 31, 2002). For these historical cases, SEER only will collect this item for breast primaries. CoC will collect this item for historical cases because the conversion rules applied to pre-2003 cases for *RX Summ/Hosp--Surg Prim Site* depend on the availability of information in this item.

It is important, therefore, that the transition from the use of ROADS and *SEER Program Code Manual, Third Edition* standards to that of FORDS and *SEER Program Code Manual Third Edition, Revision 1*, be managed with care. Specific recommendations for the preservation and conversion of items for each treatment modality are presented in this section.

The CoC forward conversion rules and the computer algorithm—originally released in August 2002, and updated in January 2003, to reflect the recommendations of this Workgroup to facilitate the transition from ROADS to FORDS for hospital/reporting facilities—are available from CoC via the ACoS Web Site at: <http://www.facs.org/dept/cancer/ncdb/roadstofords.html>. NPCR will release a parallel conversion product that will be designed specifically to accommodate additional requirements of central registries. Information announcing the availability of the NPCR conversion routines will be made using the NAACCR List Serv upon their completion.

**Technical Guidelines: Surgery Items**

Six new data items have been introduced to the NAACCR record specifications and are located at the end of the hospital and summary treatment sections of the NAACCR record layout, using available space in the *Reserved 04* (#750, Columns 478-527) and *Reserved 06* (#1190, Columns 939-987) items. These items will store the respective descriptions of surgical treatment for pre-2003 cases.

NAACCR Version 10 has been expanded to accommodate the six items listed in Table 1. NAACCR Volume II, Version 10 errata pages for these items appear in Appendix D of this document.

<b>TABLE 1. NAACCR Version 10 Six New Surgery Data Items.</b>			
<b>Item Names</b>	<b>Column #</b>	<b>Item #</b>	<b>Length</b>
RX Hosp--Surg Site 98-02	478-479	746	2
RX Hosp--Scope Reg 98-02	480	747	1
RX Hosp--Surg Oth 98-02	481	748	1
RX Summ--Surg Site 98-02	939-940	1646	2
RX Summ--Scope Reg 98-02	941	1647	1
RX Summ--Surg Oth 98-02	942	1648	1

Prior to the forward conversion of surgery items, code assignment for the six new surgery items should be completed as illustrated in Table 2.



<b>TABLE 2. Code Assignment of the Six New Surgery Data Items.</b>			
<b>Copy Code Values From the Following Items:</b>		<b>To the Following Items:</b>	
<b>Item Name</b>	<b>Item #</b>	<b>Item Name</b>	<b>Item #</b>
RX Hosp--Surg Prim Site	670	RX Hosp--Surg Site 98-02	746
RX Hosp--Scope Reg LN Sur	672	RX Hosp--Scope Reg 98-02	747
RX Hosp--Surg Oth Reg/Dis	674	RX Hosp--Surg Oth 98-02	748
RX Summ--Surg Prim Site	1290	RX Summ--Surg Site 98-02	1646
RX Summ--Scope Reg LN Sur	1292	RX Summ--Scope Reg 98-02	1647
RX Summ--Surg Oth Reg/Dis	1294	RX Summ--Surg Oth 98-02	1648

Once codes for these new items have been correctly assigned, forward conversion of the surgery items for all cases diagnosed on or before December 31, 2002, can be completed. Codes recorded in the items *RX Hosp--Surg Prim Site* (#670); *RX Hosp--Scope Reg LN Sur* (#672); *RX Hosp--Surg Oth Reg/Dis* (#674); *RX Summ--Surg Prim Site* (#1290); *RX Summ--Scope Reg LN Sur* (#1292); and *RX Summ--Surg Oth Reg/Dis* (#1294) for cases diagnosed on or before December 31, 2002, are retained and copied per the instructions shown in Table 2 above. Each of these historical ROADS surgery items is coded with blank values for cases diagnosed on January 1, 2003, or later. The updated CoC Conversion Rules documents and computer algorithm perform these functions.

After completing the steps described above (copying codes to the six new surgery items and the forward conversion of the surgery items per CoC requirements), the items in the NAACCR Version 10 record layout that describe first-course surgical therapy, by diagnosis date, are shown in Table 3.

<b>TABLE 3. NAACCR Version 10 Surgery Data Items by Diagnosis Date.</b>	
<b>Surgery Items for All Cases Diagnosed on or Before 12/31/2002:</b>	
<b>Item Name</b>	<b>Item #</b>
RX Hosp--Surg Site 98-02	746
RX Hosp--Scope Reg 98-02	747
RX Hosp--Reg LN Removed	676
RX Hosp--Surg Oth 98-02	748
RX Summ--Surgical Approach	1310
RX Summ--Surg Site 98-02	1646
RX Summ--Scope Reg 98-02	1647
RX Summ--Reg LN Examined	1296
RX Summ--Surg Oth 98-02	1648

<b>TABLE 3. NAACCR Version 10 Surgery Data Items by Diagnosis Date.</b>	
<b>Surgery Items for All Cases Diagnosed on or Before 12/31/2002:</b>	
<b>Item Name</b>	<b>Item #</b>
RX Summ--Surgical Margins	1320
RX Summ--Reconstruct 1st	1330
<b>Surgery Items for All Cases Diagnosed on or After 1/1/2003:</b>	
<b>Item Name</b>	<b>Item #</b>
RX Hosp--Surg Prim Site	670
RX Hosp--Scope Reg LN Sur	672
RX Hosp--Surg Oth Reg/Dis	674
RX Summ--Surg Prim Site	1290
RX Summ--Scope Reg LN Sur	1292
RX Summ--Surg Oth Reg/Dis	1294
RX Summ--Surgical Margins	1320

If cases diagnosed on or before December 31, 2002, are not abstracted and entered into a reporting facility’s registry by the time vendors install their FORDS product release, reporting facilities will have to double-code the surgery items appearing in Table 1. For further discussion, see Section 2.

A complete list of treatment items, as required by CoC, NPCR, and SEER, appears in Table 10.

**Technical Guidelines: Radiation Items**

CoC will require that all registries at approved cancer programs implement the forward conversion rules for the items describing administered radiation therapy. The conversion should be applied to all cases without regard to diagnosis date. However, the two items *CoC Coding System--Original* (#2150) and *CoC Coding System--Current* (#2140) must be coded to denote the application of this conversion for cases diagnosed on or before December 31, 2002. The appropriate rules, with a computer algorithm, are available from CoC via the ACoS Web Site at: <http://www.facs.org/dept/cancer/ncdb/roadstofords.html>. SEER requirements for collecting and reporting radiation therapy remain unchanged for *RX Summ--Radiation* (#1360).

Central registries in states where most hospitals follow CoC rules must be aware that CoC no longer requires collection of the item *RX Summ--Radiation* (#1360). This information can be derived with the CoC-required radiation therapy items using either of two methods: (1) *Rad--Location of RX* (#1550) and *Rad--Regional RX Modality* (#1570) (see p. 46 of the CoC Conversion Rules); or (2) *Rad--Regional RX Modality* (#1570) and *Rad--Boost RX Modality* (#3200). See “Technical Guidelines: Radiation Items” in Section 2 of this document for additional information.

**Technical Guidelines: Systemic Therapy Items**

CoC will require that all registries at approved cancer programs implement the forward conversion rules for the items describing administered systemic therapy. However, the two items *CoC Coding System--Original* (#2150) and *CoC Coding System--Current* (#2140) must be coded to denote the application of this conversion for cases diagnosed on or before December 31, 2002. The appropriate rules, with a computer algorithm, are available from CoC via the ACoS Web Site at: <http://www.facs.org/dept/cancer/ncdb/roadstofords.html>.

SEER will require the forward conversion of items describing administered systemic therapy for all cases coded according to the *SEER Program Code Manual, Third Edition* (see NAACCR Volume II, Version 10, pp. 320, 321, and 323). Because SEER did not adopt use of the *Reason No Therapy* items for the chemotherapy and hormone therapy in 1996, the conversion rules for the *SEER Program Code Manual, Third Edition*, are different than those developed by CoC for conversion from ROADS to FORDS. The forward conversion of systemic therapy items for SEER are specified in Tables 4 through 7.

<b>TABLE 4. SEER Conversion - Chemotherapy.</b>	
<b>RX Summ--Chemotherapy (#1390)</b>	
<i>SEER Program Code Manual, Third Edition</i>	<b>Conversion to New RX Summ--Chemotherapy*</b>
0	00
1	01
2	02
3	03
7	87
8	88
9	99

\*Note: Codes 82, 85, and 86 are invalid for cases using this algorithm.

<b>TABLE 5. SEER Conversion - Hormone Therapy.</b>	
<b>RX Summ--Hormone Therapy (#1400)</b>	
<i>SEER Program Code Manual, Third Edition</i>	<b>Conversion to New RX Summ--Hormone Therapy*</b>
0	00
1	01
2	00
3	01
7	87
8	88
9	99

\*Note: Codes 82, 85, and 86 are invalid for cases using this algorithm.

<b>TABLE 6. SEER Conversion - BRM.</b>	
<b>RX Summ--BRM (#1410)</b>	
<i>SEER Program Code Manual, Third Edition*</i>	<b>Conversion to New RX Summ--BRM<sup>†</sup></b>
0	00
1	01
2	00
3	00
4	00
5	00
6	01
7	87
8	88
9	99

\*Note: Codes 2 (bone marrow transplant - autologous); 3 (bone marrow transplant - allogeneic); 4 (bone marrow transplant - NOS); 5 (stem cell transplant); and 6 (combination of BRM and any of codes 2, 3, 4, or 5) are recorded in the new item *Rx Summ--Transplnt/Endocr* (#3250) and are described in Table 7.

<sup>†</sup>Note: Codes 82, 85, and 86 are invalid for cases using this algorithm.

<b>TABLE 7. SEER Conversion - Transplant/Endocrine.</b>		
<i>SEER Program Code Manual, Third Edition</i>		<b>RX Summ--Transplnt/Endocr (#3250)</b>
<b>Rx Summ--Hormone*</b>	<b>Rx Summ--BRM</b>	
0, 1, 7,8	0,1,7,8	00
0,1, 7, 8, 9	2	11
	3	12
	4, 6	10
	5	20
2,3	0, 1, 7, 8, 9	30
	2, 3, 4 , 5, 6	40
9	0, 1, 7,8	00
0,1,7,8	9	00
9	9	99

\*Note for SEER: After analysis of data, it was decided that codes 7 and 8 in *RX Summ--Hormone* would be treated as though they only referred to hormonal therapy and not endocrine surgery. Similarly, for *RX Summ--BRM*, codes 7 and 8 would only rarely reflect transplants refused or recommended. Therefore, for SEER, codes 82, 85, 86, 87, and 88 are invalid for cases using this conversion algorithm.

## Section 2: Coding Cases Diagnosed on or Before December 31, 2002

“Straggler” cases diagnosed on or before December 31, 2002, that either remain to be abstracted and entered into hospital registries after the installation of their FORDS software or that are identified after a hospital has started accessioning year 2003 cases, must be coded using the standard coding rules appropriate for the respective diagnosis year. Thus, for “straggler” cases, it will be necessary to manually double-code only the surgery items, as described below.

Supporting both ROADS/*SEER Program Code Manual, Third Edition* treatment items and FORDS/*SEER Program Code Manual Third Edition Revision 1* treatment items in hospital registries will allow flexibility for hospitals when reporting cases to central registries or standard-setters. The standard-setters clearly define their reporting requirements with respect to first-course treatment items (see Section 3).

### Technical Guidelines: Surgery Items

Vendors must provide hospital registry clients with the ability to code the surgery items appearing in Table 8 for “straggler” cases.

<b>TABLE 8. NAACCR Version 10 Surgery Data Items Vendors Must Provide to Clients (Cases Diagnosed on or Before 12/31/02).</b>	
<b>Item Name</b>	<b>Item #</b>
RX Hosp--Surg Site 98-02	746
RX Hosp--Scope Reg 98-02	747
RX Hosp--Reg LN Removed	676
RX Hosp--Surg Oth 98-02	748
RX Summ--Surgical Approch	1310
RX Summ--Surg Site 98-02	1646
RX Summ--Scope Reg 98-02	1647
RX Summ--Reg LN Examined	1296
RX Summ--Surg Oth 98-02	1648
RX Summ--Surgical Margins	1320
RX Summ--Reconstruct 1st	1330

The allowable code values and definitions for each of these items are identical to those defined for the corresponding items in either ROADS or the *SEER Program Code Manual, Third Edition*.

The changes in the allowable codes for the item *Surg Prim Site* with the introduction of FORDS included the removal of some codes and the addition of new codes and definitions. CoC has developed an Excel spreadsheet containing codes and definitions, by disease site, for both ROADS (pre-2003) and FORDS (2003+) cases. Additionally, this spreadsheet presents the correct display sequence for descriptions of surgical procedures. The spreadsheet is available from CoC via the ACoS Web Site at: <http://www.facs.org/dept/cancer/ncdb/roadstofords.html>.

With the exception of the specified surgery items, “straggler” cases can be coded to pre-2003 definitions using the 2003+ treatment items. A complete list of treatment items that have one-to-one or many-to-one correspondence from FORDS/SEER codes to ROADS/SEER Program Code Manual, Third Edition, Revision 1 codes for radiation and systemic therapy items are listed in this section.

**Technical Guidelines: Radiation Items**

- **For CoC:** The item *RX Summ--Radiation* (#1360) will no longer be collected because its code value can be derived from the items *Rad--Location of RX* (#1550) and *Rad--Regional RX Modality* (#1570).
- **For SEER:** The item *RX Summ--Radiation* will continue to be collected. For cases received from CoC-approved cancer programs that do not contain a code for the item *RX Summ--Radiation*, a code value can be derived from the items *Rad--Boost RX Modality* (#3200) and *Rad--Regional RX Modality* (#1570) using the relationships illustrated in Table 9.

TABLE 9. SEER Conversion - Radiation.		
Rad--Boost RX Modality	Rad--Regional RX Modality	RX Summ--Radiation
00	00, 99	0*
	20-43	1
	50-55	2
	60-62	3
	80-85	4
	98	5
20-43	00, 20-43, 98, 99	1
	50-55, 60-62, 80-85	4
50-55	00, 50-55, 98, 99	2
	20-43, 80-85	4
	60-62	3
60-62	00, 50-55, 60-62, 98, 99	3
	20-43, 80-85	4
80-85	00-99	4
98	00, 98, 99	5
98, 99	20-43	1
	50-55	2
	60-62	3
	80-85	4
	98	5
99	00	0*
	99	9

\*Note: If *RX Summ--Radiation* is 0 and *Reason For No Radiation* (#1430) is coded as 7, then code *RX Summ--Radiation* as 7. Also, if *RX Summ--Radiation* is 0 and *Reason No Radiation* is coded as 8, then code *RX Summ--Radiation* as 8.

### Technical Guidelines: Chemotherapy Items

- **For CoC:** For the items *RX Summ--Chemo* (#1390) and *RX Hosp--Chemo* (#700), use the codes defined in FORDS.
- **For SEER:** For the item *RX Summ--Chemo* (#1390), use the codes defined in the *SEER Program Code Manual, Third Edition, Revision 1*. However, codes 82, 85, and 86 are invalid for cases diagnosed on or before December 31, 2002, and should be reset to 00 for these cases.

### Technical Guidelines: Hormone Therapy Items

- **For CoC:** For the items *RX Summ--Hormone* (#1400) and *RX Hosp--Hormone* (#710), use the codes defined in FORDS.
- **For SEER:** For the item *RX Summ--Hormone* (#1400), use the codes defined in the *SEER Program Code Manual, Third Edition, Revision 1*. However, codes 82, 85, and 86 are invalid for cases diagnosed on or before December 31, 2002, and should be reset to 00 for these cases.

### Technical Guidelines: Immunotherapy Items

- **For CoC:** For the items *RX Summ--BRM* (#1410) and *RX Hosp--BRM* (#720), use the codes defined in FORDS.
- **For SEER:** For the item *RX Summ--BRM* (#1410), use the codes defined in the *SEER Program Code Manual, Third Edition, Revision 1*. However, codes 82, 85, and 86 are invalid for cases diagnosed on or before December 31, 2002, and should be reset to 00 for these cases.



## Section 3: NAACCR Version 10 Reporting Requirements

A complete list of data collection requirements for treatment items, as identified by CoC, NPCR, and SEER, appears in Table 10. Refer to NAACCR Volume II, Version 10, Chapter IX: Required Status Table (errata are provided in Appendix D of this document) for specific information regarding standard-setter data reporting requirements. Where necessary, refer to individual program or state central registry requirements for additional information.

CoC, NPCR, and SEER all agree that “straggler” cases must be coded using the standard coding rules for a limited number of surgery items appropriate for the respective diagnosis year. Per CoC reporting requirements, items describing first-course surgery may have to be manually double-coded using FORDS codes and definitions (see Table 8). Items describing first-course radiation and systemic therapy only need to be recorded using FORDS/SEER Program Code Manual, Third Edition, Revision 1 codes and definitions (see technical guidelines for radiation, chemotherapy, hormone therapy, and immunotherapy items in Section 2).

### Reporting Requirements Statement, CoC:

Starting with diagnosis year 2003, CoC will require full implementation of the FORDS data collection standards for hospital cancer registries at CoC-approved cancer programs, per NAACCR Volume II, Version 10. Forward conversion of all items identified by CoC (see the conversion tables and computer algorithm, updated since their original release in August 2002, posted on the Web at: <http://www.facs.org/dept/cancer/ncdb/roadstofords.html>) must be completed before registries use the NAACCR Version 10 data transmission standard.

CoC recognizes that implementation of the diagnosis year 2003 changes may impact the quality and timeliness of data across the entire cancer surveillance community. Although the changes in CoC’s data standards may present initial challenges to registries in CoC-approved hospitals, CoC believes that it is necessary to adopt these changes in an expedient manner.

### Reporting Requirements Statement, NPCR:

For diagnosis year 2003, NPCR requires 5 surgical treatment data items, and 14 additional treatment data items are recommended (see Chapter IX: Required Status Table errata, Appendix D of this document), per NAACCR Volume II, Version 10. At this time, none of the required or recommended treatment data items are included in the NPCR-Cancer Surveillance System data submission. NPCR recognizes that implementation of the diagnosis year 2003 changes will impact the quality and timeliness of data across the entire cancer surveillance community. Although changes to the data items present challenges in these areas, NPCR supports maintaining continuity in the collection of these data and making the conversion as rapidly as possible.

As such, NPCR expects the NPCR-funded registries to adopt the changes described in NAACCR Volume II, Version 10 for cancers diagnosed on or after January 1, 2003 (FORDS). For additional information, please see the August 5, 2002, memorandum titled “Diagnosis Year 2003 and 2004 Guidance—NAACCR Volume II, Version 10.” If NPCR registries experience significant delays in

timely receipt of data from the reporting facilities in their states due to FORDS software implementation issues, they should notify their NPCR Project Officer as soon as these delays are identified.

**Reporting Requirements Statement, SEER:**

Following discussions with SEER Principal Investigators and Registry Directors, NCI staff decided that there will be 1 year of transition for the treatment items collected for cases diagnosed in 2003. SEER will allow the surgery items for 2003 cases to be transmitted to SEER using either the *SEER Program Code Manual, Third Edition* codes (ROADS codes) or FORDS codes. Most SEER areas are planning to code the majority, if not all, of their cases to the FORDS codes for diagnosis year 2003. However, concerns were raised regarding the effect of the Version 10 changes on timeliness of the 2003 data. SEER does not want to stop the processing of diagnosis year 2003 cases and create a large backlog due to delays in the availability of software necessary to manage and process diagnosis year 2003 cases. The longer it takes for new software to be developed, written, tested, and implemented for reporting facilities and central registries, the greater the impact on the timeliness of the 2003 cases. This may result in a delicate balance between timeliness of case reporting and the implementation of new software for the 2003 cases. Therefore, SEER will allow either set of surgery codes for cases diagnosed in 2003, to allow central registries maximum flexibility in dealing with phasing in of new software at different times by the many facilities reporting to them. For cases diagnosed in 2003, SEER participants can choose which set of fields are filled in for each case/tumor (see Table 10; but for each specific case/tumor, the three specified items must be coded using the same set of definitions, either the *SEER Program Code Manual, Third Edition*, or FORDS.

ACoS will require that all CoC-approved cancer program registries adopt the changes outlined in FORDS for cases diagnosed on or after January 1, 2003. SEER is not in any way trying to undermine the authority of ACoS in their mandates to these hospitals. For hospitals that are planning to collect their data using FORDS items and code definitions, it is unfair for the central registry to put any additional undue burden on them by requiring that they also collect the same or similar data using item and code definitions found in the *SEER Program Code Manual, Third Edition*.

For 2003 cases, SEER is requiring either set of surgery items (the FORDS codes are preferable):

**FORDS (*SEER Program Code Manual, Third Edition, Revision 1*) standards:**

RX Summ--Surg Prim Site	(#1290)
RX Summ--Scope Reg LN	(#1292)
RX Summ--Surg Oth R/D	(#1294)

**Note:** Reconstruction (for breast) is incorporated into surgery of primary site, and number of lymph nodes examined is incorporated into scope of regional lymph node surgery. Therefore, both would be submitted as blank.

**OR**

**ROADS (*SEER Program Code Manual, Third Edition*) standards:**

RX Summ--Surg Site 98-02	(#1646)
RX Summ--Scope Reg 98-02	(#1647)
RX Summ--Reg LN Examined	(#1296)
RX Summ--Surg Oth 98-02	(#1648)
RX Summ--Reconstruct 1st	(#1330)

For each patient/tumor record, only one set of surgery codes can be used. The item *RX Coding System--Current* (#1460) should be used as a flag and coded as “05” if the ROADS (i.e., *SEER Program Code Manual, Third Edition*) codes were used, and as “06” if the FORDS (i.e., *SEER Program Code Manual, Third Edition, Revision 1*) codes were used. This code may be computer generated for each patient/tumor record.

ACoS has been extremely cooperative in making changes to FORDS so that the data are more compatible with earlier data that have been collected. A substantial effort has been put forth to ensure that the new codes and definitions in FORDS are compatible with previous code definitions. The final resolution, as expressed in these guidelines, involves the introduction of six surgery items to retain the surgery information for cases diagnosed on or before December 31, 2002.

**Standard-Setter’s Reporting Specifications**

Table 10 illustrates how each treatment item will be required to be transmitted, depending on the date of diagnosis and the standard-setter. For CoC, this table reflects the post-conversion status of items for the purposes of data transmission.

***Codes for Reporting Specifications Found in Table 10:***

- **R:** Designates ROADS codes and definitions.
- **F:** Designates FORDS codes and definitions. *Note:* For CoC, where cases are diagnosed on or before December 31, 2002, an F indicates a converted code value, or (for the surgery items only) it may represent a double-coded “straggler” case.
- **.** (dots/periods): Designates “not in data set but available.”
- **F<sup>†</sup>:** Designates year 2003 diagnoses that are coded directly using FORDS codes and definitions or that are coded using the *SEER Program Code Manual, Third Edition*, and converted to FORDS codes, with the exception that specified codes are invalid (see Tables 4 through 7 in Section 1).
- **ed 3:** Designates the codes and definitions published in the *SEER Program Code Manual, Third Edition*.
- **ed3 to F:** Designates items coded according to the *SEER Program Code Manual, Third Edition*, and converted to FORDS codes, with the exception that specified codes are invalid (see Tables 4 through 7 in Section 1).

- **F or ed3 / blank or ed3:** Designates year 2003 diagnoses that can be reported using either FORDS or the *SEER Program Code Manual, Third Edition*. For each case/tumor, the specified summary surgery items must be coded using the same set of definitions (either *SEER Program Code Manual, Third Edition*, or FORDS) and codes transmitted in the appropriate items. Cases coded using the *SEER Program Code Manual, Third Edition*, must include the items 1646, 1647, 1648, 1296, and 1330, with *RX Coding System--Current* (#1460) coded as “05”; and FORDS codes in items 1290, 1292, 1294, leaving items 1296 and 1330 blank, with *RX Coding System--Current* coded as “06.”

**Example:** Surgery of Primary Site

- For cases diagnosed on or before December 31, 2002, codes describing surgery of the primary site must be consistent with the items and code definitions appearing in ROADS (*SEER Program Code Manual, Third Edition*). This information will be transmitted to CoC, NPCR, and SEER using the item *RX Hosp/Summ--Surgery Site 98-02* (#746/#1646).
- CoC will require that cases diagnosed on or before December 31, 2002, be converted, and that the FORDS codes for these cases be reported using the item *RX Hosp/Summ--Surgery Prim Site* (#670/#1290).
- CoC will require that cases diagnosed after December 31, 2002, use the FORDS codes and be reported using the item *RX Hosp/Summ--Surgery Prim Site* (#670/#1290).
- For cases diagnosed in 2003 only, SEER will allow the RX summary information for surgery of the primary site to be coded in either *RX Summ--Surgery Prim Site* (#1290) using FORDS codes, or in *RX Summ--Surgery Site 98-02* (#1646) using the *SEER Program Code Manual, Third Edition* (ROADS), per the instructions listed earlier in SEER’s Reporting Requirements Statement.

**TABLE 10. CoC, NPCR, and SEER Data Collection Requirements for NAACCR Version 10 Treatment Items.**

Item Name	Item#	CoC		NPCR		SEER	
		Dx Date ≤ 12/31/02	Dx Date ≥ 1/1/03	Dx Date ≤ 12/31/02	Dx Date ≥ 1/1/03	Dx Date ≤ 12/31/02	2003 Diagnoses
RX Hosp--Surg Prim Site	670	F	F	.	.	.	.
RX Hosp--Surg Site 98-02	746	R	.	.	.	.	.
RX Hosp--Scope Reg LN Sur	672	F	F	.	.	.	.
RX Hosp--Scope Reg 98-02	747	R	.	.	.	.	.
RX Hosp--Reg LN Removed	676	R	.	.	.	.	.
RX Hosp--Surg Oth Reg/Dis	674	F	F	.	.	.	.
RX Hosp--Surg Oth 98-02	748	R	.	.	.	.	.
RX Hosp--Radiation	690	.	.	.	.	.	.
RX Hosp--Chemo	700	F	F	.	.	.	.
RX Hosp--Hormone	710	F	F	.	.	.	.
RX Hosp--BRM	720	F	F	.	.	.	.
RX Hosp--Other	730	F	F	.	.	.	.
RX Hosp--Palliative Proc	3280	F	F	.	.	.	.
RX Hosp--Surgical Approach	1310	R	.	.	.	.	.
RX Summ--Surg Prim Site	1290	F	F	.	F	.	F or ed3
RX Summ--Surg Site 98-02	1646	R	.	R	.	R	F or ed3
RX Summ--Scope Reg LN Sur	1292	F	F	.	F	.	F or ed3
RX Summ--Scope Reg 98-02	1647	R	.	R	.	R	F or ed3
RX Summ--Reg LN Examined	1296	R	.	R	.	R	Blank or ed3
RX Summ--Surg Oth Reg/Dis	1294	F	F	.	F	.	F or ed3
RX Summ--Surg Oth 98-02	1648	R	.	R	.	R	F or ed3
RX Summ--Surgical Margins	1320	F	F	.	.	.	.
RS Summ--Reconstruct 1st	1330	R	.	.	.	R	.
RX Summ--Surg/Rad Seq	1380	F	F	F	F	ed 3	ed 3
Reason for No Surgery	1340	F	F	.	.	ed 3	ed 3
RX Summ--Surgery Type*	1640	.	.	.	.	ed 3	.

**TABLE 10. CoC, NPCR, and SEER Data Collection Requirements for NAACCR Version 10 Treatment Items.**

Item Name	Item#	CoC		NPCR		SEER	
		Dx Date ≤ 12/31/02	Dx Date ≥ 1/1/03	Dx Date ≤ 12/31/02	Dx Date ≥ 1/1/03	Dx Date ≤ 12/31/02	2003 Diagnoses
RX Summ--Radiation	1360	.	.	.	.	ed 3	ed 3
RX Summ--Rad to CNS	1370	.	.	.	.	ed 3	ed 3
Rad--Location of RX	1550	F	F	.	.	.	.
Rad--Treatment Volume	1540	F	F	.	.	.	.
Rad--No of Treatment Vol	1520	F	F	.	.	.	.
Rad--Regional RX Modality	1570	F	F	F	F	.	.
Rad--Regional Dose: cGy	1510	F	F	.	.	.	.
Rad--Boost RX Modality	3200	F	F	.	.	.	.
Rad--Boost Dose cGy	3210	F	F	.	.	.	.
Reason for No Radiation	1430	F	F	F	F	.	.
RX Summ--Chemo	1390	F	F	F	F	ed3 to F	F <sup>†</sup>
RX Summ--Hormone	1400	F	F	F	F	ed3 to F	F <sup>†</sup>
RX Summ--BRM	1410	F	F	F	F	ed3 to F	F <sup>†</sup>
RX Summ--Transplnt/Endocr	3250	F	F	F	F	ed3 to F	F <sup>†</sup>
RX Summ--Other	1420	F	F	F	F	ed3	ed3
RX Summ--Palliative Proc	3270	F	F	.	.	.	.

\* Item *RX Summ-Surgery* Type (#1640) is only reported for cases diagnosed on or before December 31, 1997.

## Appendix A: Sequence Number--Central

Changes to the item *Sequence Number--Central* (#380) make clear that this data item “indicates the sequence of all reportable neoplasms over the lifetime of the person.” The prior description stated “in the patient’s lifetime, according to the information and rules of the central registry.” Subsequently, some registries have defined this terminology to mean within the reference year of the registry. This change creates a challenge for those registries using this later definition. NPCR recommends a twofold approach: (1) clean up the data as they are found during the normal flow of work, and (2) notify the state’s NPCR Project Officer with an estimation of the cost to find and update the sequence number for those cancers in the person’s lifetime and before the registry’s reference year.

*Sequence Number--Central* now provides a series of codes (60-88) for the assignment of sequence number for central registry-defined tumors. Alphabetic sequence numbers no longer are allowed with the implementation of Version 10. These tumors typically have a benign/borderline behavior (i.e., those tumors not required by SEER/NPCR but determined by a specific state to be reportable). Examples include benign brain tumors, borderline ovarian tumors, squamous cell and basal cell carcinomas of the skin (SCC and BCC), prostatic intraepithelial neoplasia (PIN), grade III (PIN III), and cervix carcinoma *in situ*/cervical intraepithelial neoplasia grade III (cervix CIS/CIN III). The neoplasms required by SEER/NPCR are sequenced in the traditional series of codes (00-35) and are sequenced completely independently of this other category. NPCR registries collecting tumors not required by SEER/NPCR should resequence these tumors to the national standard, 60-88, 98 series.

Refer to NAACCR Volume II, Version 10 for further clarification of the item *Sequence Number--Central*.

Table A-1 illustrates which sequence number series should be used by type of neoplasm.

<b>TABLE A-1. Sequence Number Central: Code Assignment by Type of Neoplasm.</b>	
<b>Neoplasm</b>	<b>Seq Num--Central (Numeric Series)</b>
<b><i>In Situ</i>/Malignant as Federally Required Based on Diagnosis Year</b>	
<i>In Situ</i> (behavior code = 2), Cervix CIS/CIN III (Diagnosis Year before 1996), Includes VIN III, VAIN III, AIN III	00-35
Malignant (Behavior Code = 3)	00-35
Juvenile Astrocytoma, Diagnosis Year 2001+*	00-35
Invasive Following <i>In Situ</i> - New Primary as Defined by CoC	00-35
Invasive Following <i>In Situ</i> - New Primary as Defined by SEER	00-35
Federally Required Sequence Number Unknown or Unspecified	99

<b>TABLE A-1. Sequence Number Central: Code Assignment by Type of Neoplasm.</b>	
<b>Neoplasm</b>	<b>Seq Num--Central (Numeric Series)</b>
<b>Non-Malignant Tumors as Federally Required Based on Diagnosis Year and State/Province Registry Defined</b>	
<i>Examples:</i>	
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
Cervix CIS/CIN III, Diagnosis Years 1996-2002	98
Unspecified Benign Brain, State Registry-Defined Sequence Number	88

\*Note: Per published errata, juvenile astrocytomas should be reported as 9421/3.

Tables A-2 through A-5 identify specific histologic types for which the behavior code changed between the publication of the Second and Third Editions of the *International Classification of Diseases for Oncology* (ICD-O). These tables have been adapted from those published in Appendix 6 of ICD-O-3 (pp. 239-40), terms are as they are published in ICD-O-3.

Depending on the year of diagnosis, the code assigned to *Sequence Number - Central* for the specified histologies is either 00-35 (for histologies with behavior code 3) or 60-87 (for histologies with behavior code 0 or 1). Use Tables A-2 through A-5 to determine the appropriate code assignment for the item *Sequence Number--Central*.

<b>TABLE A-2. Terms Changing From Borderline (ICD-O-2) to Malignant (ICD-O-3) - Sequence Number Assignment by Diagnosis Date.</b>				
<b>Terms Changing From: Borderline to Malignant</b>	<b>ICD-O-2</b>	<b>ICD-O-3</b>	<b>Seq Num--Central (Numeric Series)</b>	
			<b>Diagnosis on or Before 12/31/2000</b>	<b>Diagnosis on or After 01/01/2001</b>
Endometrial Stromal Sarcoma, Low Grade (C54.1)	8931/1	8931/3	60-87	00-35
Endolymphatic Stromal Myosis (C54.1)	8931/1	8931/3	60-87	00-35
Endometrial Stromatosis (C54.1)	8931/1	8931/3	60-87	00-35
Stromal Endometriosis (C54.1)	8931/1	8931/3	60-87	00-35
Stromal Myosis, NOS (C54.1)	8931/1	8931/3	60-87	00-35
Papillary Ependymoma (C71._)	9393/1	9393/3	60-87	00-35



<b>TABLE A-2. Terms Changing From Borderline (ICD-O-2) to Malignant (ICD-O-3) - Sequence Number Assignment by Diagnosis Date.</b>				
<b>Terms Changing From: Borderline to Malignant</b>	<b>ICD-O-2</b>	<b>ICD-O-3</b>	<b>Seq Num--Central (Numeric Series)</b>	
			<b>Diagnosis on or Before 12/31/2000</b>	<b>Diagnosis on or After 01/01/2001</b>
Papillary Meningioma	9538/1	9538/3	60-87	00-35
Polycythemia Vera	9950/1	9950/3	60-87	00-35
Polycythemia Rubra Vera	9950/1	9950/3	60-87	00-35
Chronic Myeloproliferative Disease, NOS	9960/1	9960/3	60-87	00-35
Chronic Myeloproliferative Disorder	9960/1	9960/3	60-87	00-35
Myelosclerosis With Myeloid Metaplasia	9961/1	9961/3	60-87	00-35
Megakaryocytic Myelosclerosis	9961/1	9961/3	60-87	00-35
Myelofibrosis With Myeloid Metaplasia	9961/1	9961/3	60-87	00-35
Idiopathic Thrombocytopenia	9962/1	9962/3	60-87	00-35
Essential Thrombocytopenia	9962/1	9962/3	60-87	00-35
Essential Hemorrhagic Thrombocytopenia	9962/1	9962/3	60-87	00-35
Idiopathic Hemorrhagic Thrombocytopenia	9962/1	9962/3	60-87	00-35
Refractory Anemia, NOS	9980/1	9980/3	60-87	00-35
Refractory Anemia Without Sideroblasts	9981/1	9980/3	60-87	00-35
Refractory Anemia With Sideroblasts	9982/1	9982/3	60-87	00-35
Refractory Anemia With Ringed Sideroblasts	9982/1	9982/3	60-87	00-35
Refractory Anemia With Excess Blasts	9983/1	9983/3	60-87	00-35
Refractory Anemia With Excess Blasts in Transformation	9984/1	9984/3	60-87	00-35
Myelodysplastic Syndrome, NOS	9989/1	9989/3	60-87	00-35
Preleukemia	9989/1	9989/3	60-87	00-35
Preleukemic Syndrome	9989/1	9989/3	60-87	00-35

<b>TABLE A-3. Terms Changing From Malignant (ICD-O-2) to Borderline (ICD-O-3) - Sequence Number Assignment by Diagnosis Date.</b>				
<b>Terms Changing From: Malignant to Borderline</b>	<b>ICD-O-2</b>	<b>ICD-O-3</b>	<b>Seq Num--Central (Numeric Series)</b>	
			<b>Diagnosis on or Before 12/31/2000</b>	<b>Diagnosis on or After 01/01/2001</b>
Serous Cystadenoma, Borderline Malignancy (C56.9)	8442/3	8442/1	00-35	60-87
Serous Tumor, NOS, of Low Malignant Potential (56.9)	8442/3	8442/1	00-35	60-87
Papillary Cystadenoma, Borderline Malignancy (C56.9)	8451/3	8451/1	00-35	60-87
Serous Papillary Cystic Tumor of Borderline Malignancy (C56.9)	8462/3	8462/1	00-35	60-87
Papillary Serous Cystadenoma, Borderline Malignancy (C56.9)	8462/3	8462/1	00-35	60-87
Papillary Serous Tumor of Low Malignant Potential (C56.9)	8462/3	8462/1	00-35	60-87
Atypical Proliferative Papillary Serous Tumor (C56.9)	8462/3	8462/1	00-35	60-87
Mucinous Cystic Tumor of Borderline Malignancy (56.9)	8472/3	8472/1	00-35	60-87
Mucinous Cystadenoma, Borderline Malignancy (C56.9)	8472/3	8472/1	00-35	60-87
Pseudomucinous Cystadenoma, Borderline Malignancy (C56.9)	8472/3	8472/1	00-35	60-87
Mucinous Tumor, NOS, of Low Malignant Potential (56.9)	8472/3	8472/1	00-35	60-87
Papillary Mucinous Cystadenoma, Borderline Malignancy (C56.9)	8473/3	8473/1	00-35	60-87
Papillary Pseudomucinous Cystadenoma, Borderline Malignancy (C56.9)	8473/3	8473/1	00-35	60-87
Papillary Mucinous Tumor of Low Malignant Potential (C56.9)	8473/3	8473/1	00-35	60-87
Pilocytic Astrocytoma (C71. )*	9421/3	9421/3	00-35	00-35
Piloid Astrocytoma (C71. )*	9421/3	9421/3	00-35	00-35
Juvenile Astrocytoma (C71. )*	9421/3	9421/3	00-35	00-35
Spongioblastoma, NOS (C71. ) [obs.]*	9422/3	9421/3	00-35	00-35

\*Note: ICD-O-3 now classifies this diagnosis as “borderline;” however, by agreement in North America, the diagnosis is still coded as “malignant.”

<b>TABLE A-4. Terms Changing From Benign (ICD-O-2) to Borderline (ICD-O-3) - Sequence Number Assignment by Diagnosis Date.</b>				
			<b>Seq Num--Central (Numeric Series)</b>	
<b>Terms Changing From: Benign to Borderline</b>	<b>ICD-O-2</b>	<b>ICD-O-3</b>	<b>Diagnosis on or Before 12/31/2000</b>	<b>Diagnosis on or After 01/01/2001</b>
Transitional Cell Papilloma, NOS	8120/0	8120/1	60-87	60-87
Glucagonoma, NOS (C25._)	8152/0	8152/1	60-87	60-87
Thymoma, NOS (C37.9)	8580/0	8580/1	60-87	60-87
Sertoli Cell Tumor, NOS	8640/0	8640/1	60-87	60-87
Pick Tubular Adenoma	8640/0	8640/1	60-87	60-87
Sertoli Cell Adenoma	8640/0	8640/1	60-87	60-87
Tubular Androblastoma, NOS	8640/0	8640/1	60-87	60-87
Testicular Adenoma	8640/0	8640/1	60-87	60-87
Neurocytoma	9506/0	9506/1	60-87	60-87

<b>TABLE A-5. Terms Changing From Borderline (ICD-O-2) to Benign (ICD-O-3) - Sequence Number Assignment by Diagnosis Date.</b>				
			<b>Seq Num--Central (Numeric Series)</b>	
<b>Terms Changing From: Borderline to Benign</b>	<b>ICD-O-2</b>	<b>ICD-O-3</b>	<b>Diagnosis on or Before 12/31/2000</b>	<b>Diagnosis on or After 01/01/2001</b>
Villous Adenoma, NOS	8261/1	8261/0	60-87	60-87
Villous Papilloma	8261/1	8261/0	60-87	60-87
Juxtaglomerular Tumor (C64.9)	8361/1	8361/0	60-87	60-87
Reninoma (C64.9)	8361/1	8361/0	60-87	60-87
Desmoplastic Fibroma	8823/1	8823/0	60-87	60-87
Mature Teratoma	9080/1	9080/0	60-87	60-87

## Appendix B: FORDS Required Override Flags and Case Administration Items

### FORDS Required Override Flags

FORDS incorporates 12 edit override items, all part of the standard NAACCR data exchange record and all designed for use with NAACCR metafile edits. The current NAACCR Data Standards and Data Dictionary identifies the NAACCR edits with which every override item is used; FORDS identifies the subset of edits that affect items required by FORDS. Complete documentation for all of these edits can be obtained by using the Report function in the EDITS EditWriter software. A document presenting a synopsis of NAACCR metafile edits that use the FORDS edit override items is available from CoC via the ACoS Web Site at: <http://www.facs.org/dept/cancer/ncdb/roadstofords.html>.

### FORDS Case Administration Items

Case administration items describe the nature of the data stored in a cancer record. As such, it is important that they be stored on a record-specific level. FORDS requires several case administration items that were not required by CoC in the past. Most of the items involved are not new to the field of cancer registration and have been included for many years in the NAACCR data exchange record layouts and data dictionaries. However, the NAACCR 2003 Implementation Workgroup believes that they are not uniformly incorporated into cancer records in facility or central registry databases. The material that follows provides guidelines for their integration into registry software systems at this time.

- *Abstracted By* (#570): This can be auto-coded based on abstractor log-in to the registry software or keyed by the abstractor. The item did not change with publication of FORDS.
- *Facility Identification Number (FIN)* (#540): The FIN can be auto-coded by the registry software. It is important to confirm that the FIN code assigned is the code provided for the facility by ACoS, available on its Cancer Programs Web Site (<http://www.facs.org/dept/cancer/index.html>). If the database uses a different facility code internally, a lookup file or similar mechanism should be available for assigning *Archive FIN* correctly (see following), and for transmitting the correct FIN for National Cancer Data Base data submission. The value assigned to the FIN changes whenever a new FIN is assigned due to a facility merger; some mechanism for updating the FIN when necessary should be built into the software.
- *Archive FIN* (# 3100): This is a newly defined item designed to preserve permanent identity of the original FIN. When the item is first established in the database, and when new cases are added, the value of *Archive FIN* should be autocoded to equal the current FIN. It is important to confirm that the current FIN code being copied is the code provided for the facility by ACoS (<http://www.facs.org/dept/cancer/index.html>). The value of *Archive FIN* never changes when facilities merge. It is not expected that original ownership of a record will be established for cases in facilities that underwent mergers prior to January 1, 2003.

Table B-1 lists the EDITS Override items required by FORDS to be available to reporting facilities.

<b>TABLE B-1. FORDS Required EDITS Override Items.</b>	
<b>Item Name</b>	<b>Item #</b>
OverRide Acsn/Class/Seq	1985
OverRide HospSeq/DxConf	1986
OverRide CoC Site/Type	1987
OverRide HospSeq/Site	1988
OverRide Site/TNM-Stage Group	1989
OverRide Age/Site/Morph	1990
OverRide Surg/DxConf	2020
OverRide Site/Type	2030
OverRide Histology	2040
OverRide Leuk, Lymphoma	2070
OverRide Site/Behavior	2071
OverRide Site/Lat/Morph	2074

These override items are designed to work with standard NAACCR edits and/or the EDITS software and metafiles distributed by NAACCR or other standard-setters to implement standard edits. Some edit errors and/or warnings can be associated with rare—but not impossible—code combinations. Usually, the error or warning message indicates a coding or data entry problem than can be corrected. However, when the registrar establishes that a rare combination was correct, entering the appropriate value for the override flag will identify that the record has been verified and allow future runs of the edit to accept the case. If no warning or error message is generated by the respective edit, the override flag remains blank (spaces). The specific edits associated with the override items are identified in FORDS and in the NAACCR Standards Volume II. Current documentation of all standard edits can be obtained from the respective metafile in the EDITS EditWriter. A printed version of the documentation for the applicable edits for the NAACCR Version 10 Metafile will be forthcoming. See the NAACCR Standards Web Site for instructions on downloading, installing, and using the EDITS software (<http://www.naacr.org/Standards/Edits.html>).

Implementation of the override items in registry software will depend on how and whether the standard NAACCR edits and/or the EDITS software have been implemented in the software.

- **Software Has no Implementation of Standard NAACCR Edits or EDITS Software.** Registry staff can edit data after extraction into a standard NAACCR transmission file running the free-standing GenEDITS software with the appropriate metafiles, then applying the results to modify the database. Special screens in the registry software that provide the registrar with the ability to enter the override codes will be needed if the edits have not otherwise been integrated into the

software. Ordinarily, central registries will not accept override flags without proper documentation. The registrar will want access to text files at the same time to document the circumstance.

- **Software Has Provider-Written Edits Encoded That Mimic the NAACCR Standard Edits.** The associated override items can be integrated into the existing provider package, with due care taken to convey to registrars that ordinarily, edit errors and warnings require correction, and overrides are, predictably, needed only rarely.
- **Software Provider Has the EDITS Metafiles Fully Integrated Into the Software.** The associated override items can be integrated into the existing provider package, with due care taken to convey to registrars that ordinarily, edit errors and warnings require correction, and overrides are, predictably, needed only rarely.

The purpose of “original” coding version items is to identify the responses and coding rules available to the registrar when the case originally was coded, information that is instrumental in interpreting long-term data trends. When a new record is abstracted, the “original” and “current” code versions are identical. The codes describing “original” versions do not change when the items described are converted. Recording of this information can be automated, requiring minimal registrar involvement when the code versions change, or perhaps to override versions when coding “old” cases.

*TNM Edition Number* is not new in FORDS, and some of the other items already may be maintained in the registry software. If the items are being added now, the information should be completed to the extent it is possible to do so accurately. If the software provider can infer correct codes based on the version of software, or if the registry has the ability to identify on a record-specific level when various versions of codes were employed, then the specific information can be inserted into existing records. In most instances, it should be possible to identify the correct code for recent records. In cases for which that information is not available, Table B-2 identifies values to assign to historic cases when the case administration items are first created in the database. The final column identifies the code versions that describe current standards for cases diagnosed on or after January 1, 2003 (the versions recorded should be consistent with the versions used).

<b>TABLE B-2. Code Value Assignment for “Coding System--Original” Case Administration Items When Record-Specific Information Is Not Available.</b>			
<b>Item Name</b>	<b>Item #</b>	<b>Historic Records if Unknown</b>	<b>Preferred Version for cases Dx'd &gt; 12/31/2002</b>
COC Coding System--Original	2150	99	08
Race Coding System--Original	180	9	6
Site Coding System--Original	460	9	5
Morphology Coding System--Original	480	9	7
TNM Edition Number	1060	99	06

The purpose “current” coding version items is to describe the meaning of the codes currently stored in the cancer record. Their values must be updated as part of any program that converts the items they describe. When a new record is abstracted, the “original” and “current” code versions are identical. The method of automated coding used for new records will be the same. In a registry with clean data, it should be possible to accurately describe the “current” code versions on a record-specific level at the time these items are added. Given, however, that this is not always the case, Table B-3 can be used to assign values to the items for records whose content is in doubt.

<b>TABLE B-3. Code Value Assignment for “Coding System--Current” Case Administration Items When Record-Specific Information Is Not Available.</b>			
<b>Item Name</b>	<b>Item #</b>	<b>Historic Records if Unknown</b>	<b>Preferred Version for cases Dx'd &gt; 12/31/2002</b>
COC Coding System--Current	2140	99	08
Race Coding System--Current	170	9	6
Site Coding System--Current	450	9	5
Morphology Coding System--Current	470	9	7
RX Coding System--Current	1460	99	06

The distributions of ICD-O-2 and ICD-O-3 site and morphology codes (histologic type and behavior) differ depending on whether the codes were assigned directly or converted from other versions, and whether or not case review took place as part of a conversion. The ICD-O conversion flags describe the origin of these codes, and are used for interpreting long-term data trends.

- *ICD-O-3 Conversion Flag* (# 2116) records the origin of ICD-O-3 morphology codes as direct-coded or converted, and—if converted—converted with or without review. The implementation guidelines for ICD-O-3 recommended including this flag; however, its specific coding had not been resolved when those guidelines were published. If the flag has not already been implemented, the following guidelines may be applied:
  - When the flag is added to a existing database, cases for which no ICD-O-3 morphology codes are stored should be flagged with a blank (spaces); the flag does not apply.
  - Because implementation of ICD-O-3 morphology codes was recent (it was supposed to have been implemented for all cases diagnosed after December 31, 2000), the correct value for this flag should be determined either from the software version code or from registry records. Depending on the software application, determination between direct-coded (flag 0) and converted from ICD-O-2 without review (flag 1) can be based initially on registrar specification of the conditions (typically, date of diagnosis, date of data entry, and/or record accession-sequence number), after which all ICD-O-3 morphologies were direct-coded. Again, depending on the existing software application, the code can be further refined if cases with specific morphologies were pulled for review or the timing of conversion versus direct-coding of ICD-O-3 was intermittent depending on specific histologic types.

- *ICD-O-2 Conversion Flag* (# 1890) describes the origin of ICD-O-2 morphology codes during and following transition from ICD-O-1 code use, and again during the transition from ICD-O-2 to ICD-O-3, when some registries may have converted from ICD-O-3 coding to ICD-O-2 codes. The meaning of lymphoma codes particularly was affected by the shift from ICD-O-1 to ICD-O-2 codes. In addition, the codes assigned to primary sites changed completely between ICD-O-1 and ICD-O-2. The conversion from ICD-O-1 to ICD-O-2 occurred early in the development of electronic data storage and transmission in an atmosphere of limited shared data standards. As a consequence, this item and the crucial information it conveys did not exist in most registries at the time. To the greatest extent possible, it is recommended that accurate record-level reconstruction of the information be attempted. Omnibus reconstruction that is not data-sensitive is not advised; the item should be left blank if more specific information is completely unobtainable. When the flag is added to an existing data set, the following suggestions may be applied:
  - If the record does not contain ICD-O-2 histology and behavior codes, leave the field blank (space); the flag does not apply.
  - If the registry direct-coded ICD-O-3 morphology and converted to ICD-O-2, the flag should be set to 5 for those cases (unless the registry is able to identify reviewed cases, which can be flagged 6). If the registry direct-coded both ICD-O-2 and ICD-O-3, no conversion took place and the ICD-O-2 conversion flag is 0.
  - If the registry never collected ICD-O-1 morphology codes or the codes published in the field trial editions that preceded ICD-O-2, all records with ICD-O-2 morphology codes in them that were not recoded from ICD-O-3 codes should be flagged 0.
  - Most registries will be able to identify a date after which all ICD-O-2 codes were direct-coded. This date may be as early as 1991, or as late as 1993 (and occasionally earlier or later). Cases after that date (not converted from ICD-O-3) should be flagged 0.

If at all possible, registries that once collected ICD-O-1 codes are encouraged to review their records to determine with more precision when their data collection switched from ICD-O-1 to ICD-O-2 coding. Some registries converted site codes separately from morphology codes, or did not convert morphology codes at all. The suggestions that follow emphasize identification of converted morphology codes. Possible information sources include the software provider's version number (software distributed prior to 1990 would have used ICD-O-1 coding), paper documentation of conversion records, or frequency counts of morphology codes valid under one but not both coding systems (the Appendix of ICD-O-2 lists morphologies introduced in ICD-O-2; 9990 was discontinued then, but many registrars continued using it or 9999 for unknown morphology long after otherwise adopting ICD-O-2, so it may not be a useful indicator). If the registry collected ICD-O-1 morphology codes and is unable to identify accurately records for which ICD-O-2 was keyed directly, the following steps should be applied (registrar assistance in reviewing the data is required if these steps are applied):

- If unconverted ICD-O-1 codes are stored in ICD-O-2 morphology fields, leave the flag blank (space) for the period involved.
- If the morphology codes for cases diagnosed prior to 1990 are all valid ICD-O-2 codes, presume that they were converted from ICD-O-1 (flag 1).



- Presume that cases with both ICD-O-1 and ICD-O-2 morphology codes stored in the record (separately) were converted from ICD-O-1 to ICD-O-2 (flag 1), unless documentation of backward conversion exists (flag 0).
- This leaves cases diagnosed during the period 1990-1993 or so in registries with a history of ICD-O-1 coding but lacking the applicable registry records or independent identification of ICD-O-1 codes in the database. If it is apparent that the fields contain only ICD-O-2 codes but the timing of conversion cannot be determined, presume that 1991 cases were converted (flag 1) and subsequent cases were direct-coded (flag 0). Otherwise, if a year-by-year check indicates that the codes are mixed, leave the flag blank (space) for years having mixed codes.

## Appendix C: Summary of Guidelines

This Appendix provides specific constituents in the cancer registry community with a summary description of how the guidelines will effect their transition from Version 9.1 standards to Version 10.

### Summary for Central Cancer Registries

The following are important points for consideration when developing Version 10 implementation plans:

- **Reportability.** CCRs must delineate any changes in their case reporting requirements for diagnosis year 2003. CCRs should assess what conditions will be reportable to them and clearly define these conditions by year of diagnosis. Differences in reporting standards from standard-setters such as CoC, NPCR, and SEER should be assessed, and state-specific edits should be generated to accommodate these differences.
- **Required Fields.** CCRs carefully should assess which Version 10 data items they will be collecting, both for cases diagnosed January 1, 2003, and later as well as for cases diagnosed prior to 2003, which are submitted using the Version 10 layout. Registry staff should delineate those fields that their CCR still may want to be required that CoC has dropped (i.e., what fields the CCR's vendors will still need to support).
- **Required Fields for Surgery and Treatment Data Items.** Special consideration should be given to the requirement of surgery and treatment data items with the Version 10 layout. CCRs should be explicitly clear with regard to the surgery and treatment items they will be requiring for cases diagnosed in 2003, as well as for cases diagnosed pre-2003.

To prevent loss of information due to forward conversion for certain surgery data items, it is essential that cases diagnosed prior to January 1, 2003, be abstracted utilizing ROADS for specific surgery data items. Version 10 has been retroactively expanded to accommodate the abstracting and reporting of the six new data items listed in Table 1 of this document. These specific surgery data items must be coded utilizing ROADS for pre-2003 diagnoses. For each of these six new ROADS data items, there is a corresponding FORDS data item (e.g., *Rx Hosp--Surg Site 98-02* [#746]/*Rx Hosp--Surg Prim Site* [#1290]).

CCRs requiring the *Rx Summ* or *Rx Hosp* version of the fields of *Surg Prim Site*, *Scope Reg LN Surg*, or *Surg Oth Reg/Dis* are strongly encouraged to require the newly added ROADS fields for pre-2003 cases and forward convert the values submitted within these fields to the corresponding FORDS fields at the level of the CCR.

CCRs in states where most hospitals follow CoC rules must be aware that CoC no longer requires collection of the item *RX Summ--Radiation* (#1360). This information can be derived using the CoC-required radiation therapy items in either of two methods: (1) *Rad--Location of RX* (#1550) and *Rad--Regional RX Modality* (#1570) (see p. 46 of the CoC Conversion Rules; or

(2) *Rad--Regional RX Modality* (#1570) and *Rad--Boost RX Modality* (#3200). See “Technical Guidelines: Radiation Items” in Section 2 of this document for additional information.

- **State-Specific Fields.** CCRs should clearly delineate any non-standard or state-specific data items that they will be collecting, and should generate detailed abstracting instructions for each item. If a CCR will be collecting a standard data item but will not be conforming to the data standards for that item (as described in NAACCR Volume II, or elsewhere by the item’s standard-setter), a clear description of the CCR’s alternate data standards for the item should be provided.
- **EDITS Metafiles.** CCRs should decide what edits within the Version 10 EDITS Metafile they will be utilizing, and should apply these edits as soon as possible to incoming Version 10 records. CCRs also should continue to check the NAACCR Web Site for expected updated metafiles following the initial release of the Version 10 Metafile. CCRs that generate and distribute their own metafiles should have a plan to keep them updated.
- **State-Specific Edits.** CCRs should note that certain Version 10 NAACCR EDITS may need to be revised to accommodate CCR-specific reporting requirements, and that special edits may need to be developed to be applied to state-specific data items. Implementation, testing, and distribution of state-specific EDITS metafiles to reporting facilities and vendors should be considered as CCRs develop their overall Version 10 implementation plans. CCRs that generate and distribute their own metafiles should have a plan to keep them updated.
- **Acceptable Record Versions.** CCRs should have a plan to accommodate incoming Version 10 records. If a CCR anticipates receiving records submitted in the Version 10 layout before the CCR’s internal data system is prepared to accommodate them, the CCR should have a plan to address the processing of these records. Some CCRs may specify a date before which they will not be willing to accept records in the Version 10 layout, and a date after which they will no longer be willing to accept earlier record versions. Other CCRs may choose to be more flexible. However a CCR chooses to proceed, large backlogs of records should be avoided, both at the level of the reporting facility (records abstracted, but not submitted at the request of the CCR) as well as at the level of the CCR (records received and put into a suspense file to be processed at a later date).
- **Accepting 2003 Cases in Version 10 Only.** CCRs are strongly encouraged to direct their reporting facilities to code and submit all cases diagnosed January 1, 2003, and later using only the 2003 data standards and Version 10 layout.
- **Conversion Tools.** CCRs are encouraged to closely examine and test any conversion programs before utilization. CoC has produced code conversion tools; however, these may be of limited value to non-CoC facilities and CCRs that do not collect all of the CoC treatment fields. A software tool for converting records in the Version 9.1 layout to the Version 10 layout will be available from NPCR in February 2003; its availability will be announced via the NAACCR List Serv upon completion. Some CCRs may wish to produce their own conversions customized for their own data systems.

- **Software Implementation Plan.** CCRs currently relying on reporting software should pay close attention to the release dates for these products and coordinate their overall CCR Version 10 implementation plan accordingly.
- **Implementation of the Version 10 Layout Within the CCR Data System.** CCRs should have a thoroughly thought-out plan for implementation of the 2003 data standards within their CCR data systems. Important issues that should be addressed by such a plan include assessing what new fields need to be added to a CCR's data system to accommodate the Version 10 layout (see Appendix D), ensuring additional space for new items, and accommodating the varying degree of Version 10 implementation across all reporting facilities.

Conversion issues at the CCR level also should be carefully considered. Because the manner in which data are stored within a CCR is not governed by any standard-setter, each CCR must assess its own needs and make its own choices about data conversion. Some CCRs may choose to convert stored codes from one data standard to the 2003 standard, regardless of diagnosis year; others may simply add new fields and not convert anything. Those that choose to convert should store the original codes when necessary for future use.

Regardless of the conversion choices made by a CCR, the proper case administration items and codes (describing current and original coding schemes) should be produced when records are exported in the Version 10 layout (Appendix D) for exchange with another registry or standard-setter.

- **Do Not Convert More Than Once.** If a CCR is accommodating the concurrent submission of different record versions, converting data from Version 10 to Version 9.1 and then back to Version 10 at a later date (i.e., backward and then forward conversion) should not occur under any circumstances.
- **Completion of 2002 Abstraction Prior to Conversion.** CCRs should strongly encourage their reporting facilities to complete the abstraction and submission of all pre-2003 cases prior to having their data converted and having their reporting software updated to Version 10.
- **Testing Initial Version 10 Submissions.** A reporting facility's first transmission in Version 10 should be tested as thoroughly as possible for layout and serious code problems before further Version 10 records are accepted from that facility. Some registries may find it useful to require a "test batch" from each vendor or facility.
- **Accommodating Reporting Delays.** Some reporting facilities will not have the capacity to report in Version 10 for quite some time in 2003. Thus, CCRs will most certainly experience reporting delays. Reporting delays should be accommodated, and reporting facilities should not be penalized for reasonable and necessary delays in the reporting of 2003 cases.
- **Communication With Reporting Facilities and Software Vendors.** CCRs will need to distribute their implementation plan and timeline to reporting facilities and vendors as early as possible, complete with identifiable checkpoints addressing at least the above-mentioned issues. Any changes to this time-line should be immediately reported to all involved parties.

CCRs should identify any reporting facility that may encounter undue problems with the transition to Version 10 data exchange standards or with maintaining timely data submission. Facilities without CoC-approved cancer programs may be less aware of upcoming changes and may need more transition time than CoC facilities.

CCRs should ensure that abstractors at reporting facilities have been exposed to pertinent FORDS and state-specific training opportunities.

CCRs should be sure that the utilization of the six “ROADS” fields retroactively being added to the Version 10 layout is clear to reporting facilities as well as software vendors. When necessary, clarify the distinction between accession year and diagnosis year. Ensure that reporting facilities and vendors understand the double-coding issue for pre-2003 cases accessioned after system conversion. In areas collecting non-analytic cases (such as Class 3s) that may have their first facility contact long after diagnosis, emphasize that such cases still will need to be coded according to the diagnosis year standards, regardless of when they are abstracted and accessioned.

- **Death Certificate Cases.** Death certificate-only (DCO) cases and other types of cases identified through death clearance activities following the CCRs’ conversion to Version 10 should be treated as straggler cases. Data items and codes appropriate for the diagnosis year (the year of death for DCOs) should be used, note that for DCOs, the correct default codes must be recorded for all treatment items per the current guidelines for straggler cases.

### **Summary for Registry Software Developers and Vendors**

Important points for consideration when supporting clients’ transition to Version 10 standards include:

- **Database Conversion.** Databases should be converted to FORDS codes when all or virtually all 2002 cases are abstracted.
- **Recording and Storing the Appropriate Code Values.** ROADS code values must be retained for all cases diagnosed on or before December 31, 2002, for the 11 items in Table C-1 (per the instructions appearing on pages 9-12 of this document).

All cases entered into a client’s registry diagnosed on or before December 31, 2002, after the client’s database has been converted to FORDS standards, will require the 11 items shown in Table C-1. Unless the FORDS release of a CCR’s product facilitates on-the-fly forward conversion of “straggler” cases, the CCR should be sure to inform hospital/reporting facility registries that these cases will have to be manually double-coded, recording the ROADS code definitions for the surgery items listed in Table C-1 in addition to the six surgery items listed in Table C-2.

<b>TABLE C-1. NAACCR Version 10 Surgery Items Required in Registry Software After Conversion (Cases Diagnosed on or Before 12/31/02).</b>	
<b>Item Name</b>	<b>Item #</b>
RX Hosp--Surg Site 98-02	746
RX Hosp--Scope Reg 98-02	747
RX Hosp--Reg LN Removed	676
RX Hosp--Surg Oth 98-02	748
RX Summ--Surgical Approch	1310
RX Summ--Surg Site 98-02	1646
RX Summ--Scope Reg 98-02	1647
RX Summ--Reg LN Examined	1296
RX Summ--Surg Oth 98-02	1648
RX Summ--Surgical Margins	1320
RX Summ--Reconstruct 1st	1330

In addition, all cases entered into a client's registry, diagnosed on or before December 31, 2002, after the client's database has been converted to FORDS standards, must be coded using FORDS codes and definitions for the six items appearing in Table C-2.

<b>TABLE C-2. NAACCR Version 10 Surgery Items Coded Using FORDS After Conversion (Cases Diagnosed on or Before 12/31/01).</b>	
<b>Item Name</b>	<b>Item #</b>
RX Hosp--Surg Prim Site	670
RX Hosp--Scope Reg LN Sur	672
RX Hosp--Surg Oth Reg/Dis	674
RX Summ--Surg Prim Site	1290
RX Summ--Scope Reg LN Sur	1292
RX Summ--Surg Oth Reg/Dis	1294

All cases diagnosed on or after January 1, 2003, require the seven items listed in Table C-3 to be coded using FORDS codes and definitions.

<b>TABLE C-3. NAACCR Version 10 Surgery Items Coded Using FORDS (Cases Diagnosed on or After 1/1/03).</b>	
<b>Item Name</b>	<b>Item #</b>
RX Hosp--Surg Prim Site	670
RX Hosp--Scope Reg LN Sur	672
RX Hosp--Surg Oth Reg/Dis	674
RX Summ--Surg Prim Site	1290
RX Summ--Scope Reg LN Sur	1292
RX Summ--Surg Oth Reg/Dis	1294
RX Summ--Surgical Margins	1320

- **Data Collection of New Items.** NAACCR Version 10 implementation will require changes to data collection for new fields and changes to existing fields (including look-ups), state reporting programs, and updates/additions to existing report design.
- **Transmission of Converted Records.** FORDS is synonymous with the NAACCR Version 10 layout. Therefore, NAACCR Versions earlier than 10 will no longer be valid after conversion to FORDS. For data submissions to CoC, a case that has not been converted should not be transmitted using NAACCR Version 10.
- **Conversion Logs.** Vendors should provide conversion logs to assist the clients in identifying the changes to data that have been made and identifying any questionable data for review. Conversion logs should include a comprehensive list of code value changes, indicating for each record in the client's database pre-converted and converted code values. This is not provided in the year 2003 conversion algorithm package and may be vendor specific.
- **Technical Support and Education.** Vendors should not be expected to be the educational source for the year 2003 changes; education must be provided by standard-setters and CCRs. Vendors will be expected to support their software changes and assist reporting facilities and CCRs in data collection and reporting requirements. Vendors should provide training on the software upgrades, which include reference to the source for information on year 2003 changes. Inquiries about FORDS fields and conversions should be referred to CoC.

### **Summary for Hospital Cancer Registrars and Reporting Facilities**

Important points for consideration when making the transition to FORDS standards include:

- **Review Data Reporting Requirements.** Version 10 of the NAACCR data exchange layout was largely developed in response to FORDS and the changes introduced by CoC's revisions to its data collection and reporting requirements for registries in approved cancer programs. Several new data items have been introduced with the publication of FORDS. Two tables listing data

items that are no longer required to be collected and data items required by approved cancer program registries are available on the CoC Web site at: <http://www.facs.org/dept/cancer/coc/fordsmanual.html>. Specific data items no longer collectable by CoC for approved cancer programs still may be required by state registries. Registrars need to check with local state registries for data requirements.

- **Prioritize Case Abstracting.** Registrars should prioritize their 2002 abstracting. Ideally, abstracting of 2002 cases should be complete before vendors convert registry data and/or begin to use FORDS-compatible software.

To record data in a consistent manner and maintain standardized analytic interpretation (see pp. 9-10 of this document) of cases diagnosed on or before December 31, 2002, that are abstracted after the registry database is converted to FORDS standards will require that six surgery items be double-coded. CCRs should check with their software providers to determine whether on-the-fly forward conversion of “straggler” cases is facilitated. It is likely, however, that “straggler” cases will have to be manually double-coded, recording the ROADS code definitions for the surgery items listed in Table C-4 in addition to the six surgery items listed in Table C-5.

ROADS code values must be used for all cases diagnosed on or before December 31, 2002, for the following 11 data items. All cases abstracted and entered into a reporting facility registry after data have been converted to FORDS standards that were diagnosed on or before December 31, 2002, are “straggler” cases and must be coded using ROADS codes and definitions for the 11 items listed in Table C-4.

<b>TABLE C-4. NAACCR Version 10 Surgery Items Coded Using ROADS After Conversion (Cases Diagnosed on or Before 12/31/02).</b>	
<b>ROADS Data Item Name</b>	<b>NAACCR Item #</b>
Surgery of the Primary Site at This Facility	746
Scope of Regional Lymph Node Surgery at this Facility	747
Number of Regional Lymph Nodes Removed at This Facility	676
Surgery of Other Regional Site(s), Distant Site(s) or Lymph Nodes at This Facility	748
Surgical Approach	1310
Surgery of the Primary Site	1646
Scope of Regional Lymph Node Surgery	1647
Number of Regional Lymph Nodes Examined	1296
Surgery of Other Regional Site(s), Distant Site(s) or Lymph Nodes	1648
Surgical Margins	1320
Reconstruction/Restoration - First Course	1330



All cases entered into a hospital/reporting facility registry diagnosed on or before December 31, 2002, after the database has been converted to FORDS standards, must be coded using FORDS codes and definitions for the six items shown in Table C-5.

<b>TABLE C-5. NAACCR Version 10 Surgery Items Coded Using FORDS After Conversion (Cases Diagnosed on or Before 12/31/02).</b>	
<b>FORDS Data Item Name</b>	<b>NAACCR Item #</b>
Surgery of the Primary Site at This Facility	670
Scope of Regional Lymph Node Surgery at This Facility	672
Surgery of Other Regional Site(s), Distant Site(s) or Lymph Nodes at This Facility	674
Surgery of the Primary Site	1290
Scope of Regional Lymph Node Surgery	1292
Surgery of Other Regional Site(s), Distant Site(s) or Lymph Nodes	1294

All cases diagnosed on or after January 1, 2003, only require the seven items in Table C-6 to be coded using FORDS codes and definitions.

<b>TABLE C-6. NAACCR Version 10 Surgery Items Coded Using FORDS (Cases Diagnosed on or After 1/1/03).</b>	
<b>FORDS Data Item Name</b>	<b>NAACCR Item #</b>
Surgery of The Primary Site at This Facility	670
Scope of Regional Lymph Node Surgery at This Facility	672
Surgery of Other Regional Site(s), Distant Site(s) or Lymph Nodes at This Facility	674
Surgery of the Primary Site	1290
Scope of Regional Lymph Node Surgery	1293
Surgery of Other Regional Site(s), Distant Site(s) or Lymph Nodes	1294
Surgical Margins	1320

Code all other treatment items using FORDS coding rules, regardless of the diagnosis date.

Enter cases diagnosed on or after January 1, 2003, into a suspense file until the FORDS-compatible software upgrade becomes available. After the ROADS-to-FORDS conversion is complete, previously suspended cases can be coded and completed using FORDS.

## **Appendix D: NAACCR Volume II, Version 10 Errata**

The six items described in Table 1 on p. 10 of this document, are specified as follows in NAACCR “Standards for Cancer Registries, Volume II, Seventh Edition, Record Layout Version 10:”

- Chapter VIII: Record Layout Table (see rows/text on pp. 48 and 51 of this Appendix).
- Chapter IX: Required Status Table (see rows/text on pp. 58 and 60 of this Appendix).
- Chapter X: Data Descriptor Table (see rows/text on pp. 70, 73, and 74 of this Appendix).
- Chapter XI: Data Dictionary (see pages 83-89 of this Appendix).

**Chapter VIII: Record Layout 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	Revised
19-19	1	50	NAACCR Record Version	Record ID	
20-29	10	40	Registry ID	Record ID	Revised
30-31	2	60	Tumor Record Number	Record ID	
32-51	20	370	Reserved 01	Record ID	Revised
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	Revised
92-92	1	120	Census Cod Sys 1970/80/90	Demographic	Revised
93-98	6	130	Census Tract 2000	Demographic	Revised
99-99	1	362	Census Tract Block Group	Demographic	
100-100	1	364	Census Tr Cert 1970/80/90	Demographic	Revised
101-101	1	365	Census Tr Certainty 2000	Demographic	New
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	
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	

Column #	Length	Item #	Item Name	Section	Note
227-228	2	3300	RuralUrban Continuum 1993	Demographic	New
229-230	2	3310	RuralUrban Continuum 2000	Demographic	New
231-280	50	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
301-304	4	522	Histologic Type ICD-O-3	Cancer Identification	Subfield
301-305	5	521	Morph--Type&Behav ICD-O-3	Cancer Identification	Group
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	
321-321	1	520	Screening Result	Cancer Identification	
322-371	50	680	Reserved 03	Cancer Identification	Revised
372-381	10	538	Reporting Hospital FAN	Hospital-Specific	
382-391	10	540	Reporting Hospital	Hospital-Specific	Revised
392-401	10	3100	Archive FIN	Hospital-Specific	New
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	620	Year First Seen This CA	Hospital-Specific	
445-446	2	630	Primary Payer at DX	Hospital-Specific	
447-447	1	640	Inpatient/Outpt Status	Hospital-Specific	
448-448	1	650	Presentation at CA Conf	Hospital-Specific	
449-456	8	660	Date of CA Conference	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	Revised
466-467	2	710	RX Hosp--Hormone	Hospital-Specific	Revised
468-469	2	720	RX Hosp--BRM	Hospital-Specific	Revised
470-470	1	730	RX Hosp--Other	Hospital-Specific	

Column #	Length	Item #	Item Name	Section	Note
471-472	2	740	RX Hosp--DX/Stg Proc	Hospital-Specific	Revised
473-473	1	3280	RX Hosp--Palliative Proc	Hospital-Specific	New
474-474	1	742	RX Hosp--Screen/BX Proc1	Hospital-Specific	
475-475	1	743	RX Hosp--Screen/BX Proc2	Hospital-Specific	
476-476	1	744	RX Hosp--Screen/BX Proc3	Hospital-Specific	
477-477	1	745	RX Hosp--Screen/BX Proc4	Hospital-Specific	
478-479	2	746	RX Hosp--Surg Site 98-02	Hospital Specific	New
480-480	1	747	RX Hosp--Scope Reg 98-02	Hospital Specific	New
481-481	1	748	RX Hosp--Surg Oth 98-02	Hospital Specific	New
482-527	46	750	Reserved 04	Hospital-Specific	Revised
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	770	Loc/Reg/Distant Stage	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	
583-584	2	1000	TNM Other T	Stage/Prognostic Factors	
585-586	2	1010	TNM Other N	Stage/Prognostic Factors	
587-588	2	1020	TNM Other M	Stage/Prognostic Factors	
589-590	2	1030	TNM Other Stage Group	Stage/Prognostic Factors	
591-591	1	1040	TNM Other Staged By	Stage/Prognostic Factors	
592-592	1	1050	TNM Other Descriptor	Stage/Prognostic Factors	
593-594	2	1060	TNM Edition Number	Stage/Prognostic Factors	Revised
595-609	15	1070	Other Staging System	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	

Column #	Length	Item #	Item Name	Section	Note
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	
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	New
632-633	2	2810	CS Extension	Stage/Prognostic Factors	New
634-634	1	2820	CS Tumor Size/Ext Eval	Stage/Prognostic Factors	New
635-636	2	2830	CS Lymph Nodes	Stage/Prognostic Factors	New
637-637	1	2840	CS Reg Nodes Eval	Stage/Prognostic Factors	New
638-639	2	2850	CS Mets at DX	Stage/Prognostic Factors	New
640-640	1	2860	CS Mets Eval	Stage/Prognostic Factors	New
641-643	3	2880	CS Site-Specific Factor 1	Stage/Prognostic Factors	New
644-646	3	2890	CS Site-Specific Factor 2	Stage/Prognostic Factors	New
647-649	3	2900	CS Site-Specific Factor 3	Stage/Prognostic Factors	New
650-652	3	2910	CS Site-Specific Factor 4	Stage/Prognostic Factors	New
653-655	3	2920	CS Site-Specific Factor 5	Stage/Prognostic Factors	New
656-658	3	2930	CS Site-Specific Factor 6	Stage/Prognostic Factors	New
659-660	2	2940	Derived AJCC T	Stage/Prognostic Factors	New
661-661	1	2950	Derived AJCC T Descriptor	Stage/Prognostic Factors	New
662-663	2	2960	Derived AJCC N	Stage/Prognostic Factors	New
664-664	1	2970	Derived AJCC N Descriptor	Stage/Prognostic Factors	New
665-666	2	2980	Derived AJCC M	Stage/Prognostic Factors	New
667-667	1	2990	Derived AJCC M Descriptor	Stage/Prognostic Factors	New
668-669	2	3000	Derived AJCC Stage Group	Stage/Prognostic Factors	New
670-670	1	3010	Derived SS1977	Stage/Prognostic Factors	New
671-671	1	3020	Derived SS2000	Stage/Prognostic Factors	New
672-672	1	3030	Derived AJCC--Flag	Stage/Prognostic Factors	New
673-673	1	3040	Derived SS1977--Flag	Stage/Prognostic Factors	New
674-674	1	3050	Derived SS2000--Flag	Stage/Prognostic Factors	New
675-679	5	3110	Comorbid/Complication 1	Stage/Prognostic Factors	New
680-684	5	3120	Comorbid/Complication 2	Stage/Prognostic Factors	New
685-689	5	3130	Comorbid/Complication 3	Stage/Prognostic Factors	New
690-694	5	3140	Comorbid/Complication 4	Stage/Prognostic Factors	New
695-699	5	3150	Comorbid/Complication 5	Stage/Prognostic Factors	New
700-704	5	3160	Comorbid/Complication 6	Stage/Prognostic Factors	New
705-754	50	1180	Reserved 05	Stage/Prognostic Factors	Revised
755-762	8	1200	RX Date--Surgery	Treatment-1st Course	
763-770	8	3170	RX Date--Most Defin Surg	Treatment-1st Course	New
771-778	8	3180	RX Date--Surgical Disch	Treatment-1st Course	New
779-786	8	1210	RX Date--Radiation	Treatment-1st Course	
787-794	8	3220	RX Date--Radiation Ended	Treatment-1st Course	New
795-802	8	3230	RX Date--Systemic	Treatment-1st Course	New
803-810	8	1220	RX Date--Chemo	Treatment-1st Course	
811-818	8	1230	RX Date--Hormone	Treatment-1st Course	

Column #	Length	Item #	Item Name	Section	Note
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	Revised
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	Revised
871-871	1	3270	RX Summ--Palliative Proc	Treatment-1st Course	New
872-872	1	3260	Pain Assessment	Treatment-1st Course	New
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	New
878-879	2	1390	RX Summ--Chemo	Treatment-1st Course	Revised
880-881	2	1400	RX Summ--Hormone	Treatment-1st Course	Revised
882-883	2	1410	RX Summ--BRM	Treatment-1st Course	Revised
884-884	1	1420	RX Summ--Other	Treatment-1st Course	
885-885	1	1430	Reason for No Radiation	Treatment-1st Course	
886-886	1	1440	Reason for No Chemo	Treatment-1st Course	
887-887	1	1450	Reason for No Hormone	Treatment-1st Course	
888-889	2	1460	RX Coding System--Current	Treatment-1st Course	Revised
890-890	1	1470	Protocol Eligibility Stat	Treatment-1st Course	
891-892	2	1480	Protocol Participation	Treatment-1st Course	
893-893	1	1490	Referral to Support Serv	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	1530	Rad--Elapsed RX Days	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	1560	Rad--Intent of Treatment	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	New
913-917	5	3210	Rad--Boost Dose cGy	Treatment-1st Course	New
918-918	1	1580	Rad--RX Completion Status	Treatment-1st Course	
919-919	1	1590	Rad--Local Control Status	Treatment-1st Course	
920-922	3	1600	Chemotherapy Field 1	Treatment-1st Course	
923-925	3	1610	Chemotherapy Field 2	Treatment-1st Course	
926-928	3	1620	Chemotherapy Field 3	Treatment-1st Course	
929-931	3	1630	Chemotherapy Field 4	Treatment-1st Course	

Column #	Length	Item #	Item Name	Section	Note
932-933	2	1640	RX Summ--Surgery Type	Treatment-1st Course	
934-934	1	1642	RX Summ--Screen/BX Proc1	Treatment-1st Course	
935-935	1	1643	RX Summ--Screen/BX Proc2	Treatment-1st Course	
936-936	1	1644	RX Summ--Screen/BX Proc3	Treatment-1st Course	
937-937	1	1645	RX Summ--Screen/BX Proc4	Treatment-1st Course	
938-938	1	3190	Readm Same Hosp 30 Days	Treatment-1st Course	New
939-940	2	1646	RX Summ--Surg Site 98-02	Treatment-1st Course	New
941-941	1	1647	RX Summ--Scope Reg 98-02	Treatment-1st Course	New
942-942	1	1648	RX Summ--Surg Oth 98-02	Treatment-1st Course	New
943-987	45	1190	Reserved 06	Treatment-1st Course	Revised
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
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
1033-1040	8	1720	Subsq RX 5th Course Date	Treatment-Subsequent & Other	
1041-1047	7	1730	Subsq RX 5th Course Codes	Treatment-Subsequent & Other	Group
1041-1042	2	1731	Subsq RX 5th Course Surg	Treatment-Subsequent & Other	Subfield
1043-1043	1	1732	Subsq RX 5th Course Rad	Treatment-Subsequent & Other	Subfield
1044-1044	1	1733	Subsq RX 5th Course Chemo	Treatment-Subsequent & Other	Subfield
1045-1045	1	1734	Subsq RX 5th Course Horm	Treatment-Subsequent & Other	Subfield
1046-1046	1	1735	Subsq RX 5th Course BRM	Treatment-Subsequent & Other	Subfield
1047-1047	1	1736	Subsq RX 5th Course Oth	Treatment-Subsequent & Other	Subfield
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	



Column #	Length	Item #	Item Name	Section	Note
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	
1060-1060	1	1737	Subsq RX 5th--Scope LN Su	Treatment-Subsequent & Other	
1061-1061	1	1738	Subsq RX 5th--Surg Oth	Treatment-Subsequent & Other	
1062-1063	2	1739	Subsq RX 5th--Reg LN Rem	Treatment-Subsequent & Other	
1064-1064	1	1741	Subsq RX--Reconstruct Del	Treatment-Subsequent & Other	
1065-1114	50	1300	Reserved 07	Treatment-Subsequent & Other	Revised
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	
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

Column #	Length	Item #	Item Name	Section	Note
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	
1148-1155	8	2114	Future Use Timeliness 1	Edit Overrides/Conversion History/System Admin	
1156-1163	8	2115	Future Use Timeliness 2	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	
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	Revised
1202-1203	2	2150	COC Coding Sys--Original	Edit Overrides/Conversion History/System Admin	Revised
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	Revised
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	

Column #	Length	Item #	Item Name	Section	Note
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	
1355-1356	2	1890	Recurrence Type--1st--Oth	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	
1397-1446	50	1740	Reserved 09	Follow-Up/Recurrence/Death	Revised
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	Revised
2148-2187	40	2335	Addr at DX--Supplementl	Patient-Confidential	New
2188-2227	40	2350	Addr Current--No & Street	Patient-Confidential	Revised
2228-2267	40	2355	Addr Current--Supplementl	Patient-Confidential	New
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	Revised
2354-2393	40	2393	Follow-Up Contact--Suppl	Patient-Confidential	New
2394-2403	10	2352	Latitude	Patient-Confidential	New
2404-2414	11	2354	Longitude	Patient-Confidential	New
2415-2464	50	1835	Reserved 10	Patient-Confidential	Revised
2465-2474	10	2430	Last Follow-Up Hospital	Hospital-Confidential	Revised
2475-2484	10	2440	Following Registry	Hospital-Confidential	Revised
2485-2494	10	2410	Institution Referred From	Hospital-Confidential	Revised
2495-2504	10	2420	Institution Referred To	Hospital-Confidential	Revised
2505-2554	50	1900	Reserved 11	Hospital-Confidential	Revised
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	

Column #	Length	Item #	Item Name	Section	Note
2587-2594	8	2500	Physician 4	Other-Confidential	
2595-2644	50	1950	Reserved 12	Other-Confidential	Revised
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	Place of Diagnosis	Text-Miscellaneous	
5925-6694	770	2700	Reserved 19	Text-Miscellaneous	Revised

**Chapter IX: Required Status Table**

Item #	Item Name	NPCR	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Source of Standard	Note
10	Record Type	.	.	R	.	R	NAACCR	Revised
20	Patient ID Number	R	.	.	R	R	Reporting Registry	
30	Registry Type	.	.	.	.	.	NAACCR	
35	FIN Coding System	S	.	.	.	.	NAACCR	
37	Reserved 00	.	.	.	.	.		
40	Registry ID	S	.	.	R	R	NAACCR	
50	NAACCR Record Version	R	.	R	.	.	NAACCR	Revised
60	Tumor Record Number	S	.	.	R	R	NAACCR	
70	Addr at DX--City	R	R	R	R	.	COC	Revised
80	Addr at DX--State	R	R	R	R	.	NAACCR	Revised
90	County at DX	R	R	R	R	R	FIPS/SEER	
100	Addr at DX--Postal Code	R	R	R	R	.	NAACCR	Revised
110	Census Tract 1970/80/90	RH	.	.	RH	RH	SEER	Revised
120	Census Cod Sys 1970/80/90	RH	.	.	RH	RH	SEER	Revised
130	Census Tract 2000	R	.	.	R	R	SEER	Revised
140	Census Tract Cod Sys--Alt	.	.	.	.	.	NAACCR	Retired
150	Marital Status at DX	S	.	.	R	R	SEER	Revised
160	Race 1	R	R	R	R	R	SEER/COC	
161	Race 2	R	R	R	R	R	SEER/COC	
162	Race 3	R	R	R	R	R	SEER/COC	
163	Race 4	R	R	R	R	R	SEER/COC	
164	Race 5	R	R	R	R	R	SEER/COC	
170	Race Coding Sys--Current	.	R	R	.	.	NAACCR	Revised
180	Race Coding Sys--Original	.	R	R	.	.	NAACCR	Revised
190	Spanish/Hispanic Origin	R	R	R	R	R	SEER/COC	
200	Computed Ethnicity	S	.	.	R	R	NAACCR	
210	Computed Ethnicity Source	S	.	.	R	R	NAACCR	
220	Sex	R	R	R	R	R	SEER/COC	
230	Age at Diagnosis	R	R	R	R	R	SEER/COC	Revised
240	Birth Date	R	R	R	R	R	SEER/COC	
250	Birthplace	R*	R	R	R	R	SEER/COC	Revised
260	Religion	.	.	.	.	.	Varies	
270	Occupation Code--Census	S	.	.	.	.	Census/NPCR	
280	Industry Code--Census	S	.	.	.	.	Census/NPCR	
290	Occupation Source	S	.	.	.	.	NPCR	
300	Industry Source	S	.	.	.	.	NPCR	
310	Text--Usual Occupation	R*	.	.	.	.	NPCR	Revised
320	Text--Usual Industry	R*	.	.	.	.	NPCR	Revised
330	Occup/Ind Coding System	S	.	.	.	.	NPCR	
340	Tobacco History	.	.	.	.	.	Varies	Revised

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Item #	Item Name	NPCR	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Source of Standard	Note
350	Alcohol History	.	.	.	.	.	Varies	Revised
360	Family History of Cancer	.	.	.	.	.	Varies	Revised
362	Census Tract Block Group	.	.	.	.	.	Census	
364	Census Tr Cert 1970/80/90	RH	.	.	RH	RH	SEER	Revised
365	Census Tr Certainty 2000	R	.	.	R	R	SEER	New
370	Reserved 01	.	.	.	.	.		
380	Sequence Number--Central	R	.	.	R	R	NAACCR	
390	Date of Diagnosis	R	R	R	R	R	SEER/COC	
400	Primary Site	R	R	R	R	R	SEER/COC	
410	Laterality	R	R	R	R	R	SEER/COC	
419	Morph--Type&Behav ICD-O-2							
420	Histology (92-00) ICD-O-2	RH	.	RH	RH	RH	SEER/COC	Revised
430	Behavior (92-00) ICD-O-2	RH	.	RH	RH	RH	SEER/COC	Revised
440	Grade	R	R	R	R	R	SEER/COC	
450	Site Coding Sys--Current	S	R	R	.	.	NAACCR	Revised
460	Site Coding Sys--Original	.	R	R	.	.	NAACCR	Revised
470	Morph Coding Sys--Current	S	R	R	.	.	NAACCR	Revised
480	Morph Coding Sys--Originl	.	R	R	.	.	NAACCR	Revised
490	Diagnostic Confirmation	R	R	R	R	R	SEER/COC	
500	Type of Reporting Source	R	.	.	R	R	SEER	Revised
510	Screening Date	.	.	.	.	.	COC	Revised
520	Screening Result	.	.	.	.	.	COC	Revised
521	Morph--Type&Behav ICD-O-3							
522	Histologic Type ICD-O-3	R	R	R	R	R	SEER/COC	
523	Behavior Code ICD-O-3	R	R	R	R	R	SEER/COC	
530	Reserved 02	.	.	.	.	.		
538	Reporting Hospital FAN	.	.	.	.	.	COC	Revised
540	Reporting Hospital	S	R	R	R	.	COC	Revised
550	Accession Number--Hosp	S	R	R	R	.	COC	Revised
560	Sequence Number--Hospital	S	R	R	R	.	COC	Revised
570	Abstracted By	.	R	R	R	.	COC	Revised
580	Date of 1st Contact	R	R	R	.	.	NAACCR	Revised
590	Date of Inpatient Adm	.	.	.	.	.	COC	Revised
600	Date of Inpatient Disch	.	.	.	.	.	COC	Revised
610	Class of Case	S	R	R	RC	.	COC	Revised
620	Year First Seen This CA	.	.	.	.	.	COC	Revised
630	Primary Payer at DX	.	R	R	.	.	COC	
640	Inpatient/Outpt Status	.	.	.	.	.	COC	Revised
650	Presentation at CA Conf	.	.	.	.	.	COC	Revised
660	Date of CA Conference	.	.	.	.	.	COC	Revised
670	RX Hosp--Surg Prim Site	.	R	R	R	.	COC	Revised
672	RX Hosp--Scope Reg LN Sur	.	R	R	R	.	COC	Revised

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Item #	Item Name	NPCR	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Source of Standard	Note
674	RX Hosp--Surg Oth Reg/Dis	.	R	R	R	.	COC	Revised
676	RX Hosp--Reg LN Removed	.	.	.	.	.	COC	Revised
680	Reserved 03	.	.	.	.	.		
690	RX Hosp--Radiation	.	.	.	R	.	SEER	Revised
700	RX Hosp--Chemo	.	R	R	R	.	COC	Revised
710	RX Hosp--Hormone	.	R	R	R	.	COC	Revised
720	RX Hosp--BRM	.	R	R	R	.	COC	Revised
730	RX Hosp--Other	.	R	R	R	.	COC	Revised
740	RX Hosp--DX/Stg Proc	.	R	R	.	.	COC	Revised
742	RX Hosp--Screen/BX Proc1	.	.	.	.	.	COC	
743	RX Hosp--Screen/BX Proc2	.	.	.	.	.	COC	
744	RX Hosp--Screen/BX Proc3	.	.	.	.	.	COC	
745	RX Hosp--Screen/BX Proc4	.	.	.	.	.	COC	
746	RX Hosp--Surg Site 98-02	.	RH*	RH*	RH/R	.	COC	New
747	RX Hosp--Scope Reg 98-02	.	RH*	RH*	RH/R	.	COC	New
748	RX Hosp--Surg Oth 98-02	.	RH*	RH*	RH/R	.	COC	New
750	Reserved 04	.	.	.	.	.		
759	SEER Summary Stage 2000	R	R	R	.	.	SEER	Revised
760	SEER Summary Stage 1977	RH	RH	RH	.	.	SEER	Revised
770	Loc/Reg/Distant Stage	.	.	.	.	.	Varies	
779	Extent of Disease 10-Dig							
780	EOD--Tumor Size	S	R	R	R	R	SEER/COC	
790	EOD--Extension	S	.	.	R	R	SEER	Revised
800	EOD--Extension Prost Path	S	.	.	R	R	SEER	
810	EOD--Lymph Node Involv	S	.	.	R	R	SEER	Revised
820	Regional Nodes Positive	S	R	R	R	R	SEER/COC	
830	Regional Nodes Examined	S	R	R	R	R	SEER/COC	
840	EOD--Old 13 Digit	.	.	.	RH	RH	SEER	Revised
850	EOD--Old 2 Digit	.	.	.	RH	RH	SEER	Revised
860	EOD--Old 4 Digit	.	.	.	RH	RH	SEER	Revised
870	Coding System for EOD	.	.	.	R	R	SEER	
880	TNM Path T	.	R	R	.	.	AJCC	
890	TNM Path N	.	R	R	.	.	AJCC	
900	TNM Path M	.	R	R	.	.	AJCC	
910	TNM Path Stage Group	.	R	R	.	.	AJCC	
920	TNM Path Descriptor	.	R	R	.	.	COC	Revised
930	TNM Path Staged By	.	R	R	.	.	COC	
940	TNM Clin T	.	R	R	.	.	AJCC	
950	TNM Clin N	.	R	R	.	.	AJCC	
960	TNM Clin M	.	R	R	.	.	AJCC	
970	TNM Clin Stage Group	.	R	R	.	.	AJCC	
980	TNM Clin Descriptor	.	R	R	.	.	COC	Revised

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Item #	Item Name	NPCR	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Source of Standard	Note
990	TNM Clin Staged By	.	R	R	.	.	COC	
1000	TNM Other T	.	.	.	.	.	AJCC	Revised
1010	TNM Other N	.	.	.	.	.	AJCC	Revised
1020	TNM Other M	.	.	.	.	.	AJCC	Revised
1030	TNM Other Stage Group	.	.	.	.	.	AJCC	Revised
1040	TNM Other Staged By	.	.	.	.	.	COC	Revised
1050	TNM Other Descriptor	.	.	.	.	.	COC	Revised
1060	TNM Edition Number	.	R	R	.	.	COC	
1070	Other Staging System	.	.	.	.	.	COC	Revised
1080	Date of 1st Positive BX	.	.	.	.	.	COC	Revised
1090	Site of Distant Met 1	.	.	RH	.	.	COC	Revised
1100	Site of Distant Met 2	.	.	RH	.	.	COC	Revised
1110	Site of Distant Met 3	.	.	RH	.	.	COC	Revised
1120	Pediatric Stage	.	.	.	.	.	COC	Revised
1130	Pediatric Staging System	.	.	.	.	.	COC	Revised
1140	Pediatric Staged By	.	.	.	.	.	COC	Revised
1150	Tumor Marker 1	.	RH	RH	R	R	SEER	Revised
1160	Tumor Marker 2	.	RH	RH	R	R	SEER	Revised
1170	Tumor Marker 3	.	RH	RH	R	R	SEER	Revised
1180	Reserved 05	.	.	.	.	.		
1190	Reserved 06	.	.	.	.	.		
1200	RX Date--Surgery	S	R	R	.	.	COC	
1210	RX Date--Radiation	S	R	R	.	.	COC	
1220	RX Date--Chemo	.	.	.	.	.	COC	Revised
1230	RX Date--Hormone	.	.	.	.	.	COC	Revised
1240	RX Date--BRM	.	.	.	.	.	COC	Revised
1250	RX Date--Other	S	R	R	.	.	COC	
1260	Date of Initial RX--SEER	#	.	.	R	R	SEER	
1270	Date of 1st Crs RX--COC	#	R	R	.	.	COC	
1280	RX Date--DX/Stg Proc	.	R	R	.	.	COC	
1290	RX Summ--Surg Prim Site	R	R	R	R	R	SEER/COC	
1292	RX Summ--Scope Reg LN Sur	R	R	R	R	R	SEER/COC	
1294	RX Summ--Surg Oth Reg/Dis	R	R	R	R	R	SEER/COC	
1296	RX Summ--Reg LN Examined	.	.	.	RH	RH	SEER/COC	Revised
1300	Reserved 07	.	.	.	.	.		
1310	RX Summ--Surgical Approach	.	.	.	.	.	COC	Revised
1320	RX Summ--Surgical Margins	.	R	R	.	.	COC	
1330	RX Summ--Reconstruct 1st	.	.	.	RH	RH	COC	Revised
1340	Reason for No Surgery	S	R	R	R	R	SEER/COC	Revised
1350	RX Summ--DX/Stg Proc	.	R	R	.	.	COC	
1360	RX Summ--Radiation	.	.	.	R	R	SEER	Revised
1370	RX Summ--Rad to CNS	.	.	.	RH	RH	SEER/COC	Revised

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Item #	Item Name	NPCR	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Source of Standard	Note
1380	RX Summ--Surg/Rad Seq	S	R	R	R	R	SEER/COC	Revised
1390	RX Summ--Chemo	S	R	R	R	R	SEER/COC	
1400	RX Summ--Hormone	S	R	R	R	R	SEER/COC	
1410	RX Summ--BRM	S	R	R	R	R	SEER/COC	
1420	RX Summ--Other	S	R	R	R	R	SEER/COC	
1430	Reason for No Radiation	S	R	R	.	.	COC	Revised
1440	Reason for No Chemo	.	.	.	.	.	COC	Revised
1450	Reason for No Hormone	.	.	.	.	.	COC	Revised
1460	RX Coding System--Current	R	R	R	.	R	NAACCR	Revised
1470	Protocol Eligibility Stat	.	.	.	.	.	COC	Revised
1480	Protocol Participation	.	.	.	.	.	COC	Revised
1490	Referral to Support Serv	.	.	.	.	.	COC	Revised
1500	First Course Calc Method	.	.	.	.	.	NAACCR	
1510	Rad--Regional Dose: cGy	.	R	R	.	.	COC	Revised
1520	Rad--No of Treatment Vol	.	R	R	.	.	COC	Revised
1530	Rad--Elapsed RX Days	.	.	.	.	.	COC	Revised
1540	Rad--Treatment Volume	.	R	R	.	.	COC	Revised
1550	Rad--Location of RX	.	R	R	.	.	COC	Revised
1560	Rad--Intent of Treatment	.	.	.	.	.	COC	Revised
1570	Rad--Regional RX Modality	S	R	R	RC	.	COC	Revised
1580	Rad--RX Completion Status	.	.	.	.	.	COC	Revised
1590	Rad--Local Control Status	.	.	.	.	.	COC	Revised
1600	Chemotherapy Field 1	.	.	.	.	.	COC	Revised
1610	Chemotherapy Field 2	.	.	.	.	.	COC	Revised
1620	Chemotherapy Field 3	.	.	.	.	.	COC	Revised
1630	Chemotherapy Field 4	.	.	.	.	.	COC	Revised
1640	RX Summ--Surgery Type	.	.	.	RH	RH	SEER	Revised
1642	RX Summ--Screen/BX Proc1	.	.	.	.	.	COC	Revised
1643	RX Summ--Screen/BX Proc2	.	.	.	.	.	COC	Revised
1644	RX Summ--Screen/BX Proc3	.	.	.	.	.	COC	Revised
1645	RX Summ--Screen/BX Proc4	.	.	.	.	.	COC	Revised
1646	RX Summ--Surg Site 98-02	RH	RH	RH	RH/R	RH/R	SEER/COC	New
1647	RX Summ--Scope Reg 98-02	RH	RH	RH	RH/R	RH/R	SEER/COC	New
1648	RX Summ--Surg Oth 98-02	RH	RH	RH	RH/R	RH/R	SEER/COC	New
1650	Reserved 08	.	.	.	.	.		
1660	Subsq RX 2nd Course Date	.	.	.	.	.	COC	Revised
1670	Subsq RX 2nd Course Codes							
1671	Subsq RX 2nd Course Surg	.	.	.	.	.	COC	Revised
1672	Subsq RX 2nd Course Rad	.	.	.	.	.	COC	Revised
1673	Subsq RX 2nd Course Chemo	.	.	.	.	.	COC	Revised
1674	Subsq RX 2nd Course Horm	.	.	.	.	.	COC	Revised
1675	Subsq RX 2nd Course BRM	.	.	.	.	.	COC	Revised

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Item #	Item Name	NPCR	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Source of Standard	Note
1676	Subsq RX 2nd Course Oth	.	.	.	.	.	COC	Revised
1677	Subsq RX 2nd--Scope LN SU	.	.	.	.	.	COC	Revised
1678	Subsq RX 2nd--Surg Oth	.	.	.	.	.	COC	Revised
1679	Subsq RX 2nd--Reg LN Rem	.	.	.	.	.	COC	Revised
1680	Subsq RX 3rd Course Date	.	.	.	.	.	COC	Revised
1690	Subsq RX 3rd Course Codes							
1691	Subsq RX 3rd Course Surg	.	.	.	.	.	COC	Revised
1692	Subsq RX 3rd Course Rad	.	.	.	.	.	COC	Revised
1693	Subsq RX 3rd Course Chemo	.	.	.	.	.	COC	Revised
1694	Subsq RX 3rd Course Horm	.	.	.	.	.	COC	Revised
1695	Subsq RX 3rd Course BRM	.	.	.	.	.	COC	Revised
1696	Subsq RX 3rd Course Oth	.	.	.	.	.	COC	Revised
1697	Subsq RX 3rd--Scope LN Su	.	.	.	.	.	COC	Revised
1698	Subsq RX 3rd--Surg Oth	.	.	.	.	.	COC	Revised
1699	Subsq RX 3rd--Reg LN Rem	.	.	.	.	.	COC	Revised
1700	Subsq RX 4th Course Date	.	.	.	.	.	COC	Revised
1710	Subsq RX 4th Course Codes							
1711	Subsq RX 4th Course Surg	.	.	.	.	.	COC	Revised
1712	Subsq RX 4th Course Rad	.	.	.	.	.	COC	Revised
1713	Subsq RX 4th Course Chemo	.	.	.	.	.	COC	Revised
1714	Subsq RX 4th Course Horm	.	.	.	.	.	COC	Revised
1715	Subsq RX 4th Course BRM	.	.	.	.	.	COC	Revised
1716	Subsq RX 4th Course Oth	.	.	.	.	.	COC	Revised
1717	Subsq RX 4th--Scope LN Su	.	.	.	.	.	COC	Revised
1718	Subsq RX 4th--Surg Oth	.	.	.	.	.	COC	Revised
1719	Subsq RX 4th--Reg LN Rem	.	.	.	.	.	COC	Revised
1720	Subsq RX 5th Course Date	.	.	.	.	.	NAACCR	Revised
1730	Subsq RX 5th Course Codes							
1731	Subsq RX 5th Course Surg	.	.	.	.	.	NAACCR	Revised
1732	Subsq RX 5th Course Rad	.	.	.	.	.	NAACCR	Revised
1733	Subsq RX 5th Course Chemo	.	.	.	.	.	NAACCR	Revised
1734	Subsq RX 5th Course Horm	.	.	.	.	.	NAACCR	Revised
1735	Subsq RX 5th Course BRM	.	.	.	.	.	NAACCR	Revised
1736	Subsq RX 5th Course Oth	.	.	.	.	.	NAACCR	Revised
1737	Subsq RX 5th--Scope LN Su	.	.	.	.	.	NAACCR	Revised
1738	Subsq RX 5th--Surg Oth	.	.	.	.	.	NAACCR	Revised
1739	Subsq RX 5th--Reg LN Rem	.	.	.	.	.	NAACCR	Revised
1740	Reserved 09	.	.	.	.	.		
1741	Subsq RX--Reconstruct Del	.	.	.	.	.	COC	Revised
1750	Date of Last Contact	R	R	R	R	R	SEER/COC	
1760	Vital Status	R	R	R	R	R	SEER/COC	
1770	Cancer Status	.	R	R	.	.	COC	

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Item #	Item Name	NPCR	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Source of Standard	Note
1780	Quality of Survival	.	.	.	.	.	COC	Revised
1790	Follow-Up Source	.	R	.	.	.	COC	Revised
1800	Next Follow-Up Source	.	R	.	.	.	COC	Revised
1810	Addr Current--City	.	R	.	R	.	COC	Revised
1820	Addr Current--State	.	R	.	R	.	NAACCR	Revised
1830	Addr Current--Postal Code	.	R	.	R	.	NAACCR	Revised
1835	Reserved 10	.	.	.	.	.		
1840	County--Current	.	.	.	.	.	COC	Revised
1842	Follow-Up Contact--City	.	.	.	R	.	NAACCR	Revised
1844	Follow-Up Contact--State	.	.	.	R	.	NAACCR	Revised
1846	Follow-Up Contact--Postal	.	.	.	R	.	NAACCR	Revised
1850	Unusual Follow-Up Method	.	.	.	.	.	COC	Revised
1860	Recurrence Date--1st	S	R	R	RC	.	COC	Revised
1871	Recurrence Distant Site 1	.	.	.	.	.	COC	Revised
1872	Recurrence Distant Site 2	.	.	.	.	.	COC	Revised
1873	Recurrence Distant Site 3	.	.	.	.	.	COC	Revised
1880	Recurrence Type--1st	S	R	R	RC	.	COC	Revised
1890	Recurrence Type--1st--Oth	.	.	.	.	.	COC	Revised
1900	Reserved 11	.	.	.	.	.		
1910	Cause of Death	R	.	.	R	R	SEER/COC	Revised
1920	ICD Revision Number	R	.	.	R	R	SEER/COC	Revised
1930	Autopsy	.	.	.	.	.	COC	Revised
1940	Place of Death	S	.	.	.	.	NAACCR	
1950	Reserved 12	.	.	.	.	.		
1960	Site (73-91) ICD-O-1	.	.	RH	RH	RH	SEER	Revised
1970	Morph (73-91) ICD-O-1	.	.	.	.	.		
1971	Histology (73-91) ICD-O-1	.	.	RH	RH	RH	SEER	Revised
1972	Behavior (73-91) ICD-O-1	.	.	RH	RH	RH	SEER	Revised
1973	Grade (73-91) ICD-O-1	.	.	RH	RH	RH	SEER	Revised
1980	ICD-O-2 Conversion Flag	.	R	R	RH	RH	SEER	Revised
1981	Over-ride SS/NodesPos	.	.	.	.	.	NAACCR	
1982	Over-ride SS/TNM-N	.	.	.	.	.	NAACCR	
1983	Over-ride SS/TNM-M	.	.	.	.	.	NAACCR	
1984	Over-ride SS/DisMet1	.	.	.	.	.	NAACCR	
1985	Over-ride Acsn/Class/Seq	.	R	R	.	.	NAACCR	Revised
1986	Over-ride HospSeq/DxConf	.	R	R	.	.	NAACCR	Revised
1987	Over-ride COC-Site/Type	.	R	R	.	.	NAACCR	Revised
1988	Over-ride HospSeq/Site	.	R	R	.	.	NAACCR	Revised
1989	Over-ride Site/TNM-StgGrp	.	R	R	.	.	NAACCR	Revised
1990	Over-ride Age/Site/Morph	R	R	R	R	R	SEER	Revised
2000	Over-ride SeqNo/DxConf	R	.	.	R	R	SEER	
2010	Over-ride Site/Lat/SeqNo	S	.	.	R	R	SEER	

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Item #	Item Name	NPCR	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Source of Standard	Note
2020	Over-ride Surg/DxConf	R	R	R	R	R	SEER	Revised
2030	Over-ride Site/Type	R	R	R	R	R	SEER	Revised
2040	Over-ride Histology	R	R	R	R	R	SEER	Revised
2050	Over-ride Report Source	R	.	.	R	R	SEER	
2060	Over-ride Ill-define Site	R	.	.	R	R	SEER	
2070	Over-ride Leuk, Lymphoma	R	R	R	R	R	SEER	Revised
2071	Over-ride Site/Behavior	R	R	R	R	R	SEER	Revised
2072	Over-ride Site/EOD/DX Dt	S	.	.	R	R	SEER	
2073	Over-ride Site/Lat/EOD	S	.	.	R	R	SEER	
2074	Over-ride Site/Lat/Morph	R	R	R	R	R	SEER	Revised
2081	CRC CHECKSUM	.	.	.	.	.	NAACCR	
2090	Date Case Completed	.	.	.	.	.	Varies	
2100	Date Case Last Changed	.	.	.	.	.	Varies	
2110	Date Case Report Exported	S	.	R	.	.	NAACCR	Revised
2111	Date Case Report Received	R	.	.	.	.	NAACCR	
2112	Date Case Report Loaded	S	.	.	.	.	NAACCR	
2113	Date Tumor Record Availbl	S	.	.	.	.	NAACCR	
2114	Future Use Timeliness 1	.	.	.	.	.		
2115	Future Use Timeliness 2	.	.	.	.	.		
2116	ICD-O-3 Conversion Flag	R	R	R	R	R	SEER/COC	
2120	SEER Coding Sys--Current	S	.	.	.	.	NAACCR	
2130	SEER Coding Sys--Original	S	.	.	.	.	NAACCR	
2140	COC Coding Sys--Current	S	R	R	.	.	COC	Revised
2150	COC Coding Sys--Original	S	R	R	.	.	NAACCR	Revised
2160	Subsq Report for Primary	.	.	.	.	.	NAACCR	Retired
2161	Reserved 20	.	.	.	.	.		Retired
2170	Vendor Name	.	.	R	.	.	NAACCR	Revised
2180	SEER Type of Follow-Up	.	.	.	R	R	SEER	
2190	SEER Record Number	.	.	.	R	R	SEER	
2200	Diagnostic Proc 73-87	.	.	.	RH	RH	SEER	Revised
2210	Reserved 14	.	.	.	.	.		
2220	State/Requestor Items	.	.	.	.	.	Varies	
2230	Name--Last	R	R	.	R	.	NAACCR	Revised
2240	Name--First	R	R	.	R	.	NAACCR	Revised
2250	Name--Middle	R	R	.	R	.	COC	Revised
2260	Name--Prefix	.	.	.	.	.	COC	Revised
2270	Name--Suffix	.	.	.	R	.	COC	Revised
2280	Name--Alias	S	.	.	R	.	COC	Revised
2290	Name--Spouse/Parent	.	.	.	.	.	Varies	
2300	Medical Record Number	S	R	.	R	.	NAACCR	Revised
2310	Military Record No Suffix	.	R	.	.	.	COC	
2320	Social Security Number	R	R	.	R	.	COC	Revised

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Item #	Item Name	NPCR	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Source of Standard	Note
2330	Addr at DX--No & Street	S	R	.	R	.	COC	Revised
2335	Addr at DX--Supplementl	S	R	.	.	.	NAACCR	New
2350	Addr Current--No & Street	S	R	.	R	.	COC	Revised
2352	Latitude	.	.	.	.	.	NAACCR	New
2354	Longitude	.	.	.	.	.	NAACCR	New
2355	Addr Current--Supplementl	.	R	.	.	.	NAACCR	New
2360	Telephone	.	R	.	R	.	COC	Revised
2370	DC State	.	.	.	.	.		Retired
2371	Reserved for Expansion	.	.	.	.	.		Retired
2380	DC State File Number	S	.	.	.	.	State	
2390	Name--Maiden	S	.	.	R	.	NAACCR	Revised
2392	Follow-Up Contact--No&St	.	.	.	R	.	NAACCR	Revised
2393	Follow-Up Contact--Suppl	.	.	.	.	.	NAACCR	New
2394	Follow-Up Contact--Name	.	.	.	R	.	NAACCR	Revised
2400	Reserved 16	.	.	.	.	.		Retired
2410	Institution Referred From	.	R	.	.	.	NAACCR	Revised
2420	Institution Referred To	.	R	.	.	.	NAACCR	Revised
2430	Last Follow-Up Hospital	.	.	.	.	.	NAACCR	
2440	Following Registry	.	R	.	R	.	NAACCR	Revised
2450	Reserved 17	.	.	.	.	.		Retired
2460	Physician--Managing	.	.	.	.	.	COC	Revised
2470	Physician--Follow-Up	.	R	.	R	.	COC	
2480	Physician--Primary Surg	.	R	.	.	.	COC	
2490	Physician 3	.	R	.	.	.	COC	Revised
2500	Physician 4	.	R	.	.	.	COC	Revised
2520	Text--DX Proc--PE	R^	.	.	R	.	NAACCR	Revised
2530	Text--DX Proc--X-ray/Scan	R^	.	.	R	.	NAACCR	Revised
2540	Text--DX Proc--Scopes	R^	.	.	R	.	NAACCR	Revised
2550	Text--DX Proc--Lab Tests	R^	.	.	R	.	NAACCR	Revised
2560	Text--DX Proc--Op	R^	.	.	R	.	NAACCR	Revised
2570	Text--DX Proc--Path	R^	.	.	R	.	NAACCR	Revised
2580	Text--Primary Site Title	S	.	.	R	.	NAACCR	Revised
2590	Text--Histology Title	S	.	.	R	.	NAACCR	Revised
2600	Text--Staging	R^	.	.	R	.	NAACCR	Revised
2610	RX Text--Surgery	R^	.	.	R	.	NAACCR	Revised
2620	RX Text--Radiation (Beam)	S	.	.	R	.	NAACCR	Revised
2630	RX Text--Radiation Other	S	.	.	R	.	NAACCR	Revised
2640	RX Text--Chemo	S	.	.	R	.	NAACCR	Revised
2650	RX Text--Hormone	S	.	.	R	.	NAACCR	Revised
2660	RX Text--BRM	S	.	.	R	.	NAACCR	Revised
2670	RX Text--Other	S	.	.	R	.	NAACCR	Revised
2680	Text--Remarks	S	.	.	R	.	NAACCR	Revised

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Item #	Item Name	NPCR	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Source of Standard	Note
2690	Place of Diagnosis	S	.	.	.	.	NAACCR	
2700	Reserved 19	.	.	.	.	.		
2800	CS Tumor Size						AJCC	New
2810	CS Extension						AJCC	New
2820	CS Tumor Size/Ext Eval						AJCC	New
2830	CS Lymph Nodes						AJCC	New
2840	CS Reg Nodes Eval						AJCC	New
2850	CS Mets at DX						AJCC	New
2860	CS Mets Eval						AJCC	New
2880	CS Site-Specific Factor 1						AJCC	New
2890	CS Site-Specific Factor 2						AJCC	New
2900	CS Site-Specific Factor 3						AJCC	New
2910	CS Site-Specific Factor 4						AJCC	New
2920	CS Site-Specific Factor 5						AJCC	New
2930	CS Site-Specific Factor 6						AJCC	New
2940	Derived AJCC T						AJCC	New
2950	Derived AJCC T Descriptor						AJCC	New
2960	Derived AJCC N						AJCC	New
2970	Derived AJCC N Descriptor						AJCC	New
2980	Derived AJCC M						AJCC	New
2990	Derived AJCC M Descriptor						AJCC	New
3000	Derived AJCC Stage Group						AJCC	New
3010	Derived SS1977						AJCC	New
3020	Derived SS2000						AJCC	New
3030	Derived AJCC--Flag						AJCC	New
3040	Derived SS1977--Flag						AJCC	New
3050	Derived SS2000--Flag						AJCC	New
3100	Archive FIN	.	R	R	.	.	COC	New
3110	Comorbid/Complication 1	.	R	R	.	.	COC	New
3120	Comorbid/Complication 2	.	R	R	.	.	COC	New
3130	Comorbid/Complication 3	.	R	R	.	.	COC	New
3140	Comorbid/Complication 4	.	R	R	.	.	COC	New
3150	Comorbid/Complication 5	.	R	R	.	.	COC	New
3160	Comorbid/Complication 6	.	R	R	.	.	COC	New
3170	RX Date--Most Defin Surg	S	R	R	.	.	COC	New
3180	RX Date--Surgical Disch	.	R	R	.	.	COC	New
3190	Readm Same Hosp 30 Days	.	R	R	.	.	COC	New
3200	Rad--Boost RX Modality	.	R	R	RC	.	COC	New
3210	Rad--Boost Dose cGy	.	R	R	.	.	COC	New
3220	RX Date--Radiation Ended	.	R	R	.	.	COC	New
3230	RX Date--Systemic	S	R	R	.	.	COC	New
3250	RX Summ--Transplnt/Endocr	S	R	R	R	R	COC	New

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Item #	Item Name	NPCR	COC Collect	COC Transmit	SEER Collect	SEER Transmit	Source of Standard	Note
3260	Pain Assessment	.	.	.	.	.	COC	New
3270	RX Summ--Palliative Proc	.	R	R	.	.	COC	New
3280	RX Hosp--Palliative Proc	.	R	R	.	.	COC	New
3300	RuralUrban Continuum 1993	D	.	.	D	D	NAACCR	New
3310	RuralUrban Continuum 2000	D	.	.	D	D	NAACCR	New

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**Chapter X: Data Descriptor Table**

Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
10	Record Type	Character		I, C, A, U, R, M	1	Revised
20	Patient ID Number	Character	Right justified, zero filled		8	
30	Registry Type	Character		1-3	1	
35	FIN Coding System	Character		1-3, 9	1	Revised
37	Reserved 00	Character			7	
40	Registry ID	Character	Right justified, zero filled	10-digit number. Reference to EDITS table REGID.DBF in Appendix B	10	Revised
50	NAACCR Record Version	Character		Blank, 1, 4-9, A	1	Revised
60	Tumor Record Number	Character	Right justified, zero filled	01-99	2	
70	Addr at DX--City	Character	Mixed case letters, no special characters, embedded spaces allowed, left justified, blank filled	City Name or UNKNOWN	20	
80	Addr at DX--State	Character	Upper case	Refer to EDITS table STATE.DBF in Appendix B	2	
90	County at DX	Character	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	
100	Addr at DX--Postal Code	Character	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	9	
110	Census Tract 1970/80/90	Character	Right justified, zero filled	Census Tract Codes 000100-949999, BNA Codes 950100-998999, 000000, 999999, blank	6	Revised
120	Census Cod Sys 1970/80/90	Character		0-3, blank	1	Revised
130	Census Tract 2000	Character	Right justified, zero filled	Census Tract Codes 000101-999998, 000000, 999999, blank	6	Revised
140	Census Tract Cod Sys--Alt	Character			0	Retired
150	Marital Status at DX	Character		1-5, 9	1	
160	Race 1	Character	Right justified, zero filled	01-14, 20-22, 25-28, 30-32, 96-99	2	
161	Race 2	Character	Right justified, zero filled	01-14, 20-22, 25-28, 30-32, 88, 96-99, blank	2	
162	Race 3	Character	Right justified, zero filled	01-14, 20-22, 25-28, 30-32, 88, 96-99, blank	2	



Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
163	Race 4	Character	Right justified, zero filled	01-14, 20-22, 25-28, 30-32, 88, 96-99, blank	2	
164	Race 5	Character	Right justified, zero filled	01-14, 20-22, 25-28, 30-32, 88, 96-99, blank	2	
170	Race Coding Sys--Current	Character		1-6, 9	1	
180	Race Coding Sys--Original	Character		1-6, 9	1	
190	Spanish/Hispanic Origin	Character		0-7, 9	1	
200	Computed Ethnicity	Character		0-7, blank	1	
210	Computed Ethnicity Source	Character		0-9, blank	1	
220	Sex	Character		1-4, 9	1	
230	Age at Diagnosis	Character	Right justified, zero filled	000-120, 999	3	
240	Birth Date	Character	MMDDCCYY	Valid date or 99999999	8	
250	Birthplace	Character	Right justified, zero filled	Reference to EDITS table BPLACE.DBF in Appendix B	3	
260	Religion	Character	No standard	Any	2	
270	Occupation Code--Census	Character		Reference Industry and Occupation Coding for Death Certificates	3	
280	Industry Code--Census	Character		Reference Industry and Occupation Coding for Death Certificates	3	
290	Occupation Source	Character		0-3, 7-9, blank	1	
300	Industry Source	Character		0-3, 7-9, blank	1	
310	Text--Usual Occupation	Character	Free text	Neither carriage return nor line feed characters allowed	40	
320	Text--Usual Industry	Character	Free text	Neither carriage return nor line feed characters allowed	40	
330	Occup/Ind Coding System	Character		1-4, 7, 9, blank	1	
340	Tobacco History	Character	No standard	Any	1	
350	Alcohol History	Character	No standard	Any	1	
360	Family History of Cancer	Character	No standard	Any	1	
362	Census Tract Block Group	Character	No standard	Any	1	
364	Census Tr Cert 1970/80/90	Character		1-5, 9, blank	1	Revised
365	Census Tr Certainty 2000	Character		1-5, 9, blank	1	New
370	Reserved 01	Character			20	
380	Sequence Number--Central	Character	Right justified, zero filled	00-35, 60-87, 88, 99	2	Revised
390	Date of Diagnosis	Character	MMDDCCYY	Valid date or 99999999	8	
400	Primary Site	Character	C followed by 3 digits, no special characters, no embedded blanks	Reference ICD-O-3 for valid entries	4	
410	Laterality	Character		0-4, 9	1	
419	Morph--Type&Behav ICD-O-2	Character		Reference to ICD-0-2	5	
420	Histology (92-00) ICD-O-2	Character		Reference to ICD-0-2	4	
430	Behavior (92-00) ICD-O-2	Character		Reference to ICD-0-2	1	
440	Grade	Character		1-9	1	

Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
450	Site Coding Sys--Current	Character		1-6, 9	1	
460	Site Coding Sys--Original	Character		1-6, 9	1	
470	Morph Coding Sys--Current	Character		1-7, 9	1	
480	Morph Coding Sys--Originl	Character		1-7, 9	1	
490	Diagnostic Confirmation	Character		1, 2, 4-9	1	
500	Type of Reporting Source	Character		1, 3-7	1	
510	Screening Date	Character	MMDDCCYY	Valid date, 00000000, 99999999	8	
520	Screening Result	Character		0-4, 8, 9	1	
521	Morph--Type&Behav ICD-O-3	Character		Reference to ICD-O-3	5	
522	Histologic Type ICD-O-3	Character		Reference to ICD-O-3	4	
523	Behavior Code ICD-O-3	Character		Reference to ICD-O-3	1	
530	Reserved 02	Character			50	
538	Reporting Hospital FAN	Character			10	
540	Reporting Hospital	Character	Right justified, zero filled	10-digit number	10	Revised
550	Accession Number--Hosp	Character		9-digit number	9	
560	Sequence Number--Hospital	Character	Right justified, zero filled	00-35, 60-87, 88, 99	2	Revised
570	Abstracted By	Character	No special characters	Letters and numbers	3	
580	Date of 1st Contact	Character	MMDDCCYY	Valid dates or 99999999	8	
590	Date of Inpatient Adm	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
600	Date of Inpatient Disch	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
610	Class of Case	Character		0-9	1	Revised
620	Year First Seen This CA	Character	CCYY	1944 to current year	4	
630	Primary Payer at DX	Character	Right justified, zero filled	01, 02, 10, 20, 31, 35, 36, 50-56, 99	2	Revised
640	Inpatient/Outpt Status	Character		1-3, 8, 9	1	
650	Presentation at CA Conf	Character		0-9	1	
660	Date of CA Conference	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
670	RX Hosp--Surg Prim Site	Character	Right justified, zero filled	00, 10-80, 90, 98, 99 (site specific)	2	Revised
672	RX Hosp--Scope Reg LN Sur	Character		0-7, 9	1	Revised
674	RX Hosp--Surg Oth Reg/Dis	Character		0-5, 9	1	Revised
676	RX Hosp--Reg LN Removed	Character		00-90, 95-99	2	
680	Reserved 03	Character			50	
690	RX Hosp--Radiation	Character		0-5, 9	1	
700	RX Hosp--Chemo	Character	Right justified, zero filled	00-03, 82, 85-88, 99	2	Revised
710	RX Hosp--Hormone	Character	Right justified, zero filled	00, 01, 82, 85-88, 99	2	Revised
720	RX Hosp--BRM	Character	Right justified, zero filled	00, 01, 82, 85-88, 99	2	Revised
730	RX Hosp--Other	Character		0-3, 6-9	1	Revised
740	RX Hosp--DX/Stg Proc	Character	Right justified, zero filled	00-07, 09	2	Revised

Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
742	RX Hosp--Screen/BX Proc1	Character		Site-specific: 0 (all cases); 1-3, 5, 9 (breast); 1-4, 9 (prostate)	1	
743	RX Hosp--Screen/BX Proc2	Character		Site-specific: 0 (all cases); 1-7, 9 (breast); 1-3, 9 (prostate)	1	
744	RX Hosp--Screen/BX Proc3	Character		Site-specific: 0 (all cases); 1, 9 (breast); 1-5, 9 (prostate)	1	
745	RX Hosp--Screen/BX Proc4	Character		Site-specific: 0 (all cases); 1-4, 9 (breast); 1-7, 9 (prostate)	1	
746	RX Hosp--Surg Site 98-02	Character	Right justified, zero filled	00, 10-90, 99 (site specific)	2	New
747	RX Hosp--Scope Reg 98-02	Character		Site specific	1	New
748	RX Hosp--Surg Oth 98-02	Character		Site specific	1	New
750	Reserved 04	Character			46	Revised
759	SEER Summary Stage 2000	Character		0-5, 7, 9	1	
760	SEER Summary Stage 1977	Character		0-5, 7, 9	1	
770	Loc/Reg/Distant Stage	Character		0-3, 9, blank	1	
779	Extent of Disease 10-Dig	Character			12	
780	EOD--Tumor Size	Character	Right justified, zero filled	See respective source references	3	
790	EOD--Extension	Character	Right justified, zero filled	Reference SEER Extent of Disease manual	2	
800	EOD--Extension Prost Path	Character	Right justified, zero filled	Reference SEER Extent of Disease manual	2	
810	EOD--Lymph Node Involv	Character		Reference SEER Extent of Disease manual	1	
820	Regional Nodes Positive	Character	Right justified, zero filled	See respective source references	2	
830	Regional Nodes Examined	Character	Right justified, zero filled	See respective source references	2	
840	EOD--Old 13 Digit	Character	Numeric and special characters		13	
850	EOD--Old 2 Digit	Character	Numeric plus special characters "&" and "dash" ("-")		2	
860	EOD--Old 4 Digit	Character			4	
870	Coding System for EOD	Character		0-4	1	
880	TNM Path T	Character	Upper case, alphanumeric, left justified, blank filled	See AJCC Cancer Staging Manual and FORDS Manual; also 88, blank	2	Revised
890	TNM Path N	Character	Upper case, alphanumeric, left justified, blank filled	See AJCC Cancer Staging Manual and FORDS Manual; also 88, blank	2	Revised

Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
900	TNM Path M	Character	Upper case, alphanumeric, left justified, blank filled	See AJCC Cancer Staging Manual and FORDS Manual; also 88, blank	2	Revised
910	TNM Path Stage Group	Character	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	Revised
920	TNM Path Descriptor	Character		0-6, 9	1	
930	TNM Path Staged By	Character		0-9	1	Revised
940	TNM Clin T	Character	Upper case, alphanumeric, left justified, blank filled	See AJCC Cancer Staging Manual and FORDS Manual; also 88, blank	2	Revised
950	TNM Clin N	Character	Upper case, alphanumeric, left justified, blank filled	See AJCC Cancer Staging Manual and FORDS Manual; also 88, blank	2	Revised
960	TNM Clin M	Character	Upper case, alphanumeric, left justified, blank filled	See AJCC Cancer Staging Manual and FORDS Manual; also 88, blank	2	Revised
970	TNM Clin Stage Group	Character	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	Revised
980	TNM Clin Descriptor	Character		0-6, 9	1	
990	TNM Clin Staged By	Character		0-9	1	Revised
1000	TNM Other T	Character	Upper case, alphanumeric, left justified, blank filled	See AJCC Cancer Staging Manual; also 88, blank	2	
1010	TNM Other N	Character	Upper case, alphanumeric, left justified, blank filled	See AJCC Cancer Staging Manual; also 88, blank	2	
1020	TNM Other M	Character	Upper case, alphanumeric, left justified, blank filled	See AJCC Cancer Staging Manual; also 88, blank	2	
1030	TNM Other Stage Group	Character	Upper case, alphanumeric. Convert AJCC Roman numerals to Arabic numerals. Left justified, blank filled	See AJCC Cancer Staging Manual; also 88, 99, blank	2	
1040	TNM Other Staged By	Character		0-9	1	
1050	TNM Other Descriptor	Character		0-6, 9	1	
1060	TNM Edition Number	Character	Right justified, zero filled	00-06, 88, 99	2	Revised
1070	Other Staging System	Character	Free text	Neither carriage return nor line feed characters allowed	15	
1080	Date of 1st Positive BX	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	

Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
1090	Site of Distant Met 1	Character		0-9	1	
1100	Site of Distant Met 2	Character		0-9	1	
1110	Site of Distant Met 3	Character		0-9	1	
1120	Pediatric Stage	Character		Reference to EDITS table PEDSTAGE.DBF.CODE in Appendix B	2	
1130	Pediatric Staging System	Character		00-15, 88, 97, 99	2	
1140	Pediatric Staged By	Character		0-9	1	
1150	Tumor Marker 1	Character		0-6, 8, 9	1	
1160	Tumor Marker 2	Character		0-6, 8, 9	1	
1170	Tumor Marker 3	Character		0-6, 8, 9	1	
1180	Reserved 05	Character			50	
1190	Reserved 06	Character			45	Revised
1200	RX Date--Surgery	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1210	RX Date--Radiation	Character	MMDDCCYY	Valid dates, 00000000, 88888888, 99999999	8	Revised
1220	RX Date--Chemo	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1230	RX Date--Hormone	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1240	RX Date--BRM	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1250	RX Date--Other	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1260	Date of Initial RX--SEER	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1270	Date of 1st Crs RX--COC	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1280	RX Date--DX/Stg Proc	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	Revised
1290	RX Summ--Surg Prim Site	Character	Right justified, zero filled	00, 10-80, 90, 98, 99 (site specific)	2	Revised
1292	RX Summ--Scope Reg LN Sur	Character		0-7, 9	1	Revised
1294	RX Summ--Surg Oth Reg/Dis	Character		0-5, 9	1	Revised
1296	RX Summ--Reg LN Examined	Character	Right justified, zero filled	00-90, 95-99	2	
1300	Reserved 07	Character			50	
1310	RX Summ--Surgical Approch	Character		0-9 (site-specific)	1	
1320	RX Summ--Surgical Margins	Character		0-3, 7-9	1	Revised
1330	RX Summ--Reconstruct 1st	Character		0-9 (site-specific)	1	
1340	Reason for No Surgery	Character		0-2, 5-9	1	Revised
1350	RX Summ--DX/Stg Proc	Character	Right justified, zero filled	00-07, 09	2	Revised
1360	RX Summ--Radiation	Character		0-5, 7-9	1	
1370	RX Summ--Rad to CNS	Character		0, 1, 7-9	1	
1380	RX Summ--Surg/Rad Seq	Character		0, 2-6, 9	1	

Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
1390	RX Summ--Chemo	Character	Right justified, zero filled	00-03, 82, 85-88, 99	2	Revised
1400	RX Summ--Hormone	Character	Right justified, zero filled	00, 01, 82, 85-88, 99	2	Revised
1410	RX Summ--BRM	Character	Right justified, zero filled	00, 01, 82, 85-88, 99	2	Revised
1420	RX Summ--Other	Character		0-3, 6-9	1	Revised
1430	Reason for No Radiation	Character		0-2, 5-9	1	Revised
1440	Reason for No Chemo	Character		0-2, 6-9	1	
1450	Reason for No Hormone	Character		0-2, 6-9	1	
1460	RX Coding System--Current	Character	Right justified, zero filled	00-06, 99	2	Revised
1470	Protocol Eligibility Stat	Character		0-4, 6-9	1	
1480	Protocol Participation	Character	Right justified, zero filled	00-99	2	
1490	Referral to Support Serv	Character		0, 1, 9	1	
1500	First Course Calc Method	Character		1, 2, 9	1	
1510	Rad--Regional Dose: cGy	Character	Right justified, zero filled	00000-99999	5	
1520	Rad--No of Treatment Vol	Character	Right justified, zero filled	00-99	2	
1530	Rad--Elapsed RX Days	Character	Right justified, zero filled	000-999	3	
1540	Rad--Treatment Volume	Character	Right justified, zero filled	00-41, 50, 60, 98, 99	2	Revised
1550	Rad--Location of RX	Character		0-4, 8, 9	1	
1560	Rad--Intent of Treatment	Character		0-2, 4-6, 8, 9	1	
1570	Rad--Regional RX Modality	Character	Right justified, zero filled	00, 20-32, 40-43, 50-55, 60-62, 80, 85, 98, 99	2	Revised
1580	Rad--RX Completion Status	Character		0-9	1	
1590	Rad--Local Control Status	Character		0-4, 8, 9	1	
1600	Chemotherapy Field 1	Character	No standard		3	
1610	Chemotherapy Field 2	Character	No standard		3	
1620	Chemotherapy Field 3	Character	No standard		3	
1630	Chemotherapy Field 4	Character	No standard		3	
1640	RX Summ--Surgery Type	Character	Right justified, zero filled	00-99 (site-specific)	2	
1642	RX Summ--Screen/BX Proc1	Character		Site-specific: 0 (all cases); 1-3, 5, 9 (breast); 1-4, 9 (prostate)	1	
1643	RX Summ--Screen/BX Proc2	Character		Site-specific: 0 (all cases); 1-7, 9 (breast); 1-3, 9 (prostate)	1	
1644	RX Summ--Screen/BX Proc3	Character		Site-specific: 0 (all cases); 1, 9 (breast); 1-5, 9 (prostate)	1	
1645	RX Summ--Screen/BX Proc4	Character		Site-specific: 0 (all cases); 1-4, 9 (breast); 1-7, 9 (prostate)	1	
1646	RX Summ--Surg Site 98-02	Character	Right justified, zero filled	00, 10-90, 99 (site specific)	2	New
1647	RX Summ--Scope Reg 98-02	Character		Site specific	1	New

Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
1648	RX Summ--Surg Oth 98-02	Character		Site specific	1	New
1650	Reserved 08	Character			50	
1660	Subsq RX 2nd Course Date	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1670	Subsq RX 2nd Course Codes	Character			7	
1671	Subsq RX 2nd Course Surg	Character	Right justified, zero filled	00, 10-90, 99	2	
1672	Subsq RX 2nd Course Rad	Character		0-5, 9	1	
1673	Subsq RX 2nd Course Chemo	Character		0-3, 9	1	
1674	Subsq RX 2nd Course Horm	Character		0-3, 9	1	
1675	Subsq RX 2nd Course BRM	Character		0-9	1	
1676	Subsq RX 2nd Course Oth	Character		0-3, 6-9	1	
1677	Subsq RX 2nd--Scope LN SU	Character		0-9	1	
1678	Subsq RX 2nd--Surg Oth	Character		0-9	1	
1679	Subsq RX 2nd--Reg LN Rem	Character	Right justified, zero filled	00-90, 95-99	2	
1680	Subsq RX 3rd Course Date	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1690	Subsq RX 3rd Course Codes	Character			7	
1691	Subsq RX 3rd Course Surg	Character	Right justified, zero filled	00, 10-90, 99	2	
1692	Subsq RX 3rd Course Rad	Character		0-5, 9	1	
1693	Subsq RX 3rd Course Chemo	Character		0-3, 9	1	
1694	Subsq RX 3rd Course Horm	Character		0-3, 9	1	
1695	Subsq RX 3rd Course BRM	Character		0-9	1	
1696	Subsq RX 3rd Course Oth	Character		0-3, 6-9	1	
1697	Subsq RX 3rd--Scope LN Su	Character		0-9	1	
1698	Subsq RX 3rd--Surg Oth	Character		0-9	1	
1699	Subsq RX 3rd--Reg LN Rem	Character	Right justified, zero filled	00-90, 95-99	2	
1700	Subsq RX 4th Course Date	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1710	Subsq RX 4th Course Codes	Character			7	
1711	Subsq RX 4th Course Surg	Character	Right justified, zero filled	00, 10-90, 99	2	
1712	Subsq RX 4th Course Rad	Character		0-5, 9	1	
1713	Subsq RX 4th Course Chemo	Character		0-3, 9	1	
1714	Subsq RX 4th Course Horm	Character		0-3, 9	1	
1715	Subsq RX 4th Course BRM	Character		0-9	1	
1716	Subsq RX 4th Course Oth	Character		0-3, 6-9	1	
1717	Subsq RX 4th--Scope LN Su	Character		0-9	1	
1718	Subsq RX 4th--Surg Oth	Character		0-9	1	
1719	Subsq RX 4th--Reg LN Rem	Character	Right justified, zero filled	00-90, 95-99	2	

Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
1720	Subsq RX 5th Course Date	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1730	Subsq RX 5th Course Codes	Character			7	
1731	Subsq RX 5th Course Surg	Character	Right justified, zero filled	00, 10-90, 99	2	
1732	Subsq RX 5th Course Rad	Character		0-5, 9	1	
1733	Subsq RX 5th Course Chemo	Character		0-3, 9	1	
1734	Subsq RX 5th Course Horm	Character		0-3, 9	1	
1735	Subsq RX 5th Course BRM	Character		0-9	1	
1736	Subsq RX 5th Course Oth	Character		0-3, 6-9	1	
1737	Subsq RX 5th--Scope LN Su	Character		0-9	1	
1738	Subsq RX 5th--Surg Oth	Character		0-9	1	
1739	Subsq RX 5th--Reg LN Rem	Character	Right justified, zero filled	00-90, 95-99	2	
1740	Reserved 09	Character			50	
1741	Subsq RX--Reconstruct Del	Character		Site-specific	1	
1750	Date of Last Contact	Character	MMDDCCYY	Valid dates or 99999999	8	
1760	Vital Status	Character		0, 1, 4	1	
1770	Cancer Status	Character		1, 2, 9	1	
1780	Quality of Survival	Character		0-4, 8, 9	1	
1790	Follow-Up Source	Character		0-5, 7-9	1	
1800	Next Follow-Up Source	Character		0-5, 8, 9	1	
1810	Addr Current--City	Character	Mixed case letters, no special characters, embedded spaces allowed, left justified, blank filled		20	
1820	Addr Current--State	Character	Upper case	See EDITS table STATE.DBF in Appendix B	2	
1830	Addr Current--Postal Code	Character	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	9	
1835	Reserved 10	Character			50	
1840	County--Current	Character	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	Character	Mixed case letters, no special characters, embedded spaces allowed, left justified, blank filled		20	
1844	Follow-Up Contact--State	Character	Upper case	See EDITS table STATE.DBF in Appendix B	2	



Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
1846	Follow-Up Contact--Postal	Character	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, 8888888888, 999999999	9	
1850	Unusual Follow-Up Method	Character		0-9	1	
1860	Recurrence Date--1st	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	
1871	Recurrence Distant Site 1	Character		0-9	1	
1872	Recurrence Distant Site 2	Character		0-9	1	
1873	Recurrence Distant Site 3	Character		0-9	1	
1880	Recurrence Type--1st	Character	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	Revised
1890	Recurrence Type--1st--Oth	Character		00, 01, 06, 10, 11, 15-17, 20-22, 25-27, 30, 36, 40, 46, 70, 88, 99	2	
1900	Reserved 11	Character			50	
1910	Cause of Death	Character	4 digits (for ICD-7, 8, 9) or upper case letter followed by 3 digits (for ICD-10)	Valid ICD-7, ICD-8, ICD-9, and ICD-10 codes; also 0000, 7777, 7797	4	
1920	ICD Revision Number	Character		0, 1, 7, 8, 9	1	
1930	Autopsy	Character		0-2, 9	1	
1940	Place of Death	Character	Right justified, zero filled	Reference SEER Manual	3	
1950	Reserved 12	Character			50	
1960	Site (73-91) ICD-O-1	Character	Four digits, first digit equals 1	Reference ICD-O-1 for valid entries	4	
1970	Morph (73-91) ICD-O-1	Character		Reference ICD-O-1 for valid entries	6	
1971	Histology (73-91) ICD-O-1	Character		Reference ICD-O-1 for valid entries	4	
1972	Behavior (73-91) ICD-O-1	Character		Reference ICD-O-1 for valid entries	1	
1973	Grade (73-91) ICD-O-1	Character		Reference ICD-O-1 for valid entries	1	
1980	ICD-O-2 Conversion Flag	Character		0-6	1	
1981	Over-ride SS/NodesPos	Character		1 or blank	1	
1982	Over-ride SS/TNM-N	Character		1 or blank	1	
1983	Over-ride SS/TNM-M	Character		1 or blank	1	
1984	Over-ride SS/DisMet1	Character		1 or blank	1	
1985	Over-ride Acsn/Class/Seq	Character		1 or blank	1	
1986	Over-ride HospSeq/DxConf	Character		1 or blank	1	
1987	Over-ride COC-Site/Type	Character		1 or blank	1	
1988	HospSeq/Site	Character		1 or blank	1	
1989	Over-ride Site/TNM-StgGrp	Character		1 or blank	1	
1990	Over-ride Age/Site/Morph	Character		1 or blank	1	
2000	Over-ride SeqNo/DxConf	Character		1 or blank	1	

Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
2010	Over-ride Site/Lat/SeqNo	Character		1 or blank	1	
2020	Over-ride Surg/DxConf	Character		1 or blank	1	
2030	Over-ride Site/Type	Character		1 or blank	1	
2040	Over-ride Histology	Character		1-3 or blank	1	
2050	Over-ride Report Source	Character		1 or blank	1	
2060	Over-ride Ill-define Site	Character		1 or blank	1	
2070	Over-ride Leuk, Lymphoma	Character		1 or blank	1	
2071	Over-ride Site/Behavior	Character		1 or blank	1	
2072	Over-ride Site/EOD/DX Dt	Character		1 or blank	1	
2073	Over-ride Site/Lat/EOD	Character		1 or blank	1	
2074	Over-ride Site/Lat/Morph	Character		1 or blank	1	
2081	CRC CHECKSUM	Character		Calculated or blank	10	
2090	Date Case Completed	Character	MMDDCCYY		8	
2100	Date Case Last Changed	Character	MMDDCCYY		8	
2110	Date Case Report Exported	Character	MMDDCCYY		8	
2111	Date Case Report Received	Character	MMDDCCYY		8	
2112	Date Case Report Loaded	Character	MMDDCCYY		8	
2113	Date Tumor Record Availbl	Character	MMDDCCYY		8	
2114	Future Use Timeliness 1	Character	No standard'		8	
2115	Future Use Timeliness 2	Character	No standard		8	
2116	ICD-O-3 Conversion Flag	Character		Blank, 0, 1, 3	1	
2120	SEER Coding Sys--Current	Character		0-6	1	Revised
2130	SEER Coding Sys--Original	Character		0-6	1	Revised
2140	COC Coding Sys--Current	Character	Right justified, zero filled	00-08, 99	2	Revised
2150	COC Coding Sys--Original	Character	Right justified, zero filled	00-08, 99	2	Revised
2160	Subsq Report for Primary	Character			0	Retired
2161	Reserved 20	Character			0	Retired
2170	Vendor Name	Character	Embedded spaces allowed		10	
2180	SEER Type of Follow-Up	Character		1-4	1	
2190	SEER Record Number	Character	Right justified, zero filled	01-99	2	
2200	Diagnostic Proc 73-87	Character			2	
2210	Reserved 14	Character			0	Retired
2220	State/Requestor Items	Character			500	
2230	Name--Last	Character	Mixed case, no embedded spaces, left justified, blank filled. Embedded hyphen allowed, but no other special characters		25	
2240	Name--First	Character	Mixed case, no embedded spaces, no special characters, left justified, blank filled		14	
2250	Name--Middle	Character	Mixed case, no embedded spaces, no special characters, left justified, blank filled		14	

Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
2260	Name--Prefix	Character	Mixed case, no special characters		3	
2270	Name--Suffix	Character	Mixed case, no special characters		3	
2280	Name--Alias	Character	Left justified, blank filled		15	
2290	Name--Spouse/Parent	Character	No standard		50	
2300	Medical Record Number	Character	Leading spaces, right justified		11	
2310	Military Record No Suffix	Character	Right justified, zero filled	01-20, 30-69, 98, 99	2	
2320	Social Security Number	Character	9 digits, no dashes	Any 9-digit number except 000000000	9	
2330	Addr at DX--No & Street	Character	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		40	Revised
2335	Addr at DX--Supplementl	Character	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		40	New
2350	Addr Current--No & Street	Character	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		40	Revised
2352	Latitude	Character	Right justified	See Data Dictionary	10	New
2354	Longitude	Character	Right justified	See Data Dictionary	11	New
2355	Addr Current--Supplementl	Character	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		40	New
2360	Telephone	Character	10-digit number	Any 10-digit number	10	
2370	DC State	Character			0	Retired
2371	Reserved for Expansion	Character			0	Retired
2380	DC State File Number	Character		Any characters or blank	6	
2390	Name--Maiden	Character	Mixed case, no embedded spaces, left justified, blank filled, embedded hyphen allowed, no other special characters		15	
2392	Follow-Up Contact--No&St	Character	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		40	Revised

Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
2393	Follow-Up Contact--Suppl	Character	Mixed case, embedded spaces, punctuation limited to periods, slashes, hyphens, and pound signs. Left justified, space filled		40	New
2394	Follow-Up Contact--Name	Character	Mixed case, embedded spaces, no special characters, left justified, blank fill		30	
2400	Reserved 16	Character			0	Retired
2410	Institution Referred From	Character	Right justified and zero filled	10-digit number	10	Revised
2420	Institution Referred To	Character	Right justified and zero filled	10-digit number	10	Revised
2430	Last Follow-Up Hospital	Character	Right justified and zero filled,	10-digit number	10	Revised
2440	Following Registry	Character	Right justified and zero filled	10-digit number	10	Revised
2450	Reserved 17	Character			0	Retired
2460	Physician--Managing	Character	Left justified		8	
2470	Physician--Follow-Up	Character	Left justified		8	
2480	Physician--Primary Surg	Character	Left justified		8	
2490	Physician 3	Character	Left justified		8	
2500	Physician 4	Character	Left justified		8	
2520	Text--DX Proc--PE	Character	Free text	Neither carriage return nor line feed characters allowed	200	
2530	Text--DX Proc--X-ray/Scan	Character	Free text	Neither carriage return nor line feed characters allowed	250	
2540	Text--DX Proc--Scopes	Character	Free text	Neither carriage return nor line feed characters allowed	250	
2550	Text--DX Proc--Lab Tests	Character	Free text	Neither carriage return nor line feed characters allowed	250	
2560	Text--DX Proc--Op	Character	Free text	Neither carriage return nor line feed characters allowed	250	
2570	Text--DX Proc--Path	Character	Free text	Neither carriage return nor line feed characters allowed	250	
2580	Text--Primary Site Title	Character	Free text	Neither carriage return nor line feed characters allowed	40	
2590	Text--Histology Title	Character	Free text	Neither carriage return nor line feed characters allowed	40	
2600	Text--Staging	Character	Free text	Neither carriage return nor line feed characters allowed	300	
2610	RX Text--Surgery	Character	Free text	Neither carriage return nor line feed characters allowed	150	

Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
2620	RX Text--Radiation (Beam)	Character	Free text	Neither carriage return nor line feed characters allowed	150	
2630	RX Text--Radiation Other	Character	Free text	Neither carriage return nor line feed characters allowed	150	
2640	RX Text--Chemo	Character	Free text	Neither carriage return nor line feed characters allowed	200	
2650	RX Text--Hormone	Character	Free text	Neither carriage return nor line feed characters allowed	200	
2660	RX Text--BRM	Character	Free text	Neither carriage return nor line feed characters allowed	100	
2670	RX Text--Other	Character	Free text	Neither carriage return nor line feed characters allowed	100	
2680	Text--Remarks	Character	Free text	Neither carriage return nor line feed characters allowed	350	
2690	Place of Diagnosis	Character	Free text	Neither carriage return nor line feed characters allowed	50	
2700	Reserved 19	Character			770	
2800	CS Tumor Size	Character	Right justified, zero filled	000-990, 999	3	New
2810	CS Extension	Character	Right justified, zero filled	00-99 (site specific)	2	New
2820	CS Tumor Size/Ext Eval	Character		0-3, 5, 6, 8, 9	1	New
2830	CS Lymph Nodes	Character	Right justified, zero filled	00-99 (site specific)	2	New
2840	CS Reg Nodes Eval	Character		0-3, 5, 6, 8, 9	1	New
2850	CS Mets at DX	Character	Right justified, zero filled	00-99 (site specific)	2	New
2860	CS Mets Eval	Character		0-3, 5, 6, 8, 9	1	New
2880	CS Site-Specific Factor 1	Character	Right justified, zero filled	000-999 (site specific)	3	New
2890	CS Site-Specific Factor 2	Character	Right justified, zero filled	000-999 (site specific)	3	New
2900	CS Site-Specific Factor 3	Character	Right justified, zero filled	000-999 (site specific)	3	New
2910	CS Site-Specific Factor 4	Character	Right justified, zero filled	000-999 (site specific)	3	New
2920	CS Site-Specific Factor 5	Character	Right justified, zero filled	000-999 (site specific)	3	New
2930	CS Site-Specific Factor 6	Character	Right justified, zero filled	000-999 (site specific)	3	New
2940	Derived AJCC T	Character		Derived from Collaborative Stage fields	2	New
2950	Derived AJCC T Descriptor	Character		c, p, a, y (derived from Collaborative Stage fields)	1	New
2960	Derived AJCC N	Character		Derived from Collaborative Stage fields	2	New
2970	Derived AJCC N Descriptor	Character		c, p, a, y (derived from Collaborative Stage fields)	1	New

Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
2980	Derived AJCC M	Character		Derived from Collaborative Stage fields	2	New
2990	Derived AJCC M Descriptor	Character		c, p, a, y (derived from Collaborative Stage fields)	1	New
3000	Derived AJCC Stage Group	Character		Derived from Collaborative Stage fields	2	New
3010	Derived SS1977	Character		0-5, 7, 9 (derived from Collaborative Stage fields)	1	New
3020	Derived SS2000	Character		0-5, 7, 9 (derived from Collaborative Stage fields)	1	New
3030	Derived AJCC--Flag	Character		1, 2, blank	1	New
3040	Derived SS1977--Flag	Character		1, 2, blank	1	New
3050	Derived SS2000--Flag	Character		1, 2, blank	1	New
3100	Archive FIN	Character	Right justified, zero filled	10-digit number	10	New
3110	Comorbid/Complication 1	Character	Left justified, zero filled	00000, 00100-13980, 24000-99990, E8700-E8799, E9300-E9499	5	New
3120	Comorbid/Complication 2	Character	Left justified, zero filled	00100-13980, 24000-99990, E8700-E8799, E9300-E9499, blank	5	New
3130	Comorbid/Complication 3	Character	Left justified, zero filled	00100-13980, 24000-99990, E8700-E8799, E9300-E9499, blank	5	New
3140	Comorbid/Complication 4	Character	Left justified, zero filled	00100-13980, 24000-99990, E8700-E8799, E9300-E9499, blank	5	New
3150	Comorbid/Complication 5	Character	Left justified, zero filled	00100-13980, 24000-99990, E8700-E8799, E9300-E9499, blank	5	New
3160	Comorbid/Complication 6	Character	Left justified, zero filled	00100-13980, 24000-99990, E8700-E8799, E9300-E9499, blank	5	New
3170	RX Date--Most Defin Surg	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	New
3180	RX Date--Surgical Disch	Character	MMDDCCYY	Valid dates, 00000000, 99999999	8	New
3190	Readm Same Hosp 30 Days	Character		0-3, 9	1	New
3200	Rad--Boost RX Modality	Character	Right justified, zero filled	00, 20-32, 40-43, 50-55, 60-62, 98, 99	2	New
3210	Rad--Boost Dose cGy	Character	Right justified, zero filled	00000-99999	5	New
3220	RX Date--Radiation Ended	Character	MMDDCCYY	Valid dates, 00000000, 88888888, 99999999	8	New
3230	RX Date--Systemic	Character	MMDDCCYY	Valid dates, 00000000, 88888888, 99999999	8	New
3250	RX Summ--Transplnt/Endocr	Character	Right justified, zero filled	00, 10-12, 20, 30, 40, 82, 85-88, 99	2	New
3260	Pain Assessment	Character		0-3, 9	1	New

Item #	Item Name	Data Type	Format	Allowable Values	Length	Note
3270	RX Summ--Palliative Proc	Character		0-7, 9	1	New
3280	RX Hosp--Palliative Proc	Character		0-7, 9	1	New
3300	RuralUrban Continuum 1993	Character	Right justified, zero filled	00-09, 98, 99, blank (calculated)	2	New
3310	RuralUrban Continuum 2000	Character	Right justified, zero filled	00-09, 98, 99, blank (calculated)	2	New

**Chapter XI: Data Dictionary**

**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	50		705-754

**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	50		1397-1446

**RESERVED 10**

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



**RX HOSP--SCOPE REG 98-02**

**(New Field)**

Alternate Name	Item #	Length	Source of Standard	Column #
	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 also is to be used to code Scope of Regional Lymph Node Surgery at the reporting facility for all cases 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*, 1998 (RX Coding System #1460, code 5), for site-specific codes.

**RX HOSP--SURG OTH 98-02**

**(New Field)**

Alternate Name	Item #	Length	Source of Standard	Column #
	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 also is to be used to code Surgery Other Regional/Distant Sites at the reporting facility for all cases 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*, 1998 (RX Coding System #1460, code 5) for site-specific codes.

**RX HOSP--SURG SITE 98-02**

**(New Field)**

Alternate Name	Item #	Length	Source of Standard	Column #
	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 also is to be used to code Surgery Primary Site at the reporting facility for all cases 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 cancer-directed surgery performed.
- 99 Unknown if cancer-directed surgery performed.

*Note:* See the CoC *ROADS Manual*, 1998 Supplement (CoC Coding System #2140, code 7), and the *SEER Program Code Manual*, 1998 (RX Coding System #1460, code 5), for site-specific codes.

**RX SUMM--SCOPE REG 98-02**

**(New Field)**

Alternate Name	Item #	Length	Source of Standard	Column #
	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 also is to be used to code Scope of Regional Lymph Node Surgery at all facilities for all cases 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*, 1998 (RX Coding System #1460, code 5), for site-specific codes.

**RX SUMM--SURG OTH 98-02**

**(New Field)**

Alternate Name	Item #	Length	Source of Standard	Column #
	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 also is to be used to code Surgery Regional/Distant Sites at all facilities for all cases 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*, 1998 (RX Coding System #1460, code 5), for site-specific codes.

**RX SUMM--SURG SITE 98-02**

**(New Field)**

Alternate Name	Item #	Length	Source of Standard	Column #
	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 also is to be used to code Surgery Primary Site at all facilities for all cases 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*, 1998 (RX Coding System #1460, code 5), for site-specific codes.

## Appendix E: 2003 Implementation Documentation and Tools

The documentation and conversion tools presented in Table E-1 have been or will be made available to facilitate the implementation of NAACCR Version 10 standards.

<b>TABLE E-1. Documentation/Conversion Tools Available for NAACCR Version 10 Implementation.</b>	
<b>Documentation/Tools</b>	<b>Anticipated Availability</b>
NAACCR Volume II, Version 10	June 10, 2002
NAACCR Volume II, Version 10, Errata	January 6, 2003
FORDS	July 15, 2002
FORDS, Published Page Revisions	August - December 2002
<i>SEER Program Code Manual, Third Edition, Revision 1</i>	January 2003
CoC ROADS to FORDS Conversion Rules and Computer Code	August 15, 2002
CoC ROADS to FORDS Conversion Rules and Computer Code, Revisions	January 3, 2003
NPCR NAACCR Version 9.1 to Version 10 Conversion Computer Code	February 2003
NAACCR Version 10 EDITS Metafile	End of January 2003

