Standards for Cancer Registries, Volume I

Data Exchange Standards and Record Descriptions

Version 18
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Edited by
Lori A. Havener, CTR
Program Manager of Standards
North American Association of Central Cancer Registries

Sponsoring Organizations
Canadian Partnership Against Cancer
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Commission on Cancer-ACoS
National Cancer Institute
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Public Health Agency of Canada

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American Cancer Society

Edited by:
Lori A. Havener, CTR

For further information, contact:
NAACCR, Inc.
Phone: (217) 698-0800
http://www.naaccr.org

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

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

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

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

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

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

Copies of the standards documents can be viewed or downloaded from NAACCR's website at http://www.naaccr.org.

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

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NAACCR BOARD OF DIRECTORS

Standardization and Registry Development Steering Committee
2017 - 2018

Mary Jane King, MPH, CTR (Co-Chair)
Ontario Cancer Registry
Email: maryjane.king@cancercare.on.ca

Lori Koch (Co-Chair)
Illinois State Cancer Registry
Email: lori.koch@illinois.gov

Lori A. Havener, CTR
NAACCR
Email: lhavener@naaccr.org

Eric B. Durbin, Dr.PH, MS
Kentucky Cancer Registry
Email: ericd@kcr.uky.edu

Jim Hofferkamp, CTR
NAACCR
Email: jhofferkamp@naaccr.org

Sandy Jones
Centers for Disease Control and Prevention
National Program of Cancer Registries
Email: sthames@cdc.gov

Gary M. Levin, BA, CTR
Florida Cancer Data System
University of Miami
Email: glevin@med.miami.edu

Rich Pinder
Los Angeles Cancer Surveillance Program
Email: rpinder@usc.edu

Winny Roshala, BA, CTR
Cancer Registry of Greater California
Email: wroshala@crgc-cancer.org

Randi Rycroft, MSPH, CTR
Colorado Central Cancer Registry
Email: randi.rycroft@state.co.us

Heather Stuart-Panko, CHIM
Saskatchewan Cancer Agency
E-mail: heather.stuart-panko@saskcancer.ca

STANDARD SETTING ORGANIZATIONS

American Joint Committee on Cancer (AJCC)
633 N. Saint Clair Street
Chicago, IL 60611
Telephone: (312) 202-5290
Fax: (312) 202-5205
E-mail: ajcc@facs.org
Website: www.cancerstaging.org

Canadian Council of Cancer Registries
c/o Statistics Canada
Health Statistics Section
Health Statistics Division
Main Building, Room 220, Section F
120 Parkdale Ave.
Ottawa, ON K1A 0T6
Telephone: (613) 951-1630
Fax: (613) 951-0792

Centers for Disease Control and Prevention (CDC)
National Program of Cancer Registries (NPCR)
Division of Cancer Prevention and Control
National Center for Chronic Disease
Prevention and Health Promotion
MS-K53
4770 Bufford Highway, NE
Atlanta, GA 30341-3724
Telephone: (770) 488-4783
Fax: (770) 488-4759
Website: www.cdc.gov/nccdphp/dcpc/npcr

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

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

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

North American Association of Central Cancer Registries, Inc. (NAACCR)
2050 W. Iles Avenue, Suite A
Springfield, IL 62704
Telephone: (217) 698-0800
Fax: (217) 698-0188
E-mail: info@naaccr.org
Website: www.naaccr.org

1. INTRODUCTION

1.1 Version 18 of the Record Layout

The Standards for Cancer Registries, Volume II, *Data Standards and Data Dictionary*, Version 18 (January 1, 2018 implementation) requires a new record layout and includes over 200 new data items with several revisions to existing data items. Many of the new data items are site-specific data items that are either required for AJCC 8th Edition staging or required by one of the standard setting agencies. There are a number of new radiation treatment data items; AJCC T, N, and M data items; EOD data items; and other new data items for Rural Urban Commuting Area (RUCA) and the Urban Rural Indicator Code (URIC), Geographic Location IDs, County at DX, etc. The CS PreRX and PostRX data items are retired in Version 18. Data item names have been expanded from 25 characters to 50 characters. Refer to the Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary*, Version 18 for detailed information.

Note: This document was revised in May 2018 to remove Record Type V (Virtual Pooled Registry). It was determined that there will not be a Record Type V.

2. PURPOSE AND USE OF DATA EXCHANGE LAYOUTS

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

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

2.1. RECORD LAYOUT DESIGN DECISIONS

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

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

2.1.1. Data Exchange Records

2.1.1.1. Incidence Record (record type I)

These records include all the coded fields for each case, including demographic, tumor, staging, treatment, and follow-up fields. The primary use of the incidence record is to transmit data for multi-registry research projects or surveillance. See Appendix C, columns 1 – 4048, for the Incidence Record.

2.1.1.2. Confidential Record (record type C)

These records include all the data items in the Incidence Record (record type I) plus items such as patient name and Social Security Number that identify the case. Also included are other data items such as referring hospital or primary physician, items which some agencies are required to keep confidential**.** This record type can be used to exchange cases between registries, whether central-based or hospital-based. See Appendix C, columns 1 – 6154, for the Confidential Record.

2.1.1.3. Full Case Abstract (record type A)

These records contain all fields noted above (record types I and C) plus the supportive text required in the transmission of full case abstracts. The Full Case Abstract allows the receiving registry to perform a higher degree of quality control with each case report. See Appendix C, columns 1 – 24194, for the Full Case Abstract.

2.1.1.4. Pathology Laboratory Record (record type L)

The Pathology Laboratory Record is designed for electronic transmission of reports from pathology laboratories to central registries. Health Level 7 (HL7) Version 2.x is recommended as the data format for transmitting pathology laboratory reports. A standard pathology laboratory dataset, data dictionary, and HL7 transmission format were developed to enhance the completeness, timeliness, consistency, and efficiency with which tumor data are transmitted by pathology laboratories and received and processed by central cancer registries (see Standards for Cancer Registries, Volume V, *Pathology Laboratory Electronic Reporting*).

2.1.1.5. Update/Correction (record type U) and Modified Record (record type M)

Two record layout types, an Update/Correction and a Modified Record, provide data layouts to transmit changes or revisions to data that have already been sent to a receiving registry.

The Update/ Correction (record type U) which has its own record version data items (see section 2.3.1), is a short format record that can be used to transmit corrections to specific data items that were already submitted. The record length is 1543 bytes. This record type is for use by those registries and software vendors that do not already have a well-functioning corrections system, or who wish to use a standardized format. In this volume, version 18 of the update/correction record is documented. Version 18 of the "U" record can be used only to update data that are already coded according to the standards documented in version 18 of the NAACCR data exchange record types I, C, and A. See Appendix D for the Update/Correction record layout.

The Modified Record (record type M) is the same length (24194 characters) and contains the same fields, in the same locations, as the Full Case Abstract (record type A). A Modified Record represents an alternative way for submitting changed information to a receiving registry, on tumor records that have already been submitted. It is designed for transmitting an entire tumor record in which one or more modifications, updates, or corrections have been made since the last time the tumor record was submitted to the receiving registry. Like record type 'U', the 'M' record may be used to transmit corrections or follow-up.

Like the "U" record, a version 18 "M" record can be used only to update data already coded according to the standards documented in version 18 of the NAACCR data exchange record. This is because the definitions, data length, and code meanings for certain variables changed between version 18 and previous versions.

2.1.1.7. Canadian Data

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

2.2. SUMMARY OF NAACCR DATA EXCHANGE RECORD TYPES

Record Type is a generated field that identifies which of the six NAACCR data exchange record types is being used in a file of data exchange records. Since Record Type R (Analysis/Research Record) was not used it was removed from Standards Volume I Version 12.1. Data dictionary descriptions for record types I, C, A, and M (data item numbers 10 – 7600) can be found in the NAACCR Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary*. The record layout for these record types can be found in Appendix C of this document. Record Type V was added in Standards Volume I Version 18.

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

Contents:	Demographic, Tumor and Staging, Treatment, and Follow-up (Optional)
Use:	Combined studies
Length:	4048 characters

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

Contents:	Demographic, Tumor and Staging, Treatment, Follow-up, and Pathology, plus Patient Identifiers and Physicians
Use:	Case sharing between central registries
Length:	6154 characters

RECORD TYPE A: FULL CASE ABSTRACT (incidence record that includes confidential data plus text)

Contents:	Demographic, Tumor and Staging, Treatment, Follow-up, and Pathology, Patient Identifiers & Physicians, plus Text
Use:	Sending abstracts between registries, reporting to central registries
Length:	24194 characters

RECORD TYPE L: PATHOLOGY LABORATORY

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

RECORD TYPE U: UPDATE/CORRECTION RECORD (short format record)

Contents:	Sender ID Section, Record ID Section, Correction Section
Use:	Transmitting changes or corrections for previously submitted cases
Length:	1543 characters

RECORD TYPE M: RECORD MODIFIED SINCE PREVIOUS SUBMISSION TO CENTRAL REGISTRY (identical to Record Type A – Full Case Abstract)

Contents:	Demographic, Tumor and Staging, Treatment, and Follow-up, Patient Identifiers and Physicians, plus Text
Use:	Transmitting changes or corrections for previously submitted cases
Length:	24194 characters

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

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

2.3.1. Record Type "U" Update/Correction Record

2.3.1.1. Data Dictionary Descriptions

Each item in the Update/Correction record is described briefly. The standard item number in square brackets follows the item name. For data items with numbers 1-7600, see NAACCR Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary* for more information.

2.3.1.2. Sender ID Section of Update/Correction Record

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

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

Update/Correction Record Version [9000]
1 = Version 1, first approved version, September 1997
2 = Version 2, February 1998
7 = Version 7, June 2000
A = Version 10, June 2003
B = Version 11, January 2006 (layout same as A; content, however may be different)
120 = Version 12, January 2010
121 = Version 12.1, January 2011
122 = Version 12.2, January 2012
130 = Version 13, January 2013
140 = Version 14, January 2014
150 = Version 15, January 2015
160 = Version 16, January 2016
180 = Version 18, January 2018

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

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

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

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

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

2.3.1.3. Record ID Section of Update/Correction Record

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

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

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

Name-Last [2230], Name-First [2240], Name-Middle [2250], Social Security Number [2320], Sex [220], Date of Birth [240], Date of Birth Flag [241], Date of Diagnosis [390], Date of Diagnosis Flag [391], Primary Site [400], Laterality [410], Histology (92-00) ICD-O-2 [420], Histologic Type ICD-O-3 [522], Behavior (92-00) ICD-O-2 [430], Behavior Code ICD-O-3 [523]
Consolidated value for each item as reflected in the sending registry's database. There should be one value for each item for each patient or tumor. If the value of any of these items is being changed in the update/correction record, the ORIGINAL unchanged value should be included in the Record ID segment of the update/correction record.

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

2.3.1.4. Correction Section of the Update/Correction Record

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

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

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

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

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

A NAACCR group prepared recommendations for a CRC algorithm to be used with NAACCR-formatted data transmissions. Their report is on the NAACCR website (www.naaccr.org), under the Standards and Registry Operations page.

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

Examples of manually entered comments:

1) Autopsy: small cell CA RUL lung, mets to L lung, lymph nodes, and brain
2) Pt remarried 6/5/97; new husband is Hispanic, pt is not
3) Slide review AFIP 6/5/09 final DX neuroblastoma
4) Name spelling changed per patient signature on 3 admissions
5) Per MD follow up letter, pt initially dx'd while resident of New Jersey

Examples of software-entered comments:

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

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

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

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

2.3.1.5.1. What is an update/correction record?

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

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

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

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

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

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

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

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

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

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

2.3.1.5.9. How about corrections made to the same record during two different work sessions (i.e., changes made one day and subsequent changes to the same record made on the next day)? Should the Record ID section of the update/correction records be the same?
Same answer as number 2.3.1.5.8. Since they have different time stamps, they can have different Record ID values.

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

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

2.3.1.5.12. What is required for internal processing?
See answer to number 2.3.1.5.11.

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

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

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

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

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

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

2.3.2. Record Type 'M' Modified Record

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

2.3.2.2. Questions & Answers about the "M" record

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

2.3.2.2.2. When should an "M" record be generated by my software?
It depends upon the central registry to which you report. Some central registries require that updates be submitted in the "U" record format; other central registries require the "M" format. If a central registry requires "M" records, then "M" records should be system-generated whenever a transmit file is created (see also 2.3.2.2.3). Tumor records that have not been reported to the central registry should be written in the "A" format, and tumor records that have already been transmitted but that have had an update to any field, should be written in the "M" format. (The Date Case Report Exported field [2110] can be used to identify tumor records, which have already been transmitted, and a comparison of item #2110 to the Date Case Last Changed field [2100] can be used to identify records that have been modified since the last time they were exported. Also, it is assumed that the Date Case Report Exported field will be updated when an "M" record is generated.) Note that the only difference between an "A" record and an "M" record is the code found in the Record Type [10]. Some central registries will require that a submission file contain only "A" or only "M" records; other central registries may allow both "A" and "M" records to be within the same file. At this time there is no standard set of items for which "M" records are to be required. Systems should have the potential to note a change/correction/update to any field.

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

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

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

2.3.2.2.6. How do I accommodate sending update/corrections to multiple requesters?
We suggest that you use the same methods you use to handle multiple case transmits. The software would not need to select which fields to send each party, since receiving parties will have the ability to ignore data they are not requesting. If you submit data to some registries that require "U" records and some that require "M" records, then "U" records should be generated according to the guidelines provided in NAACCR Standards Volume 1.

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

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

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

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

2.3.2.2.11. What is required for internal processing?
The central registry should maintain and be able to update the source records submitted by each facility. See also answer in 2.3.2.2.10.

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

2.3.2.2.13. How will a vendor of central registry software assist in incorporating corrections into the central system?
This may vary. The vendor needs to provide basic capabilities for receiving, linking, and displaying the contents of modified records. The vendor may also need to apply consolidation/ reconciliation procedures that exist in ordinary records processing to the modified records. See also answer in 2.3.2.2.10.

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

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

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

3. CODING STANDARDS

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

- *AJCC Cancer Staging Manual (TNM)*
- *Canadian Cancer Registry Data Dictionary*
- *COC Standards for Oncology Registry Entry (STORE)*
- *EOD General Coding Instructions (1/1/2018 and forward)*
- *Hematopoietic Manual and Database*
- *NAACCR Standards for Cancer Registries Volume I: Data Exchange Standards and Record Description*
- *NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary*
- *SEER Program Code Manual*
- *SEER*RSA*
- *Site-Specific Data Item (SSDI) Manual*
- *M/PH Histology rules/Solid Tumor Rules*
- *Summary Stage*
- *WHO ICD-O Third Edition*

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

- COC Coding Sys-Current [2140]
- COC Coding Sys-Original [2150]
- Coding System for EOD [870]
- CS Version Derived [2936]
- CS Version Input Current [2937]
- CS Version Original [2953]
- ICD-O-2 Conversion Flag [1980]
- ICD-O-3 Conversion Flag [2116]
- Morph Coding Sys-Current [470]
- Morph Coding Sys-Originl [480]
- Race Coding Sys-Current [170]
- Race Coding Sys-Original [180]
- RX Coding System-Current [1460]
- SEER Coding Sys-Current [2120]
- SEER Coding Sys-Original [2130]
- Site Coding Sys-Current [450]
- Site Coding Sys-Original [460]
- TNM Edition Number [1060]

3.1. DATE FORMAT

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

YYYYMMDD – when complete date is known and valid.
YYYYMM – when year and month are known and valid, and day is unknown.
YYYY – when year is known and valid, and month and day are unknown.

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

Standard edits check that no dates are later than today's date.

Prior to Version 12 many NAACCR date fields were used to convey non-date information (e.g., the use of 0s in the field RX Date--Surgery [1200] to indicate "no surgery"). For each date item for which an "unknown" or "not applicable" value is appropriate, an auxiliary data item is used, to serve as a flag or indicator (e.g., Date Conclusive DX Flag [448] or RX Summ--Treatment Status [1285]). This item would be blank if a valid date is transmitted in its associated date item. The only date fields that would not have this flag are system-generated dates (e.g., Date Case Completed [2090]), for which "unknown" would never be a legitimate value.

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

3.2. REQUIRED FIELDS FOR DATA EXCHANGE

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

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

3.3. NAACCR NAMING AND NUMBERING CONVENTIONS

Item names are a maximum of 50 characters (prior to 2018 the limit was 25 characters). Standardized abbreviations are used when necessary. Standardized punctuation and spacing are also used. Related fields are sometimes named with an identical stem and changing suffix. For example, names of all modalities of treatment in the first course of therapy have the identical stem "RX Summ", for Treatment Summary, followed by an indicator of the type of treatment, for example, "Chemo". Item names, while relatively stable, can change and have changed with different versions of the layout. Item numbers, in contrast, are unchanged during the life of the data item. Item numbers have been retired when items have been deleted from the layout, but item numbers will never be reused for a different item. Ranges of item numbers have been assigned to different uses, as follows:

Range	**Use**
00001 - 04999	Data items in new case layouts, record types I, C, A, M or V
05000 - 06999	Data items in Analysis/Research record only (These data items are not within the purview of NAACCR, and NAACCR will not use the data item numbers in this range.)

07000 - 08999	Pathology Laboratory record
09000 - 09099	Data items in Update/Correction record only
09100 - 09499	Future use
09500 - 09999	Data items for Local use
10000 - 10499	System variables for Local use
12000 – 12999	For NPCR use.
13000 – 13999	For SEER use.
14000 – 14999	For CoC use.
20000 - 20999	Data items for International use. These data items are not within the purview of NAACCR, and NAACCR will not use the data item numbers in this range.
99000 - 99999	Data items for Patient Care Evaluation studies. These may be assigned by CoC or others. A large range is allotted because many new items may be assigned each year for individual studies.

APPENDIX A. Abbreviations and Symbols Used

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

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

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

Version 16
The North American Association of Central Cancer Registries, Inc. (NAACCR) Standards for Cancer Registries, Volume I, *Data Exchange Standards and Record Descriptions, Version 18* (January 1, 2018 implementation) includes several new data items and revisions to the record layout. New data items include the geocoded county fields as well as new data items for the transition from collaborative stage (CS) to TNM. The Electronic Health Record (EHR) Reporting and Volume II Harmonization Task Force submitted changes to harmonize Volume II to better accommodate EHR reporting, most of these were wording modifications (e.g., change "hospital" to "reporting facility"), these changes do not impact Standards Volume I. Refer to the Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary*, Version 16 for detailed information.

Version 15
There are minimal changes to the North American Association of Central Cancer Registries, Inc. (NAACCR) Standards for Cancer Registries, Volume I, *Data Exchange Standards and Record Descriptions, Version 15.* The NAACCR Version 15 data exchange record layout is effective for cases diagnosed on or after January 1, 2015.

This edition of Standards Volume I, Version 15 includes revisions to the standard setters' requirements and the addition of seven new survival data items which are designed to facilitate a common approach to survival analysis by NAACCR registries. Other changes to note in Standards Volume II include the addition of new codes for Sex [220] and RX Date Other Flag [1251]. These changes are reported in detail in the companion volume, Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary*, Version 15.

Version 14
There are minimal changes to the North American Association of Central Cancer Registries, Inc. (NAACCR) Standards for Cancer Registries, Volume I, *Data Exchange Standards and Record Descriptions, Version 14.* The NAACCR Version 14 data exchange record layout is effective for cases diagnosed on or after January 1, 2014.

This edition of Standards Volume I, Version 14 includes several revisions to the standard setters' requirements. Other changes to Standards Volume II include adding 'blank' as an allowable value for Place of Death Country [1944] and Place of Death State [1942]; updating the Rationale in the NPI fields; and, adding a Note to the Chemo and BRM fields regarding the change in classification for some targeted therapies, such as Herceptin.

Version 13
There are several changes to the North American Association of Central Cancer Registries, Inc. (NAACCR) Standards for Cancer Registries, Volume I, *Data Exchange Standards and Record Descriptions, Version 13.* The NAACCR Version 13 data exchange record layout is effective for cases diagnosed on or after January 1, 2013.

This edition of Standards Volume I, Version 13 includes several new data items and changes to existing data items. New data items include: Census Code 2010, NPCR Specific field, Census Tract Poverty

Indicator, Place of Death (State and Country), Secondary Diagnosis for ICD-10-CM (1-10) and fields to collect country information. Some of the changes include renaming many of the data item names so they would alphabetically follow corresponding data items (e.g., date and date flag data items); Unusual Follow-up Method length was changed to 2 characters; and, the retirement of First Course Calc Method [1500].

Version 12.2
There are minimal changes to the North American Association of Central Cancer Registries, Inc. (NAACCR) Standards for Cancer Registries, Volume I, *Data Exchange Standards and Record Descriptions, Version 12.2.* This edition includes clarification of descriptions, rationales and coding instructions, and the retirement of FIN Coding System [35]. The NAACCR Version 12.2 data exchange record layout is effective for cases diagnosed on or after January 1, 2012.

The implementation of CS PostRX and CS PreRX input and derived data items has been deferred indefinitely.

Version 12.1
This edition of the Standards for Cancer Registries, Volume I, *Data Exchange Standards and Record Descriptions* includes new data items, addition of new codes to existing data items, and clarification of descriptions, rationales and coding instructions. New data items include: Census Tract 2010 [135], Census TR Certainty 2010 [367], Census Block Group 2010 [363], and Over-ride CS 1-20 [3750 - 3769]. There are two fields with new codes Multiplicity Counter [446] and Marital Status at DX [150]. Version 12.1 of the NAACCR (all abbreviations are listed in Appendix A) data exchange record layout reflects the needed changes for the reporting of tumors diagnosed from January 1, 2011 onward.

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

Version 12
Version 12 of the NAACCR (all abbreviations are listed in Appendix A) data exchange record layout reflects the needed changes for the reporting of tumors diagnosed from January 1, 2010 onward. To begin the process of bringing standard registry items into a form more consistent with widely-accepted data transmission formats many new data items and changes to existing data items were recommended by the NAACCR Interoperability Ad Hoc Committee. For example, the date format has changed to CCYYMMDD and the non-date values (i.e., 00000000, 88888888 and 99999999) are incorporated into new status fields and date field flags using the HL7 flavors of null. Some of the new data items and changes to existing data items came from the work and coordinated efforts between the taskforces that developed the AJCC Cancer Staging Manual 7th Edition and the Collaborative Staging System Version 2.00.00. Text fields were expanded and many doubled in size.

Due to the many new data items, changes to existing data items and the expansion of text fields, the record layout has increased to 22,824 characters. Record type I (Incidence Record) is 3339 characters, record type C (Confidential Record) is 5564 characters and Record type A (Full Case Abstract) is 22824 characters.

Since Record Type R (Analysis/Research Record) is not used; it has been removed from Standards Volume I Version 12.

Version 11.3
Version 11.3 of the NAACCR (all abbreviations are listed in Appendix A) data exchange record layout reflects the needed changes for the reporting of tumors diagnosed from January 1, 2009 onward. New data items, Race—NAPIIA [193] and Date of Death—Canada [1755], as well as revisions to existing data

items reflect changes introduced for the needs of the various standard setting organizations. These changes are reported in detail in the companion volume, Standards for Cancer Registries, Volume II: *Data Standards and Data Dictionary*, Thirteenth Edition, Version 11.3.

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

Version 11.2
Version 11.2 of the NAACCR (all abbreviations are listed in Appendix A) data exchange record layout reflects the needed changes for the reporting of tumors diagnosed from January 1, 2008 onward. New data items as well as revisions to existing data items reflect changes introduced for the needs of the various standard setting organizations. These changes are reported in detail in the companion volume, Standards for Cancer Registries, Volume II: *Data Standards and Data Dictionary*, Twelfth Edition, Version 11.2.

NAACCR and the Canadian Council of Cancer Registries (CCCR) have been working in a collaborative effort to resolve discrepancies among standards. Through this collaborative effort the CCCR requirements and recommendations for collection of data items are included in Standards for Cancer Registries, Volume II: *Data Standards and Data Dictionary*, Twelfth Edition, Version 11.2, Chapter VIII, Required Status Table as well as Appendix C of this document.

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

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

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

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

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

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

Version 9

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

Version 8

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

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

Version 7

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

Version 6

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

Version 5

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

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

Version 4

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

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

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

Version 3

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

APPENDIX C. NAACCR Case Record Layout, Version 18 For Implementation 1/1/2018 Record Types I, C, A, and M

The following table represents the NAACCR record layout Version 18 for January 1, 2018 implementation.

Codes:
D = Derived
D* = Derived, when available
D+ = Derived; central registries may collect either SEER Summary Stage 2000 or Collaborative Stage
DH = Historically derived and currently transmitted
R = Required
R* = Required when available
R^ = Required, these text requirements may be met with one or several text block fields
R+ = Required, central registries may collect either SEER Summary Stage 2000 or Collaborative Stage
R$ = Requirements differ by year
R# = Required, central registries may code available data using either SEER or CoC data items and associated rules
R#* = Required, when available; central registries may code available data using either SEER or CoC data items and associated rules
RC = Collected by SEER from COC-accredited hospitals
RH = Historically collected and currently transmitted
RH* = Historically collected and currently transmitted when available
RN = Collect according to NPCR stage transition schedule
RS = Required, site-specific
RS* = Required, site-specific; when available
RS# = Required, site-specific; central registries may code available data using either SEER or CoC data items and associated rules
S = Supplementary/recommended
• = No recommendation

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
10	Record Type	1	1	1	R	.	R	.	R	R	R	NAACCR
30	Registry Type	2	2	1	.	.	.	.	.	.	.	NAACCR
37	Reserved 00	3	16	14								
50	NAACCR Record Version	17	19	3	R	.	R	R	R	.	.	NAACCR
45	NPI--Registry ID	20	29	10	.	.	.	R*	.	.	.	CMS
40	Registry ID	30	39	10	R	.	.	R	R	R	R	NAACCR
60	Tumor Record Number	40	41	2	.	.	.	S	S	R*	R*	NAACCR
20	Patient ID Number	42	49	8	R	.	.	R	R	R*	R*	Reporting Registry
21	Patient System ID-Hosp	50	57	8	.	.	.	.	.	.	.	NAACCR
370	Reserved 01	58	73	16								
70	Addr at DX--City	74	123	50	R	R	R	R	.	R*	R*	CoC
80	Addr at DX--State	124	125	2	R	R	R	R	R	.	.	CoC
100	Addr at DX--Postal Code	126	134	9	R	R	R	R	.	R*	R*	CoC
90	County at DX Reported	135	137	3	R	R	R	R	R	.	.	FIPS/SEER
2450	Reserved 16	138	149	12								
89	County at DX Analysis	150	152	3	D	.	.	R	R	.	.	NAACCR
351	GeoLocationID - 1970/80/90	153	164	12	D	.	.	R	R	.	.	NAACCR
81	State at DX Geocode 1970/80/90	153	154	2	D	.	.	R	R	.	.	NAACCR
94	County at DX Geocode 1970/80/90	155	157	3	D	.	.	D	R	.	.	NAACCR
110	Census Tract 1970/80/90	158	163	6	RH*	.	.	RH	RH	.	.	SEER
368	Census Block Grp 1970/80/90	164	164	1	.	.	.	S	.	.	.	Census
120	Census Cod Sys 1970/80/90	165	165	1	RH*	.	.	RH	RH	.	.	SEER
364	Census Tr Cert 1970/80/90	166	166	1	RH*	.	.	RH	RH	.	.	SEER
352	GeoLocationID - 2000	167	178	12	D	.	.	R	R	.	.	NAACCR
82	State at DX Geocode 2000	167	168	2	D	.	.	R	R	.	.	NAACCR
95	County at DX Geocode2000	169	171	3	D	.	.	D	R	.	.	NAACCR
130	Census Tract 2000	172	177	6	RH	.	.	RH	RH	.	.	NAACCR

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
362	Census Block Group 2000	178	178	1	.	.	.	S	.	.	.	Census
365	Census Tr Certainty 2000	179	179	1	RH	.	.	RH	RH	.	.	NAACCR
353	GeoLocationID - 2010	180	191	12	D	.	.	R	R	.	.	NAACCR
83	State at DX Geocode 2010	180	181	2	D	.	.	R*	R*	.	.	NAACCR
96	County at DX Geocode2010	182	184	3	D	.	.	D	R	.	.	NAACCR
135	Census Tract 2010	185	190	6	R	.	.	R	R	.	.	NAACCR
363	Census Block Group 2010	191	191	1	.	.	.	R	.	.	.	Census
367	Census Tr Certainty 2010	192	192	1	R	.	.	R	R	.	.	NAACCR
354	GeoLocationID - 2020	193	204	12	D	.	.	.	.	.	.	NAACCR
84	State at DX Geocode 2020	193	194	2	D	.	.	.	.	.	.	NAACCR
97	County at DX Geocode2020	195	197	3	D	.	.	.	.	.	.	NAACCR
125	Census Tract 2020	198	203	6	D	.	.	R*	R*	.	.	NAACCR
361	Census Block Group 2020	204	204	1	.	.	.	.	.	.	.	Census
369	Census Tract Certainty 2020	205	205	1	D	.	.	.	.	.	.	NAACCR
150	Marital Status at DX	206	206	1	.	.	.	R	R	.	.	SEER
160	Race 1	207	208	2	R	R	R	R	R	.	.	SEER/CoC
161	Race 2	209	210	2	R	R	R	R	R	.	.	SEER/CoC
162	Race 3	211	212	2	R	R	R	R	R	.	.	SEER/CoC
163	Race 4	213	214	2	R	R	R	R	R	.	.	SEER/CoC
164	Race 5	215	216	2	R	R	R	R	R	.	.	SEER/CoC
170	Race Coding Sys--Current	217	217	1	.	R	R	.	.	.	.	NAACCR
180	Race Coding Sys--Original	218	218	1	.	R	R	.	.	.	.	NAACCR
190	Spanish/Hispanic Origin	219	219	1	R	R	R	R	R	.	.	SEER/CoC
200	Computed Ethnicity	220	220	1	R	.	.	D	R	.	.	SEER
210	Computed Ethnicity Source	221	221	1	R	.	.	R	R	.	.	SEER
220	Sex	222	222	1	R	R	R	R	R	R	R	SEER/CoC
230	Age at Diagnosis	223	225	3	R	R	R	R	R	D	D	SEER/CoC
240	Date of Birth	226	233	8	R	R	R	R	R	R	R	SEER/CoC

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
241	Date of Birth Flag	234	235	2	R	R	R	R	R	R*	R*	NAACCR
250	Birthplace	236	238	3	RH*	.	.	.	.	.	.	SEER/CoC
270	Census Occ Code 1970-2000	239	241	3	R*	.	.	.	.	.	.	Census/NPCR
280	Census Ind Code 1970-2000	242	244	3	R*	.	.	.	.	.	.	Census/NPCR
290	Occupation Source	245	245	1	R*	.	.	.	.	.	.	NPCR
300	Industry Source	246	246	1	R*	.	.	.	.	.	.	NPCR
310	Text--Usual Occupation	247	346	100	R*	.	.	.	.	.	.	NPCR
320	Text--Usual Industry	347	446	100	R*	.	.	.	.	.	.	NPCR
330	Census Occ/Ind Sys 70-00	447	447	1	R*	.	.	.	.	.	.	NPCR
191	NHIA Derived Hisp Origin	448	448	1	D	.	.	D	R	.	.	NAACCR
193	Race--NAPIIA(derived API)	449	450	2	R	.	.	D	R	.	.	NAACCR
192	IHS Link	451	451	1	R*	.	.	.	R	.	.	NPCR
366	GIS Coordinate Quality	452	453	2	R*	.	.	S	.	.	.	NAACCR
3300	RuralUrban Continuum 1993	454	455	2	D	.	.	.	.	.	.	NAACCR
3310	RuralUrban Continuum 2003	456	457	2	D	.	.	.	.	.	.	NAACCR
3312	RuralUrban Continuum 2013	458	459	2	D	.	.	D	R	.	.	NAACCR
339	RUCA 2000	460	460	1	D	.	.	D	R	.	.	NAACCR
341	RUCA 2010	461	461	1	D	.	.	D	R	.	.	NAACCR
345	URIC 2000	462	462	1	D	.	.	D	R	.	.	NAACCR
346	URIC 2010	463	463	1	D	.	.	D	R	.	.	NAACCR
102	Addr at DX--Country	464	466	3	.	R	R	R	.	.	.	NAACCR
1832	Addr Current--Country	467	469	3	.	R	.	R	.	.	.	NAACCR
252	Birthplace--State	470	471	2	R*	R	R	R	R	R	R	NAACCR
254	Birthplace--Country	472	474	3	R*	R	R	R	R	R	R	NAACCR
1847	FollowUp Contact--Country	475	477	3	.	.	.	.	.	.	.	NAACCR
1942	Place of Death--State	478	479	2	R	.	.	R*	R*	D	D	NAACCR
1944	Place of Death--Country	480	482	3	R*	.	.	R*	R*	D	D	NAACCR
272	Census Ind Code 2010 CDC	483	486	4	R*	.	.	.	.	.	.	Census/NPCR

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
282	Census Occ Code 2010 CDC	487	490	4	R*	.	.	.	.	.	.	Census/NPCR
145	Census Tr Poverty Indictr	491	491	1	R	.	.	D	R	.	.	NAACCR
530	Reserved 02	492	541	50								
380	Sequence Number--Central	542	543	2	R	.	.	R	R	D	D	SEER
390	Date of Diagnosis	544	551	8	R	R	R	R	R	R	R*	SEER/CoC
391	Date of Diagnosis Flag	552	553	2	R	.	.	R	R	.	.	NAACCR
400	Primary Site	554	557	4	R	R	R	R	R	R	R	SEER/CoC
410	Laterality	558	558	1	R	R	R	R	R	R	R	SEER/CoC
419	Morph--Type&Behav ICD-O-2	559	563	5	.	.	.	.	.	.	.	
420	Histology (92-00) ICD-O-2	559	562	4	RH	RH	RH	RH	RH	RH	RH	SEER/CoC
430	Behavior (92-00) ICD-O-2	563	563	1	RH	RH	RH	RH	RH	RH	RH	SEER/CoC
521	Morph--Type&Behav ICD-O-3	564	568	5	.	.	.	.	.	.	.	
522	Histologic Type ICD-O-3	564	567	4	R	R	R	R	R	R	R	SEER/CoC
523	Behavior Code ICD-O-3	568	568	1	R	R	R	R	R	R	R	SEER/CoC
440	Grade	569	569	1	R	RH	RH	RH	RH	RH	RH	SEER/CoC
441	Grade Path Value	570	570	1	RH*	RH	RH	RH	RH	.	.	AJCC
449	Grade Path System	571	571	1	RH*	RH	RH	RH	RH	.	.	AJCC
450	Site Coding Sys--Current	572	572	1	R	R	R	.	.	.	.	NAACCR
460	Site Coding Sys--Original	573	573	1	.	R	R	.	.	R*	R*	NAACCR
470	Morph Coding Sys--Current	574	574	1	R	R	R	.	.	.	.	NAACCR
480	Morph Coding Sys--Originl	575	575	1	.	R	R	.	.	R*	R*	NAACCR
490	Diagnostic Confirmation	576	576	1	R	R	R	R	R	R	R	SEER/CoC
500	Type of Reporting Source	577	577	1	R	.	.	R	R	.	.	SEER
501	Casefinding Source	578	579	2	R*	.	.	.	.	.	.	NAACCR
442	Ambiguous Terminology DX	580	580	1	.	RH	RH	RH	RH	.	.	SEER
443	Date Conclusive DX	581	588	8	.	RH	RH	RH	RH	.	.	SEER
448	Date Conclusive DX Flag	589	590	2	.	RH	RH	RH	RH	.	.	NAACCR
444	Mult Tum Rpt as One Prim	591	592	2	.	RH	RH	RH	RH	.	.	SEER

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
445	Date of Mult Tumors	593	600	8	.	RH	RH	RH	RH	.	.	SEER
439	Date of Mult Tumors Flag	601	602	2	.	RH	RH	RH	RH	.	.	NAACCR
446	Multiplicity Counter	603	604	2	.	RH	RH	RH	RH	.	.	SEER
680	Reserved 03	605	704	100								
545	NPI--Reporting Facility	705	714	10	R*	R	R	R*	.	.	.	CMS
540	Reporting Facility	715	724	10	R	R	R	R	.	.	.	CoC
3105	NPI--Archive FIN	725	734	10	.	R	R	.	.	.	.	CMS
3100	Archive FIN	735	744	10	.	R	R	.	.	.	.	CoC
550	Accession Number--Hosp	745	753	9	.	R	R	R	.	.	.	CoC
560	Sequence Number--Hospital	754	755	2	.	R	R	R	.	.	.	CoC
570	Abstracted By	756	758	3	.	R	R	R	.	.	.	CoC
580	Date of 1st Contact	759	766	8	R	R	R	.	.	.	.	CoC
581	Date of 1st Contact Flag	767	768	2	R	R	R	.	.	.	.	NAACCR
590	Date of Inpt Adm	769	776	8	.	.	.	.	.	.	.	NAACCR
591	Date of Inpt Adm Flag	777	778	2	.	.	.	.	.	.	.	NAACCR
600	Date of Inpt Disch	779	786	8	.	.	.	.	.	.	.	NAACCR
601	Date of Inpt Disch Flag	787	788	2	.	.	.	.	.	.	.	NAACCR
605	Inpatient Status	789	789	1	.	.	.	.	.	.	.	NAACCR
610	Class of Case	790	791	2	R	R	R	RC	.	.	.	CoC
630	Primary Payer at DX	792	793	2	R*	R	R	R	R	.	.	CoC
668	RX Hosp--Surg App 2010	794	794	1	.	R	R	.	.	.	.	CoC
670	RX Hosp--Surg Prim Site	795	796	2	.	R	R	R	.	.	.	CoC
672	RX Hosp--Scope Reg LN Sur	797	797	1	.	R	R	R	.	.	.	CoC
674	RX Hosp--Surg Oth Reg/Dis	798	798	1	.	R	R	R	.	.	.	CoC
676	RX Hosp--Reg LN Removed	799	800	2	.	RH	RH	.	.	.	.	CoC
690	RX Hosp--Radiation	801	801	1	.	.	.	RH	.	.	.	SEER
700	RX Hosp--Chemo	802	803	2	.	R	R	R	.	.	.	CoC
710	RX Hosp--Hormone	804	805	2	.	R	R	R	.	.	.	CoC

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
720	RX Hosp--BRM	806	807	2	.	R	R	R	.	.	.	CoC
730	RX Hosp--Other	808	808	1	.	R	R	R	.	.	.	CoC
740	RX Hosp--DX/Stg Proc	809	810	2	.	R	R	.	.	.	.	CoC
3280	RX Hosp--Palliative Proc	811	811	1	.	R	R	.	.	.	.	CoC
746	RX Hosp--Surg Site 98-02	812	813	2	.	RH	RH	RH	.	.	.	CoC
747	RX Hosp--Scope Reg 98-02	814	814	1	.	RH	RH	RH	.	.	.	CoC
748	RX Hosp--Surg Oth 98-02	815	815	1	.	RH	RH	RH	.	.	.	CoC
750	Reserved 04	816	865	50								
930	TNM Path Staged By	866	867	2	.	RH	RH	RH	RH	.	.	CoC
990	TNM Clin Staged By	868	869	2	.	RH	RH	RH	RH	.	.	CoC
1112	Mets at DX-Bone	870	870	1	.	R	R	R	R	R*	R*	SEER
1113	Mets at DX-Brain	871	871	1	.	R	R	R	R	R*	R*	SEER
1114	Mets at Dx-Distant LN	872	872	1	.	R	R	R	R	R*	R*	SEER
1115	Mets at DX-Liver	873	873	1	.	R	R	R	R	R*	R*	SEER
1116	Mets at DX-Lung	874	874	1	.	R	R	R	R	R*	R*	SEER
1117	Mets at DX-Other	875	875	1	.	R	R	R	R	R*	R*	SEER
752	Tumor Size Clinical	876	878	3	.	.	.	R	R	R*	R*	SEER
754	Tumor Size Pathologic	879	881	3	.	.	.	R	R	R*	R*	SEER
756	Tumor Size Summary	882	884	3	R	R	R	S	S	.	.	NPCR/CoC
3605	Derived SEER Path Stg Grp	885	889	5	.	.	.	DH	RH	.	.	SEER
3610	Derived SEER Clin Stg Grp	890	894	5	.	.	.	DH	RH	.	.	SEER
3614	Derived SEER Cmb Stg Grp	895	899	5	.	.	.	DH	RH	.	.	SEER
3616	Derived SEER Combined T	900	904	5	.	.	.	DH	RH	.	.	SEER
3618	Derived SEER Combined N	905	909	5	.	.	.	DH	RH	.	.	SEER
3620	Derived SEER Combined M	910	914	5	.	.	.	DH	RH	.	.	SEER
3622	Derived SEER Cmb T Src	915	915	1	.	.	.	DH	RH	.	.	SEER
3624	Derived SEER Cmb N Src	916	916	1	.	.	.	DH	RH	.	.	SEER
3626	Derived SEER Cmb M Src	917	917	1	.	.	.	DH	RH	.	.	SEER

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
772	EOD Primary Tumor	918	920	3	.	.	.	R	R	.	.	SEER
774	EOD Regional Nodes	921	923	3	.	.	.	R	R	.	.	SEER
776	EOD Mets	924	925	2	.	.	.	R	R	.	.	SEER
785	Derived EOD 2018 T	926	940	15	RN	.	.	D	R	.	.	SEER
815	Derived EOD 2018 N	941	955	15	RN	.	.	D	R	.	.	SEER
795	Derived EOD 2018 M	956	970	15	RN	.	.	D	R	.	.	SEER
818	Derived EOD 2018 Stage Group	971	985	15	RN	.	.	D	R	.	.	SEER
762	Derived Summary Stage 2018	986	986	1	RN	.	.	D	R	.	.	SEER
764	Summary Stage 2018	987	987	1	R	R	R	R*	R*	.	.	SEER
759	SEER Summary Stage 2000	988	988	1	R	RH	RH	RH	RH	.	.	SEER
760	SEER Summary Stage 1977	989	989	1	RH	RH	RH	.	S	.	.	SEER
779	Extent of Disease 10-Dig	990	1001	12	RN	.	.	.	.	.	.	
780	EOD--Tumor Size	990	992	3	RN	RH	RH	RH	RH	.	.	SEER/CoC
790	EOD--Extension	993	994	2	RN	.	.	RH	RH	.	.	SEER
800	EOD--Extension Prost Path	995	996	2	RN	.	.	RH	RH	.	.	SEER
810	EOD--Lymph Node Involv	997	997	1	.	.	.	RH	RH	.	.	SEER
820	Regional Nodes Positive	998	999	2	R	R	R	R	R	R*	R*	SEER/CoC
830	Regional Nodes Examined	1000	1001	2	R	R	R	R	R	R*	R*	SEER/CoC
682	Date Regional Lymph Node Dissection	1002	1009	8	.	R	R	RC	RC	.	.	NAACCR
683	Date Regional Lymph Node Dissection Flag	1010	1011	2	.	.	.	RC	RC	.	.	NAACCR
835	Sentinel Lymph Nodes Positive	1012	1013	2	.	RS	RS	R*	R*	.	.	CoC
834	Sentinel Lymph Nodes Examined	1014	1015	2	.	RS	RS	R*	R*	.	.	CoC
832	Date of Sentinel Lymph Node Biopsy	1016	1023	8	.	RS	RS	R*	R*	.	.	CoC
833	Date Sentinel Lymph Node Biopsy Flag	1024	1025	2	.	RS	RS	R*	R*	.	.	CoC
840	EOD--Old 13 Digit	1026	1038	13	.	.	.	RH	RH	.	.	SEER
850	EOD--Old 2 Digit	1039	1040	2	.	.	.	RH	RH	.	.	SEER
860	EOD--Old 4 Digit	1041	1044	4	.	.	.	RH	RH	.	.	SEER
870	Coding System for EOD	1045	1045	1	.	.	.	RH	RH	.	.	SEER

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
1060	TNM Edition Number	1046	1047	2	R	RH	RH	RH	RH	R	R	CoC
880	TNM Path T	1048	1051	4	RH	RH	RH	RH	RH	.	.	AJCC
890	TNM Path N	1052	1055	4	RH	RH	RH	RH	RH	.	.	AJCC
900	TNM Path M	1056	1059	4	RH	RH	RH	RH	RH	.	.	AJCC
910	TNM Path Stage Group	1060	1063	4	RH	RH	RH	RH*	RH*	.	.	AJCC
920	TNM Path Descriptor	1064	1064	1	RH	RH	RH	RH	RH	.	.	CoC
940	TNM Clin T	1065	1068	4	RH	RH	RH	RH	RH	.	.	AJCC
950	TNM Clin N	1069	1072	4	RH	RH	RH	RH	RH	.	.	AJCC
960	TNM Clin M	1073	1076	4	RH	RH	RH	RH	RH	.	.	AJCC
970	TNM Clin Stage Group	1077	1080	4	RH	RH	RH	RH*	RH*	.	.	AJCC
980	TNM Clin Descriptor	1081	1081	1	RH	RH	RH	RH	RH	.	.	CoC
1001	AJCC TNM Clin T	1082	1096	15	RN	R	R	R*	R*	R*	R*	AJCC
1031	AJCC TNM Clin T Suffix	1097	1100	4	RN	.	.	R*	R*	R*	R*	AJCC
1002	AJCC TNM Clin N	1101	1115	15	RN	R	R	R*	R*	R*	R*	AJCC
1034	AJCC TNM Clin N Suffix	1116	1119	4	RN	.	.	R*	R*	R*	R*	AJCC
1003	AJCC TNM Clin M	1120	1134	15	RN	R	R	R*	R*	R*	R*	AJCC
1004	AJCC TNM Clin Stage Group	1135	1149	15	RN	R	R	R*	R*	R*	R*	AJCC
1011	AJCC TNM Path T	1150	1164	15	RN	R	R	R*	R*	R*	R*	AJCC
1032	AJCC TNM Path T Suffix	1165	1168	4	RN	.	.	R*	R*	R*	R*	AJCC
1012	AJCC TNM Path N	1169	1183	15	RN	.	.	R*	R*	R*	R*	AJCC
1035	AJCC TNM Path N Suffix	1184	1187	4	RN	.	.	R*	R*	R*	R*	AJCC
1013	AJCC TNM Path M	1188	1202	15	RN	R	R	R*	R*	R*	R*	AJCC
1014	AJCC TNM Path Stage Group	1203	1217	15	RN	R	R	R*	R*	R*	R*	AJCC
1021	AJCC TNM Post Therapy T	1218	1232	15	RN	R	R	R*	R*	R*	R*	AJCC
1033	AJCC TNM Post Therapy T Suffix	1233	1236	4	RN	.	.	R*	R*	R*	R*	AJCC
1022	AJCC TNM Post Therapy N	1237	1251	15	RN	R	R	R*	R*	R*	R*	AJCC
1036	AJCC TNM Post Therapy N Suffix	1252	1255	4	RN	.	.	R*	R*	R*	R*	AJCC
1023	AJCC TNM Post Therapy M	1256	1270	15	RN	R	R	R*	R*	R*	R*	AJCC

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
1024	AJCC TNM Post Therapy Stage Group	1271	1285	15	RN	R	R	R*	R*	R*	R*	AJCC
3843	Grade Clinical	1286	1286	1	RN	R	R	R	R	R*	R*	NAACCR
3844	Grade Pathological	1287	1287	1	RN	R	R	R	R	R*	R*	NAACCR
3845	Grade Post Therapy	1288	1288	1	.	R	R	RS	RS	R*	R*	NAACCR
1120	Pediatric Stage	1289	1290	2	.	.	.	.	.	.	.	CoC
1130	Pediatric Staging System	1291	1292	2	.	.	.	.	.	.	.	CoC
1140	Pediatric Staged By	1293	1293	1	.	.	.	.	.	.	.	CoC
1150	Tumor Marker 1	1294	1294	1	.	RH	RH	RH	RH	.	.	SEER
1160	Tumor Marker 2	1295	1295	1	.	RH	RH	RH	RH	.	.	SEER
1170	Tumor Marker 3	1296	1296	1	.	RH	RH	RH	RH	.	.	SEER
1182	Lymph-vascular Invasion	1297	1297	1	R*	R	R	RS	RS	R*	R*	AJCC
2800	CS Tumor Size	1298	1300	3	RH*	RH	RH	RH*	RH*	RH*	RH*	AJCC
2810	CS Extension	1301	1303	3	RH*	RH	RH	RH*	RH*	RH*	RH*	AJCC
2820	CS Tumor Size/Ext Eval	1304	1304	1	RH*	RH	RH	RH*	RH*	RH*	RH*	AJCC
2830	CS Lymph Nodes	1305	1307	3	RH*	RH	RH	RH*	RH*	RH*	RH*	AJCC
2840	CS Lymph Nodes Eval	1308	1308	1	RH*	RH	RH	RH*	RH*	RH*	RH*	AJCC
2850	CS Mets at DX	1309	1310	2	RH*	RH	RH	RH*	RH*	RH*	RH*	AJCC
2860	CS Mets Eval	1311	1311	1	RH*	RH	RH	RH*	RH*	RH*	RH*	AJCC
2851	CS Mets at Dx-Bone	1312	1312	1	.	RH	RH	RH	RH	RH*	RH*	AJCC
2852	CS Mets at Dx-Brain	1313	1313	1	.	RH	RH	RH	RH	RH*	RH*	AJCC
2853	CS Mets at Dx-Liver	1314	1314	1	.	RH	RH	RH	RH	RH*	RH*	AJCC
2854	CS Mets at Dx-Lung	1315	1315	1	.	RH	RH	RH	RH	RH*	RH*	AJCC
2880	CS Site-Specific Factor 1	1316	1318	3	RS*	RH	RH	RH	RH	RH*	RH*	AJCC
2890	CS Site-Specific Factor 2	1319	1321	3	RS*	RH	RH	RH	RH	RH*	RH*	AJCC
2900	CS Site-Specific Factor 3	1322	1324	3	RH*	RH	RH	RH	RH	RH*	RH*	AJCC
2910	CS Site-Specific Factor 4	1325	1327	3	RH*	RH	RH	RH	RH	RH*	RH*	AJCC
2920	CS Site-Specific Factor 5	1328	1330	3	RS*	RH	RH	RH	RH	RH*	RH*	AJCC
2930	CS Site-Specific Factor 6	1331	1333	3	RS*	RH	RH	RH	RH	RH*	RH*	AJCC

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
2861	CS Site-Specific Factor 7	1334	1336	3	RH*	RH	RH	RH	RH	RH*	RH*	AJCC
2862	CS Site-Specific Factor 8	1337	1339	3	RS*	RH	RH	RH	RH	RH*	RH*	AJCC
2863	CS Site-Specific Factor 9	1340	1342	3	RS*	RH	RH	RH	RH	RH*	RH*	AJCC
2864	CS Site-Specific Factor10	1343	1345	3	RS*	RH	RH	RH	RH	RH*	RH*	AJCC
2865	CS Site-Specific Factor11	1346	1348	3	RS*	RH	RH	RH	RH	RH*	RH*	AJCC
2866	CS Site-Specific Factor12	1349	1351	3	RH*	RH	RH	RH	RH	RH*	RH*	AJCC
2867	CS Site-Specific Factor13	1352	1354	3	RS*	RH	RH	RH	RH	RH*	RH*	AJCC
2868	CS Site-Specific Factor14	1355	1357	3	RS*	RH	RH	RH	RH	RH*	RH*	AJCC
2869	CS Site-Specific Factor15	1358	1360	3	RS*	RH	RH	RH	RH	RH*	RH*	AJCC
2870	CS Site-Specific Factor16	1361	1363	3	RS*	RH	RH	RH	RH	RH*	RH*	AJCC
2871	CS Site-Specific Factor17	1364	1366	3	RH*	RH	RH	RH	RH	RH*	RH*	AJCC
2872	CS Site-Specific Factor18	1367	1369	3	.	RH	RH	RH	RH	RH*	RH*	AJCC
2873	CS Site-Specific Factor19	1370	1372	3	.	RH	RH	RH	RH	RH*	RH*	AJCC
2874	CS Site-Specific Factor20	1373	1375	3	.	RH	RH	RH	RH	RH*	RH*	AJCC
2875	CS Site-Specific Factor21	1376	1378	3	.	RH	RH	RH	RH	RH*	RH*	AJCC
2876	CS Site-Specific Factor22	1379	1381	3	.	RH	RH	RH	RH	RH*	RH*	AJCC
2877	CS Site-Specific Factor23	1382	1384	3	.	RS	RS	RH	RH	RH*	RH*	AJCC
2878	CS Site-Specific Factor24	1385	1387	3	.	RH	RH	RH	RH	RH*	RH*	AJCC
2879	CS Site-Specific Factor25	1388	1390	3	RS*	RH	RH	RH	RH	RH*	RH*	AJCC
2940	Derived AJCC-6 T	1391	1392	2	.	DH	DH	DH	RH	DH	DH	AJCC
2950	Derived AJCC-6 T Descript	1393	1393	1	.	DH	DH	DH	RH	DH	DH	AJCC
2960	Derived AJCC-6 N	1394	1395	2	.	DH	DH	DH	RH	DH	DH	AJCC
2970	Derived AJCC-6 N Descript	1396	1396	1	.	DH	DH	DH	RH	DH	DH	AJCC
2980	Derived AJCC-6 M	1397	1398	2	.	DH	DH	DH	RH	DH	DH	AJCC
2990	Derived AJCC-6 M Descript	1399	1399	1	.	DH	DH	DH	RH	DH	DH	AJCC
3000	Derived AJCC-6 Stage Grp	1400	1401	2	.	DH	DH	DH	RH	DH	DH	AJCC
3400	Derived AJCC-7 T	1402	1404	3	RH*	DH	DH	DH	RH	DH	DH	AJCC
3402	Derived AJCC-7 T Descript	1405	1405	1	RH*	DH	DH	DH	RH	DH	DH	AJCC

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
3410	Derived AJCC-7 N	1406	1408	3	RH*	DH	DH	DH	RH	DH	DH	AJCC
3412	Derived AJCC-7 N Descript	1409	1409	1	RH*	DH	DH	DH	RH	DH	DH	AJCC
3420	Derived AJCC-7 M	1410	1412	3	RH*	DH	DH	DH	RH	DH	DH	AJCC
3422	Derived AJCC-7 M Descript	1413	1413	1	RH*	DH	DH	DH	RH	DH	DH	AJCC
3430	Derived AJCC-7 Stage Grp	1414	1416	3	RH*	DH	DH	DH	RH	DH	DH	AJCC
3440	Derived PreRx-7 T	1417	1419	3	.	.	.	.	.	.	.	AJCC
3442	Derived PreRx-7 T Descrip	1420	1420	1	.	.	.	.	.	.	.	AJCC
3450	Derived PreRx-7 N	1421	1423	3	.	.	.	.	.	.	.	AJCC
3452	Derived PreRx-7 N Descrip	1424	1424	1	.	.	.	.	.	.	.	AJCC
3460	Derived PreRx-7 M	1425	1427	3	.	.	.	.	.	.	.	AJCC
3462	Derived PreRx-7 M Descrip	1428	1428	1	.	.	.	.	.	.	.	AJCC
3470	Derived PreRx-7 Stage Grp	1429	1431	3	.	.	.	.	.	.	.	AJCC
3480	Derived PostRx-7 T	1432	1434	3	.	.	.	.	.	.	.	AJCC
3482	Derived PostRx-7 N	1435	1437	3	.	.	.	.	.	.	.	AJCC
3490	Derived PostRx-7 M	1438	1439	2	.	.	.	.	.	.	.	AJCC
3492	Derived PostRx-7 Stge Grp	1440	1442	3	.	.	.	.	.	.	.	AJCC
3010	Derived SS1977	1443	1443	1	.	DH	DH	D*	S	DH	DH	AJCC
3020	Derived SS2000	1444	1444	1	RH*	DH	DH	D+	R+	DH	DH	AJCC
3600	Derived Neoadjuv Rx Flag	1445	1445	1	.	.	.	.	.	.	.	AJCC
3030	Derived AJCC--Flag	1446	1446	1	.	DH	DH	DH	RH	.	.	AJCC
3040	Derived SS1977--Flag	1447	1447	1	.	DH	DH	D*	S	.	.	AJCC
3050	Derived SS2000--Flag	1448	1448	1	RH*	DH	DH	D*	S	.	.	AJCC
3650	NPCR Derived Clin Stg Grp	1449	1452	4	R	.	.	.	.	.	.	NPCR
3655	NPCR Derived Path Stg Grp	1453	1456	4	R	.	.	.	.	.	.	NPCR
3645	NPCR Derived AJCC 8 TNM Clin Stg Grp	1457	1471	15	RN	.	.	.	.	R*	R*	NPCR
3646	NPCR Derived AJCC 8 TNM Path Stg Grp	1472	1486	15	RN	.	.	.	.	R*	R*	NPCR
3647	NPCR Derived AJCC 8 TNM Post Therapy Stg Grp	1487	1501	15	.	.	.	.	.	R*	R*	NPCR
2937	CS Version Input Current	1502	1507	6	R*	RH	RH	RH*	RH*	RH*	RH*	AJCC

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
2935	CS Version Input Original	1508	1513	6	R*	RH	RH	RH*	RH*	RH*	RH*	AJCC
2936	CS Version Derived	1514	1519	6	RH*	DH	DH	D*	DH*	DH	DH	AJCC
3700	SEER Site-Specific Fact 1	1520	1520	1	.	.	.	R	R	.	.	SEER
3702	SEER Site-Specific Fact 2	1521	1521	1	.	.	.	.	.	.	.	SEER
3704	SEER Site-Specific Fact 3	1522	1522	1	.	.	.	.	.	.	.	SEER
3706	SEER Site-Specific Fact 4	1523	1523	1	.	.	.	.	.	.	.	SEER
3708	SEER Site-Specific Fact 5	1524	1524	1	.	.	.	.	.	.	.	SEER
3710	SEER Site-Specific Fact 6	1525	1525	1	.	.	.	.	.	.	.	SEER
3165	ICD Revision Comorbid	1526	1526	1	.	.	.	.	.	.	.	CoC
3110	Comorbid/Complication 1	1527	1531	5	.	RH	RH	.	.	.	.	CoC
3120	Comorbid/Complication 2	1532	1536	5	.	RH	RH	.	.	.	.	CoC
3130	Comorbid/Complication 3	1537	1541	5	.	RH	RH	.	.	.	.	CoC
3140	Comorbid/Complication 4	1542	1546	5	.	RH	RH	.	.	.	.	CoC
3150	Comorbid/Complication 5	1547	1551	5	.	RH	RH	.	.	.	.	CoC
3160	Comorbid/Complication 6	1552	1556	5	.	RH	RH	.	.	.	.	CoC
3161	Comorbid/Complication 7	1557	1561	5	.	RH	RH	.	.	.	.	CoC
3162	Comorbid/Complication 8	1562	1566	5	.	RH	RH	.	.	.	.	CoC
3163	Comorbid/Complication 9	1567	1571	5	.	RH	RH	.	.	.	.	CoC
3164	Comorbid/Complication 10	1572	1576	5	.	RH	RH	.	.	.	.	CoC
3780	Secondary Diagnosis 1	1577	1583	7	.	RH	RH	.	.	.	.	CoC
3782	Secondary Diagnosis 2	1584	1590	7	.	RH	RH	.	.	.	.	CoC
3784	Secondary Diagnosis 3	1591	1597	7	.	RH	RH	.	.	.	.	CoC
3786	Secondary Diagnosis 4	1598	1604	7	.	RH	RH	.	.	.	.	CoC
3788	Secondary Diagnosis 5	1605	1611	7	.	RH	RH	.	.	.	.	CoC
3790	Secondary Diagnosis 6	1612	1618	7	.	RH	RH	.	.	.	.	CoC
3792	Secondary Diagnosis 7	1619	1625	7	.	RH	RH	.	.	.	.	CoC
3794	Secondary Diagnosis 8	1626	1632	7	.	RH	RH	.	.	.	.	CoC
3796	Secondary Diagnosis 9	1633	1639	7	.	RH	RH	.	.	.	.	CoC

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
3798	Secondary Diagnosis 10	1640	1646	7	.	RH	RH	.	.	.	.	CoC
3720	NPCR Specific Field	1647	1721	75	R	.	.	.	.	.	.	NPCR
995	AJCC ID	1722	1725	4	D	D	R	R*	R*	.	.	NAACCR
3800	Schema ID	1726	1730	5	D	D	D	D	R	.	.	NAACCR
3926	Schema Discriminator 1	1731	1731	1	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3927	Schema Discriminator 2	1732	1732	1	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3928	Schema Discriminator 3	1733	1733	1	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3908	Percent Necrosis Post Neoadjuvant	1734	1738	5	.	RS	RS	RC	RC	RS*	RS*	NAACCR
2400	Reserved 15	1739	1739	1								
3801	Chromosome 1p: Loss of Heterozygosity (LOH)	1740	1740	1	.	RS	RS	RS	RS	.	.	NAACCR
3802	Chromosome 19q: Loss of Heterozygosity (LOH)	1741	1741	1	.	RS	RS	RS	RS	.	.	NAACCR
3889	Methylation of O6-Methylguanine-Methyltransferase	1742	1742	1	.	RS	RS	RS	RS	.	.	NAACCR
3827	Estrogen Receptor Summary	1743	1743	1	R	RS	RS	RS	RS	RS*	RS*	NAACCR
3855	HER2 Overall Summary	1744	1744	1	R	RS	RS	RS	RS	RS*	RS*	NAACCR
3882	LN Positive Axillary Level I-II	1745	1746	2	RN	RS	RS	RS	RS	.	.	NAACCR
3894	Multigene Signature Method	1747	1747	1	.	RS	RS	RS	RS	.	.	NAACCR
3895	Multigene Signature Results	1748	1749	2	RN	RS	RS	RS	RS	.	.	NAACCR
3915	Progesterone Receptor Summary	1750	1750	1	R	RS	RS	RS	RS	RS*	RS*	NAACCR
3922	Response to Neoadjuvant Therapy	1751	1751	1	.	RS	RS	RC	RC	.	.	NAACCR
3826	Estrogen Receptor Percent Positive or Range	1752	1754	3	RN	.	.	RC	RC	.	.	NAACCR
3828	Estrogen Receptor Total Allred Score	1755	1756	2	RN	RS	RS	RC	RC	.	.	NAACCR
3850	HER2 IHC Summary	1757	1757	1	.	RS	RS	RS*	RS*	RS*	RS*	NAACCR
3851	HER2 ISH Dual Probe Copy Number	1758	1761	4	.	RS	RS	RS*	RS*	.	.	NAACCR
3852	HER2 ISH Dual Probe Ratio	1762	1765	4	.	RS	RS	RS*	RS*	.	.	NAACCR
3853	HER2 ISH Single Probe Copy Number	1766	1769	4	.	RS	RS	RS*	RS*	.	.	NAACCR
3854	HER2 ISH Summary	1770	1770	1	.	RS	RS	RS*	RS*	RS*	RS*	NAACCR
3863	Ki-67	1771	1775	5	.	RS	RS	RC	RC	.	.	NAACCR
3903	Oncotype Dx Recurrence Score-DCIS	1776	1778	3	.	RS	RS	RC	RC	.	.	NAACCR

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
3904	Oncotype Dx Recurrence Score-Invasive	1779	1781	3	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3905	Oncotype Dx Risk Level-DCIS	1782	1782	1	.	RS	RS	RC	RC	.	.	NAACCR
3906	Oncotype Dx Risk Level-Invasive	1783	1783	1	RN	RS	RS	RC	RC	.	.	NAACCR
3914	Progesterone Receptor Percent Positive or Range	1784	1786	3	RN	RS	RS	RC	RC	.	.	NAACCR
3916	Progesterone Receptor Total Allred Score	1787	1788	2	RN	RS	RS	RC	RC	.	.	NAACCR
3819	CEA Pretreatment Interpretation	1789	1789	1	.	RS	RS	RS	RS	RS*	RS*	NAACCR
3820	CEA Pretreatment Lab Value	1790	1795	6	.	RS	RS	RS	RS	.	.	NAACCR
3823	Circumferential Resection Margin (CRM)	1796	1799	4	.	RS	RS	RS	RS	RS*	RS*	NAACCR
3866	KRAS	1800	1800	1	.	RS	RS	RS	RS	.	.	NAACCR
3890	Microsatellite Instability (MSI)	1801	1801	1	RS*	RS	RS	RS	RS	RS*	RS*	NAACCR
3909	Perineural Invasion	1802	1802	1	.	RS	RS	RS	RS	.	.	NAACCR
3934	Tumor Deposits	1803	1804	2	.	RS	RS	RS	RS	.	.	NAACCR
3901	Number of Positive Para-Aortic Nodes	1805	1806	2	.	RS	RS	RC	RC	.	.	NAACCR
3899	Number of Examined Para-Aortic Nodes	1807	1808	2	.	RS	RS	RC	RC	.	.	NAACCR
3902	Number of Positive Pelvic Nodes	1809	1810	2	.	RS	RS	RC	RC	.	.	NAACCR
3900	Number of Examined Pelvic Nodes	1811	1812	2	.	RS	RS	RC	RC	.	.	NAACCR
3911	Peritoneal Cytology	1813	1813	1	RN	RS	RS	RS	RS	.	.	NAACCR
3829	Esophagus and EGJ Tumor Epicenter	1814	1814	1	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3865	KIT Gene Immunohistochemistry	1815	1815	1	RN	RS	RS	RC	RC	RS*	RS*	NAACCR
3836	FIGO Stage	1816	1817	2	.	RS	RS	RS	RS	.	.	NAACCR
3831	Extranodal Extension Head and Neck Clinical	1818	1818	1	.	RS	RS	RC	RC	.	.	NAACCR
3832	Extranodal Extension Head and Neck Pathological	1819	1821	3	.	RS	RS	RS	RS	RS*	RS*	NAACCR
3876	LN Head and Neck Levels I-III	1822	1822	1	.	RS	RS	RS	RS	.	.	NAACCR
3877	LN Head and Neck Levels IV-V	1823	1823	1	.	RS	RS	RS	RS	.	.	NAACCR
3878	LN Head and Neck Levels VI-VII	1824	1824	1	.	RS	RS	RS	RS	.	.	NAACCR
3879	LN Head and Neck Other	1825	1825	1	.	RS	RS	RS	RS	.	.	NAACCR
3883	LN Size	1826	1829	4	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3862	JAK2	1830	1830	1	.	RS	RS	RS	RS	.	.	NAACCR

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
3917	Primary Sclerosing Cholangitis	1831	1831	1	RN	RS	RS	RC	RC	.	.	NAACCR
3935	Tumor Growth Pattern	1832	1832	1	.	RS	RS	RS	RS	.	.	NAACCR
3861	Ipsilateral Adrenal Gland Involvement	1833	1833	1	.	RS	RS	RS	RS	.	.	NAACCR
3864	Invasion Beyond Capsule	1834	1834	1	.	RS	RS	RS	RS	.	.	NAACCR
3886	Major Vein Involvement	1835	1835	1	.	RS	RS	RS	RS	.	.	NAACCR
3925	Sarcomatoid Features	1836	1838	3	.	RS	RS	RS	RS	.	.	NAACCR
3803	Adenoid Cystic Basaloid Pattern	1839	1843	5	.	RS	RS	RS	RS	.	.	NAACCR
3809	AFP Pretreatment Interpretation	1844	1844	1	RN	RS	RS	RC	RC	RS*	RS*	NAACCR
3810	AFP Pretreatment Lab Value	1845	1850	6	.	RS	RS	RC	RC	.	.	NAACCR
3813	Bilirubin Pretreatment Total Lab Value	1851	1855	5	.	RS	RS	RC	RC	.	.	NAACCR
3814	Bilirubin Pretreatment Unit of Measure	1856	1856	1	.	RS	RS	RC	RC	.	.	NAACCR
3824	Creatinine Pretreatment Lab Value	1857	1860	4	.	RS	RS	RC	RC	.	.	NAACCR
3825	Creatinine Pretreatment Unit of Measure	1861	1861	1	.	RS	RS	RS	RS	.	.	NAACCR
3835	Fibrosis Score	1862	1862	1	R	RS	RS	RC	RC	.	.	NAACCR
3860	International Normalized Ratio Prothrombin Time	1863	1865	3	.	RS	RS	RC	RC	.	.	NAACCR
3929	Separate Tumor Nodules	1866	1866	1	.	RS	RS	RS	RS	.	.	NAACCR
3937	Visceral and Parietal Pleural Invasion	1867	1867	1	.	RS	RS	RS	RS	.	.	NAACCR
3812	B symptoms	1868	1868	1	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3859	HIV Status	1869	1869	1	.	RS	RS	RS	RS	.	.	NAACCR
3896	NCCN International Prognostic Index (IPI)	1870	1871	2	.	RS	RS	RS	RS	.	.	NAACCR
3893	Mitotic Rate Melanoma	1872	1873	2	.	RS	RS	RS	RS	RS*	RS*	NAACCR
3821	Chromosome 3 Status	1874	1874	1	.	RS	RS	RC	RC	.	.	NAACCR
3822	Chromosome 8q Status	1875	1875	1	.	RS	RS	RC	RC	.	.	NAACCR
3834	Extravascular Matrix Patterns	1876	1876	1	.	RS	RS	RC	RC	.	.	NAACCR
3887	Measured Basal Diameter	1877	1880	4	RN	RS	RS	RS	RS	.	.	NAACCR
3888	Measured Thickness	1881	1884	4	RN	RS	RS	RS	RS	.	.	NAACCR
3891	Microvascular Density	1885	1886	2	.	RS	RS	RC	RC	.	.	NAACCR
3892	Mitotic Count Uveal Melanoma	1887	1890	4	.	RS	RS	RC	RC	.	.	NAACCR

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
3817	Breslow Tumor Thickness	1891	1894	4	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3870	LDH Upper Limits of Normal	1895	1897	3	R	RS	RS	RC	RC	.	.	NAACCR
3932	LDH Pretreatment Lab Value	1898	1904	7	R	RS	RS	RS	RS	.	.	NAACCR
3936	Ulceration	1905	1905	1	.	RS	RS	RS	RS	RS*	RS*	NAACCR
3880	LN Isolated Tumor Cells (ITC)	1906	1906	1	.	RS	RS	RS	RS	.	.	NAACCR
3918	Profound Immune Suppression	1907	1907	1	.	RS	RS	RS	RS	.	.	NAACCR
3910	Peripheral Blood Involvement	1908	1908	1	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3856	Heritable Trait	1909	1909	1	R	RS	RS	RS	RS	RS*	RS*	NAACCR
3804	Adenopathy	1910	1910	1	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3811	Anemia	1911	1911	1	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3885	Lymphocytosis	1912	1912	1	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3907	Organomegaly	1913	1913	1	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3933	Thrombocytopenia	1914	1914	1	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3857	High Risk Cytogenetics	1915	1915	1	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3869	LDH Pretreatment Level	1916	1916	1	R	RS	RS	RS	RS	RS*	RS*	NAACCR
3930	Serum Albumin Pretreatment Level	1917	1917	1	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3931	Serum Beta-2 Microglobulin Pretreatment Level	1918	1918	1	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3818	CA-125 Pretreatment Interpretation	1919	1919	1	.	RS	RS	RS	RS	RS*	RS*	NAACCR
3921	Residual Tumor Volume Post Cytoreduction	1920	1921	2	.	RS	RS	RS	RS	.	.	NAACCR
3830	Extranodal Extension Clin (non-Head and Neck)	1922	1922	1	.	RS	RS	RC	RC	.	.	NAACCR
3833	Extranodal Extension Path (non-Head and Neck)	1923	1923	1	.	RS	RS	RC	RC	.	.	NAACCR
3837	Gestational Trophoblastic Prognostic Scoring Index	1924	1925	2	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3913	Pleural Effusion	1926	1926	1	.	RS	RS	RS	RS	.	.	NAACCR
3838	Gleason Patterns Clinical	1927	1928	2	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3839	Gleason Patterns Pathological	1929	1930	2	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3840	Gleason Score Clinical	1931	1932	2	RN	RS	RS	RC	RC	RS*	RS*	NAACCR
3841	Gleason Score Pathological	1933	1934	2	RN	RS	RS	RC	RC	RS*	RS*	NAACCR
3842	Gleason Tertiary Pattern	1935	1936	2	RN	RS	RS	RC	RC	RS*	RS*	NAACCR

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
3897	Number of Cores Examined	1937	1938	2	.	RS	RS	RS	RS	RS*	RS*	NAACCR
3898	Number of Cores Positive	1939	1940	2	.	RS	RS	RS	RS	RS*	RS*	NAACCR
3919	Prostate Pathological Extension	1941	1943	3	.	RS	RS	RS	RS	.	.	NAACCR
3920	PSA (Prostatic Specific Antigen) Lab Value	1944	1948	5	RN	RS	RS	RS	RS	RS*	RS*	NAACCR
3858	High Risk Histologic Features	1949	1949	1	.	RS	RS	RS	RS	.	.	NAACCR
3815	Bone Invasion	1950	1950	1	.	RS	RS	RS	RS	.	.	NAACCR
3807	AFP Pre-Orchiectomy Lab Value	1951	1957	7	.	RS	RS	RC	RC	.	.	NAACCR
3808	AFP Pre-Orchiectomy Range	1958	1958	1	RN	RS	RS	RC	RC	.	.	NAACCR
3805	AFP Post-Orchiectomy Lab Value	1959	1965	7	.	RS	RS	RC	RC	.	.	NAACCR
3806	AFP Post-Orchiectomy Range	1966	1966	1	RN	RS	RS	RC	RC	.	.	NAACCR
3848	hCG Pre-Orchiectomy Lab Value	1967	1973	7	.	RS	RS	RC	RC	.	.	NAACCR
3849	hCG Pre-Orchiectomy Range	1974	1974	1	RN	RS	RS	RS	RS	.	.	NAACCR
3846	hCG Post-Orchiectomy Lab Value	1975	1981	7	.	RS	RS	RC	RC	.	.	NAACCR
3847	hCG Post-Orchiectomy Range	1982	1982	1	RN	RS	RS	RS	RS	.	.	NAACCR
3868	LDH Pre-Orchiectomy Range	1983	1983	1	R	RS	RS	RS	RS	.	.	NAACCR
3867	LDH Post-Orchiectomy Range	1984	1984	1	R	RS	RS	RS	RS	.	.	NAACCR
3923	S Category Clinical	1985	1985	1	.	RS	RS	RS	RS	RS*	RS*	NAACCR
3924	S Category Pathological	1986	1986	1	.	RS	RS	RS	RS	RS*	RS*	NAACCR
3872	LN Assessment Method Para-Aortic	1987	1987	1	.	RS	RS	RC	RC	.	.	NAACCR
3873	LN Assessment Method Pelvic	1988	1988	1	.	RS	RS	RC	RC	.	.	NAACCR
3874	LN Distant Assessment Method	1989	1989	1	.	RS	RS	RC	RC	.	.	NAACCR
3875	LN Distant: Mediastinal, Scalene	1990	1990	1	.	RS	RS	RC	RC	.	.	NAACCR
3884	LN Status Femoral-Inguinal, Para-Aortic, Pelvic	1991	1991	1	.	RS	RS	RS	RS	.	.	NAACCR
3871	LN Assessment Method Femoral-Inguinal	1992	1992	1	.	RS	RS	RC	RC	.	.	NAACCR
3881	LN Laterality	1993	1993	1	.	RS	RS	RS	RS	.	.	NAACCR
3816	Brain Molecular Markers	1994	1995	2	RN	.	.	RS	RS	.	.	NAACCR
1180	Reserved 05	1996	2093	98								
1260	Date Initial RX SEER	2094	2101	8	R#	.	.	R	R	.	.	SEER

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
1261	Date Initial RX SEER Flag	2102	2103	2	R#	.	.	R	R	.	.	NAACCR
1270	Date 1st Crs RX CoC	2104	2111	8	R#	R	R	.	.	.	.	CoC
1271	Date 1st Crs RX CoC Flag	2112	2113	2	R#	R	R	.	.	.	.	NAACCR
1200	RX Date Surgery	2114	2121	8	R	R	R	RC	RC	.	.	CoC
1201	RX Date Surgery Flag	2122	2123	2	R	R	R	RC	RC	.	.	NAACCR
3170	RX Date Mst Defn Srg	2124	2131	8	R	R	R	R*	R*	.	.	CoC
3171	RX Date Mst Defn Srg Flag	2132	2133	2	R	R	R	R*	R*	.	.	NAACCR
3180	RX Date Surg Disch	2134	2141	8	.	R	R	.	.	.	.	CoC
3181	RX Date Surg Disch Flag	2142	2143	2	.	R	R	.	.	.	.	NAACCR
1210	RX Date Radiation	2144	2151	8	R	R	R	RC	RC	.	.	CoC
1211	RX Date Radiation Flag	2152	2153	2	R	R	R	RC	RC	.	.	NAACCR
3220	RX Date Rad Ended	2154	2161	8	.	R	R	.	.	.	.	CoC
3221	RX Date Rad Ended Flag	2162	2163	2	.	R	R	.	.	.	.	NAACCR
3230	RX Date Systemic	2164	2171	8	.	R	R	RC	RC	.	.	CoC
3231	RX Date Systemic Flag	2172	2173	2	.	R	R	RC	RC	.	.	NAACCR
1220	RX Date Chemo	2174	2181	8	R	R	R	RC	RC	.	.	CoC
1221	RX Date Chemo Flag	2182	2183	2	R	R	R	RC	RC	.	.	NAACCR
1230	RX Date Hormone	2184	2191	8	R	R	R	RC	RC	.	.	CoC
1231	RX Date Hormone Flag	2192	2193	2	R	R	R	RC	RC	.	.	NAACCR
1240	RX Date BRM	2194	2201	8	R	R	R	RC	RC	.	.	CoC
1241	RX Date BRM Flag	2202	2203	2	R	R	R	RC	RC	.	.	NAACCR
1250	RX Date Other	2204	2211	8	R	R	R	RC	RC	.	.	CoC
1251	RX Date Other Flag	2212	2213	2	R	R	R	RC	RC	.	.	NAACCR
1280	RX Date DX/Stg Proc	2214	2221	8	.	R	R	.	.	.	.	CoC
1281	RX Date DX/Stg Proc Flag	2222	2223	2	.	R	R	.	.	.	.	NAACCR
1285	RX Summ--Treatment Status	2224	2224	1	R#	R	R	R	R	.	.	SEER/CoC
1290	RX Summ--Surg Prim Site	2225	2226	2	R	R	R	R	R	.	.	SEER/CoC
1292	RX Summ--Scope Reg LN Sur	2227	2227	1	R	R	R	R	R	.	.	SEER/CoC

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
1294	RX Summ--Surg Oth Reg/Dis	2228	2228	1	R	R	R	R	R	.	.	SEER/CoC
1296	RX Summ--Reg LN Examined	2229	2230	2	.	RH	RH	RH	RH	.	.	SEER/CoC
1310	RX Summ--Surgical Approch	2231	2231	1	.	RH	RH	.	.	.	.	CoC
1320	RX Summ--Surgical Margins	2232	2232	1	.	R	R	R*	R*	.	.	CoC
1330	RX Summ--Reconstruct 1st	2233	2233	1	.	RH	RH	RH	RH	.	.	SEER
1340	Reason for No Surgery	2234	2234	1	R	R	R	R	R	.	.	SEER/CoC
1350	RX Summ--DX/Stg Proc	2235	2236	2	.	R	R	.	.	.	.	CoC
3270	RX Summ--Palliative Proc	2237	2237	1	.	R	R	.	.	.	.	CoC
1360	RX Summ--Radiation	2238	2238	1	RH	.	.	RH	RH	.	.	SEER
1370	RX Summ--Rad to CNS	2239	2239	1	.	.	.	RH	RH	.	.	SEER/CoC
1380	RX Summ--Surg/Rad Seq	2240	2240	1	R	R	R	R	R	.	.	SEER/CoC
3250	RX Summ--Transplnt/Endocr	2241	2242	2	R	R	R	R	R	.	.	CoC
1390	RX Summ--Chemo	2243	2244	2	R	R	R	R	R	.	.	SEER/CoC
1400	RX Summ--Hormone	2245	2246	2	R	R	R	R	R	.	.	SEER/CoC
1410	RX Summ--BRM	2247	2248	2	R	R	R	R	R	.	.	SEER/CoC
1420	RX Summ--Other	2249	2249	1	R	R	R	R	R	.	.	SEER/CoC
1430	Reason for No Radiation	2250	2250	1	R	R	R	.	.	.	.	CoC
1460	RX Coding System--Current	2251	2252	2	R	R	R	.	RH	.	.	NAACCR
1510	Rad--Regional Dose: cGy	2253	2257	5	.	RH	RH	.	.	.	.	CoC
1520	Rad--No of Treatment Vol	2258	2260	3	.	RH	RH	.	.	.	.	CoC
1540	Rad--Treatment Volume	2261	2262	2	.	RH	RH	.	.	.	.	CoC
1550	Rad--Location of RX	2263	2263	1	.	RH	RH	.	.	.	.	CoC
1570	Rad--Regional RX Modality	2264	2265	2	R	RH	RH	RH	.	.	.	CoC
3200	Rad--Boost RX Modality	2266	2267	2	.	RH	RH	RC	.	.	.	CoC
3210	Rad--Boost Dose cGy	2268	2272	5	.	RH	RH	.	.	.	.	CoC
1639	RX Summ--Systemic/Sur Seq	2273	2273	1	R	R	R	R	R	.	.	CoC
1640	RX Summ--Surgery Type	2274	2275	2	.	.	.	RH	RH	.	.	SEER
3190	Readm Same Hosp 30 Days	2276	2276	1	.	R	R	.	.	.	.	CoC

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
1646	RX Summ--Surg Site 98-02	2277	2278	2	.	RH	RH	RH	RH	.	.	SEER/CoC
1647	RX Summ--Scope Reg 98-02	2279	2279	1	.	RH	RH	RH	RH	.	.	SEER/CoC
1648	RX Summ--Surg Oth 98-02	2280	2280	1	.	RH	RH	RH	RH	.	.	SEER/CoC
1504	Phase I Radiation Primary Treatment Volume	2281	2282	2	.	R	R	R*	R*	.	.	CoC
1505	Phase I Radiation to Draining Lymph Nodes	2283	2284	2	.	R	R	R*	R*	.	.	CoC
1506	Phase I Radiation Treatment Modality	2285	2286	2	R	R	R	R	R	.	.	CoC
1502	Phase I Radiation External Beam Planning Tech	2287	2288	2	.	R	R	R*	R*	.	.	CoC
1501	Phase I Dose per Fraction	2289	2293	5	.	R	R	R*	R*	.	.	CoC
1503	Phase I Number of Fractions	2294	2296	3	.	R	R	R*	R*	.	.	CoC
1507	Phase I Total Dose	2297	2302	6	.	R	R	R*	R*	.	.	CoC
1514	Phase II Radiation Primary Treatment Volume	2303	2304	2	.	R	R	R*	R*	.	.	CoC
1515	Phase II Radiation to Draining Lymph Nodes	2305	2306	2	.	R	R	R*	R*	.	.	CoC
1516	Phase II Radiation Treatment Modality	2307	2308	2	.	R	R	R	R	.	.	CoC
1512	Phase II Radiation External Beam Planning Tech	2309	2310	2	.	R	R	R*	R*	.	.	CoC
1511	Phase II Dose per Fraction	2311	2315	5	.	R	R	R*	R*	.	.	CoC
1513	Phase II Number of Fractions	2316	2318	3	.	R	R	R*	R*	.	.	CoC
1517	Phase II Total Dose	2319	2324	6	.	R	R	R*	R*	.	.	CoC
1524	Phase III Radiation Primary Treatment Volume	2325	2326	2	.	R	R	R*	R*	.	.	CoC
1525	Phase III Radiation to Draining Lymph Nodes	2327	2328	2	.	R	R	R*	R*	.	.	CoC
1526	Phase III Radiation Treatment Modality	2329	2330	2	.	R	R	R	R	.	.	CoC
1522	Phase III Radiation External Beam Planning Tech	2331	2332	2	.	R	R	R*	R*	.	.	CoC
1521	Phase III Dose per Fraction	2333	2337	5	.	R	R	R*	R*	.	.	CoC
1523	Phase III Number of Fractions	2338	2340	3	.	R	R	R*	R*	.	.	CoC
1527	Phase III Total Dose	2341	2346	6	.	R	R	R*	R*	.	.	CoC
1532	Number of Phases of Rad Treatment to this Volume	2347	2348	2	.	R	R	R*	R*	.	.	CoC
1531	Radiation Treatment Discontinued Early	2349	2350	2	.	R	R	R*	R*	.	.	CoC
1533	Total Dose	2351	2356	6	.	R	R	R*	R*	.	.	CoC
1190	Reserved 06	2357	2456	100								

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
1660	Subsq RX 2nd Course Date	2457	2464	8	.	.	.	.	.	.	.	CoC
1661	Subsq RX 2ndCrs Date Flag	2465	2466	2	.	.	.	.	.	.	.	NAACCR
1670	Subsq RX 2nd Course Codes	2467	2477	11	.	.	.	.	.	.	.	
1671	Subsq RX 2nd Course Surg	2467	2468	2	.	.	.	.	.	.	.	CoC
1677	Subsq RX 2nd--Scope LN SU	2469	2469	1	.	.	.	.	.	.	.	CoC
1678	Subsq RX 2nd--Surg Oth	2470	2470	1	.	.	.	.	.	.	.	CoC
1679	Subsq RX 2nd--Reg LN Rem	2471	2472	2	.	.	.	.	.	.	.	CoC
1672	Subsq RX 2nd Course Rad	2473	2473	1	.	.	.	.	.	.	.	CoC
1673	Subsq RX 2nd Course Chemo	2474	2474	1	.	.	.	.	.	.	.	CoC
1674	Subsq RX 2nd Course Horm	2475	2475	1	.	.	.	.	.	.	.	CoC
1675	Subsq RX 2nd Course BRM	2476	2476	1	.	.	.	.	.	.	.	CoC
1676	Subsq RX 2nd Course Oth	2477	2477	1	.	.	.	.	.	.	.	CoC
1680	Subsq RX 3rd Course Date	2478	2485	8	.	.	.	.	.	.	.	CoC
1681	Subsq RX 3rdCrs Date Flag	2486	2487	2	.	.	.	.	.	.	.	NAACCR
1690	Subsq RX 3rd Course Codes	2488	2498	11	.	.	.	.	.	.	.	
1691	Subsq RX 3rd Course Surg	2488	2489	2	.	.	.	.	.	.	.	CoC
1697	Subsq RX 3rd--Scope LN Su	2490	2490	1	.	.	.	.	.	.	.	CoC
1698	Subsq RX 3rd--Surg Oth	2491	2491	1	.	.	.	.	.	.	.	CoC
1699	Subsq RX 3rd--Reg LN Rem	2492	2493	2	.	.	.	.	.	.	.	CoC
1692	Subsq RX 3rd Course Rad	2494	2494	1	.	.	.	.	.	.	.	CoC
1693	Subsq RX 3rd Course Chemo	2495	2495	1	.	.	.	.	.	.	.	CoC
1694	Subsq RX 3rd Course Horm	2496	2496	1	.	.	.	.	.	.	.	CoC
1695	Subsq RX 3rd Course BRM	2497	2497	1	.	.	.	.	.	.	.	CoC
1696	Subsq RX 3rd Course Oth	2498	2498	1	.	.	.	.	.	.	.	CoC
1700	Subsq RX 4th Course Date	2499	2506	8	.	.	.	.	.	.	.	CoC
1701	Subsq RX 4thCrs Date Flag	2507	2508	2	.	.	.	.	.	.	.	NAACCR
1710	Subsq RX 4th Course Codes	2509	2519	11	.	.	.	.	.	.	.	
1711	Subsq RX 4th Course Surg	2509	2510	2	.	.	.	.	.	.	.	CoC

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
1717	Subsq RX 4th--Scope LN Su	2511	2511	1	.	.	.	.	.	.	.	CoC
1718	Subsq RX 4th--Surg Oth	2512	2512	1	.	.	.	.	.	.	.	CoC
1719	Subsq RX 4th--Reg LN Rem	2513	2514	2	.	.	.	.	.	.	.	CoC
1712	Subsq RX 4th Course Rad	2515	2515	1	.	.	.	.	.	.	.	CoC
1713	Subsq RX 4th Course Chemo	2516	2516	1	.	.	.	.	.	.	.	CoC
1714	Subsq RX 4th Course Horm	2517	2517	1	.	.	.	.	.	.	.	CoC
1715	Subsq RX 4th Course BRM	2518	2518	1	.	.	.	.	.	.	.	CoC
1716	Subsq RX 4th Course Oth	2519	2519	1	.	.	.	.	.	.	.	CoC
1741	Subsq RX--Reconstruct Del	2520	2520	1	.	.	.	.	.	.	.	CoC
1300	Reserved 07	2521	2570	50								
1981	Over-ride SS/NodesPos	2571	2571	1	.	.	.	R	R	.	.	NAACCR
1982	Over-ride SS/TNM-N	2572	2572	1	.	.	.	R	R	.	.	NAACCR
1983	Over-ride SS/TNM-M	2573	2573	1	.	.	.	R	R	.	.	NAACCR
1985	Over-ride Acsn/Class/Seq	2574	2574	1	.	R	R	.	.	.	.	CoC
1986	Over-ride HospSeq/DxConf	2575	2575	1	.	R	R	.	.	.	.	CoC
1987	Over-ride CoC-Site/Type	2576	2576	1	.	R	R	.	.	.	.	CoC
1988	Over-ride HospSeq/Site	2577	2577	1	.	R	R	.	.	.	.	CoC
1989	Over-ride Site/TNM-StgGrp	2578	2578	1	R	R	R	.	.	.	.	CoC
1990	Over-ride Age/Site/Morph	2579	2579	1	R	R	R	R	R	.	.	SEER
1992	Over-ride TNM Stage	2580	2580	1	RN	.	.	.	.	.	.	NAACCR
1993	Over-ride TNM Tis	2581	2581	1	RN	.	.	.	.	.	.	NAACCR
1994	Over-ride TNM 3	2582	2582	1	RN	.	.	.	.	.	.	NAACCR
2000	Over-ride SeqNo/DxConf	2583	2583	1	R	.	.	R	R	.	.	SEER
2010	Over-ride Site/Lat/SeqNo	2584	2584	1	R	.	.	R	R	.	.	SEER
2020	Over-ride Surg/DxConf	2585	2585	1	R	R	R	R	R	.	.	SEER
2030	Over-ride Site/Type	2586	2586	1	R	R	R	R	R	.	.	SEER
2040	Over-ride Histology	2587	2587	1	R	R	R	R	R	.	.	SEER
2050	Over-ride Report Source	2588	2588	1	R	.	.	R	R	.	.	SEER

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
2060	Over-ride Ill-define Site	2589	2589	1	R	.	.	R	R	.	.	SEER
2070	Over-ride Leuk, Lymphoma	2590	2590	1	R	R	R	R	R	.	.	SEER
2071	Over-ride Site/Behavior	2591	2591	1	R	R	R	R	R	.	.	SEER
2072	Over-ride Site/EOD/DX Dt	2592	2592	1	.	.	.	R	R	.	.	SEER
2073	Over-ride Site/Lat/EOD	2593	2593	1	.	.	.	R	R	.	.	SEER
2074	Over-ride Site/Lat/Morph	2594	2594	1	R	R	R	R	R	.	.	SEER
2078	Over-ride Name/Sex	2595	2595	1	R	.	.	R	R	.	.	NAACCR
1960	Site (73-91) ICD-O-1	2596	2599	4	.	.	.	RH	RH	.	.	SEER
1970	Morph (73-91) ICD-O-1	2600	2605	6	.	.	.	.	.	.	.	
1971	Histology (73-91) ICD-O-1	2600	2603	4	.	.	.	RH	RH	.	.	SEER
1972	Behavior (73-91) ICD-O-1	2604	2604	1	.	.	.	RH	RH	.	.	SEER
1973	Grade (73-91) ICD-O-1	2605	2605	1	.	.	.	RH	RH	.	.	SEER
1980	ICD-O-2 Conversion Flag	2606	2606	1	.	RH	RH	R	R	.	.	SEER
2081	CRC CHECKSUM	2607	2616	10	.	.	.	S	S	.	.	NAACCR
2120	SEER Coding Sys--Current	2617	2617	1	.	.	.	.	R	.	.	NAACCR
2130	SEER Coding Sys--Original	2618	2618	1	.	.	.	.	R	.	.	NAACCR
2140	CoC Coding Sys--Current	2619	2620	2	.	R	R	.	.	.	.	CoC
2150	CoC Coding Sys--Original	2621	2622	2	.	R	R	.	.	.	.	CoC
2155	RQRS NCDB Submission Flag	2623	2623	1	.	R	R	.	.	.	.	CoC
2152	CoC Accredited Flag	2624	2624	1	R	.	.	R*	R*	.	.	NPCR
2170	Vendor Name	2625	2634	10	.	R	R	.	.	.	.	NAACCR
2180	SEER Type of Follow-Up	2635	2635	1	.	.	.	R	R	.	.	SEER
2190	SEER Record Number	2636	2637	2	.	.	.	.	R	.	.	SEER
2200	Diagnostic Proc 73-87	2638	2639	2	.	.	.	RH	RH	.	.	SEER
2085	Date Case Initiated	2640	2647	8	.	.	.	.	.	.	.	NAACCR
2090	Date Case Completed	2648	2655	8	.	.	.	.	.	.	.	NAACCR
2092	Date Case Completed--CoC	2656	2663	8	.	D	D	.	.	.	.	CoC
2100	Date Case Last Changed	2664	2671	8	.	D	D	.	.	.	.	NAACCR

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
2110	Date Case Report Exported	2672	2679	8	R	.	.	.	.	.	.	NPCR
2111	Date Case Report Received	2680	2687	8	R	.	.	.	.	.	.	NPCR
2112	Date Case Report Loaded	2688	2695	8	R	.	.	.	.	.	.	NPCR
2113	Date Tumor Record Availbl	2696	2703	8	R	.	.	.	.	.	.	NPCR
2116	ICD-O-3 Conversion Flag	2704	2704	1	R	.	.	R	R	.	.	SEER/CoC
3750	Over-ride CS 1	2705	2705	1	.	RH	RH	.	.	.	.	AJCC
3751	Over-ride CS 2	2706	2706	1	.	RH	RH	.	.	.	.	AJCC
3752	Over-ride CS 3	2707	2707	1	.	RH	RH	.	.	.	.	AJCC
3753	Over-ride CS 4	2708	2708	1	.	RH	RH	.	.	.	.	AJCC
3754	Over-ride CS 5	2709	2709	1	.	RH	RH	.	.	.	.	AJCC
3755	Over-ride CS 6	2710	2710	1	.	RH	RH	.	.	.	.	AJCC
3756	Over-ride CS 7	2711	2711	1	.	RH	RH	.	.	.	.	AJCC
3757	Over-ride CS 8	2712	2712	1	.	RH	RH	.	.	.	.	AJCC
3758	Over-ride CS 9	2713	2713	1	.	RH	RH	.	.	.	.	AJCC
3759	Over-ride CS 10	2714	2714	1	.	RH	RH	.	.	.	.	AJCC
3760	Over-ride CS 11	2715	2715	1	.	RH	RH	.	.	.	.	AJCC
3761	Over-ride CS 12	2716	2716	1	.	RH	RH	.	.	.	.	AJCC
3762	Over-ride CS 13	2717	2717	1	.	RH	RH	.	.	.	.	AJCC
3763	Over-ride CS 14	2718	2718	1	.	RH	RH	.	.	.	.	AJCC
3764	Over-ride CS 15	2719	2719	1	.	RH	RH	.	.	.	.	AJCC
3765	Over-ride CS 16	2720	2720	1	.	RH	RH	.	.	.	.	AJCC
3766	Over-ride CS 17	2721	2721	1	.	RH	RH	.	.	.	.	AJCC
3767	Over-ride CS 18	2722	2722	1	.	RH	RH	.	.	.	.	AJCC
3768	Over-ride CS 19	2723	2723	1	.	RH	RH	.	.	.	.	AJCC
3769	Over-ride CS 20	2724	2724	1	RH	RH	RH	RH	RH	.	.	AJCC/NPCR
1650	Reserved 08	2725	2774	50								
1750	Date of Last Contact	2775	2782	8	R	R	R	R	R	.	.	SEER/CoC
1751	Date of Last Contact Flag	2783	2784	2	R	R	R	R	R	.	.	NAACCR

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
1760	Vital Status	2785	2785	1	R	R	R	R	R	D	D	SEER/CoC
1762	Vital Status Recode	2786	2786	1	D	.	.	D	R	.	.	NAACCR
1770	Cancer Status	2787	2787	1	.	R	R	.	.	.	.	CoC
1772	Date of Last Cancer (tumor) Status	2788	2795	8	.	R	R	.	.	.	.	CoC
1773	Date of Last Cancer (tumor) Status Flag	2796	2797	2		R	R	.	.	.	.	CoC
1775	Record Number Recode	2798	2799	2	.	.	.	D	R	.	.	NAACCR
1780	Quality of Survival	2800	2800	1	.	.	.	.	.	.	.	CoC
1790	Follow-Up Source	2801	2801	1	R*	R	.	.	.	.	.	CoC
1800	Next Follow-Up Source	2802	2802	1	.	R	.	.	.	.	.	CoC
1810	Addr Current--City	2803	2852	50	.	R	.	R	.	.	.	CoC
1820	Addr Current--State	2853	2854	2	.	R	.	R	.	.	.	CoC
1830	Addr Current--Postal Code	2855	2863	9	.	R	.	R	.	.	.	CoC
1840	County--Current	2864	2866	3	.	.	.	.	.	.	.	NAACCR
1860	Recurrence Date--1st	2867	2874	8	.	R	R	RC	.	.	.	CoC
1861	Recurrence Date--1st Flag	2875	2876	2	.	R	R	RC	.	.	.	NAACCR
1880	Recurrence Type--1st	2877	2878	2	.	R	R	RC	.	.	.	CoC
1842	Follow-Up Contact--City	2879	2928	50	.	.	.	.	.	.	.	SEER
1844	Follow-Up Contact--State	2929	2930	2	.	.	.	.	.	.	.	SEER
1846	Follow-Up Contact--Postal	2931	2939	9	.	.	.	.	.	.	.	SEER
1910	Cause of Death	2940	2943	4	R	.	.	R	R	R*	R*	SEER
1914	SEER Cause Specific COD	2944	2944	1	D	.	.	D	R	.	.	SEER
1915	SEER Other COD	2945	2945	1	D	.	.	D	R	.	.	SEER
1920	ICD Revision Number	2946	2946	1	R	.	.	R	R	.	.	SEER
1930	Autopsy	2947	2947	1	.	.	.	.	.	.	.	NAACCR
1940	Place of Death	2948	2950	3	RH	.	.	.	.	R*	R*	NPCR
1791	Follow-up Source Central	2951	2952	2	R	.	.	.	.	.	.	NAACCR
1755	Date of Death--Canada	2953	2960	8	.	.	.	.	.	R*	R*	CCCR
1756	Date of Death--CanadaFlag	2961	2962	2	.	.	.	.	.	R*	R*	NAACCR

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
1850	Unusual Follow-Up Method	2963	2964	2	.	.	.	.	.	.	.	NAACCR
1782	Surv-Date Active Followup	2965	2972	8	.	.	.	D	R	.	.	NAACCR
1783	Surv-Flag Active Followup	2973	2973	1	.	.	.	D	R	.	.	NAACCR
1784	Surv-Mos Active Followup	2974	2977	4	.	.	.	D	R	.	.	NAACCR
1785	Surv-Date Presumed Alive	2978	2985	8	D	.	.	D	R	.	.	NAACCR
1786	Surv-Flag Presumed Alive	2986	2986	1	D	.	.	D	R	.	.	NAACCR
1787	Surv-Mos Presumed Alive	2987	2990	4	D	.	.	D	R	.	.	NAACCR
1788	Surv-Date DX Recode	2991	2998	8	D	.	.	D	R	.	.	NAACCR
1740	Reserved 09	2999	3048	50								
2220	State/Requestor Items	3049	4048	1000	.	.	.	.	.	.	.	Varies
2230	Name--Last	4049	4088	40	R	R	.	R	.	R*	R*	CoC
2240	Name--First	4089	4128	40	R	R	.	R	.	R*	R*	CoC
2250	Name--Middle	4129	4168	40	R	R	.	R	.	R*	R*	CoC
2260	Name--Prefix	4169	4171	3	.	.	.	.	.	.	.	NAACCR
2270	Name--Suffix	4172	4174	3	.	.	.	R	.	.	.	NAACCR
2280	Name--Alias	4175	4214	40	R	.	.	R	.	.	.	NAACCR
2390	Name--Maiden	4215	4254	40	R	.	.	R	.	R*	R*	NAACCR
2290	Name--Spouse/Parent	4255	4314	60	.	.	.	.	.	.	.	NAACCR
2300	Medical Record Number	4315	4325	11	R	R	.	R	.	.	.	CoC
2310	Military Record No Suffix	4326	4327	2	.	.	.	.	.	.	.	CoC
2320	Social Security Number	4328	4336	9	R	R	.	R	.	.	.	CoC
2315	Medicare Beneficiary Identifier	4337	4347	11								NAACCR
2330	Addr at DX--No & Street	4348	4407	60	R	R	.	R	.	.	.	CoC
2335	Addr at DX--Supplementl	4408	4467	60	R	R*	.	R	.	.	.	CoC
2350	Addr Current--No & Street	4468	4527	60	.	R	.	R	.	.	.	CoC
2355	Addr Current--Supplementl	4528	4587	60	.	R*	.	R*	.	.	.	CoC
2360	Telephone	4588	4597	10	.	R	.	R	.	.	.	CoC
2380	DC State File Number	4598	4603	6	R	.	.	R*	.	.	.	State

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
2394	Follow-Up Contact--Name	4604	4663	60	.	.	.	.	.	.	.	SEER
2392	Follow-Up Contact--No&St	4664	4723	60	.	.	.	.	.	.	.	SEER
2393	Follow-Up Contact--Suppl	4724	4783	60	.	.	.	.	.	.	.	SEER
2352	Latitude	4784	4793	10	R*	.	.	S	.	.	.	NAACCR
2354	Longitude	4794	4804	11	R*	.	.	S	.	.	.	NAACCR
1835	Reserved 10	4805	4904	100								
2445	NPI--Following Registry	4905	4914	10	.	.	.	RH*	.	.	.	CMS
2440	Following Registry	4915	4924	10	.	.	.	RH	.	.	.	CoC
2415	NPI--Inst Referred From	4925	4934	10	.	R	.	.	.	.	.	CMS
2410	Institution Referred From	4935	4944	10	.	.	.	.	.	.	.	CoC
2425	NPI--Inst Referred To	4945	4954	10	.	R	.	.	.	.	.	CMS
2420	Institution Referred To	4955	4964	10	.	.	.	.	.	.	.	CoC
1900	Reserved 11	4965	5014	50								
2465	NPI--Physician--Managing	5015	5024	10	.	R	.	.	.	.	.	CMS
2460	Physician--Managing	5025	5032	8	.	.	.	.	.	.	.	NAACCR
2475	NPI--Physician--Follow-Up	5033	5042	10	.	R	.	R*	.	.	.	CMS
2470	Physician--Follow-Up	5043	5050	8	.	.	.	R	.	.	.	CoC
2485	NPI--Physician--Primary Surg	5051	5060	10	.	R	R	.	.	.	.	CMS
2480	Physician--Primary Surg	5061	5068	8	.	.	.	.	.	.	.	CoC
2495	NPI--Physician 3	5069	5078	10	.	R	R	.	.	.	.	CMS
2490	Physician 3	5079	5086	8	.	.	.	.	.	.	.	CoC
2505	NPI--Physician 4	5087	5096	10	.	R	R	.	.	.	.	CMS
2500	Physician 4	5097	5104	8	.	.	.	.	.	.	.	CoC
2508	EHR Reporting	5105	6104	1000	.	.	.	.	.	.	.	NAACCR
2510	Reserved 12	6105	6154	50								
7010	Path Reporting Fac ID 1	6155	6179	25	.	.	.	.	.	.	.	HL7
7090	Path Report Number 1	6180	6199	20	.	.	.	.	.	.	.	HL7
7320	Path Date Spec Collect 1	6200	6213	14	.	.	.	.	.	.	.	HL7

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
7480	Path Report Type 1	6214	6215	2	.	.	.	.	.	.	.	HL7
7190	Path Ordering Fac No 1	6216	6240	25	.	.	.	.	.	.	.	HL7
7100	Path Order Phys Lic No 1	6241	6260	20	.	.	.	.	.	.	.	HL7
7011	Path Reporting Fac ID 2	6261	6285	25	.	.	.	.	.	.	.	HL7
7091	Path Report Number 2	6286	6305	20	.	.	.	.	.	.	.	HL7
7321	Path Date Spec Collect 2	6306	6319	14	.	.	.	.	.	.	.	HL7
7481	Path Report Type 2	6320	6321	2	.	.	.	.	.	.	.	HL7
7191	Path Ordering Fac No 2	6322	6346	25	.	.	.	.	.	.	.	HL7
7101	Path Order Phys Lic No 2	6347	6366	20	.	.	.	.	.	.	.	HL7
7012	Path Reporting Fac ID 3	6367	6391	25	.	.	.	.	.	.	.	HL7
7092	Path Report Number 3	6392	6411	20	.	.	.	.	.	.	.	HL7
7322	Path Date Spec Collect 3	6412	6425	14	.	.	.	.	.	.	.	HL7
7482	Path Report Type 3	6426	6427	2	.	.	.	.	.	.	.	HL7
7192	Path Ordering Fac No 3	6428	6452	25	.	.	.	.	.	.	.	HL7
7102	Path Order Phys Lic No 3	6453	6472	20	.	.	.	.	.	.	.	HL7
7013	Path Reporting Fac ID 4	6473	6497	25	.	.	.	.	.	.	.	HL7
7093	Path Report Number 4	6498	6517	20	.	.	.	.	.	.	.	HL7
7323	Path Date Spec Collect 4	6518	6531	14	.	.	.	.	.	.	.	HL7
7483	Path Report Type 4	6532	6533	2	.	.	.	.	.	.	.	HL7
7193	Path Ordering Fac No 4	6534	6558	25	.	.	.	.	.	.	.	HL7
7103	Path Order Phys Lic No 4	6559	6578	20	.	.	.	.	.	.	.	HL7
7014	Path Reporting Fac ID 5	6579	6603	25	.	.	.	.	.	.	.	HL7
7094	Path Report Number 5	6604	6623	20	.	.	.	.	.	.	.	HL7
7324	Path Date Spec Collect 5	6624	6637	14	.	.	.	.	.	.	.	HL7
7484	Path Report Type 5	6638	6639	2	.	.	.	.	.	.	.	HL7
7194	Path Ordering Fac No 5	6640	6664	25	.	.	.	.	.	.	.	HL7
7104	Path Order Phys Lic No 5	6665	6684	20	.	.	.	.	.	.	.	HL7
2080	Reserved 13	6685	6934	250								

Item #	Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Source of Standard
2520	Text--DX Proc--PE	6935	7934	1000	R^	.	.	R	.	.	.	NPCR
2530	Text--DX Proc--X-ray/Scan	7935	8934	1000	R^	.	.	R	.	.	.	NPCR
2540	Text--DX Proc--Scopes	8935	9934	1000	R^	.	.	R	.	.	.	NPCR
2550	Text--DX Proc--Lab Tests	9935	10934	1000	R^	.	.	R	.	.	.	NPCR
2560	Text--DX Proc--Op	10935	11934	1000	R^	.	.	R	.	.	.	NPCR
2570	Text--DX Proc--Path	11935	12934	1000	R^	.	.	R	.	.	.	NPCR
2580	Text--Primary Site Title	12935	13034	100	R^	.	.	R	.	.	.	NPCR
2590	Text--Histology Title	13035	13134	100	R^	.	.	R	.	.	.	NPCR
2600	Text--Staging	13135	14134	1000	R^	.	.	R	.	.	.	NPCR
2610	RX Text--Surgery	14135	15134	1000	R^	.	.	R	.	.	.	NPCR
2620	RX Text--Radiation (Beam)	15135	16134	1000	R^	.	.	R	.	.	.	NPCR
2630	RX Text--Radiation Other	16135	17134	1000	R^	.	.	R	.	.	.	NPCR
2640	RX Text--Chemo	17135	18134	1000	R^	.	.	R	.	.	.	NPCR
2650	RX Text--Hormone	18135	19134	1000	R^	.	.	R	.	.	.	NPCR
2660	RX Text--BRM	19135	20134	1000	R^	.	.	R	.	.	.	NPCR
2670	RX Text--Other	20135	21134	1000	R^	.	.	R	.	.	.	NPCR
2680	Text--Remarks	21135	22134	1000	.	.	.	R	.	.	.	NPCR
2690	Text--Place of Diagnosis	22135	22194	60	.	.	.	.	.	.	.	NPCR
2210	Reserved 14	22195	24194	2000								

APPENDIX D. NAACCR Update/Correction Record, Version 18 Record Type U

						* Required for		
Item #	**Item Name**	**Length**	**Begin**		**End**	**Central**	**Hospital**	**Notes**
	Sender ID Section							
10	Record Type	1	1		1	R	R	U = Correction
9000	Update/Correction Record Version	3	2		4	R	R	180 = Version 18
2170	Vendor Name	10	5		14	R	R	Vendor of correction record
30	Registry Type	1	15		15	R		Sending registry
40	Registry ID	10	16		25	R	R	Sending registry
21	Patient System ID-Hosp	8	26		33	R		Sending registry
60	Tumor Record Number	2	34		35	R	R	Sending registry
9002	Reserved for expansion	20	36		55			
	Record ID Section							
9010	Patient ID Number--Receiver	8	56		63			Receiving registry
9011	Tumor Record Number--Receiver	2	64		65			Receiving registry
2230	Name--Last	40	66		105			
2240	Name--First	40	106		145			
2250	Name--Middle	40	146		185			
2300	Medical Record Number	11	186		196		R	
2310	Military Record No Suffix	2	197		198			
2320	Social Security Number	9	199		207			
220	Sex	1	208		208			
240	Date of Birth	8	209		216			
241	Date of Birth Flag	2	217		218			
540	Reporting Hospital	10	219		228		R	
545	NPI—Reporting Facility	10	229		238			
550	Accession Number--Hosp	9	239		247		R	CCYY12345
390	Date of Diagnosis	8	248		255			
391	Date of Diagnosis Flag	2	256		257			

						* Required for		
Item #	**Item Name**	**Length**	**Begin**		**End**	**Central**	**Hospital**	**Notes**
560	Sequence Number--Hospital	2	258		259		R	
400	Primary Site	4	260		263			
410	Laterality	1	264		264			
420	Histology (92-00) ICD-O-2	4	265		268			
430	Behavior (92-00) ICD-O-2	1	269		269			
522	Histologic Type ICD-O-3	4	270		273			
523	Behavior Code ICD-O-3	1	274		274			
9050	Reserved for Expansion	40	275		314			
	Correction Section							
9005	Date of This Change	8	315		322	R	R	
9006	Time of This Change	6	323		328	R	R	
2081	CRC CHECKSUM	10	329		338			
9020	Correction Comments	200	339		538			
9030	Changed Item NAACCR Number	5	539		543	R	R	
9040	Changed Item New Value	1000	544		1543	R	R	Left-justify

APPENDIX E. NAACCR Data Descriptor Table for Record Type U

Item #	Item Name	Format	Allowable Values	Length	Source of Standard
10	Record Type		I, C, A, U, M, L	1	NAACCR
20	Patient ID Number	Right justified, zero filled		8	Reporting Registry
21	Patient System ID-Hosp	Right justified, zero filled		8	NAACCR
30	Registry Type		1-3	1	NAACCR
40	Registry ID	Right justified, zero filled	10-digit number. Reference to EDITS table REGID.DBF in Vol. II, Appendix B	10	NAACCR
60	Tumor Record Number	Right justified, zero filled	01-99	2	NAACCR
220	Sex		1-6, 9	1	SEER/CoC
240	Date of Birth	YYYYMMDD	Valid date	8	SEER/CoC
241	Date of Birth Flag			2	NAACCR
390	Date of Diagnosis	YYYYMMDD	Valid date	8	SEER/CoC
391	Date of Diagnosis Flag			2	NAACCR
400	Primary Site	C followed by 3 digits, no special characters, no embedded blanks	Reference ICD-O-3 for valid entries	4	SEER/CoC
410	Laterality		0-5, 9	1	SEER/CoC
420	Histology (92-00) ICD-O-2		Reference to ICD-O-2	4	SEER/CoC
430	Behavior (92-00) ICD-O-2		0-3; Reference to ICD-O-2	1	SEER/CoC
522	Histologic Type ICD-O-3		Reference to ICD-O-3	4	SEER/CoC
523	Behavior Code ICD-O-3		0-3; Reference to ICD-O-3	1	SEER/CoC
540	Reporting Hospital	Right justified, zero filled	10-digit number	10	CoC
545	NPI—Reporting Facility		10-digit NPI code (9-digit NPI integer plus 1 check digit), blank	10	CMS
550	Accession Number--Hosp		9-digit number	9	CoC
560	Sequence Number--Hospital	Right justified, zero filled	00-59, 60-87, 88, 99	2	CoC
2081	CRC CHECKSUM		Calculated or blank	10	NAACCR
2170	Vendor Name	Embedded spaces allowed		10	NAACCR
2230	Name--Last	Mixed case, no embedded spaces, left justified, blank filled. Embedded hyphen allowed, but no other special characters		40	CoC
2240	Name--First	Mixed case, no embedded spaces, no special characters, left justified, blank filled		40	CoC
2250	Name--Middle	Mixed case, no embedded spaces, no special characters, left justified, blank filled		40	CoC
2300	Medical Record Number	Leading spaces, right justified		11	CoC
2310	Military Record No Suffix	Right justified, zero filled	01-20, 30-69, 98, 99, or blank	2	CoC
2320	Social Security Number	9 digits, no dashes	Any 9-digit number except 000000000	9	CoC
9000	Update/Correction Record Version		1, 2, 7, A, B, 120, 121, 122, 130, 140, 150, 160, 180	3	
9002	Reserved for expansion			20	
9005	Date of this Change	YYYYMMDD		8	
9006	Time of this Change	HHMMSS		6	
9010	Patient ID Number-Receiver		Blank	8	
9011	Tumor Record Number-Receiver		Blank	2	
9020	Correction comments			200	
9030	Changed Item NAACCR Number			5	
9040	Changed Item New Value			1000	
9050	Reserved for expansion			40	

*Record Types I, C, A, and M (data items #10 –7600) see NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary; Chapter IX Data Descriptor Table.