NEVADA CENTRAL CANCER REGISTRY

NEVADA CANCER REPORTING MANUAL FOR HOSPITALS

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

DEPARTMENT OF HUMAN SERVICES

STATE OF NEVADA



REV. JULY 26

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SECTION 1: INTRODUCTION TO THE NCCR

Nevada Central Cancer Registry Overview

The Nevada Central Cancer Registry (NCCR) is a state-mandated population-based cancer surveillance system that maintains data on all cancer patients within the state of Nevada. The Registry is housed under the Nevada Division of Public and Behavioral Health (DPBH) Office of Public Health Investigations and Epidemiology (OPHIE) and began collecting cancer incidence data in 1989. In 1995, NCCR began receiving funding from the National Program of Cancer Registries (NPCR) through the Centers for Disease Control and Prevention (CDC). The NCCR reference date is January 1, 1995.

The goal of NCCR is to gather comprehensive, timely, and accurate data on the incidences of cancer among Nevada residents.

The registry provides statistical data for use by epidemiologists, health researchers and others in the medical and allied health professions. Information from the registry is intended to identify cancer risk, evaluate cancer patient care, and characterize leading trends in cancer incidence, survival, and mortality among state residents.

NCCR provides the following services:

- Processes cases and conducts quality control audits on cases abstracted by health care facilities and providers of health care.
- Receives and processes reports from pathology laboratories.
- Executes Data Exchange Agreements with other states.
- Provides training to cancer registrars in the state.
- Provides statistical cancer data for researchers, prevention programs, medical professionals, and community partners.

Cancer Reporting Law

NCCR is regulated by both Nevada Revised Statues (NRS) 457.230-457.280 and Nevada Administrative Codes (NAC) 457.045-457.150. In 1983 state regulations made cancer a reportable disease and gave authority to require licensed health care facilities, medical laboratories, and providers of health care who diagnose or provide treatment for cancer to report cancer cases diagnosed and treated in Nevada.

NCCR Contact Information

Nevada Central Cancer Registry

10375 Professional Circle, 3rd Floor

Reno, NV 89521

Telephone: 775-684-5968

Fax: 775-684-5999

E-Mail: dpbhnccr@health.nv.gov

Web site: nvrose/NCCR

Data Requests

- data@dhhs.nv.gov

Web Plus Technical Assistance

- Rani Reed, Data Manager
  - rrreed@health.nv.gov

Abstracting Questions

- Catherina Short, ODS-Certified
  - Quality Assurance Manager
    (702) 486-0799 | cshort@health.nv.gov

- Tiffany Goulding, ODS-Certified
  - Education and Training Coordinator
    (775) 688-0428 | tgoulding@health.nv.gov

- Vacant
  - Cancer Registrar Specialist II

Facility Updates

If your facility has a change in personnel, address, telephone, etc., please notify NCCR immediately.

SECTION 2: GENERAL PROCEDURES

Traditional cancer data collection has been primarily from hospitals. As medical advances have occurred, diagnosis and treatment of certain cancers have moved from the acute care setting to being fully cared for within a physician/medical office and therefore was never received and counted by the registry.

In addition, death certificates and pathology laboratory reports are used to help identify cases that are missed in this routine reporting by health care facilities and providers of health care offices. Any duplicate reports are consolidated in the data editing process. The purpose of this concerted effort is to alleviate under-reporting or a delay in reporting which can adversely affect incidence rates and research from incomplete data collection.

The NCCR operates under the Standards set by the National Program of Cancer Registries (NPCR) and the North American Association of Central Cancer Registries (NAACCR).

Information collected includes:

- Patient information (e.g. age, gender, race, address at diagnosis, place of birth, marital status, occupation and industry)
- Anatomic site of the primary tumor
- Histology (cell type) of cancer
- Stage of disease at diagnosis
- First course of treatment

Confidentiality of Data Exchange

According to NRS and NAC 457, “patient-identifying information may be exchanged among agencies authorized by the Department and upon receipt by the Department of satisfactory assurances by those agencies of preservation of the confidentiality of such information”.

HIPPA

Under the HIPAA Privacy Rule (1996), healthcare providers (“covered entities”) may legally disclose protected health information to public health authorities—such as cancer registries—without patient authorization when required by law [45 CFR 164.512(a)(1)].

Quality Control

Accuracy and consistency are essential components of any hospital and central registry. The data must be accurate, complete, and timely. Visual editing is conducted at NCCR on a percentage of all reported cases.

The NCCR conducts audits on quality control and completeness of data at randomly selected facilities. These audits are a useful tool to identify consistent reporting problems and supply meaningful training throughout the state on cancer data collection. The goal of the NCCR is to obtain complete reporting of all cancer cases in Nevada and to exceed the accuracy rate of 95 percent. The NCCR monitors completeness of reporting by reviewing frequency distribution reports for each facility.

It is the responsibility of the facility that is administering care to report cases to NCCR. If your hospital employs an external professional contract service for abstracting services to

comply with NCCR reporting requirements, your facility is still fully responsible for all cancer reporting activities including but not limited to:

- Data quality
- Corrections
- Documentation

It is up to the facility to ensure that:

- All data quality expectations are met
- All deadlines are met
- All requirements are met

All activities are carried out to meet the facility responsibilities to the Nevada Department of Public and Behavior Health through NCCR.

NCCR is a state-mandated population-based statewide cancer surveillance system. Participation in NCCR is mandated under Nevada statute and is not a voluntary reporting system like the Commission on Cancer's National Cancer Database.

Cancer Data

NCCR annually compiles comprehensive cancer data collected for all years of operation and submits the data to the Centers for Disease Control and Prevention (CDC)/National Program of Cancer Registries (NPCR) and the North American Association of Central Cancer Registries (NAACCR) and for analysis, certifications, and inclusion in national cancer statistics.

NPCR Data Evaluation and Publication Criteria

Criteria	Advanced National Data Quality Standard (12 Month Standard)	National Data Quality Standard (23 Month Standard)	US Cancer Statistics Publication
Completeness	90%	95%	
% Passing Edits	97%	99%	97%
Death Certificate Only Cases	N/A	Less than 3%	Less than 5%
Duplicate Reports	Less than 2/1000	Less than 1/1000	
Missing Age	Less than 3%	Less than 2%	Less than 3%
Missing Sex	Less than 3%	Less than 2%	Less than 3%
Missing Race	Less than 5%	Less than 3%	Less than 5%
Missing County	Less than 3%	Less than 2%	

NAACCR Certification and Publication Criteria

Criteria	Silver Certification (23 Month Standard)	Gold Certification (23 Month Standard)
Completeness	90%	95%
% Passing Edits	97%	100%
Death Certificate Only Cases	Less than 5%	Less than 3%
Duplicate Reports	Less than 0.2%	Less than 0.1%
Missing Sex, Age, County	Less than 3%	Less than 2%
Missing Race	Less than 5%	Less than 3%
Cancer Type, Sex, Race, Age and County	97% Error free	100%

NCCR is a vital tool for monitoring the incidence of cancer within the state and sharing that information with health care professionals, researchers, and the public. This data is used to evaluate the appropriateness of measures for the prevention and control of cancer and conduct comprehensive epidemiological surveys of cancer and cancer-related deaths statewide and nationally.

SECTION 3: GENERAL REPORTING FOR ALL CANCERS

This section provides a reporting overview for all cancers to the NCCR.

Who is Required to Report

Hospitals

General, Critical Access, Rural, and Specialty/Surgery Hospitals must report all required inpatient and outpatient cancer cases.

Non-Hospitals

Physicians in private or group practice must report all required cancer cases. This includes:

- Patients who are clinically diagnosed and receive no further work-up or treatment, or who have been referred to another physician.
- Patients who are newly diagnosed in the physician's own laboratory or by sending a specimen from the office to an outside laboratory, whether hospital or independent
- Patients whose first course of treatment is initiated in the physician's office or clinic. This includes cancer treatment by surgery, radiation, chemotherapy, immunotherapy, or hormones.

Dentists must report all required cancer cases that are diagnosed and/or treated in their practice, or who have been referred to another physician. This includes:

- Patients who are diagnosed or treated by a dentist who performs a biopsy and/or receives a pathology report of a reportable case.

Dermatologists must report all required cancer cases diagnosed and/or treated in their practice. This includes:

- Patients who are diagnosed or treated by a dermatologist who performs a biopsy and/or receives a pathological report of a reportable case.

Freestanding radiation or medical oncology clinics must report any patient initially diagnosed with reportable cancer or when the physician initiates the first course of treatment (FCOT). This includes cancer treatment by surgery, radiation, chemotherapy, immunotherapy, or hormones.

Surgery Centers – Freestanding surgery centers-includes plastic reconstructive, oral and maxillofacial surgery centers (independent centers not affiliated with any hospital) must report any patient undergoing a biopsy or other surgical procedure at the facility for a newly diagnosed reportable cancer. This includes cases also reported by either a hospital based or a private/independent medical laboratory.

Other Facilities - Facilities that provide cancer screening services, diagnostic services, or therapeutic cancer services must report confirmed cancer cases which are subject to reporting. This includes facilities that provide mammography or radiology services, palliative, prophylactic, or adjuvant therapy for reportable cases.

Long-term acute care hospitals, hospices and skilled nursing facilities must report the following types of diagnosed reportable cancer cases:

- Cases clinically diagnosed but not confirmed through biopsy, cytology, or other microscopic methods.
- Cases for whom the first course of cancer treatment is initiated at the facility (treatment may include chemotherapy, immunotherapy, or hormone therapy), and
- Cases admitted with active cancer for the purpose of receiving supportive care, palliative care, pain management and/or hospice services.

Medical Laboratories

Medical laboratories must report each specimen which shows evidence of cancer which is subject to reporting. This includes:

- Hospital-based laboratories
- Private laboratories, and
- Independent laboratories

How to Start Reporting

Please contact the NCCR office to initiate reporting. All reporting entities must complete a Facility Demographic form first. One of our NCCR representatives will contact you with instructions and resources to start reporting.

How to Report to NCCR

To streamline resources and workload the NCCR will move to an electronic reporting system and phase out paper reporting. The registry offers different electronic reporting options depending on your facility environment.

Options available:

Electronic:

- Electronic reporting through your registry software system. The file must follow the NAACCR Data Standards and Data Dictionary for hospitals for the specific reporting year. The file must be in .xml format and uploaded to the registry Web Plus module.
- Direct abstracting to the Registry Web Plus software module.

Paper:

- Cancer Reports must be completed using the NCCR cancer reporting form and uploaded through the NCCR Web Plus module.

How to Submit Files

All .xml and paper reports must be uploaded to the NCCR Web Plus module.

Before access to Web Plus is granted the NCCR will create one facility account for use with Web Plus. The account can have different users depending on their role.

To access Web Plus, each user must complete the Web Plus User Form. Once approved, NCCR will provide:

- A User ID (sent via the Web Plus system)
- A temporary password (sent separately by the Web Plus Administrator). Users must change their password upon first login.
- Once a user leaves your facility you must contact the NCCR to deactivate the user.

SECTION 4: HOSPITAL REPORTING OVERVIEW

All hospitals (CoC-accredited and non-CoC-accredited) must report all required inpatient and outpatient cancer cases. This includes General, Critical Access, Rural, and Specialty/Surgery Hospitals.

- A hospital that has reported more than 50 patients with cancer each year for 3 consecutive years shall report an "Abstract" electronically.
    - Abstract means to create an electronic summary, synopsis or abbreviated record that identifies pertinent information about the patient, disease, treatment for the disease and the process of the disease from the time of diagnosis until the death of the patient.
- A hospital that has reported less than 50 patients with cancer each year for 3 consecutive years shall "Report" a report.
    - Report means to submit a summary of data from the medical record of a patient.

If your hospital employs an external professional contract service for abstracting services to comply with NCCR reporting requirements, your facility is still fully responsible for all cancer reporting activities including but not limited to:

- All data quality expectations are met
- All deadlines are met
- All requirements are met

When to Report to NCCR

The timely reporting schedule includes all cases (analytic and nonanalytic) diagnosed and/or treated for cancer, having a cancer-related health visit while undergoing cancer treatment, or having any evidence of disease at the time of the encounter. All cases must be abstracted and transmitted to NCCR within 6 months of the date of the first encounter.

The June 30th deadline is the annual call for data (CFD) milestone for cancer reporting in Nevada. All cases must be reported to NCCR on or before June 30, 2027, as required by Nevada law.

Note: Any facility not in compliance may be asked to develop a remedial plan to bring the facility back into compliance with the Nevada Revised Statutes. At the discretion of the Program Manager and/or Chief Medical Officer, the plan must include at minimum, a detailed overview of the root cause of the underlying delays in reporting, and specific action steps that will outline how the facility will address the issues to improve reporting timelines.

2026 Reporting Calendar

Patient First Contact	Monthly Submission Due Date
January	July 31st
February	August 31st
March	September 30th
April	October 31st
May	November 30th
June	December 31st
July	January 31st
August	February 28th
September	March 31st
October	April 30th
November	May 31st
December	June 30th

Data Standards

The NCCR follows the volumes in the Standards for Cancer Registries published by the North American Association of Central Cancer Registries:

- Volume I, *Data Exchange Standards and Record Descriptions*.
- Volume II, *Data Standards and Data Dictionary*.
- Volume III, *Standards for Completeness, Quality, Analysis, Management, Security, and Confidentiality of Data*.
- Volume IV, *Standard Data EDITS*; and
- Volume V, *Pathology Laboratory Electronic Reporting*.

A copy of each volume may be obtained, free of charge, from the North American Association of Central Cancer Registries at the Internet address https://www.naaccr.org/

- The International Classification of Diseases for Oncology, published by the World Health Organization. A copy of this publication may be obtained, free of charge, from the World Health Organization at the Internet address http://www.iacr.com.fr/index.php?Itemid=577
- The Standards for Oncology Registry Entry (STORE) published by the American College of Surgeons. A copy of this publication may be obtained, free of charge, from the American College of Surgeons at the Internet address https://www.facs.org/quality-programs/cancer-programs/national-cancer-database/ncdb-data-submission/

SECTION 5: HOSPITAL REPORTING GUIDELINES

Reportable Conditions

Public Law 102-515 and its amendments identify reportable conditions for NPCR registries; therefore, Nevada refers to the histology and behavior codes of the *International Classification of Diseases for Oncology, 3rd Edition, 2nd Revision Morphology* (ICD-O-3.2) including approved updates and errata published by the WHO and approved by NAACCR for ICD-O-3.2. There is still no PDF version of ICD-O-3.2. Use the ICD-O-3.2 tables from IACR/WHO in addition to the current Solid Tumor Rules and current SEER Hematopoietic Database to determine whether a neoplasm is reportable to NCCR.

All diseases with a behavior code of "/2," in situ disease, or "/3" malignant disease

All solid tumors of brain and central nervous system, including meninges and intracranial endocrine structures with behavior codes of:

"/0" benign disease

"/1" disease of uncertain malignant potential

"/2" in situ disease

"/3" malignant disease

This includes:

- Diagnoses that include the following terminology are malignant neoplasms and are reportable:

cancer	*carcinoma*
carcinoma in situ	*malignant*
leukemia	*lymphoma*
melanoma	*sarcoma*

- Malignant diagnoses that are not histologically confirmed, but are described by one of the following ambiguous terms, are considered confirmed cases and are reportable:

apparent, apparently	*most likely*
appears	*presumed*
comparable with	*probable, probably*
compatible with	*suspect, suspected*
consistent with	*suspicious (for)*
favors	*typical of*
malignant appearing	

- Basal or squamous cell carcinoma originating in mucoepidermoid or genital sites This includes VIN III, VAIN III, and AIN III.
- A clinical diagnosis or any case that is stated to be cancer by a recognized medical practitioner, even if there is no histologic or cytologic confirmation.
- Any reportable cancer listed on the death certificate.

- Patients undergoing prophylactic or adjuvant therapy for a reportable condition
- Hematopoietic and lymphoid neoplasms

Casefinding

Casefinding is a system for identifying all reportable cases through review of source documents and case listings. Casefinding covers a range of cases that need to be assessed to determine whether they are reportable. A current ICD-10-CMCasefinding List can be found here in pdf or excel format Casefinding List

NCCR ICD-10 Casefinding List	
REPORTABLE NEOPLASMS FOR CASES DIAGNOSED IN 2026	
ICD-10 Code	Explanation
C00.-C43.-, C4A.-, C45.-C96.-	Malignant neoplasms (excluding categories C44 and 49.A), stated or presumed to be primary (of specified site) and certain specified histologies.
C50.A (C50.A0, C50.A1, C50.A2)	Malignant inflammatory neoplasm of breast Note: New codes effective 10/1/25
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.10-, C44.19-	Unspecified/other malignant neoplasm of skin of eyelid
C44.13-	Sebaceous cell carcinoma of skin of eyelid, including canthus. Effective 10/1/2018
C44.20-, C44.29-	Unspecified/other malignant neoplasm skin of ear and external auricular canal
C44.30-, C44.39-	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.40, C44.49-	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50-, C44.59-	Unspecified/other malignant neoplasm of skin of trunk
C44.60-, C44.69-	Unspecified/other malignant neoplasm of skin of upper limb, incl. shoulder
C44.70-, C44.79-	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin
C49.A-	Gastrointestinal Stromal Tumors
D00.- -D05.-, D07.- - D09.-	In-situ neoplasms Note 1: Excludes carcinoma in situ tumors of the cervix (D06._) Note 2: Excludes prostatic intraepithelial neoplasia (PIN III) (8148/2) of the prostate. Other prostate in situ histologies are reportable Note 3: For D04 (carcinoma in situ of skin), excludes basal and squamous cell in situ lesions

NCCR ICD-10 Casefinding List	
REPORTABLE NEOPLASMS FOR CASES DIAGNOSED IN 2026	
ICD-10 Code	Explanation
D18.02	Hemangioma of intracranial structures and any site
D32.-	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.-	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3) ICD-10-CM Coding instruction note: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)
D46.-	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9993)
D47.02	Systemic mastocytosis
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3) ICD-10-CM Coding instruction note: Excludes the following: Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_) Chronic myeloid leukemia BCR/ABL-positive (C92.1) Myelofibrosis & Secondary myelofibrosis (D75.81) Myelophthisic anemia & Myelophthisis (D61.82)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia
D47.4	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis, Myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) (with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D47.Z-	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3) Note: Effective 1/1/2021, PTLD (9971/3) is no longer reportable (9971/1)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
D72.11-	Hypereosonophilic syndrome [HES] (9964/3)
K31.A22	Gastric intestinal metaplasia with high grade dysplasia
N85.02	Endometrial intraepithelial neoplasia [EIN]
R85.613	High grade squamous intraepithelial lesion on cytologic smear of anus (HGSIL)

NCCR ICD-10 Casefinding List	
REPORTABLE NEOPLASMS FOR CASES DIAGNOSED IN 2026	
ICD-10 Code	Explanation
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.623	High grade squamous intraepithelial lesion on cytologic smear of vagina (HGSIL)
R87.624	Cytologic evidence of malignancy on smear of vagina
R90.0	Intracranial space-occupying lesion found on diagnostic imaging of central nervous system

Types of Casefinding

Active casefinding is performed by facility personnel who screen the source documents themselves and is usually performed in a hospital setting by a designated cancer reporter. The skillset for this task would include medical terminology, experience navigating through health records, knowledge of national and state reporting requirements, and a basic understanding of the cancer disease process. The State Cancer Registry recommends hiring a person with an Oncology Data Specialist (ODS) credential. Investing in hiring or contracting an ODS would ensure that your facility identifies and submits all reportable cases with accurate and quality data. Active casefinding can be a little more costly at first, but the overall process is more thorough and accurate and saves time in the longer run.

Passive casefinding is when other departments notify the cancer registry of potentially reportable cases. Incomplete casefinding may occur because this process relies on other healthcare professionals that are not as familiar with reporting terminology rules. Best practices include a combination of both active and passive casefinding activities and are commonly used in most registries.

Casefinding Sources

Although 95% of reportable cancer cases are from pathology reports, review of only one type of source document cannot identify all cancer cases diagnosed or treated in a hospital. Source documents for casefinding may vary but in general hospital registry source documents can include, but are not limited to, the following:

- Other facilities and/or departments with potential sources for finding eligible cancer cases
- Outpatient, clinic and ambulatory care services/surgery
- Disease index
- Daily facility and clinic discharges
- Surgery and visit logs
- Billing form copies (contain both diagnosis and ICD codes)
- Oncology related services
- Radiation therapy logs
- Nuclear Medicine Logs
- Radiology logs, including logs of scans
- Radiation and chemotherapy appointment books/logs

- Staff physicians' offices
- Disease index
- Long-term care facility/skilled nursing facility
- Admission and discharge documents
- Hospice
- Monitor admissions to facility hospice units for casefinding purposes. Collect eligible cases where:
- Palliative or comfort care is provided
- Active cancer cases whether patients have been diagnosed and/or have received treatment at the facility or not
- Death certificates
- Recognizing Cancer Terms

The following examples use general terms commonly found in pathology reports and medical reports:

- MRI brain: 12 mm area right frontal lobe likely representing indeterminate neoplasm (not reportable)
- Patient history: Patient has a nephrectomy some years ago for kidney tumor of unknown type (not reportable)
- Report on pelvic ultrasound: 7.4 hypoechoic pelvic mass (not reportable)
- Patient history: Patient reports a resection of a benign breast tumor several years ago, with no evidence of recurrence (not reportable)
- Pleural fluid cytology: Cells positive for metastatic malignancy (reportable)

Ambiguous Terminology Diagnostic of Cancer

The diagnosis of cancer is made when a recognized medical practitioner states that the patient has cancer. As part of the registry casefinding processes, all diagnostic reports should be reviewed to confirm whether a case is required to be reported. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included. Words or phrases that appear to be synonyms of these terms do not constitute a diagnosis such as "supposed" for "presumed" or "equal" for "comparable with". "Likely" alone does not constitute a diagnosis however "most likely" does. Use only the exact words on the lists. See the STORE manual Ambiguous Terms at Diagnosis.

The first and foremost resource for the registrar for questionable cases is a physician who diagnosed and/or staged the tumor. If the physician is not available, the medical record and any other relevant reports, such as the pathology report, should be read carefully for the required information. The purpose of the ambiguous terminology listed below is to help registrars make consistent decisions with respect to reportability when no further information is available from any resource. When there is a clear statement of malignancy, the registrar should not refer to the list of ambiguous terms. Registrars should only rely on these terms when the situation is not clear, and the case cannot be discussed with the appropriate physician or pathologist.

Ambiguous terms can be found in pathology reports, radiology reports, or clinical reports. The following terms are reportable when used with a term like cancer, carcinoma, sarcoma, etc.

Analytic Cases for Class of Case 00-22

Patients who were diagnosed and/or administered any of their first course of treatment at the accessioning facility after the registry's reference date are analytic (Class of Case 00-22). A network clinic or outpatient center belonging to the facility is considered part of the facility.

NonAnalytic Case Reporting for Class of Case 30-99

NCCR requires the collection and reporting of both analytic and nonanalytic cases that meet reporting requirements. Your facility's lack of involvement in initial diagnosis and/or treatment of a patients' cancer make it nonanalytic. A nonanalytic case is reportable if a patient comes to your facility with evidence of cancer but was diagnosed and treated elsewhere. Nevada must have 100% cancer case reporting for accurate cancer incidence figures to be calculated.

Facilities with CoC-accredited cancer programs voluntarily abstract/report analytic cases to a clinical research database known as the National Cancer Database (NCDB). This voluntary reporting accounts to 70%-80% of hospitals in the United States – not 100% reporting.

Hospital analytic cases are not the only part of the cancer registry database. Nonanalytic cases are, indeed, equally important particularly when the patient has evidence of cancer, recurrence of cancer, or progression of cancer. Furthermore, nonanalytic cases of recurrent/progressive cancers bring in more revenue from treatment than do your analytic cases. Reporting nonanalytic cases also assists NCCR when finding a match during the death clearance process which helps reduce the number of "death clearance only cases" for the annual Call for Data submission; and assists in populating key demographic information (SSN, race, address, etc.) which are increasingly difficult for NCCR to acquire.

We've collected some nonanalytic case scenarios to assist your decision-making process as you analyze whether a case needs to be abstracted and reported to NCCR. Consider the following:

- Has the case been previously submitted by your facility?
- Do you have any information to piece together a case?
- Did the patient come in with a history of some type of cancer and then have a procedure done or scan showing METS at your facility?

Examples of Reportable NonAnalytic Cases:

The patient recently moved to Nevada from California and presents to your facility with severe abdominal pain; CT reveals liver METS; record indicates HX of breast cancer DX and TX in California; decision is made for hospice.

Example 1 for Class of Case 32: The patient recently moved to Nevada from California and presents to your facility with severe abdominal pain; CT reveals liver METS; record indicates HX of breast cancer DX and TX in California; decision is made for hospice.

> Rationale: This case should be reported because the patient will expire in Nevada and the only way, we would catch this case is by death certificate. *Make sure to complete the address at diagnosis fields to reflect where the patient was diagnosed.

Example 2 for Class of Case 32: The patient has an enlarged lymph node with a history of cervical cancer diagnosed elsewhere; a biopsy is performed at your facility; pathology is positive for metastatic disease from previous cervical cancer.

> Rationale: This case should be reported because the patient has pathologic confirmation metastatic disease, this was the first time your facility is reporting cervical cancer to the state registry.

Example 3 for Class of Case 32: Chart reads "PT has HX of lung cancer S/P lobectomy in 2003; presents W/dizziness; CT shows brain METS; BX shows brain METS and METS lung cancer."

> Rationale: If this case has not previously been reported, it should be reported because there is enough information to estimate diagnosis date and treatment information.

Example 4 for Class of Case 33: Chart reads: "PT has HX of CLL DX 5 years ago and was TX W/CHEMO."

> Rationale: Abstract this case because date of diagnosis and treatment can be estimated.

Example 5 for Class of Case 43: Lab receives specimen for pathology only case. Patient is not registered to your facility.

> Rationale: Your hospital receives consult slides for second opinion. NCCR conducts annual hospital pathology audits and this class of case is required to report.

Examples of Cases Not Reportable

- The patient comes in due to a motor vehicle accident and has a HX of CLL. There is no other information available about diagnosis date, treatment, etc.
- The patient is seen due to dehydration and there is a mention of a HX of cancer but insufficient information to construct a case.
- The patient comes in with a history of prostate cancer and is only seen for lab work.
- The patient is seen for a port-a-cath insertion only and there is no other information about the patient's cancer.

We strongly suggest developing a process to track all skipped cases with the reason why the case was not abstracted. Tracking these cases on an Excel spreadsheet, for example, would assist your facility when NCCR conducts a case finding audit on your facility.

Non-Reportable Cases

- Skin neoplasms (C44.0 – C44.9) that are NOT reportable
  - 8000-8005 malignant neoplasms, NOS of the skin
  - 8010-8046 epithelial carcinomas, NOS of the skin
  - 8050-8084 papillary and squamous cell carcinoma of the skin
  - 8090-8110 basal cell carcinoma of the skin

  - 8077/2 squamous intraepithelial neoplasia III (SIN III) of the skin

- BIRADS Category 4 and BIRADS Category 5 Diagnosis without biopsy is not reportable. A positive/suspicious mammogram date should be used as the date of diagnosis ONLY when the patient goes on to subsequently have a positive biopsy and/or resection that confirms the suspicious abnormality is in fact a malignancy.
- Colorectal tumors with the following morphologic description: serrated dysplasia, high grade; adenomatous polyp, high grade dysplasia; tubular adenoma, high grade; villous adenoma, high grade; tubule-villous adenoma, high grade.
- Microscopic thymoma or thymoma benign (8580/0), micronodular thymoma with lymphoid stroma (8580/1), and ectopic hamartomatous thymoma (8587/0).
- Patients who have a history of cancer, but diagnosis or treatment were not performed at your facility. (Class of case 33)
- Patients who receive transient care to avoid interruption of therapy started elsewhere (Class of case 31).
- Patients are seen only in consultation to confirm a diagnosis (Class of case 30).
- Patients with adenocarcinoma in situ and carcinoma in situ of the cervix, cervical intraepithelial neoplasia (CIN) or prostatic intraepithelial neoplasia (PIN).
- Patients with a pre-cancerous condition or benign tumor (other than CNS sites stated above).
- Patients above who are not reportable for your facility, but who die at your facility with active cancer. Although these cases are not required, they may be reported to NCCR. Cases not reported at the time of death may appear later on a Death Certificate Only listing (list of patients who died at your facility with cancer but not listed in the NCCR database). These will require additional follow-back by the registry and research by the registrar. A minimal abstract prepared with documentation of any available information regarding date of diagnosis, primary site, histology, or treatment is very useful.

SECTION 6: REQUIRED DATA ITEMS

This portion of the manual is intended to explain in detail each data item required by NCCR. It should be used as the primary information resource for any data item that must be coded and documented in accordance with Nevada cancer reporting law.

For more information on what is required by the standard setters, see v26: Required Status Table at the NAACCR website.

Data item descriptions and instructions are included in the CoC Store Manual, the NAACCR Volume II Data Dictionary, and the SEER Coding and Staging Manual; all are essentially comparable in content, rules, instructions, and examples provided to ensure consistent coding across platforms.

If your hospital uses cancer reporting software to abstract cancer cases or utilizes the registry Web Plus module all required data items must be included.

The descriptions and instructions for the data items are organized into sections following the same order as they appear in Web Plus. The sections include:

- Hospital Specific
- Patient Information
- Demographic
- Cancer Information
- Text Fields
- Stage of Disease
- Site Specific Data Items (SSDIs)
- Diagnostic Biopsy Procedures
- First Course of Treatment
- Radiation Therapy
- Chemotherapy
- Hormone Therapy
- Immunotherapy
- Other Treatment
- Patient Outcomes

Hospital Specific Data Items

AJCC TNM lookup tables are not available in Registry Plus software effective NAACCR v26. Refer to AJCC TNM 8th edition and AJCC Cancer Staging Protocols version 9 for AJCC TNM content.

Abstracted By: (570)

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

Reporting Facility: (540)

- The Reporting Facility identification number or FIN is used to identify a reporting facility in the central registry database and is useful for monitoring data submission, ensuring the accuracy of data and identifying areas for special studies.

NPI-Reporting Facility: (545)

- The NPI (National Provider Identifier) code for the facility submitting the data in the record.
- NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Date of 1st Contact: (580)

- YYYYYY date format.
- If the patient is diagnosed at the reporting facility, the date of diagnosis and the date of first contact will be the same. If the patient is diagnosed at an outside facility, the date of first contact is the date the treatment starts at the reporting facility.
- Date of first patient contact, as inpatient or outpatient, with the reporting facility for the diagnosis and/or treatment of the tumor.
- The date may represent the date of an outpatient visit for a biopsy, x-ray, scan, or laboratory test.
- When pathology-specimen-only tumors are collected (Class of Case 43, Type of Reporting Source 3), the date of specimen collection from the pathology report should be used as the Date of 1st Contact.
- If a pathology-specimen-only case is followed by patient contact with a facility for diagnosis and/or treatment of the respective tumor, ACoS coding rules require the hospital registry to change the Date of 1st Contact to reflect the date the patient first registered at that facility. Central registries, however, should retain the earlier date in their consolidated files, as that shows the patient's first recorded contact with the healthcare system for this disease.
- When death certificate only (Class of Case 49, Type of Reporting Source 7) tumors are collected, the date of death should be used as the Date of 1st Contact.
- When Autopsy Only (Class of Case 38, Type of Reporting Source 6) tumors are collected, the date of death should be used as the Date of 1st Contact.

Date Case Initiated: (2085)

- Date the electronic abstract is initiated in the reporting facility's cancer registry database.
- Standard edits check that no dates are later than the current date or the date completed.

Accession Number-Hosp: (550)

- Provides a unique identifier for the patient consisting of the year in which the patient was first seen at the reporting facility and the consecutive order in which the patient was abstracted.
- The first four digits of the Accession Number specify the year in which the patient had first contact with the reporting facility in the format CCYY. The last

five digits are the sequential/numeric order in which the registry entered the case into the database.

- Each patient receives only one accession number from your facility for a lifetime, regardless of the facility "reference date," number of primary cancers reported, or alternate numbering assignment.
- Within a registry, all primaries for an individual must have the same accession number. The first four digits must be greater than or equal to 1944.

Class of Case: (610)

- Use the drop down and select the Class of Case code to reflect the facility's role in managing the cancer.
- Class of Case divides cases into two groups. A decision to not treat is still considered treatment.
- Analytic cases (codes 00-22) which are grouped according to the location of diagnosis and first course of treatment.
- Nonanalytic cases (codes 30-49 and 99) which are grouped according to the reason a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.
- All analytic and certain types of nonanalytic cases are reportable to the NCCR.

Analytic Classes of Case Required by NCCR	
Code	Label
Initial diagnosis at reporting facility or in a staff physician's office	
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere.
10	Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS.
11	Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility.
12	Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility.
13	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility.
Initial diagnosis elsewhere, facility involved in first course treatment	
20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS.
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility.

Nonanalytic Classes of Case Required by NCCR	
Code	Label
Patients appear in person at reporting facility; both initial and treatment elsewhere	
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere).
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement).
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease).
33	Diagnosis AND all first course treatment provided elsewhere AND patients present at reporting facility with disease history only (disease not active).
34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility.
35	Case diagnosed before the program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility.
36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility.
37	Case diagnosed before the program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility.
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death.
Patient does not appear in person at reporting facility	
40	Diagnosis AND all first course treatment given at the same staff physician's office.
41	Diagnosis and all first course treatment are given in two or more different offices of physicians with admitting privileges.
42	Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility).
43	Pathology or other lab specimens only.
49	Death certificate only.
Unknown relationship with reporting facility	
99	Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).

Primary Payer at DX: (630)

- Use the drop-down and select the code that describes the primary payer or insurance carrier at the time of the initial diagnosis and/or treatment.
- If primary payer is unknown, select "99" for unknown.
- Do not leave blank.

Medicare Beneficiary Identifier: (2315)

- Congress passed the Medicare Access and CHIP Reauthorization ACT to remove Social Security Number (SSN) from Medicare ID card and replace the existing Medicare Health Insurance Claim Numbers with a Medicare Beneficiary Identifier (MBI).
- The MBI will be a randomly generated identifier that will not include an SSN or any personal identifiable information.
- The identifier consists of 11 characters using numbers 1-9 and letters A to Z. Record the Medicare Beneficiary ID number if the patient is a Medicare recipient and you have access to the Medicare Beneficiary ID.
- If the Medicare Beneficiary ID is unknown, leave blank.

Patient Information

Name-Last: (2230)

- Record the last name of the patient.
- Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.
- If the last name is unknown, record as UNKNOWN.
- Do not leave blank.

Example: Record with space "Mc Donald"; record with a hyphen "Smith-Jones"

Name-First: (2240)

- Record the first name of the patient.
- Blanks, spaces, hyphens, and apostrophes ARE allowed. Do not use other punctuation.
- If the first name is unknown, leave blank.

Name-Middle: (2250)

- Record the middle name of the patient.
- Blanks, spaces, hyphens, and apostrophes ARE allowed. Do not use other punctuation.
- If only a middle initial is known, record the letter only.
- If the middle name is unknown, leave blank.

Name-Suffix: (2270)

- Record the title that follows a patient's last name, such as generation order or credential status. (e.g., "Jr" or "MD").
- If the name suffix is unknown or not applicable, leave blank.

Name-Birth Surname: (2232)

- Record patient's last name (surname) at birth, regardless of gender or marital status.

- Other alternate names should be recorded in the data item, Name--Alias [2280].
- This data item may also be used to determine Hispanic origin.
- If birth surname is unknown or not applicable, leave blank.

Social Security No: (2320)

- Record the patient's social security number without dashes and without any letter suffix.
- If social security number is unknown or the patient does not have one, code as 999999999.
- If a partial social security only is known, code as 999999999.

Medical Record Number: (2300)

- Record the medical record number, usually assigned by the reporting facility's health information management (HIM) department.
- If the medical record number is unknown, leave blank.

Addr at DX-No & Street: (2330)

Note: All address data items should conform to the U.S. Postal Service Postal Addressing Standards. The address should be fully spelled out with standard use of abbreviations and punctuation per USPS postal addressing standards. The current USPS Pub. 28 may be found and downloaded here.

- Record the physical address of the patient at the time of diagnosis.
- Only record a post office box if you cannot locate in the medical record the physical address where the patient resided at diagnosis.
- Standard abbreviations:

Name	Abbreviation
Avenue	Ave
Boulevard	Blvd
Circle	Cr
Court	Ct
Drive	Dr
Lane	Ln
Place	Pl
Road	Rd
Street	St

Addr at DX-Supplemental: (2335)

- Record additional information listed for the patient's address at diagnosis, including nursing home, post office box, etc.
- If supplemental address is unknown or not applicable, leave blank.

Addr at DX-City: (70)

- Record the city of patient's physical address at the time of diagnosis.
- If the patient resides in a rural area, record the name of the city used in the mailing address.
- If the patient has multiple primaries, the city of residence may be different for each primary.
- If the city is unknown, enter unknown.

Addr at DX-State: (80)

- Default is “NV”.
- Use the drop-down and select the patient’s state of residence at the time of diagnosis.

Addr at DX-Postal Code: (100)

- Identifies the postal code of the patient’s address at diagnosis.
- For consolidated records, postal code may be based on reported or corrected residential address information.
- Record the extended 9-digit code or the short 5-digit code for the patient’s address at the time of diagnosis.
- If the patient is a resident of the United States and the postal code is unknown, enter 999999999.

County at DX Reported: (90)

- Use the magnifying glass to select the county of the patient’s residence at time of diagnosis.
- For U.S. residents, standard codes are those of the FIPS publication "Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas."
- The FIPS code is a number used by State and Federal agencies that uniquely identify geographic areas. Visit https://tinyurl.com/FIPSCountyCode for a table with all the cities in Nevada group by county.
- If the patient has multiple tumors, the county codes may be different for each tumor.
- Detailed standards have not been set for Canadian provinces/territories. Use code 998 for Canadian residents.
- If the county is unknown, enter 999.

Addr at DX-Country: (102)

- Default is “USA”.
- Use the magnifying glass to select the country in which the patient was born.
- Country code for the address of the patient's residence at the time the reportable tumor is diagnosed.
- If the patient has multiple tumors, the country of residence may be different for each tumor.
- This data item became part of the NAACCR transmission record effective with Volume II, Version 13 to include country and state for each geographic item and to use interoperable codes.
- It supplements the item Addr at Dx--State [80].
- If the country is unknown, enter ZZU.

Demographic

The Patient Demographics section of the abstract includes the set of data items used to describe personal information about an individual patient. When grouped, these data can be used to study how cancer rates differ by geographic location, as well as what groups are at a higher risk of certain types of cancer. Much of the information in this section is confidential in nature and can be used to identify individual patients. Care must be always taken to assure patient confidentiality when reporting cases.

Date of Birth: (240)

- Date of birth of the patient.
- YYYYMMDD date format.
- If age at diagnosis and year of diagnosis are known, but year of birth is unknown, then year of birth should be calculated and so coded. Only the year should be entered, left-justified.
- Estimate date of birth when information is not available. It is better to estimate than to leave birth date unknown.

Example:

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

Sex Assigned at Birth: (225) NEW V26

- Use the drop-down and select the code for the sex of the patient assigned at birth.
- This new data item will replace existing data item Sex [220] for all cases regardless of diagnosis year.
- Existing data in Sex [220] will be converted and used to populate the new data item.

Marital Status at DX: (150)

- Use the drop-down and choose the appropriate code to record the marital status of the patient.
- If the patient has multiple tumors, marital status may be different for each tumor.

Tobacco Use Smoking Status: (344)

- Use the drop-down and select the code that describes the code that best describes the patients' smoking status.
- Tobacco Use Smoking Status indicates the patient's past or current smoking use of tobacco (cigarette, cigar and/or pipe).
- Tobacco Use Smoking Status does not include marijuana, chewing tobacco, e-cigarettes, or vaping devices.
- Tobacco smoking history can be obtained from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats or Nursing Assessment section, or other available sources from the patient's hospital medical record or physician office record.
- Use code 1 if there is evidence in the medical record that the patient quit smoking within 30 days prior to diagnosis. The 30 days prior information is intended to differentiate patients who may have quit recently due to symptoms that led to a cancer diagnosis.
- Use code 2 if medical record indicates patient smoked tobacco in the past but does not smoke now. Patient must have quit 31 or more days prior to cancer diagnosis to be coded as 'Former smoker.'

- Use code 3 if it cannot be determined whether the patient currently smokes or formerly smoked. For example, the medical record only indicates "Yes" for smoking without further information.
- Use code 9 (Unknown if ever smoked) rather than code 0 (Never smoker), if
  - the medical record only indicates "No" for tobacco use;
  - smoking status is not stated or provided; or
  - the method (cigarette, pipe, cigar) used cannot be verified in the chart.
- This data item can be left blank for cases diagnosed prior to 1/1/2022.

Race 1: (160)

- Use the drop-down and choose the appropriate code to record the patient's race.
- Race is coded separately from Spanish/Hispanic Origin [190].
- All tumors for the same patient should have the same race codes.
- If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164].
- For coding instructions and race code history see the current SEER Program Coding and Staging Manual to accurately code this data item.

Special Note for Nevada Registrars:

- Code Race 1 as 01 (White) when the race is described as White or Caucasian regardless of place of birth OR if there is a statement that the patient is Hispanic or Latino(a) and no further information is available.
- Race 2 through Race 5 should be coded to 99. Do not use code 98 (Other).

Race 2-5: (161-164)

- Default is "88".
- Use the drop-down and choose the appropriate code to record the patient's race.
- Race codes 2-5 must ALL be completed, even if race is unknown.
- Race is coded separately from Spanish/Hispanic Origin [190].
- All tumors for the same patient should have the same race codes.
- If the patient is multiracial, code all races using RACE 2 through RACE 5 [161-164].
- For coding instructions and race code history see the current SEER Program Coding and Staging Manual to accurately code this data item.

Spanish/Hispanic Origin: (190)

Ethnic origin has a significant association with cancer rates and outcomes. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the "white" category of race data item (160). The following coding instructions are from the SEER Program and Staging Manual (page 86):

Coding Instructions

- Coding Spanish Surname or Origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.
- Use all information to determine the Spanish/Hispanic origin including:
  - The ethnicity stated in the medical record
  - Hispanic origin stated on the death certificate
  - Birthplace

    - Information about life history and/or language spoken found in the abstracting process
    - A last name or maiden name (birth surname) found on a list of Hispanic/Spanish names
- Assign code 6 when there is more than one ethnicity/origin (multiple codes), such as Mexican (code 1) and Dominican Republic (code 8). There is no hierarchy among the codes 1-5 or 8.
- Assign code 7 when the only evidence of the patient's Hispanic origin is a surname or maiden name (birth surname) and there is no evidence that the patient is not Hispanic. Code 7 is ordinarily for central registry use only.
- Portuguese, Brazilians, and Filipinos are not presumed to be Spanish or non-Spanish:
    - Assign code 7 when the patient is Portuguese, Brazilian, or Filipino and their name appears on a Hispanic surname list
    - Assign code 0 when the patient is Portuguese, Brazilian, or Filipino and their name does NOT appear on a Hispanic surname list
- Assign code 9:
    - For death certificate only (DCO) cases when Spanish/Hispanic origin is unknown
    - When there is no written or verbal indication of Spanish origin, the patient declined to answer their Spanish origin, or the patient does not know their Spanish origin.

Example: The patient's race is white or black, they were born in the United States, their last name is not on a Spanish surname list, and there is no mention of Spanish origin in the patient record. Code to Non-Hispanic.

Birthplace-State: (252)

- Default is "US".
- Use the drop down and select the state in which the patient was born.
- USPS abbreviation for the state, commonwealth, U.S. possession; or CanadaPost abbreviation for the Canadian province/territory in which the patient was born.
- If the patient has multiple primaries, the state of birth is the same for each tumor.
- This data item became part of the NAACCR transmission record effective with Volume II, Version 13 to include country and state for each geographic item and to use interoperable codes. It supplements the item BIRTHPLACE--COUNTRY [254]. These two data items are intended to replace the item BIRTHPLACE [250].
- If unknown, select "ZZ" for unknown.

Birthplace-Country: (254)

- Default is "USA".
- Use the magnifying glass to select the country in which the patient was born.
- Code for the country in which the patient was born.
- If the patient has multiple tumors, all records should contain the same code. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 to include country and state for each geographic item and to use interoperable codes. It supplements the item BIRTHPLACE--STATE [252]. These two data items are intended to replace the use of BIRTHPLACE [250].

- Use “ZZU” for unknown.

Text-Usual Occupation: (310)

- Text area for information about the patient’s usual occupation, also known as usual type of job or work.
- **Required when available** Record the longest held occupation of the patient if known.”
- If the patient was a homemaker and worked outside the home during most of his/her adult life, record the usual occupation outside the home; if the patient was a homemaker *and* did not work outside the home for most of his/her adult life, record “homemaker.”
- If the patient was not a student or homemaker and had never worked, record “never worked” as the usual occupation.
- Do NOT record “retired. If retired enter UNKNOWN.
- If not known enter UNKNOWN.

Example: Teacher

Use the Cancer Registrar’s Guide to Collecting Industry and Occupation for more instructions and information.

Text-Usual Industry: (320)

- Text area for information about the patient’s usual industry, also known as usual kind of business/industry.
- **Required when Available** Record the industry of the longest held occupation.
- If not known enter UNKNOWN.

Example: Education.

Cancer Information

Sequence Number-Hospital: (560)

- Default is “00”.
- Item indicates the sequence of all malignant and non-malignant neoplasms over the lifetime of the patient.
- The code may differ from the Sequence Number--Central [380] because the definitions of reportable neoplasms often vary between a hospital and a central registry. The two items also handle different types of tumors.
- Each neoplasm is assigned to a different number.
- Sequence Number 00 indicates that the person has only one malignant neoplasm in his lifetime (regardless of hospital registry reference date).
- Sequence Number 01 indicates the first of two or more malignant neoplasms, while 02 indicates the second of two or more malignant neoplasms, and so on.
- Because the time period of Sequence Number is a person’s lifetime, reportable neoplasms not included in the hospital registry are also allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the hospital registry’s reference date.
- Similarly, Sequence Number 60 indicates the patient has only one non-malignant neoplasm, and Sequence Number 61 represents the first of multiple non-malignant neoplasms.

- Sequence numbers should be reassigned if the facility subsequently learns of an unaccessioned tumor that affects sequencing. Sequence Number-Central [380] does not affect Sequence Number-Hospital. The two notational systems are independent.

Timing Rule
If two or more malignant tumors are diagnosed at the same time, the lowest sequence number will be assigned to the diagnosis with the worst prognosis. Likewise, if two or more non-malignant tumors are diagnosed at the same time, the lowest sequence number is assigned to the diagnosis with the worse prognosis. If no difference in prognosis is evident, the decision is arbitrary.

Date of Diagnosis: (390)

- YYYYMMDD format.
- Record the date the cancer was first diagnosed, whether clinically (physician's documentation, x-ray, CT scan) or pathologically (biopsy, surgery).
- For more discussion on determining date of diagnosis, consult the SEER Program and Staging Manual or CoC STORE manual.

Age at Diagnosis: (230)

- Click the calculation icon and this field will auto populate.
- Data items Date of Diagnosis and Date of Birth must be completed to derive the age at diagnosis.
- Different tumors for the same patient may have different values.

Text-Place of Diagnosis: (2690)

- Text area for manual documentation of the facility, physician office, city, state, or county where the diagnosis was made.
- The complete name of the hospital or the physician office where diagnosis occurred. The initials of a hospital are not adequate.
- For out-of-state residents and facilities, including the city and the state where the medical facility is located.

Text-Primary Site Title: (2580)

- Text area for manual documentation of information regarding the primary site and laterality of the tumor being reported.
- State the specific location of the primary site, including subsite.
- Include available information on tumor laterality.
- Do not leave blank.

Example 1: Right lower lobe of lung

Example 2: Skin, left forearm

Primary Site: (400)

- Use the magnifying glass to search for the topography code for the site of origin of the primary solid tumor from the *International Classification of Disease for Oncology* (ICD-O-3).
- The terms site, primary site, and topography are used synonymously.

- You can still use the "purple book" to find the topography code for the primary site of origin. If the medical record does not contain the information, consult with the physician to identify the primary site.
- Follow the coding instructions in ICD-O-3 and in the most current version of the SEER Solid Tumor Rules to assign primary site for solid tumors.
- Try not to assign unknown/ill-defined site topography codes; they are general terms with vague anatomy. Unknown/ill-defined sites include: 069, 189, 260-269, 328-329, 390-399, 409, 419, 479, 499, 559, 579, 639, 760-769, and 809.
- Assigning code C80.9 should be a rare occurrence. Hospital registrars should take the time to research these cases in order to avoid using C80.9. This would include scrubbing the medical record for any clues that could lead to a better code, or, if possible, presenting the case at cancer conference (tumor board) to obtain more definitive information about the tumor.
- If it is still not possible to determine primary site, abstract the case as an unknown primary and document as much information in the text fields from the pathology report, operative report, etc.
- NCCR plans on following back to facilities with a list of abstracts that were coded to C80.9 (unknown primary, NOS). Every attempt should be made to determine the most appropriate code to avoid using C80.9.
- When coding specific tissue with ill-defined sites use the alphabetic index in ICD-O-3 to assign the most specific code if only a general location is specified in the record.
- Do not use topography codes in the C76 series for soft tissue neoplasms or neoplasms of unknown primary. Use the most specific soft/tissue primary site codes.
- Use Code C76.0 for node positive head and neck cancer without evidence of a primary site.

Use the following table to assign primary site where the only information available is the histologic type of tumor and the patient has metastatic disease without an identifiable primary site.

Histologic Groups	Preferred Site Codes for Ill-Defined Primary Sites
Melanoma	C44.9 Skin, NOS
Sarcoma	C49.9 Connective & Subcutaneous Soft Tissue
Meningioma	C70.9 Meninges, NOS
Cholangiocarcinoma	C24.0 Bile Duct, NOS
Hepatocellular Carcinoma	C22.0 Liver
Retinoblastoma	C69.2 Retina
Lymphoma	C77.9 Lymph Nodes, NOS
Multiple Myeloma	C42.1 Bone Marrow
Leukemia/Hodgkins	C77.9
Kaposi Sarcoma	C44.9 Skin

Laterality: (410)

- Use the drop down and select the laterality of the primary tumor.
- Code for the side of a paired organ, or the side of the body on which the reportable tumor originated.

- This applies to the primary site only.
- Review the list of paired organ sites to determine which primary sites require tumor laterality coded.
- For tumors which are not listed as a paired organ, select “0” (organ is not a paired site.

LIST OF PAIRED ORGANS	
ICD-0-3 Code	Site
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum - use code 0)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina - use code 0)
C34.1	Upper lobe, lung
C34.2	Middle lobe, lung
C34.3	Lower lobe, lung
C34.8	Other parts of lung or bronchus
C34.9	Lung, NOS
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bones of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum - use code 0)
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis - use code 0)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face (if midline, code 5)
C44.4	Skin of scalp and neck
C44.5	Skin of trunk (if midline, code 5)
C44.6	Skin of arm and shoulder
C44.7	Skin of leg and hip
C50.0-C50.9	Breast (male and female)
C56.9	Ovary
C57.0	Fallopian tube
C62.0	Undescended testis
C62.1	Descended testis
C62.9	Testis, NOS

LIST OF PAIRED ORGANS	
ICD-0-3 Code	Site
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges
C71.0	Cerebrum
C71.1	Frontal lobe
C71.2	Temporal lobe
C71.3	Parietal lobe
C71.4	Occipital lobe
C72.2	Olfactory nerve
C72.3	Optic nerve
C72.4	Acoustic nerve
C72.5	Cranial nerve, NOS
C74.0-C74.9	Suprarenal gland
C75.4	Carotid body

Text-Histology Title: (2590)

- Text area for manual documentation of information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.
- Information on histologic type and behavior.
- Information on differentiation from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc.
- Do not leave blank.

Example: Superficial spreading melanoma

Example: Ductal carcinoma in situ

Histologic Type ICD-O-3: (522)

- Use the magnifying glass to search by histology name for the histology code.
- For solid tumors, use the search icon or use the ICD-O-3.2 Spreadsheet to search for the histology code. The ICD-O-3.2 histology lists have been updated; however, a published manual has been delayed due to the COVID-19 pandemic.
- If a report only has a diagnosis of "cancer" or "malignancy," code to 8000, malignant neoplasm.
- If a diagnosis is reported as "carcinoma," code to 8010.

For hematopoietic and lymphoid neoplasms, use the following guide for histology coding:

- Acute myeloid leukemia (AML) – 9861
- Chronic myeloid leukemia (CML) – 9863
- Acute lymphoblastic leukemia (ALL) – 9811
- Chronic lymphocytic leukemia (CLL) – 9823

- Non-Hodgkin lymphoma – 9591
- Hodgkin's Disease (lymphoma) – 9650
- Multiple myeloma (Plasma Cell Myeloma) – 9732
- Myelodysplastic syndrome – 9989

Behavior Code ICD-O-3: (523)

- Use the drop-down and select the behavior of the primary tumor.
- Code for the behavior of the tumor being reported using ICD-O-3. NAACCR adopted ICD-O-3 as the standard coding system for tumors diagnosed beginning January 1, 2001, and later recommended that prior cases be converted from ICD-O-2. See Behavior (92-00) ICD-O-2 [430], for ICD-O-2 codes.
- Juvenile astrocytoma is coded as borderline in ICD-O-3; North American registries report as 9421/3.
- Tumor behavior is used by pathologists to describe whether the tumor is benign (0), borderline (1), in situ (2) or malignant (3).
- Benign and borderline behavior codes are used for intracranial and central nervous system primary sites only.
- In the absence of pathologic examination, code behavior as invasive (3). In situ behavior (2) can only be identified by pathologic examination.

ICD-O-3 Conversion Flag: (2116)

- Default is "0".
- Use the drop down and select the code specifying how the conversion of site and morphology codes from ICD-O-2 to ICD-O-3 was accomplished.

Grade: (440)

- Use the drop down and select the code for the grade or degree of differentiation of the reportable tumor.
- For lymphomas and leukemias, field also is used to indicate T-, B-, Null-, or NK-cell origin.
- Code 8 was adopted for use with lymphoma cases diagnosed in 1995 and later.

Grade Clinical: (3843)

- This data item records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant).
- For cases diagnosed January 1, 2018, and later, this data item, along with Grade Pathological and Grade Post-Neoadjuvant, replaces NAACCR Data Item Grade [440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).
- Record the grade of the primary tumor from the biopsy specimen. This data item cannot be blank.
- Benign Brain, CNS and Other Intracranial gland: For benign tumors ONLY (behavior 0), code 1 can be automatically assigned for all histologies. This was confirmed by the College of American Pathology (CAP) Cancer Committee.
- Do not leave blank.

Grade Pathological: (3844)

- This data item records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered.
- If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup.
- Record the highest grade documented from any microscopic specimen of the primary site whether from the clinical work-up or the surgical resection.
- For cases diagnosed January 1, 2018, and later, this data item, along with Grade Clinical and Grade Post-Neoadjuvant, replaces NAACCR Data Item Grade [440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).
- If the patient has not yet had or there is no plan to have a surgical resection, use code 9.
- Do not leave blank.

Grade Post Therapy Clinical (yc): (1068)

- This data item records the grade of a solid primary tumor that has been microscopically sampled following neoadjuvant therapy or primary systemic/radiation therapy.
- If AJCC staging is being assigned, the tumor must have met the neoadjuvant therapy or primary systemic/radiation therapy requirements in the AJCC manual or according to national treatment guidelines.
- Record the highest grade documented from the microscopically sampled specimen of the primary site following neoadjuvant therapy or primary systemic/radiation therapy.
- For cases diagnosed January 1, 2021, and later, this data item, along with Grade Clinical, Grade Pathological, and Grade Post Therapy Path (yp), replaces NAACCR Data Item Grade [440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Grade Post Therapy Path (yp): (3845)

- This data item records the grade of a solid primary tumor that has been resected following neoadjuvant therapy. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual.
- Record the highest grade documented from the surgical treatment resection specimen of the primary site following neoadjuvant therapy.
- For cases diagnosed January 1, 2018, and later, this data item, along with Grade Clinical and Grade Pathological, replaces NAACCR Data Item Grade [440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Diagnostic Confirmation: (490)

- Use the drop-down and select the appropriate method of diagnostic confirmation.
- Code for the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history.

Casefinding Source: (501)

- Default is "22".
- These variable codes the earliest source of identifying information.
- For cases identified by a source other than reporting facilities (such as through death clearance or as a result of an audit), this variable codes the type of source through which the tumor was first identified.
- This data item cannot be used by itself as a data quality indicator. The timing of the casefinding processes (e.g., death linkage) varies from registry to registry, and the coded value of this variable is a function of that timing.

Schema Selection

AJCC ID: (995)

- AJCC TNM lookup tables are not available in Registry Plus software effective NAACCR v26. Refer to AJCC TNM 8th edition and AJCC Cancer Staging Protocols version 9 for AJCC TNM content.
- The values for this data item are based on the chapters of the AJCC manual and will be derived primarily from the site/histology fields and other data items as required. IDs are assigned to cases for which AJCC staging is applicable.
- When staging is not applicable, code 'XX' is used.

Schema ID: (3800)

- Click the calculate icon and this field will auto populate.
- Records a site-specific data item.
- The derived values in this data item link Site-Specific Data Items (including grade data items) with the appropriate site/histology grouping and accounts for every combination of primary site and histology.
- The values for this data item are derived based on primary site, histology, and schema discriminator fields (when required). The derived values link Site-Specific Data Items with the appropriate site/histology grouping.
- For example, the Schema ID for adenocarcinoma of the lung is 00360. This value links the Site-Specific Data Items associated with adenocarcinoma of the lung: Separate Tumor Nodules [3929], Visceral and Parietal Pleural Invasion [3937], and Pleural Effusion [3913].
- The Schema ID would also link to the appropriate grade data items an adenocarcinoma of the lung.
- The AJCC ID [995] code for Lung is 36. The AJCC ID [995] would link to the AJCC TNM Data items (Clin T, Clin N, Etc.) specific to Lung.

Schema Discriminator 1: (3926)

- Use the magnifying glass for applicable codes and instructions.
- Captures additional information needed to generate AJCC ID [995] and Schema ID [3800] for some anatomic sites.
- Discriminators can be based on sub site, histology or other features which affect prognosis.

Schema Discriminator 2: (3927)

- Use the magnifying glass for applicable codes and instructions.

- Captures additional information needed to generate AJCC ID [995] and Schema ID [3800] for some anatomic sites.
- Discriminators can be based on sub site, histology or other features which affect prognosis.

CS Site-Specific Factor25: (2879)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Text Fields

See Text Documentation Requirements under the appendices section for more instructions and resources for text documentation.

Text-DX Proc-Path: (2570)

- Text area for manual documentation of information from cytology and histopathology reports.
    - Date(s) of procedure(s)
    - Anatomic source of specimen
    - Type of tissue specimens
    - Tumor type and grade (including all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.)
    - Gross tumor size
    - Extent of tumor spread
    - Involvement of resection margins
    - Number of lymph nodes involved and examined
    - Record both positive and negative findings. Record positive test results first.
    - Note if pathology report is a slide review or a second opinion from an outside source, i.e., AFIP, Mayo, etc.
    - Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored
- Do not repeat information from other text fields.
- If Pathology is unknown or not applicable, record 'NONE' in the text field.
- Do not leave blank.

Example: 9/5/18 (2023-00021): wide EXC skin LT forearm: BX site changes; no residual melanoma identified; MARG (-); no LNs examined.

Text-DX Proc-PE: (2520)

- Text area for manual documentation from the history and physical examination about the history of the current tumor and the clinical description of the tumor.
    - Date of physical exam
    - Age, sex, race/ethnicity
    - History that relates to cancer diagnosis
    - Primary site
    - Histology (if diagnosis prior to this admission)
    - Tumor location
    - Tumor size
    - Palpable lymph nodes

  - Record positive and negative clinical findings. Record positive results first
  - Impression (when stated and pertains to cancer diagnosis)
  - Treatment plan
- If Physical Exam is unknown or not applicable, record “NONE”.
- Do not leave blank.

Example: 54-year-old white male with a dark brown area on the left forearm approximately 1 cm. History of smoking, 2 packs a day for 20 years. No personal history of cancer.

Text Remarks: (2680)

- Text area for information that is given only in coded form elsewhere or for which the abstract provides no other place.
- Overflow data can also be placed here. Problematic coding issues can also be discussed in this section.
  - Smoking history
  - Family and personal history of cancer
  - Comorbidities
  - Information on sequence numbers if a person was diagnosed with another primary out-of-state or before the registry’s reference date
  - Place of birth
  - Justification of over-ride flags
  - Information clarifying anything unusual such as reason for reporting a case seemingly not reportable for that facility or reason for coding numerous fields as “unknown.”
- If remarks are unknown or not applicable, record “NONE”.
- Do not leave blank.

Example: Married, white, non-Hispanic; Medicare managed care; former 1 PPD smoker x 20 years (quit 2010); no ETOH HX; no family HX or personal HX of cancer; patient record says “born in Los Angeles, CA”; worked as nurse in healthcare industry.

Text-DX Proc-X-ray/Scan: (2530)

- Text area for manual documentation from all X-rays, scan, and/or other imaging examinations that provide information about staging.
  - Date(s) and type(s) of X-ray/Scan(s)
  - Primary site
  - Histology (if given)
  - Tumor location
  - Tumor size
  - Lymph nodes
  - Record positive and negative clinical findings. Record positive results first
  - Distant disease or metastasis
- If X-ray/Scan is unknown or not applicable, record ‘NONE’ in the text box.
- Do not leave blank.

Note: Do not record Bi-Rads for mammograms. This cannot be used to determine reportable status.

Example: 11/21/12 CT Chest: 2.5 cm lesion within the RML of lung, with hilar and mediastinal adenopathy. Largest lymph node, right hilum 2.2 cm.

Text-DX Proc-Lab Tests: (2550)

- Text area for manual documentation of information from laboratory examinations other than cytology or histopathology.
    - Date(s) and type(s) of X-ray/Scan(s)
    - Primary site
    - Histology (if given)
    - Tumor location
    - Tumor size
    - Lymph nodes
    - Record positive and negative clinical findings. Record positive results first
    - Distant disease or metastasis
- If Lab Tests are unknown or not applicable, record 'NONE' in the text box.
- Do not leave blank.

Text-DX Proc-Scopes: (2540)

- Text area for manual documentation from endoscopic examinations that provide information for staging and treatment.
    - Date(s) of endoscopic exam(s)
    - Primary site
    - Histology (if given)
    - Tumor location
    - Tumor size
    - Record site and type of endoscopic biopsy
    - Record positive and negative clinical findings. Record positive results first.
- If Scopes is unknown or not applicable, record 'NONE' in the text box.
- Do not leave blank.

Example: 4/2/18 Colonoscopy: Large fungating mass in the sigmoid colon beginning at 20 cm from the anal verge and extending to 24 cm, 4 cm in length, biopsied.

Text-DX Proc-Op: (2560)

- Text area for manual documentation of all surgical procedures that provide information for staging.
    - Date(s) of endoscopic exam(s)
    - Primary site
    - Histology (if given)
    - Tumor location
    - Tumor size
    - Record site and type of endoscopic biopsy
    - Record positive and negative clinical findings. Record positive results first.
- Also called "findings" this text area is for manual documentation of all biopsy and surgical procedures that provide information for staging.
- Document dates, names of procedures, along with abnormal findings, and location of tumor.
- Document observations of the surgeon (what is seen/felt/palpated) when the patient is opened up/explored.
- Do not record what surgeon did (step by step procedure). Do not record path findings.

- If Operative Report is unknown or not applicable, record 'NONE' in the text field. Do not leave blank. Record "technique only" if no findings are documented.

Example: 8/6/18 Punch biopsy of dark skin lesion on left forearm.

Stage of Disease

Text-Staging: (2600)

- Additional text area for staging information not already entered in other Text fields.
    - TNM and Stage Group information.
    - Date(s) of procedure(s), including clinical procedures, that provided information for assigning stage
    - Organs involved by direct extension
    - Size of tumor
    - Status of margins
    - Number and sites of positive lymph nodes
    - Site(s) of distant metastasis
    - Physician's specialty and comments
- If Staging information is unknown or not applicable, record 'NONE' in the text box.
- Do not leave blank.

Note: Text-Staging: SS2018 (description) clinical and pathologic TNM for case.

Example: SS2018 Localized cT1 cN0 cM0 Stage 1 pT1 cN0 cM0 Stage 1.

SEER Summary Stage 1977: (760)

- Use the dropdown for applicable codes.
- Code for summary stage at the initial diagnosis or treatment of the reportable tumor. This has traditionally been used by central registries to monitor time trends.
- For hospital registries, CoC requires its use in the absence of a defined AJCC classification.
- For site-specific definitions of categories, see the SEER Summary Staging Guide.
- SEER Summary Stage 1977 is limited to information available within 2 months of the date of diagnosis.
- NAACCR approved extension of this time period to 4 months for prostate tumors diagnosed beginning January 1, 1995.

SEER Summary Stage 2000: (759)

- Use the dropdown for applicable codes.
- Code for summary stage at the initial diagnosis or treatment of the reportable tumor.
- For hospital registries, CoC requires its use in the absence of a defined AJCC classification.
- For site-specific definitions of categories, see SEER Summary Staging Manual 2000.
- Summary stage should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Summary Stage 2018: (764)

NCCR and NPCR requires directly assigned Summary Stage 2018 and voluntary capture of AJCC TNM staging.

- Use the magnifying glass for applicable codes and instructions.
- This item stores the directly assigned Summary Stage 2018. Effective for cases diagnosed 1/1/2018+.
- Summary Stage groups cases into broad categories of in situ, local, regional, and distant.
- Summary Stage can be used to evaluate disease spread at diagnosis, treatment patterns and outcomes over time.
- Use the Summary Stage 2018 Manual, (published November 2025) to help you determine the stage.
- A new SS2018 chapter for Medulloblastoma has been added for cases diagnosed from January 1, 2023, and forward.

Regional Nodes Positive: (820)

- Default is “98”.
- Use the magnifying glass for applicable codes and instructions.
- Records the exact number of regional nodes examined by the pathologist and found to contain metastases.
- Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system.
- For tumors diagnosed from 1988 through 2003, this item was part of the 10-digit EOD [779], detailed site-specific codes for anatomic EOD.
- If biopsy or aspiration of regional node is positive, code “95”.
- If no regional lymph nodes were examined by pathologist, code “98”.

Example: Two regional nodes are positive as reported by the pathologist. Record Regional LN Positive as 02.

Regional Nodes Examined: (830)

- Default is “00”.
- Use the magnifying glass for applicable codes and instructions.
- Records the total number of regional lymph nodes that were removed and examined by the pathologist.
- Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system.
- If only biopsy or aspiration of regional node is performed, code “95”.
- If no regional lymph nodes were examined by pathologist, code “00”.

Example: Pathologist states that 15 regional lymph nodes were removed during resection of a colon cancer. Record Regional LN Examined as 15.

Date Regional Lymph Node Dissection: (682)

- YYYYMMDD format.
- Records the date of the non-sentinel regional node dissection was performed.
- This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.

Date of Sentinel Lymph Node Biopsy: (832)

- YYYYMMDD format.
- Records the date of the sentinel lymph node(s) biopsy procedure.
- This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.
- This data item is required for breast and melanoma cases only.

Sentinel Lymph Nodes Positive: (835)

- Use the magnifying glass for applicable codes and instructions.
- Records the exact number of sentinel lymph nodes biopsied by the pathologist and found to contain metastases.
- This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.
- This data item is required for breast and melanoma cases only.

Sentinel Lymph Nodes Examined: (834)

- Use the magnifying glass for applicable codes and instructions.
- Records the total number of lymph nodes sampled during the sentinel node biopsy and examined by the pathologist.
- This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.
- This data item is required for breast and melanoma cases only.

Tumor Size Summary: (756)

- Use the magnifying glass for applicable codes and instructions.
- This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.
- Record the largest dimension or diameter of the primary tumor in millimeters in this 3-digit field. 1 centimeter (cm) is equal to 10 millimeters (mm). To convert centimeters to millimeters, multiply by 10.
- Do not add the size of pieces or chips together to create a whole; they may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size.
- If the only measurement describes pieces or chips, record tumor size as 999.

Example: Tumor is described as 3.5 cm. 3.5 cm x 10 = 35 mm. Record Tumor Size as 035.

Lymphovascular Invasion (LVI): (1182)

- Use the dropdown for applicable codes.
- Lymphovascular invasion (LVI) indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist.
- LVI includes lymphatic invasion, vascular invasion, and lymphovascular invasion.

Mets at DX-Bone: (1112)

- Use the dropdown for applicable codes.
- This field identifies whether bone is an involved metastatic site.

- The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Mets at DX-Brain: (1113)

- Use the dropdown for applicable codes.
- This field identifies whether brain is an involved metastatic site.
- The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Mets at DX-Distant Ln: (1114)

- Use the dropdown for applicable codes.
- This field identifies whether distant lymph node(s) are an involved metastatic site.
- The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Mets at DX-Liver: (1115)

- Use the dropdown for applicable codes.
- This field identifies whether liver is an involved metastatic site.
- The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Mets at DX-Lung: (1116)

- Use the dropdown for applicable codes.
- This field identifies whether lung is an involved metastatic site.
- The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Mets at DX-Other: (1117)

- Use the dropdown for applicable codes.
- The six Mets at Dx-Metastatic Sites fields provide information on metastases for data analysis.
- This field identifies any type of distant involvement not captured in the Mets at Dx-Bone [1112], Mets at Dx-Brain [1113], Mets at Dx-Liver [1115], Mets at Dx-Lung [1116], and Mets at Dx-Distant LN [1114] fields. It includes involvement of other specific sites and more generalized metastases such as carcinomatosis. Some examples include but are not limited to the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum, and skin.

TNM Edition Number: (1060)

- Use the dropdown for applicable codes.
- A code that indicates the edition of the AJCC manual used to stage the case. This applies to the manually coded AJCC fields. It does not apply to the Derived AJCC T, N, M and AJCC Stage Group fields [2940, 2960, 2980, and 3000].

AJCC API Version Current: (2156)

- This item indicates the version of the AJCC TNM API incorporated into the cancer registry software that created the record with TNM staging data in the 8th and later versions. It should be recorded the first time the AJCC Release ID (including a value of 08.01.00) is determined and should be updated each time the related input fields listed below are modified.

- A valid value is required for all cases diagnosed 2018 or later that have values entered in the AJCC or related data items. Cases abstracted prior to implementation of this data item will be assigned a value of 08.XX.XX during the conversion to v21.

Site Specific Data Items (SSDI)

Site specific data items apply to specific primary sites, histologies and years of diagnosis. To display the relevant SSDIs for the case, you must first enter the Date of first contact, Sex, Date of diagnosis, Primary site, Histology and Behavior then click Save. Use the magnifying glass next to the data item for code choices and instructions for coding.

Note: Some site and histology combinations also require schema discriminators. These will be listed in the SSDI section. You will also be notified with a pop-up message letting you know a schema discriminator is required.

Adenopathy: (3804)

- Use the magnifying glass for applicable codes and instructions.
- Adenopathy is defined as the presence of lymph nodes greater than 1.5 cm on physical examination (PE) and is part of the staging criteria for Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL).

AFP Post-Orchiectomy Range: (3806)

- Use the magnifying glass for applicable codes and instructions.
- AFP (Alpha Fetoprotein) Post-Orchiectomy Range identifies the range category of the lowest AFP value measured post-orchiectomy.
- AFP is a serum tumor marker that is often elevated in patients with nonseminomatous germ cell tumors of the testis.
- The post-orchiectomy lab value is used to monitor response to therapy.

AFP Pre-Orchiectomy Range: (3808)

- Use the magnifying glass for applicable codes and instructions.
- AFP (Alpha Fetoprotein) Pre-Orchiectomy Range identifies the range category of the highest AFP value measured prior to treatment.
- AFP is a serum tumor marker that is often elevated in patients with nonseminomatous germ cell tumors of the testis.

AFP Pretreatment Interpretation: (3809)

- Use the magnifying glass for applicable codes and instructions.
- AFP (Alpha Fetoprotein) Pretreatment Interpretation, a nonspecific serum protein that generally is elevated in the setting of hepatocellular carcinoma (HCC), is a prognostic factor for liver cancer.

AFP Pretreatment Lab Value: (3810)

- Use the magnifying glass for applicable codes and instructions.
- AFP (Alpha Fetoprotein) Pretreatment Lab Value is a nonspecific serum protein that generally is elevated in the setting of hepatocellular carcinoma (HCC).
- This data item pertains to the pre-treatment lab value.

ALK Rearrangement: (3938)

- Use the magnifying glass for applicable codes and instructions.

- ALK rearrangement is recommended by treatment guidelines for patients with advanced lung cancer as a prognostic marker and factor in determining appropriate therapy.
- It is a new data item for cases diagnosed 01/01/2021+.

Anemia: (3811)

- Use the magnifying glass for applicable codes and instructions.
- Anemia is defined by a deficiency of red blood cells or of hemoglobin in the blood.
- In staging of Chronic Lymphocytic Leukemia/Small Lymphocytic Leukemia (CLL/SLL), anemia is defined as Hgb less than 11.0 g/dL.

B Symptoms: (3812)

- Use the magnifying glass for applicable codes and instructions.
- B symptoms refer to systemic symptoms of fever, night sweats, and weight loss which can be associated with both Hodgkin lymphoma and some non-Hodgkin lymphomas.
- The presence of B symptoms is a prognostic factor for some lymphomas.

BRAF Mutational Analysis: (3940)

- Use the magnifying glass for applicable codes and instructions.
- The BRAF oncoprotein is involved in transmitting cell growth and proliferation signals from KRAS and NRAS.
- The BRAF V600E mutation is associated with poorer prognosis and predicts lack of response to anti-EGFR therapies.

Brain Molecular Markers: (3816)

- Use the magnifying glass for applicable codes and instructions.
- Multiple brain molecular markers have become standard pathology components necessary for diagnosis.
- This data item captures clinically important brain cancer subtypes identified by molecular markers that are not distinguishable by ICD-O-3 codes.

Brain Primary Tumor Location: (3964)

- Use the magnifying glass for applicable codes and instructions.
- The Pons and other subsites of the Brain Stem have the same ICD-O topography code (C717), which is for subsites of the Brain Stem.
- Clinically, information regarding the Pons is very important, especially for pediatric cases.
- A schema discriminator is necessary to distinguish between the pons and other subsites of the brain stem.

Breslow Tumor Thickness: (3817)

- Use the magnifying glass for applicable codes and instructions.
- Breslow Tumor Thickness, the measurement of the thickness of a melanoma as defined by Dr. Alexander Breslow, is a prognostic factor for Melanoma of the Skin.

CA 19-9 PreTX Lab Value: (3942)

- Use the magnifying glass for applicable codes and instructions.
- Carbohydrate Antigen (CA) 19-9 Pretreatment Lab Value records the CA 19-9 value prior to treatment.

- CA 19-9 is a tumor marker that has prognostic significance for pancreatic cancer.

Clinical Margin Width: (3961)

- Use the magnifying glass for applicable codes and instructions.
- Clinical Margin Width describes the margins from a wide excision for a melanoma primary. The margin width is measured by the surgeon prior to the procedure.
- The measurement is taken, in centimeters, from the edge of the lesion or the prior excision scar to the peripheral margin of the specimen.

Derived Rai Stage: (3955)

- Use the dropdown for applicable codes.
- Derivation will be run on all cases diagnosed 1/1/2018 and forward.
- This data item stores the Derived Rai stage value derived from the values coded in the following SSDIs for the Lymphoma-CLL/SLL schema (9823/3).
  - Lymphocytosis [3885]
  - Adenopathy [3804]
  - Organomegaly [3907]
  - Anemia [3811]
  - Thrombocytopenia [3933]
- The Rai stage is only applicable for Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL) (9823/3) cases where the primary site is bone marrow (C421).
- For cases with a primary site other than bone marrow (C421), the derived Rai stage will be 8 and all the SSDIs will be coded to 5.

EGFR Mutational Analysis: (3939)

- Use the magnifying glass for applicable codes and instructions.
- Epidermal growth factor receptor (EGFR) mutational analysis is performed for patients with advanced non-small cell lung cancer (NSCLC) to identify patients with certain activating mutations in the EGFR gene which are sensitive to tyrosine kinase inhibitors.

Estrogen Receptor Percent Positive or Range: (3826)

- Use the magnifying glass for applicable codes and instructions.
- Estrogen Receptor, Percent Positive Range is the percent of cells staining estrogen receptor positive by IHC.
- It is a new data item for cases diagnosed 1/1/2018 and later.

Estrogen Receptor Summary: (3827)

- Use the magnifying glass for applicable codes and instructions.
- Required for breast.
- ER (Estrogen Receptor) Summary is a summary of results of the estrogen receptor (ER) assay.
- This is found on the pathology report or separate scanned report from pathology. Use the magnifying glass for applicable codes and instructions.

Estrogen Receptor Total Allred Score: (3828)

- Use the magnifying glass for applicable codes and instructions.
- Estrogen Receptor, Total Allred Score is based on the percentage of cells that stain positive by IHC for estrogen receptor (ER) and the intensity of that staining.

Esophagus and EGJ Tumor Epicenter: (3829)

- Use the magnifying glass for applicable codes and instructions.
- Required for Esophagus squamous tumors.
- Esophagus and Esophagogastric Junction (EGJ), Squamous Cell (including adenosquamous).
- Tumor Location refers to the position of the epicenter of the tumor in the esophagus.

Fibrosis Score: (3835)

- Use the magnifying glass for applicable codes and instructions.
- Required for liver.
- Fibrosis Score, the degree of fibrosis of the liver based on pathological examination, is a prognostic factor for liver cancer.

Gestational Trophoblastic Prognostic: (3837)

- Use the magnifying glass for applicable codes and instructions.
- Gestational Trophoblastic Prognostic Scoring Index, a score based on the FIGO-modified World Health Organization (WHO) Prognostic Scoring Index, is used to stratify women with gestational trophoblastic neoplasia in addition to the anatomical stage group.
- The risk score is appended to the anatomic stage.

Gleason Patterns Clinical: (3838)

- Use the magnifying glass for applicable codes and instructions.
- Required for prostate.
- Prostate cancers are graded using Gleason score or pattern.
- This data item represents the Gleason primary and secondary patterns from needle core biopsy or TURP.

Gleason Patterns Pathological: (3839)

- Use the magnifying glass for applicable codes and instructions.
- Required for prostate.
- Prostate cancers are graded using Gleason score or pattern.
- This data item represents the Gleason primary and secondary patterns from prostatectomy or autopsy.

Gleason Score Clinical: (3840)

- Use the magnifying glass for applicable codes and instructions.
- Required for prostate.
- This data item records the Gleason score based on adding the values for primary and secondary patterns in Needle Core Biopsy or TURP.

Gleason Score Pathological: (3841)

- Use the magnifying glass for applicable codes and instructions.
- Required for prostate.
- Prostate cancers are graded using Gleason score or pattern.
- This data item represents the Gleason primary and secondary patterns from prostatectomy or autopsy.

Gleason Tertiary Pattern: (3842)

- Use the magnifying glass for applicable codes and instructions.
- Required for prostate.
- Prostate cancers are graded using Gleason score or pattern.
- This data item represents the tertiary pattern value from prostatectomy or autopsy.

hCG Post-Orchiectomy Range: (3847)

- Use the magnifying glass for applicable codes and instructions.
- Human Chorionic Gonadotropin (hCG) Post-orchiectomy Range identifies the range category of the lowest hCG value measured post-orchiectomy.
- hCG is a serum tumor marker that is often elevated in patients with nonseminomatous germ cell tumors of the testis.
- The Post-Orchiectomy lab value is used to monitor response to therapy.

hCG Pre-Orchiectomy Range: (3849)

- Use the magnifying glass for applicable codes and instructions.
- Human Chorionic Gonadotropin (hCG) Pre-orchiectomy Range identifies the range category of the highest hCG value measured prior to treatment.
- hCG is a serum tumor marker that is often elevated in patients with nonseminomatous germ cell tumors of the testis.

HER2 Overall Summary: (3855)

- Use the magnifying glass for applicable codes and instructions.
- HER2 Overall Summary is a summary of results from HER2 testing.
- This data item is required for prognostic stage grouping in AJCC 8th edition, Chapter 48, Breast. It was previously collected as Breast, CS SSF # 15. (Experts recommend that every invasive breast cancer be tested for the presence of HER2 because anti-HER2 treatments are highly effective for these tumors.
- It will be collected for Esophagus and Esophagogastric Junction and Stomach for cases diagnosed 1/1/21+ because NCCN guidelines recommend HER2 testing at time of diagnosis if patients are documented or suspected of having metastatic disease.
- HER2 monoclonal antibodies may be added to chemotherapy for patients with HER2 positive disease.

Heritable Trait: (3856)

- Use the magnifying glass for applicable codes and instructions.
- Heritable trait pertains to evidence that a tumor is associated with a heritable mutation.
- In retinoblastoma, the heritable trait is a germline mutation in the RB1 gene, which is associated with bilateral disease, family history of retinoblastoma, presence of concomitant CNS midline embryonic tumor (commonly in pineal region), or retinoblastoma with an intracranial primitive neuroectodermal tumor (i.e., trilateral retinoblastoma).
- Children with any of these features may be assigned the H1 status without molecular testing.
- High quality molecular testing for RB1 mutation is required to determine the presence or absence of RB1 mutation for children without clinical features of a heritable mutation.

High Risk Cytogenetics: (3857)

- Use the magnifying glass for applicable codes and instructions.
- High Risk Cytogenetics is defined as one or more of t(4;14), t(14;16), or del 17p identified from FISH test results and is part of the staging criteria for plasma cell myeloma.

Histologic Subtype: (3960)

- Use the magnifying glass for applicable codes and instructions.
- Histology code for appendiceal tumors (8480) is defined as "Mucinous Adenocarcinoma (in situ or invasive)."
- In the AJCC 8th chapter for Appendix-Carcinoma, there are also low-grade appendiceal mucinous neoplasm (LAMN) and high-grade appendiceal mucinous neoplasm (HAMN) diagnoses that are assigned to the same histology. Due to the different natures of these histologies, there is interest in tracking these different types of tumors.
- With the current histology codes, a distinction cannot be made. A histology subtype data item is needed.

KIT Gene Immunohistochemistry: (3865)

- Use the magnifying glass for applicable codes and instructions.
- KIT Gene Immunohistochemistry (IHC) is the expression of the KIT gene in tumor tissue specimens based on immunohistochemical (IHC) stains.
- A positive test is a diagnostic and predictive marker for GIST tumors.

LDH Post-Orchiectomy Range: (3867)

- Use the magnifying glass for applicable codes and instructions.
- LDH (Lactate Dehydrogenase) Post-Orchiectomy Range identifies the range category of the lowest LDH value measured post-orchiectomy.
- LDH is a nonspecific marker for testicular cancer that is elevated in some germ cell tumors.
- The post-orchiectomy lab value is used to monitor response to therapy.

LDH Pre-Orchiectomy Range: (3868)

- Use the magnifying glass for applicable codes and instructions.
- Lactate Dehydrogenase (LDH) Range identifies the range category of the highest LDH value measured prior to treatment.
- LDH is a nonspecific marker for testicular cancer that is elevated in some germ cell tumors.
- This data item refers to the pre-orchiectomy range.

LDH Level: (3869)

- Use the magnifying glass for applicable codes and instructions.
- LDH (Lactate Dehydrogenase) is an enzyme involved in conversion of sugars to energy and present in most cells in the body.
- Elevated pretreatment LDH is an adverse prognostic factor for plasma cell myeloma and melanoma of the skin.

LDH Upper Limits of Normal: (3870)

- Use the magnifying glass for applicable codes and instructions.

- LDH (Lactate Dehydrogenase), an enzyme involved in converting sugars to energy in the body, is elevated in some malignancies.
- LDH level is a prognostic factor for patients with Stage IV melanoma.
- This data Item refers to the Upper Limit of Normal in the laboratory test used to interpret the Serum LDH result.

LN Positive Axillary Level I-II: (3882)

- Use the magnifying glass for applicable codes and instructions.
- This data item pertains to the number of positive ipsilateral level I and II axillary lymph nodes, and intramammary lymph nodes based on pathological information.

LN Size: (3883)

- Use the magnifying glass for applicable codes and instructions.
- Lymph Nodes Size records diameter of the involved regional lymph node(s) with the largest diameter of any involved regional lymph node(s).
- Pathological measurement takes precedence over a clinical measurement for the same node.

LN Status Femoral-Inguinal: (3959)

- Use the magnifying glass for applicable codes and instructions.
- This data item describes the status of femoral-inguinal lymph nodes associated with certain female genital cancers.

LN Status Para-Aortic: (3958)

- Use the magnifying glass for applicable codes and instructions.
- This data item describes the status of para-aortic lymph nodes associated with certain female genital cancers.

LN Status Pelvic: (3957)

- Use the magnifying glass for applicable codes and instructions.
- This data item describes the status of pelvic lymph nodes associated with certain female genital cancers.

Lymphocytosis: (3885)

- Use the magnifying glass for applicable codes and instructions.
- Lymphocytosis is defined by an excess of lymphocytes in the blood.
- In staging of Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL), lymphocytosis is defined as an absolute lymphocyte count (ALC) greater than 5,000 cells/µL.

Macroscopic Evaluation of Mesorectum: (3950)

- Use the magnifying glass for applicable codes and instructions.
- This data item records the results of a macroscopic evaluation of the mesorectum from a total mesorectal excision (TME).

Measured Basal Diameter: (3887)

- Use the magnifying glass for applicable codes and instructions.
- Measured Basal Diameter, the largest basal diameter of a uveal melanoma, is a prognostic indicator for this tumor.

Measured Thickness: (3888)

- Use the magnifying glass for applicable codes and instructions.
- Measured Thickness, or height, of a uveal melanoma, is a prognostic indicator for this tumor.

Microsatellite Instability (MSI): (3890)

- Use the magnifying glass for applicable codes and instructions.
- The microsatellite instability (MSI) test is a genetic test performed on tumor tissue to look for differences in length of certain non-functioning sections of DNA. The differences are caused by problems with the genes that encode proteins that normally repair certain types of DNA damage. Knowing whether cancer is microsatellite instability high may help plan the best treatment.
- Microsatellites are short, repeated, sequences of DNA. Cancer cells that have large numbers of microsatellites that may have defects in the ability to correct mistakes that occur when DNA is copied in the cell.
- Microsatellite instability is found most often in colorectal cancer, other types of gastrointestinal cancer, and endometrial cancer. It may also be found in cancers of the breast, prostate, bladder, and thyroid.

Multigene Signature Results: (3895)

- Use the magnifying glass for applicable codes and instructions.
- Multigene signatures or classifiers are assays of a panel of genes from a tumor specimen, intended to provide a quantitative assessment of the likelihood of response to chemotherapy and to evaluate prognosis or the likelihood of future metastasis.
- This data item identified the multigene signature result.
- Oncotype Dx is coded elsewhere.

NRAS Mutational Analysis: (3941)

- Use the magnifying glass for applicable codes and instructions.
- NRAS is a signaling intermediate in the growth receptor pathway. Certain NRAS mutations predict poor response to anti-EGFR therapy in patients with metastatic colorectal cancer.

Oncotype Dx Recurrence Score-Invasive: (3904)

- Use the magnifying glass for applicable codes and instructions.
- Oncotype Dx Recurrence Score-Invasive is a numeric score of a genomic test to predict the likelihood of distant recurrence of invasive breast cancer based on the assessment of 21 genes.

Oncotype Dx Risk Level-Invasive: (3906)

- Use the magnifying glass for applicable codes and instructions.
- Oncotype Dx Risk Level-Invasive stratifies Oncotype Dx recurrence scores into low, intermediate, and high risk of distant recurrence.

Organomegaly: (3907)

- Use the magnifying glass for applicable codes and instructions.

- Organomegaly is defined as presence of enlarged liver and/or spleen on physical examination and is part of the staging criteria for Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL).

p16: (3956)

- Use the magnifying glass for applicable codes and instructions.
- Required for Cervix.
- The p16 biomarker is over-expressed (produced) in response to HPV. It is therefore a surrogate marker for HPV disease.

PD-L1: (1174)

- Use the magnifying glass for applicable codes and instructions.
- The absence or presence of PD-L1 expression determines if the tumor will respond to treatment with a targeted inhibitor (immunotherapy). PD-L1 is done for Non-small cell lung cancers (NSCLC).
- It is recommended by treatment guidelines for lung cancer to
- determine if the patient may benefit from checkpoint inhibitor drugs (immunotherapy).
- It is a new data item for cases diagnosed 1/1/2025+.

Peripheral Blood Involvement: (3910)

- Use the magnifying glass for applicable codes and instructions.
- Peripheral blood involvement, summarized in "B category", refers to the percentage of peripheral blood lymphocytes that are atypical (Sezary) cells and whether they are "Clone negative" or "Clone positive".

Post Transplant Lymphoproliferative Disorder-PTLD: (1172)

- Use the magnifying glass for applicable codes and instructions.
- Post Transplant Lymphoproliferative Disorder (PTLD) is a lymphoid proliferation arising in a recipient of a solid organ transplant, allogeneic bone marrow transplantation, or an umbilical cord blood transfusion.
- The patient must have a history of a solid organ transplant or an allogeneic bone marrow transplant. Both polymorphic and monomorphic PTLD are actually caused by post-transplant immunosuppression. Most cases of PTLD occur within a year of transplantation; however, they can occur any time after the transplant.
- Monomorphic PTLD may have histology indistinguishable from that of various malignant hematopoietic neoplasms, particularly lymphomas such as Diffuse Large B-cell Lymphoma.
- The presence of PTLD, either polymorphic or monomorphic, has clinical significance and prognostic value, especially in the Pediatric and Adolescence and Young Adult (AYA) populations.

Progesterone Receptor Percent Positive or Range: (3914)

- Use the magnifying glass for applicable codes and instructions.
- Progesterone Receptor, Percent Positive or Range is the percent of cells staining progesterone receptor positive measured by IHC.
- It is a Registry Data Collection Variable in AJCC.
- It is a new data item for cases diagnosed 1/1/2018+.

Progesterone Receptor Summary: (3915)

- Use the magnifying glass for applicable codes and instructions.
- Required for Breast.
- PR (Progesterone Receptor) Summary is a summary of results from the progesterone receptor (PR) assay. This is found on the pathology report or separate scanned report from pathology.

Progesterone Receptor Total Allred Score: (3916)

- Use the magnifying glass for applicable codes and instructions.
- Progesterone Receptor, Total Allred Score is based on the percentage of cells that stain by IHC for progesterone receptor (PR) and the intensity of that staining.

Primary Sclerosing Cholangitis: (3917)

- Use the magnifying glass for applicable codes and instructions.
- Primary sclerosing cholangitis denotes a chronic autoimmune inflammation of the bile ducts that leads to scar formation and narrowing of the ducts over time.
- It is a prognostic factor for intrahepatic bile duct cancer.

PSA (Prostatic Specific Antigen) Lab Value: (3920)

- Use the magnifying glass for applicable codes and instructions.
- Required for prostate.
- PSA (Prostatic Specific Antigen) is a protein produced by cells of the prostate gland and is elevated in patients with prostate cancer.
- This data item pertains to PSA lab value.

Residual Cancer Burden (RCB): (1178) New for 2026

- Use the dropdown for applicable codes.
- Residual Cancer Burden (RCB) is a score that measures the amount of cancer remaining in the breast and the regional lymph nodes after neoadjuvant therapy and surgical resection. The RCB score is based on 4 independent prognostic factors measuring the primary tumor bed and 2 independent factors measuring the lymph nodes.
- The RCB score combines these 6 independently prognostic factors from the surgical specimen after neoadjuvant therapy into a single continuous score. This score is prognostic across breast cancer subtypes, different treatments, and within existing stage groups.
- The independent prognostic factors include:
    - Primary Tumor Bed
        - Primary Tumor Bed area (measured in millimeters)
        - Includes the largest two dimensions
    - Overall, Cancer Cellularity (as percentage of area)
    - Percentage of cancer that is invasive disease
    - Percentage of cancer that is in situ disease
    - Lymph nodes
        - Number of positive lymph nodes
        - Diameter of largest metastasis

Residual Cancer Burden Class: (1179) New for 2026

- Use the dropdown for applicable codes.

- Residual Cancer Burden (RCB) is a score that measures the amount of cancer remaining in the breast and the regional lymph nodes after neoadjuvant therapy and surgical resection. The RCB score is based on 4 independent prognostic factors measuring the primary tumor bed and 2 independent factors measuring the lymph nodes.
    - See Residual Cancer Burden (RCB) Score for further information on these prognostic factors.
- Based on the RCB score, patients are then divided into four different classes. These classes are used to determine the likelihood of a patient being cancer free after treatment.
    - RCB-0 (pathologic complete response). No residual invasive cancer is present.
    - RCB-1 (minimal burden). Very little residual invasive cancer is present.
    - RCB-2 (moderate burden). A moderate amount of residual invasive cancer is present.
    - RCB-3 (extensive burden). A large amount of residual invasive cancer is present.

S Category Clinical: (3923)

- Use the magnifying glass for applicable codes and instructions.
- S Category Clinical combines the results of pre-orchiectomy Alpha Fetoprotein (AFP), Human Chorionic Gonadotropin (hCG) and Lactate Dehydrogenase (LDH) into a summary S value.

S Category Pathological: (3924)

- Use the magnifying glass for applicable codes and instructions.
- S Category Pathological combines the results of post-orchiectomy Alpha Fetoprotein (AFP), Human Chorionic Gonadotropin (hCG) and Lactate Dehydrogenase (LDH) into a summary S value.

Schema Discriminator 3: (3928)

- Use the magnifying glass for applicable codes and instructions.
- Captures additional information needed to generate AJCC ID [95] and Schema ID [3800] for some anatomic sites.
- Discriminators can be based on sub site, histology or other features which affect prognosis.

Serum Albumin Pretreatment Level: (3930)

- Use the magnifying glass for applicable codes and instructions.
- Albumin is the most abundant protein in human blood plasma. Serum albumin pretreatment level is a prognostic factor for plasma cell myeloma.

Serum Beta-2 Microglobulin Pretreatment Level: (3931)

- Use the magnifying glass for applicable codes and instructions.
- Serum Beta-2 Microglobulin is a protein that is found on the surface of many cells and plentiful on the surface of white blood cells. Increased production or destruction of these cells causes Serum β2 (beta-2) Microglobulin level to increase.
- Elevated Serum β2 (beta-2) Microglobulin level is a prognostic factor for plasma cell myeloma.

Spread Through Air Spaces (STAS): (1176) NEW for 2026

- Use the dropdown for applicable codes.
- Spread Through Air Spaces (STAS) is defined as micropapillary clusters, solid nests, or single cells of tumor extending beyond the edge of the tumor into the air spaces of the surrounding lung parenchyma.

LDH Lab Value: (3932)

- Use the magnifying glass for applicable codes and instructions.
- Required for melanoma.
- LDH (Lactate Dehydrogenase) Lab Value, measured in serum, is a predictor of treatment response, progression-free survival and overall survival for patients with Stage IV melanoma of the skin.

Thrombocytopenia: (3933)

- Use the magnifying glass for applicable codes and instructions.
- Thrombocytopenia is defined by a deficiency of platelets in the blood.
- In staging of Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL), thrombocytopenia is defined as Platelets (Plt) less than 100,000/µL.

AJCC 8th Edition

AJCC TNM lookup tables are not available in Registry Plus software effective NAACCR v26. Refer to AJCC TNM 8th edition and AJCC Cancer Staging Protocols version 9 for AJCC TNM content.

AJCC TNM Clin T: (1001)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the clinical tumor (T) as defined by the current AJCC edition.
- Diagnosis Years 2018+.

AJCC TNM Clin T Suffix: (1031)

- Use the dropdown for applicable codes.
- Detailed site-specific codes for the clinical T category suffix as defined by AJCC.
- Clinical, pathological, and post neoadjuvant therapy stage data are given three separate areas in the NAACCR Data Exchange Record Layout.
- Diagnosis Years 2018+.

AJCC TNM Clin N: (1002)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the clinical nodes (N) as defined by the current AJCC edition.
- Diagnosis Years 2018+.

AJCC TNM Clin N Suffix: (1034)

- Use the dropdown for applicable codes.
- Detailed site-specific codes for the clinical N category suffix as defined by AJCC.
- Clinical, pathological, and post neoadjuvant therapy stage data are given three separate areas in the NAACCR Data Exchange Record Layout.
- Diagnosis Years 2018+.

AJCC TNM Clin M: (1003)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the clinical metastases (M) as defined by the current AJCC edition.
- Diagnosis Years 2018+.

ACJJ TNM Clin Stage Group: (1004)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the clinical stage group as defined by the current AJCC edition.

AJCC TNM Path T: (1011)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the pathologic tumor (T) as defined by the current AJCC edition.
- Diagnosis Years 2018+.

AJCC TNM Path T Suffix: (1032)

- Use the dropdown for applicable codes.
- Detailed site-specific codes for the pathological T category suffix as defined by AJCC.
- Clinical, pathological, and post neoadjuvant therapy stage data are given three separate areas in the NAACCR Data Exchange Record Layout.
- Diagnosis Years 2018+.

AJCC TNM Path N: (1012)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the pathologic nodes (N) as defined by the current AJCC edition.

AJCC TNM Path N Suffix: (1035)

- Use the dropdown for applicable codes.
- Detailed site-specific codes for the pathological N category suffix as defined by AJCC.
- Clinical, pathological, and postneoadjuvant therapy stage data are given three separate areas in the NAACCR Data Exchange Record Layout.
- Diagnosis Years 2018+.

AJCC TNM Path M: (1013)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the clinical path (M) as defined by the current AJCC edition.
- Diagnosis Years 2018+.

AJCC TNM Path Stage Group: (1014)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the pathologic stage group as defined by the current AJCC edition.

AJCC TNM Post Therapy Clin (yc) T: (1062)

- Use the magnifying glass for applicable codes and instructions.

- Detailed site-specific codes for the post therapy clinical (yc) tumor (T) as defined by AJCC.
- Clinical, pathological, and post therapy yc and yp stage data are given four separate areas in the NAACCR Data Exchange Record Layout.

AJCC TNM Post Therapy Clin (yc) T Suffix: (1063)

- Use the dropdown for applicable codes.
- Detailed site-specific codes for the post therapy clinical (yc) tumor T category suffix as defined by AJCC.
- Clinical, pathological, and post therapy yc and yp stage data are given four separate areas in the NAACCR Data Exchange Record Layout.

AJCC TNM Post Therapy Clin (yc) N: (1064)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the post therapy clinical (yc) nodes (N) as defined by AJCC.
- Clinical, pathological, and post therapy yc and yp stage data are given four separate areas in the NAACCR Data Exchange Record Layout.

AJCC TNM Post Therapy Clin (yc) N Suffix: (1065)

- Use the dropdown for applicable codes.
- Detailed site-specific codes for the post therapy clinical (yc) N category suffix as defined by AJCC.
- Clinical, pathological, and post therapy yc and yp stage data are given four separate areas in the NAACCR Data Exchange Record Layout.

AJCC TNM Post Therapy Clin (yc) M: (1066)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the post therapy clinical (yc) metastases (M) as defined by AJCC.
- Clinical, pathological, and post therapy yc and yp stage data are given four separate areas in the NAACCR Data Exchange Record Layout.

AJCC TNM Post Therapy Clin (yc) Stage Group: (1067)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the post therapy clinical (yc) stage group as defined by AJCC.
- Clinical, pathological, and post therapy yc and yp stage data are given four separate areas in the NAACCR Data Exchange Record Layout.

AJCC TNM Post Therapy Path (yp) T: (1021)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the postneoadjuvant therapy Path tumor (T) as defined by AJCC.
- Clinical, pathological, and post therapy yc and yp stage data are given four separate areas in the NAACCR Data Exchange Record Layout.

AJCC TNM Post Therapy Path (yp) T Suffix: (1033)

- Use the dropdown for applicable codes.

- Detailed site-specific codes for the postneoadjuvant therapy Path T category suffix as defined by AJCC.
- Clinical, pathological, and post therapy yc and yp stage data are given four separate areas in the NAACCR Data Exchange Record Layout.

AJCC TNM Post Therapy Path (yp) N: (1022)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the postneoadjuvant therapy Path nodes (N) as defined by AJCC.
- Clinical, pathological, and post therapy yc and yp stage data are given four separate areas in the NAACCR Data Exchange Record Layout.

AJCC TNM Post Therapy Path (yp) N Suffix: (1036)

- Use the dropdown for applicable codes.
- Detailed site-specific codes for the postneoadjuvant therapy Path N category suffix as defined by AJCC.
- Clinical, pathological, and post therapy yc and yp stage data are given four separate areas in the NAACCR Data Exchange Record Layout.

AJCC TNM Post Therapy Path (yp) M: (1023)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the postneoadjuvant therapy category metastases (M) as defined by AJCC.
- Clinical, pathological, and post therapy yc and yp stage data are given four separate areas in the NAACCR Data Exchange Record Layout.

AJCC TNM Post Therapy Path (yp) Stage Group: (1024)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the postneoadjuvant therapy Path stage group as defined by AJCC.
- Clinical, pathological, and post therapy yc and yp stage data are given four separate areas in the NAACCR Data Exchange Record Layout.

AJCC 7th Edition

AJCC TNM lookup tables are not available in Registry Plus software effective NAACCR v26. Refer to AJCC TNM 8th edition and AJCC Cancer Staging Protocols version 9 for AJCC TNM content.

TNM Clin T: (940)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the clinical tumor (T) as defined by AJCC and recorded by the physician.
- Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.
- Diagnosis Years 2010-2016.

TNM Clin N: (950)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the clinical nodes (N) as defined by AJCC and recorded by the physician.

- Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

TNM Clin M: (960)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the clinical metastases (M) as defined by AJCC and recorded by the physician.
- Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.
- Diagnosis Years 2010-2016.

TNM Clin Stage Group: (970)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the clinical stage group as defined by AJCC and recorded by the physician.
- Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

TNM Clin Descriptor: (980)

- Use the dropdown for applicable codes.
- Identifies the AJCC clinical stage (prefix/suffix) descriptor as recorded by the physician.
- AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.
- Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.
- CoC defines a descriptor and “Staged By” item for each of these three areas.

TNM Path T: (880)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the pathologic tumor (T) as defined by AJCC and recorded by the physician.
- Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.
- Diagnosis Years 2015+.

TNM Path N: (890)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the pathologic nodes (N) as defined by AJCC and recorded by physician.
- Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.
- Diagnosis Years 2015+.

TNM Path M: (900)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the pathologic metastases (M) as defined by AJCC and recorded by the physician.

- Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.
- Diagnosis Years 2015+.

TNM Path Stage Group: (910)

- Use the magnifying glass for applicable codes and instructions.
- Detailed site-specific codes for the pathologic stage group as defined by AJCC and recorded by the physician.
- Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout.

TNM Path Descriptor: (920)

- Use the dropdown for applicable codes.
- Identified the AJCC pathologic stage (prefix/suffix) descriptor as recorded by the physician.
- AJCC stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.
- Pathologic and clinical stage data are given three separate areas in the NAACCR Data Exchange Record Layout. CoC defines a descriptor and "Staged By" item for each of these three areas.

Collaborative Stage

CS Tumor Size: (2800)

- Use the magnifying glass for applicable codes and instructions.
- Records the largest dimension or diameter of the primary tumor in millimeters.
- Diagnosis Years 2004-2015.

CS Extension: (2810)

- Use the magnifying glass for applicable codes and instructions.
- Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in CS Extension.
- Diagnosis Years 2004-2015.

CS Tumor Size/Ext Eval: (2820)

- Use the magnifying glass for applicable codes and instructions.
- Records how the codes for the two items CS Tumor Size [2800] and CS Extension [2810] were determined, based on the diagnostic methods employed.
- Diagnosis Years 2004-2015.

CS Lymph Nodes: (2830)

- Use the magnifying glass for applicable codes and instructions.
- Identifies the regional lymph nodes involved with cancer at the time of diagnosis.

CS Lymph Nodes Eval: (2840)

- Use the magnifying glass for applicable codes and instructions.
- Records how the code for CS Lymph Nodes [2830] was determined, based on the diagnostic methods employed.
- Diagnosis Years 2004-2015.

CS Mets at DX: (2850)

- Use the magnifying glass for applicable codes and instructions.
- Identifies the distant site(s) of metastatic involvement at time of diagnosis.
- Diagnosis Years 2004-2015.

CS Mets Eval: (2860)

- Use the magnifying glass for applicable codes and instructions.
- Records how the code for CS Mets at Dx [2850] was determined based on the diagnostic methods employed.

CS Mets at Dx-Bone: (2851)

- Use the dropdown for applicable codes.
- Identifies the presence of distant metastatic involvement of bone at time of diagnosis.

CS Mets at DX-Brain: (2852)

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

CS Mets at Dx-Liver: (2853)

- Use the dropdown for applicable codes.
- Identifies the presence of distant metastatic involvement of the liver at time of diagnosis.

CS Mets at Dx-Lung: (2854)

- Use the dropdown for applicable codes.
- Identifies the presence of distant metastatic involvement of the lung at time of diagnosis.

CS Site-Specific Factor 1: (2880)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 2: (2890)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 3: (2900)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 4: (2910)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 5: (2920)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 6: (2930)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 7: (2861)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 8: (2862)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 9: (2863)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 10: (2864)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 11: (2865)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 12: (2866)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 13: (2867)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 14: (2868)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 15: (2869)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 16: (2870)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Site-Specific Factor 17: (2871)

- Use the magnifying glass for applicable codes and instructions.
- Identifies additional information needed to generate stage, or prognostic factors that influence stage or survival.

CS Version Input Current: (2937)

- This item indicates the version of CS input fields after they have been updated or recoded. This data item is recorded the first time the CS input fields are entered and should be updated each time the CS input fields are modified.
- Leave blank unless diagnosis date is prior to 2018, enter 020550.

CS Version Input Original: (2935)

- This item indicates the number of the version initially used to code Collaborative Staging (CS) fields. The CS version number is returned as part of the output of the CS algorithm.
- Leave blank unless diagnosis date is prior to 2018, enter 020550.

CS Version Derived: (2936)

- This data item is recorded the first time the CS output fields are derived and should be updated each time the CS Derived items are recomputed. The CS version number is returned as part of the output of the CS algorithm.
- Press F5 to derive staging.

Derived SS1977: (3010)

- Click the calculate button to compute/derive stage.
- This item is the derived “SEER Summary Stage 1977” from the CS algorithm (or EOD codes)
- Effective with 2004 diagnosis.

Derived SS1977-Flag: (3040)

- Click the calculation icon and this field will auto populate.
- Flag to indicate whether the derived SEER Summary Stage 1977 was derived from CS or EOD codes.

Derived SS2000: (3020)

- Click the calculation icon and this field will auto populate.
- This item is the derived “SEER Summary Stage 2000” from the CS algorithm (or EOD codes) effective with 2004 diagnosis.
- Effective with 2004 diagnosis.

Derived SS2000-Flag: (3050)

- Click the calculation icon and this field will auto populate.
- Flag to indicate whether the derived SEER Summary Stage 2000 was derived from CS or EOD codes.

Diagnostic Biopsy Procedure

RX Date DX/Stg Proc: (1280)

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

RX Summ-DX/Stg Proc: (1350)

- Use the dropdown for applicable codes.
- Identifies the surgical procedure(s) performed to diagnose and/or stage disease, usually biopsy of primary site or biopsy of another site.
- If no diagnostic procedure was performed, leave blank or code 00-No surgical diagnostic or staging procedure performed.

Cancer Directed Treatment

It is necessary to distinguish cancer-directed treatment from non-cancer directed treatment, which are recorded differently in cancer data fields.

Cancer-Directed Treatment

Any treatment that is given to modify, control, remove or destroy primary or metastatic cancer tissues is cancer directed treatment. The type of treatment is meant to remove a tumor or minimize the size of tumor or delay the spread of disease.

- Surgery (-ectomy) to remove cancer tissue, organ, or lymph nodes
- Exenteration to remove the contents of a body cavity
- Fulguration to destroy tissue with the use of electric sparks
- Debulking to remove as much tumor as possible to reduce tumor volume

Non-Cancer Directed Treatment

Any treatment designed to prepare the patient for cancer-directed treatment, prolong a patient's life, alleviate pain, or make the patient comfortable. Non-cancer directed treatments are not meant to destroy the tumor, control the tumor, or delay the spread of disease. These treatments include diagnostic tests and supportive care.

- Biopsy to remove a tissue to determine a diagnosis
- Palliative care to relieve symptoms but not to cure patient
- Bypass (-ostomy) to create a path around an area blocked by tumor
- Stent placement to alleviate obstruction

To ensure complete and accurate treatment data, terms such as "first course of treatment" and "treatment for recurrence or progression" should be defined.

First course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. In cancer treatment data registration, the date of the first course treatment is the month, day, and year of the first cancer-directed treatment that is administered.

Treatment of recurrence or progression (also called "subsequent treatment") includes all cancer-directed treatments administered after the first course of treatment is completed, stopped, or changed. For the date of "Subsequent Treatment(s) For Recurrence or Progression," the date(s) of treatment(s) administered for progression or recurrence of disease is(are) recorded. In short, subsequent treatment starts after the first course of treatment has been completed, stopped, or changed.

Treatment 1st Course

It is important for registrars to differentiate between cancer-directed treatment and non-cancer directed, as well as what would be considered FCOT.

RX Summ-Treatment Status: (1285)

- Use the dropdown for applicable codes.
- This data item is a summary of the status for all treatment modalities.
- This field will document active surveillance (watchful waiting) and eliminate searching each treatment modality to determine whether treatment was given.
- It is used in conjunction with Date Initial RX SEER [1260] and/or Date 1st Crs RX CoC [1270] and each modality of treatment with their respective date field to document whether treatment was given or not given, whether it is unknown if treatment was given, or whether treatment was given on an unknown date. Also indicates active surveillance (watchful waiting).
- This data item is effective for January 2010+ diagnoses.

Date 1st Crs RX CoC: (1270)

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

RX Date Surgery: (1200)

- YYYYMMDD date format.
- Record the date of the surgical procedure to the primary site.
- Date the first surgery of the type described under Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes was performed. See also RX Summ--Surg Prim Site [1290], RX Summ--Scope Reg LN Sur [1292], and RX Summ--Surg Oth Reg/Dis [1294].
- If there is no surgery, leave, BLANK.

RX Date Mst Defn Srg: (3170)

- YYYYMMDD date format.
- Date of most definitive surgical resection of the primary site performed as part of the first course of treatment.
- When the patient has more than one surgical procedure, use the date of the most definitive surgery. e.g., Patient has surgery of the primary site, and the margins are positive. The patient has a re-excision and margins are now negative. The re-excision date is the most definitive.

- Use RX DATE MST DEFN SRG FLAG [3171] if there is no appropriate or known date for this item.

RX Text Surgery: (2610)

- Text area for information describing all surgical procedures performed as part of treatment.
- If Surgery is unknown or not applicable, record 'NONE' in the text field.
- Do not leave blank.

Example: 2/12/18 Wide local excision of malignant melanoma, Rt chest, with 2cm margins.

RX Summ-Surg Prim Site 03-2022: (1290)

- Use the magnifying glass for applicable codes and instructions.
- Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment. This includes treatment given at all facilities as part of the first course of treatment.

RX Summ-Surgery Prim Site 2023: (1291)

- Use the magnifying glass for applicable codes and instructions.
- Surgery of Primary Site describes a surgical procedure that removes and/or destroys tissue of the primary site that is performed as part of the initial diagnostic and staging work-up or first course of therapy.
- Link to NAACCR crosswalk surgery codes.

RX Summ-Reconstruct 1st: (1330)

- Codes for surgical procedures done to reconstruct, restore, or improve the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or therapies.
- Reconstructive/restorative procedures are coded here when started during the first course of therapy.
- CoC introduced site-specific codes for this item in the CoC ROADS Manual 1998 Supplement. RX Coding System--Current [1460] identifies which coding system applies.
- SEER collects reconstructive procedures for breast cancer tumors only.
- For reconstructive/restorative procedures performed later, see Subseq RX--Reconstruct Del [1741]. See also RX Summ--Surgery Type [1640].

RX Summ-Recon Breast: (1335)

- Use the dropdown for applicable codes.
- Records the reconstruction procedure immediately following resection performed at any facility.
- For diagnosis year 2024+ and breast cases only.

RX Summ-Scope of Reg LN Sur: (1292)

- Use the dropdown for applicable codes.
- Describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at all facilities.

- Codes (Refer to the most recent versions of STORE and the SEER Program Code Manual for instructions that should be applied to all surgically treated cases for all types of cancers.)
- The treatment of breast and skin cancers are where the distinction between sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes is most frequently encountered.
- For all other sites, non-sentinel regional node dissections are typical, and codes 2, 6 and 7 are infrequently used.

RX Summ-Reg LN Examined: (1296)

- Codes for the number of regional lymph nodes examined in conjunction with surgery performed as part of the first-course treatment.
- This includes treatment given at all facilities as part of the first course of treatment. See also RX Summ--Scope Reg LN Sur [1292].

RX Summ-Surg Oth Reg/Dis: (1294)

- Default is "0".
- Use the dropdown for applicable codes.
- Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

RX Summ-Surg Site 98-02: (1646)

- Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment.
- This includes treatment given at all facilities as part of the first course of treatment.
- This field is to be used for ROADS codes after the ROADS to FORDS conversion.
- It is also to be used to code Surgery Primary Site at all facilities for all tumors diagnosed before January 1, 2003.

RX Summ-Scope Reg 98-02: (1647)

- Describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at all facilities.
- This field is to be used for ROADS codes after the ROADS to FORDS conversion.
- It is also to be used to code Scope of Regional Lymph Node Surgery at all facilities for all tumors diagnosed before January 1, 2003.

RX Summ-Surg Oth 98-02: (1648)

- Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site given at all facilities as part of the first course of treatment.
- This field is to be used for ROADS codes after the ROADS to FORDS conversion.
- It is also to be used to code Surgery Regional/Distant Sites at all facilities for all tumors diagnosed before January 1, 2003.

RX Summ-Surgical Margins: (1320)

- Use the dropdown for applicable codes.
- Codes describe the final status of surgical margins after resection of the primary tumor. See also RX Summ--Surg Prim Site [1290].

Reason No Surgery: (1340)

- Use the dropdown for applicable codes.

- Records the reason that no surgery was performed on the primary site.

Stage/Prognostic Factors

Secondary Diagnosis 1: (3780)

- Records the patient's preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer.
- Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes.
- Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes.
- Complications may be related to the quality of care.
- ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Secondary Diagnosis 2: (3782)

- Records the patient's preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer.
- Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes.
- Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes.
- Complications may be related to the quality of care.
- ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Secondary Diagnosis 3: (3784)

- Records the patient's preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer.
- Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes.
- Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes.
- Complications may be related to the quality of care.
- ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Secondary Diagnosis 4: (3786)

- Records the patient's preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer.

- Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes.
- Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes.
- Complications may be related to the quality of care.
- ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Secondary Diagnosis 5: (3788)

- Records the patient's preexisting medical conditions, factors influencing health status, and/or complications for the treatment of this cancer.
- Both are considered secondary diagnoses. Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes.
- Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes.
- Complications may be related to the quality of care.
- ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Radiation Therapy

RX Text-Radiation (Beam): (2620)

- Default is "NONE".
- Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation.
- Minimum required text: dates and treatment modality.
- If there is no radiation, document NONE.

RX Text-Radiation Other: (2630)

- Default is "NONE".
- Text area for manual documentation of information regarding treatment of the tumor being reported with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy.
- Minimum required text: dates and treatment modality.
- If there is no radiation, document NONE.

RX Summ-Surg/Rad Seq: (1380)

- Default is "0".
- Use the dropdown for applicable codes
- Codes for the sequencing of radiation and surgery given as part of the first course of treatment.
- See also RX Summ--Surg Prim Site [1290], RX Summ--Scope LN Surg [1292], RX Summ--Surg Oth Reg/Dis [1294], and RX Summ--Radiation [1360].

Reason for No Radiation: (1430)

- Default is “1”.
- Use the dropdown for applicable codes.
- Code the reason the patient did not receive radiation treatment as part of first course of therapy. See also RX--Regional RX Modality [1570].

Rad-Location of RX: (1550)

- Default is ”0”.
- Use the dropdown for applicable codes.
- Identifies the location of the facility where radiation treatment was administered during first course of treatment. See also RX Summ--Radiation [1360].

RX Date Radiation: (1210)

- YYYYYY date format.
- Records the date on which radiation therapy began at any facility that is part of the first course of treatment.

RX Date Rad Ended: (3220)

- YYYYYY date format.
- The date on which the patient completes or receives the last radiation treatment at any facility.
- Use RX DATE RAD ENDED FLAG [3221] if there is no appropriate or known date for this item.

RX Summ- Radiation: (1360)

- Use the dropdown for applicable codes.
- Codes for the type of radiation therapy performed as part of the first course of treatment.

Rad-Regional RX Modality: (1570)

- Use the dropdown for applicable codes.
- Records the dominant modality of radiation therapy used to deliver the clinically most significant regional dose to the primary volume of interest during the first course of treatment.

Number of Phases of Rad Treatment to this Volume: (1532)

- Default is “00”.
- Use the dropdown for applicable codes.
- Identifies the total number of phases administered to the patient during the first course of treatment.
- A “phase” consists of one or more consecutive treatments delivered to the same anatomic volume with no change in the treatment technique. Although the majority of courses of radiation therapy are completed in one or two phases (historically, the “regional” and “boost” treatments) there are occasions in which three or more phases are used, most typically with head and neck malignancies.
- This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.

Radiation Treatment Discontinued Early: (1531)

- Default is “00”.
- Use the dropdown for applicable codes.
- This field is used to identify patients/tumors whose radiation treatment course was discontinued earlier than initially planned.
- That is the patients/tumors received fewer treatment fractions (sessions) than originally intended by the treating physician.
- This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.

Total Dose: (1533)

- Default is “000000”.
- Identifies the total radiation dose administered to the patient across all phases during the first course of treatment.
- The unit of measure is centiGray (cGy).
- This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.

Phase I Radiation Primary Treatment: (1504)

- Default is “00”.
- Use the dropdown for applicable codes.
- Identifies the primary treatment volume or primary anatomic target treated during the first phase of radiation therapy during the first course of treatment.
- This data item is required for CoC-accredited facilities as of 01/01/2018.

Phase I Radiation to Draining Lymph Nodes: (1505)

- Default is “00”.
- Use the dropdown for applicable codes.
- Identifies the draining lymph nodes treated (if any) during the first phase of radiation therapy delivered to the patient during the first course of treatment.
- This data item is required for CoC-accredited facilities as of 01/01/2018.

Phase I Radiation Treatment Modality: (1506)

- Default is “00”.
- Use the dropdown for applicable codes.
- Identifies the radiation modality administered during the first phase of radiation treatment delivered as part of the first course of treatment.
- This data item is required for CoC-accredited facilities as of 01/01/2018.

Phase I Radiation External Beam Planning Tech: (1502)

- Default is “00”.
- Use the dropdown for applicable codes.
- Identifies the external beam radiation planning technique used to administer the first phase of radiation treatment during the first course of treatment.
- This data item is required for CoC-accredited facilities as of 01/01/2018.

Phase I Dose per Fraction: (1501)

- Default is “00000”.

- Records the dose per fraction (treatment session) delivered to the patient in the first phase of radiation during the first course of treatment.
- The unit of measure is centiGray (cGy).
- This data item is required for CoC-accredited facilities as of 01/01/2018.

Phase I Number of Fractions: (1503)

- Default is "000".
- Records the total number of fractions (treatment sessions) delivered to the patient in the first phase of radiation during the first course of treatment.
- This data item is required for CoC-accredited facilities as of 01/01/2018.

Phase I Total Dose: (1507)

- Default is "000000".
- Identifies the total radiation dose delivered to the patient in the first phase of radiation treatment during the first course of treatment.
- The unit of measure is centiGray (cGy).
- This data item is required for CoC-accredited facilities as of 01/01/2018.

RX Summ-Rad to CNS: (1370)

- Use the dropdown for applicable codes.
- For lung and leukemia cases only, codes for radiation given to the brain or central nervous system.
- Includes treatment given at all facilities as part of the first course. See Chapter V, Unresolved Issues, for more information.
- Note: SEER does not collect this data item beginning with 1998 cases. They retain the codes for older cases in this field, and they have also recorded radiation coded here as radiation in RX Summ--Radiation [1360].
- CoC does not collect this data item beginning with 1996 cases.

Chemotherapy

RX Text-Chemo: (2640)

- Default is "NONE".
- Text area for manual documentation of information regarding chemotherapy treatment of the reported tumor.
- Document dates and names of drugs administered.

RX Summ-Chemo: (1390)

- Default is "00".
- Use the dropdown for applicable codes.
- Codes for chemotherapy given as part of the first course of treatment or the reason chemotherapy was not given. Use SEER*Rx to determine drug categories and reportability. https://seer.cancer.gov/seertools/seerrx/

RX Date Chemo: (1220)

- YYYYYY date format.
- Date of initiation of chemotherapy that is part of the first course of treatment. See also RX Summ--Chemo [1390].

Hormone Therapy

RX Text-Hormone: (2650)

- Default is “NONE”.
- Text area for information about hormonal treatment.
- Include dates and names of drugs administered.
  - Date treatment was started
  - Where treatment was given, e.g., at this facility, at another facility
  - Name of physician
  - Type of hormone or antihormone, e.g., Tamoxifen
  - Other treatment information, e.g., treatment cycle incomplete; unknown if hormones were given If no hormone therapy, enter: None

Example: 2/14/2023 Some Hospital Dr. John Smith: Lupron.

RX Summ-Hormone: (1400)

- Default is “00”.
- Use the dropdown for applicable codes.
- Records whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given.
- Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer’s growth. It is not usually used as a curative measure.
- Use SEER*Rx to determine drug categories and reportability. https://seer.cancer.gov/seertools/seerrx/

RX Date Hormone: (1230)

- YYYYYY date format.
- Date of initiation for hormone therapy as part of the first course of treatment.
- If there is no hormone therapy, leave BLANK.

Biological Response Modifier

RX Text-BRM: (2660)

- Default is “NONE”.
- Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.
  - Date treatment began.
  - Where treatment was given, e.g., at this facility, at another facility.
  - Type of BRM agent, e.g., Interferon, BCG.
  - BRM procedures, e.g., bone marrow transplant, stem cell transplant.
  - Other treatment information, e.g., treatment cycle incomplete; unknown if BRM was given.

RX Summ-BRM: (1410)

- Default is “00”.
- Use the dropdown for applicable codes.
- Records whether immunotherapeutic (biologic response modifiers) agents were administered as first-course treatment at all facilities or the reason they were not given.

- Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.
- Use SEER*Rx to determine drug categories and reportability. https://seer.cancer.gov/seertools/seerrx/

RX Date BRM: (1240)

- YYYYYY date format.
- Date of initiation for immunotherapy (a.k.a. biological response modifier) that is part of the first course of treatment.
- See also RX Summ--BRM [1410].

Other Treatment

RX Text-Other: (2670)

- Default is "NONE".
- Text area for manual documentation of information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy.
- This includes experimental treatments (when the mechanism of action for a drug is unknown), and blinded clinical trials.
- If the mechanism of action for the experimental drug is known, code to the appropriate treatment field.
- Use SEER*Rx to determine drug categories and reportability. https://seer.cancer.gov/seertools/seerrx/

RX Summ-Systemic/Sur Seq: (1639)

- Default is "0".
- Use the dropdown for applicable codes.
- Records the sequencing of systemic therapy (RX Summ-Chemo [1390], RX Summ-Hormone [1400], RX Summ-BRM [1410], and RX Summ-Transplnt/Endocr [3250]) and surgical procedures given as part of the first course of treatment.
- See also RX Summ--Surg Prim Site [1290], RX Summ--Scope LN Surg [1292], and RX Summ--Surg Oth Reg/Dis [1294].

RX Date Systemic: (3230)

- YYYYYY date format.
- Date of initiation of systemic therapy that is part of the first course of treatment.
- Systemic therapy includes the administration of chemotherapy agents, hormone agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy.
- Use RX DATE SYSTEMIC FLAG [3231] if there is no appropriate or known date for this item.

RX Summ-Other: (1420)

- Default is "0".
- Use the dropdown for applicable codes.
- Identifies other treatment given at all facilities that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.

- Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment modifies, controls, removes, or destroys proliferating cancer tissue.
- Such treatments include phlebotomy, transfusions, and aspirin.

RX Date Other: (1250)

- YYYYYY date format.
- Date of initiation for other treatment that is part of the first course of treatment at any facility.
- See RX Summ--Other [1420].

RX Summ-Palliative Proc: (3270)

- Default is “0”.
- Use the dropdown for applicable codes.
- Identifies any care provided in an effort to palliate or alleviate symptoms.
- Palliative care is performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or pain management therapy.

RX Summ-TransplntEndocr: (3250)

- Default is “00”.
- Use the dropdown for applicable codes.
- Identifies systemic therapeutic procedures administered as part of the first course of treatment at this and all other facilities.
- If none of these procedures were administered, then this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

Follow-Up/Recurrence/Death

Recurrence Type-1st: (1880)

- Default is “00”.
- Use the dropdown for applicable codes.
- Code for the type of first recurrence after a period of documented disease-free intermission or remission.

Recurrence Date-1st: (1860)

- YYYYYY date format.
- The date of the first recurrence of this tumor.

Date of Last Contact: (1750)

- YYYYYY date format.
- Date of last contact with the patient, or date of death.
- If the patient has multiple tumors, Date of Last Contact should be the same for all tumors.

Vital Status: (1760)

- Default is “1”.
- Use the dropdown for applicable codes.
- Vital status of the patient as of the date entered in Date of Last Contact [1750].

- If the patient has multiple tumors, vital status should be the same for all tumors.

Cause of Death: (1910)

- Default is “0000”.
- Official underlying cause of death as coded from the death certificate in valid ICD-7, ICD-8, ICD-9, and ICD-10 codes.

DC State File Number: (2380)

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

ICD Revision Number: (1920)

- Default is “0”.
- Use the dropdown for applicable codes.
- Indicator for the coding scheme used to code the cause of death.

Place of Death-State: (1942)

- Use the dropdown for applicable codes.
- State or Province where the patient died and where certificate of death is filed.
- This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes.
- It supplements the item PLACE OF DEATH--COUNTRY [1944]. It replaces the use of PLACE OF DEATH [1940].
  https://seer.cancer.gov/manuals/2022/SPCSM_2022_Appendix_B.pdf

Place of Death-Country: (1944)

- Use the magnifying glass for applicable codes and instructions.
- Code for the country in which the patient died and where certificate of death is filed.
- If the patient has multiple tumors, all records should contain the same code.
- This data item became part of the NAACCR transmission record effective with Volume II, Version 13 to include country and state for each geographic item and to use interoperable codes. It supplements the item Place of Death--State [1942]. It replaces the use of Place of Death [1940].
  https://seer.cancer.gov/manuals/2022/SPCSM_2022_Appendix_B.pdf

Physician-Managing: (2460)

- Use the magnifying glass for applicable codes and instructions.
- Code for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.
- Registry may use physicians’ medical license numbers or may create individual numbering systems.

NPI-Physician-Managing: (2465)

- The NPI (National Provider Identifier) code identifies the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.

- NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Physician-Follow-Up: (2470)

- Use the magnifying glass for applicable codes and instructions.
- Code for the physician currently responsible for the patient's medical care.
- Registry may use physicians' medical license numbers or may create individual numbering systems.

NPI-Physician-Follow-Up: (2475)

- The NPI (National Provider Identifier) code for the physician currently responsible for the patient's medical care.
- NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

NPI-Inst Referred To: (2425)

- The NPI (National Provider Identifier) code identifies the facility to which the patient was referred for further care.
- NPI, a unique identification number for US health care providers, was scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008.

Over-Ride Flags

Over-ride CS 20: (3769)

- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- Over-ride CS 20 has been designated as a flag for directly coded SEER Summary Stage 2000 [759] to support CDC's National Program of Cancer Registries (NPCR) requirements.

Over-ride SS/NodesPos: (1981)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

- This override is used with the following edits in the NAACCR Metafile of the EDITS software:
    - Summary Stage 1977, Regional Nodes Pos (NAACCR).
    - Summary Stage 2000, Regional Nodes Pos (NAACCR).

Over-ride HospSeq/DXConf: (1986)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software:
    - Diagnostic Confirm, Seq Num--Hosp (CoC).

Over-ride CoC-Site/Type: (1987)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This override is used with the following edits in the NAACCR Metafile of the EDITS software:
    - Primary Site, Morphology-Type ICDO2 (CoC).
    - Primary Site, Morphology-Type ICDO3 (CoC).
    - Primary Site, Morphology-Type, Behavior ICDO3 (CoC).

Over-ride HospSeq/Site: (1988)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This override is used with the following edits in the NAACCR Metafile of the EDITS software:
    - Seq Num--Hosp, Primary Site, Morph ICDO2 (CoC).
    - Seq Num--Hosp, Primary Site, Morph ICDO3 (CoC).

Over-ride Site/TNM-StgGrp: (1989)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This override is used with the following edits in the NAACCR Metafile of the EDITS software:
    - Primary Site, AJCC Stage Group - Ed 6, (NAACCR).
    - Primary Site, AJCC Stage Group - Ed 6, ICDO3 (CoC).
    - Primary Site, AJCC Stage Group - Ed 7, ICDO3 (CoC).

- Primary Site, AJCC Stage Group - Ed 7, ICDO3 (NPCR).

Over-ride Age/Site/Morph: (1990)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This override is used with the following edits in the NAACCR Metafile of the EDITS software:
  - Age, Primary Site, Morphology ICDO2 (SEER IF15.)
  - Age, Primary Site, Morphology ICDO3 (SEER IF15).
  - Age, Primary Site, Morph ICDO3--Adult (SEER).
  - Age, Primary Site, Morph ICDO3--Pediatric (NPCR).

Over-ride SeqNo/DxConf: (2000)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This override is used with the following edits in the NAACCR Metafile of the EDITS software:
  - Diagnostic Confirm, Seq Num--Central (SEER IF23).

Over-ride Histology: (2040)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This override is used with the following edits in the NAACCR Metafile of the EDITS software:
  - Diagnostic Confirmation, Behavior ICDO2 (SEER IF31).
  - Diagnostic Confirmation, Behavior ICDO3 (SEER IF31).
  - Morph (1973-91) ICD-O-1 (SEER MORPH).
  - Morphology--Type/Behavior ICDO2 (SEER MORPH).
  - Morphology--Type/Behavior ICDO3 (SEER MORPH).

Over-ride Ill-define Site: (2060)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This override is used with the following edits in the NAACCR Metafile of the EDITS software:
  - Seq Num--Central, Prim Site, Morph ICDO2 (SEER IF22).
  - Seq Num--Central, Prim Site, Morph ICDO3 (SEER IF22).

Over-ride Leuk, Lymphoma: (2070)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This override is used with the following edits in the NAACCR Metafile of the EDITS software:
    - Diagnostic Confirmation, Histology ICDO2 (SEER IF48).
    - Diagnostic Confirmation, Histology ICDO3 (SEER IF48).

Over-ride Report Source: (2050)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This override is used with the following edits in the NAACCR Metafile of the EDITS software:
    - Type of Rep Srce (DC), Seq Num--Cent, ICDO2 (SEER IF04).
    - Type of Rep Srce (DC), Seq Num--Cent, ICDO3 (SEER IF04).

Over-ride Site/Behavior: (2071)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This override is used with the following edits in the NAACCR Metafile of the EDITS software:
    - Primary Site, Behavior Code ICDO2 (SEER IF39).
    - Primary Site, Behavior Code ICDO3 (SEER IF39).

Over-ride Site/Lat/Morph: (2074)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This override is used with the following edits in the NAACCR Metafile of the EDITS software:
    - Laterality, Primary Site, Morph ICDO2 (SEER IF42).
    - Laterality, Primary Site, Morph ICDO3 (SEER IF42).

Over-ride Site/Lat/SeqNo: (2010)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases

repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This over-ride is used with the following Interrecord Edit from the SEER Program:
  - Verify Same Primary Not Reported Twice for a Person (SEER IR09).
- Presently, documentation on interrecord edits is not included in the EDITS software.

Over-ride Site/Type: (2030)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This override is used with the following edits in the NAACCR Metafile of the EDITS software:
  - Primary Site, Morphology-Type ICDO2 (CoC).
  - Primary Site, Morphology-Type ICDO3 (CoC).
  - Primary Site, Morphology-Type ICDO2 (SEER IF25).
  - Primary Site, Morphology-Type ICDO3 (SEER IF25).
  - Primary Site, Morphology-Type, Behavior ICDO3 (SEER IF25).
  - Primary Site, Morphology-Type, Behavior ICDO3 (CoC).

Over-ride Surg/DXConf: (2020)

- Use the dropdown for applicable codes.
- Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.
- This override is used with the following edits in the NAACCR Metafile of the EDITS software:
  - RX Summ--Surg Prim Site, Diag Conf (SEER IF76).
  - RX Summ--Surg Site 98-02, Diag Conf (SEER IF106).
  - RX Summ--Surgery Type, Diag Conf (SEER IF46).

Conversion/System Admin Fields

NAACCR Record Version: (50)

- Default is “260”.
- Use the dropdown for applicable codes.
- This item applies only to record types I, C, A, and M. Code the NAACCR record version used to create the record. The correction record (U) has its own record version data item.

Text Documentation Requirements

Text validation of codes is required by NCCR. Writing text is required to supplement and support coded information. The codes entered in the abstract should mirror the text fields. Text documentation is used for general quality control, visual editing, re-abstracting studies, special research projects, and consolidation by NCCR. Proper text documentation allows for the review and correction of abstracts without access to the patient's actual medical record. Furthermore, text from the original abstract is used to audit NCCR's consolidation practices by our standard setters.

Each abstract takes a significant amount of time and effort to produce. We are all striving for consistent, accurate data. Your text validates the codes selected in your abstract and is vital to resolving discrepancies between multiple facilities who may have submitted an abstract on the same patient.

General guidelines for recording text information.

- All coded data fields must have text support recorded on the abstract. Record text to validate coded data fields.
- Fields requiring text verification include patient race, age, sex, and other demographics (marital status, insurance at diagnosis, and vital status/death information), primary site, histology, extent of disease, treatment, and any other positive/negative findings that validate the primary site, histology, extent of disease and treatment.
- Data fields that do not need text support include date of birth, social security number, NPI or facility numbers, phone numbers, patient address information, and medical record number.
- Text should be completed by the abstractor. Text generated by the computer is not acceptable.
- Record pertinent site-specific cancer information.
- We recommend completing the text fields *before* assigning codes.
- Record text in a concise and organized manner.
- Complete sentences are not required or necessary.
- Key phrases are separated by punctuation, either periods, or semicolons.
- Use standard medical abbreviations. Avoid abbreviations with many different meanings in different contexts.
- Use either lower case or a combination of upper and lower case. Avoid all capital letters (we recommend lower case text with all abbreviations in capital letters).
- Do not repeat the same information in multiple fields.
- Avoid including irrelevant information.
- Dates may be estimated and should be documented as estimated dates. Suggestions for concise text and successful abbreviations.
- Leave out articles, such as "a," "an," and "the."
- Leave out verbs (complete sentences not necessary).
- Use symbols with distinct meanings, such as (+) for positive and (-) for negative.
- Use standard abbreviations wherever possible.
- When in doubt. Just write it out.

Text Field Documentation	
Text Field	Instructions
Text-Usual Occupation NAACCR Item # 310	Instructions: Record the patient's usual occupation (i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor). Do not record "retired." If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation. If no information is available, record "unknown."
	Rationale: Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies occupational groups in which cancer screening or prevention activities may be beneficial
	Example: "High School Teacher".
Text-Usual Industry NAACCR Item # 320	Instructions: Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the greatest number of years before diagnosis of this tumor. Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that performs more than one of these components. There should be an entry for Text-Usual Industry if any occupation is recorded. If no information is available regarding the industry in which the reported occupation was carried out, record "unknown." If the patient was not a student or homemaker and had never worked, record "never worked" as the usual industry.
	Rationale: Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.
	Example: If Usual Occupation is "High School Teacher" than the industry would be "Education Services" or "Education."
Text-DX Proc-PE (Physical exam) NAACCR Item #2520	Instructions: Document the history, physical examination and clinical presentation information including any symptoms that led to workup and evaluation for cancer. This includes date of exam, age, sex, race/ethnicity, clinical tumor size, tumor location, palpability of lymph nodes, and positive and negative clinical findings.
	Rationale: Validates date of diagnosis, class of case, diagnostic confirmation, clinical staging information, race, sex, Spanish/Hispanic ethnicity, and site-specific factors.

Text Field Documentation	
Text Field	Instructions
	Example: 52 Y/O, white, Hispanic male; referred to MED ONC for consult for recent DX of cancer in RLL lung; PT originally presented in ER elsewhere PTA for severe cough W/blood in sputum; WU showed nodule RT lung; BX revealed ADENOCA; presents now for TX; PE on 4/4/2021 showed no LN PALP and BILAT crackles.
Text-DX Proc-X-Ray/Scan (imaging) NAACCR Item #2530	Instructions: Document date, facility, imaging test performed and any pertinent results, findings, and impressions.
	Rationale: Validates date of diagnosis, clinical stage related fields, tumor size summary, extent of disease related fields, and diagnostic confirmation.
	Example: 6/4/2020 (ABC Hospital) CT ABD/pelvis: two pancreatic masses, one 2.5 CM arising in head of pancreas and second 2.3 CM arising in junction of head and body of pancreas. 7/18/2020 MRI ABD: progressive pancreatic duct dilation, suggesting intraductal mucinous tumor of pancreas, solid component arising in head of pancreas, suspicious for MALIG.
Text-DX Proc-Scopes NAACCR Item #2540	Instructions: Document all endoscopic examinations and findings that provide information for staging and treatment. Document the date and location of where the study occurred.
	Rationale: Validates RX Summ-DX/Stg Proc, Surgery Primary Site, staging decisions, Laterality, Primary Site, Diagnostic Confirmation, and Histology.
	Example: 5/13/2023 (office of Dr. John Doe) colonoscopy: fungated ulcerated mass in terminal ileum, 2.0 CM extends to MARG, polyp near mass resected; 6/1/2023 (UNK facility) EUS W/FNA: 3.0 CM colon mass found 42 CM from anal verge.
TEXT-DX Proc-Lab Tests NAACCR Item #2550	Instructions: Text area for manual documentation of information from laboratory examinations other than cytology or histopathology. Document cancer-specific tumor markers, serum and urine electrophoresis, special studies, etc. Record both positive and negative findings. Record positive results first.
	Rationale: This field validates the coding for site specific factors, special studies, some staging items, and validates information used to assign more specific histology types. If the diagnosis was made clinically, it is used to confirm clinical diagnosis.

Text Field Documentation	
Text Field	Instructions
	Example: Breast: 1/1/2022 ER (+)/ PR (+), HER-2 (-) on IHC (score 0). 1/10/2022 HER-2 by FISH (-), ratio: 1.7 Prostate: 7/2/2022 PSA 10 ng/mL (elevated)
TEXT-DX Proc OP (findings) NAACCR Item #2560	Instructions: Document dates, names of procedures, along with abnormal findings, and location of tumor. Document observations of the surgeon (what is seen/felt/palpated) when the patient is opened up/explored. Do not record what surgeon did (step by step procedure). Do not record path findings. If no findings are found, record "technique only."
	Rationale: Validates RX Summary, Surgery of Primary Site, Reason for no Surgery, and staging decisions.
	Example: 8/15/2022 sigmoid colectomy, RT colectomy, and RT oophorectomy: PALP LSN in LT flank; colon was noted 2B dilated as well as small bowel; a near obstructing LSN found in sigmoid colon; cecal area had large tumor noted involving the RT ovary; ovary was noted 2B enlarged and abnormal.
TEXT-DX Proc Path NAACCR Item #2570	Instructions: Use this field to pull pertinent information from pathology reports. This includes specimen collection date, pathology report number (specimen number), procedure, tissue specimen and any language that describes primary site, histology, laterality, behavior, grade, extent of disease, tumor size, margins, or status of lymph nodes. Note if pathology report is a slide review or a second opinion from an outside source, i.e., AFIP, Mayo, etc. Record any additional comments from the pathologist, including differential diagnosis considered and any ruled out or favored.
	Rationale: Validates the coding of Primary Site, Date of Diagnosis, Histology, Grade, Behavior, Diagnostic Confirmation, Extent of Disease related fields, values selected for site-specific factors, and surgical procedures and treatment fields. Validates staging information such as Pathologic Size and/or Tumor Size Summary, lymph node involvement and metastasis.
	Example: Colon 1/1/2020 ABC Hospital (NV-20-01456) ascending colon mass BX: INV MOD DIFF ADENOCA W/mucinous and signet ring cell features. 1/15/2020 ABC Hospital (NV-20-01503) hemicolectomy: sigmoid colon; 8.0 CM; LVI: (-); PNI: (-); MARG (-); 2(+)/5 LNs. Liver BX C/W METS; omentum (-) for MALIG.

Text Field Documentation	
Text Field	Instructions
	Prostate 8/21/2021 ABC Hospital (NV-21-01245) prostate BX: prostatic ADENOCA; Gleason 4+3=7 (group 3); PNI is identified. 11/13/2021 ABC Hospital (NV-21-02546) radical prostatectomy: ADENOCA; Gleason 3+4=7 (group 2); EPE: (-); urinary bladder neck INV: (-); SV INV: (-); carcinoma focally extends to apex MARG of prostatectomy; 0(+)/8 LNs; pT2 pN0.
TEXT-Primary Site Title NAACCR Item #2580	Instructions: Document the primary site including applicable subsite along with laterality.
	Rationale: Validates coded values of primary site and laterality
	Example: RT breast 10:00 OR RT breast UOQ.
TEXT-Histology NAACCR Item #2590	Instructions: Document the histology, grade, and behavior of the tumor.
	Rationale: Validates that text agrees with coded values for Histology, Grade, and Behavior.
	Example: Skin: SCC, G2. Skin: Melanoma in situ. Prostate: ADENOCA, Gleason 6. Breast: DCIS, HG.
TEXT-Staging NAACCR Item #2600	Instructions: Record highest stage prior to treatment. Document tumor size and extension, lymph node involvement, sites of distant metastasis, and any other information related to staging.
	Rationale: Validate staging fields
	Example: Prostate confined to prostate, no REG LNs, no DIST METS. Breast: PT received NEOADJ TX; 2 LT breast tumors, largest 4.0 CM confined to breast, large mass in axilla C/W METS to LNs, no DIST METS. Skin: Clark level IV, 1(+)/4 LNs, no DIST METS.
TEXT-Surgery NAACCR Item #2610	Instructions: Enter dates and text describing each surgical procedure(s) performed as first course treatment. Including other treatment information, e.g., planned procedure aborted, unknown if surgery performed, patient refused.

Text Field Documentation	
Text Field	Instructions
	Rationale: Validates date first course treatment, date of diagnosis, surgery primary site, date surgery, surgery/radiation sequence, and reason no surgery.
	Example: Breast: 3/15/2021 ABC Hospital: RT breast lumpectomy W/LN dissection. Colon: 1/1/2022 ABC Hospital: RT hemicolectomy W/LN dissection. Skin: 3/27/2021 ABC Hospital: RT punch BX. 4/2/2021 RT wide re-excision.
TEXT- Radiation (Beam) NAACCR Item #2620	Instructions: Document dates and detailed information regarding radiation treatment for the tumor being reported. Enter date and type (modality) of radiation. If the sequence of surgery and radiation is not apparent, indicate sequence.
	Rationale: Validates Date of First Course TX, Reason for no Radiation, RX Date of Radiation, RX-Summ Surg/Rad Seq, and Regional RX Modality.
	Example: 2/25/2021 45 GY in 25 FX at 180 CGY per FX using photon modality.
TEXT- Radiation (other) NAACCR Item #2630	Instructions: Document dates and detailed information regarding radiation treatment that is non-beam, e.g., seed implant, radioisotopes (I-131).
	Rationale: Validates Date of First Course TX, Reason for no Radiation, RX Date of Radiation, RX-Summ Surg/Rad Seq, and Regional RX Modality
	Example: 2/25/2021single injection of 150 millicuries of radioiodine (I-131).
TEXT – Chemo NAACCR Item #2640	Instructions: Document start date and chemotherapy agents or regimen. If treatment was discontinued or not completed, state.
	Rationale: Validates Date of First Course TX, RX Date Systemic, RX Date Chemo, RX Summ-Systemic/Surg Seq, and/or Date of First Course RX
	Example: 1/2/2022 Carboplatin and Taxol. 1/4/2021 recommended Carboplatin and Taxol, PT refused.

Text Field Documentation	
Text Field	Instructions
	1/31/2022 referred to ABC Oncology, unknown if CHEMO recommended or performed.
TEXT- Hormone NAACCR Item #2650	Instructions: Document start date and drug used. If treatment was discontinued or not completed, state.
	Rationale: Validates Date of First Course TX, RX Date Systemic, RX Date Hormone, RX Summ-Systemic/Surg Seq, and/or Date of First Course RX
	Example: 2/1/2022 levothyroxine.
TEXT- BRM NAACCR Item #2660	Instructions: Document start date and immunotherapy agents. If treatment was discontinued or not completed, state. Examples include bone marrow transplant and stem cell transplant.
	Rationale: Validates Date of First Course TX, RX Hosp-BRM, RX Date Systemic, RX Summ Tranplnt/Endocr, RX Summ BRM, RX Date BRM, and RX Summ-Systemic/Surg Seq
	Example: 3/26/2021 interferon.
TEXT – Other NAACCR Item #2670	Instructions: Document date treatment started and type of other treatment.
	Rationale: Validates Date of First Course TX, RX Summ-Other, RX Date Other, and RX Hosp-Other
	Example: 4/7/2021 blinded clinical trial.
TEXT – Remarks NAACCR Item #2680	Instructions: Document pertinent information not indicated in other text fields. Include marital status, race, ethnicity, smoking history, insurance at diagnosis, family and personal history of cancer, birthplace, occupation, industry, date of death, and justification of over-ride flags.
	Rationale: Validates Marital Status, Race/Ethnicity fields, Sequence Number Insurance at Diagnosis, Birthplace, Occupation, Industry, and Date of Death.
	Example: Married, white, non-Hispanic; Medicare managed care; former 1 PPD smoker x 20 years (quit 2010); no ETOH HX; no family HX or personal HX of cancer; birthplace: Los Angeles, CA; worked as nurse in healthcare industry.

Text Field Documentation	
Text Field	Instructions
TEXT – Place of Diagnosis NAACCR Item #2690	Instructions: Document the facility, physician office, city, state, or country where the diagnosis was made. If the diagnosis was made at a small clinic or family practice, do not abbreviate the name of the practice ("University of California San Francisco" versus "UCSF"). For out-of-state residents and facilities, include the city and state where the facility is located.
	Rationale: Text documentation is an essential component of a complete electronic report and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.
	Example: Smith Family Medical.

Resources for Text Documentation

- A Cancer Registrar's Guide to Collecting Industry and Occupation
- NAACCR Recommended Abbreviations for Abstractors
- NCRA has published a series of Informational abstracts that provide cancer-site specific guidelines for text to be included in abstracts. Updated 2025. These are available as a set and can be downloaded here.

SECTION 7: SUMMARY OF 2026 CHANGES

The following describes the changes to required data items and coding instructions effective for cases diagnosed 1/1/2026 and after. Additional changes required for CoC Accredited Cancer Programs can be found in the STORE Manual and the NAACCR Implementation Guidelines

Below are links to key resources registries may find useful to plan to transition to V26.

- NAACCR Implementation Guidelines
- NAACCR Data Standards and Data Dictionary – formerly Volume II
- NAACCR XML Dictionaries
- NAACCR v26 Edits Metafile – including Changes Spreadsheet
- SEER Program Coding and Staging Manual – includes Summary of Changes
- Commission on Cancer STORE Manual
- Site Specific Data Items (SSDI) and Grade Manual v3.3
- AJCC Cancer Staging System
- SEER RSA (EOD, Summary Stage, SSDIs, Grade) v3.3
- Summary Stage 2018 – includes revision history
- Extent of Disease (EOD) 2018 Manual – includes change log
- Solid Tumor Rules – includes summary and changes
- ICD O New histologies, terms, and changes in behavior
- Cancer PathCHART Morphology Validation List and Search tool
- Hematopoietic Manual and Database – see revision history on the left
- Surgery Codes and Surgery Code Crosswalks – no changes for 2026

ICD-O-3 and Reportability

Reportability for cases diagnosed in 2026 is based on the ICD-O Third Edition, Second Revision Morphology (ICD-O-3.2) plus the ICD-O-3.2 updates posted on the NAACCR website.

There are no code changes for ICD-O-3 or changes to Reportability for cases diagnosed in 2026. New and related terms for ICD-O-3 are posted on the NAACCR website.

New Data Items

2026 New Data Item	
NAACCR Item #	Data Item Name
225	Sex Assigned at Birth
1176	SSDI: Spread Through Air Spaces (STAS)
1178	SSDI: Residual Cancer Burden (RBC)
1179	SSDI: Residual Cancer Burden (RBC Class

Sex Assigned at Birth: (225)

- Sex Assigned at Birth [225] replaces the existing data item Sex [220] for all cases regardless of diagnosis year.
- Sex [220] is retired in v26.

Spread Through Air Spaces (STAS): (1176)

- Spread Through Air Spaces (STAS) [1176] is added to Lung V9 (09360) to record micropapillary clusters, solid nests, or single cells of tumor extending beyond the

edge of the tumor into the air spaces of the surrounding lung parenchyma. This SSDI applies to cases diagnosed on January 1, 2026, or later; cases diagnosed prior to that must be left blank. All new SSDI information is incorporated into the Staging APIs.

Residual Cancer Burden (1178) and Residual Cancer Burden Class (1179):

- Residual Cancer Burden [1178] and Residual Cancer Burden Class [1179] are added to Breast (00480) to record a score that measures the amount of cancer remaining in the breast and the regional lymph nodes after neoadjuvant therapy and surgical resection.
- This SSDI applies to cases diagnosed on January 1, 2026, or later; cases diagnosed prior to that must be left blank. All new SSDI information is incorporated into the Staging APIs.

Revised Data Items

Some SSDI codes and code descriptions are changed to reflect changes in clinical management and/or staging and to improve clarity or to address questions that were raised in the various forums. Code changes for SSDIs are applicable to cases diagnosed January 1, 2018, and forward, but registrars will not be required to update previously coded information.

2026 Revised Data Items	
NAACCR Item #	Data Item Name
3890	Microsatellite Instability (MSI)
3926	Schema Discriminator 1
3927	Schema Discriminator 2
3908	Percent Necrosis Post Neoadjuvant
3906	Oncotype DX Risk Level-Invasive

Microsatellite Instability (MSI): (3890)

- Microsatellite Instability (MSI) [3890] which is an existing SSDI for the Colon and Rectum (00200) schema, is added to the Corpus Carcinoma and Carcinosarcoma schema (00530). For Corpus Carcinoma and Carcinosarcoma cases diagnosed prior to January 1, 2026, Microsatellite Instability must be left blank.

Schema Discriminator: (3926)

- Schema Discriminator 1 [3926] for Nasopharynx and Oropharynx schemas was revised to reflect the new names of the schemas (see section 5.4) and to limit the use of this discriminator with C11.1 to diagnosis years 2018-2024. This field was removed from Nasopharynx V9 (09090) which only includes cases diagnosed on January 1, 2025, or later.

Schema Discriminator 2: (3927)

- Schema Discriminator 2 [3927] for Oropharynx schemas was revised to reflect the new names of the schemas (see section 5.4) and to include the Oropharynx HPV-Associated V9 schema in the validation table Schema ID column.

Percent Necrosis Post Neoadjuvant: (3908)

- Percent Necrosis Post Neoadjuvant [3908] included in the Bone schemas (00381, 00382, 00382, 00383) will no longer be required by any standard setters as of January 1, 2026.

Oncotype DX Risk Level-Invasive: (3906)

- Oncotype DX Risk Level-Invasive [3906] and Oncotype Dx Risk Level – DCIS [3905] included in the Breast Schema (00480) will no longer be required by any standard setters as of January 1, 2026.
- To streamline maintenance, several SSDIs in the Head and Neck related schemas were adjusted to share the same validation table and notes wherever they are included. These SSDIs include:
  - Extranodal Extension Head and Neck Clinical [3831]
  - Extranodal Extension Head and Neck Pathological [3832]
  - LN Size [3883]
  - LN Head and Neck Levels I-III [3876]
  - LN Head and Neck Levels IV-V [3877]
  - LN Head and Neck Levels VI-VII [3878]
  - LN Head and Neck Other [3879]

New SSDIs and code changes are incorporated in the SEER Staging REST API/library. Other than updating the staging API that you use, there is no need for action for these types of changes. They are documented in the change log which can be accessed on https://apps.naaccr.org/ssdi/list/. Also, the SSDI Manual, Version 3.3 provides changes to existing notes, codes, and code descriptions.

Retired Data items

Several data items were retired in v26 including the following that may have been collected at some point in the past. Retired means that the data item is not maintained by a standard setting agency and is no longer in the data transmission layout; however, it does not impact on the data previously collected and stored in a registry database.

V26 Retired Data Items		
Item #	Item Name	Source of Standard
3110	Comorbid/Complications 1	CoC
3120	Comorbid/Complications 2	CoC
3130	Comorbid/Complications 3	CoC
3140	Comorbid/Complications 4	CoC
3150	Comorbid/Complications 5	CoC
3160	Comorbid/Complications 6	CoC
3161	Comorbid/Complications 7	CoC
3162	Comorbid/Complications 8	CoC
3163	Comorbid/Complications 9	CoC
3164	Comorbid/Complications 10	CoC
3645	NPCR Derived AJCC 8 TNM Clin Stg Grp	NPCR
3646	NPCR Derived AJCC 8 TNM Path Stg Grp	NPCR
3647	NPCR Derived AJCC 8 TNM Post Therapy Stg Grp	NPCR
1120	Pediatric Stage	CoC
1130	Pediatric Staging System	CoC
1140	Pediatric Staged By	CoC
220	Sex	SEER/CoC

Solid Tumor Rules

The Solid Tumor Rules Reformatting Work Group has implemented the following changes for the 2026 Solid Tumor Rules.

- The Specific Histologies, NOS/NST, and Subtypes/Variants tables have been reformatted from 3 columns to 2. Table notes have been moved to footnotes. Relevant M and H rules that refer to these tables have been updated.
- General Instructions have been reformatted. Redundant instructions from each site group module have been removed and added to the General Instructions.
- Ambiguous terminology for determining histology has been revised by a joint physician and oncology data specialist (ODS) panel. The associated instructions have been updated.
- Rule M10 in the breast site group has been removed, and subsequent rule numbering has been adjusted.

A history revision will be posted along with the manual. New site-specific modules are not planned for 2026.

Hematopoietic and Lymphoid Neoplasms Manual and Database

- The Hematopoietic Database was updated to reflect the new terms from the WHO 5th edition. A complete list of these terms can be found here: ICD O 3 Coding Updates for 2026. In addition, the same primaries for histologies 9811-9819 were changed to reflect that all ALL's are the same primary. This was confirmed with a hematopoietic expert.
- The manual was also updated with new formatting, updated sections and additional information. See the Hematopoietic Manual for a complete listing of changes.

Summary Stage 2018

Notes and code descriptions for some schemas, including Prostate, have been updated similarly to the EOD fields to improve clarity. Registrars are not required to update previously coded information.

AJCC Cancer Surveillance Reportability

- AJCC is developing a new AJCC Cancer Surveillance DLL (V26) that will provide AJCC data only, decoupled from SEER-specific dependencies. This new design will make the DLL simpler, easier to maintain, and more reliable, helping to streamline future releases and reduce the risk of bugs.
- Notable changes include: a SQLite database and error messages when developers attempt to retrieve SEER data. Documentation will be provided. Release is targeted for December 2025.

AJCC Version 9 Protocols

AJCC Cancer Staging System will release two Version 9 Protocols to go into effect with cases diagnosed January 1, 2026, and forward:

- Salivary Glands (9017)
- Oropharynx (HPV-Associated) (9018)

These Version 9 protocols replace the current AJCC 8th edition chapters for these disease sites.

- Major Salivary Glands name changed to Salivary Glands. For 2026+ this will only include Major Salivary glands. Minor Salivary Glands will be added for 2027+.
- The two original Oropharynx chapters were renamed to align with current terminology. The new names are Oropharynx HPV-Associated [8th: 2018-2025] (AJCC ID: 10) and Oropharynx (HPV-Independent) and Hypopharynx (AJCC ID: 11.1). In addition, C11.1 was removed and C10.1 was added for Oropharynx (HPV-Associated) [8th Edition] (AJCC ID: 10) and Oropharynx (HPV-Independent) (AJCC ID: 11.1). C10.1 was removed from the Larynx [8th Edition] (AJCC ID: 13.1).

AJCC TNM Protocols replace the current AJCC 8th edition chapters for these disease sites. The protocol version and implementation date are listed below:

Protocol Site	Protocol Version	Protocol Effective Date
Cervix Uteri	9	2021+
Appendix	9	2023+
Anus	9	2023+
Brain/Spinal Cord	9	2023+
Vulva	9	2024+
Neuroendocrine Tumors of the Stomach	9	2024+
Neuroendocrine Tumors of the Duodenum and Ampulla of Vater	9	2024+
Neuroendocrine Tumors of the Jejunum and Ileum	9	2024+
Neuroendocrine Tumors of the Appendix	9	2024+
Neuroendocrine Tumors of the Colon and Rectum	9	2024+
Neuroendocrine Tumors of the Pancreas	9	2024+
Thymus	9	2025+
Lung	9	2025+
Diffuse Pleural Mesothelioma	9	2025+
Nasopharynx	9	2025+
Salivary Glands Major Salivary Glands Minor Salivary Glands	9	 2026+ 2027+
Oropharynx (HPV-Associated)	9	2026+

RESOURCES

References for Abstracting

References for Abstracting		
Resource	Description	Website
ACS/NCDB	The National Cancer Database is a clinical oncology database sourced from hospital registry data collected in more than 1,500 Commission on Cancer-accredited facilities. These data are used to analyze and track patients with malignant neoplastic diseases, their treatments, and outcomes.	NCDB
AHD	The American Hospital Directory provides data, statistics, and analytics about more than 7,000 hospitals nationwide.	AHD
AIM	The Administrators in Medicine (AIM) DocFinder contains the licensing background and disciplinary information of physicians and other health care practitioners from those states that practice.	AIMS Doc Finder
AJCC	American College of Surgeons Cancer Staging information.	AJCC Cancer Staging System
AMA	American Medical Association Doctor Finder provides you with basic professional information on virtually every licensed physician in the United States.	AMA
CoC	Commission on Cancer Standards for Oncology Registry Data Entry Manual.	CoC STORE Manual
IACR	IACR/WHO Histology/Behavior ICD-O-3.2.	IACR ICD-O-3
Industry/Occupation	Guide to collecting Industry and Occupation coding information.	Industry and Occupation Coding
NAACCR	Site Specific Data Items (SSDI) and Grade.	NAACCR SSDI
NAACCR	Implementation Guidelines and Recommendations.	NAACCR Implementation Guidelines
NAACCR	Data Standards and Data Dictionary. It provides detailed specifications and codes for each data item in the NAACCR data exchange record layout.	NAACCR Data Dictionary
NAACCR	XML Data Dictionary for Data Exchange.	NAACCR XML Data Dictionary
NAACCR	V26 Edits Metafile and Associated Documents.	NAACCR V26 Edits
NAACCR	Guidelines for ICD-O-3.2 Update Implementation.	NAACCR ICD-O-3 Updates
NAACCR	Surgery Codes and Surgery Codes Crosswalk.	NAACCR Surgery Codes

NAACCR	Recommended Abbreviations for Abstractors.	NAACCR Abbreviations
NCCN	National Comprehensive Cancer Network Treatment by Cancer Type.	NCCN
NIH	The NCI Dictionary of Cancer Terms features 9,416 terms related to cancer and medicine.	Dictionary of Cancer Terms
NPI	National Provider Identifier Registry enables you to search for providers in the National Plan and Provider Enumeration System (NPPES).	NPPES NPI Registry
SEER	ICD-O-3 SEER Site/Histology Validation List.	SEER ICD-O-3 Coding
SEER	General Instructions for Staging.	SEER Cancer Schema List
SEER	Summary Stage uses all information available in the medical record; in other words, it is a combination of the most precise clinical and pathological documentation of the extent of disease.	SEER Summary Stage 2018
SEER	Solid Tumor Rules determine the number of primaries to abstract and the histology code.	SEER Solid Tumor Rules
SEER	Cancer Pathology Coding Histology and Registration Terminology (Cancer PathCHART) is a first-of-its-kind initiative in North America and around the world to update cancer surveillance standards for tumor site, histology, and behavior code combinations and associated terminology.	SEER PathCHART
SEER	Hematopoietic & Lymphoid Neoplasm Database (HemeDB) provides data collection rules for hematopoietic and lymphoid neoplasms for 2010+.	SEER Heme DB
SEER	SEER Program Coding and Staging Manual.	SEER Coding and Staging Manual
SEER	SEER*RSA (Registry Staging Assistant).	SEER RSA
SEER	SEER*Rx Online Interactive Drug Database.	SEER Rx
SSA	The Social Security Administration (SSA) collects death information to administer its programs.	SSA
USPS	United States Postal Service Zip Code Search.	Zip Code Search
WHO	ICD-O-3 Manual, 3rd Edition–the “purple” book pdf download.	ICD-O-3 Manual/Purple Book

Resources for Education & Training

American Health Information Management Association

AHIMA-certified professionals are leading healthcare organizations through education and experience. AHIMA awards credentials for coding and health information careers. NCRA and AHIMA together offer an online, self-directed Certificate in Cancer Registry Management.

Fundamental Learning Collaborative for the Cancer Surveillance Community

The Fundamental Learning Collaborative for the Cancer Surveillance Community (FLccSC- pronounced as "flossy") is Nevada's go-to learning management system. Silver State registrars can access CE-eligible courses from NAACCR's Cancer Registry and Surveillance Webinar Series, as well as course modules that have been created and shared by other states. The webinar recordings and materials are FREE at no cost to Nevada cancer reporters. To access the training, you must have a free FLccSC account.

Click here to register as new user. You will receive an email from the NCCR Education and Training Coordinator with instructions once your registration has been processed.

AJCC Curriculum for Registrars

This free self-guided learning is designed to provide education in a stepwise learning environment. The curriculum breaks down the content into Introduction, Beginning, Intermediate, and Advanced. After the Introduction, the modules will provide lessons in a consistent order of classifications; categories T, N, and M; stage group; additional resources; and a quiz.

SEER Training Modules

The SEER training website provides web-based training on cancer registration, including site-specific cancer instructions. This website contains resources that are free and can be used by anyone.

SEER Educate

This FREE comprehensive training platform is tailored specifically for cancer registry professionals to improve technical skills through applied testing on the latest coding guidelines and concepts.

NCRA's Center for Cancer Registry Education

The Center for Cancer Registry Education is designed to provide easy access to high-quality educational programming to support both seasoned professionals and those new to the field. This one-stop access site offers a variety of products and services, allowing you to tailor your training and manage continuing education credits.

NAACCR Cancer Registrar Training Guide

The NAACCR Cancer Registrar Training Guide is intended for use by central cancer registries (CCRs) in training individuals new to the cancer registry profession. It consists of one-on-one mentorship, independent learning, hands-on exercises, and practical experience. The primary goal of the Guide is to prepare new staff to become productive, effective members of the Central Registry Workforce using existing education and training resources. Each student should work with a mentor who is a Certified Tumor Registrar with experience in central cancer registry operations.

[Tour of the Hematopoietic Data Base]

Working on the live SEER web site, Jennifer Ruhl, MSHCA, RHIT, ODS will demonstrate how registrars can navigate the Hematopoietic Database successfully. Using case scenarios, she will provide tips to help registrars achieve the best and most accurate outcomes for determining reportability requirements and hematopoietic and lymphoid neoplasm cases. CE credit is not available for this activity.

Cancer Organizations

American Cancer Society

The American Cancer Society is a leading cancer-fighting organization with a vision to end cancer as we know it, for everyone. We are improving the lives of people with cancer and their families as the only organization combating cancer through advocacy, research, and patient support, to ensure that everyone has an opportunity to prevent, detect, treat, and survive cancer.

- American Cancer Society Glossary: Definitions & Phonetic Pronunciations

American College of Surgeons (ACS)

The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

- News
- CANswer Forum

American Joint Committee on Cancer (AJCC)

The American Joint Committee on Cancer (AJCC) provides worldwide leadership in the development, promotion and maintenance of evidence-based systems for the classification and management of cancer in collaboration with multidisciplinary organizations dedicated to cancer surveillance and to improving care.

American Society of Clinical Oncology (ASCO)

American Society of Clinical Oncology (ASCO) is committed to making a world of difference in cancer care. As the world's leading organization of its kind, ASCO represents more than 45,000 oncology professionals who care for people living with cancer, through research, education, and promotion of the highest-quality treatment and care.

Centers for Disease Control and Prevention (CDC)

CDC is the nation's leading science-based, data-driven, service organization that protects the public's health.

- United States Cancer Statistics
- National Program of Cancer Registries (NPCR)

College of American Pathologists (CAP)

The College of American Pathologists (CAP), the leading organization of board-certified pathologists, serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide.

- Cancer Protocols

Commission on Cancer (CoC)

The Commission on Cancer (CoC) is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and monitoring comprehensive quality of care.

- Standards and Resources

National Cancer Institute (NCI)

NCI is the federal government's principal agency for cancer research and training. NCI leads, conducts, and supports cancer research to advance scientific knowledge and help all people live longer, healthier lives.

NCI/Surveillance, Epidemiology, and End Result Program (SEER)

- Reporting Guidelines

National Cancer Registrars Association (NCRA)

NCRA is non-profit organization that represents over 7,000 cancer registry professionals and administers the ODS credential. The mission of NCRA is to empower and advance registry professionals through innovations in education, advocacy, credentialing, and strategic partnerships.

National Comprehensive Cancer Network (NCCN)

The National Comprehensive Cancer Network (NCCN) is a not-for-profit alliance of 34 leading cancer centers devoted to patient care, research, and education. NCCN is dedicated to defining and advancing quality, effective, equitable, and accessible cancer care and prevention so all people can live better lives.

North American Association of Central Cancer Registries (NAACCR)

Established in 1987, NAACCR, Inc. is a collaborative umbrella organization for cancer registries, governmental agencies, professional associations, and private groups in North America interested in enhancing the quality and use of cancer registry data. All central cancer registries in the United States and Canada are members.

World Organization (WHO)

Our team of 8000+ professionals includes the world's leading public health experts, including doctors, epidemiologists, scientists and managers. Together, we coordinate the world's response to health emergencies, promote well-being, prevent disease and expand access to health care. By connecting nations, people and partners to scientific evidence they can rely on, we strive to give everyone an equal chance at a safe and healthy life.

- International Classification of Diseases for Oncology

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