2016 Cancer Program Manual

DCH-0916 Rev. 2/9/2016 for diagnosis year 2016
Based on NAACCR v16.0

Michigan Department of Health and Human Services
Division for Vital Records and Health Statistics

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MICHIGAN CANCER SURVEILLANCE PROGRAM
CANCER PROGRAM MANUAL

Michigan Department of Health and Human Services
Michigan Cancer Surveillance Program
DCH-0916 Rev. 2/9/2016
By Authority of Act 82, P.A. 1984

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MICHIGAN CANCER SURVEILLANCE PROGRAM
CANCER PROGRAM MANUAL

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INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) is mandated by Act 82 of 1984, effective July 1, 1984, to establish a cancer registry for the State of Michigan. This statute states "the department shall establish a registry to record cases of cancer and other specified tumorous and precancerous diseases that occur in the state, and to record information concerning these cases as the department considers necessary and appropriate in order to conduct epidemiologic surveys of cancer and cancer-related diseases in the state."

Reports of diagnosed cancers are required of a facility diagnosing and/or treating a cancer patient. ALL hospitals, clinical laboratories, physician offices, dentists and clinic directors who have knowledge of a case of cancer shall report the case to the MDHHS.

Reporting of diagnosed cancers statewide is effective for those cases diagnosed on or after January 1, 1985. This manual is intended to provide those responsible for reporting with specific instructions on the proper and complete reporting of cancer diagnoses.

In October 1, 2004, the Michigan Cancer Surveillance Program (MCSP) implemented the collection of benign/ borderline intracranial and Central Nervous System (CNS) tumors as a new requirement.

If you should need assistance, please contact the following staff at MCSP.

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HISTORY OF THE MICHIGAN CENTRAL CANCER REGISTRY

The history of cancer reporting in Michigan dates back to 1947 when an administrative rule was enacted to require the reporting of cancer cases. This rule was never effectively enforced until 1978, when a governor's task force was empaneled to examine the need for cancer reporting in Michigan. The recommendations from this panel prompted the department in 1980, to initiate a pilot program. By 1984, 52 hospitals were reporting cancer cases on a voluntary basis, which resulted in approximately 6,000 cases being reported each year. As the pilot project progressed, legislation to require state wide reporting was developed. On April 17, 1984, a bill to mandate state wide reporting was signed into law.

A panel was assembled to develop and design the rules for reporting incidence of cancer to the state wide central cancer registry. In 1984, the "Task Force on Administrative Rules to Implement Act 82" began meeting. The task force consisted of professional groups throughout the state who in some way dealt with cancer patients or cancer data systems. In addition, public health officials involved in health programs concerned with cancer control, and individuals involved with epidemiological cancer research, were also assigned to the task force.

The objective of the task force was to "provide advice to the department on a set of administrative rules as required by the authorizing legislation." This panel made recommendations on data items to be collected, methods of reporting, quality control issues, confidentiality, as well as rules for reporting facilities. These cancer reporting rules were developed and outlined in the original 1984 Cancer Reporting Manual, which was approved by the original task force. On January 1, 1985, the rules for reporting cancer cases went into effect.

MCSP began tabulating cancer incidence reports on January 1, 1985. By the end of 2005, the state central cancer registry contained 1.5 million reports with 1 million individual cancer cases. These cases represent approximately 180 reporting facilities, which include hospitals, physician offices and laboratories.

The Detroit Metropolitan Cancer Surveillance System operates a Surveillance Epidemiology End Results (SEER) registry which reports for all hospitals and majority of the laboratories within Oakland, Macomb, and Wayne counties. The SEER registry represents approximately 100 hospitals and laboratories in these three counties.

Facilities area able to report cancer cases to the state central cancer registry either manually on the cancer report form or electronically through the State's free software, *Abstract Plus*. Hospital registries are becoming more sophisticated in their collection and transferal methods since the state cancer registry began in 1985. As of October 2007, approximately 90 percent of the cases from hospitals and regional registries are involved in an automated reporting system. Automated facilities send their data through a secure FTP (file transfer protocol) site.

State cancer data has been compiled and analyzed annually since 1985. These yearly reports are produced using the submitted data and are made available on the Michigan Department of Health and Human Services - Cancer web site (http://www.michigan.gov/mdch/0,4612,7-132-2944_5323---,00.html). As new annual reports are prepared, updated data for prior years is developed and released to ensure that the most complete information is made available. Processing time for a report from diagnosis to manual statistics is approximately two years.

PURPOSE

A state wide population based cancer registry is the only means whereby state wide incidence data for cancers by type and by area of residence can be developed. Timely information on cancer cases is employed as a basis for cancer surveillance, as a tool for initial evaluation of cancer incidence within regions of particular interest, and as a source of baseline incidence data. The registry is of value in examining the frequency of cancer by demographic characteristics such as age, race and sex and is of significant value to researchers in epidemiological case control studies. This data is also helpful in the areas of planning health education and addressing public health concerns.

CONFIDENTIALITY

Cancer incidence reports and data files on cancer cases which are received by the department are afforded confidential handling as required by Act 82 of 1984, being section 2631 of Act 368 of 1978 as amended, and by administrative rule. The release of data in identifiable form is specifically prohibited, except as outlined in Rule Four. Under the rules, release of this data or reports is permitted to the individual patient or to the patient's legal representative. Information may be provided to a researcher conducting approved research, following specific protocol based upon the nature of the research. Release is permitted to a cancer registry from another state with regard to residents of that state so long as the state agrees to restrict the use of the information to statistical tabulations. Further protection of the data is afforded by sections 2632 and 2633 of Act 368 of 1978 which designates that the reports or information thereon are inadmissible as evidence in a court and which establishes a shield from liability for furnishing the information. In addition, the privacy regulations enacted in conjunction with the Health Insurance Portability and Accountability Act (HIPAA) has a specific exemption to permit disclosing identifiable patient data to the official public health agency of a state.

REVISED REPORTING REQUIREMENTS

In 2011, changes to the information being reported for cancer cases was initiated. These new reporting standards are designed to ensure that the registry in Michigan conforms as closely to central incidence registries operated in other states. The new data set collected conforms to the items recommended for collection by the North American Association of Central Cancer Registries (NAACCR) and are nearly the same as the recommendations by the National Program for Cancer Registries (NPCR).

The decision to change the reporting requirements was precipitated by two important developments. The first was the release of standards for the operation of a central registry which were produced by NAACCR in 2011. Concurrent with the release of these new standards were recommendations on standard items for collection released by NPCR within the Centers for Disease Control (CDC). The information being collected in Michigan did not conform to these two new sets of standards. It was apparent that the long term usefulness of the state central cancer registry hinged upon careful review of the new standards and the development of specific recommendations for implementation in Michigan.

The initial structure for cancer reporting used in Michigan was developed in consultation with an "ad hoc task force" with members representing key organizations of cancer care and cancer research in Michigan. This group provided counsel on a number of important matters that needed to be addressed when the registry was first established. These issues included determining who was responsible for reporting, the manner the information was to be reported, timeliness requirements, and finally the specific items to be reported. The advice of this group proved to be an important key to the success of the state wide cancer registry. This same approach was adopted with regard to re-evaluating the basic operational principles for the Michigan registry in light of the recommendations of NAACCR and NPCR.

The standards set forth by the Commission on Cancer (CoC) were also taken under advisement. A strategy for required data sets takes place in a tiered priority which conforms to the requirements of the CoC. Those facilities approved by the CoC, are required to submit more detailed information, which includes further information on staging and treatment. Those facilities with CoC approved cancer registries are perceived to have the ability of their staff to supply the central registry with this further information. A table has been developed to distinguish the reporting requirements for approved facilities, non-approved facilities and laboratories.

Act No. 82
Public Acts of 1984
Approved by the Governor
April 17, 1984

Filed with the Secretary of State
April 19, 1984

STATE OF MICHIGAN
82ND LEGISLATURE
REGULAR SESSION OF 1984

Introduced by Reps. Spaniola, Hertel, Barns, Dutko, Porreca, Sitz, Maynard and DeMars

ENROLLED HOUSE BILL No. 4090

AN ACT to amend Act No. 368 of the Public Acts of 1978, entitled "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties for governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide the certain immunity from liability; to provide for penalties and remedies; and to repeal certain acts and parts of acts," as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws, by adding section 2619.

The People of the State of Michigan enact:

Section 1. Act No. 368 of the Public Acts of 1978, as amended, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws, is amended by adding section 2619 to read as follows:

Sec. 2619. (1) The department shall establish a registry to record cases of cancer and other specified tumorous and precancerous diseases that occur in the state, and to record information concerning these cases as the department considers necessary and appropriate in order to conduct epidemiologic surveys of cancer and cancer-related diseases in the state.
(2) Each diagnosed case of cancer and other specified tumorous and precancerous diseases shall be reported to the department pursuant to subsection (4), or reported to a cancer reporting registry if the cancer reporting registry meets standards established pursuant to subsection (4) to ensure that accuracy and completeness of the reported information. A person or facility required to report a diagnosis pursuant to subsection (4) may elect to report the diagnosis to the state through an existing cancer registry only if the registry meets minimum reporting standards established by the department.
(3) The department shall maintain comprehensive records of all reports submitted pursuant to this section. These report shall be subject to the same requirements of confidentiality as provided in section 2631 for data or records concerning medical research projects.
(4) The director shall promulgate rules which provide for all of the following:
(a) A list of tumorous and precancerous disease other than cancer to be reported pursuant to subsection (2).
(b) The quality and manner in which the cases and other information described in subsection (1) are reported to the department.
(c) The terms and conditions under which records disclosing the name and medical condition of a specific individual and kept pursuant to this section are released by the department.
(5) This section does not compel an individual to submit to medical or department examination or supervision.
(6) The department may contract for the collection and analysis of, and research related to, the epidemiologic data required under this section.
(7) Within 2 years after the effective date of this section, the department shall begin evaluating the reports collected pursuant to subsection (2). The department shall publish and make available to the public reports summarizing the information collected.

The first summary report shall be published not later than 180 days after the end of the first 2 full calendar years after the effective date of this section. Subsequent annual summary reports shall be made on a full calendar year basis and published not later than 180 days after the end of each calendar year.
(8) Reporting pursuant to subsection (2) shall begin the next calendar year after the effective date of this section.
(9) This section shall take effect July 1, 1984.

This act is ordered to take immediate effect.

William A. Ryan
.....
Clerk of the House of Representatives

William C. Kandler
.....
Secretary of the Senate

Approved. . . . . .

. . . . . .
Governor

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DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF THE STATE REGISTRAR

ADMINISTRATIVE RULES ON CANCER REPORTING

Filed with the Secretary of State on April 16, 1985. These rules take effect 15 days after filing with the Secretary of State.

(By authority conferred on the department of public health by section 2619 of Act No. 368 of the Public Acts of 1978, as amended, being 333.2619 of the Michigan Compiled Laws.)

R 325.9050 Registry

Rule 9050. (1) The department shall establish a registry to record cases of cancer and other specified tumorous and precancerous diseases that occur in the state. The registry shall include information concerning these cases as the department considers necessary and appropriate to conduct epidemiologic surveys of cancer and cancer-related diseases in the state.

(2) Each diagnosed case of cancer and other specified tumorous and precancerous diseases shall be reported to the department pursuant to subrule (4) of this rule, or reported to a cancer reporting registry if the cancer reporting registry meets standards established pursuant to subrule (4) of this rule to ensure the accuracy and completeness of the reported information. A person or facility required to report a diagnosis pursuant to subrule (4) of this rule may elect to report the diagnosis to the state through an existing cancer registry only if the registry meets minimum reporting standards established by the department.

(3) The department shall maintain comprehensive records of all reports submitted pursuant to this rule. These reports shall be subject to the same requirements of confidentiality as provided in section 2631 of 1978 PA 368, MCL 333.2619 for data or records concerning medical research projects.

(4) The director shall provide for all of the following:

(a) A list of tumorous and precancerous disease other than cancer to be reported pursuant to subrule (2) of this rule.

(b) The quality and manner in which the cases and other information described in subrule (1) of this rule are reported to the department.

(c) The terms and conditions under which records disclosing the name and medical condition of a specific individual and kept pursuant to this rule are released by the department.

(5) This rule does not require an individual to submit to medical or department examination or supervision.

(6) The department may contract for the collection and analysis of, and research related to, the epidemiologic data required by this rule.

(7) Within 2 years after the effective date of these rules, the department shall begin evaluating the reports collected pursuant to subrule (2) of this rule. The department shall publish and make available to the public reports summarizing the information collected. The first summary report shall be published not later than 180 days after the end of the first 2 full calendar years after the effective date of this rule. Subsequent annual summary reports shall be made on a full calendar year basis and published not later than 180 days after the end of each calendar year.

(8) Reporting pursuant to subrule (2) of this rule shall begin the next calendar year after the effective date of this rule.

History: 2004 MR 14, Eff. July 23, 2004.

R 325.9051 Definitions

Rule 9051. (1) As used in these rules:

(a) "Primary brain-related tumor" means a primary tumor, whether malignant or benign, of the brain, meninges, spinal cord, cauda equina, a cranial nerve or nerves, or any part of the central nervous system or of the pituitary gland, pineal gland, or craniopharyngeal gland.

(b) "Cancer" means all diagnosis with a behavior code of 2 (carcinoma in situ) or 3 (malignant primary site) as listed in the publication entitled "International Classification of Diseases for Oncology," 1976, excluding basal,

epithelial, papillary, and squamous cell carcinomas of the skin, but including carcinomas of skin of the vagina, prepuce, clitoris, vulva, labia, penis, and scrotum.
(c) "Department" means the department of community health.
(2) The terms "clinical laboratory" and "hospital," as defined in sections 20104 and 20106, respectively, of 1978 PA 368 and MCL 333.20106 have the same meanings when used in these rules.

History: 1985 MR 4, Eff. May 2, 1985; 2004 MR 14, Eff. July 23, 2004.

R 325.9052 Reportable diagnoses
Rule 9052. (1) Cancer diagnoses, diagnoses of benign brain-related tumors and any tumorous and precancerous diseases otherwise required to be reported by state or federal law shall be reported to the department in a manner consistent with these rules and procedures issued by the department.
(2) Diagnoses shall be reported by all hospitals and clinical laboratories.
(3) A hospital or clinical laboratory may elect to report cases through a hospital or regional cancer registry that meets the rules set by the department.
(4) Reports shall be submitted within 180 days of a diagnosis on a form prescribed or approved by the department, except for reports forwarded on electronic media.
(5) Reports submitted on electronic media shall meet data quality, format, and timeliness standards prescribed by the department.

History: 1985 MR 4, Eff. May 2, 1985; 2004 MR 14, Eff. July 23, 2004.

R 325.9053 Quality assurance.
Rule 3. (1) For the purpose of assuring the quality of submitted data, each reporting entity shall allow the department to inspect such parts of a patient's medical records as are necessary to verify the accuracy of submitted data.
(2) A reporting entity which meets the standards of quality and completeness set by the department shall be subject to inspection not more than once every 2 years for the purpose of assessing the quality and completeness of reporting from the entity.
(3) A reporting entity shall, upon request of the department, supply missing information, if known, or clarify information submitted to the department.
(4) Upon mutual agreement between a reporting entity and the department, the reporting entity may elect to submit copies of medical records instead of inspection. Each copy of a medical record or part thereof submitted to the department pursuant to this rule shall be used only for verification of corresponding reported data, shall not be recopied by the department, and shall be kept in a locked file cabinet when not being used. Such copies shall be destroyed promptly following verification of the corresponding reported data or, if the reported data appears to be inaccurate, following clarification or correction of the reported data.
(5) Both of the following provisions shall be complied with to preserve the confidentiality of each patient's medical records:
(a) Each reporting entity shall provide to the department, for inspection only, all of the following records and reports:
(i) Reports of tissue analyses which have been performed for the purpose of determining the presence or absence of malignant disease.
(ii) Reports of radiological examinations performed for the purpose of determining the presence or absence of malignant disease.
(iii) Reports of diagnoses of malignant disease and notations of the reasons for such diagnoses, including both the primary clinician's reports and consultation reports.
(iv) Those parts of medical records which contain the specific information required to be reported.
(b) A reporting entity shall not be required by this rule to allow inspection of any part of any patient's medical record other than those parts listed in subrule (3) of this rule. A reporting entity may allow the inspection of medical records from which parts, other than those specified, have been deleted, masked, crossed out, or otherwise rendered illegible.

History: 1985 MR 4, Eff. May 2, 1985.

R 325.9054 Confidentiality of reports.

Rule 4. (1) The department shall maintain the confidentiality of all reports of cancer submitted to the department and shall not release such reports, or any information which, because of name, identifying number, mark, or description, can be readily associated with a particular individual, except in accordance with subrules (2), (3), (4), and (5) of this rule. The department shall not release any information that would indicate whether or not the name of a particular person is listed in the cancer registry, except in accordance with subrules (2), (3), (4), and (5) of this rule.

(2) A report of cancer submitted to the department concerning a particular individual, and any other information maintained in the cancer reporting system which, because of name, identifying number, mark, or description, can be readily associated with a particular individual, shall be released as follows:

(a) To the particular individual upon compliance with both of the following provisions:

(i) Receipt of a written request which is signed by the particular individual and which is witnessed or notarized as required by subrule (3) of this rule.

(ii) Presentation by the particular individual of suitable identification as required by subrule (4) of this rule.

(b) If the particular individual is a minor, to a parent of the particular individual upon compliance with all of the following provisions:

(i) Receipt of a written request which is signed by the parent and which is witnessed or notarized as required by subrule (3) of this rule.

(ii) Receipt of a certified copy of the birth certificate of the particular individual.

(iii) Presentation by the parent of suitable identification as required by subrule (4) of this rule.

(c) If the particular individual has a court-appointed guardian or if the particular individual is deceased, to the court-appointed guardian or to the executor or administrator of the particular individual's estate upon compliance with all the following provisions:

(i) Receipt of a written request which is signed by the court-appointed guardian, executor, or administrator and which is witnessed or notarized as required by subrule (3) of this rule.

(ii) Receipt of a certified copy of the order or decree which appoints the guardian, executor, or administrator.

(iii) Presentation by the guardian, executor, or administrator of suitable identification as required by subrule (4) of this rule.

(d) To an attorney or other person designated by the particular individual upon compliance with both of the following provisions:

(i) Receipt of a written request which is signed by the particular individual, which is witnessed or notarized as required by subrule (3) of this rule, and which requests release of the information to the attorney or other person.

(ii) Presentation by the attorney or other person of suitable identification as required by subrule (4) of this rule.

(e) To an attorney or other person designated by the court-appointed guardian of the particular individual or designated by the executor or administrator of the estate of the particular individual upon compliance with all of the following provisions:

(i) Receipt of a written request which is signed by the court-appointed guardian, executor, or administrator, which is witnessed or notarized as required by subrule (3) of this rule, and which requests release of the information to the attorney or other person.

(ii) Receipt of a certified copy of the order or decree which appoints the guardian, executor, or administrator.

(iii) Presentation by the attorney or other person of suitable identification as required by subrule (4) of this rule.

(f) If the particular individual is a minor, to an attorney or other person designated by the parent of the particular individual upon compliance with all of the following provisions:

(i) Receipt of a written request which is signed by the parent, which is witnessed or notarized as required by subrule (3) of this rule, and which requests release of the information to the attorney or other person.

(ii) Receipt of a certified copy of the birth certificate of the particular individual.

(iii) Presentation by the attorney or other person of suitable identification as required by subrule (4) of this rule.

(3) Every written request for the release of information submitted pursuant to subrule (2) of this rule shall be signed by the person making the written request. Such signature shall comply with either of the following provisions:

(a) Be witnessed by an employee of the department who has been designated to witness such requests and to whom the person making the request presents suitable identification as required by subrule (4) of this rule.
(b) Be notarized by a notary public or magistrate.
(4) Any person who is required by subrule (2) or (3) of this rule to present suitable identification shall present an identification document, such as a driver's license, or other document which contains both a picture of the person and the signature or mark of the person.
(5) The director of the department may, pursuant to R 325.9055, release information from the cancer reporting system to an authorized representative of a study or research project reviewed by the scientific advisory panel and approved by the director. The department shall not release any part of a patient's medical record obtained pursuant to R 325.9053.

History: 1985 MR 4, Eff. May 2, 1985.

R 325.9055 Scientific advisory panel; release of information for research.
Rule 5. (1) The director of the department shall appoint a scientific advisory panel of not less than 3 scientists to review research proposals whereby a release of information maintained by the department which identifies an individual reported to have a diagnosis of cancer is required.
(2) All research proposals which require the release of information that identifies individuals with reported diagnoses of cancer shall be reviewed by the scientific advisory panel.
(3) The panel shall, in writing, advise the director concerning the merits of the study.
(4) The release of information for research which identifies individuals with reported diagnoses of cancer shall be subject to the terms and conditions set by the department. Such study or research project shall not publish the name of any individual who is or was the subject of a report of cancer submitted to the department, and such study or research project shall not release any identifying number, mark, or description which can be readily associated with an individual who is or was the subject of a report of cancer submitted to the department.
(5) A reporting entity shall, upon notification that the director has approved a research project, provide to the department or a researcher named by the director the name of the primary physician responsible for the medical care of persons selected for the research study as indicated in the reporting entity's records.

History: 1985 MR 4, Eff. May 2, 1985.
R 325.9056 Exchange of records.
Rule 6. The department, by agreement, may transmit transcripts or copies of reports of cancer diagnoses to state or national cancer registries when the reports relate to residents of other states or countries. The agreement shall require that the transcripts or records be used for statistical purposes only as specified in the agreement and that the identity of a person subject to the report shall not be released.

History: 1985 MR 4, Eff. May 2, 1985.

R 325.9057 Adoption by reference.
Rule 7. The publication entitled "International Classifications of Diseases for Oncology," 1976, specified in R 325.9051 is adopted by reference in these rules. Copies of the adopted matter may be obtained from the World Health Organization Publications Center, U.S.A., 49 Sheridan Avenue, Albany, NY 12210, or from the Department of Public Health, Box 30035, 3500 N. Martin Luther King, Jr. Blvd., Lansing, Michigan 48909. At the time of adoption of these rules the cost per copy is $10.00.

History: 1985 MR 4, Eff. May 2, 1985.

R 325.971 Reporting of cancer.
Rule 1. (1) On and after May 1, 1947, every physician, dentists, hospital superintendent, and clinic director who has knowledge of a case of cancer shall, within 10 days, report the same to the Michigan department of health on a form provided by said department. The report shall contain the name and address of the patient and either the name and address of the physician, or of the dentist, or of the hospital superintendent and hospital, or of the clinic director and clinic, and such other data as may be required.

(2) All such reports and records of the Michigan department of health pertaining to cancer are hereby declared to be confidential.

History: 1944 ACS 10. p. 16: 1954 AC. P. 2317.

Editor's note: This rule appears in the Michigan Administrative code of 1954 as R 325.975.

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REPORTING RESPONSIBILITIES

RESPONSIBILITIES OF MICHIGAN HOSPITALS AND LABORATORIES

1. Know the MCSP reporting requirements and attend the educational workshops when rules change or deemed necessary by the quality assurance field representative.

2. Select an abstract reporting option; whether on paper or electronic and establish a schedule for regular reporting. Notify the MCSP of any changes in the method of reporting.

3. Perform all casefinding activities to ensure completeness of reporting.

4. Regardless of submission format (paper forms or electronic file), all reportable cases MUST be submitted to the MCSP within six months or 180 days from the initial date of diagnosis. Refer to the table below to determine when abstracts are to be submitted based upon the date of diagnosis.

5. Electronic data submissions are required on a monthly basis and are to be received by MCSP on or before the first working day of each month.

Example Patient diagnosed January 15, 2016. *Case is due to the MCSP by July 2016.*

Abstract Submission Schedule for Diagnosed Cases	
Month of Diagnosis…	**Submit Abstract to MCSP no later than…**
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

6. Inform the MCSP of ALL facility or contact person changes (e.g., mailing address, contact name, phone, email) using the "Reporting Facility Contact Information Form" on the MCSP website (http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5221-16586--,00.html)

7. Facilities will be involved in periodic quality control visits by a quality improvement field representative from the MCSP. These reporting facilities will be requested to do the following:

- provide access to all health records as requested for quality review
- submit master disease index and pathology reports as requested for complete casefinding
- provide adequate work space for field representative
- provide access to pathology, radiation, chemotherapy, and other treatment indices for complete casefinding
- be available for consultation during quality control reviews and summation

8. Maintain some type of accession log or master file of submissions which will serve as a quick reference of all cases sent to the MCSP. This may be as simple as keeping copies of the cancer report forms or maintaining a reporting log which includes name, primary site, date of diagnosis, and date case was submitted to the state.

9. Download to your computer and/or print the following manuals to use when completing the required data items on the cancer report form or abstracting a case into Abstract Plus.

There are certain advantages to using online or electronic versions of reference manuals over printed versions. Online versions are always current, often use embedded hyperlinks for easy navigation to required information, as well as allow for real time searches by text string. Online or electronic versions save paper and ink resources and reduce the need for hard copy storage and manual updating of outdated material.

- Collaborative Stage Data Collection System Manual at https://cancerstaging.org/cstage/Pages/default.aspx

- SEER Multiple Primary and Histology Coding Rules at http://seer.cancer.gov/tools/mphrules/download.html

- SEER Summary Staging Manual at http://seer.cancer.gov/tools/ssm/

- ICD-O-3 SEER Primary Site/Histology Validation List at http://seer.cancer.gov/icd-o-3/

- Facility Oncology Registry Data Standards (FORDS) at http://www.facs.org/cancer/coc/fordsmanual.html

- Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual at http://seer.cancer.gov/tools/heme/

- SEER*Rx - Interactive Antineoplastic Drugs Database at http://www.seer.cancer.gov/tools/seerrx/

- International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3). This book can be purchased through any book store or ordered from online sources. Electronic CSV database files or print copies of the classifications are available from the World Health Organization at http://www.who.int/classifications/icd/adaptations/oncology/en/

- For ICD-O-3 errata and clarifications go to: http://seer.cancer.gov/icd-o-3

- Directly coded TNM Stage values are required by the Michigan Cancer Surveillance Program for Hospitals with a Registry and for Hospitals without a Registry for all cases diagnosed in 2016 and forward. To obtain the current edition of the AJCC Cancer Staging Manual or the AJCC Cancer Staging handbook, go to https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

RESPONSIBILITIES OF THE MICHIGAN CANCER SURVEILLANCE PROGRAM

1. Provide all reporting facilities the current cancer report form and/or software for reporting.
2. Provide educational workshops and instructions to locate online reference materials.
3. Perform all computer data entry of manually submitted reports and process patient data updates.
4. Conduct procedures to un-duplicate the cancer patient file.
5. Edit the file following NAACCR and NPCR standards.
6. Clarify and resolve issues relative to data quality that are encountered during the editing process.
7. Provide specific reports to verify data submission as requested by the reporting facility.
8. Release a statistical report, Cancer Incidence and Mortality, annually and have available on the web at MDHHS - Cancer Statistics (http://www.michigan.gov/mdch/0,4612,7-132-2944_5323---,00.html).

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PREPARATION OF THE CANCER REPORT FORM

Whenever a cancer case is diagnosed or first treated within a hospital or laboratory, an abstract of the case must be prepared and forwarded to the MCSP. The abstract MUST be sent within 180 days or six months from the initial date of diagnosis or initial treatment. Report cancer cases using the "MCSP Cancer Report Form" located on the MCSP website (http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5221-16586--,00.html). Proper completion of this form is important to the development of a high quality cancer registry for the State of Michigan. The instructions contained in this MCSP Program Manual are intended to outline what information is needed and to provide specific guidance for completing the form, and meeting state reporting requirements. Should the instructions need clarification, or if special problems exist that make reporting as outlined difficult, do not hesitate to contact MCSP to discuss the matter.

Specific instructions for identifying cases, determining primary site, assigning histology and stage are discussed in detail in sections to follow.

GENERAL REPORTING INSTRUCTIONS

Upon reaching a diagnosis of an in situ or invasive cancer or providing treatment for a patient diagnosed elsewhere, a hospital or laboratory is to report the case via a paper or electronic abstract. In addition, any tumor diagnosed October 1, 2004 or later with a behavior code of "0" or "1" for the following site codes must be reported: meninges (C70.0 – C70.9); brain (C71.0 – C71.9); spinal cord, cranial nerves, and other parts of the central nervous system (C72.0 – C72.9); pituitary gland (C75.1); craniopharyngeal duct (C75.2); and pineal gland (C75.3). **The abstract MUST be in a format provided or approved by MCSP and submitted within 180 days or six months from the initial date of diagnosis.**

- Each primary cancer diagnosed or treated within a hospital or laboratory must be reported to the MCSP on a separate cancer report form (abstract).
- The diagnosis and/or treatment of a patient for a primary tumor that was previously reported by the facility need not be reported a second time.
- However, revisions and corrections to previously submitted information are important and should be reported to MCSP. (See "Submitting Corrections" later in this section for instructions on how to report revisions or corrections to previously submitted abstracts.)
- New primary tumors diagnosed in previously reported patients are reportable.

As abstracts are received by the department, they will be reviewed, queried, electronically recorded and edited. In the course of assembling the data into a registry, duplicate reports of primary tumor diagnoses will be identified and tagged. The resulting file can therefore be used to develop accurate incidence information. There will be no active follow-up on the status or treatment of reported cases. MCSP maintains an incidence-based central registry – follow-up is limited to quality control issues or specific research projects.

The use of acceptable casefinding and record abstracting procedures are essential to complete reporting. The basic elements of reporting include sound casefinding techniques, correct identification of reportable cases, as well as the proper preparation and prompt submission of completed cancer reports.

Because the state maintains an incidence registry only, the information required for the state cancer report is limited compared to what is collected by a typical hospital cancer registry. Reporting of annual follow-up information on the status of a case is not necessary. However, a change in vital status must be reported. MCSP requires that facilities report basic items of information that identify and describe the patient or that relate to the reportable conditions with which the patient has been diagnosed. In addition, information regarding the types of therapy provided as the first course of therapy is also required. The instructions which follow are organized alphabetically by NAACCR data item name.

The cancer report (abstract) form may be typed or completed by hand. The four-page "MCSP Cancer Report Form" can be downloaded and printed from the MCSP website (http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5221-16586--,00.html).

During internal quality control reviews, a number of essential data items are routinely queried for clarification, as the majority of quality-related problems are associated with their data.

Patient's First Name	blank, inconsistent, unknown or illegible
Patient's Last Name	blank, unknown or illegible
Complete Address	blank, illegible or inconsistent
Sex	blank, inconsistent with name or site
Date of Birth	blank, inconsistent with site, report date, or date of diagnosis
Social Security Number	blank
Primary Site	blank or inconsistent with histology
Laterality	a paired organ is reported for the primary site, but laterality is blank
Histology	blank, inconsistent with the primary site, or indicates the condition may not be reportable
Stage	blank, inconsistent with histology, or invalid values based upon specific staging system
Method of Diagnosis	blank or inconsistent, e.g., in situ diagnosis not based upon a microscopic method of diagnosis
First Course of Treatment	blank but the report is from a hospital with a treatment center

If the reporting facility is unable to provide information for a required data item, the next step is to query the attending physician. For independent laboratories that do not have access to requested patient demographic information, adding the name and office address of the doctor to the abstract report is extremely helpful. Contact information about the physician should be added to the bottom of the cancer report form for any case with missing information. Be sure to supply the doctor's full name and complete mailing address.

MANUAL SUBMISSION

The cancer report (abstract) form may be typed or completed by hand. The four-page "MCSP Cancer Report Form" is available in PDF format and can be downloaded and printed from the MCSP website (http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5221-16586--,00.html). **Fully completed forms must be submitted within 180 days or six months from the initial date of diagnosis.**

An abstract report for each separate primary tumor is required. A second report is NOT required if a patient is diagnosed with a recurrence that is confirmed to NOT be a second primary.

If mailed via United States Postal Service, send completed cancer report forms to:

MCSP/Cancer & Birth Defects Surveillance Section
Attention: Elaine Snyder
P.O. Box 30691
Lansing, MI 48909-8191

If shipped prior to June 1, 2016 via commercial courier, send completed cancer report forms to:
MCSP/Cancer & Birth Defects Surveillance Section
Attention: Elaine Snyder
201 Townsend, 2nd Floor
Capitol View Building
Lansing, MI 48913

If shipped on or after June 1, 2016 via commercial courier, send completed cancer report forms to:
MCSP/Cancer & Birth Defects Surveillance Section
Michigan Department of Health and Human Services
Attention: Elaine Snyder
333 Grand
Lansing, MI 48933

ELECTRONIC SUBMISSION

Facilities submitting cases electronically must submit their data in the NAACCR format version stipulated by the state central registry. Please contact MCSP with specific questions regarding data format requirements for data submission.

Facilities having tumor registries that utilize computer software may submit cancer reports via File Transfer Protocol (FTP) site to MCSP. This section contains instructions for facilities wishing to submit cancer reports via electronic/automated methods. Hospitals may select from a variety of commercially available software as well as the method of data transmission. These software programs are usually amenable to easy transmission of data to the MCSP.

Labeling Your Electronic Submission File

Once the export file has been created, enter a file name that begins with MI (Michigan) followed by your 5-digit Michigan Facility Number, then add the date stamp (YYYYMMDD) which is the date the file was created. For example, facility 98765 creates an export file on April 28, 2016. The file will be named MI9876520160428, plus the extension assigned by their software. The extension for Metriq is either **.xva** (new case) or **.xvm** (updated case) and will automatically be assigned. The extension assigned by Abstract Plus is always **.txt**.

If you are sending more than one file at a time, please make sure that EACH file is numbered appropriately by adding -1, -2, -3, etc. to the file name. For example, the same facility could have two files −

MI9876520160428-1of2.txt and MI9876520160428-2of2.txt.

Although each facility saves its files to unique folder on the FTP site, it is important that you accurately label your file for additional security − if a file is not accurately labeled, it cannot be loaded into the MCSP registry.

In order to avoid data submission backlogs, facilities are requested to submit completed abstracts on a monthly basis.

Submission of Data Using FTP

For the fastest and most secure data transfer, submit the exported file using the MCSP FTP site.

The instructions are as follows:

1. Go to https://sso.state.mi.us and login using the Single Sign On (SSO) User ID assigned to you
2. Click on DCH-File Transfer
3. Click on Upload File
4. Click on Browse button and select the directory/path and file name
5. The path and file name will show up on the box next to the Browse button
6. Click on Upload

If you have any questions regarding the file transfer procedure, or if you need to set up an FTP account, contact David Westover at WestoverD1@michigan.gov or phone 517-335-9624. For additional information you may request a copy of the MCSP FileXFr User Manual.

Electronic Software

The software programs used by facilities in Michigan that are approved by the American College of Surgeons (ACoS) include *Metriq* and *OncoLog*.

High volume facilities are no longer permitted to submit their cases on paper cancer abstract report forms. Facilities with 100 or more yearly cases must submit electronic abstract data generated by abstracting software such as *Metriq* or *OncoLog*. Alternatively, non-registry hospitals, clinics, and laboratories may use *Abstract Plus,* which can be acquired free-of-charge through the MCSP.

Abstract Plus is a free-of-charge cancer data collection tool developed by the CDC. A customized version for the Michigan central cancer registry enables facilities within the state to report cancer cases electronically. Although the product is not designed to include all functionality required for an ACoS-approved hospital cancer registry, it is suitable for reporting cancer incident reports to central registries from non-registry hospitals, clinics, laboratories, and other healthcare sources.

The abstracting capability of *Abstract Plus* is used to summarize medical records into an electronic report of cancer diagnosis and treatment by abstractors or anyone working with cancer data. *Abstract Plus* supports the abstraction of all data items in national standard data sets, including all text fields, as well as, any state-specific data items. The output of *Abstract Plus* is an electronic abstract in the format of the NAACCR data exchange layout.

Abstracts entered into *Abstract Plus* are validated by customizable edits, allowing for an interactive error correction while abstracting. *Abstract Plus* includes *Registry Plus* Online Help, a collection of standard coding manuals that are cross-referenced, indexed, and context-linked to minimize the need for reference to printed manuals during abstracting.

For *Abstract Plus* support such as software installation, FTP site issues, password reset or other related technical difficulties, please contact Jetty Alverson at alversong@michigan.gov or 517-335-8855.

SUBMITTING CORRECTIONS

At the present time MCSP is unable to process electronic update submissions – all changes must be submitted manually per the following instructions.

A correction to the previously submitted report MUST be forwarded when one of the following conditions occurs:

- A cancer case has been reported but is later determined to be *not reportable*
- Information to resolve an unknown variable has been obtained

- Information for a particular variable of a previously submitted case was later determined to be submitted incorrectly

It is especially important to submit corrections involving changes to the date of diagnosis, primary site, histology, tumor grade, or stage, etc.

Manual Correction Submission

1. Copy the cancer abstract report form that was submitted that you have on file.
2. Draw a line through the INCORRECT information.
3. Pencil in and HIGHLIGHT the corrected information.
4. Check UPDATE in the upper right hand corner.
5. Mail corrected cases to:
   Michigan Cancer Surveillance Program
   Cancer & Birth Defects Surveillance Section
   Attention: Elaine Snyder
   P.O. Box 30691
   Lansing, MI 48909-8191

TEXT DOCUMENTATION

Text documentation is an essential component of a complete abstract and is heavily utilized for quality control and special studies. Text is required 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.

As the purpose of text information is to provide the opportunity to review and check coded values, important information that documents the disease process should be entered manually from the medical record. This text should not be electronically generated from coded values. If cancer abstracting software generates text automatically from codes, the text cannot be utilized to check coded values. Another registrar should be able to completely and accurately re-abstract the case relying solely on the furnished text data.

If there is no information to record in the text field, DO NOT leave the field blank. Type "N/A" or "No Info" to indicate that there is no information. By doing so, you confirm that information was sought, but none could be found; otherwise it will be assumed that the information is actually missing.

Examples

Physical Examination (PE)
• 2012/02/15: 49 year old white, non-Hispanic male presenting w/enlarged prostate. Retired farmer.

Lab Tests
• 02/15/2012: PSA elevated 4.6 ng/ml
• 2012/04/20: ER/PR positive or (+), HER2 negative or (-)

Pathology
• 11/12/2012 colon polyp, 1.2 x 1.0 x 0.8cm. Adenocarcinoma contained within polyp showing invasion of submucosa. Stalk: no evidence of adenocarcinoma or dysplasia.
• 2012/07/04 mastectomy of breast for R upper outer quadrant mass; 1.0 x 1.3 x 0.9cm. Ductal carcinoma, infiltrating, Grade III. Margins clear; 01/12/12: lymph nodes negative for cancer; no metastasis noted; Positive histology; ERA negative.

For guidance on the collection of supporting text, refer to General Coding Instructions for Text Field Items along with TEXT -- and RX TEXT-- item-specific instructions for capturing pertinent text data.

NOTICE: An abstract submitted with codes that lack supporting text data will be rejected in its entirety.

REPORTING REQUIREMENTS BY ITEM AND FACILITY TYPE FOR DIAGNOSIS YEAR 2016

Specific reporting requirements for hospitals with a registry, hospitals without a registry, and independent laboratories are summarized in the table below. The need to report an item has been assigned to the levels of required, reportable, and not required. These requirements are patterned after the American College of Surgeons (ACoS) levels for inclusion of information within a hospital registry. The practical definitions of these levels of reportability are best termed as levels of effort associated with collecting and providing the information.

If there is no information available, and inquiries have been made, do not leave the item blank (unless specifically noted in the individualized data item instructions, e.g. Name--Alias.) Instead, record the appropriate NOS or default code.

[**REQ**] Required	The facility MUST collect and report the information with data collection efforts including review of the patient's hospital charts, outpatient records or other available records, as well as making inquiries with other facilities or the physician on record as is necessary to obtain the information.

NOTE: For instructions on how to code missing information, refer to the applicable coding manual for that data item.

[REP] Reportable	The facility MUST report the information if it can be located within the patient's chart, outpatient records or other available records, but need not make inquiries of other facilities or physician's offices. For example, if AJCC Stage is documented in the medical record, it must be reported.
[N/R] Not Required/ Not Reportable	Item considered generally not available to the facility and/or not considered as reliably available. Information may be reported if available to the facility. While many items are considered non-reportable, this does not mean that the field may be left blank. <u>An appropriate default value must be reported for all non-reportable items.</u>

CS Site Specific Factor Field Requirements
Field values for all applicable fields are reportable by all facilities if information is available in the medical record for cases diagnosed in 2016. If applicable value is not found within the medical record, then facilities are to report the appropriate default value for the field. <u>Fields cannot be left blank.</u>

Facility Type
When two facilities with different reporting requirement levels coordinate reporting responsibilities, the requirements for reporting are determined by the facility with the highest reporting level. For example, should a laboratory and a hospital with a registry agree to share reporting responsibilities, the reporting requirement to meet would be of a 'hospital with a registry.'

Once you have determined your facility type, use the table on the following pages to determine the level of reporting requirement for each data item. The definitions for the three facility types are as follows:

Hospital with a Registry - an entity that has an approved cancer program by the American College of Surgeons (ACoS) or working towards ACoS approval or a regional registry that houses data for surrounding facilities.

Hospital without a Registry - geared towards smaller entities that do not have an approved cancer program or have limited resources to diagnosis and treat cancer patients.

Independent Laboratories - a separate laboratory from a hospital that reads specimens for either a hospital or physician's office.

Note: Regardless of facility type, all data item fields must contain values unless it is stated in the MCSP Cancer Program Manual that a particular field can be left blank. If value is required, but it does not exist or cannot be found, then the appropriate default value must be entered. **Fields cannot be left blank unless specifically allowed.**

LIST OF REQUIRED ITEMS BY ITEM AND FACILITY TYPE

NAACCR Item Name	*NAACCR Item*	*Hospital with Registry*	*Hospital without Registry*	*Independent Laboratory*	*MCSP 2016 Report Form Item*
Abstracted By	570	REQ	REQ	REQ	100
Accession Number--Hosp	550	REQ	N/R	N/R	21
Addr at DX--City	70	REQ	REQ	REQ	5b
Addr at DX--Country	102	REQ	REQ	REQ	5g
Addr at DX--No & Street	2330	REQ	REQ	REQ	5a
Addr at DX--Postal Code	100	REQ	REQ	REQ	5e
Addr at DX--State	80	REQ	REQ	REQ	5d
Addr at DX--Supplementl	2335	REQ	REQ	REQ	5c
Addr Current--City	1810	REQ	REQ	REQ	6
Addr Current--Country	1832	REQ	REQ	REQ	6
Addr Current--No & Street	2350	REQ	REQ	REQ	6
Addr Current--Postal Code	1830	REQ	REQ	REQ	6
Addr Current--State	1820	REQ	REQ	REQ	6
Addr Current--Supplemental	2355	REQ	REQ	REQ	6
Alcohol Use (State-specific item 9521)		REP	REP	N/R	17
Behavior Code ICD-O-3	523	REQ	REQ	REQ	33b
Birthplace--Country	254	REP	REP	N/R	8b
Birthplace--State	252	REP	REP	N/R	8a
Casefinding Source	501	REQ	REQ	REQ	23
Cause of Death	1910	REQ	REP	N/R	103
Class of Case	610	REQ	REQ	REQ	26
Comorbid/Complication (1-10)	3110-3164	REQ	REQ	N/R	14a
County at DX	90	REQ	REQ	REQ	5f
County--Current	1840	REQ	REQ	REQ	6
CS Site-Specific Factor 1	2880	REP	REP	N/R	48
CS Site-Specific Factor 2	2890	REP	REP	N/R	49
CS Site-Specific Factor 3	2900	REP	REP	N/R	50
CS Site-Specific Factor 4	2910	REP	REP	N/R	51
CS Site-Specific Factor 5	2920	REP	REP	N/R	52
CS Site-Specific Factor 6	2930	REP	REP	N/R	53
CS Site-Specific Factor 7	2861	REP	REP	N/R	54
CS Site-Specific Factor 8	2862	REP	REP	N/R	55

NAACCR Item Name	*NAACCR Item*	*Hospital with Registry*	*Hospital without Registry*	*Independent Laboratory*	*MCSP 2016 Report Form Item*
CS Site-Specific Factor 9	2863	REP	REP	N/R	56
CS Site-Specific Factor 10	2864	REP	REP	N/R	57
CS Site-Specific Factor 11	2865	REP	REP	N/R	58
CS Site-Specific Factor 12	2866	REP	REP	N/R	59
CS Site-Specific Factor 13	2867	REP	REP	N/R	60
CS Site-Specific Factor 14	2868	REP	REP	N/R	61
CS Site-Specific Factor 15	2869	REP	REP	N/R	62
CS Site-Specific Factor 16	2870	REP	REP	N/R	63
CS Site-Specific Factor 17	2871	REP	REP	N/R	64
CS Site-Specific Factor 18	2872	REP	REP	N/R	65
CS Site-Specific Factor 19	2873	REP	REP	N/R	66
CS Site-Specific Factor 20	2874	REP	REP	N/R	67
CS Site-Specific Factor 21	2875	REP	REP	N/R	68
CS Site-Specific Factor 22	2876	REP	REP	N/R	69
CS Site-Specific Factor 23	2877	REP	REP	N/R	70
CS Site-Specific Factor 24	2878	REP	REP	N/R	71
CS Site-Specific Factor 25	2879	REP	REP	N/R	72
Date 1st Crs RX CoC	1270	REQ	REQ	N/R	74a
Date 1st Crs RX CoC Flag	1271	REQ	REQ	N/R	74b
Date Case Completed	2090	REQ	REQ	REQ	105
Date of 1st Contact	580	REQ	REQ	N/R	29
Date of 1st Contact Flag	581	REQ	REQ	N/R	N/A
Date of Birth	240	REQ	REQ	REQ	7
Date of Death (Required on paper report form only)	1750	N/A	REP	N/R	102
Date of Diagnosis	390	REQ	REQ	REQ	30
Date of Inpt Adm	590	N/R	N/R	N/R	27a
Date of Inpt Adm Flag	591	N/R	N/R	N/R	27b
Date of Inpt Disch	600	N/R	N/R	N/R	28a
Date of Inpt Disch Flag	601	N/R	N/R	N/R	28b
Date of Last Contact	1750	REQ	REQ	N/R	94a
Date of Last Contact Flag	1751	REQ	REQ	N/R	94b
Diagnostic Confirmation	490	REQ	REQ	REQ	36
Family History of Cancer (State-specific item 9520)		REP	REP	N/R	16a-c
Grade	440	REQ	REQ	REQ	34
Histologic Type ICD-O-3	522	REQ	REQ	REQ	33a
Laboratory Report Number (State-specific item 9507)		REP	REP	REQ	20
Laterality	410	REQ	REQ	REQ	32
Lymph-vascular Invasion	1182	REQ	REQ	REP	35

NAACCR Item Name	*NAACCR Item*	*Hospital with Registry*	*Hospital without Registry*	*Independent Laboratory*	*MCSP 2016 Report Form Item*
Marital Status at DX	150	REP	REP	REP	12
Medical Record Number	2300	REQ	REQ	N/R	19
Mets at DX-Bone	1112	REQ	REQ	N/R	42
Mets at DX-Brain	1113	REQ	REQ	N/R	43
Mets at DX-Distant LN	1114	REQ	REQ	N/R	44
Mets at DX-Liver	1115	REQ	REQ	N/R	45
Mets at DX-Lung	1116	REQ	REQ	N/R	46
Mets at DX-Other	1117	REQ	REQ	N/R	47
Michigan Facility Number (State-specific item 9508)		REQ	REQ	REQ	25
Name--Alias	2280	REP	REP	N/R	3
Name--First	2240	REQ	REQ	REQ	1b
Name--Last	2230	REQ	REQ	REQ	1a
Name--Maiden	2390	REP	REP	N/R	2
Name--Middle	2250	REQ	REQ	REQ	1c
Place of Death--Country	1944	REQ	REP	N/R	104b
Place of Death--State	1942	REQ	REP	N/R	104a
Primary Payer at DX	630	REQ	REQ	REP	13
Primary Site	400	REQ	REQ	REQ	31
Race (1-5)	160-164	REQ	REQ	REQ	11
Rad--Regional RX Modality	1570	REQ	REQ	N/R	84
Reason for No Radiation	1430	REQ	REQ	N/R	83
Reason for No Surgery	1340	REQ	REQ	N/R	76
Regional Nodes Examined	830	REQ	REQ	N/R	41
Regional Nodes Positive	820	REQ	REQ	N/R	40
Reporting Facility	540	REQ	REQ	REQ	24a
RX Date BRM	1240	REQ	REQ	N/R	90a
RX Date BRM Flag	1241	REQ	REQ	N/R	90b
RX Date Chemo	1220	REQ	REQ	N/R	85a
RX Date Chemo Flag	1221	REQ	REQ	N/R	85b
RX Date Hormone	1230	REQ	REQ	N/R	88a
RX Date Hormone Flag	1231	REQ	REQ	N/R	88b
RX Date Mst Defn Srg	3170	REQ	REQ	N/R	77c
RX Date Mst Defn Srg Flag	3171	REQ	REQ	N/R	77d
RX Date Other	1250	REQ	REQ	N/R	92a
RX Date Other Flag	1251	REQ	REQ	N/R	92b
RX Date Radiation	1210	REQ	REQ	N/R	82a
RX Date Radiation Flag	1211	REQ	REQ	N/R	82b
RX Date Surgery	1200	REQ	REQ	N/R	77a
RX Date Surgery Flag	1201	REQ	REQ	N/R	77b

NAACCR Item Name	*NAACCR Item*	*Hospital with Registry*	*Hospital without Registry*	*Independent Laboratory*	*MCSP 2016 Report Form Item*
RX Summ--BRM	1410	REQ	REQ	N/R	91
RX Summ--Chemo	1390	REQ	REQ	N/R	86
RX Summ--Hormone	1400	REQ	REQ	N/R	89
RX Summ--Other	1420	REQ	REQ	N/R	93
RX Summ--Scope Reg NL Sur	1292	REQ	REQ	N/R	80
RX Summ--Surg Oth Reg/Dis	1294	REQ	REQ	N/R	79
RX Summ--Surg Prim Site (Code the most definitive surgical procedure of primary site)	1290	REQ	REQ	N/R	78
RX Summ--Surg/Rad Seq	1380	REQ	REQ	N/R	81
RX Summ--Systemic/Sur Seq	1639	REQ	REQ	N/R	75
RX Summ--Transplnt/Endocr	3250	REQ	REQ	N/R	87
RX Summ--Treatment Status	1285	REQ	REQ	N/R	73
RX Text--BRM	2660	REQ	REQ	N/R	98
RX Text--Chemo	2640	REQ	REQ	N/R	98
RX Text--Hormone	2650	REQ	REQ	N/R	98
RX Text--Other	2670	REQ	REQ	N/R	98
RX Text--Radiation (Beam)	2620	REQ	REQ	REQ	99
RX Text--Radiation Other	2630	REQ	REQ	REQ	99
RX Text--Surgery	2610	REQ	REQ	N/R	78
Secondary Diagnosis (1-10)	3780-3798	REQ	REQ	N/R	14b
SEER Summary Staging 2000* (Directly coded)	759	REQ	REQ	REQ	37
Sequence Number--Hospital	560	REQ	N/R	N/R	21
Sex	220	REQ	REQ	REQ	9
Social Security Number	2320	REQ	REQ	REQ	4
Spanish/Hispanic Origin	190	REQ	REQ	REP	10
Text--DX Proc--Lab Tests	2550	REQ	REQ	REQ	95
Text--DX Proc--OP	2560	REQ	REQ	N/R	78
Text--DX Proc--Path	2570	REQ	REQ	REQ	33a
Text--DX Proc--PE	2520	REQ	REQ	REQ	95
Text--DX Proc--Scopes	2540	REQ	REQ	REQ	97
Text--DX Proc--X-ray/Scan	2530	REQ	REQ	N/R	96
Text--Histology Title	2590	REQ	REQ	REQ	33a
Text--Place of Diagnosis	2690	REP	REP	REP	24b
Text--Primary Site Title	2580	REQ	REQ	REQ	31
Text--Remarks	2680	REQ	REQ	REQ	99
Text--Staging	2600	REQ	REQ	REQ	97
Text--Usual Industry	320	REP	REP	N/R	15b
Text--Usual Occupation	310	REP	REP	N/R	15a
TNM Clin Descriptor (Directly assigned)*	980	REQ	REQ	N/R	38

NAACCR Item Name	*NAACCR Item*	*Hospital with Registry*	*Hospital without Registry*	*Independent Laboratory*	*MCSP 2016 Report Form Item*
TNM Clin M (Directly assigned)*	960	REQ	REQ	N/R	38
TNM Clin N (Directly assigned)*	950	REQ	REQ	N/R	38
TNM Clin Stage Group (Directly assigned)*	970	REQ	REQ	N/R	38
TNM Clin T (Directly assigned)*	940	REQ	REQ	N/R	38
TNM Edition Number*	1060	REQ	REQ	N/R	N/A
TNM Path Descriptor (Directly assigned)*	920	REQ	REQ	N/R	38
TNM Path M (Directly assigned)*	900	REQ	REQ	N/R	38
TNM Path N (Directly assigned)*	890	REQ	REQ	N/R	38
TNM Path Stage Group (Directly assigned)*	910	REQ	REQ	N/R	38
TNM Path T (Directly assigned)*	880	REQ	REQ	N/R	38
Tobacco Use (State-specific item)	9522	REP	REP	N/R	18
Tumor Size Clinical	752	REQ	REQ	REP	39
Tumor Size Pathologic	754	REQ	REQ	REP	39
Tumor Size Summary	756	REQ	REQ	REP	N/A
Type of Reporting Source	500	REQ	REQ	REQ	22
Vital Status	1760	REQ	REQ	REQ	101

* Both directly assigned TNM Stage ***and*** directly coded SEER Summary Stage values are ***Required*** by the Michigan Cancer Surveillance Program for Hospitals with a Registry ***and*** for Hospitals without a Registry for all cases ***diagnosed in 2016 and forward.***

NOTE: If your registry is located within Wayne, Oakland, or Macomb counties and you have questions regarding submission of data, please contact your SEER-State Coordinator, Jeanne Witlock at 313-578-4219 or whitlock@med.wayne.edu.

GENERAL CODING INSTRUCTIONS FOR FIRST COURSE OF TREATMENT DATA ITEMS

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. "Active surveillance" is a form of planned treatment for some patients; its use is coded in the RX SUMM--TREATMENT STATUS item. "No therapy" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given. If the patient refuses all treatment, code "patient refused" (code 7 or 87) for all treatment modalities.

DO NOT leave treatment items blank. If a particular treatment (or any type of treatment) was not administered, enter the "Unknown" value for that item.

Treatment Plan
A treatment plan describes the type(s) of therapies intended to modify, control, remove, or destroy proliferating cancer cells. The documentation confirming a treatment plan may be found in several different sources; for example, medical or clinic records, consultation reports, and outpatient records.

- All therapies specified in the physician(s) treatment plan are a part of the first course of treatment if they are actually administered to the patient.
- A discharge plan must be part of the patient's record in a Joint Commission-accredited hospital and may contain part or all of the treatment plan.
- An established protocol or accepted management guidelines for the disease can be considered a treatment plan in the absence of other written documentation.
- If there is no treatment plan, established protocol, or management guidelines, and consultation with a physician advisor is not possible, use the principle: "initial treatment must begin within four months of the date of initial diagnosis."

Time Periods for First Course of Treatment
If first course treatment was provided, the Date of First Course of Treatment is the earliest of Date of First Surgical Procedure, Date Radiation Started, Date Systemic Therapy Started, or Date Other Treatment Started.

- If no treatment is given, record the date of the decision not to treat, the date of patient refusal, or the date the patient expired if the patient died before treatment could be given.
- If active surveillance ("watchful waiting") was selected, record the date of that decision.
- Additional data items further define the parameters for specific treatments and treatment modalities, as described in the following sections.
- RX SUMM--TREATMENT STATUS summarizes whether the patient received any first course treatment, no treatment, or is being managed by active surveillance.

All Malignancies except Leukemias
The first course of treatment includes all therapy planned and administered by the physician(s) during the first diagnosis of cancer. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more. Any therapy administered after the discontinuation of first course treatment is subsequent treatment.

Leukemias
The first course of treatment includes all therapies planned and administered by the physician(s) during the first diagnosis of leukemia. Record all remission-inducing or remission-maintaining therapy as the first course of treatment. Treatment regimens may include multiple modes of therapy. The administration of these therapies can span a year or more. A patient may relapse after achieving a first remission. All therapy administered after the relapse is secondary or subsequent treatment.

SURGERY
First course surgery items describe the most definitive type of surgical treatment the patient received from any facility, when it was performed, and its efficacy. When no surgical treatment is given, the reason is recorded. Major aspects of surgical care provided by the individual facility are also recorded so that hospital cancer programs can evaluate local patient care.

Relationships among Surgical Items
Date of First Surgical Procedure is the date that the first Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, or Surgical Procedure/OtherSite is performed as part of first course treatment.

- If surgery was the only type of first course treatment performed or was the first of multiple treatment modalities, Date of First Surgical Procedure is the same as Date of First Course of Treatment. Both dates can be used to describe lag time between diagnosis and initialization of specific aspects of treatment.

Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, and Surgical Procedure/Other Site record three distinct aspects of first course therapeutic surgical procedures that may be performed during one or multiple surgical events. If multiple primaries are treated by a single surgical event, code the appropriate surgical items separately for each primary.

- Surgical Procedure of Primary Site is a site-specific item that describes the most invasive extent of local tumor destruction or surgical resection of the primary site and of surrounding tissues or organs that are removed in continuity with the primary site.

- Scope of Regional Lymph Node Surgery describes the removal, biopsy, or aspiration of sentinel nodes and other regional lymph nodes that drain the primary site and may include surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease as well as removal of nodes for treatment of the disease.

Surgical Procedure/Other Site describes first course resection of distant lymph node(s) and/or regional or distant tissue or organs beyond the Surgical Procedure of the Primary Site code.

If surgery of the respective type was performed, the code that best describes the surgical procedure is recorded whether or not any cancer was found in the resected portion. Incidental removal of tissue or organs, when it is not performed as part of cancer treatment (for example, incidental removal of an appendix), does not alter code assignment.

The code ranges and corresponding descriptions for site-specific Surgical Procedure of Primary Site code are grouped according to the general nature of the procedure:

- Codes 10 through 18 are site-specific descriptions of tumor-destruction procedures that do not produce a pathologic specimen.

- Codes 20 through 80 are site-specific descriptions of resection procedures.

- The special code 98 applies to specific tumors that cannot be clearly defined in terms of primary non-primary site. Surgical Procedure of Primary Site should be coded 98 for any tumor characterized by the specific sites and/or morphologies identified in the site-specific code instructions for Unknown and Ill-Defined Primary Sites and Hematopoietic/Reticuloendothelial/Immunoproliferating/Myeloproliferative Disease. The item Surgical Procedure/Other Site is used to indicate whether surgery was performed for these tumors.

When multiple first course primary site surgical procedures are performed for a single tumor, the most extensive or definitive is the last performed, and the code represents the cumulative effect of the separate procedures.

Response categories are defined in logical sequence. Within groups of codes, procedures are defined with increasing degrees of descriptive precision. Succeeding groups of codes define progressively more extensive forms of resection.

For codes 00 through 79, the descriptions of the surgical procedures are hierarchical. Last-listed responses take precedence over earlier-listed responses (regardless of the code or numeric value).

To the extent possible, codes and their definitions are the same as those previously assigned in ROADS to accommodate analysis in registries that maintain unconverted data. As a result of added and modified codes, however, the numeric code sequence may deviate from the order in which the descriptions of the surgical procedures are listed.

Example A rectosigmoid primary surgically treated by polypectomy with electrocautery, which is listed **after** polypectomy alone, *is coded 22.*

20 Local tumor excision, NOS
26 Polypectomy
27 Excisional biopsy
Combination of 20 or 26–27 WITH
21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

Scope of Regional Lymph Node Surgery distinguishes between sentinel lymph node biopsy and removal of other regional lymph nodes and distinguishes removal of regional lymph nodes during the same surgical procedure as a sentinel node biopsy from subsequent removal.

One important use of registry data is the tracking of treatment patterns over time. In order to compare contemporary treatment to previously published treatment based on the former codes, or to data still unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. The compromise incorporated in the Scope of Regional Lymph Node Surgery codes separates removal of one to three nodes (code 4) from removal of four or more nodes in the response categories (code 5). It is important to note that this distinction is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than four nodes was not reflected in surgery codes. The distinction between fewer than four nodes and four or more nodes removed is not intended to reflect clinical significance when applied to a particular surgical procedure.

Surgical Procedure/Other Site describes surgery performed on tissue or organs other than the primary site or regional lymph nodes. It is also used to describe whether surgery was performed for tumors having unknown or ill-

defined primary sites or hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease morphologies. If any surgical treatment was performed on these cancers, Surgical Procedure/Other Site is coded 1.

RADIATION

Date Radiation Started is the date that the first radiation therapy was delivered to the patient as part of all of the first course of therapy. This item in combination with Date Radiation Ended allows the duration of treatment to be calculated.

If radiation was the only type of first course treatment performed or was the first of multiple treatment modalities, Date Radiation Started is the same as Date of First Course of Treatment. Both dates can be used to describe lag time between diagnosis and initialization of specific aspects of treatment.

The type of regional dose therapy and its concomitant dose are captured by the items Regional Treatment Modality and Regional Dose (cGy). These two items describe the type of radiation delivered to the patient and the most significant therapeutic dose delivered.

• Codes 20 through 32 of Regional Treatment Modality apply to the delivery of beam radiation. If the patient record does not specify the specific modality employed, then code the most general description of the modality, code 20.

• Codes 40 through 43 describe proton radiation (code 40) and specific type of stereotactic radiotherapy(codes 41–43). If stereotactic radiotherapy is delivered to a patient but the exact modality is not recorded, use code 41 (Stereotactic radiosurgery, NOS).

• Codes 50 through 55 are used to record different types of brachytherapy administration, also known as radioactive seed implants. Code 50 should be used to record the application of radioactive materials not otherwise specified.

• Codes 60 through 62 provide codes to describe the administration of specific radioisotopes. Code 60 (Radioisotopes, NOS) should be used when specific details of the radioisotope administration is not available.

• Code 98 is reserved for cases where it is known that radiation therapy was delivered but the modality is not recorded in the patient record.

• The unit of measure for radiologic dosing is the centigray (cGy), which has replaced the use of “rads” to describe radiation dose.

• If only one radiation treatment modality is delivered to a patient and it is not specified as either regional or boost treatment, assume it’s regional treatment and code the items Regional Treatment Modality accordingly. A boost treatment is provided to a smaller volume within the same volume as regional radiation in order to enhance the effect of the regional treatment.

• The boost dose may or may not employ the same treatment modality. For example, external beam radiation may be used for regional treatment and be followed by brachytherapy to provide the boost dose.

• Not all patients who receive radiation therapy receive a boost dose radiation. For these cases, boost modality and dose should be coded as 00 and 00000, respectively.

• Radiation/Surgery Sequence identifies those instances where radiation therapy and the surgical management of the patient are not discrete and overlap with respect to time. Radiation therapy can precede the surgical resection of a tumor and then be continued after the patient’s surgery, or radiation can be administered intraoperatively.

• Reason for No Radiation identifies why radiation therapy was not provided to the patient and distinguishes a physician's not recommending this therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan.

SYSTEMIC THERAPY

Systemic therapy encompasses the treatment modalities captured by the items chemotherapy, hormone therapy, and immunotherapy. The systemic therapy items on the cancer report form separate the administration of systemic agents or drugs from medical procedures which affect the hormonal or immunologic balance of the patient.

Clarification of Systemic Therapy Terms	
Term	**Definition**
Chemotherapy	Cancer therapy that achieves its antitumor effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.
Hormone Therapy	Cancer therapy that achieves its antitumor effect through changes in hormonal balance. This type of therapy includes the administration of hormones, agents acting via hormonal mechanisms, antihormones, and steroids.
Immunotherapy / Biologic Response Modifier (BRM)	Cancer therapy that achieves its antitumor effect by altering the immune system or changing the host's response to the tumor cells.
Endocrine Therapy	Cancer therapy that achieves its antitumor effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient (when the cancer occurs at another site) and, therefore, alter or affect the long-term control of the cancer's growth
Hematologic Transplants	Bone marrow or stem cell transplants performed to protect patients from myelosuppression or bone marrow ablation associated with the administration of high-dose chemotherapy or radiation therapy.

Chemotherapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more chemotherapy drugs. If a patient has an adverse reaction, the managing physician may change one of the agents in a combination regimen. If the replacement agent belongs to the same group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) as the original agent, there is no change in the regimen. However, if the replacement agent is of a different group than the original agent, the new regimen represents the start of subsequent therapy, only the original agent or regimen is recorded as first course therapy. Refer to the SEER*Rx Interactive Drug Database - http://seer.cancer.gov/tools/seerrx/ - for a list of chemotherapeutic agents.

Systemic agents may be administered by intravenous infusion or given orally. Other methods of administration include the following:

Method	Administration
Intrathecal	Administered directly into the cerebrospinal fluid through a lumbar puncture needle into an implanted access device (for example, Ommaya reservoir).
Pleural/Pericardial	Injected directly into pleural or pericardial space to control malignant effusions.
Intraperitoneal	Injected into the peritoneal cavity.
Hepatic Artery	Injected into a catheter inserted into the artery that supplies blood to the liver.

Relationships among Systemic Therapy Items

The data item Date Systemic Therapy Started describes the first date on which any first course systemic treatment was administered to the patient. Nine out of 10 patients treated with systemic therapy receive only a single class

of drugs (chemotherapy, hormone therapy, or immunotherapy). Of the remaining patients who receive a combined regimen of systemic therapies, two-thirds begin these combined regimens simultaneously. For the purposes of clinical surveillance, the collection of multiple dates to describe the sequence of systemic therapy administration is not necessary.

The data items Chemotherapy, Hormone Therapy, and Immunotherapy describe whether or not each respective class of agent(s) or drug(s) were administered to the patient as part of first course therapy, based on SEER*Rx. In the case of chemotherapy, additional distinction is allowed for instances where single or multiagent regimens were administered. Each of these three items includes code values that describe the reason a particular class of drugs is not administered to the patient and distinguishes a physician's not recommending systemic therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan.

Hematologic Transplant and Endocrine Procedures captures those infrequent instances in which a medical, surgical, or radiation procedure is performed on a patient that has an effect on the hormonal or immunologic balance of the patient. Hematologic procedures, such as bone marrow transplants or stem cell harvests, are typically employed in conjunction with administration of systemic agent(s), usually chemotherapy.

• Endocrine procedures, either radiologic or surgical, may be administered in combination with systemic agent(s), typically hormonal therapeutic agents.

• As first course therapy, hematologic procedures will rarely be administered in conjunction with endocrine radiation or surgery. The use of code 40 in response to this data item should be reviewed and confirmed with the managing physician(s).

OTHER TREATMENT

Other Treatment encompasses first course treatment that cannot be described as surgery, radiation, or systemic therapy according to the defined data items found in this manual.

This item is also used for supportive care treatment for reportable hematopoietic diseases that do not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Treatments such as phlebotomy, transfusions, and aspirin are recorded in Other Treatment data item for certain hematopoietic diseases, and should be coded 1.

The National Cancer Institute provides a website that describes typical treatment modalities for a wide variety of cancer types − http://www.cancer.gov/

INSTRUCTIONS FOR COMPLETING ALL MCSP REPORTABLE DATA ITEMS

In describing the proper reporting of cancer patient information, reference will frequently be made to standard reference sources. Links to these reference sites can be found at the back of this manual. These reference sources are abbreviated within the instructions as follows:

SEER	Surveillance, Epidemiology and End Results
CoC	Commission on Cancer within the American College of Surgeons
ACoS	American College of Surgeons
FORDS	Facility Oncology Registry Data Standards manual produced by the CoC
NAACCR	North American Association of Central Cancer Registries
AJCC	American Joint Committee on Cancer
ICD-O-3	International Classification of Diseases for Oncology, Third Edition, World Health Organization (WHO)
CS	Collaborative Stage Data Collection System Manual
NPCR	National Program of Cancer Registries

Item: ABSTRACTED BY — NAACCR Item 570

An alphanumeric code assigned by the reporting facility that identifies the individual abstracting the case. If the paper cancer report form is used, enter the name and phone number of the person who prepared the report form.

Item: ACCESSION NUMBER--HOSP — NAACCR Item 550

Alternate Name: Accession Number

The **Accession Number** is **required only for hospitals with a registry**, in which case, the number would be assigned as the patient is enrolled into the system.

The accession number is a unique nine-digit identifier that indicates when the patient was first seen at the reporting facility for the diagnosis and/or treatment of cancer. Registry software usually assigns this identifier automatically. The first four digits of the accession number specify the year in which the patient was first seen at the reporting institution for the diagnosis and/or treatment of cancer. The last five digits of the accession number is the numeric order in which the registrar entered the case into the registry.

The accession number is used by the facility to uniquely identify the patient; therefore the same accession number must be used for any subsequent primary tumors that patient develops in the future.

When a patient is deleted from the database, DO NOT reuse the accession number for another patient. A patient's accession number is never reassigned.

Numeric gaps are allowed in accession numbers.

Examples

Code	Explanation
201200054	Patient enters the hospital in 2012, and is diagnosed with prostate cancer. The patient is the fifty-fourth patient accessioned in 2012.
201200092	Patient diagnosed in staff physician office in November 2011, now enters the reporting facility in February 2012, and is the ninety-second case accessioned in 2012.
201200235	A patient with the accession number 201200235 for a colon primary returns to the hospital with a subsequent prostate primary in 2013. The accession number will remain the same. The Sequence Number will identify this primary.

Item: ADDR AT DX--CITY **NAACCR Item 70**

Alternate Name: City/Town at Diagnosis

Enter the postal city, village or town in which the patient resides at the initial time of diagnosis.

Do not update this data item if the patient's address changes.

If the patient has more than one primary tumor, the city at diagnosis may be different for each primary.

Do not leave this data item blank. If the city is unknown, enter "unknown."

Item: ADDR AT DX--COUNTRY **NAACCR Item 102**

Enter the country of the patient's residence at the time of diagnosis.

If the country is the United States, enter USA.

If the patient has multiple tumors, the country at diagnosis may be different for each tumor.

If the country is NOT the United States and country is unknown, enter ZZU or Unknown.

ISO alpha-3 Country Codes can be found at the back of this manual or refer to Appendix B of the SEER Program Code Manual at seer.cancer.gov/tools/codingmanuals/index.html

Item: ADDR AT DX--NO & STREET **NAACCR Item 2330**

Alternate Name: Patient Address (Number and Street) at Diagnosis

Enter the Number and Street address of the patient's usual residence at the time the reportable tumor was diagnosed. DO NOT update this data item if the patient's address changes – always maintain the address in which the patient resided at the time of diagnosis.

The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S Postal Service postal addressing standards. These standards are referenced in current USPS Publication 28, Postal Addressing Standards located at http://pe.usps.gov/text/pub28/welcome.htm

Canadian addresses should conform to the current Canada Postal Guide located at https://www.canadapost.ca/tools/pg/manual/default-e.asp.

Additional address information such as facility, nursing home, or name of apartment complex should be entered in ADDR AT DX--SUPPLEMENTL (NAACCR Item 2335).

If the patient has more than one primary tumor, the address at diagnosis may be different for each primary.

If a rural route number or post office box is given, this can be recorded, but ONLY if the street and numbers are NOT available. In abbreviating street and place names, use standard U.S. Postal abbreviations.

Do not leave this data item blank. If the address is unknown, enter "unknown."

Item: ADDR AT DX--POSTAL CODE **NAACCR Item 100**

Alternate Name: Zip Code, Postal Code at Diagnosis

Type the patient's extended (nine digit) Postal Code at the time of diagnosis and treatment. (If the extended zip code is not available, enter the five-digit zip code. For Canadian residents, record the six-character postal code.)

When available, record the postal code for other countries.

If "Not US and Not Canada," and if the postal code is unknown, enter 888888888.

If "US/Canada" but the postal code is unknown; OR if the residence is unknown, type 999999999.

Do not update this data item if the patient's postal code changes.

If the patient has multiple tumors, the postal code may be different for subsequent primaries.

Do not leave this data item blank.

Item: ADDR AT DX--STATE **NAACCR Item 80**

Alternate Name: State at Diagnosis

Enter the U.S. Postal abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province or territory in which the patient resides **at the time the reportable tumor was diagnosed.**

If the patient has multiple tumors, the state of residence may be different for each tumor.

Codes other than United States:

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

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

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

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

ZZ Residence unknown

NOTE: Reports on Michigan residents, as well as nonresidents are required.

Do not leave this data item blank. If the information is unknown or unreported in the patient's record, enter "ZZ" or "Unknown."

A complete list of state, territory, commonwealth, U.S. possession, or Canadian province or territory codes can be found at the back of this manual, or refer to Appendix B of the SEER Program Code Manual at seer.cancer.gov/tools/codingmanuals/index.html

Item: ADDR AT DX--SUPPLEMENTL **NAACCR Item 2335**

Alternate Name: Patient Address (Number and Street) at Diagnosis--Supplemental

Type the place or facility (e.g., a nursing home or name of an apartment complex) of the patient's usual residence at the time the reportable tumor was diagnosed.

Do not update this data item if the patient's address changes.

If the patient has more than one primary tumor, this supplemental address information may be different for each primary.

If not applicable or unknown, leave this data item blank.

Item: ADDR CURRENT--CITY **NAACCR Item 1810**

Alternate Name: City/Town--Current

This data item provides a current city used for follow-up purposes. It may or may not be different than the patient's address at the initial time of diagnosis. If the patient has multiple tumors, the current city must be the same for ALL tumors.

Enter the postal city, village or town in which the patient currently resides.

Do not leave this data item blank. If the city is unknown, enter "unknown."

Item: ADDR CURRENT--COUNTRY **NAACCR Item 1832**

This data item provides a current country used for follow-up purposes. It may or may not be different than the patient's address at the initial time of diagnosis. If the patient has multiple tumors, the current country must be the same for ALL tumors.

Enter the country of the patient's current residence.

If the country is the United States, enter USA.

If the country is NOT the United States and country is unknown, enter ZZU or Unknown.

ISO alpha-3 Country Codes can be found at the back of this manual or refer to Appendix B of the SEER Program Code Manual at seer.cancer.gov/tools/codingmanuals/index.html

Item: ADDR CURRENT--NO & STREET **NAACCR Item 2350**

Alternate Name: Patient Address (Number and Street)-Current

This data item provides a current address used for follow-up purposes. It may or may not be different than the patient's address at the initial time of diagnosis. If the patient has multiple tumors, the current address must be the same for ALL tumors.

Enter the Number and Street address of the patient's current residence. The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S Postal Service postal addressing standards. These standards are referenced in current USPS Publication 28, Postal Addressing Standards located at http://pe.usps.gov/text/pub28/welcome.htm

Canadian addresses should conform to the current Canada Postal Guide located at https://www.canadapost.ca/tools/pg/manual/default-e.asp.

Additional address information such as facility, nursing home, or name of apartment complex should be entered in ADDR CURRENT--SUPPLEMENTL (NAACCR Item 2355).

If a rural route number or post office box is given, this can be recorded, but ONLY if the street and numbers are NOT available. In abbreviating street and place names, use standard U.S. Postal abbreviations.

Do not leave this data item blank. If the address is unknown, enter "unknown."

Item: ADDR CURRENT--POSTAL CODE **NAACCR Item 1830**

Alternate Name: Postal Code--Current

This data item provides a current postal code used for follow-up purposes. It may or may not be different than the patient's postal code at the initial time of diagnosis. If the patient has multiple tumors, the current postal code must be the same for ALL tumors.

Type the patient's current extended (nine digit) Postal Code. (If the extended zip code is not available, enter the five-digit zip code. For Canadian residents, record the six-character postal code.)

When available, record the postal code for other countries.

If "Not US and Not Canada," and if the postal code is unknown, enter 888888888.

If "US/Canada" but the postal code is unknown; OR if the residence is unknown, type 999999999.

Do not leave this data item blank.

Item: ADDR CURRENT--STATE **NAACCR Item 1820**

Alternate Name: State--Current

This data item provides a current state or province used for follow-up purposes. It may or may not be different than the patient's state/province at the initial time of diagnosis. If the patient has multiple tumors, the current state/province must be the same for ALL tumors.

Enter the U.S. Postal abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province or territory in which the patient currently resides.

Codes other than United States:

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

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

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

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

ZZ Residence unknown

Do not leave this data item blank. If the information is unknown or unreported in the patient's record, enter "ZZ" or "Unknown."

A complete list of state, territory, commonwealth, U.S. possession, or Canadian province or territory codes can be found at the back of this manual, or refer to Appendix B of the SEER Program Code Manual at seer.cancer.gov/tools/codingmanuals/index.html

Item: ADDR CURRENT--SUPPLEMENTL **NAACCR Item 2355**

Alternate Name: Patient Address (Number and Street) Current--Supplemental

This data item provides supplemental address information used for follow-up purposes. It may or may not be different than that at the initial time of diagnosis. If the patient has multiple tumors, the supplemental address information must be the same for ALL tumors.

Type the place or facility (e.g., a nursing home or name of an apartment complex) of the patient's current residence.

If not applicable or unknown, leave this data item blank.

Item: ALCOHOL USE **State-Specific Item 254**

Records whether or not the patient has a history of alcohol use.

This is a Michigan-specific data item. Abstracts submitted with incorrect format or missing values will be rejected by MCSP.

Paper form submission:

Mark appropriate value: current use, prior use, never used or unknown

Electronic submission:

This is a Michigan-specific data item. Starting with data submitted in NAACCR version 13, facilities that submit electronic abstract data to MCSP must coordinate with their software vendors to ensure that data value is recorded in NAACCR record layout, column number 2448. After that date, abstracts submitted with incorrect format or missing values will be rejected by MCSP.

If unknown, enter 9.

Alcohol History Data Values

Code	Current	Prior	Never
1	Yes	Blank	Blank
2	Blank	Yes	Blank
3	Blank	Blank	Yes
9	Blank (Unknown)	Blank (Unknown)	Blank (Unknown)

Item: BEHAVIOR CODE ICD-O-3 **NAACCR Item 523**

Alternate Name: Behavior Code

You MUST obtain and use these required reference and coding resources:

- ***Multiple Primary and Histology Coding Rules manual from*** http://seer.cancer.gov/tools/mphrules/download.html
- ***International Classification of Diseases for Oncology, Third Edition (ICD-O-3) coding book.*** This book can be purchased through any book store or ordered from online sources. Electronic CSV database files or print copies of the classifications are available from the World Health Organization at http://www.who.int/classifications/icd/adaptations/oncology/en/
- ***Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual at http://seer.cancer.gov/tools/heme/ to assist with coding these primaries. These references apply only to cases diagnosed January 1, 2010 and forward.***

The Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual apply to only those **non-solid tumor cases diagnosed January 1, 2010 and forward.** The ICD-O-3 coding book is obsolete for coding non-solid tumors after this date. You must use the Hematopoietic and Lymphoid Neoplasm Database and Coding Manual to assign the histology code.

Record the behavior of the tumor being reported. The fifth digit of the morphology code is the behavior code. The behavior code is used by pathologists to describe whether tissue samples are benign (0), borderline (1), in situ (2), or invasive (3).

Code 3 if any invasion is present, no matter how limited. If the specimen is from a metastatic site, code the histology of the metastatic site and code 3 for behavior code for the behavior of the tumor being reported.

EXCEPTION 1: Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, is REQUIRED and should be recorded as 9421/3 in the registry.

Nonmalignant primary intracranial and central nervous system tumors diagnosed on or after January 1, 2004, with an ICD-O-3 behavior code of 0 or 1 are required for the following sites: meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of central nervous system (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3).

Code	Label	Definition
0	Benign	• Benign
1	Borderline	• Uncertain whether benign or malignant • Borderline malignancy • Low malignant potential • Uncertain malignant potential
2	In situ and/or carcinoma in situ	•Adenocarcinoma in an adenomatous polyp with no invasion of stalk • Clark level 1 for melanoma (limited to epithelium) • Comedocarcinoma, non-infiltrating (C50._)

Code	Label	Definition
2	Synonymous with in situ	• Confined to epithelieum • Hutchinson melanotic freckle, NOS (C44._) • Intracystic, non-infiltrating • Intraductal • Intraepidermal, NOS • Intraepithelial, NOS • Involvement up to, but not including the basement membrane • Lentigo maligna (C44._) • Lobular neoplasia (C50._) • Lobular, non-infiltrating (C50._) • Non-infiltrating • No stromal involvement • Papillary, non-infiltrating or intraductal • Precancerous melanosis (C44._) • Queyrat erythroplasia (C60._)
3	Invasive	• Invasive or micro-invasive

Item: BIRTHPLACE--COUNTRY **NAACCR Item 254**

Enter the name or code for the country of the patient's birth. If the country is the United States, enter USA.

If the patient has multiple primaries, the country of birth is the same for each tumor.

Do not leave this data item blank. If unknown or unreported in the patient's record, enter "ZZU" or "Unknown."

ISO alpha-3 Country Codes can be found at the back of this manual or refer to Appendix B of the SEER Program Code Manual at seer.cancer.gov/tools/codingmanuals/index.html.

Item: BIRTHPLACE--STATE **NAACCR Item 252**

Enter the USPS abbreviation for the state, commonwealth, U.S. possession; or CanadaPost abbreviation for the Canadian province/territory in which the patient was born. For example, if the state in which the patient was born is Michigan, use "MI".

If the patient has multiple primaries, the state of birth is the same for each tumor.

Do not leave this data item blank. If the information is unknown or unreported in the patient's record, enter "ZZ" or "Unknown."

A complete list of state, territory, commonwealth, U.S. possession, or Canadian province or territory codes can be found at the back of this manual, or refer to Appendix B of the SEER Program Code Manual at seer.cancer.gov/tools/codingmanuals/index.html.

Item: CASEFINDING SOURCE **NAACCR Items 501**

This item records where the case was first identified and what mechanism was used to identify the case for review.

Each case may have a different casefinding source.

If a death certificate, independent pathology laboratory report, consultation-only report from a hospital, or other report was used to identify a case that was then abstracted from a different source, enter the code for the source that first identified that case, not the source from which it was subsequently abstracted.

Codes are as follows:

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

Case first identified by source other than a reporting facility covered in the codes above:

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

Item: CAUSE OF DEATH **NAACCR Items 1910**

Alternate Name: Underlying Cause of Death

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

Special codes in addition to ICD-7, ICD-8, ICD-9, and ICD-10 (refer to *SEER Program Code Manual* for additional instructions.)

0000 - Patient alive at last contact
7777 - State death certificate not available
7797 - State death certificate available but underlying cause of death is not coded

Item: CLASS OF CASE **NAACCR Items 610**

NOTE: Class of Case is a REQUIRED data item regardless of facility type.

Analytic Classes of Case (REQUIRED by CoC to be abstracted by accredited programs)

Initial diagnosis at reporting facility

00 Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere

10 Initial diagnosis at the reporting facility or in a staff physician's office AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS

11 Initial diagnosis in staff physician's office AND part of first course treatment was done at the reporting facility

12 Initial diagnosis in staff physician's office AND all first course treatment or a decision not to treat was done at the reporting facility

13 Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; 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

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

Patient appears in person at reporting facility

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 patient presents 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 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 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 given in two or more different staff physician offices

42 Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)

43 Pathology or other lab specimens only

49 Death certificate only

99 Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).

If not reporting, leave item blank.

Item: COMORBID/COMPLICATION (1-10) NAACCR Items 3110-3164

Alternate Name: Comorbidities and Complications (#1-#10)

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer **using ICD-9-CM values**. All 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 outcomes statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Co-morbidities are pre-existing medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM or ICD-10-CM codes. All are considered secondary diagnoses or conditions that were present at the time the patient was diagnosed with this cancer (e.g. chronic conditions such as COPD, diabetes, and hypertension). Depending on whether the hospital has implemented use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-CM form.

Use this item to record ICD-9-CM codes. Use SECONDARY DIAGNOSIS (1-10) (NAACCR Items 3780-3798) to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.

NOTE: DO NOT record ICD-10-CM codes in the COMORBID/COMPLICATION (1-10) fields.

Secondary diagnoses are found on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available. Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility.

Five digits must be entered in order for the code to pass edits. Example: 401.9 must be entered as 40190. Omit the decimal point when coding. If no secondary diagnoses are documented, or if this information is unknown or unavailable, leave this data item blank.

Report the secondary diagnoses for this cancer using the following priority rules.

Surgically treated patients:

a) Following the most definitive surgery of the primary site
b) Following other non-primary site surgeries

Non-surgically treated patients:

Following the first treatment encounter/episode

In cases of non-treatment:

Following the last diagnostic/evaluative encounter

The following codes are reportable ICD-9-CM comorbidities/complications:

Code	Definition and instructions
00000	No comorbid conditions or complications documented
00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Do **NOT** review the medical record and assign codes to these conditions – only record the above conditions if they have been identified by the medical records coder and appear on the face sheet.

For more information, refer to Facility Oncology Registry Data Standards (FORDS) at http://www.facs.org/cancer/coc/fordsmanual.html.

Item: COUNTY AT DX — NAACCR Item 90

Alternate Name: County, County at Diagnosis

Enter the county FIPS code of the county of the patient's residence at the time of diagnosis.

If the county is unknown or obtainable, or if Out-of-State county or non-US resident, enter 999 (or "unknown" if submitting paper reporting form.)

Do not leave this data item blank.

For a complete listing of Michigan county names and FIPS codes, see the "FIPS County Codes for Michigan Counties" table at the back of this manual.

Item: COUNTY--CURRENT — NAACCR Item 1840

This data item provides a current county used for follow-up purposes. It may or may not be different than the patient's county at the initial time of diagnosis. If the patient has multiple tumors, the current county must be the same for ALL tumors.

Enter the FIPS code of the county of the patient's current residence.

If the county is unknown or obtainable, or if Out-of-State county or non-US resident, enter 999 (or "unknown" if submitting paper reporting form.)

Do not leave this data item blank.

For a complete listing of Michigan county names and FIPS codes, see the "FIPS County Codes for Michigan Counties" table at the back of this manual.

Item: CS SITE-SPECIFIC FACTORS (1-25) NAACCR Items 2861-2930

These schema-specific factors identify additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

All facilities must report values for site-specific factor fields as documented in the medical record for cases diagnosed in 2016. If applicable value is not found within the medical record, then facilities are to report the appropriate default value for the field. Not all site-specific factors are required for all schemas. Refer to site/histology-specific instructions in the applicable Collaborative Stage Data Collection System Manual (based on diagnosis year) for schema-specific information. You MUST download appropriate manual from https://cancerstaging.org/cstage/Pages/default.aspx to code these fields.

For additional staging information, see Cancer Staging section in this manual.

Item: DATE 1ST CRS RX COC NAACCR Item 1270

Alternate Name: Date of First Course Treatment

Enter the year, month and day (**YYYY/MM/DD**) for the date of first course of treatment. Consider ALL therapies that have been administered. This includes any surgery, radiation therapy, chemotherapy, hormone therapy or immunotherapy (biological response modifier therapy) that has been described as a recommended part of the treatment plan. The date of first treatment includes the date a decision was made not to treat the patient.

Record the FIRST date that the patient received treatment.

Item: DATE 1ST CRS RX COC FLAG NAACCR Item 1271

Alternate Name: Date of 1st Crs Rx Flag

This flag explains why there is no appropriate value in the corresponding date field, DATE 1ST CRS RX COC.

Codes are as follows:

10 No information whatsoever can be inferred from this exceptional value; unknown if treatment was given

11 No proper value is applicable in this content (for example, autopsy only)

12 A proper value is applicable but not known. This event occurred, but the date is unknown (for example, treatment was given, but date is unknown.)

BLANK - Valid date provided for item DATE 1ST CRS RX COC

Item: DATE CASE COMPLETED NAACCR Item 2090

Enter the year, month, and day (**YYYY/MM/DD**) the abstract or cancer report form was completed.

Item: DATE OF 1ST CONTACT NAACCR Item 580

Alternate Name: Date of Adm/First Contact

Enter the year, month and day (**YYYY/MM/DD**) for the first date of contact.

Date of first contact with the reporting facility for diagnosis and/or treatment of this cancer. Record the date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or first course treatment of a reportable tumor. The date may be the date of an outpatient visit for a biopsy, x-ray, or laboratory test, or the date a pathology specimen was collected at the hospital.

If this is an autopsy-only or death certificate-only case, then use the date of death.

When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient is physically first seen at the reporting facility.

Item: DATE OF 1ST CONTACT FLAG **NAACCR Item 581**

Alternate Name: Date of First Contact Flag

This flag explains why there is no appropriate value in the corresponding date field.

12 A proper value is applicable but not known (e.g., date of 1st contact is unknown)

Blank - A valid date value is provided in item DATE OF 1ST CONTACT

Item: DATE OF BIRTH **NAACCR Item 240**

Alternate Name: Birth Date

Enter the date of birth of the patient using **YYYY/MM/DD** (*for example 1958/09/12*) as the 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.

For in utero diagnosis and treatment, record the actual date of birth. It will follow one or both dates for these events.

Estimate date of birth when information is not available. It is better to estimate than to leave birthdate unknown.

Item: DATE OF DEATH **NAACCR Item 1750**

See instructions for DATE OF LAST CONTACT

Item: DATE OF DIAGNOSIS **NAACCR Item 390**

Alternate Name: Date of Initial Diagnosis

Enter the year, month and day (**YYYY/MM/DD**) for the date of diagnosis.

Date of initial diagnosis by a recognized medical practitioner for the tumor being reported whether clinically or microscopically confirmed.

If the diagnosis was determined by pathological examination, use the date the specimen was taken (date of biopsy or surgery), NOT the date the specimen was read by the pathologist or the date the report was dictated, transcribed or printed.

If the physician states that in retrospect the patient had cancer at an earlier date, then use the earlier date as the date of diagnosis.

Though the original diagnosis may be a clinical diagnosis that is later confirmed through pathological examination or other procedures, the clinical diagnosis date should be reported.

Example A patient underwent a mammogram on August 25, 2012. The radiologist read the report as suspicious for cancer, recommending biopsy. The patient does not get a biopsy until February 4, 2013 which reveals an infiltrating ductal adenocarcinoma. *Record the date of diagnosis as August 25, 2012.*

Ambiguous terminology must be taken into consideration when determining the initial date of diagnosis.

Refer to the section Ambiguous Terminology for a list of specific terms and further instructions.

If the month is unknown, use the month of **July (7)** for the month of diagnosis.

If the day is unknown, use the **fifteenth (15)** for the day of diagnosis.

If the year is unknown, estimate the diagnosis year based upon documentation in the medical record and how long the patient has had the diagnosis.

If an approximation is not possible, use the date first confirmed, first treated, or in the case of death, the date of death, whichever is earliest.

If a patient is diagnosed elsewhere before entering the reporting facility and the date of diagnosis is unknown, record the date the patient was first seen at the reporting hospital.

Use the date therapy was started as the date of diagnosis if the patient receives cancer directed treatment before a definitive diagnosis.

The date of death is the date of diagnosis for cases diagnosed at autopsy.

If information is limited to a description, use the following guidelines.

- Spring of 2014 code date of diagnosis as April 15, 2014
- Middle of 2014 code date of diagnosis as July 15, 2014
- Fall of 2014 code date of diagnosis as October 15, 2014
- Winter of 2014 code date of diagnosis as December 15, 2014 or January 15, 2015 (further investigation may need to be done to determine the year of diagnosis.)

Item: DATE OF INPT ADM **NAACCR Item 590**

Alternate Name: Date of Inpatient Admission

This item is not required for any facility type, but may be reported if available to the facility. If unknown, the appropriate value must be entered for item DATE OF INPT ADM FLAG (NAACCR Item 591).

Enter the year, month and day (**YYYY/MM/DD**) of the inpatient admission.

Date of the inpatient admission to the reporting facility for the most definitive surgery. In the absence of surgery, use date of inpatient admission for any other therapy. In the absence of therapy, use date of inpatient admission for diagnostic evaluation.

Item: DATE OF INPT ADM FLAG **NAACCR Item 591**

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if patient was an inpatient.)

11 No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility.)

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., the patient was an inpatient but the date is unknown.)

Blank - a valid date value is provided in item DATE OF INPT ADM

Item: DATE OF INPT DISCH **NAACCR Item 600**

Alternate Name: Date of Inpatient Discharge

This item is not required for any facility type, but may be reported if available to the facility. If unknown, the appropriate value must be entered for item DATE OF INPT DISCH FLAG (NAACCR Item 601).

Enter the year, month and day (**YYYY/MM/DD**) of the inpatient discharge.

Date of the inpatient discharge from the reporting facility after the most definitive surgery. In the absence of surgery, use date of inpatient discharge for other therapy. In the absence of therapy, use date of inpatient discharge for diagnostic evaluation. This discharge date corresponds to the admission date described by Date of Inpatient Admission.

Item: DATE OF INPT DISCH FLAG **NAACCR Item 601**

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if patient was an inpatient.)

11 No proper value is applicable in this context (e.g., patient was never an inpatient at the reporting facility.)

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., the patient was an inpatient but the date is unknown.)

Blank - a valid date value is provided in item DATE OF INPT DISCH

Item: DATE OF LAST CONTACT **NAACCR Item 1750**

Alternate Name: Date of Last Contact or Death

Enter the year, month and day (**YYYY/MM/DD**) for the last date of contact.

Records the date of last contact with the patient or the date of death.

Record the last date on which the patient was known to be alive or the date of death.

Item: DATE OF LAST CONTACT FLAG **NAACCR Item 1751**

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:

12 A proper value is applicable but not known. This event occurred, but the date is unknown (that is, the date of last contact is unknown.)

BLANK - Valid date provided for item DATE OF LAST CONTACT item field.

Item: DIAGNOSTIC CONFIRMATION **NAACCR Item 490**

There are separate coding schemes for solid tumors and for non-solid tumors/hematopoietic and lymphoid neoplasms M9590-9992.

Instructions for Coding Solid Tumors (all tumors *except* M9590-9992)

• The codes are in priority order; code 1 has the highest priority. Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods. This data item must be changed to the lower (higher priority) code if a more definitive method confirms the diagnosis **at any time during** the course of the disease.

• Assign code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy or D&C or from aspiration of biopsy of bone marrow specimens.

• Assign code 2 when the microscopic diagnosis is based on cytologic examination of *cells* such as sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. CoC does not require programs to abstract cases that contain ambiguous terminology regarding a cytologic diagnosis.

• Code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer.

• Code 6 when the diagnosis is based only on the surgeon's operative report from a surgical exploration or endoscopy or from gross autopsy findings in the absence of tissue or cytological findings.

Method of Diagnosis - Codes for Solid Tumors		
Code	**Definition**	**Explanation**
1	Positive histology	Histologic confirmation; tissue microscopically examined.
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined.) Fine needle aspiration (FNA) is frequently used to obtain a cytologic specimen. Cells may be recovered from exudate, secretions, or washings from tissue.
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were examined by histology or cytology.

Method of Diagnosis - Codes for Solid Tumors		
Code	**Definition**	**Explanation**
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on certain laboratory tests or marker studies that are CLINICALLY DIAGNOSTIC for cancer. Examples include alpha-fetoprotein for liver cancer and an abnormal electrophoretic spike for multiple myeloma. An elevated PSA is **NOT** diagnostic of cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, record as a code 5.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only; **NO** tissue was resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only. Example: ultrasound, computerized (axial) tomography (CT or CAT scans) and magnetic resonance imaging (MRI).
8	Clinical diagnosis only, other than 5,6, or 7	Cases diagnosed by clinical methods not mentioned previously. e.g., mass in breast suspect a malignancy; no biopsies were taken. Refer to the list of "Ambiguous Terminology" for language that represents a diagnosis of cancer.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed.

Instructions for Coding Non-Solid Tumors/Hematopoietic and Lymphoid Neoplasms (M9590-9992)

• There is no priority hierarchy for coding Diagnostic Confirmation for hematopoietic and lymphoid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing See the Hematopoietic Database (DB) for information on the definitive diagnostic confirmation for specific types of tumors.

• Code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, or autopsy or bone marrow specimens from aspiration or biopsy.

• **For leukemia only, code 1 when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear.** DO NOT use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow, or blood.

• Use code 2 when the microscopic diagnosis is based on cytologic examination of *cells* (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.

• Assign code 3 when there is a histology positive for cancer AND positive immunophenotyping and/or positive genetic testing results. DO NOT use code 3 for neoplasms diagnosed prior to January 1, 2010.

• Assign code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer, but no positive histologic confirmation.

• Assign code 6 when the diagnosis is based only on the surgeon's report from a surgical exploration or endoscopy or from gross autopsy findings without tissue or cytological findings.

• Assign code 8 when the case was diagnosed by any clinical method that cannot be coded as a 6 or 7. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.

Method of Diagnosis - Codes for Hematopoietic and Lymphoid Neoplasms		
Code	**Definition**	**Explanation**
1	Positive histology	Histologic confirmation; tissue microscopically examined.
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined.)
3	Positive histology PLUS • Positive immunophenotyping AND/OR •positive genetic studies	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results. For example, bone marrow examination is positive for acute myeloid leukemia (9861/3). Genetic testing shows AML with inv (16)(p13.1q22) (9871/3.) NOTE: Do not use this code for neoplasms diagnosed prior to January 1, 2010.
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were examined by histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for cancer.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only; ***NO*** tissue was resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only, other than 5,6 or 7	The malignancy was reported by the physician in the medical record.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed.

Item: FAMILY HISTORY OF CANCER — State-specific Item 9520

This item records whether or not the patient has a family history of cancer.

This is a Michigan-specific data item. Abstracts submitted with incorrect format or missing values will be rejected by MCSP.

Explanation of terminology:

"Immediate Family Member": Mother, Father, Brother, Sister, Son, Daughter.

"Non-Immediate Family Member": Aunt, Uncle, Niece, Nephew, Cousin, Half-brother, and Half-sister.

An immediate relative, or first degree family member, is any relative who is one meiosis away from a particular individual in a family (i.e., parent, sibling, and offspring). A half-brother, half-sister, would be considered as a non-immediate family member, or second-degree family member.

There will be cases in which a cancer patient has both a first degree relative and a second degree relative with a history of cancer. If the patient and a relative share a common primary site, record these fields in regard to the relative with same primary site, regardless of degree of relationship. If the patient and all relatives have tumors involving non-similar primary sites, record these fields in regard to the cancer history of the first degree relative.

Example 1 Patient is diagnosed with breast cancer. Father has history of colon cancer; maternal aunt has history of breast cancer.
Refer to the aunt's cancer history since she shares the same primary site.

Example 2 Patient is diagnosed with breast cancer. Father has history of colon cancer; a maternal uncle has history of prostate cancer.
Refer to the father's cancer history since he is the immediate (first degree) family member.

Paper form submission:

Item 16a. **Family History of Cancer**

Enter whether or not the patient has a family history of cancer.

If unknown, enter "9" or "Unknown."

Item 16b. **If yes, Immediate Family Member**

Enter whether or not the patient is an immediate family member.

If unknown, enter "9" or "Unknown."

Item 16c. **If yes, Same Anatomical Site**

Enter whether or not the individual has the same type of cancer as the patient. "Same Cancer" means the same organ site or, in the case of a sarcoma, leukemia and lymphomas, the same cancer type.

If unknown, enter "9" or "Unknown."

Electronic submission:

This is a Michigan-specific data item. Starting with data submitted in NAACCR version 13, facilities that submit electronic abstract data to MCSP must coordinate with their software vendors to ensure that data value is recorded in NAACCR record layout, column number 2449. After that date, abstracts submitted with incorrect format or missing values will be rejected by MCSP.

If unknown, enter 9.

Family History of Cancer Data Values

Code	Family History	Immediate Family Member	Same Site
0	No	No	No
1	Yes	Yes	Yes
2	Yes	Yes	No
3	Yes	No	Yes
4	Yes	No	No
5	Yes	Yes	Blank
6	Yes	Blank	Yes
7	Yes	Blank	No
8	Yes	Blank	Blank
A	Yes	No	Blank
9	Blank (Unknown)	Blank (Unknown)	Blank (Unknown)

Item: GRADE **NAACCR Item 440**

Alternate Name: Grade, Differentiation, or Cell Lineage Indicator

The tumor grade applies to the primary site ONLY.

Code the grade or differentiation as stated in the **final** pathologic diagnosis. If grade is not stated in the final pathologic diagnosis, use the information from the microscopic description or comments.

Example Microscopic Description: Poorly differentiated, squamous cell carcinoma, invading the adventitia.
Final Description: Squamous cell carcinoma, invading the adventitia.
Code the tumor grade as: 3 - poorly differentiated

The grade of a tumor represents the pathological description of the degree to which the tumor tissue resembles normal tissue for that primary site. This is expressed in degrees of differentiation.

Grade/Differentiation for solid tumors (codes 1, 2, 3, 4, 9) and Cell Indicator for Lymphoid Neoplasms (Codes 5, 6, 7, 8, 9).

Hematopoietic and Lymphoid Neoplasms Cell Indicator (Codes 5, 6, 7, 8, 9)

Cell Indicator (Codes 5, 6, 7, 8) describes the lineage or phenotype of the cell. Codes 5, 6, 7, and 8 are used only for hematopoietic and lymphoid neoplasms. Code 9 indicates cell type not determined, not stated, or not applicable.

Coding Grade for Hematopoietic and Lymphoid Neoplasms

1. Determine the histology based on the current Hematopoietic and Lymphoid Neoplasm Database and Coding Manual http://seer.cancer.gov/tools/heme/

2. Determine the Cell Indicator by applying the "Grade of Tumor Rules" within the current Hematopoietic and Lymphoid Neoplasm Database and Coding Manual to code the grade http://seer.cancer.gov/tools/heme/

Grade codes for hematopoietic and lymphoid neoplasms

Terminology	Grade Code
T-cell; T-precursor	5
B-cell; Pre-B; B-precursor	6
Null cell; Non T-non B	7
NK cell (natural killer cell)	8
Grade unknown, not stated, or not applicable	9

DO NOT use "high grade," "low grade," or "intermediate grade" descriptions for lymphomas as a basis for differentiation. These terms are categories in the Working Formulation of Lymphoma Diagnoses and do not relate to grade/differentiation.

Codes 5–8 define T-cell or B-cell origin for leukemias and lymphomas. T-cell, B-cell, or null cell classifications have precedence over grading or differentiation.

Solid Tumors
Grade/Differentiation (Codes 1, 2, 3, 4, 9)

Pathologic examination determines the grade, or degree of differentiation, of the tumor. For these cancers, the grade is a measurement of how closely the tumor cells resemble the parent tissue (organ of origin). Well-differentiated tumor cells closely resemble the tissue from the organ of origin. Poorly differentiated and undifferentiated tumor cells are disorganized and abnormal looking; they bear little (poorly differentiated) or no (undifferentiated) resemblance to the tissue from the organ of origin. These similarities/differences may be based on pattern (architecture), cytology, nuclear (or nucleolar) features, or a combination of these elements, depending upon the grading system that is used. Some grading systems use pattern, for example Gleason grading in prostate. Others use only a nuclear grade (usually size, amount of chromatin, degree of irregularity, and mitotic activity.) Fuhrman's grade for kidney is based only on nuclear features. Most systems use a combination of pattern and cytologic and nuclear features; for example Nottingham's for breast combines numbers for pattern, nuclear size and shape, and mitotic activity. The information from this data item is useful for determining prognosis and treatment.

Pathologists describe the tumor grade using three systems or formats:

1. Two levels of similarity; also called a two-grade system
2. Three levels of similarity; also called a three-grade system (code according to "Coding for solid tumors."
    a. Grade I, well
    b. Grade II, moderately
    c. Grade III, poorly (undifferentiated carcinoma is usually separated from this system, since "poorly" bears some, albeit little, similarity to the host tissue, while "undifferentiated" has none, e.g., Undifferentiated carcinoma).
3. Four levels of similarity; also called a four-grade system. The four-grade system describes the tumor as:
    a. Grade I; also called well-differentiated
    b. Grade II; also called moderately differentiated
    c. Grade III; also called poorly differentiated
    d. Grade IV; also called undifferentiated or anaplastic

Breast and prostate grades may convert differently than other sites. These exceptions are noted in "Coding for Solid Tumors", #7-8 below.

Coding for Solid Tumors

1. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code grade based on information prior to neoadjuvant therapy even if grade is unknown. If there is no pathology report prior to neoadjuvant treatment, assign code 9.

2. Code the grade from the primary tumor only.
   a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site.
   b. If primary site is unknown, code grade to 9.

3. Code the grade shown below (6th digit) for specific histologic terms that imply a grade.
   Carcinoma, undifferentiated (8020/34)
   Carcinoma, anaplastic (8021/34)
   Follicular adenocarcinoma, well differentiated (8331/31)
   Thymic carcinoma, well differentiated (8585/31)
   Sertoli-Leydig cell tumor, poorly differentiated (8631/33)
   Sertoli-Leydig cell tumor, poorly differentiated with heterologous elements (8634/33)
   Undifferentiated sarcoma (8805/34)
   Liposarcoma, well differentiated (8851/31)
   Seminoma, anaplastic (9062/34)
   Malignant teratoma, undifferentiated (9082/34)
   Malignant teratoma, intermediate type (9083/32)
   Intraosseous osteosarcoma, well differentiated (9187/31)
   Astrocytoma, anaplastic (9401/34)
   Oligodendroglioma, anaplastic (9451/34)
   Retinoblastoma, differentiated (9511/34)
   Retinoblastoma, undifferentiated (9512/34)

4. In situ and/or combined in situ/invasive components:
   a. If a grade is given for an in situ tumor, code it. Do NOT code grade for dysplasia such as high grade dysplasia.
   b. If there are both in situ and invasive components, code the grade for the invasive portion even if its grade is unknown. If the invasive component grade is unknown, then code 9.

   There are several diagnoses that usually do not have a statement as to the tumor grade, therefore the tumor grade is coded as "9 - Unknown." However, if a tumor grade is specified by a pathologist for any of these diagnoses, it MUST be coded accordingly. These diagnoses are as follows:

   In-situ lesions (any site)
   Lobular carcinoma of the breast
   Malignant melanoma of the skin
   Multiple myeloma (bone marrow)
   Unknown primary site

5. If there is more than one grade, code the highest grade within the applicable system. Code the highest grade even if it is only a focus (ICD-O-3 Rule G, ICD-O-3 code book, p. 21).

   Examples Moderate to poorly differentiated carcinoma.
   Code the tumor grade as: 3 - poorly differentiated

Predominately grade II, focally grade III.
Code the tumor grade as: 3 - poorly differentiated

If a needle biopsy or incisional biopsy of a primary site has a differentiation given and the excision or resection does NOT, code the grade from the biopsy or incisional biopsy.

Example Biopsy of sigmoid colon: poorly differentiated adenocarcinoma. Sigmoidectomy: adenocarcinoma invading the pericolonic tissue.
Code the tumor grade as: 3 - poorly differentiated

When there is no tissue diagnosis, it may be possible to establish grade through magnetic resonance imaging (MRI) or positron emission tomography (PET). When available, code grade based on the recorded findings from these imaging reports.

Example MRI of the brain indicated as mass in the temporal lobe. Suspect anaplastic astrocytoma, recommend biopsy.
Code the tumor grade as: 4 - anaplastic

A tumor grade will often be described using a slash (/) or a dash (-). The slash describes a specific grading system and the dash describes a range. Code the tumor grade using the slash according to the grading system. Code the tumor grade using the dash to the numerically higher grade code described.

Examples Mucinous adenocarcinoma of the rectum, Grade 1/2.
Code the tumor grade as: 2 - low grade

Transitional cell carcinoma of the bladder, Grade 1-2/3.
Code the tumor grade as: 3 - poorly differentiated

Large cell carcinoma of the lung, Grade 2-3/4
Code the tumor grade as: 3 - poorly differentiated

Code grade in the following priority order using the first applicable system:
a. special grade systems for the sites listed in Coding for Solid Tumors #6
b. differentiation: use Coding for Solid Tumors #7: 2-, 3-, or 4-grade system
c. nuclear grade: use Coding for Solid Tumors #7: 2-, 3-, or 4-grade system
d. If it isn't clear whether it is a differentiation or nuclear grade and a 2-, 3-, or 4-grade system was used, code it.
e. Terminology (use Coding for Solid Tumors #8)

FIGO Stage/Grade
DO NOT code FIGO stage/grade as a tumor grade. FIGO stage is based on the percentage of non-squamous portions of the tumor and corresponds roughly to a three grade differentiation system. For a diagnosis that includes a term and a FIGO stage, such as "moderately differentiated, FIGO grade II," disregard the FIGO grade and code according to the term "moderately differentiated."

6. Use the information from the special grade systems first. If no special grade can be coded, continue with Coding for Solid Tumors #7-9.
Special grade systems for solid tumors
Grade information based on CS Site-specific factors for breast, prostate, heart, mediastinum, peritoneum, retroperitoneum, soft tissue, and kidney parenchyma is used to code grade See

Special Grade System Rules section below for details on how to use this information to code grade.

CS Schema	Special Grade System
Breast	Nottingham or Bloom-Richardson (BR) Score/Grade (SSF 7)
Prostate	Gleason's Score on Needle Core Biopsy/Transurethral Resection of Prostate (TURP) (SSF 8)
Prostate	Gleason's Score on Prostatectomy/Autopsy (SSF 10)
Heart, Mediastinum	Grade for Sarcomas (SSF 1)
Peritoneum	Grade for Sarcomas (SSF 1)
Retroperitoneum	Grade for Sarcomas (SSF 1)
Soft Tissue	Grade for Sarcomas (SSF 1)
Kidney Parenchyma	Fuhrman Nuclear Grade (SSF 6)

Do not use these tables to code grade for any other groups including WHO (CNS tumors), WHO/ISUP (bladder, renal pelvis), or FIGO (female gynecologic sites) grades.

7. Use the Two-, Three- or Four-grade system information
   a. Two-grade system

Term	Description	Grade Code	Exception for Breast and Prostate Grade Code
1/2, I/II	Low grade	2	1
2/2, II/II	High grade	4	3

In transitional cell carcinoma for bladder, the terminology high grade TCC and low grade TCC are coded in the two-grade system.

   b. Three-grade system

Term	Description	Grade Code	Exception for Breast and Prostate Grade Code
1/3	Low grade	2	1
2/3	Intermediate grade	3	2
3/3	High grade	4	3

Example Adenocarcinoma of the sigmoid colon. Grade 2 of 3.
Code the tumor grade as: 3

   c. Four-grade system: Any four-grade system including Edmondson and Steiner grade for liver.

Term	Description	Grade Code
1/4	Grade I; Well differentiated	1
2/4	Grade II; Moderately differentiated	2
3/4	Grade III; Poorly differentiated	3
4/4	Grade IV; Undifferentiated	4

Example Squamous cell carcinoma, Grade 3/4 of the distal esophagus.
Code the tumor grade as: 3 - poorly differentiated

8. Terminology: use the "Description" column or the "Grade" column to code grade. Breast and Prostate use the same grade code with a few noted exceptions.

Description	Grade	Assign Grade Code	Exception for Breast and Prostate Grade Code
Differentiated, NOS	I	1	
Well differentiated	I	1	
Only stated as "Grade I"	I	1	
Fairly well differentiated	II	2	
Intermediate differentiation	II	2	
Low grade	I-II	2	1
Mid differentiated	II	2	
Moderately differentiated	II	2	
Moderately well differentiated	II	2	
Partially differentiated	II	2	
Partially well differentiated	I-II	2	1
Relatively or generally well differentiated	II	2	
Only stated as "Grade II"	II	2	
Medium grade, intermediate grade	II-III	3	2
Moderately poorly differentiated	III	3	
Moderately undifferentiated	III	3	
Poorly differentiated	III	3	
Relatively poorly differentiated	III	3	
Relatively undifferentiated	III	3	
Slightly differentiated	III	3	
Dedifferentiated	III	3	
Only stated as "Grade III"	III	3	
High grade	III-IV	4	3
Undifferentiated, anaplastic, not differentiated	IV	4	
Only stated as "Grade IV"	IV	4	
Non-high grade		9	

9. If no description fits or grade is unknown prior to neoadjuvant therapy, code as a 9 (unknown).

SPECIAL GRADE SYSTEMS RULES

Breast (site: breast excluding lymphomas; CS schema: breast)

Use Bloom Richardson (BR) or Nottingham score/grade to code grade based on CSv2 site-specific factor 7 (SSF) as stated below. If your registry does not collect this SSF, use the description in the table below to determine grade. If you collect this SSF, codes 030-130 could be automatically converted into the grade field.

BR could also be referred to as: Bloom-Richardson, modified Bloom-Richardson, BR, BR grading, Scarff-Bloom-Richardson, SBR grading, Elston-Ellis modification of Bloom-Richardson score, Nottingham modification of Bloom-Richardson score, Nottingham modification of Scarff-Bloom-Richardson, Nottingham-Tenovus grade, or Nottingham grade.

Code the tumor grade using the following priority order

a. BR scores 3-9
b. BR grade (low, intermediate, high)

BR score may be expressed as a range, 3-9. The score is based on three morphologic features: degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism/nuclear grade of tumor cells. If a report uses words such as low, intermediate, or high rather than numbers, use the table below to code grade.

If only a grade of 1 through 4 is given with no information on the score and it is unclear if it is a Nottingham or BR Grade, do not use the table below. Continue with the next priority according to "Coding for Solid Tumors" #7 above.

Code the highest score if multiple scores are reported (exclude scores from tests after neoadjuvant therapy began). Examples: different scores may be reported on multiple pathology reports for the same primary cancer; different scores may be reported for multiple tumors assigned to the same primary cancer.

CS Site-Specific Factor 7: Nottingham or Bloom-Richardson (BR) Score/Grade

Description	CS Code	Grade Code
Score of 3	030	1
Score of 4	040	1
Score of 5	050	1
Score of 6	060	2
Score of 7	070	2
Score of 8	080	3
Score of 9	090	3
Low Grade, Bloom-Richardson (BR) grade 1, score not given	110	1
Medium (Intermediate) Grade, BR grade 2, score not given	120	2
High Grade, BR grade 3, score not given	130	3

Examples Ductal carcinoma of the breast, Bloom-Richardson 3 + 2 + 4 = 9.
Code the tumor grade as:3 - poorly differentiated

Ductal adenocarcinoma of the breast, Bloom-Richardson, low grade.
Code the tumor grade as:1 - well differentiated

Kidney Parenchyma (site: kidney parenchyma excluding lymphomas; CS schema: KidneyParenchyma): Fuhrman Nuclear Grade

The Fuhrman Nuclear Grade should be used to code grade for kidney parenchyma only based on CSv2 SSF 6 as stated below. Do not use for kidney renal pelvis. If your registry does not collect this SSF, use the description in the table to determine grade. If you collect this SSF, the information could be automatically converted into the grade field if it is coded 010-040. Fuhrman nuclear grade is a four-grade system based on nuclear diameter and shape, the prominence of nucleoli, and the presence of chromatin clumping in the highest grade.

Description	CS Code	Grade Code
Grade 1	010	1
Grade 2	020	2
Grade 3	030	3
Grade 4	040	4

SoftTissue (sites exluding lymphomas: soft tissue, heart, mediastinum, peritoneum, and retroperitoneum; for CS users: SoftTissue, HeartMediastinum, Peritoneum, Retroperitoneum schemas): Grade for Sarcomas

The Grade for Sarcomas should be used to code grade based on CSv2 SSF 1 as stated below. If your registry does not collect this SSF, use the description in the table to determine grade. If you collect this SSF, the information could be automatically converted into the grade field if it is coded 010-200. The grading system of the French Federation of Cancer Centers Sarcoma Group (FNCLCC) is the preferred system.

Record the grade from any three-grade sarcoma grading system the pathologist uses. For terms such as "well differentiated" or "poorly differentiated," go to Coding for Solid Tumors #8.

In some cases, especially for needle biopsies, grade may be specified only as "low grade" or "high grade." The numeric grade takes precedence over "low grade" or high grade."

Description	CS Code	Grade Code
Specified as Grade 1 [of 3]	010	2
Specified as Grade 2 [of 3]	020	3
Specified as Grade 3 [of 3]	030	4
Grade stated as low grade, NOS	100	2
Grade stated as high grade, NOS	200	4

Prostate (site: prostate excluding lymphomas; CS schema: prostate)

Use the highest Gleason score from the biopsy/TURP or prostatectomy/autopsy. Use a known value over an unknown value. Exclude results from tests performed after neoadjuvant therapy began. This information is collected in CSv2 SSF 8 (Gleason score from biopsy/TURP) and SSF 10 (Gleason score from prostatectomy/ autopsy) as stated below. Use the table below to determine grade even if your registry does not collect these SSFs. If you collect these SSFs, the information could be converted into the grade field automatically.

Usually prostate cancers are graded using Gleason score or pattern. Gleason grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason grade, and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10. If there are two numbers, assume that they refer to two patterns (the first number being the primary pattern and the second number the secondary pattern), and sum them to obtain the score. If only one number is given on a particular test and it is less than or equal to 5 and not specified as a score, do not use the information because it could refer to either a score or a grade. If only one number is given and it is greater than 5, assume that it is a score and use it. If the pathology report specifies a specific number out of a total of 10, the first number given is the score. Example: The pathology report says Gleason 3/10. The Gleason score would be 3.

Gleason score	CS Code	Grade Code	Description
2	002	1	Well differentiated
3	003	1	Well differentiated
4	004	1	Well differentiated
5	005	2	Moderately differentiated
6	006	2	Moderately differentiated
7	007	2	Moderately differentiated
8	008	3	Poorly differentiated

Gleason score	CS Code	Grade Code	Description
9	009	3	Poorly differentiated
10	010	3	Poorly differentiated

Examples Adenocarcinoma of the prostate, Gleason 4 + 5 = 9.
Code the tumor grade as: 3 - poorly differentiated

Adenocarcinoma of the prostate, Gleason 3/10.
Code the tumor grade as: 1 - well differentiated

Malignant Brain and Spinal Cord

Oftentimes, brain and spinal cord diagnoses are assigned a WHO (World Health Organization) grade. This type of grading is NOT the same as the ICD-O differentiation or tumor grade code. The WHO grading system is used to estimate prognosis and is for the purpose of staging.

If the ICD-O grade or differentiation code is used for central nervous system tumors, coders should give preference to terms from the diagnosis - such as low grade (Code 2) or anaplastic (Code 4) - rather than using the reported WHO grade. In many cases, there will be no verbal description of the grade and these cases must be coded as
"9 - Unknown" for the ICD-O grade/differentiation.

In the absence of other information on grade, code cases as follows:

Description	Code
Astrocytoma grade 1	1
Astrocytoma grade 2 Astrocytoma (low grade)	2
Astrocytoma grade 3	3
Astrocytoma grade 4 Anaplastic astrocytoma	4
Glioblastoma multiforme (grade unspecified) Pilocytic astrocytoma (grade unspecified) Astrocytoma, NOS (grade unspecified)	9

Examples Glioblastoma multiforme of the frontal lobe, WHO grade 3.
Code the tumor grade as: 9 – unknown

Anaplastic astrocytoma of the cerebellum.
Code the tumor grade as: 4 – anaplastic

Low grade astrocytoma of the cerebrum.
Code the tumor grade as: 2 - low grade

Benign/Borderline Brain and CNS
The tumor grade for benign/borderline intracranial and CNS tumors is ALWAYS coded as a "9 – not determined, not stated or not applicable." DO NOT record the World Health Organization (WHO) grade in the sixth digit of the histology code.

The World Health Organization (WHO) grade should be recorded in site specific factor 1 of the Collaborative Stage Data Collection System Manual. Attention must be paid to the preservation of histologic grade, which will continue to be collected as the histology sixth digit "Grade."

For additional information review the "Grade, Differentiation or Cell Indicator" section of the SEER Program Coding and Staging Manual http://seer.cancer.gov/manuals/2015/SPCSM_2015_maindoc.pdf.

Item: HISTOLOGIC TYPE ICD-O-3 **NAACCR Item 522**

Alternate Name: ICD-O-3 Histology

Codes for the histologic type of the tumor being reported using ICD-O-3. This data item is required by all standard-setting organizations for tumors diagnosed on or after January 1, 2001, and recommended (by conversion from ICD-O-2 codes when conversion algorithms and tables are available) for tumors diagnosed before 2001.

See full histology coding instructions in current FORDS manual
https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals/fordsmanual

The Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual apply to only those **non-solid tumor cases diagnosed January 1, 2010 and forward.** The ICD-O-3 coding book is obsolete for coding non-solid tumors after this date. Use the Hematopoietic and Lymphoid Neoplasm Database and Coding Manual to assign the histology code http://seer.cancer.gov/tools/heme/

Item: LABORATORY REPORT NUMBER **State-specific Item 9507**

If a case has been assigned a laboratory record number or pathology report specimen number, enter that number.

This number can be alphanumeric. If more than one laboratory record number has been assigned to the case, enter the number which most closely corresponds with the initial diagnosis of the primary tumor being reported.

If no laboratory number exists, enter "none."

If not reporting, leave the item blank.

Item: LATERALITY **NAACCR Item 410**

Alternate Name: Laterality at Diagnosis

Laterality (paired organs) refers to a specific side of the body or lobe of an organ. In the case of paired or bilateral organs, it is important to indicate whether the primary site of the tumor is the right organ, the left organ, or bilateral involvement. Laterality refers to the primary site only; DO NOT code the laterality of the metastatic site(s).

If the primary site is reported as "unknown primary site," code the laterality to "0 - not a paired site."

If the primary site being reported is NOT defined as a paired site, laterality must be coded as "0 – not a paired site" **regardless of facility type.**

Codes are as follows:

0 Not a paired site
1 Right: origin of primary
2 Left: origin of primary

3 Only one side involved, right or left origin unspecified
4 Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5 Paired site: midline tumor *
9 Paired site, but no information concerning laterality
* "Midline" in this context refers to the point where the "right" and "left" sides of paired organs come into direct contact and a tumor forms at that point. Most paired sites cannot develop midline tumors. Code 5 - Midline is an allowable value for the following sites only: C700, C710-C714, C722-C725, C443, and C445.

Laterality MUST be recorded for the following paired organs as 1-5 or 9.

Use code "3 - One side only, NOS" if the laterality is not known but the tumor is confined to a single side of a paired organ.

Examples The pathology report states that the "patient has a 2 cm carcinoma in the upper pole of the kidney."
Code laterality as"3 - One side only, NOS" because laterality is not specified but the tumor is not present on both sides of a paired site.

Admitting history states that the patient has a positive, sputum cytology but is being treated with radiation for painful bony metastases.
Code laterality as "9 - Unknown," because there is no information concerning laterality in the implied diagnosis of lung cancer and the case is metastatic.

Patient has a melanoma of skin just above the umbilicus.
Code laterality as "5 - Midline."

The skin of the lip, scalp and neck is NOT considered a paired organ, laterality for these subcategories is coded as "0 - Not a paired site."

If reporting the primary site of the skin as "skin, NOS (C44.9)" the laterality is coded as "0 - Not a paired site."

NOTE 1: The prostate and thyroid are made up of lobes, which are represented by left and right - DO NOT code as a paired organ.

NOTE 2: The description of right colon and left colon does NOT apply to laterality, but to the exact location (sub-site) of the tumor origin in the colon. Code right colon to ascending colon (C18.2) and the left colon to descending colon (C18.6). DO NOT code as a paired organ.

Paired Organs Requiring Laterality Codes	
Primary Site Description	**Topography Code**
Acoustic nerve (excluding diagnoses prior to 2004)	C72.4
Adrenal gland	C74.0 – C74.9
Breast	C50.0 - C50.9
Carotid body	C75.4
Cerebral meninges, NOS (excluding diagnoses prior to 2004)	C70.0
Cerebrum (excluding diagnoses prior to 2004)	C71.0
Connective, subcutaneous and other soft tissue of upper limb and shoulder	C49.1
Connective, subcutaneous, and other soft tissue of lower limb and hip	C49.2
Cranial Nerve, NOS (excluding diagnoses prior to 2004)	C72.5

Paired Organs Requiring Laterality Codes	
Primary Site Description	**Topography Code**
Epididymis	C63.0
Eye and lacrimal gland	C69.0 – C69.9
Fallopian tube	C57.0
Frontal lobe (excluding diagnoses prior to 2004)	C71.1
Frontal sinus	C31.2
Kidney, NOS	C64.9
Long bones of lower limb and associated joints	C40.2
Long bones of upper limb, scapula and associated joints	C40.0
Lung	C34.1 – C34.9
Main bronchus (excluding carina code 0)	C34.0
Maxillary sinus	C31.0
Middle ear	C30.1
Nasal cavity (excluding nasal cartilage and nasal septum code 0)	C30.0
Occipital lobe (excluding diagnoses prior to 2004)	C71.4
Olfactory nerve (excluding diagnoses prior to 2004)	C72.2
Optic nerve (excluding diagnoses prior to 2004)	C72.3
Ovary	C56.9
Parietal lobe (excluding diagnoses prior to 2004)	C71.3
Parotid gland	C07.9
Pelvic bones (excluding sacrum, coccyx and symphysis pubis, code “0’)	C41.4
Peripheral nerves and autonomic nervous system of lower limb and hip	C47.2
Peripheral nerves and autonomic nervous system of upper limb and shoulder	C47.1
Pleura	C38.4
Renal pelvis	C65.9
Rib and clavicle (excluding sternum code 0)	C41.3
Short bones of lower limb and associated joints	C40.3
Short bones of upper limb and associated joints	C40.1
Skin of external ear	C44.2
Skin of eyelid	C44.1
Skin of lower limb and hip	C44.7
Skin of other unspecified parts of face (midline code 5)	C44.3
Skin of trunk (midline code 5)	C44.5
Skin of upper limb and shoulder	C44.6
Spermatic cord	C63.1
Sublingual gland	C08.1
Submandibular gland	C08.0
Temporal lobe (excluding diagnoses prior to 2004)	C71.2
Testis	C62.0 – C62.9
Tonsil, NOS (faucial tonsil, palatine tonsil)	C09.9
Tonsil, overlapping lesion	C09.8
Tonsillar fossa	C09.0
Tonsillar pillar	C09.1
Ureter	C66.9

For a standalone list of allowable laterality codes by primary site code and description, download “MCSP Laterality Codes by Primary Site” from the MCSP website http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5221-16586--,00.html.

Item: LYMPH-VASCULAR INVASION — NAACCR Item 1182

This field records the absence or presence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist. The presence of lymph-vascular invasion may affect the patient's prognosis.

Code	Description
0	Lymph-vascular invasion not present (absent)/Not identified
1	Lymph-vascular invasion present/Identified
8	Not applicable
9	Unknown if lymph-vascular invasion present; Indeterminate

Lymph-vascular invasion is defined as the presence of tumor cells found inside small blood vessels or lymphatic channels within the tumor and surrounding tissues in the primary site. The tumor cells have broken free of the primary tumor and now have the capability to float throughout the body. Other names for lymph-vascular invasion are LVI, lymphovascular invasion, vascular invasion, blood vessel invasion, and lymphatic invasion. Vascular invasion is not the same as direct tumor extension from the primary tumor into adjacent blood vessels; LVI cells are not attached to or growing into the wall of the blood vessel. Lymphatic invasion is not the same as involvement of regional lymph nodes. Lymph-vascular invasion does not include perineural invasion.

1. Code from pathology report(s). Code the absence or presence of lymph-vascular invasion as described in the medical record.
   a. The primary sources of information about lymph-vascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from the pathology report or a physician's statement, in that order.

   b. Do not code perineural invasion in this field.

   c. Information to code this field can be taken from any specimen from the primary tumor.

   d. If lymph-vascular invasion is identified anywhere in the resected specimen, it should be coded as present/identified.

2. Use of codes.
   a. Use code 0 when the pathology report indicates that there is no lymph-vascular invasion. **This includes cases of purely in situ carcinoma,** which biologically have no access to lymphatic or vascular channels below the basement membrane.

   b. Use code 1 when the pathology report or a physician's statement indicates that lymph-vascular invasion (or one of its synonyms) is present in the specimen.

   c. Use code 8 for the following primary sites.
      Hodgkin and Non-Hodgkin lymphoma
      Leukemias
      Hematopoietic and reticuloendothelial disorders
      Myelodysplastic syndromes including refractory anemias and refractory cytopenias
      Myeloproliferative disorders

   d. Use code 9 when
      i. There is no microscopic examination of a primary tissue specimen

ii. The primary site specimen is cytology only or a fine needle aspiration
iii. The biopsy is only a very small tissue sample
iv. It is not possible to determine whether lymph-vascular invasion is present
v. The pathologist indicates the specimen is insufficient to determine lymph-vascular invasion
vi. Lymph-vascular invasion is not mentioned in the pathology report

Item: MARITAL STATUS AT DX **NAACCR Item 150**

Alternate Name: Marital Status at Diagnosis

Enter the marital status of the patient at time of diagnosis. The codes are as follows:

1 Single (never married)
2 Married (including common law)
3 Separated
4 Divorced
5 Widowed
6 Unmarried or Domestic Partner
9 Unknown

NOTE: If the patient has multiple tumors, the Marital Status may be different for each tumor.

Do not leave this data item blank.

Item: MEDICAL RECORD NUMBER **NAACCR Item 2300**

If the patient has been assigned a medical record number, enter that number.

If your hospital registry abstracts cases for another hospital, it should have a system that identifies the facility associated to the patient. This can be done by assigning a unique suffix or a prefix number to correspond with each facility and by communicating the system to the state registry staff. If no medical record number exists for the patient, enter "none."

Item: METS AT DX-BONE **NAACCR Item 1112**

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.

Codes

0 - None; no bone metastases
1 - Yes; distant bone metastases
8 - Not applicable
9 - Unknown whether bone is an involved metastatic site. Not documented in patient record.

Item: METS AT DX-BRAIN **NAACCR Item 1113**

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.

Codes

0 - None; no brain metastases
1 - Yes; distant brain metastases

2 - Not applicable
9 - Unknown whether brain is involved metastatic site. Not documented in patient record.

Item: METS AT DX-DISTANT LN **NAACCR Item 1114**

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.

Codes
0 - None; no distant lymph node metastases
1 - Yes; distant lymph node metastases
8 - Not applicable
9 - Unknown whether distant lymph node(s) are involved metastatic site. Not documented in patient record.

Item: METS AT DX-LIVER **NAACCR Item 1115**

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.

Codes
0 - None; no liver metastases
1 - Yes; distant liver metastases
8 - Not applicable
9 - Unknown whether liver is involved metastatic site. Not documented in patient record.

Item: METS AT DX-LUNG **NAACCR Item 1116**

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.

Codes
0 - None; no lung metastases
1 - Yes; distant lung metastases
8 - Not applicable
9 - Unknown whether lung is involved metastatic site. Not documented in patient record.

Item: METS AT DX-OTHER **NAACCR Item 1117**

This field identifies whether other metastatic involvement, other than bone, brain, liver, lung or distant lymph nodes exists. Some examples include but are not limited to the adrenal gland, bone marrow, pleura, peritoneum and skin. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Codes
0 - None; no other metastases
1 - Yes; distant metastases in known site(s) other than bone, brain, liver, lung or distant lymph nodes
8 - Not applicable
9 - Unknown whether any other metastatic site. Not documented in patient record.

Item: MICHIGAN FACILITY NUMBER **State-specific Item 9508**

Enter the Michigan Facility Number that has been assigned to your institution by the Michigan Cancer Surveillance Program.

If you do not know your Michigan Facility Number, contact your field representative.

Item: NAME--ALIAS **NAACCR Item 2280**

Alternate Name: Alias

Enter the alternate name or "AKA" (also known as) used by the patient. Note that maiden name is entered in Maiden Name field.

If unknown or not reporting, press Enter to move to the next field

Item: NAME--FIRST **NAACCR Item 2240**

Alternate Name: First Name

Type the legal First Name of the patient. Truncate if more than 40 letters long, but do not abbreviate, i.e., do not use "Robt" for "Robert." Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation. Do not use nicknames in this field; nicknames should be used in Alias Name field only.

If the patient's first name is not available, type Unknown.

This field may be updated, if the first name changes. For information on how to submit corrections, refer to "Submitting Corrections" in the MCSP Cancer Reporting Manual.

Do not leave this data item blank.

Item: NAME--LAST **NAACCR Item 2230**

Alternate Name: Last Name

Type the legal Last Name of the patient. Truncate name if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed. Include Jr. or Sr. with the last name when applicable.

If the last name is not available, type Unknown.

This field may be updated, if the last name changes. For information on how to submit corrections, refer to "Submitting Corrections" in the MCSP Cancer Reporting Manual.

Do not leave this data item blank.

Item: NAME--MAIDEN **NAACCR Item 2390**

Alternate Name: Maiden Name

Enter the Maiden Name of female patients who are or have been married. Do not abbreviate. Leave this item blank if it is not appropriate for the patient being reported, or is not available in the records, or when not reporting this item.

Item: NAME--MIDDLE **NAACCR Item 2250**

Alternate Name: Middle Name

Type the legal Middle Name or Middle Initial of the patient. If only an initial is available for the middle name, enter the initial. Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation. If no middle name or initial, leave field blank.

For information on how to submit corrections, refer to "Submitting Corrections" in the MCSP Cancer Reporting Manual.

Item: PLACE OF DEATH--COUNTRY **NAACCR Item 1944**

Enter the name or code for the country where the patient expired. If the country is the United States, enter "USA."

If the patient has multiple primaries, the Place of Death - Country is the same for each tumor.

If the information is unknown or unreported in the patient's record, enter "ZZU" or "Unknown."

If the patient is still alive, leave this field BLANK.

ISO alpha-3 Country Codes can be found at the back of this manual or refer to Appendix B of the SEER Program Code Manual at seer.cancer.gov/tools/codingmanuals/index.html

Item: PLACE OF DEATH--STATE **NAACCR Item 1942**

Enter the USPS abbreviation for the state, commonwealth, U.S. possession; or CanadaPost abbreviation for the Canadian province/territory in which the patient expired. For example, if the state in which the patient expired is Michigan, use "MI."

If the patient has multiple primaries, the Place of Death - State is the same for each tumor.

If the information is unknown or unreported in the patient's record, enter "ZZ" or "Unknown."

If the patient is still alive, leave this field BLANK.

A complete list of state, territory, commonwealth, U.S. possession, or Canadian province or territory codes can be found at the back of this manual, or refer to Appendix B of the SEER Program Code Manual at seer.cancer.gov/tools/codingmanuals/index.html

Item: PRIMARY PAYER AT DX **NAACCR Item 630**

Alternate Name: Primary Payer at Diagnosis

Enter primary payer/insurance carrier **at the time of initial diagnosis** at the reporting facility. If the patient is diagnosed elsewhere or the payer at the time of diagnosis is not known, record the payer when the patient is initially admitted for treatment.

Record the type of insurance reported on the patient's admission page.

Codes 21 and 65–68 are to be used for patients diagnosed on or after January 1, 2006.

If more than one payer or insurance carrier is listed on the patient's admission page, record the first.

Do not change the initially recorded code if the patient's payer or insurance carrier changes, or if an initially uninsured patient subsequently acquires health insurance.

Example At time of diagnosis, patient is not covered by insurance. A week later, the patient becomes eligible for Medicaid. *Code data item "01 – Not insured".*

Do NOT update the Primary Payer at DX code for a particular primary tumor; however, multiple primaries may have different codes depending upon the insurance in effect at time of diagnosis.

Do not leave this data item blank. If the Insurance status is unknown or not reporting, enter "Unknown" or 99.

Codes are as follows:

01 Not insured
02 Not insured, self-pay
10 Insurance, NOS
20 Private Insurance: Managed care, HMO, or PPO
21 Private Insurance: Fee-for-Service
31 Medicaid
35 Medicaid Administered through a Managed Care plan
60 Medicare/Medicare, NOS
61 Medicare with supplement, NOS
62 Medicare Administered through a Managed Care plan
63 Medicare with private supplement
64 Medicare with Medicaid eligibility
65 TRICARE
66 Military
67 Veterans Affairs
68 Indian/Public Health Service
99 Insurance status unknown

Item: PRIMARY SITE **NAACCR Item 400**

Enter the primary anatomical site where the cancer began or originated. Include description of tumor origin or primary site. For example: C34.1 = upper lobe lung

For solid tumors: Use the International Classification of Diseases for Oncology, Third Edition (ICD-O-3) coding book to assign the topography code or primary site.

For non-solid tumors: Use the Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual at http://seer.cancer.gov/tools/heme/ to assist with coding these primaries. These references apply only to cases diagnosed January 1, 2010 and forward.

The primary site can be located on the pathology report, history and physical examination, discharge summary, operative report, x-rays and scans.

Be as specific as possible, as many organs can be sub-divided into specific segments.

Example The pathology report indicates the tumor originated in the ascending colon.
The primary site should be recorded as C18.2, ascending colon and NOT C18.9, colon, NOS.

For leukemia and multiple myeloma, enter the primary site as bone marrow (C42.1).

Record the primary anatomical site where the cancer began or originated. If multiple primary tumors are diagnosed, complete a separate cancer report form for each primary site.

Examples Bilateral mammogram impression: Development of a 1cm irregularly marginated and slightly spiculated mass in the upper outer quadrant of the right breast, surgical consultation recommended. Right breast mastectomy: "Infiltrating moderately differentiated ductal cell carcinoma."
Record the primary site as reported in the mammogram as "breast, UOQ (C50.4)."

Operative report, right colectomy: Gross description revealed a tan-pink mass 2.5cm in size located at approximately 52cm, in the sigmoid colon. Right colectomy: "Infiltrating poorly differentiated mucinous producing adenocarcinoma."
Record the primary site as reported in the operative report as "sigmoid colon (C18.7)" or "colon, 52cm."

Do NOT report the metastatic site as the primary site. After investigation, if the primary site cannot be determined record/code the primary site as "unknown primary site (C80.9)."

Examples Fine needle aspiration (FNA) of the liver: "Metastatic adenocarcinoma, possible primary sites to consider include the colon, breast and lung." Discharge summary: Liver consistent with metastatic adenocarcinoma, primary site not determined.
Record the primary site as "unknown primary site (C80.9)."

Left upper lobe bronchoscopy: "Metastatic adenocarcinoma, consistent with breast primary." Subsequently a bilateral mammogram was performed and revealed a poorly defined lesion in the lower outer quadrant of the left breast, suspicious for malignancy. Discharge summary: Metastatic adenocarcinoma of the lung, consistent with breast primary.
Record the primary site as "breast, LOQ (C50.5)."

It is important to be as specific as possible when recording the primary site. Many organs can be sub-divided into specific segments.

Example The pathology report indicates adenocarcinoma of the left upper lobe, lung.
Record the primary site as "lung, upper lobe (C34.1)."

When recording the primary site, following are examples of sites to be sub-divided. (These are not all the primary sites that can be sub-divided - just a few).

Breast

Nipple (areola) (C50.0)
Central portion (subareolar, retroareolar) (C50.1)
Axillary tail (C50.6)
Inner/outer/lower/upper breast, midline (overlapping lesion) (C50.8)

Right Side	Left Side
Upper-inner quadrant (UIQ) (C50.2) (12:00 o'clock to 3:00 o'clock)	Upper-inner quadrant (UIQ) (C50.2) (9:00 o'clock to 12:00 o'clock)
Lower-inner quadrant (LIQ) (C50.3) (3:00 o'clock to 6:00 o'clock	Lower-inner quadrant (LIQ) (C50.3) (6:00 o'clock to 9:00 o'clock)
Upper-outer quadrant (UOQ) (C50.4) (9:00 o'clock to 12:00 o'clock)	Upper-outer quadrant (UOQ) (C50.4) (12:00 o'clock to 3:00 o'clock)

Right Side	Left Side
Lower-outer quadrant (LOQ) (C50.5) (6:00 o'clock to 9:00 o'clock)	Lower-outer quadrant (LOQ) (C50.5) (3:00 o'clock to 6:00 o'clock)

NOTE 1: If the pathology report indicates that the mass is located at the 12:00, 3:00, 6:00 or 9:00 position, consider the lesion to be overlapping and code to "breast, overlapping lesion (C50.8)."

NOTE 2: If the exact location of the mass is not reported in the operative or pathology report, review the mammogram and/or history and physical examination report for the specific location.

Esophagus (C15.0 - C15.9)
The esophagus is a muscular tube about ten inches (25 cm) long extending from the hypopharynx to the stomach. The location of esophageal lesions is frequently measured from the incisors (front teeth) and may be
approximated as follows.

Primary Site	Topography Code
Cervical - begins at the lower border of the cricoid cartilage and ends at the thoracic inlet (suprasternal notch) approximately 18 cm measuring from the upper incisors	C15.0
Upper thoracic - extends from the thoracic inlet to the level of the tracheal bifurcation, approximately 24 cm from the upper incisors	C15.1
Mid thoracic - proximal half of the esophagus between the tracheal bifurcation and the esophago-gastric junction. The lower level is approximately 32 cm from the upper incisor teeth	C15.2
Upper third (proximal) - extends from the sixth cervical vertebra to the sixth thoracic vertebra	C15.3
Middle third - extends from the sixth thoracic vertebra to the ninth thoracic vertebra	C15.4
Lower third (distal) - extends from the ninth thoracic vertebra to the cardioesophageal junction	C15.5

Stomach (C16.0 - C16.9)
The stomach lies just below the diaphragm in the upper part of the abdominal cavity primarily to the left of the midline under a portion of the liver.

Primary Site	Topography Code
Cardia - portion of the stomach surrounding the cardioesophageal junction, or cardiac orifice (the opening of the esophagus into the stomach)	C16.0
Fundus (or Fornix) – enlarged portion to the left and above the cardiac orifice	C16.1
Body (or Corpus) - central part of the stomach	C16.2
Pyloric antrum – between the body of the stomach and the pyloric canal	C16.3
Pylorus – distal section of stomach connecting to the duodenum (the beginning of the small intestine)	C16.4

Small Intestine (C17.0 - C17.9)

The small intestine is a tube measuring about 2.5 cm in diameter and over 20 feet (600 cm) in length coiled in loops which fills most of the abdominal cavity.

Primary Site	Topography Code
Duodenum - located just below the pyloric portion of the stomach and is about 25 cm long. The duodenum extends from the pyloric sphincter and becomes the jejunum where the tube turns forward and downward	C17.0
Jejunum - continues for over 200 cm and then becomes the ileum, although there is no demarcation between the two divisions	C17.1
Ileum - over 300 cm long and joins the large intestine at the ileocecal valve	C17.2

Large Intestine (C18.0 - C20.9)
The large intestine (colon, rectum and anus) is approximately five feet (150 cm) long with a diameter of about 6cm, decreasing towards the lower end. The measurements listed next to each sub-site are from the anal verge.

Primary Site	Measurement	Topography Code
Rectum - extends down to the anal canal	4 - 12 cm	C20.9
Rectosigmoid - upper part of the rectum, generally that above the peritoneal reflection	10 - 17 cm	C19.9
Sigmoid - joins the rectum at the rectosigmoid junction	17 - 57 cm	C18.7
Descending (left colon) - starts at the splenic flexure and passes downward until it turns towards the midline at the rim of the pelvis and continues downward to become the sigmoid colon	57 - 82 cm	C18.6
Transverse (middle colon) - begins at the hepatic flexure passing horizontally across the abdomen, below the liver and stomach and above the small intestine. On the left side of the abdomen near the spleen, the colon turns downward at the junction of the transverse and descending colon forming the splenic flexure	82 - 132 cm	C18.4
Ascending (right colon) - extends upward from the cecum on the right side of the abdomen to the under surface of the right lobe of the liver where it turns to the left forming the hepatic flexure	132 - 147 cm	C18.2
Cecum - large cul-de-sac at the lower end of the ascending colon (proximal to the entrance of the ileum into the colon; it comprises the first 5-7 cm of the large intestine)	at 150 cm	C18.0
Hepatic Flexure - connects ascending to transverse (lies under the right lobe of the liver near the duodenum)		C18.3
Splenic Flexure - connects transverse to descending (located near the spleen and tail of the pancreas)		C18.5
Anal Canal - constitutes the final 2.5cm of the digestive tract. It begins at the anorectal junction and ends at the anal verge where the anal tube turns outward to blend with the perianal skin		C21.1

Primary Site	Measurement	Topography Code
NOTE: Each individual's anatomic make-up is different, as such the measurements listed above should be used as a GUIDELINE only.		

Lung (C34.0 - C34.9)

Primary Site	Topography Code
Main bronchus (Carina, Hilar)	C34.0
Upper lobe (Apex, Lingual)	C34.1
Middle lobe (only the right lung has a middle lobe)	C34.2
Lower lobe	C34.3

Lymphoma
Refer to the Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual at http://seer.cancer.gov/tools/heme/ to assist with coding these primaries. These references apply only to cases diagnosed January 1, 2010 and forward.

Lymphomas are considered a systemic (generalized) disease in contrast to solid tumors, such as breast or stomach cancer. The majority of lymphomas arise in lymph nodes (C77.0 - C77.9) or lymphatic tissue, such as tonsils (C09._), spleen (C42.2), Waldeyer's Ring (C14.2), or thymus (C37.9). These are all called "nodal" lymphomas.

Lymphomas that arise from lymphatic cells in organs, such as stomach or intestine, are called extranodal or extralymphatic. The terms extranodal and extralymphatic are sometimes used interchangeably. Extranodal means that the lymphoma does not arise in a lymph node but may arise in one of the lymphatic tissues mentioned above. While extralymphatic means the lymphoma arises in a non-lymphatic organ or tissue. When referring to nodal versus extra nodal lymphomas, it is important to identify the primary site of the tumor, which may not be the site of the biopsy, the site of spread, or metastasis. For example, diffuse large B-cell lymphoma can be either a nodal or extranodal tumor depending on the primary site. The biopsy may be of a lymph node, but the bulk of the primary disease may be in a primary extranodal organ.

If the site of origin of the lymphoma is in the lymph nodes, record/code the primary site to that specific lymph node chain (C77.0 - C77.5).

Example A 60 year old female was seen with an enlarged left cervical lymph node that had been present for three months. History and physical examination revealed left cervical lymphadenopathy, and the remainder of examination is within normal limits. Excision of left cervical lymph node revealed: "diffuse large cell non-Hodgkin lymphoma." Staging work-up included a CT scan of the abdomen/pelvis and a bone marrow biopsy, both of which were negative for malignancy.
Record the primary site as "cervical lymph node (C77.0)."

If a lymphoma mass is identified as "retroperitoneal," "inguinal," "mediastinal," or "mesentery, " record/code the primary site that specific lymph node region/chain. For example, a retroperitoneal mass would be coded to retroperitoneal lymph nodes C77.2.

If a lymphoma involves multiple lymph node regions, record/code the primary site as "lymph nodes of multiple regions (C77.8)." DO NOT code a specific lymph node chain.

Example A 53 year old male relatively healthy and physically active recently noted fatigue and groin soreness. Physical examination revealed several small 1cm nodes in the supraclavicular and axillary areas and two larger 2cm firm inguinal lymph nodes. The rest of the exam was within normal limits. Supraclavicular lymph node biopsy was positive for "B-cell chronic lymphocytic lymphoma."
Record the primary site as "multiple lymph nodes (C77.8)."

NOTE: supraclavicular lymph node is C77.0; axillary lymph node is C77.3; inguinal lymph node is code C77.4. Each of the lymph nodes are in a different region, therefore the primary site code is C77.8 for multiple regions.

If a lymphoma arises in an extranodal site, record/code the site of origin, which may or may not be the site of the biopsy.

Example Abdominal exploration with biopsy, mass body of stomach: "mixed large and small cell non-Hodgkin lymphoma." CT abdomen: no lymphadenopathy.
Record the primary site as "body of stomach (C16.2)."

Code the primary site to lymph nodes, NOS (C77.9) when lymph node(s) are involved but no primary site/particular lymph node region is identified.

Code the primary site to bone marrow (C42.1) when lymphoma is **present only in the bone marrow.**

Example Bone marrow biopsy positive for "diffuse large cell non-Hodgkin lymphoma. CT scan impression: Retroperitoneal mass suspicious for malignancy.
Record the primary site as "retroperitoneal lymph nodes, (C77.2)."

Record/code mycosis fungoides and cutaneous lymphomas to the appropriate site of the skin (C44.0 - C44.9).

Example Patient presented with a large, raised mole on the back of the left arm. A biopsy revealed: mycosis fungoides. *Record the primary site as "skin, arm (C44.6).***"**

NOTE: The World Health Organization (WHO) diagnosis of "B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma" is coded as 9823/3, and cross-referenced to 9670/3, "malignant lymphoma, small B lymphocytic." Code to the following scenarios.

If this WHO term is diagnosed in blood or bone marrow, record/code the histology as *"B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma (9823/3)"* and record the primary site as "*bone marrow (C42.1)."*

If this WHO term is diagnosed in tissue, lymph nodes or any organ in combination with blood or bone marrow, record/code the histology as *"B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma,"* which is cross referenced to *"small B-Cell lymphocytic lymphoma (9670/3)"* and record the primary site to the *"specific lymph node chain (C77.0 -C77.9) or to the extranodal site of origin."*

Melanoma of the Skin (C44.0 - C44.9)
Each occurrence of melanoma of the skin is a NEW AND SEPARATE primary unless a physician states otherwise. If a patient is diagnosed with metastatic melanoma and the primary site is not identified, record as "*skin, NOS (C44.9)."*

Examples A 46 year old female presented in January 2012, with a skin biopsy positive for "malignant melanoma." Past medical history was positive for malignant melanoma of the right arm in July 2011. Pathology report impression: "skin, right arm positive for malignant melanoma." *Record as a new/separate primary "skin, arm (C44.6)."*

Wide excision skin of mid back: "metastatic malignant melanoma." Past medical history negative for malignant melanoma. Physical exam revealed scar of mid back from recent excision. Remainder of exam within normal limits, no other skin lesions identified. *Record the primary site as "skin, NOS (C44.9)."*

Code to skin, NOS (C44.9) if a patient is diagnosed with metastatic melanoma at the time of diagnosis and the primary site is not identified.

Kaposi Sarcoma
Code to the **site in which it arises.** If Kaposi sarcoma arises in the skin and another site simultaneously, code to skin (C44.9).

Leukemia (C42.1)
Code the primary site for leukemia as "bone marrow (C42.1)."

Multiple Myeloma (C42.1)
Code the primary site for multiple myeloma as "bone marrow (C42.1)."

Item: RACE (1-5) **NAACCR Item 160-164**

Enter the patient's race according to the documentation in the medical record.

NOTE: ALL tumors for the same patient should have the same race code(s).

If multi-racial, enter each race according to the documentation in the patient's chart, for a total of five races.

In general, race should be reported as American Indian, white, black, etc.

White includes Mexican, Puerto Rican, Cuban, and all other Caucasians.

If Asian, enter the national origin as Chinese, Vietnamese, Japanese, Hmong, etc.

Race is a required data item for all facilities regardless of the facility type. If the patient's race is not available in the medical record, it may be necessary to contact the physician's office.

If the patient is multiracial, code all races using Race 1 through Race 5. Code any subsequent unused Race fields as 88 (no further race documented.)

If the person is multiracial and one of the races is white, code the other race(s) first with white in the next race field.

If the person is multiracial and one of the races is Hawaiian, code Hawaiian as Race 1, followed by the other race(s).

If Race 1 is coded 99, then Race 2 through Race 5 must all be coded 99.

The codes are as follows:

01 White
02 Black
03 American Indian/Aleutian/Eskimo (includes all indigenous populations of the Western hemisphere)
04 Chinese
05 Japanese
06 Filipino
07 Hawaiian
08 Korean
09 Code retired; DO NOT use.
10 Vietnamese
11 Laotian
12 Hmong
13 Kampuchean (Cambodian)
14 Thai
15 Asian Indian or Pakistani, NOS (code 09 prior to Version 12)
16 Asian Indian
17 Pakistani
20 Micronesian, NOS
21 Chamorran
22 Guamanian, NOS
25 Polynesian, NOS
26 Tahitian
27 Samoan
28 Tongan
30 Melanesian, NOS
31 Fiji Islander
32 New Guinean
88 No further race documented
96 Other Asian, including Asian, NOS and Oriental, NOS
97 Pacific Islander, NOS
98 Other
99 Unknown

Item: RAD--REGIONAL RX MODALITY NAACCR Item 1570

Alternate Name: Regional Treatment Modality

Record the dominant modality of radiation therapy used to deliver the most clinically significant dose to the primary volume of interest during the first course of treatment.

Include a description and sites radiated along with start dates.

Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment.

Codes are as follows:

00 No radiation treatment - Radiation therapy was not administered to the patient; diagnosed at autopsy.

20 External beam, NOS - The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.

21 Orthovoltage - External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).

22 Cobalt-60, Cesium-137 - External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.

23 Photons (2–5 MV) - External beam therapy using a photon producing machine with a beam energy in the range of 2–5 MV.

24 Photons (6–10 MV) - External beam therapy using a photon producing machine with a beam energy in the range of 6–10 MV.

25 Photons (11–19 MV) - External beam therapy using a photon producing machine with a beam energy in the range of 11–19 MV.

26 Photons (>19 MV) - External beam therapy using a photon producing machine with a beam energy of more than 19 MV.

27 Photons (mixed energies) - External beam therapy using more than one energy over the course of treatment.

28 Electrons - Treatment delivered by electron beam.

29 Photons and electrons mixed - Treatment delivered using a combination of photon and electron beams.

30 Neutrons, with or without photons/electrons - Treatment delivered using neutron beam.

31 IMRT - Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.

32 Conformal or 3-D therapy - An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.

40 Protons - Treatment delivered using proton therapy.

41 Stereotactic radiosurgery, NOS - Treatment delivered using stereotactic radiosurgery, type not specified in patient record.

42 Linac radiosurgery - Treatment categorized as using stereotactic technique delivered with a linear accelerator.

43 Gamma Knife Treatment - categorized as using stereotactic technique delivered using a Gamma Knife machine.

50 Brachytherapy, NOS- Brachytherapy, interstitial implants, molds, seeds, needles, radioembolization, or intracavitary applicators of radioactive materials not otherwise specified.

51 Brachytherapy, Intracavitary, LDR- Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).

52 Brachytherapy, Intracavitary, HDR- Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.

53 Brachytherapy, Interstitial, LDR- Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.

54 Brachytherapy, Interstitial, HDR- Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.

55 Radium- Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.

60 Radioisotopes, NOS Iodine-131, Phosphorus-32, etc.

61 Strontium-89 - Treatment primarily by intravenous routes for bone metastases.

62 Strontium-90

98 Other, NOS - Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown.

99 Unknown - It is unknown whether radiation therapy was administered.

DO NOT leave item blank. If no treatment (surgery, chemo, radiation, hormone, immunotherapy or other) was administered, enter value "9 - Unknown" into the field.

Item: REASON FOR NO RADIATION **NAACCR Item 1430.**

Alternate Name: Reason for No Regional Radiation Therapy

Records the reason that no regional radiation therapy was administered to the patient.

0 Radiation therapy was administered.

1 Radiation therapy was not administered because it was not part of the planned first course treatment.

2 Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation etc.).

5 Radiation therapy was not administered because the patient died prior to planned or recommended therapy.

6 Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.

7 Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in record.

8 Radiation therapy was recommended, but it is unknown whether it was administered.

9 It is unknown if radiation therapy was recommended or administered. Death certificate and autopsy cases only

DO NOT leave item blank. If no treatment (surgery, chemo, radiation, hormone, immunotherapy or other) was administered, enter value "9 - Unknown" into the field.

Item: REASON FOR NO SURGERY **NAACCR Item 1340**

Alternate Name: Reason for No Cancer-Directed Surgery, Reason for No CA Dir Surgery

Enter the reason no cancer directed surgery was performed for the primary site. Use the number that best describes why the primary site surgery was not performed.

If Surgical Procedure of Primary Site is coded 00, then record the reason based on documentation in the patient record.

- Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include surgery of the primary site, or if the option of "no treatment" was accepted by the patient.
- Code 1 if Surgical Procedure of Primary Site is coded 98.
- Code 7 if the patient refused recommended surgical treatment, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 8 if it is known that a physician recommended primary site surgery, but no further documentation is available yet to determine whether surgery was performed.
- Cases coded 8 should be followed and updated to a more definitive code as appropriate.
- Code 9 if the treatment plan offered multiple choices, but it is unknown which treatment, if any was provided.

Code	Description
0	Surgery of primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned surgery etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in patient record.
7	Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only.

DO NOT leave item blank. If no treatment (surgery, chemo, radiation, hormone, immunotherapy or other) was administered, enter value "9 - Unknown" into the field.

Item: REGIONAL NODES EXAMINED **NAACCR Item 830**

Alternate Name: Number of Regional Lymph Nodes Examined, Regional Lymph Nodes Examined

This field records the total number of regional lymph nodes that were removed and examined by the pathologist.

Code	Description
00	No nodes examined
01 – 89	1 to 89 lymph nodes are examined (code exact number of nodes examined.)
90	90 or more nodes are examined
95	No regional nodes removed, but aspiration or core biopsy of regional nodes performed. See rule 5.
96	Regional lymph node removal documented as a sampling, and the number of nodes unknown/not stated. See rule 7.
97	Regional lymph node removal documented as dissection, and the number of nodes unknown/not stated. See rule 8.
98	Regional lymph nodes surgically removed, but number of lymph nodes unknown/not stated and not documented as sampling or dissection; nodes examined, but the number unknown. See rule 4e.
99	Unknown whether nodes are examined; not applicable or negative; not documented in patient record.

Instructions for Coding

1. **Regional lymph nodes only.** Record information about only regional lymph nodes in this field. Distant lymph node information should be coded in the METS AT DX-DISTANT LN field.

2. This field is **based on pathologic information only**. This field is to be recorded regardless of whether the patient received preoperative treatment.

3. **Use of code 00.** Code 00 may be used in several situations.
   a. When the assessment of lymph nodes is clinical.
   b. When no lymph nodes are removed and examined.
   c. When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
   d. If Regional Nodes Examined is coded 00, Regional Nodes Positive is coded as 98.

4. **Cumulative nodes removed and examined**. Record the total number of regional lymph nodes removed and examined by the pathologist.
   a. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment with the exception of aspiration or core biopsies coded to 95.

   b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Examined.

      Example Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected.
      Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.

c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Examined.

Example Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive.
Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.

d. If the location of the lymph node that is aspirated or core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and DO NOT include it in the count of Regional Nodes Examined.

Example Patient record states that core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection.
Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.

e. When neither the type of lymph node removal procedure nor the number of lymph nodes examined is known, use code 98.

5. **Priority of lymph node counts**. If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.

6. **Use of code 95**. Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

Example Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery.
Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.

7. **Lymph node biopsy**. If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, use code 96.

8. **Definition of "sampling" (code 96).** A lymph node "sampling" is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.

9. **Definition of "dissection" (code 97).** A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed and the number is unknown.

10. **Multiple lymph node procedures**. If both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown, use code 97.

11. **Use of code 99**. If it is unknown whether nodes were removed or examined, code as 99.

12. **Primary sites always coded 99**. For the following schemas, the Regional Nodes Examined field is ALWAYS coded as 99.
    Placenta
    Brain and Cerebral Meninges

Other Parts of Central Nervous System
Intracranial Gland
Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
Hodgkin and non-Hodgkin Lymphoma
Myeloma and Plasma Cell Disorders
Other and Ill-Defined Primary Sites
Unknown Primary Site

Item: REGIONAL NODES POSITIVE **NAACCR Item 820**

Alternate Name: Pathologic Review of Regional Lymph Nodes, Regional Lymph Nodes Positive

This field records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases.

Code	Description
00	All nodes examined are negative
01 – 89	1 to 89 lymph nodes are positive (code exact number of nodes positive.)
90	90 or more nodes are positive
95	Positive aspiration or core biopsy of lymph node(s) was performed. *See rule 6.*
97	Positive nodes are documented, but the number is unspecified. *See rule 7.*
98	No nodes were examined. *See rule 8.*
99	It is unknown whether nodes are positive; not applicable; not stated in patient record.

Instructions for Coding

1. **Regional lymph nodes only.** Record information about only regional lymph nodes in this field. Involved distant lymph nodes should be coded in the METS AT DX-DISTANT LN field.

2. This field is **based on pathologic information only**. This field is to be recorded regardless of whether the patient received preoperative treatment.

3. True in situ cases cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined). Codes 01-97 and 99 are not allowed.

4. **Cumulative nodes positive.** Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.

   a. The number of regional lymph nodes positive is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.

   b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection. In other words, if there are positive regional lymph nodes in a lymph node dissection, DO NOT count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also Definition of Code 95 below.

      Example Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected.
      Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.

Example Positive right cervical lymph node aspiration followed by right cervical lymph node dissection showing 1 of 6 nodes positive.
Code Regional Nodes Positive as 01 and Regional Nodes Examined as 06.

c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Positive.

Example Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive.
Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.

d. If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and DO NOT include it in the count of Regional Nodes Positive.

Example Patient record states that core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection.
Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.

5. **Priority of lymph node counts.** If there is a discrepancy regarding the number of positive lymph nodes, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.

6. **Use of code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

a. Use code 95 when a positive lymph node is aspirated and there are no surgically resected lymph nodes.

Example Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery.
Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95
.

b. Use code 95 when a positive lymph node is aspirated and surgically resected lymph nodes are negative. .

Example Lung cancer patient has aspiration of suspicious hilar mass, which shows metastatic squamous carcinoma in lymph node tissue. Patient undergoes preoperative radiation therapy followed by lobectomy showing 6 negative hilar lymph nodes.
Code Regional Nodes Positive as 95 and Regional Nodes Examined as the 06 nodes surgically resected.

7. **Definition of code 97**. Use code 97 for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.

Example Patient with carcinoma of the pyriform sinus has a mass in the mid neck. Fine needle aspiration (FNA) of one node is positive. The patient has neoadjuvant chemotherapy, then resection of the primary tumor and a radical neck dissection. In the radical neck dissection "several" of 10 nodes are positive; the remainder of the nodes show chemotherapy effect.
Code Regional Nodes Positive as 97 because the total number of positive nodes biopsied and removed is unknown, and code Regional Nodes Examined as 10.

NOTE*:* For primary sites where the number of involved nodes must be known in order to map to N1, N2, etc., code 97 maps to N1and therefore should be avoided.

NOTE*:* If the aspirated node is the only one that is microscopically positive, use code 95.

NOTE*:* Avoid using Regional Nodes Positive code 97 if possible, even if this means slightly undercounting the number of nodes positive.

8. **Use of code 98**. Code 98 may be used in several situations.

    a. When the assessment of lymph nodes is clinical only.

    b. When no lymph nodes are removed and examined.

    c. When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.

    d. If Regional Nodes Positive is coded as 98, Regional Nodes Examined is usually coded 00.

9. **Isolated tumor cells (ITCs) in lymph nodes**. For all primary sites except cutaneous melanoma and Merkel cell carcinoma of skin, count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size). DO NOT include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs). If the path report indicates that nodes are positive but the size of metastasis is not stated, assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive.

    a. For cutaneous melanoma and Merkel cell carcinoma, count nodes with ITCs as positive lymph nodes.

10. **Use of code 99**. Use code 99 if it is unknown whether regional lymph nodes are positive.

11. **Primary sites always coded 99**. For the following primary sites and histologies, the Regional Nodes Positive field is ALWAYS coded as 99:

    Placenta
    Brain and Cerebral Meninges
    Other Parts of Central Nervous System
    Intracranial Gland
    Hodgkin and non-Hodgkin Lymphoma
    Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
    Myeloma and Plasma Cell Disorders
    Other and Ill-Defined Primary Sites
    Unknown Primary Site

Item: REPORTING FACILITY — NAACCR Item 540

The Reporting Facility ten-digit 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.

A listing of valid FINs can be found at https://www.facs.org/quality-programs/cancer/accredited/info/fin.

Item: RX DATE BRM **NAACCR Item 1240**

Alternate Name: Date Immunotherapy Started, RX Date--BRM

Date of initiation for immunotherapy, a.k.a. biological response modifier (BRM), which is part of the first course of treatment.

Enter the year, month and day (**YYYY/MM/DD**) for the date immunotherapy/BRM was started.

Record the date on which immunotherapy/BRM was administered at any facility that is part of the first course of treatment.

Item: RX DATE BRM FLAG **NAACCR Item 1241**

Alternate Name: RX Date--BRM Flag

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:

10 No information whatsoever can be inferred from this exceptional value (that is, unknown if any immunotherapy/BRM was given.)

11 No proper value is applicable in this context (for example, no immunotherapy/BRM given.)

12 A proper value is applicable but not known. This event occurred, but the date is unknown (that is, immunotherapy/BRM was given but the date is unknown.)

15 – Information is not available at this time, but it is expected that it will be available later (that is, immunotherapy/BRM is planned as part of first course treatment, but had not yet started at the time of the last follow-up.)

BLANK - Valid date provided for item RX DATE BRM

Item: RX DATE CHEMO **NAACCR Item 1220**

Alternate Name: Date Chemotherapy Started, RX Date--Chemo

Enter the year, month and day (**YYYY/MM/DD**) for the date chemotherapy was started.

Record the date on which chemotherapy was administered at any facility that is part of the first course of treatment.

Item: RX DATE CHEMO FLAG **NAACCR Item 1221**

Alternate Name: RX Date--Chemo Flag

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:

10 No information whatsoever can be inferred from this exceptional value (that is, unknown if any chemotherapy was given).

11 No proper value is applicable in this context (for example, no chemotherapy given).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (that is, chemotherapy was given but the date is unknown).

15 Information is not available at this time, but it is expected that it will be available later (that is, chemotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).

BLANK - Valid date provided for item RX DATE CHEM

Item: RX DATE HORMONE **NAACCR Item 1230**

Alternate Name: Date Hormone Therapy Started, RX Date--Hormone

Enter the year, month and day (**YYYY/MM/DD**) for the date hormone was started.

Record the date on which hormone was administered at any facility that is part of the first course of treatment.

Item: RX DATE HORMONE FLAG **NAACCR Item 1231**

Alternate Name: RX Date--Hormone Flag

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:

10 No information whatsoever can be inferred from this exceptional value (that is, unknown if any hormone therapy was given.)

11 No proper value is applicable in this context (for example, no hormone therapy given.)

12 A proper value is applicable but not known. This event occurred, but the date is unknown (that is, hormone therapy was given but the date is unknown.)

15 Information is not available at this time, but it is expected that it will be available later (that is, hormone therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up.)

BLANK - Valid date provided for item RX DATE HORMONE field

Item: RX DATE MST DEFN SRG **NAACCR Item 3170**

Alternate Name: Date of Most Definitive Surgical Resection of the Primary Site, RX Date--Most Defin Surg

Record the date (**YYYY/MM/DD**) of the most definitive surgical procedure of the primary site performed as part of the first course of treatment.

Record the date on which the surgery described by Surgical Procedure of Primary Site was performed at this or any facility.

If surgery is the first or only treatment administered to the patient, then the date of surgery should be the same as the date entered into the item Date of First Course of Treatment.

Item: RX DATE MST DEFN SRG FLAG **NAACCR Item 3171**

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:

10 No information whatsoever can be inferred from this exceptional value; unknown if surgery performed

11 No proper value is applicable in this content (no surgery performed.)

12 A proper value is applicable but not known. This event occurred, but the date is unknown (surgery was performed, but date is unknown.)

BLANK - Valid date provided for item RX DATE MST DEFN SRG

Item: RX DATE OTHER **NAACCR Item 1250**

Alternate Name: Date Other Treatment Started, RX Date--Other

Enter the year, month and day (**YYYY/MM/DD**) for the date other treatment was started.

Record the date on which other treatment was administered at any facility that is part of the first course of treatment.

Item: RX DATE OTHER FLAG **NAACCR Item 1251**

Alternate Name: RX Date--Other Flag

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:

10 No information whatsoever can be inferred from this exceptional value (that is, unknown if any Other Treatment was given.)

11 No proper value is applicable in this context (for example, no Other Treatment given).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (that is, Other Treatment was given but the date is unknown).

15 Other therapy is planned as part of the first course of treatment, but had not been started at the time of the most recent follow-up.

BLANK - Valid date provided for item RX DATE OTHER

Item: RX DATE RADIATION **NAACCR Item 1210**

Alternate Name: Date Radiation Started, RX Date--Radiation

Enter the year, month and day (**YYYY/MM/DD**) for the date radiation was started.

Record the date on which radiation therapy began at any facility that is part of the first course of treatment.

Item: RX DATE RADIATION FLAG **NAACCR Item 1211**

Alternate Name: RX Date--Radiation Flag

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:

10 No information whatsoever can be inferred from this exceptional value (that is, unknown if any radiation was given).

11 No proper value is applicable in this context (for example, no radiation given).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (that is, radiation was given but the date is unknown).

15 Information is not available at this time, but it is expected that it will be available later (for example, radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).

BLANK - Valid date provided for item RX DATE RADIATION

Item: RX DATE SURGERY **NAACCR Item 1200**

Alternate Name: Date of Cancer-Directed Surgery, Date of Surgery, Date of First Surgical Procedure, RX Date--Surgery

Record the date (**YYYY/MM/DD**) of the first surgical procedure of the primary site performed as part of the first course of treatment.

Record the date on which the surgery described by Surgical Procedure of Primary Site was performed at this or any facility.

If surgery is the first or only treatment administered to the patient, then the date of surgery should be the same as the date entered into the item Date of First Course of Treatment.

Item: RX DATE SURGERY FLAG **NAACCR Item 1201**

Alternate Name: RX Date--Surgery Flag

This flag explains why there is no appropriate value in the corresponding date field.

Codes are as follows:

10 No information whatsoever can be inferred from this exceptional value; unknown if surgery performed

11 No proper value is applicable in this content (no surgery performed.)

12 A proper value is applicable but not known. This event occurred, but the date is unknown (surgery was performed, but date is unknown.)

BLANK - Valid date provided for item RX DATE SURGERY

Item: RX SUMM--BRM **NAACCR Item 1410**

Alternate Name: Biological Response Modifiers

Records the type of immunotherapy − biologic response modifiers (BRM) − administered as first course treatment at this facility. If immunotherapy was not administered, then this item records the reason it was not administered to the patient. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Refer to the SEER*Rx Interactive Drug Database http:/www.seer.cancer.gov/tools/seerrx/ ***for a list of immunotherapeutic/BRM agents.***

• Code 00 if immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.

• Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include immunotherapy.

• If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

• Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

• Code 88 if it is known that a physician recommended immunotherapy but no further documentation is available yet to confirm its administration.

• Code 88 to indicate a referral was made to a medical oncologist about immunotherapy and the registry should follow the case to determine whether it was given or why not. If follow-up to the specialist or facility determines the patient was never there, code 00.

• Cases coded 88 should be followed and the code updated as appropriate.

• Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.

Codes are as follows:

00 None, immunotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.

01 Immunotherapy administered as first course therapy.

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

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

86 Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.

87 Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.

88 Immunotherapy was recommended, but it is unknown if it was administered.

99 It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

DO NOT leave item blank. If no treatment (surgery, chemo, radiation, hormone, immunotherapy or other) was administered, enter value "9 - Unknown" into the field.

Item: RX SUMM--CHEMO **NAACCR Item 1390**

Alternate Name: Chemotherapy

Records the type of chemotherapy administered as first course treatment at this facility. If chemotherapy was not administered, then this item records the reason it was not administered to the patient. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Refer to the SEER*Rx Interactive Drug Database http:/www.seer.cancer.gov/tools/seerrx/ ***for a list of chemotherapeutic agents.***

• Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.

• Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy.

• If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

• Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

• Code 88 if it is known that a physician recommended the patient receive chemotherapy but no further documentation is available yet to confirm its administration

• Code 88 to indicate referral was made medical oncologist and the registry must follow to determine whether it was given. If follow-up with the specified specialist or facility indicates the patient was never there, code 00.

• Cases coded 88 must be followed to determine what kind of chemotherapy was administered or why it was not.

• Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.

• Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved.

• If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy, and **only the original agent or regimen is recorded as first course therapy.**

Codes are as follows:

00 None; no chemotherapy administered

01 Chemotherapy administered as first course therapy; type/agents not documented

02 Single-agent chemotherapy administered as first course therapy

03 Multi-agent chemotherapy administered as first course therapy

82 Chemo was not recommended/administered because it was contraindicated due to patient risk factors

85 Chemotherapy was not administered because patient expired prior to planned therapy

86 Chemotherapy recommended but not administered; reason unknown

87 Chemotherapy recommended but refused by patient or family

88 Chemotherapy recommended but unknown if administered

99 Unknown whether chemotherapy was recommended or administered

DO NOT leave item blank. If no treatment (surgery, chemo, radiation, hormone, immunotherapy or other) was administered, enter value "9 - Unknown" into the field.

Item: RX SUMM--HORMONE **NAACCR Item 1400**

Alternate Name: Hormone Therapy

Records the type of hormone therapy administered as first course treatment at this and all other facilities. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. 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.

Refer to the SEER*Rx Interactive Drug Database http:/www.seer.cancer.gov/tools/seerrx/ ***for a list of hormonal agents.***

• Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

• DO NOT code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.

• Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. DO NOT code hormone replacement therapy as part of first course therapy.

• Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.

• Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include hormone therapy.

• Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.

• If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

• Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

• Code 88 if it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration.

• Code 88 to indicate the patient was referred to a medical oncologist and the registry should follow the case for hormone therapy. If follow-up with the specified specialist or facility indicates the patient was never there, code 00
.
• Cases coded 88 should be followed to determine whether they received hormone therapy or why not.

• Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.

Codes are as follows:

00 None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.

01 Hormone therapy administered as first course therapy.

82 Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age, progression of tumor prior to administration, etc.)

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

86 Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.

87 Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.

88 Hormone therapy was recommended, but it is unknown if it was administered.

99 It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

DO NOT leave item blank. If no treatment (surgery, chemo, radiation, hormone, immunotherapy or other) was administered, enter value "9 - Unknown" into the field.

Item: RX SUMM--OTHER **NAACCR Item 1420**

Alternate Name: Other Treatment, Other Cancer-Directed Therapy

Identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.

• The principal treatment for certain reportable hematopoietic diseases could be supportive care that does not meet the usual definition of treatment that "modifies, controls, removes, or destroys" proliferating cancer tissue. Supportive care may include phlebotomy, transfusion, or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the Commission on Cancer have agreed to record treatments such as phlebotomy, transfusion, or aspirin as "Other Treatment" (Code 1) for the hematopoietic diseases ONLY. (See instructions for coding in Section One).

• Code 1 for embolization using alcohol as an embolizing agent.

• Code 1 for embolization to a site other than the liver where the embolizing agent is unknown.

• Code 1 for PUVA (psoralen and long-wave ultraviolet radiation.)

• DO NOT code pre-surgical embolization that given for a purpose to shrink the tumor.

• Code 8 if it is known that a physician recommended treatment coded as Other Treatment, and no further documentation is available yet to confirm its administration.

• Code 8 to indicate referral to a specialist for Other Treatment and the registry should follow. If follow-up with the specialist or facility determines the patient was never there, code 0.

Codes are as follows:

0 None − All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.

1 Other − Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy).

2 Other - Experimental − This code is not defined. It may be used to record participation in institution based clinical trials.

3 Other - Double Blind − A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.

6 Other - Unproven − Cancer treatments administered by nonmedical personnel.

7 Refusal - Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.

8 Recommended; unknown if administered; Other treatment was recommended, but it is unknown whether it was administered.

9 Unknown - It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.

DO NOT leave item blank. If no treatment (surgery, chemo, radiation, hormone, immunotherapy or other) was administered, enter value "9 - Unknown" into the field.

Item: RX SUMM--SCOPE REG NL SUR **NAACCR Item 1292**

Alternate Name: Scope of Regional Lymph Node Surgery

Identifies 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.

• The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.

• Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item. Record the date of this surgical procedure in data item Date of First Course of Treatment and/or Date of First Surgical Procedure if applicable.

• Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.

• For intracranial and central nervous system primaries (C70.0-C70.9, C71.0-C71.9, C72.0-C72.9, C75.1-C75.3), code 9.

• For lymphomas (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971) with a lymph node primary site (C77.0-C77.9), code 9.

• For an unknown or ill-defined primary site (C76.0-C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992), code 9.

• DO NOT code distant lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field Surgical Procedure/Other Site.

Codes are as follows:

Code	Label	Definition
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph node, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease.
2	Sentinel lymph node biopsy	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	Number of regional lymph node removed unknown or not stated; regional lymph node, NOS	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel node biopsy.
4	1 to 3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
6	Sentinel node biopsy and code 3, 4 or 5 at same time, or timing not stated	Code 2 was performed in a single surgical event with code 3, 4, or 5. Or, code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.

Code	Label	Definition
9	Unknown or not applicable	It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

DO NOT leave item blank. If no treatment (surgery, chemo, radiation, hormone, immunotherapy or other) was administered, enter value "9 - Unknown" into the field.

Item: RX SUMM--SURG OTH REG/DIS **NAACCR Item 1294**

Alternate Name: Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes

Record the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

If other tissue or organs are removed during primary site surgery that are not specifically defined by the site specific Surgical Procedure of the Primary Site code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.

• Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.

• Assign the highest numbered code that describes the surgical resection of distant lymph node(s).

• Incidental removal of tissue or organs is not a "Surgical Procedure/Other Site."

• Surgical Procedure/Other Site is collected for each surgical event even if surgery of the primary site was not performed.

• Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0–76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992).

Codes are as follows:

0 None
1 Non-primary surgical procedure performed
2 Non-primary surgical procedure to other regional sites
3 Non-primary surgical procedure to *distant lymph node(s)*
4 Non-primary surgical procedure to distant site
5 Combination of codes 2, 3, or 4
9 Unknown

DO NOT leave item blank. If no treatment (surgery, chemo, radiation, hormone, immunotherapy or other) was administered, enter value "9 - Unknown" into the field.

Item: RX SUMM--SURG PRIM SITE **NAACCR Item 1290**

Alternate Name: Surgery of Primary Site

Site-specific codes for this data item can be found in Appendix B of the current Facility Oncology Registry Data Standards (FORDS) Manual http://www.facs.org/cancer/coc/fordsmanual.html.

Record the most definitive surgical procedure(s) performed to the primary site. If registry software allows only one procedure to be collected, document the most definitive surgical procedure for the primary site.

• For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is not available.

• Excisional biopsies (those that remove the entire tumor and/or leave only microscopic margins) are to be coded in this item.

• Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted.

• If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results.

In addition to the procedure code, record the description as documented on the operative report.

DO NOT leave item blank. If no treatment (surgery, chemo, radiation, hormone, immunotherapy or other) was administered, enter value "9 - Unknown" into the field.

Item: RX SUMM--SURG/RAD SEQ **NAACCR Item 1380**

Alternate Name: Radiation Sequence with Surgery

Records the sequencing of radiation and surgical procedures given as part of the first course of treatment.

Codes are as follows:

0 No radiation therapy and/or surgical procedure(s)
2 Radiation therapy before surgery
3 Radiation therapy after surgery
4 Radiation therapy both before AND after surgery
5 Intraoperative radiation therapy
6 Intraoperative radiation therapy w/other therapy administered before OR after surgery
9 Sequence unknown

DO NOT leave item blank. If no treatment (surgery, chemo, radiation, hormone, immunotherapy or other) was administered, enter value "9 - Unknown" into the field.

Item: RX SUMM--SYSTEMIC/SUR SEQ **NAACCR Item 1639**

Alternate Name: Systemic/Surgery Sequence

Record the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment.

Codes are as follows:

0 No systemic therapy and/or surgical procedure(s)
2 Systemic therapy before surgery
3 Systemic therapy after surgery
4 Systemic therapy both before AND after surgery
5 Intra-operative systemic therapy
6 Intra-operative systemic therapy w/other systemic therapy administered before OR after surgery

9 Sequence unknown

Item: RX SUMM--TRANSPLNT/ENDOCR **NAACCR Item 3250**

Alternate Name: Hematologic Transplant and Endocrine Procedures

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.

• Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.

• Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.

• Endocrine irradiation and/or endocrine surgery are procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or affect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.

• Code 00 if a transplant or endocrine procedure was not administered to the patient, and it is known that these procedures are not usually administered for this type and stage of cancer.

• Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include a transplant or endocrine procedure.

• If it is known that a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

• Code 87 if the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

• Code 88 if it is known that a physician recommended a hematologic transplant or endocrine procedure, but no further documentation is available yet to confirm its administration.

• Code 88 to indicate referral to a specialist for hematologic transplant or endocrine procedures and the registry should follow the case. If follow-up to the specified specialist or facility determines the patient was never there, code 00.

• Cases coded 88 should be followed to determine whether they were given a hematologic transplant or endocrine procedure or why not.

• Code 99 if it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.

Codes are as follows:

00 No transplant procedure or endocrine therapy was administered as part of first course therapy. Diagnosed at autopsy.

10 A bone marrow transplant procedure was administered, but the type was not specified.

11 Bone marrow transplant–autologous.

12 Bone marrow transplant–allogeneic.

20 Stem cell harvest and infusion. Umbilical cord stem cell transplant.

30 Endocrine surgery and/or endocrine radiation therapy.

40 Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20.)

82 Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age, progression of disease prior to administration, etc.).

85 Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.

86 Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.

87 Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.

88 Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.

99 It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record. Death certificate only.

DO NOT leave item blank. If no treatment (surgery, chemo, radiation, hormone, immunotherapy or other) was administered, enter value "9 - Unknown" into the field.

Item: RX SUMM--TREATMENT STATUS NAACCR Item 1285

Summary of the status for ALL treatment modalities (i.e., surgery, chemotherapy, radiation therapy, BRM, immunotherapy, etc.)

Codes are as follows:
0 No treatment given
1 Treatment given
2 Active Surveillance (watchful waiting)
9 Unknown if treatment given

DO NOT leave item blank. If no treatment (surgery, chemo, radiation, hormone, immunotherapy or other) was administered, enter value "9 - Unknown" into the field.

General Instructions for Text Field Entries (RX TEXT-- and TEXT-- data items)
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry. The text field MUST contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. When the supporting text information is printed for review, one should be able to re-abstract the case without obtaining additional medical records and have the same codes as the original abstract. If there is no information to record in the text field, DO NOT leave the field blank. Type "N/A" or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: RX TEXT--BRM **NAACCR Items 2660**

Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.

Required for Text:

- When Treatment was given, e.g., at this facility; at another facility
- Type of BRM agent, e.g., Interferon, BCG
- BRM procedures, e.g., bone marrow transplant, stem cell transplant
- Other treatment information, e.g., treatment cycle incomplete; unknown if BRM was given

If there is no information to record in the text field, DO NOT leave the field blank. Type "N/A" or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: RX TEXT--CHEMO **NAACCR Items 2640**

Text area for information regarding chemotherapy treatment of the reported tumor.

Required for Text:

- Date when chemotherapy began
- Where treatment was given, e.g., name of agent(s) or protocol
- Other treatment information, e.g., treatment cycle incomplete, unknown if chemotherapy was given

If there is no information to record in the text field, DO NOT leave the field blank. Type "N/A" or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: RX TEXT--HORMONE **NAACCR Items 2650**

Text area for information about hormonal treatment

Required for Text:

- Date treatment was started
- Where treatment was given, e.g., at this facility, at another facility
- Type of hormone or antihormone, e.g., Tamoxifen
- Type of endocrine surgery or radiation, e.g., 3-D conformal
- Other treatment information, e.g., treatment cycle incomplete; unknown if hormones were given.

If there is no information to record in the text field, DO NOT leave the field blank. Type “N/A” or “No Info” to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: RX TEXT--OTHER **NAACCR Items 2670**

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.

Required for Text:

- Date treatment was started
- Where treatment was given, e.g., at this facility, at another facility
- Type of other treatment, e.g., blinded clinical trial, hyperthermia
- Other treatment information, e.g., treatment cycle incomplete; unknown if other treatment was given.

If there is no information to record in the text field, DO NOT leave the field blank. Type “N/A” or “No Info” to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: RX TEXT--RADIATION (BEAM) **NAACCR Items 2620**

Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation.

Required for Text:

- Date radiation treatment began
- Where treatment was given, e.g., at this facility, at another facility
- Type(s) of beam radiation, e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities
- Other treatment information, e.g., patient discontinued after 5 treatments; unknown if radiation was given

If there is no information to record in the text field, DO NOT leave the field blank. Type “N/A” or “No Info” to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: RX TEXT--RADIATION OTHER **NAACCR Items 2630**

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.

Required for Text:

- Date treatment was started
- Where treatment was given, e.g., at this facility, at another facility
- Type(s) of non-beam radiation, e.g., High Dose rate brachytherapy, seed implant, Radioisotopes (I-131)
- Other treatment information, e.g., unknown if radiation was given

If there is no information to record in the text field, DO NOT leave the field blank. Type “N/A” or “No Info” to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: RX TEXT--SURGERY **NAACCR Items 2610**

Text area for information describing all surgical procedures performed as part of treatment.

Required for Text:

- Date of each procedure.
- Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites.
- Lymph nodes removed.
- Regional tissues removed.
- Metastatic sites.
- Facility where each procedure was performed.
- Record positive and negative findings. Record positive findings first.
- Other treatment information, e.g., planned procedure aborted; unknown if surgery performed.

If there is no information to record in the text field, DO NOT leave the field blank. Type "N/A" or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: SECONDARY DIAGNOSIS (1-10) NAACCR Items 3780-3798

Alternate Name: Secondary DX ICD-10 (1-10)

The COMORBID/COMPLICATION (1-10) items (NAACCR Items 3110-3164) were based on ICD-9-CM codes and only allowed 5 characters. The introduction of ICD-10-CM requires the accommodation of 7-character codes – these codes are to be recorded in the SECONDARY DIAGNOSIS (1-10) fields (NAACCR Items 3780-3798).

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer **using ICD-10-CM values**. 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.

Use this item to record ICD-10-CM codes. Use COMORBID/COMPLICATION (1-10) (NAACCR Items 3110-3164) to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.

NOTE: While the ICD-9-CM COMORBID/COMPLICATION codes were to be followed by zeroes if they did not fill the 5-character field, only the actual ICD-10-CM code is to be entered for SECONDARY DIAGNOSIS fields, leaving blanks beyond those characters. Omit the decimal point when coding. If no secondary diagnoses are documented, or if this information is unknown or unavailable, leave this data item blank. **DO NOT use ICD-9-CM codes in the SECONDARY DIAGNOSIS (1-10) fields.**

Secondary diagnoses are found on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available. Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility.

Report the secondary diagnoses for this cancer using the following priority rules.
Surgically treated patients:

a) Following the most definitive surgery of the primary site
b) Following other non-primary site surgeries

Non-surgically treated patients:

Following the first treatment encounter/episode

In cases of non-treatment:

Following the last diagnostic/evaluative encounter

The codes start with a character and have a presumed decimal point between the third and fourth characters in the reported value. The following are reportable ICD-10-CM Secondary Diagnoses:

Code	Description
0000000	No applicable ICD-10-CM codes are recorded in patient record.
A00.0-B99.9	Infectious and parasitic diseases
E00.0-E89.89	Endocrine and metabolic diseases
G00.0-P96.9	Diseases of the nervous system, eye, ear, skin, circulatory, respiratory, and digestive, musculoskeletal, genitourinary systems, pregnancy, childbirth and perinatal conditions.
R00.0-S99.929	Symptoms, signs and abnormal clinical and lab findings
T36.0-T50.996	Medical poisonings
Y62.0-Y84.9	Medical misadventures
Z14.0-Z22.9	Genetic susceptibility/infection disease carrier
Z68.1-Z68.54	BMI
Z80.0-Z80.9	Family history of malignant neoplasms
Z85.0-Z99.89	Personal history of malignant neoplasms; other personal health status

Do NOT review the medical record and assign codes to these conditions – only record the above conditions if they have been identified by the medical records coder and appear on the face sheet.

For more information, refer to Facility Oncology Registry Data Standards (FORDS) at http://www.facs.org/cancer/coc/fordsmanual.html.

Item: SEER SUMMARY STAGE 2000 **NAACCR Items 759**

Directly coded SEER Summary Stage is Required for all facilities regardless of type. Use SEER Summary Staging Manual – 2000 for cases diagnosed on or after January 1, 2001. Download and print the manual from http://seer.cancer.gov/tools/ssm/.

The summary stage should include all information available through completion of surgery(ies) in the **first course of treatment or within four months from the date of initial diagnosis**.

For additional staging information, see Cancer Staging section in this manual.

Code	Description
0	In situ, Intraepithelial, Non-invasive, Non-infiltrating
1	Localized ONLY (within organ)
2	Regional by direct extension ONLY
3	Regional to lymph node(s) ONLY
4	Regional by BOTH direct extension AND regional lymph node(s) involved
5	Regional, NOS (not otherwise specified)
7	Distant site(s)/lymph node(s) involved or Systemic
8	Benign
9	Unknown if extension or metastasis ; Unknown primary site

Item: SEQUENCE NUMBER--HOSPITAL **NAACCR Item 560**

Alternate Name: Sequence Number

The **Sequence Number** uniquely identifies separate primary tumors for each patient. It indicates the sequence of malignant and nonmalignant neoplasms over the lifetime of the patient. It is used by hospitals with or without a registry.

This item is required for hospitals with and without a registry. This item is not required for labs or other non-reporting facilities. If not reporting, leave this item blank.

If two or more invasive or in situ neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident the decision is arbitrary.

Any tumor in the patient's past which is reportable or reportable-by-agreement at the time the current tumor is diagnosed must be taken into account when sequencing subsequently accessioned tumors. However, DO NOT reassign sequence numbers if one of those tumors becomes non-reportable later.

Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence, e.g. a new primary diagnosed at another facility.

Malignant or In Situ Primaries:

Code	Definition
00	One malignant or in situ primary only in the patient's lifetime
01	First of two or more independent malignant or in situ primaries
02	Secord of two or more independent malignant or in situ primaries
---	
---	(Actual sequence of this malignant or in situ primary)

59	Fifty-ninth of 59 or more independent malignant or in situ primaries
99	Unknown number of malignant or in situ primaries

Non-Malignant Primaries:

Code	Definition
60	One non-malignant primary only in the patient's lifetime.
61	First of two or more independent non-malignant primaries
62	Second of two or more independent non-malignant primaries

---	(Actual sequence of this non-malignant or in situ primary)

87	Twenty-seventh of 27 or more independent non-malignant primaries
88	Unspecified number of independent non-malignant primaries

Examples

Code	Explanation
00	Patient with no previous history of cancer diagnosed with in situ breast carcinoma on June 13, 2011
01	The sequence number is changed when the patient with an in situ breast carcinoma diagnosed June 13, 2011, is diagnosed with a subsequent melanoma on August 30, 2011
02	Sequence number assigned to the melanoma diagnosed on August 30, 2011, following a breast cancer in situ diagnosed on June 13, 2011

Code	Explanation
04	A nursing home patient is admitted to the hospital for first course surgery for a colon adenocarcinoma. The patient has a prior history of three malignant cancers of the type the registry is required to accession, though the patient was not seen for these cancers at the hospital. No sequence numbers 01, 02, or 03 are accessioned for this patient.
60	The sequence number assigned to a benign brain tumor diagnosed on November 1, 2013, following a breast carcinoma diagnosed on June 13, 2011, and a melanoma on August 30, 2011
63	Myeloproliferative disease (9975/1) is diagnosed by the facility in 2011 and accessioned as Sequence 60. A benign brain tumor was diagnosed and treated elsewhere in 2010; the patient comes to the facility with a second independent benign brain tumor in 2012. Un-accessioned earlier brain tumor is counted as Sequence 61, myeloproliferative disease is re-sequenced to 62, and second benign brain tumor is Sequence 63.

The above tables and information can be found in Facility Oncology Registry Data Standards (FORDS) at https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals/fordsmanual.

Item: SEX **NAACCR Item 220**

Note: The word "hermaphrodite" formerly classified under code 3 is outdated. Beginning with cases diagnosed in 2016, the definition has been updated to code "3 - Other (intersex, disorders of sexual development/DSD)."

Record the sex of the patient by entering the corresponding code.

The codes are as follows:

1 Male
2 Female
3 Other (intersex, disorders of sexual development/DSD)
4 Transsexual, NOS
5 Transsexual, natal male
6 Transsexual, natal female
9 Not Stated/Unknown

NOTE: The same sex code should appear in each abstract for a patient with multiple tumors.

Do not leave this data item blank.

Item: SOCIAL SECURITY NUMBER **NAACCR Item 2320**

Enter the social security number of the patient. (NOTE: A patient's Medicare claim number may not always be identical to the patient's social security number.)

Code Social Security Numbers that end with "B" or "D" as 999-99-9999. (The patient receives benefits under the spouse's number and this is the spouse's Social Security Number.)

If the patient does not have a social security number, or if the patient's Social Security Number is not available, type 999-99-9999.

NOTE: Social Security Number is a required data item regardless of facility type. If after review of the patient's hospital charts, outpatient records, other available records, other facility inquiries, or follow-back with the physician on record, the social security number is unknown, type 999-99-9999.

Item: SPANISH/HISPANIC ORIGIN **NAACCR Item 190**

Alternate Name: Spanish Surname or Origin

Indicate whether the patient is of Hispanic origin, by entering the number which corresponds to their status.

Codes are as follows:

0 Non-Spanish; Non-Hispanic
1 Mexican (includes Chicano)
2 Puerto Rican
3 Cuban
4 South or Central American (except Brazil)
5 Other specified Spanish/Hispanic origin
6 Spanish, NOS; Hispanic NOS; Latino NOS
7 Spanish surname ONLY
8 Dominican Republic
9 Unknown whether Spanish or not

Note: Record "0- Non-Spanish, Non-Hispanic" when there is no documentation of Hispanic descent in the medical record.

Independent laboratories are not expected to report this item and may leave the item blank, otherwise DO NOT leave this item blank.

General Instructions for Text Field Entries (RX TEXT-- and TEXT-- data items)
Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry. The text field MUST contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. When the supporting text information is printed for review, one should be able to re-abstract the case without obtaining additional medical records and have the same codes as the original abstract. If there is no information to record in the text field, DO NOT leave the field blank. Type "N/A" or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: TEXT--DX PROC--LAB TESTS **NAACCR Item 2550**

Text area for information from laboratory examinations other than cytology or histopathology. Data should verify/validate the coding of the following fields: Date of Diagnosis, Primary Site, Laterality, Histology ICD-O-3, Grade, CS Site-Specific Factors, and Diagnostic Confirmation.

Required for Text:

- Type of lab test/tissue specimen(s)
- Record both positive and negative findings, record positive test results first.
- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Date(s) of lab test(s)
- Tumor markers included, but are not limited to:
    - Breast Cancer: Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), HER 2/NEU.
    - Prostate Cancer: Prostatic Specific Antigen (PSA)

- Testicular Cancer: Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH)

If there is no information to record in the text field, DO NOT leave the field blank. Type "N/A" or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: TEXT--DX PROC--OP **NAACCR Item 2560**

Text area for manual documentation of all surgical procedures that provide information for staging. Data should verify/validate the coding of date of first positive biopsy; date of diagnosis; diagnostic and staging procedures; primary surgery site.

Required for Text:

- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived
- Number of lymph nodes removed
- Size of tumor removed
- Documentation of residual tumor
- Evidence of invasion of surrounding areas
- Reason primary site surgery could not be completed

If there is no information to record in the text field, DO NOT leave the field blank. Type "N/A" or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: TEXT--DX PROC--PATH **NAACCR Item 2570**

Review the pathology report and type in the text from cytology and histopathology reports.

Required for Text:

- Date(s) of procedure(s)
- Anatomic source of specimen
- Type of tissue specimen(s)
- Tumor type and grade (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.)
- Gross tumor size
- Extent of tumor spread
- Involvement of resection margins
- Number of lymph nodes involved and examined
- Record both positive and negative findings. Record positive test results first.
- Note if path 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

Examples

- 11/12/2006 colon polyp, 1.2x1.0x.0.8 cm. Adenocarcinoma contained within polyp showing invasion of submucosa. Stalk: no evidence of adenocarcinoma or dysplasia.
- 7/4/06 mastectomy of breast for R upper outer quadrant mass; 1.0 x 1.3 x .9 cm. Ductal carcinoma, infiltrating, Grade III. Margins clear; 12/12 lymph nodes negative for cancer; no metastasis noted; Positive histology; ERA negative.

If there is no information to record in the text field, DO NOT leave the field blank. Type “N/A” or “No Info” to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: TEXT--DX PROC--PE **NAACCR Item 2520**

Text area for the history and physical examination related to the current tumor and the clinical description of the tumor.

Required for Text:

- Date of physical exam
- Age, sex, race/ethnicity
- Family history of cancer
- History of tobacco use
- History of alcohol use
- Personal history of previous cancers
- 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
- Treatment plan

If there is no information to record in the text field, DO NOT leave the field blank. Type “N/A” or “No Info” to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: TEXT--DX PROC--SCOPES **NAACCR Item 2540**

Text area for endoscopic examinations that provide information for staging and treatment.

Required for Text:

- Date(s) of endoscopic exam(s)
- Primary site
- Histology (if given)
- Tumor location
- Tumor size
- Lymph nodes
- Record positive and negative clinical findings. Record positive results first.

If there is no information to record in the text field, DO NOT leave the field blank. Type “N/A” or “No Info” to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: TEXT--DX PROC--X-RAY/SCAN **NAACCR Item 2530**

Text area for all X-rays, scan, and/or other imaging examinations that provide information about staging.

Required for Text:

- Date(s) of X-ray/Scan(s)
- Age, sex, race/ethnicity (when given)
- Primary site

- Histology (if given)
- Tumor location
- Tumor size
- Lymph nodes
- Record positive and negative clinical findings. Record positive results first
- Distant disease or metastasis

If there is no information to record in the text field, DO NOT leave the field blank. Type "N/A" or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: TEXT--HISTOLOGY TITLE **NAACCR Item 2590**

Review the pathology report and type in the histologic type (adenocarcinoma, squamous cell cancer, etc.), the *behavior* (malignant, in situ, benign), and the tumor grade (differentiation) of the tumor being reported.

Required for text:

- Histologic type and behavior
- Information on differentiation from scoring system such as Gleason score, Bloom-Richardson for tumor grade; laterality (if paired site)

Examples

- Adenocarcinoma of transverse colon, invasive, grade III
- Adenocarcinoma of prostate, Gleason score 5, Grade 2
- Melanoma skin right arm, in situ, grade 0
- Melanoma skin left leg, in situ, grade not stated

You MUST obtain and use these required reference and coding resources:

- ***Multiple Primary and Histology Coding Rules manual*** http://seer.cancer.gov/tools/mphrules/download.html

- ***International Classification of Diseases for Oncology, Third Edition (ICD-O-3) coding book.*** This book can be purchased through any book store or ordered from online sources. Electronic CSV database files or print copies of the classifications are available from the World Health Organization at http://www.who.int/classifications/icd/adaptations/oncology/en/

- ***Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual at*** http://seer.cancer.gov/tools/heme/ ***to assist with coding these primaries. These references apply only to cases diagnosed January 1, 2010 and forward.***

The Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic and Lymphoid Neoplasms Database, applies to only those **non-solid tumor cases diagnosed January 1, 2010 and forward.** The ICD-O-3 coding book is obsolete for coding non-solid tumors after this date. You must use the Hematopoietic and Lymphoid Neoplasms Database to assign the histology code.

Record the clinical/histological diagnosis for the primary site being reported. For hematopoietic and lymphoid neoplasms, code the histology diagnosed by the definitive diagnostic method(s) stated in the Hematopoietic database. The definitive diagnostic method can be a clinical diagnosis, genetic test, immunophenotyping, cytology, or pathology. When a pathology report is the definitive diagnostic method, code the histology from the final diagnosis, comment on the final diagnosis, addenda to the final diagnosis, or CAP protocol.

Be as specific as possible when describing the histology of the primary site, as multiple terms may describe a single histology. Record ALL histological types and descriptive adjectives identified.

Example The pathology report diagnosis is that of a "diffuse, large cell, non-cleaved lymphoma."
Record the histology as "diffuse, large cell, non-cleaved lymphoma (9680/3)" − not just "lymphoma.'

Review ALL pathology reports as specimens from the surgery are usually the most explicit.

Example The histology from a colon biopsy is reported as "adenocarcinoma, NOS 8140/3)." The histology from the right hemicolectomy is reported as 'mucinous carcinoma (8480/3)."
Record the histology as "mucinous carcinoma (8480/3).'

EXCEPTION: There may be times when the biopsy removes all the tumor and the margins are negative. A wide excision will be performed for precautionary measures.

Example The pathology report from a skin biopsy identifies "superficial malignant melanoma (8720/3)." At wide excision, no residual tumor is identified.
Record the histology as "superficial malignant melanoma (8720/3)" from the biopsy.

Record the histology from the **most representative** tumor specimen examined and from the **final diagnosis.** The pathology reports takes precedence over ALL other reports.

NOTE 1**:** Use information from **addenda** and **comments** associated with the final diagnosis to code the histology.

NOTE 2: A **revised/amended diagnosis** replaces the original final diagnosis. Code the histology from the revised/amended diagnosis.

NOTE 3**:** The new rules **limit** the information **to the final diagnosis**. The old rules allowed coding from information in the microscopic description. You will only use information from the microscopic portion of the pathology report when instructed to do so in one of the site-specific rules.

If there is **NOT** a pathology report and a **cytology report** is available, use the cytology report to determine the histology.

When you do not have either a pathology report or cytology report:
a. use documentation in the medical record that references pathology or cytology findings
b. assign the histology from mention of a type of cancer (histology) in the medical record

The words "carcinoma" and "adenocarcinoma" and "cancer" are NOT interchangeable.
Record the histology exactly as it is reported.

If the histology is reported as "carcinoma," record the histology as "carcinoma (8010/3)."

If the histology is reported as "adenocarcinoma," record the histology as "adenocarcinoma, NOS (8140/3).'

If the diagnosis is "cancer" and there is no mention of a specific histology type (carcinoma or adenocarcinoma), record the histology as "cancer, NOS (8000/3).'

If no microscopic diagnosis is available, record the clinical diagnosis that describes the primary tumor being reported.

Example MRI of the brain demonstrates a mass in the frontal lobe. The radiologist indicates that the diagnosis is an anaplastic astrocytoma.
Record the clinical diagnosis of "anaplastic astrocytoma (9401/3)" made from MRI.

If no histological diagnosis can be reached, or if no microscopic exam is available but a reportable diagnosis is suspected by a physician, report the suspected diagnosis.

Example Chest x-ray and CT scan reveals a mass in the right upper lobe. Right upper lobe bronchoscopy is performed and the diagnosis is negative for malignancy. Discharge diagnosis is reported as "right lung cancer."
Record the histology as "cancer," which is the suspected diagnosis by the managing physician.

If there is no information to record in the text field, DO NOT leave the field blank. Type "N/A" or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: TEXT--PLACE OF DIAGNOSIS **NAACCR Item 2690**

Alternate Name: Place of Diagnosis

Text area for the facility, physician office, city, state, or county where the diagnosis was made.

Required for Text:

- The complete name of the hospital or the physician office where diagnosis occurred. The initials of a hospital are not adequate.
- For out-of-state residents and facilities, include the city and the state where the medical facility is located.

If there is no information to record in the text field, DO NOT leave the field blank. Type "N/A" or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: TEXT--PRIMARY SITE TITLE **NAACCR Item 2580**

Type in the primary site of the tumor being reported and the laterality (side of the body) if it is a paired site (some sites are not paired such as the prostate, uterus, esophagus, pancreas, and colon.)

Required for text:

- Location of the primary site of the tumor
- Available information on tumor laterality (if paired site)

Examples

- Lung, L lower lobe
- Prostate
- Breast, R upper outer quadrant
- Sigmoid colon
- Left temporal lobe of brain

If there is no information to record in the text field, DO NOT leave the field blank. Type "N/A" or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: TEXT--REMARKS **NAACCR Item 2680**

Type in more information that you have or use if you ran out of room in other text fields. Problematic coding issues can also be discussed in this section.

Required for Text:

- Overflow of information from any other Text field
- Justification of over-ride flags
- Family and personal history of cancer
- Comorbidities
- Information on sequence numbers if a person was diagnosed with another cancer out-of-state or before the registry's reference date
- Place of birth
- Smoking history

Example

- Patient severely ill; could not undergo further surgery or staging; no treatment planned

If there is no information to record in the text field, DO NOT leave the field blank. Type "N/A" or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: TEXT--STAGING **NAACCR Item 2600**

Additional text area for staging information not already entered in other TEXT or RX-TEXT fields.

Required for Text:

- Date(s) of procedure(s), including clinical procedures that provided information for assigning stage
- Organs involved by direct extension
- Size of tumor
- Status of margins
- Number and sites of positive lymph nodes
- Site(s) of distant metastasis
- Physician's specialty and comments

If there is no information to record in the text field, DO NOT leave the field blank. Type "N/A" or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Item: TEXT--USUAL INDUSTRY **NAACCR Item 320**

Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Enter the kind of business or industry to which the occupation identified in TEXT--OCCUPATION (NAACCR Item 310) was related, such as insurance, automobile, government, school, church, etc. Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components within industries that perform more than one of these components.

Examples Inadequate: "automobile industry"
Adequate: "automobile manufacturing"

Inadequate: "manufacturing"
Adequate: "automobile manufacturing"

Inadequate: “fire department”
Adequate: “city fire department”

Do NOT include descriptive terms with the Usual Industry such as “longest,” “current,” “last 10 years,” etc.

Do NOT record “retired.”

If the primary activity of the industry is unknown, record the name of the company (with city or town) in which the patient worked the most number of years before diagnosis.

If the patient was never employed, enter “never employed.”

If this information is unknown, enter “unknown.”

For further information, refer to A Cancer Registrar's Guide to Collecting Industry and Occupation to assist with coding this data item. The guide can be downloaded at http://www.cdc.gov/niosh/docs/2011-173/ and has been provided by CDC.

Do not leave this data item blank.

Item: TEXT--USUAL OCCUPATION **NAACCR Item 310**

Enter the usual occupation of the patient prior to retirement. “Usual Occupation” is the kind of work the patient did during most of his/her working life before retirement, e.g., claim adjuster, farm hand, coal miner, janitor, store manager, research chemist, civil engineer, college professor, teacher, etc.

Enter “student” if the patient was a student at the time of diagnosis and was never regularly employed.

This data item applies only to patients who are 14 years of age or older at the time of diagnosis.

If the Usual Occupation is not available or is unknown, record the patient’s current or most recent occupation, or any available occupation.

Examples

Inadequate: “teacher”
Adequate: “preschool teacher,” “high school teacher”

Inadequate: “laborer”
Adequate: “residential bricklayer”

Inadequate: “worked in a warehouse,” “worked in a shipping department”
Adequate: “warehouse forklift operator”

Do **NOT** include descriptive terms with the Usual Occupation such as “longest,” “current,” “last 10 years,” etc.

Do not use “retired.” If the patient has retired from his or her usual occupation, the “usual occupation and business/industry” of the patient must be specified.

If the patient was never employed enter “never employed.”

If the usual occupation of the patient is unknown, enter “unknown.”

If the patient was a homemaker at the time of diagnosis, but had worked outside the household during his or her working life, enter that occupation.

If the patient was a homemaker during most of his or her working life, and never worked outside the household, enter "homemaker."

Examples If patient worked only at home, then record:
Occupation: "homemaker"
Industry: "own home"

If patient worked at someone else's home for pay, then record:
Occupation: "housekeeper" (or "nurse," "babysitter," etc.)
Industry: "private home"

"Self-employed" by itself is incomplete. The kind of work must be determined. The entry for business/industry should include both the proper business/industry and the entry "self-employed."

For further information, refer to A Cancer Registrar's Guide to Collecting Industry and Occupation to assist with coding this data item. The guide can be downloaded at http://www.cdc.gov/niosh/docs/2011-173/ and has been provided by CDC.

Do not leave this data item blank.

Item: TOBACCO USE **State-specific Item 9522**

Records whether or not the patient has a history of tobacco use (cigarettes, pipe, cigars, snuff, chew).

If the patient quit smoking one year or less from the initial date of diagnosis, indicate "current use."

This is a MCSP-required data item. Abstracts submitted with incorrect format or missing values will be rejected by MCSP.

Paper form submission:

Mark appropriate value: current use, prior use, never used or unknown

Electronic submission:

Enter whether or not the patient has a history of tobacco use (cigarettes, pipe, cigars, snuff, or chew.)

This is a Michigan-specific data item. Starting with data submitted in NAACCR version 13, facilities that submit electronic abstract data to MCSP must coordinate with their software vendors to ensure that this data value is recorded in NAACCR record layout, column number 2447. After that date, abstracts submitted with incorrect format or missing values will be rejected by MCSP.

If unknown, enter 9.

Tobacco History Data Values

Code	Current	Prior	Never
1	Yes	Blank	Blank
2	Blank	Yes	Blank

Code	Current	Prior	Never
3	Blank	Blank	Yes
9	Blank (Unknown)	Blank (Unknown)	Blank (Unknown)

Item: TNM CLIN DESCRIPTOR **NAACCR Item 980**

Alternate Name: Clinical Stage (Prefix/Suffix) Descriptor

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.

Codes

0 - None
1 - E (Extranodal, lymphomas only)
2 - S (Spleen, lymphomas only)
3 - M (Multiple primary tumors in a single site)
5 - E & S (Extranodal and spleen, lymphomas only)
9 - Unknown, not stated in patient record

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

For additional staging information, see Cancer Staging section in this manual.

Item: TNM CLIN M **NAACCR Item 960**

Alternate Name: Clinical M

Detailed site-specific codes for the clinical metastases (M) as defined by AJCC and recorded by the physician.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

For additional staging information, see Cancer Staging section in this manual.

Item: TNM CLIN N **NAACCR Item 950**

Alternate Name: Clinical N

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

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

For additional staging information, see Cancer Staging section in this manual.

Item: TNM CLIN STAGE GROUP **NAACCR Item 970**

Alternate Name: Clinical Stage Group

Detailed site-specific codes for the clinical stage group as defined by AJCC and recorded by the physician.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

For additional staging information, see Cancer Staging section in this manual.

Item: TNM CLIN T **NAACCR Item 940**

Alternate Name: Clinical T

Detailed site-specific codes for the clinical tumor (T) as defined by AJCC and recorded by the physician.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

For additional staging information, see Cancer Staging section in this manual.

Item: TNM EDITION NUMBER **NAACCR Item 1060**

A code that indicates the edition of the AJCC manual used to stage the case. This applies to the manually coded AJCC fields. TNM codes have changed over time and conversion is not always simple. Therefore, a case-specific indicator is needed to allow grouping of cases for comparison.

Codes

00 - Not staged (cases that have AJCC staging scheme and staging was not done)
01 - First Edition
02 - Second Edition (published 1983)
03 - Third Edition (published 1988)
04 - Fourth Edition (published 1992), recommended for use for cases diagnosed 1993-1997
05 - Fifth Edition (published 1997), recommended for use for cases diagnosed 1998-2002
06 - Sixth Edition (published 2002), recommended for use for cases diagnosed 2003-2009
07 - Seventh Edition (published 2009), recommended for use with cases diagnosed 2010+
88 - Not applicable (cases that do not have an AJCC staging scheme)
99 - Edition Unknown

For additional staging information, see Cancer Staging section in this manual.

Item: TNM PATH DESCRIPTOR **NAACCR Item 920**

Alternate Name: Pathologic Stage (Prefix/Suffix) Descriptor

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.

Codes

0 - None
1 - E (Extranodal, lymphomas only)
2 - S (Spleen, lymphomas only)
3 - M (Multiple primary tumors in a single site)
4 - Y (Classification during or after initial multimodality therapy)—pathologic staging only
5 - E & S (Extranodal and spleen, lymphomas only)
6 - M & Y (Multiple primary tumors and initial multimodality therapy)
9 - Unknown, not stated in patient record

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

For additional staging information, see Cancer Staging section in this manual.

Item: TNM PATH M **NAACCR Item 900**

Alternate Name: Pathologic M

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

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

For additional staging information, see Cancer Staging section in this manual.

Item: TNM PATH N **NAACCR Item 890**

Alternate Name: Pathologic N

Detailed site-specific codes for the pathologic nodes (N) as defined by AJCC and recorded by physician.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

For additional staging information, see Cancer Staging section in this manual.

Item: TNM PATH STAGE GROUP **NAACCR Item 910**

Alternate Name: Pathologic Stage Group

Detailed site-specific codes for the pathologic stage group as defined by AJCC and recorded by the physician.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

For additional staging information, see Cancer Staging section in this manual.

Item: TNM PATH T **NAACCR Item 880**

Alternate Name: Pathologic T

Detailed site-specific codes for the pathologic tumor (T) as defined by AJCC and recorded by the physician.

Note: See the *AJCC Cancer Staging Manual*, current edition for site-specific categories for the TNM elements and stage groups https://cancerstaging.org/references-tools/deskreferences/Pages/default.aspx

For additional staging information, see Cancer Staging section in this manual.

Item: TUMOR SIZE CLINICAL **NAACCR Item 752**

This data item records the size of a solid primary tumor before **any** treatment. Clinical tumor size (pretreatment size) is essential for treatment decision making and prognosis determination for many types of cancer.

Codes (Refer to the most recent version of *SEER Program Coding and Staging Manual* for additional instructions.)

000 No mass/tumor found
001 1 mm or described as less than 1 mm
002-988 Exact size in millimeters (2 mm to 988 mm)
989 989 millimeters or larger
990 Microscopic focus or foci only and no size of focus is given
998 Alternate descriptions of tumor size for specific sites:
Familial/multiple polyposis:
Rectosigmoid and rectum (C19.9, C20.9)
Colon (C18.0, C18.2-C18.9)

If no size is documented:
Circumferential:
Esophagus (C15.0 C15.5, C15.8 C15.9)
Diffuse; widespread: 3/4s or more; linitis plastica:
Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9)
Diffuse, entire lung or NOS:
Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9)
Diffuse:
Breast (C50.0 C50.6, C50.8 C50.9)

999 Unknown; Size not stated; Not documented in patient record; Size of tumor cannot be assessed; Not applicable

Item: TUMOR SIZE PATHOLOGIC **NAACCR Item 754**

This data item records the size of a solid primary tumor that has been resected. Pathologic tumor size is an important prognostic indicator and valuable for clinical practice and research on surgically treated patients.

Codes (Refer to the most recent version of *SEER Program Coding and Staging Manual* for additional instructions.)

000 No mass/tumor found
001 1 mm or described as less than 1 mm
002-988 Exact size in millimeters (2 mm to 988 mm)
989 989 millimeters or larger
990 Microscopic focus or foci only and no size of focus is given
998 Alternate descriptions of tumor size for specific sites:
Familial/multiple polyposis:
Rectosigmoid and rectum (C19.9, C20.9)
Colon (C18.0, C18.2-C18.9)

If no size is documented:
Circumferential:
Esophagus (C15.0 C15.5, C15.8 C15.9)
Diffuse; widespread: 3/4s or more; linitis plastica:
Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9)
Diffuse, entire lung or NOS:
Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9)
Diffuse:
Breast (C50.0 C50.6, C50.8 C50.9)

999 Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed; Not applicable

Item: TUMOR SIZE SUMMARY — NAACCR Item 756

This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen. Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Codes: (See the most recent version of the *FORDS* manual for additional instructions.)

000 No mass/tumor found
001 1 mm or described as less than 1 mm
002-988 Exact size in millimeters (2mm-988mm)
989 989 millimeters or larger
990 Microscopic focus or foci only and no size of focus is given
998 SITE-SPECIFIC CODES
Alternate descriptions of tumor size for specific sites:
Familial/multiple polyposis:
Rectosigmoid and rectum (C19.9, C20.9)
Colon (C18.0, C18.2-C18.9)

If no size is documented:
Circumferential:
Esophagus (C15.0 C15.5, C15.8 C15.9)
Diffuse; widespread: 3/4s or more; linitis plastica:
Stomach and Esophagus GE Junction (C16.0 C16.6, C16.8 C16.9)
Diffuse, entire lung or NOS:
Lung and main stem bronchus (C34.0 C34.3, C34.8 C34.9)
Diffuse:
Breast (C50.0 C50.6, C50.8 C50.9)

999 Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed; Not applicable

Item: TYPE OF REPORTING SOURCE — NAACCR Item 500

Code the source documents used to abstract the majority of information on the tumor being reported. This may not be the source of original casefinding.

Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7, as this reflects the addition of codes 2 and 8 as well as prioritizing laboratory reports over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.

This data item is intended to indicate the completeness of information available to the abstractor. Reports from health plans (e.g., Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally and is available to the abstractor are expected to be at least as complete as reports for hospital inpatients, which is why these sources are grouped with inpatients and given the code with the highest priority.

Sources coded with “2” usually have complete information on the cancer diagnosis, staging, and treatment.

Sources coded with "8" would include, but would not be limited to, outpatient surgery and nuclear medicine services. A physician's office that calls itself a surgery center should be coded as a physician's office. Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. If a physician's office calls itself a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

Codes are as follows:

1 Hospital inpatient; Managed health plans with comprehensive, unified medical records
2 Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
3 Laboratory only (hospital-affiliated or independent)
4 Physician's office/private medical practitioner (LMD)
5 Nursing/convalescent home/hospice
6 Autopsy only
7 Death certificate only
8 Other hospital outpatient units/surgery centers (outpatient surgery & nuclear medicine services)

Do not leave this data item blank. One of the above values must be recorded.

Item: VITAL STATUS **NAACCR Item 1760**

Record the vital status of the patient as of the date of last contact. If the patient has multiple tumors, vital status should be the same for all tumors.

Codes

0 - Dead
1 - Alive

FOLLOW-UP WORK ON REPORTED CASES

Contact with the reporting entity concerning an individual cancer report or a specific patient will occur under four separate circumstances. As is consistent with Administrative Rules; the cooperation of facility personnel in these four areas is essential. Should problems or concerns arise, please feel free to contact the office.

1. As cancer reports are received and processed, each will be reviewed for completeness, legibility and consistency. Contact with the reporting entity will occur to resolve identified problems in these areas as reports are initially processed and later as final processing occurs. Contacts will generally be by e-mail (with no patient identifiers) or phone. Prompt attention to such issues by the personnel responsible for completing these reports is important for smooth processing.

2. In assessing the quality of the cancer reports received from across the state, the office will contact hospitals, laboratories or registries for access to or copies of pertinent records. This is necessary in order to evaluate the quality and completeness of the information received from individual reporting entities. Problems that are identified during such reviews will be addressed as necessary to maintain or improve data quality and usefulness.

3. Contact may also occur to conduct approved epidemiological research projects. When a research study is approved by the Director of the Michigan Department of Health and Human Services, study subjects will be drawn from the state registry. Hospitals, laboratories and registries will be contacted concerning each case reported by them to ascertain the physician treating the patient. Through this process, physicians can then be contacted and patient consent obtained.

4. Death follow back study (also known as “unlinked deaths’) is part of the department's passive casefinding system. The process of the death follow back study can be summarized as follows:

    a. the previous year’s death file is reviewed for all death certificates that indicate some involvement of cancer
    b. the cases that indicate involvement of cancer are then matched against the cancer registry
    c. those decedents that do not match the cancer registry and indicate involvement of cancer are then identified and the death certificate is pulled
    d. these cases are reviewed to see if they appear to meet the reporting criteria
    e. if after review they appear to be unreported cancer cases, the cases are queried
    f. unreported cases are either queried through the hospital where the patient died or through the certifying physician for follow up information
    g. after receiving the follow up information a decision is made: either the case meets reporting criteria and a cancer report is filed, or the case does not meet reporting criteria and is not added to the cancer registry

The death certificate information is a valuable tool in casefinding. The types of cases that we have found are those that have not been definitively diagnosed, or cases that are not diagnosed until death occurred. Through the death follow back study we add cases yearly which helps to create a more complete state cancer registry.

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REPORTABLE CONDITIONS

The first step in any casefinding effort is to outline what is reportable. The administrative rules on cancer reporting provide the definition of a reportable cancer. ALL cases satisfying this definition are reportable. The residence of the patient is NOT a factor.

Cases diagnosed on or after **January 1, 1985 to date** MUST be reported to the Michigan Cancer Surveillance Program **within 180 days or six months from the date of initial diagnosis**.

> "Cancer" means all diagnoses with a behavior code of "2" (carcinoma in situ) or "3" (malignant primary site) as listed in the most recently amended International Classification of Diseases for Oncology, EXCLUDING basal, epithelial, papillary and squamous cell carcinomas of the skin, but **including** carcinomas of the skin prepuce, clitoris, vulva, labia, penis and scrotum.

Carcinoma in situ of the cervix (CIS) and intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III) ARE a reportable condition.

Juvenile astrocytoma listed as 9421/**1** in ICD-O-3 are required and should be recorded as 9421/**3**, thereby making it a reportable condition.

Non-malignant primary intracranial and central nervous system tumors diagnosed on or after **October 1, 2004** with an ICD-O-3 behavior code of "0" or "1" are required for the following sites: meninges (C70.0 – C70.9); brain (C71.0 – C71.9); spinal cord, cranial nerves, and other parts of the central nervous system (C72.0 – C72.9); pituitary gland (C75.1); craniopharyngeal duct (C75.2); and pineal gland (C75.3). Those facilities approved by the American College of Surgeons (ACoS) began collecting non-malignant primary intracranial and central nervous system tumors on January 1, 2004.

Malignant primary skin cancers (C44._) with histology codes 8000–8110 are NOT a reportable condition.

Once a tumor has been identified, it is assigned a six digit morphology code (e.g. 8522/34) from the International Classification of Diseases for Oncology, Third Edition (ICD-O-3) coding book. The first four digits record the cell type or histology. The fifth digit, after the slash or solidus (/), is the behavior code and the sixth digit is the tumor grade. ALL tumors assigned a fifth digit behavior code of "2" or "3" in the ICD-O-3 are reportable.

ICD-O-3 Fifth Digit Behavior Codes for Neoplasms			
Behavior Code	**Definition**	**Reportable**	**Non-Reportable**
/0	Benign EXCEPTION: Brain and CNS		**X**
/1	Uncertain whether benign or malignant Borderline malignancy Low malignant potential Uncertain malignant potential EXCEPTION: Brain and CNS		**X**
/2	Carcinoma In Situ Intraepithelial Non-infiltrating Noninvasive	**X**	
/3	Malignant, primary site	**X**	
/6*	Malignant, metastatic site Malignant, secondary site		**X**

ICD-O-3 Fifth Digit Behavior Codes for Neoplasms			
Behavior Code	**Definition**	**Reportable**	**Non-Reportable**
/9*	Malignant, uncertain whether primary or metastatic site * Not used by cancer registries.		**X**

NOTE*:* Screening of diagnostic codes for behavior codes "6 - malignant, metastatic site," and "9 - malignant, uncertain whether primary or metastatic site" is necessary for casefinding. If this is the first diagnosis of this cancer and even though it is the metastatic site, it is still a reportable condition. The first time a diagnosis of cancer is made with an "unknown primary" it should be reported as such. If the primary site is determined after further study and it was originally reported as an unknown primary, a correction MUST be reported. The behavior code of "6" is only allowed to be used by central registries. When reporting an unknown primary site, a behavior code "3 - malignant" must be used.

Newly Reportable Conditions and Other Changes

Effective January 1, 2016

Per the NAACCR 2016 Implementation Guidelines and Recommendations, the CDC recommends adding the following conditions/tumors to ICD-O-3 Manuals and educating reporting sources about these new updates.

1. Non-invasive mucinous cystic neoplasm of the pancreas with high-grade dysplasia replaces mucinous cystadenocarcinoma, non-invasive (8470/2).
2. Solid pseudopapillary neoplasm of pancreas (8452/3) is synonymous with solid pseudopapillary carcinoma (C25._).
3. Based on pathologist consultation, metastases have been reported in some cystic pancreatic endocrine neoplasm (CPEN) cases. With all other pancreatic endocrine tumors now considered malignant, CPEN will also be considered malignant, until proven otherwise. Most CPEN cases are non-functioning and are REPORTABLE using histology code 8150/3, unless the tumor is specified as a neuroendocrine tumor, grade 1 (assign code 8240/3) or neuroendocrine tumor, grade 2 (assign code 8249/3).
4. Laryngeal intraepithelial neoplasia, grade III (LINIII) (8077/2), C320-C329
5. Squamous intraepithelial neoplasia, grade III (SINIII) (8077/2), except Cervix and Skin
6. Mature teratoma of the testes in adults is malignant and REPORTABLE as 9080/3, but continues to be non-reportable in prepubescent children (9080/0). The following provides additional guidance:
   - Adult is defined as post puberty
   - Pubescence can take place over a number of years
   - Do not rely solely on age to indicate pre or post puberty status. Review all information (physical history, etc.) for documentation of pubertal status. When testicular teratomas occur in adult males, pubescent status is likely to be stated in the medical record because it is an important factor of the diagnosis.
   - Do not report if unknown whether patient is pre or post pubescent. When testicular teratoma occurs in a male and there is no mention of pubescence, it is likely that the patient is a child, or pre-pubescent, and the tumor is benign.

Effective January 1, 2015

The NAACCR Guidelines for ICD-O-3 Update Implementation (published December 2013) included a table of new ICD-O-3 codes and terms effective for 2015; however, the use of the new codes was postponed due to issues with adding these codes to the CSv2 software. For diagnosis year 2016, all standard setters have agreed to postpone these codes once again, and to use the alternate codes as noted in the chart below.

Hospital registrars should look for use, by their pathologists, of the terms listed in this chart. Since these terms have not yet been officially adopted for cancer surveillance in North America, registrars should abstract cases using the acceptable codes listed in the chart to report them to central registries and to CoC.

ICD-O-3 change	New code in ICD-O-3 (do NOT use these codes)	Description	Comment	Use this code in 2015 and 2016
New term and code	8158/1	Endocrine tumor, functioning, NOS	Not reportable	
New related term	8158/1	ACTH-producing tumor	Not reportable	
New term and code	8163/3	Pancreatobiliary-type carcinoma (C24.1)	DO NOT use new code	8255/3
New synonym	8163/3	Adenocarcinoma, pancreatobiliary-type (C24.1)	DO NOT use new code	8255/3
New term	8213/3	Serrated adenocarcinoma		8213/3*
New code and term	8265/3	Micropapillary carcinoma, NOS (C18._, C19.9, C20.9)	DO NOT use new code	8507/3*
New code and term	8480/1	Low grade appendiceal mucinous neoplasm (C18.1)	Not reportable	
New term and code	8552/3	Mixed acinar ductal carcinoma	DO NOT use new code	8523/3
New term and code	8975/1	Calcifying nested epithelial stromal tumor (C22.0)	Not reportable	
New term and code	9395/3	Papillary tumor of the pineal region	DO NOT use new code	9361/3*
New term and code	9425/3	Pilomyxoid astrocytoma	DO NOT use new code	9421/3
New term and code	9431/1	Angiocentric glioma	DO NOT use new code	9380/1*
New term and code	9432/1	Pituicytoma	DO NOT use new code	9380/1*
New term and code	9509/1	Papillary glioneuronal tumor	DO NOT use new code	9505/1
New related term	9509/1	Rosette-forming glioneuronal tumor	DO NOT use new code	9505/1
New term and code	9741/1	Indolent systemic mastocytosis	Not reportable	

* ICD-O-3 rule F applies (code the behavior stated by the pathologist). If necessary, over-ride any advisory messages.

Effective January 1, 2014

Use the following new terms, synonyms, and related terms for existing ICD-O-3 codes.
Bold indicates a preferred term.

New preferred term..... 8150/0 **Pancreatic endocrine tumor, benign (C25._)**
Move former preferred term to synonym ..... 8150/0 Islet cell adenoma (C25._)
New related term ..... 8150/0 Pancreatic microadenoma (C25._)

New preferred term..... 8150/1 **Pancreatic endocrine tumor, NOS (C25._)**
Move former preferred term to synonym ..... 8150/1 Islet cell tumor, NOS (C25._)

New preferred term	8150/3	**Pancreatic endocrine tumor, malignant (C25._)**
Move former preferred term to synonym	8150/3	Islet cell carcinoma (C25._)
New related term	8150/3	Pancreatic endocrine tumor, nonfunctioning (C25._)
New related term	8152/1	L-cell tumor
New related term	8152/1	Glucagon-like peptide-producing tumor (C25._)
New related term	8152/1	Pancreatic peptide and pancreatic peptide-like peptide within terminal tyrosine amide producing tumor
New synonym for related term	8152/1	PP/PYY producing tumor
New preferred term	8154/3	**Mixed pancreatic endocrine and exocrine tumor, malignant (C25._)**
New related term	8154/3	Mixed endocrine and exocrine adenocarcinoma (C25._)
New synonym for related term	8154/3	Mixed islet cell and exocrine adenocarcinoma (C25._)
New related term	8154/3	Mixed acinar-endocrine-ductal carcinoma
New related term	8201/3	Cribriform comedo-type carcinoma (C18._, C19.9, C20.9)
New synonym	8201/3	Adenocarcinoma, cribriform comedo-type (C18._, C19.9, C20.9)
New synonym to primary term	8213/0	Traditional serrated adenoma
New related term	8213/0	Sessile serrated adenoma
New related term	8213/0	Sessile serrated polyp
New related term	8213/0	Traditional sessile serrated adenoma
New related term	8240/3	Neuroendocrine tumor, grade 1
New related term	8240/3	Neuroendocrine carcinoma, low grade
New related term	8240/3	Neuroendocrine carcinoma, well-differentiated
New preferred term	8244/3	**Mixed adenoneuroendocrine carcinoma**
Move former preferred term to synonym	8244/3	Composite carcinoid
New synonym	8244/3	Combined/mixed carcinoid and adenocarcinoma
New synonym	8244/3	MANEC
New synonym	8249/3	Neuroendocrine tumor, grade 2
New related term	8249/3	Neuroendocrine carcinoma, moderately differentiated
New synonym	8263/0	Tubulo-papillary adenoma
New related term	8290/0	Spindle cell oncocytoma (C75.1)
New related term	8490/3	Poorly cohesive carcinoma
New related term	8811/0	Plexiform fibromyxoma
New related term	8970/3	Hepatoblastoma, epitheliod (C22.0)
New related term	8970/3	Hepatoblastoma, mixed epithelial-mesenchymal (C22.0)
New related term	9471/3	Medulloblastoma with extensive nodularity

New related term ..... 9474/3 Anaplastic medulloblastoma

New related term ..... 9506/1 Extraventricular neurocytoma

NOTE: It is important to understand that cancer registry reportability rules based on behavior code still apply. With the exception of primary intracranial and central nervous system benign and borderline tumors, the addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable.

Other Changes

Make the following reportability change.
Behavior code change:

- Delete code and term, 8240/1, Carcinoid tumor, NOS, of appendix (C18.1).
- Code carcinoid tumor, NOS, of appendix to 8240/3.

Recode the following conditions as shown.

1. Recode all cases of enteroglucagonoma, NOS, as 8152/1.
   (Enteroglucagonoma is now a related term for glucagonoma.)
2. Then delete code 8157/1 Enteroglucagonoma, NOS.
3. Recode all cases of enteroglucagonoma, malignant as 8152/3.
   (Enteroglucagonoma, malignant is now a related term for glucagonoma, malignant.)
4. Then delete code 8157/3 Enteroglucagonoma, malignant.

NOTE: It is important to understand that cancer registry reportability rules based on behavior code still apply. With the exception of primary intracranial and central nervous system benign and borderline tumors, the addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable.

BENIGN/BORDERLINE INTRACRANIAL AND CNS TUMORS

For benign/borderline intracranial and central nervous system tumors, the terms “tumor” and “neoplasm” are considered diagnostic for the purpose of case reporting, in addition to the terms generally applicable to malignant tumors.

If the final pathologic diagnosis is “CNS neoplasm” or “mass,” there MUST be an ICD-O-3 code for the mass or neoplasm. If there is not an ICD-O-3 code, the case is NOT reportable.

Diagnoses like “hypodense mass” or “cystic neoplasm” are NOT reportable even for CNS sites.

If the ONLY diagnosis available is “CNS tumor” or “neoplasm” the case is reportable and the histology is coded as M-8000/1 (Neoplasm, NOS, uncertain whether benign or malignant.)

Reportable Histologies

Meningiomas (M9530)
Craniopharyngioma (M9350)
Rathke Pouch Tumor (M9350)
Chordomas (M9370)
Schwannoma (M9560)
Acoustic Schwannoma/Neuroma
Dermoid Cyst (M9084)
Granular Cell Tumor (M9580)
Embryonal Tumors

Retinoblastoma (M9510)
Primitive Neuroectodermal Tumors (PNET)
Lymphoma
Vascular Tumors (arise from blood vessels of brain and spinal cord)
Hemangioblastoma (M9161)

NOTE*:* This is NOT a complete list of all possible reportable histologies.

Non-Reportable Histologies

Rathke Cleft Cyst
Epidermoid Cyst
Colloid cyst
Enterogenous Cyst
Neuroglial Cyst
Plasma Cell Granuloma
Nasal Glial Heterotopia
Venous Angiomas (of brain and CNS)

NOTE*:* This is NOT a complete list of all possible non-reportable histologies.

REPORTABLE CONDITIONS FOR AIN III, CIN III, HSIL/HGSIL, VAIN III, VIN III

For these cases, histology is based on a histologically confirmed diagnosis that includes at least one of the following terms: "cervical intraepithelial neoplasia grade III (CIN III)," "HGSIL," "HSIL," or "severe dysplasia." Histology for any of these cervical neoplasia conditions is coded as 8077 with or without the term "carcinoma in situ."

Example: Final diagnosis on the pathology report is "high grade squamous intraepithelial neoplasia (HGSIL)."
Code histology as 8077.
Do NOT code the histology in this instance as 8070.

For pre-invasive cervical lesions, cases identified by only a PAP smear **ARE NOT** eligible for inclusion. The diagnosis must be confirmed by some other method, which could include a clinical diagnosis (physician's statement) or positive biopsy pathology.

For Cervical Intraepithelial Neoplasia, Grade III, code Local Tumor Excision, Excisional Biopsy, Dilation and Curettage, Copy Biopsy with gross excision of lesion, LEEP and/or combinations of surgical procedures as defined in FORDS: Appendix B: Site-Specific Surgery Codes as first course of treatment. (*Note:* For invasive cancers, dilation and curettage is coded as an incision biopsy code 02 under the data item Surgical Diagnostic and Staging Procedure (NAACCR Item # 1350).

For non-invasive cancers, code Dilation and Curettage for in situ ONLY as code 25.

Example: First course of treatment for a non-invasive cancer is documented as LEEP.
Code the RX Summ--Surgery Primary Site as 28.

Code an excision biopsy, even when documented as incisional, when:

- All disease is removed (margins free) OR
- All gross disease is removed and there is only microscopic residual at the margin
- Do NOT code an excision biopsy when there is macroscopic residual disease

The following conditions are considered reportable and MUST be reported to the Michigan Cancer Surveillance Program **regardless of facility type.**

Reportable Conditions				
ICD-10-CM Code	**ICD-9-CM Code**	**Primary Site**	**Histology Code**	**Topography Code**
D01.3	230.5	AIN III (anal intraepithelial neoplasia – histologically confirmed) *NOTE: "Severe dysplasia **alone** IS reportable." A diagnosis of "High grade dysplasia" **only** IS NOT reportable.*	8077/2	C21.1
D06.9	233.1	CIN III (cervical intraepithelial neoplasia - histologically confirmed) with or without carcinoma in situ (CIS) *"Severe dysplasia" **alone is reportable*** *"High grade dysplasia" **alone is not reportable***	8077/2	C53.0 - C53.9
D06.9	233.1	HSIL/HGSIL (high-grade squamous intraepithelial lesion - histologically confirmed) with or without carcinoma in situ (CIS); with or without CIN III; with or without severe dysplasia *"High grade dysplasia" **alone is not reportable***	8077/2	C53.0 - C53.9
D07.2	233.31	VAIN III (vaginal intraepithelial neoplasia) with or without carcinoma in situ (CIS) *"Severe dysplasia" **alone is reportable*** *"High grade dysplasia" **alone is not reportable***	8077/2	C52.0 - C52.9
D07.1	233.32	VIN III (vulvar intraepithelial neoplasia - histologically confirmed) with or without carcinoma in situ (CIS) *"Severe dysplasia" **alone is reportable*** *"High grade dysplasia" **alone is not reportable***	8077/2	C51.0 - C51.9

Examples

Reportable
"CIN 2 and 3" is reportable
"CIN 2 & 3" is reportable
"CIN 2 + 3" is reportable
"Moderate and severe dysplasia" is reportable

Not Reportable
"CIN 2-3" is NOT reportable
"CIN 2/3" is NOT reportable
"Moderate to severe dysplasia" is NOT reportable

Instructions for Coding Histology and Histology Terminology for Pre-invasive (Non-invasive) Lesions
Do not use a physician's statement to decide whether the patient has a recurrence of a previous cancer or a new primary unless a pathologist compares the present tumor to the "original" tumor and states that this tumor is a recurrence of cancer from the previous primary.

Assigning Sequence Numbers
These pre-invasive lesions must be coded in sequence range 00-59. **Do not use the 60-88 non-malignant sequence range or sequence 98 for these lesions** as these cases are required by the MCSP (not reportable by agreement.)

Included Histologies
Use histology code 8077/2 for diagnoses of HGSIL, CIN III, VIN III, VAIN III, or AIN III (Multiple Primary and Histology Coding Rules – Rule H21). All 8077 lesions are to have a coded Grade/Differentiation value of 9.

Lesions with ICD-O-3 histology codes 8010, 8050, 8052, 8070, 8071, 8072, 8076, 8077, and 8140 are eligible for inclusion. Lesions with histology code 8560 and behavior code 2 may also be eligible if it is determined that behavior code 2 is appropriate – the pathology report should specifically indicate "in situ" behavior [since histology 8560 (adenosquamous carcinoma) is normally an invasive cancer.] An entry should be made in pathology text field to the effect that "eligibility is confirmed for this 8560 case."

Number of Reportable Conditions
All types of squamous histologies (8010, 8050, 8052, 8070, 8071, 8072, 8076, and 8077) are considered to be the same for determining inclusion eligibility when reviewing multiple reports for the same patient. If a patient has more than one lesion with these squamous histologies **within a 12-month period,** only the lesion with earliest diagnosis date (or one lesion, if the lesions have the same diagnosis date) is eligible for inclusion.

Histology codes 8140 (adenocarcinoma in situ) and 8560 (adenosquamous carcinoma) with behavior code 2 are considered to be the same for determining inclusion eligibility when reviewing multiple reports for the same patient. If a patient has more than one lesion with either of these histologies **within a 12-month period,** only the lesion with earliest diagnosis date (or one lesion, if the lesions have the same diagnosis date) is eligible for inclusion.

A subsequent lesion is eligible for inclusion **only if its histology is different** from the first eligible lesion. If a lesion is described as having both squamous cell carcinoma in situ **and** adenocarcinoma in situ, then it should be entered as two separate abstracts, one with each histology code.

If a patient is diagnosed with another pre-invasive lesion with the same histology **after** the 12-month period following the first eligible lesion, the subsequent lesion is eligible for inclusion.

If a patient has **both** an in situ and invasive diagnosis **on the same date,** or if the invasive diagnosis follows a previously included in situ diagnosis **within 60 days,** the in situ diagnosis is no longer considered to be eligible and should be removed from the database.

If a patient is diagnosed with a pre-invasive (in situ) lesion **within a 12-month period after** having been diagnosed with an invasive lesion, the pre-invasive lesion is not considered to be eligible for inclusion.

Histology Terminology
It is important to document in the abstract the terminology used in the path report to describe these pre-invasive lesions. MCSP uses this terminology to assign hierarchically codes to these lesions as part of its reporting responsibility to other cancer data collection agencies. In descending order from "highest" to "lowest", these histology terminologies are:

AIS (adenocarcinoma in situ)	Highest
CIN III (cervical intraepithelial neoplasia III)	…
CIS (carcinoma in situ)	…

Severe dysplasia Lowest

If more than one terminology is used in the pathology description of a single tumor, the "highest" terminology should be documented in the abstract. If separate tumors are diagnosed on the same date with differing histologies (adenocarcinoma, CIN III), code each tumor per the terminology used in the pathology description.

Examples If a lesion has two pathology reports with the same histology, but different diagnosis dates and different terminologies, only the lesion with the earliest diagnosis date is eligible for inclusion. In the following example, only report #1, the lesion with the 3/15/2009 DxDate, is eligible for inclusion:

Report #1: DxDate = 3/15/2009, Histology = 8010, Terminology = severe dysplasia
Report #2: DxDate = 4/30/2009, Histology = 8010, Terminology = CIN III

If a lesion has two pathology reports with the same histology and the same diagnosis dates, but with different terminologies, the hierarchy of terminology should be used to determine which report is eligible for inclusion. In the following example, only report #2, the lesion with CIN III, is eligible for inclusion:

Report #1: DxDate = 3/15/2009, Histology = 8010, Terminology = severe dysplasia
Report #2: DxDate = 3/15/2009, Histology = 8010, Terminology = CIN III

For pre-invasive cervical lesions, cases identified by only a PAP smear **ARE NOT** eligible for inclusion. The diagnosis must be confirmed by some other method, which could include a clinical diagnosis (physician's statement) or positive biopsy pathology.

NON-REPORTABLE CONDITIONS FOR AIN I/II, CIN I/II, HSIL/HGSIL, VAIN I/II, VIN I/II

The following conditions are NOT reportable to the Michigan Cancer Surveillance Program. ICD-10-CM codes are effective as of October 1, 2015.

Non-Reportable Conditions				
ICD-10-CM Code	**ICD-9-CM Code**	**Primary Site**	**Histology Code**	**Topography Code**
K62.82	569.44	AIN I (anal intraepithelial neoplasia) with or without mild dysplasia	8077/0	C21.1
K62.82	569.44	AIN II (anal intraepithelial neoplasia) with or without moderate dysplasia	8077/0	C21.1
N87.0	622.11	CIN I (cervical intraepithelial neoplasia) with or without mild dysplasia	8077/0	C53.0 - C53.9
N87.1	622.12	CIN II (cervical intraepithelial neoplasia) with or without moderate dysplasia	8077/0	C53.0 - C53.9
N89.3	795.1	LSIL (low-grade squamous intraepithelial lesion) with or without mild dysplasia	8077/0	C53.0 - C53.9
N89.3	623.0	VAIN I (vaginal intraepithelial neoplasia) with or without mild dysplasia	8077/0	C52.9
N89.3	623.0	VAIN II (vaginal intraepithelial neoplasia) with or without moderate dysplasia	8077/0	C52.9
N90.0	624.01	VIN I (vulvar intraepithelial neoplasia) with or without mild dysplasia	8077/0	C51.0 - C51.9
N90.1	624.02	VIN II (vulvar intraepithelial neoplasia) with or without moderate dysplasia	8077/0	C51.0 - C51.9
N42.3	602.3	PIN I (Prostatic Intraepithelial Neoplasia)	8077/0	C61.9

Non-Reportable Conditions				
ICD-10-CM Code	**ICD-9-CM Code**	**Primary Site**	**Histology Code**	**Topography Code**
N42.3	602.3	PIN II (Prostatic Intraepithelial Neoplasia)	8077/0	C61.9
D07.5	233.4	PIN III (Prostatic Intraepithelial Neoplasia)	8077/0	C61.9

EXCLUSIONS TO REPORTABLE CONDITIONS

The Michigan Cancer Surveillance Program has exclusions to the collection of skin malignancies based upon the primary site and histology.

If the following histologies arise in the skin (C44.0 - C44.9) they are NOT reportable regardless of the stage at the initial time of diagnosis. ALL other histologies of the skin are reportable, e.g.: melanoma, Kaposi sarcoma, mycosis fungoides, cutaneous lymphomas, Merkel cell carcinoma, etc.

Description of Histology Codes
Malignant Neoplasm (Carcinoma), NOS of the skin 8000 - 8004
Epithelial Neoplasms (Carcinoma), NOS of the skin 8010 - 8045
Papillary and Squamous Cell Neoplasm (Carcinoma) of the skin 8050 - 8082
Basal Cell Neoplasm (Carcinoma) of the skin 8090 - 8110

EXCEPTION: The above histologies MUST be reported if the primary site is skin of the male and female genital sites. See “Reportable vs. Non-Reportable Conditions of the Skin” table.

NOTE: ICD-10-CM went into effect October 1, 2015.

REPORTABLE VS. NON-REPORTABLE CONDITIONS OF THE SKIN

ICD-10-CM Code	ICD-9-CM Code	Primary Site	Topography Code	Reportable	Non-Reportable
C52	184.0	Skin of Vagina	C52.9	**X**	
C51.2	184.1	Skin of Labia Majora	C51.0/ C51.1	**X**	
C51.1	184.2	Skin of Labia Minora	C51.1	**X**	
C51.2	184.3	Skin of Clitoris	C51.2	**X**	
C51.9	184.4	Skin of Vulva, NOS	C51.9	**X**	
C57.8	184.8	Skin Lesion of Overlapping	C51.9	**X**	
C60.0	187.1	Skin of Prepuce	C60.0	**X**	
C60.9	187.4	Skin of Penis, NOS	C60.9	**X**	
C63.2	187.7	Skin of Scrotum	C63.2	**X**	
C44.00 C44.01 C44.02 C44.09	173.0	Skin of Lip	C44.0		**X**
C44.101 C44.111 C44.121 C44.191	173.1	Skin of Eyelid/Other Unspecified Parts of Face	C44.1/C44.3		**X**

ICD-10-CM Code	ICD-9-CM Code	Primary Site	Topography Code	Reportable	Non-Reportable
C44.201 C44.211 C44.221 C44.291	173.2	Skin of External Ear/Auditory Canal	C44.2		**X**
C44.300 C44.301 C44.309 C44.310 C44.311 C44.319 C44.320 C44.321 C44.329 C44.390 C44.391 C44.399	173.3	Skin of Other & Unspecified Parts of the Face	C44.3		**X**
C44.40 C44.41 C44.42 C44.49	173.4	Skin of Scalp and Neck	C44.4		**X**
C44.509 C44.519 C44.529 C44.599	173.5	Skin of Anus & Skin of Trunk (Except Scrotum)	C44.5		**X**
C44.601 C44.611 C44.621 C44.691	173.6	Skin of Upper Limb and Shoulder	C44.6		**X**
C44.701 C44.711 C44.721 C44.791	173.7	Skin of Lower Limb and Hip	C44.7		**X**
C44.80 C44.81 C44.82 C44.89	173.8	Skin, Overlapping Lesion	C44.8		**X**
C44.90 C44.91 C44.92 C44.99	173.9	Skin, NOS	C44.9		**X**

CASE SCENARIOS

The following scenarios and definitions are to assist with determining whether or not the patient has a reportable condition.

Reportable Case Scenarios

1 If a lesion is originally assigned a behavior code of “0 - benign” or “1 - uncertain” and is later assigned a behavior code of “2 - in situ” or “3 - malignant” by the pathologist, the case is reportable.

2. If a lesion is originally assigned a behavior code of “0 - benign” or “1 - uncertain” and is later assigned a behavior code of “2 - in situ” or “3 - malignant” by the managing physician, the case is reportable.

3. If a specimen is sent to your facility from a staff physician’s office and read by your pathologist (e.g., pap smear, stereotatic needle biopsy for a breast mass, or excisional biopsy for a suspicious skin lesion) the case is to be reported.

4. An incidental finding of a malignancy at the time of an autopsy, with no suspicion of cancer prior to death, MUST be reported.

5. All malignant histologically confirmed specimens identified by your facility, e.g., tissue specimens from biopsy, frozen section, surgery, autopsy, or dilation and curettage (D&C); bone marrow biopsy, bone marrow aspiration; hematologic confirmation of leukemia (peripheral blood smear); loop electrocautery excision procedure (LEEP), are reportable.

6. All malignant cytological confirmed specimens identified by your facility, e.g.,, breast secretion, bronchial brushing, bronchial washings, cervical smear (pap smear), fine needle aspirate (FNA), gastric fluid, peritoneal fluid, pleural fluid, prostatic secretions, spinal fluid, sputum smears, tracheal washings, urinary sediment, vaginal smears, are reportable.

7. Patient is diagnosed in a staff physician’s office and treated at your facility.

8. Patient is diagnosed at your facility and treated elsewhere, whether by referral or by choice.

9. Patient is diagnosed at your facility and receives all or part of his/her treatment at your facility.

10. Patient is diagnosed at your facility and refuses therapy.

11. Patient is diagnosed at your facility and the family/guardian refuses therapy.

12. Patient is diagnosed at your facility and is untreatable due to age, advanced disease or other medical conditions.

13. Patient is diagnosed at your facility and specific therapy was recommended but not received at your facility or unknown if administered.

14. Patient was diagnosed elsewhere, but received all or part of his/her treatment at your facility.

15. Patient is diagnosed at your facility but unknown if therapy was recommended or administered.

16. Patient was diagnosed by death certificate only.

17. Patient receives all or part of the first course of therapy for a malignancy, regardless of where they were first diagnosed.

18. Patient is a non-resident of Michigan and is receiving treatment at your facility.

19. Patient is a Michigan resident diagnosed out of state but receiving treatment at your facility.

20. Patient is a Michigan resident diagnosed and treated out of state, e.g., The patient is diagnosed and treated in Wisconsin for breast cancer, but is admitted to the cardiac care unit at your facility. You recognize that the patient has breast cancer and is receiving their first course of treatment in Wisconsin. The patient is a Michigan resident, therefore the case is reportable.

Non-Reportable Case Scenarios

1. Precancerous or benign conditions (except benign or borderline intracranial CNS tumors).

2. Patients seen only in consultation to establish or confirm a diagnosis of cancer or treatment plan when the patient was first seen in a known Michigan facility.

3. Patient is diagnosed with a recurrence or progression of a previously diagnosed malignancy.

4. The patient's malignancy was originally diagnosed prior to January 1, 1985.

5. Patient receives a radiographic exam (MRI, X-ray, CT) which reveals an ill-defined "mass." If the patient does NOT return to your facility for diagnostic confirmation or treatment of cancer, the case is not reportable. For example: an outpatient CT scan of the pelvis reads, probable carcinoma of the right kidney. The patient did not return to your facility for diagnostic confirmation or treatment; therefore the case is not reportable.

   NOTE: In order for a "radiographic diagnosis" to be reportable, the patient's primary care physician MUST state in the medical record that the patient has cancer and treatment has been decided upon. Keep in mind, that refusal of treatment and the decision not to treat is still classified as treatment and the case is to be reported.

6. Patient visits your facility for blood work (lab only) and is NOT admitted for treatment, e.g., blood drawn to monitor anemia for patients receiving chemotherapy elsewhere; blood drawn to monitor PSA levels for prostate cancer.

7. Patient has an active malignancy but is admitted to your facility for an unrelated medical condition and does not receive first course of treatment for their cancer.

8. Patient is admitted to your facility with an active malignancy and receives supportive or palliative care, e.g., gastrostomy tubes for enteral nutrition, if previously reported or diagnosed/treated through another Michigan hospital.

9. Patients with a history of cancer who are clinically free of disease.

10. Patients admitted for terminal supportive care, including home care services, if previously reported or diagnosed/treated through another Michigan hospital.

11. Patients admitted to a designated hospice, if previously reported or diagnosed/treated through another Michigan hospital.

12. Patient's specimen slides are sent to your pathologist for a second opinion.

13. Patients with skin cancer that does NOT meet the histology and site requirements listed previously.

Facility Specific Case Scenario

Your facility may receive specimens from a separate facility that are read by your pathologist due to the facility not having a pathologist or a laboratory. Once the specimen is read, the final report and specimen(s) are sent back to the original facility. You may or may not be responsible for reporting the ones that are malignancies. A verbal or written contract between the two facilities must exist that designates which facility will be responsible for reporting these cases to the Michigan Cancer Surveillance Program. If an agreement does NOT exist, BOTH facilities are expected to report each case.

AMBIGUOUS TERMINOLOGY

As part of the registry case-finding activities, ALL pathology reports should be reviewed to confirm whether a case is required. 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. For example, "likely" alone does not constitute a diagnosis.

Ambiguous terms may originate from any source document, such as pathology report, radiology report, or from a clinical report.

Ambiguous terms that constitute a diagnosis

Apparent(ly)
Appears
Comparable with
Compatible with
Consistent with
Favors
Malignant appearing
Most likely
Neoplasm* (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)
Presumed
Probable
Suspect(ed)
Suspicious (for)
Tumor* (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)
Typical of

*additional terms for nonmalignant primary intracranial and central nervous system tumors only

EXCEPTION: If a cytology is identified only with an ambiguous term, DO NOT interpret it as a diagnosis of cancer.

- Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Examples of Diagnostic Terms:

- The inpatient discharge summary documents a chest X ray *consistent with carcinoma* of the right upper lobe. The patient refused further work-up or treatment. *Consistent with carcinoma* is indicative of cancer.
- The mammogram report states *suspicious for malignancy*. *Suspicious for malignancy* is indicative of cancer.

Ambiguous terms that DO NOT constitute a diagnosis without additional information

Cannot be ruled out
Equivocal
Possible
Potentially malignant
Questionable
Rule Out
Suggests
Worrisome

Examples of Non-diagnostic Terms:

- The inpatient discharge summary documents a chest x-ray consistent with neoplasm of the right upper lobe. The patient refused further work-up or treatment. Consistent with neoplasm is not indicative of cancer. While "consistent with" can indicate involvement, "neoplasm" without specification of malignancy is not considered diagnostic except for non-malignant primary intracranial and central nervous system tumors.
- Final diagnosis is reported as possible carcinoma of the breast. Possible is not a diagnostic term for cancer.

Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only and DO NOT constitute a diagnosis.

Interpreting ambiguous terminology for collaborative stage

Determination of the cancer stage is both a subjective and objective assessment of how far the cancer has spread. Sometimes the clinician is hesitant to commit to a definite statement that a particular organ or tissue is involved by the cancer and uses what data collectors refer to as "ambiguous terminology." The following lists can generally be used to interpret the intent of the clinician if there is no specific statement of involvement in the medical record. However, if individual clinicians use these terms differently, the clinician's definitions and choice of therapy should be recognized. If a term used in a diagnostic statement is not listed below, consult the clinician to determine the intent of the statement.

NOTE: Some schemas interpret certain words as involvement, such as "encasing" the carotid artery for a head and neck site. Terminology in the schema takes priority over this list.

The following terms are considered as involvement:

Adherent
Apparent(ly)
Appears to
Comparable with
Compatible with
Consistent with
Contiguous
Continuous with
Encroaching upon *
Extension to
Extension into
Extension onto
Extension out onto
Features of
Fixation to structure other than primary**
Fixed to another structure**
Impending perforation of
Impinging upon
Impose on
Imposing on
Incipient invasion
Induration
Infringe
Infringing
Into *
Intrude
Invasion to into
Invasion onto
Invasion out onto
Most likely
Neoplasm*** (beginning with 2004 diagnoses and only for C70.0-C72.9, C75.1-C75.3)
Onto *
Overstep
Presumed
Probable
Protruding into (unless encapsulated)
Suspect(ed)
Suspicious
To
Tumor*** (beginning with 2004 diagnoses and only for C70.0-C72.9, C75.1-C75.3)
Up to

* interpreted as involvement whether the description is clinical, operative or pathological
** interpreted as involvement of another organ or tissue
*** additional terms for non-malignant primary intracranial and central nervous system tumors only

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The following terms ARE NOT to be considered as involvement.

Abuts
Approaching
Approximates
Attached
Cannot be excluded
Cannot be ruled out
Efface/effacing/effacement
Encased
Encasing
Encompass(ed)
Entrapped
Equivocal
Extension to without invasion
Extension to without involvement of
Kiss/kissing
Matted (except for lymph nodes)
Possible
Questionable
Reaching
Rule out
Suggests
Very close to
Worrisome

Ambiguous terminology for hematopoietic and lymphoid neoplasm

Report the case when the diagnosis of a hematopoietic or lymphoid neoplasm is preceded by one of the following ambiguous terms. For additional information, refer to the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual http://www.seer.cancer.gov/tools/heme/.

NOTE: **DO NOT report cases diagnosed only by ambiguous cytology** (cytology diagnosis preceded by ambiguous term).

Apparent(ly)
Appears
Comparable with
Compatible with
Consistent with
Favor(s)
Malignant appearing
Most likely
Presumed
Probable
Suspect(ed)
Suspicious (for)
Typical (of)

NOTE 1: Reportable diagnoses are described in Case Reportability Instructions 4-10

NOTE 2: Use these terms when screening all diagnoses other than cytology and tumor markers.

NOTE 3: Report only those cases that use the words on the list or an equivalent word such as “favored” rather than “favor(s)”. DO NOT substitute synonyms such as “supposed” for “presumed” or “equal” for “comparable.”

NOTE 4: Accept the reportable term and report the case when one part of the medical record uses a reportable ambiguous term such as “apparently” and another section of the medical record(s) uses a term that is not on the reportable list.

NOTE 5: Diagnoses based on ambiguous terminology require follow-back to see if the diagnosis has been confirmed or proven to be incorrect (see NOTE 6).

NOTE 6: DO NOT report the case when biopsy or physician’s statement proves the ambiguous diagnosis is wrong (for example, pathology diagnosis is benign or borderline).

Example CT scan shows enlarged lymph nodes suspicious for lymphoma. Subsequent biopsies of the lymph nodes thought to be involved with a neoplasm are negative for malignancy. The pathology is more reliable than the scan; the negative biopsy proves that the presumed malignancy does not exist. DO NOT report the case.

CASEFINDING PROCEDURES

Casefinding is a systematic process used to identify all cases eligible to be included in the central cancer registry. Cases include those patients that were diagnosed and/or treated with a reportable condition in your facility.

One source for casefinding is NOT enough to identify all cancer cases diagnosed or treated at your facility and multiple sources MUST be used to obtain a complete description of each patient's course of cancer care.

Each facility should have written procedures and instructions for carrying out complete casefinding. This will ensure that casefinding is performed on a regular basis and allow personnel to know the status of casefinding at all times. A written log or tracking system should be in place to monitor all casefinding sources. Casefinding sources may be monitored daily, weekly, monthly or quarterly.

Having a system for recognizing reportable conditions is essential to complete reporting. A process which will identify all cancer cases that are diagnosed or treated within a facility must be devised. All pertinent medical records which may contain information on any case of diagnosed cancer must be reviewed, whether that diagnosis is clinical or histological. The hospital where a diagnosis is reached or a patient is treated must endeavor to report all cases regardless of the patient's status. This includes outpatients and patients diagnosed elsewhere when the place of diagnosis is unknown or is outside the state. An independent laboratory must similarly ascertain needed information upon determining that a reportable condition exists. It is important to report all patients, including patients who DO NOT live in Michigan.

Patients who were diagnosed elsewhere and newly admitted to your facility for further treatment, are to be reported provided the first diagnosis occurred after the start date of the state registry on January 1, 1985. This may result in multiple reports on one patient, but it will enable the MCSP to have the most comprehensive data on each case and serves as a quality control mechanism.

Cancer registries should first examine the sources used to identify malignant CNS tumors and expand the procedures to include non-malignant CNS tumors.

Since surgery is often the treatment for CNS tumors of all behaviors, pathology reports are an excellent casefinding source. Inpatient and outpatient surgery logs should also be reviewed. Many patients with CNS tumors of all behaviors are treated with adjuvant radiation therapy and review of radiation oncology appointment logs is a way to identify these cases.

Gamma/cyber knife is becoming a common treatment for non-malignant CNS tumors. If the hospital has a gamma/cyber knife center, review logs and schedules as part of casefinding. Hormone therapy and immunotherapy are medical treatments given for both non-malignant and malignant CNS tumors.

Reports are necessary for outpatients who are diagnosed as having cancer based upon a laboratory diagnosis of submitted specimens as well as those cases where outpatient surgery is the only means of diagnosis. Outpatients initially treated for cancer who were not diagnosed within a facility should also be reported if receiving outpatient radiotherapy or chemotherapy.

A report is not required when initially treating a patient diagnosed elsewhere **if it is known that the patient was first diagnosed AND treated in some other MICHIGAN hospital, and you have the name of the diagnosing hospital in the medical record**. Patients that have been diagnosed out of state e.g. Mayo Clinic or in an unknown facility, who come to your facility for treatment must be reported. This requirement includes the reporting of "historic" cases that otherwise meet the definition of a reportable case.

In many facilities, these functions and/or record systems are coordinated which can greatly simplify the process of casefinding. What is important, is that all sources of information pertinent to case identification must be reviewed. The development of a coordinated screening of these various files is essential to assuring complete reporting.

A second report is not necessary upon confirmation or re-diagnosis of a specific primary tumor or the metastasis therefrom, if that specific primary is known to have been reported earlier. Send a second report only if the information first reported on the patient requires correction or can be reported more completely than previously known.

It is very important to report ALL cases regardless of state residency. Data on all cancer cases is of value in several ways. In particular, Michigan currently has resident data exchange agreements with several states concerning cancer cases diagnosed and/or treated within our respective borders. Michigan sends reports of nonresident patients to their state of residency and these states reciprocate by sending MCSP records of MI residents diagnosed or treated for cancer in their state.

When in doubt about submitting a cancer case to the Michigan Cancer Surveillance Program (MCSP), ask these three questions:

1. Does the patient have a diagnosis of cancer that is reportable?

2. Is it a new reportable condition?

3. Was the case diagnosed since the start date of the central registry January 1, 1985?

If the answer is yes to these questions and the case has not yet been submitted by your hospital, report the case.

If you have questions about a particular case, submit the case with an attached note of explanation or call the state registry.

A record of those cases submitted to the central state registry MUST be maintained. It is recommended for those facilities that submit manually, to make a copy of the completed cancer report form, submit the original form to the state central cancer registry and file the copy alphabetically by last name combining all diagnosis years. For those facilities that submit electronically, a list of cases submitted to the state central cancer registry can easily be generated via the software.

The MCSP recommends retaining copies of the cancer report forms or submission log for a period of **three full years**. Legislation indicates that an audit may be conducted "not more than once every two years for the purpose of assessing the quality and completeness of cancer reporting." During the audit process, the MDI and submission logs are reviewed. As a result, maintaining these records for a period of three years, will be useful during the audit process.

If a submission log is maintained, it should contain at a minimum, the following items: patient's full name, medical record number, social security number, date of birth, date of diagnosis, primary site, laterality and summary stage. The submission log is not necessarily the best mechanism for keeping track of those cases submitted to the MCSP, but those facilities that wish to maintain a log are free to do so.

Examples and definitions of sources for casefinding are as follows:

PATHOLOGY REPORTS
Review ALL pathology reports from the pathology department for reportable conditions on a weekly, monthly or quarterly basis.

If the final pathologic diagnosis is "CNS neoplasm" or "mass," there must be an ICD-O-3 code for the mass or neoplasm. If there is not an ICD-O-3 code, the case is NOT reportable.

If the ONLY diagnosis available is "CNS tumor" or "neoplasm" the case is reportable and the histology is coded as M-8000/1 (Neoplasm, NOS, uncertain whether benign or malignant.)

This includes specimens sent to your facility from physician's offices to be read by the hospital pathologist.

CYTOLOGY REPORTS
Review ALL cytology reports from the pathology department for reportable conditions on a weekly, monthly or quarterly basis.

This includes pap smears, or specimens sent to your facility from a physician's offices to be read by the hospital pathologist.

BONE MARROW REPORTS
Review ALL bone marrow reports from the pathology department for reportable conditions on a weekly, monthly or quarterly basis.

AUTOPSY REPORTS
Review ALL autopsy reports from the pathology department at least twice a year. Review all diagnoses recorded, not just the cause of death, as occult or unexpected malignancies can be found on autopsy reports. If your facility does not perform autopsies, these reports may be located in the health information department.

MEDICAL ONCOLOGY LOGS (CHEMOTHERAPY)
Chemotherapy is administered either as an inpatient, outpatient, in a free-standing facility or a physician's office. Develop a system for identifying patients who receive chemotherapy at any facility affiliated with the reporting institution. Review the list of patients on a monthly or quarterly basis. e.g., billing, summary sheet, appointment book, treatment record.

RADIATION ONCOLOGY LOGS
Radiation therapy is administered either as an inpatient, outpatient or in a free-standing facility. Develop a system for identifying patients who receive radiation therapy at any facility affiliated with the reporting institution. Review the list of patients on a monthly or quarterly basis. e.g., billing, summary sheet, appointment book, treatment record.

RADIOLOGY
Review CT scans of the head, MRI's of the head and any additional scans of the head to identify reportable benign conditions of the brain and/or central nervous system. Review the reports from radiology on a monthly or quarterly basis.

For benign/borderline intracranial and central nervous system tumors, the terms "tumor" and "neoplasm" are considered diagnostic for the purpose of case reporting, in addition to the terms generally applicable to malignant tumors.

Diagnoses like "hypodense mass" or "cystic neoplasm" are NOT reportable even for CNS sites.

MASTER DISEASE INDEX (MDI)
Generate a MDI on a monthly or quarterly basis by discharge date which is based upon the diagnosis year.

Effective dates for ICD-9-CM codes is 10/1/2013 – 9/30/2015. **NOTE: ICD-10-CM is in effect as of October 1, 2015.**

Use the applicable casefinding list to generate the MDI.

Select those patients seen at your facility as an inpatient and/or as an outpatient for surgery, endoscopy, chemotherapy, radiation therapy, etc. **Exclude laboratory visits. Include radiology visits ONLY for benign/borderline brain/CNS tumors.**

List the principle code, primary code and secondary codes to include up to ***six*** diagnostic codes that have been assigned.

The MDI should include the following items: last name, first name, middle initial, date of birth, social security number, medical record number, laboratory number (if applicable), admit date, discharge date, patient type, the six ICD-9-CM or ICD-10-CM codes and descriptions that have been assigned.

Once the MDI has been generated, it must be compared with the log (or copies) of previously submitted cases. Sort the MDI **alphabetically** by last name. This will make it easier when comparing the MDI to previously submitted cases.

If the name from the MDI appears on the log of previously submitted cases, determine whether this is a new primary, recurrence or progression of disease from the original primary. (Refer to the Multiple Primary and Histology Coding Rules for clarification.)

a. A separate report MUST be submitted for each NEW primary.
b. Additional reports for recurrence or progression of disease are NOT required.

If the name from the MDI does NOT appear on the log of previously submitted cases, determine whether this a NEW case, MISSED case or NON-REPORTABLE CONDITION.

a. A separate report MUST be submitted for a new or missed case.
b. If a non-reportable condition exists, document on the MDI next to the patient's name the condition that was determined to be non-reportable. This will be helpful when reviewing future MDI's.

Examples John Doe - NR SCC skin (non-reportable squamous cell carcinoma)
James Doe - NR recurrent bladder cancer

Based upon your facility's needs, it may be beneficial to maintain a separate log of those cases determined to be non-reportable. This can easily be achieved by completing the demographic information only on the cancer report form and documenting the non-reportable condition in the primary anatomical site field.

The MCSP recommends retaining the MDI log for a period of **three full years**. Legislation indicates that an audit may be conducted "not more than once every two years for the purpose of assessing the quality and completeness of cancer reporting." During the audit process, the MDI and submission logs are reviewed. As a result, maintaining these records for a period of three years, will be useful during the audit.

The tables that follow illustrate the applicable ICD-CM codes that should be used to generate the Master Disease Index (MDI).

Please refer to the Reportable Conditions Section for ICD-0-3 Updates that are effective on January 1, 2014 and January 1, 2015.

Please use the listing below until September 30, 2016. **ICD-10-CM is in effect as of October 1, 2015.**

ICD-9-CM CASEFINDING LIST. Effective dates: 10/1/2013 – 9/30/2015.

ICD-9-CM Code	Explanation of Code
140.0 – 172.9, 174.0 – 208.9	Malignant neoplasms: stated or presumed to be primary (of specified sites and certain specified histologies)
209.0 – 209.29	Neuroendocrine tumors
209.30	Malignant poorly differentiated neuroendocrine tumors; Other malignant neuroendocrine tumors Reportable inclusion terms: High grade neuroendocrine carcinoma, any site Malignant poorly differentiated neuroendocrine tumor, NOS, any site
209.31 – 209.36	Merkel cell carcinoma NOTE: Effective date 10/1/09
209.70 – 209.74	Secondary neuroendocrine tumors NOTE: Effective Date 10/1/09 Reportable inclusion terms: Secondary carcinoid tumors NOTE: ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
209.75	Secondary Merkel cell carcinoma Reportable inclusion terms: Merkel cell carcinoma nodal presentation Merkel cell carcinoma visceral metastatic presentation Secondary Merkel cell carcinoma, any site NOTE: ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
209.79	Secondary neuroendocrine tumors of other sites NOTE: ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
225.0 – 225.9	Benign neoplasm of brain and other parts of nervous system
227.3	Benign neoplasm of pituitary gland and craniopharyngeal duct (pouch) Reportable inclusion terms: Benign neoplasm of Craniobuccal pouch, Hypophysis, Rathke's pouch or Sella turcica
227.4	Benign neoplasm of pineal gland (pineal body)
227.9	Benign neoplasm of unspecified endocrine gland
228.02	Hemangioma; of intracranial structures Reportable inclusion terms: Angioma, NOS Cavernous nevus Glomus tumor NOTE: Venous angioma of the brain/CNS is not reportable. Venous angioma is a malformation (developmental venous anomaly), not a tumor.

ICD-9-CM Code	Explanation of Code
228.1	Lymphangioma, any site NOTE: Includes only lymphangioma of the brain, other parts of nervous system and endocrine gland.
230.0 – 234.9	Carcinoma in situ Reportable inclusion terms: Cervical Intraepithelial neoplasia, Grade III Erythroplasia, Queryrat's AIN III, CIN III, VAIN III, VIN III
237.0 – 237.1	Neoplasm of uncertain behavior [borderline] of Endocrine glands and Nervous system: Pituitary gland, Craniopharyngeal duct and Pineal gland
237.5, 237.6, 237.9	Neoplasm of uncertain behavior [borderline] of Endocrine glands and Nervous system: Brain and Spinal cord, Meninges, Endocrine glands and Other and unspecified parts of nervous system
238.4	Polycythemia vera (9950/3): Excludes: Familial polycythemia (D75.0) Secondary polycythemia (D75.1)
238.6	Plasma cells
238.7	Other Lymphatic and Hematopoietic tissues NOTE: This code was expanded in 10/2006. It is now a subcategory and is no longer valid for coding purposes; however, it should be included in extract programs for quality control purposes.
238.71 – 238.77, 238.79	Other Lymphatic and Hematopoietic tissues: Essential thrombocythemia, Myelodysplastic syndromes, Lymphoproliferative disorders, and Other lymphatic and hematopoietic tissues
239.6, 239.7	Neoplasms of unspecified nature; Brain, Endocrine glands and Other parts of Nervous system NOTE: Category D49 classifies by site neoplasms of unspecified morphology and behavior. The term "mass," unless otherwise stated, is not to be regarded as a neoplastic growth. Includes: 'growth, NOS' 'neoplasm, NOS' 'new growth, NOS' 'tumor, NOS' 'neoplasm of uncertain behavior" (D37-D44, D48) Excludes: Neoplasm of unspecified behavior of cerebral meninges (D49.7) Neoplasm of unspecified behavior of cranial nerves (D49.7) Neoplasm of unspecified behavior of peripheral, sympathetic, and parasympathetic nerves and ganglia (D49.2)
273.2	Other paraproteinemias (Cryoglobulinemia) Reportable inclusion terms: Franklin's disease (heavy chain) (9762/3) Heavy chain disease (9762/3) Mu-chain disease (9762/3)
273.3	Macroglobulinemia (Waldenstrom's macroglobulinemia)

ICD-9-CM Code	Explanation of Code
277.89	Other specified disorders of metabolism Reportable inclusion terms: Hand-Schuller-Christian disease Histiocytosis (acute) (chronic) Histiocytosis X (chronic) [OBS] Langerhans-cell histiocytosis, NOS (diagnosed 2010 and later)
285.0	Sideroblastic anemia Reportable inclusion terms: Acquired idiopathic sideroblastic anemia Pure sideroblastic anemia Refractory anemia with hemochromatosis Refractory anemia with sideroblasts Refractory anemia with ringed sideroblasts (RARS) Sideroblastic anemia
288.3	Eosinophilia NOTE: This code is for eosinophilia, which is not reportable. DO NOT abstract unless diagnosis is: Chronic eosinophilic leukemia (CEL) Chronic eosinophilic leukemia (and the hyperosinophilic syndrome) Hypereosinophilic (idiopathic) syndrome (HES)
288.4	Hemophagocytic syndromes (Histiocytic syndromes)
289.6	Familial polycythemia (synonym for polycythemia vera)
795.04	Papanicolaou smear of cervix with high grade squamous intraepithelial lesion (HGSIL)
795.06	Papanicolaou smear of cervix with cytologic evidence of malignancy
795.14	Papanicolaou smear of vagina with high grade squamous intraepithelial lesion (HGSIL)
795.16	Papanicolaou smear of vagina with cytologic evidence of malignancy
795.74	Papanicolaou smear of anus with high grade squamous intraepithelial lesion (HGSIL)
796.76	Papanicolaou smear of anus with cytologic evidence of malignancy

NOTE: Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. However, SEER registries will CONTINUE to report these cases and code behavior as /3 (malignant).

ICD-10-CM CASEFINDING LIST. Effective as of October 1, 2015.

ICD-10-CM Code	Explanation of Code
C00.0 – C43.9, C45.0 – C96.6, C96.9, C96.A, C96.Z	Malignant neoplasms: stated or presumed to be primary (of specified sites and certain specified histologies)
C4A._	Merkel cell carcinoma NOTE: Effective date 10/1/09
C75.0	Familial polycythemia (synonym for polycythemia vera)
C7A.00 – C7A.098	Neuroendocrine tumors

ICD-10-CM Code	Explanation of Code
C7A.1, C7A.8	Malignant poorly differentiated neuroendocrine tumors; Other malignant neuroendocrine tumors Reportable inclusion terms: High grade neuroendocrine carcinoma, any site Malignant poorly differentiated neuroendocrine tumor, NOS, any site
C7B.00 – C7B.04, C7B.09	Secondary neuroendocrine tumors NOTE: Effective Date 10/1/09 Reportable inclusion terms: Secondary carcinoid tumors NOTE: ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
C7B.1	Secondary Merkel cell carcinoma Reportable inclusion terms: Merkel cell carcinoma nodal presentation Merkel cell carcinoma visceral metastatic presentation Secondary Merkel cell carcinoma, any site NOTE: ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
C7B.8	Secondary neuroendocrine tumors of other sites NOTE: ALL neuroendocrine or carcinoid tumors specified as secondary are malignant.
C88.0	Macroglobulinemia (Waldenstrom's macroglobulinemia)
C96.5, C96.6	Other specified disorders of metabolism Reportable inclusion terms: Hand-Schuller-Christian disease Histiocytosis (acute) (chronic) Histiocytosis X (chronic) [OBS] Langerhans-cell histiocytosis, NOS (diagnosed 2010 and later)
D00.00 – D03.9, D05.00 – D09.9	Carcinoma in situ Reportable inclusion terms: Cervical Intraepithelial neoplasia, Grade III Erythroplasia, Queryrat's AIN III, CIN III, VAIN III, VIN III
D18.1	Lymphangioma, any site NOTE: Includes only lymphangioma of the brain, other parts of nervous system and endocrine gland.
D18.02	Hemangioma; of intracranial structures Reportable inclusion terms: Angioma, NOS Cavernous nevus Glomus tumor NOTE: Venous angioma of the brain/CNS is not reportable. Venous angioma is a malformation (developmental venous anomaly), not a tumor.
D32.0 – D33.9	Benign neoplasm of brain and other parts of nervous system
D35.2 – D35.3	Benign neoplasm of pituitary gland and craniopharyngeal duct (pouch) Reportable inclusion terms: Benign neoplasm of Craniobuccal pouch, Hypophysis, Rathke's pouch or Sella turcica
D35.4	Benign neoplasm of pineal gland (pineal body)

ICD-10-CM Code	Explanation of Code
D35.9	Benign neoplasm of unspecified endocrine gland
D42.0, D42.1, D42.9, D43.2, D43.3, D43.4, D43.9	Neoplasm of uncertain behavior [borderline] of Endocrine glands and Nervous system: Brain and Spinal cord, Meninges, Endocrine glands and Other and unspecified parts of nervous system
D44.3 – D44.5	Neoplasm of uncertain behavior [borderline] of Endocrine glands and Nervous system: Pituitary gland, Craniopharyngeal duct and Pineal gland
D45	Polycythemia vera (9950/3): Excludes: Familial polycythemia (D75.0) Secondary polycythemia (D75.1)
D46.0 – D46.2, D46.20 – D46.22, D46.A, D46.B, D46.C, D47.3, D46.9, D47.1, D47.Z1, D47.7, D47.9, D47.Z9	Other Lymphatic and Hematopoietic tissues: Essential thrombocythemia, Myelodysplastic syndromes, Lymphoproliferative disorders, and Other lymphatic and hematopoietic tissues
D47.Z9	Plasma cells
D49.6, D49.7	Neoplasms of unspecified nature; Brain, Endocrine glands and Other parts of Nervous system NOTE: Category D49 classifies by site neoplasms of unspecified morphology and behavior. The term "mass," unless otherwise stated, is not to be regarded as a neoplastic growth. Includes: 'growth, NOS' 'neoplasm, NOS' 'new growth, NOS' 'tumor, NOS' 'neoplasm of uncertain behavior" (D37-D44, D48) Excludes: Neoplasm of unspecified behavior of cerebral meninges (D49.7) Neoplasm of unspecified behavior of cranial nerves (D49.7) Neoplasm of unspecified behavior of peripheral, sympathetic, and parasympathetic nerves and ganglia (D49.2)
D64.0 – D64.3	Sideroblastic anemia Reportable inclusion terms: Acquired idiopathic sideroblastic anemia Pure sideroblastic anemia Refractory anemia with hemochromatosis Refractory anemia with sideroblasts Refractory anemia with ringed sideroblasts (RARS) Sideroblastic anemia
D72.1	Eosinophilia NOTE: This code is for eosinophilia, which is not reportable. DO NOT abstract unless diagnosis is: Chronic eosinophilic leukemia (CEL) Chronic eosinophilic leukemia (and the hyperosinophilic syndrome) Hypereosinophilic (idiopathic) syndrome (HES)
D76.1 – D76.3	Hemophagocytic syndromes (Histiocytic syndromes)

ICD-10-CM Code	Explanation of Code
D89.1	Other paraproteinemias (Cryoglobulinemia) Reportable inclusion terms: Franklin's disease (heavy chain) (9762/3) Heavy chain disease (9762/3) Mu-chain disease (9762/3)
R87.613	Papanicolaou smear of cervix with high grade squamous intraepithelial lesion (HGSIL)
R87.614	Papanicolaou smear of cervix with cytologic evidence of malignancy
R87.623	Papanicolaou smear of vagina with high grade squamous intraepithelial lesion (HGSIL)
R87.624	Papanicolaou smear of vagina with cytologic evidence of malignancy
R85.613	Papanicolaou smear of anus with high grade squamous intraepithelial lesion (HGSIL)
R85.614	Papanicolaou smear of anus with cytologic evidence of malignancy

NOTE: Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. However, SEER registries will CONTINUE to report these cases and code behavior as /3 (malignant).

Select those patients seen at your facility as an inpatient and/or as an outpatient for surgery, endoscopy, chemotherapy, radiation therapy, etc. **Exclude ALL laboratory visits. Include radiology visits for benign/borderline intracranial and CNS tumors ONLY:**

- Endoscopy short stay
- Inpatient admission
- Outpatient surgery, short stay
- Outpatient surgery
- Outpatient care unit
- Outpatient endoscopy
- Outpatient administration of chemotherapy
- Outpatient administration of radiation therapy

BENIGN/BORDERLINE INTRACRANIAL AND CNS TUMORS CASEFINDING LIST

Due to a change in the federal law affected by passage of Public Law 107-260, which requires the collection of case information for benign brain and CNS tumors, revisions to the administrative rules that govern Michigan cancer reporting have been made. Reporting of benign brain and CNS related tumors is now required. This new requirement is effective with cases diagnosed on October 1, 2004 forward.

Any tumor diagnosed October 1, 2004 or later with a behavior code of "0" or "1" for the following site codes: meninges (C70.0 – C70.9); brain (C71.0 – C71.9); spinal cord, cranial nerves, and other parts of the central nervous system (C72.0 – C72.9); pituitary gland (C75.1); craniopharyngeal duct (C75.2); and pineal gland (C75.3) MUST be reported.

Juvenile astrocytomas should continue to be reported as 9421/3.

The casefinding list for Benign/Borderline Intracranial and Central Nervous System (CNS) Tumors listed below should include radiology visits.

Use the applicable casefinding list based on diagnosis year. Effective dates for ICD-9-CM codes is 10/1/2013 – 9/30/2016. **ICD-10-CM is in effect as of October 1, 2015.**

Casefinding List for Benign/Borderline Intracranial and CNS Tumors			
ICD-9-CM Code	**ICD-10-CM Code**	**ICD-O-3 Code**	**Explanation of Code**
225.2	D32.0	C70.0	Cerebral Meninges
225.4	D32.1	C70.1	Spinal Meninges
237.6	D42.0, D42.1, D42.9	C70.9	Meninges, NOS
225.0	D33.0, D43.0		Brain: Supratentorial
		C71.0	Cerebrum (Supratentorial, NOS)
		C71.1	Frontal Lobe
		C71.2	Temporal Lobe
		C71.3	Parietal Lobe
		C71.4	Occipital Lobe
		C71.5	Ventricle Includes: Ventricle, NOS Cerebral Lateral Third Excludes: Fourth Ventricle
225.0, 237.5	D33.1, D43.1		Brain, Infratentorial
		C71.6	Cerebellum, NOS
		C71.7	Brain Stem
		C71.7	Fourth Ventricle
225.0, 237.5	D33.1 – D33.9, D43.2	C71.8	Overlapping lesion of Brain
225.0, 237.5	D33.2, D43.2	C71.9	Brain, NOS
225.3, 237.5	D33.4, D43.4	C72.0	Spinal Cord
		C72.1	Cauda Equina
225.1	D33.3, D43.3		Nerves: Olfactory, Optic, Acoustic, NOS
		C72.2	Olfactory Nerve
		C72.3	Optic Nerve
		C72.4	Acoustic Nerve
		C72.5	Cranial Nerve, NOS
225.8, 225.9, 237.9	D33.7, D33.9, D43.8, D43.9	C72.8	Overlapping lesion of Brain and CNS
		C72.9	Central Nervous System, NOS: Other Specified Sites of Nervous System; Nervous System, Part Unspecified
227.3, 237.0	D35.2, D44.3	C75.1	Pituitary Gland
227.3, 237.0	D35.3, D44.4	C75.2	Craniopharyngeal Duct
227.4, 237.1	D35.4, D44.5	C75.3	Pineal Gland

Select those patients seen at your facility as an inpatient and/or as an outpatient for surgery, endoscopy, chemotherapy, radiation therapy, etc. **Exclude ALL laboratory visits. Include radiology visits for benign/borderline intracranial and CNS tumors ONLY:**

- Endoscopy short stay
- Inpatient admission
- Outpatient surgery, short stay
- Outpatient surgery
- Outpatient care unit
- Outpatient endoscopy
- Outpatient administration of chemotherapy
- Outpatient administration of radiation therapy

COMPONENTS OF GOOD REPORTING

Quality control field projects carried out within Michigan have been designed to measure the completeness and accuracy of the cancer data as well as timeliness of reporting. The results indicated the following quality control problems that need to be addressed if a facility is to satisfy the obligation to report all cancer cases. These issues are identified separately with recommendations that would help avoid reporting problems. The topics are discussed below and are divided into those that affect casefinding and those that affect the accuracy of reports.

CASEFINDING PROBLEMS

1. Completeness

Reporting responsibility placed solely in the pathology department results in cases being missed that are diagnosed through other means. This especially pertains to cases involving the primary sites of the trachea, bronchus, pancreas, brain or lung, chronic leukemia and lymphoma.

In hospitals with no tumor registry there needs to be an established procedure that ensures ALL cases are reported. These procedures must **include every department in the hospital which deals with cancer patients**. A procedure for reporting should be in place within all departments involved in either diagnosing or treating cancer patients. One approach is to develop a communication system between each department, and the group coordinating reporting, by placing one person in charge of reporting across all departments. Training staff within each area to follow coordinated procedures will eliminate missing cases. This should be covered within the written procedures on reporting in place within each facility.

2. Registries in Transition

Hospital cancer registries changing from manual reporting to a software system, or updating to a new software system, tend to have more missing cases. The registry staff while learning the new software system abstracts into the hospital registry while continuing to report manually this can be confusing and can result in cases that need to be sent to the state registry being overlooked.

During a transition stage **a procedure needs to be developed which will ensure all cases are properly reported**. One approach is to maintain a log of reported cases, or some type of recording system, to allow comparison between the cases in the hospital registry and those cases sent to the central registry. The log needs to be updated and checked on a monthly basis through this transition period.

3. Class of Case

All approved hospital registries classify cases as analytical or non-analytical. Sometimes registries mistakenly send only the analytical cases. Completeness of reporting is improved by registries being sure they are sending **ALL cancer patient data regardless of class of case**. Though this may result in duplication, it is the best way to ensure that all cases are reported to the state and none are skipped due to confusion on a patient's status.

The MCSP accepts ALL cases regardless of their class of case status.

4. Reporting Outpatient Cases

Outpatient cases can be overlooked by reporting facilities due to a lack of communication and lack of a reliable reporting system within the facility. It is important to establish a referral procedure that will identify

and prompt the reporting of **ALL outpatient cancer cases which are diagnosed or treated in your facility, clinics operated by your facility or through an affiliated laboratory**.

Reporting personnel should set up a reporting system with personnel having access to outpatient records relative to outpatient treatment and outpatient diagnosis. It is important to include diagnostic work for specimens submitted to the laboratory in this process. Outpatient cancer case information can be reported independently, or preferably, routed to the personnel responsible for all cancer case reporting. This should be done on a regular basis, i.e., weekly or daily depending upon the size of the hospital, to insure timeliness of reporting and to avoid backlogs.

5. Reporting Michigan Residents Diagnosed Out of State

Michigan residents diagnosed out of state but receiving treatment in a Michigan hospital can mistakenly not be reported. If a patient has been diagnosed out of state it is important to report the case in all instances. (Michigan does have an exchange agreement with some states to exchange data concerning cancer cases of Michigan residents, BUT NOT with all states.) These cases MUST be reported regardless of the state of diagnosis. **Report all cases treated in your facility that were diagnosed outside Michigan or in an UNKNOWN FACILITY.**

6. Reporting Non-residents

Out of state residents are reportable. Non-resident cases cannot be skipped due to a presumption that only resident cases are necessary. ALL cancer cases are required to be reported regardless of residency.

Report ALL cases regardless of the patient's address or state of residency.

7. Referrals to Another Facility

Cases can be missed if there is a lack of communication between facilities. Especially in instances where a patient was diagnosed at one facility and then referred to a second facility for treatment and each facility assumed that the other had reported the case. The end result was often that neither had reported this case.

In a situation where hospitals are referring patients, it is recommended that the diagnosing facility and the hospital initially treating the patient **both** report the case. This recommendation applies to clinically diagnosed cases, in particular.

DETERMINING MULTIPLE PRIMARY TUMORS

For both solid tumors and hematopoietic/lymphoid neoplasms, there are specific rules to determine a new or subsequent primary. You must review the rules for each case to determine if a new primary exists.

Solid Tumor Rules
The most recent SEER Multiple Primary and Histology Coding Rules contain site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, and malignant and nonmalignant brain primaries. A separate set of rules addresses the specific and general rules for all other sites. The multiple primary rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions.

You MUST download the complete SEER Multiple Primary and Histology Coding Rules from: http://seer.cancer.gov/tools/mphrules/download.html.

Non-Solid Tumor Rules (Hematopoietic and Lymphoid Neoplasms 9590/3-9992/3)
The SEER Multiple Primary and Histology Coding Rules DO NOT apply to hematopoietic and lymphoid tumors. Use the Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual at http://seer.cancer.gov/tools/heme/ to assist with coding these primaries. These references apply only to cases diagnosed January 1, 2010 and forward.

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ICD-O-3 SEER SITE/HISTOLOGY VALIDATION LIST

Specific histologies arise in specific tissue types. Refer to the SEER site/histology validation list to determine valid primary site and histology combinations for cases diagnosed **on or after** January 1, 2001.

The Site/Histology Validation List can be downloaded by visiting the SEER website at: http://seer.cancer.gov/icd-o-3/.

Most comparisons can be made to the three-digit histology code but a four-digit histology comparison is required whenever an "!" appears to the left of the three-digit histology name.

To use the SEER site/histology validation list:

a. Locate the three-digit topography code in ICD-O-3, for the primary site in question.

b. Locate the five-digit morphology code in ICD-O-3, for the primary site in question.

c. Locate the three-digit topography code in the SEER site/histology validation list in the left hand column, in numeric order by topography code.

d. Locate the five-digit morphology code in the SEER site/histology validation list in the right hand column, in numeric order by morphology code.

e. If the five-digit morphology code is listed in the right hand column, the site/histologic type is valid.

f. If the five-digit morphology code is NOT listed in the right hand column, the site/histologic type is NOT valid.

** Confirm with your pathologist and/or managing physician if the site/histology is valid and code appropriately.

NOTE: If the primary site/histology is valid according to the pathologist and/or managing physician, document this in the text to justify the selected codes. As the purpose of text information is to provide the opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should NOT be generated electronically from coded values.

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DIAGNOSTIC CONFIRMATION

Descriptions of procedures performed to determine the method of diagnosis are listed below. A low number takes precedence over all higher numbers regardless of the type of procedure performed.

Positive Histology

Use code 1 for the following methods of diagnoses.

1. Bone Marrow Biopsy - examination of a piece of bone marrow by puncture or trephine (removing a circular disc of bone) for possible diagnosis of leukemia or multiple myeloma

2. Curettage - removal of growths or other material by scraping with a curette (D&C)

3. Excisional Biopsy - the removal of a growth in its entirety and having a therapeutic as well as diagnostic purpose

4. Frozen Section - a thin slice of tissue cut from a frozen specimen, often used for rapid microscopic diagnosis

5. Hematologic examination - microscopic examination of the cells of the blood or blood-forming tissues (especially bone marrow) for possible diagnosis of leukemia or multiple myeloma

6. Incisional Biopsy - incomplete removal of a growth for the purpose of diagnostic study

7. Punch Biopsy - biopsy of material obtained from the body tissue by a punch technique

8. Surface Biopsy - scraping of cells from surface epithelium, especially from the cervix, for microscopic examination

9. Surgical Biopsy - removal of tissue from the body by surgical excision for examination

Endoscopic Procedures

Use code 1 (histology) if a "piece of tissue" is taken and examined under a microscope.

Use code 2 (cytology) if "fluid" is taken and examined under a microscope.

Use code 6 (visualization) if no tissue or fluid is taken and a diagnosis of cancer is made.

Examples A patient undergoes a bronchoscopy with a bronchial washing. *Code the method of diagnosis as: 2 - cytology*

A patient undergoes a colonoscopy with a biopsy of a mass. *Code the method of diagnosis as: 1 - histology*

1. Bronchoscopy - examination of the bronchi

2. Colonoscopy - examination of the colon and rectum by means of an elongated flexible fiberscope

3. Colposcopy - examination of tissue of the cervix and vagina by use of a magnifying lens inserted into the vagina

4. Culdoscopy - visual examination of the female pelvic viscera by means of an endoscope introduced through the posterior vaginal wall into that part of the pelvic cavity known as the rectovaginal pouch or cul de sac

5. Cystoscopy - examination of the interior of the urinary bladder by means of a cystoscope

6. Esophagoscopy - observation of the interior of the esophagus

7. Gastroscopy - visual examination of the interior of the stomach

9. Laryngoscopy - examination of the larynx

10. Laparoscopy - examination of intra-abdominal structures by means of an illuminated tubular instrument inserted through a small incision in the abdominal wall

11. Mediastinoscopy - examination of the mediastinum by means of a tubular instrument permitting direct inspection of the area between the lungs

12. Nasopharyngoscopy - examination of the nasopharynx, pharynx, and the pharyngeal end of the auditory tube by lighted telescopic endoscope

13. Ophthalmoscopy - an examination in which an instrument containing a perforated mirror and lenses is used to examine the interior of the eye

14. Otoscopy - inspection of the internal ear

15. Panendoscopy - a cystoscopy that permits wide angle viewing of the urinary bladder

16. Peritoneoscopy - examination of the peritoneal cavity by an instrument inserted through the abdominal wall

17. Proctoscopy - inspection of the rectum

18. Sigmoidoscopy - inspection of the colon up to sigmoid flexure

19. Thoracoscopy - direct examination of the pleural cavity by means of an endoscope which is inserted into the cavity through an intercostal space

Positive Cytology

Use code 2 for the following methods of diagnoses.

1. Aspiration Biopsy - biopsy of material obtained by suction through a needle attached to a syringe

2. Brushings - the procedure of brushing the lining of an organ for the purpose of obtaining cells

3. Fine Needle Aspiration (FNA) - a hollow needle used for withdrawing fluid from a cavity

4. Paracentesis - surgical puncture of a cavity, such as the abdominal cavity, for aspiration of fluid

5. Punctures - inserting a hollow needle into a cavity or organ for the purpose of removal of some portion of the contents

6. Scraping - the procedure of scraping the lining of a structure with an instrument for the purpose of obtaining cells

7. Swab - using a swab or similar device to obtain fluid and secretions which then can be used to make a smear

8. Thoracentesis - surgical puncture for aspiration of fluid from the chest

9. Washings - the removal of fluid from a hollow organ or structure for the purpose of collecting cells

Visualization

Use code 6 for the following method of diagnosis.

1. Exploratory surgery - surgery is performed to determine whether or not a cancerous condition exists and the degree to which the cancer may have affected other organs and structures within the observed area; no biopsies are taken

Radiographic Examination

Use code 7 for the following methods of diagnoses.

Radiographic examination refers to a negative image on photographic film made by exposure to x-rays or gamma rays that have passed through matter or tissue.

1. Angiography - radiographic study of the vascular system

    a. cerebral angiogram - x-ray of the vessels of the brain

    b. cardiac angiogram - x-ray showing the functions of the heart and large blood vessels

    c. lymphangiogram - x-ray study of the vessels of the lymphatic system

    d. arteriography - x-ray examination of arteries

    e. venography - x-ray examination of veins

2. Bronchography - radiographic study of the bronchi of the lung

    a. bronchogram - x-ray of the bronchial system

3. Cholecystography - radiologic study of the function of the gallbladder and bile ducts after an opaque medium has been introduced either orally or intravenously

    a. cholangiogram - x-ray of extrahepatic ducts

    b. cholecystogram - x-ray of the gallbladder

4. Computerized (Axial) Tomography (CT) - examination of body tissue; directs a thin, concentrated beam of radiation through a cross-section of the body to detectors; the technique involves recording of “slices” of the body with an x-ray scanner

5. Hysterosalpingography - radiography of the uterus and fallopian tubes after the injection of radiopaque material

6. Infusion Nephrotomography - radiographic visualization of the kidney by tomography after intravenous introduction of contrast medium

7. Intraoperative Imaging - an imaging procedure such as x-ray, CT scan, ultrasound, or mammogram that is performed during an operative procedure, e.g., to direct a biopsy or to verify the position of a prosthesis

8. KUB (Kidneys, Ureter, Bladder) - a frontal film of the abdomen taken in the supine position

9. Laminography - x-ray of a selected layer of the body; usually performed on joints and eye orbits

10. Lower GI series or Barium Enema - x-ray studies, following rectal injection of barium, of the large bowel; air and barium are used as contrast materials

11. Mammogram - several x-ray views are taken of one or both breasts and the radiographs are examined for the presence of a lesion, mass or calcification

12. Magnetic Resonance Imaging (MRI) - based on magnetization of the various biological tissues; does not use any ionizing radiation (such as x-rays) and is capable of direct imaging in any plane without reformatting

13. Myelography - radiologic study of the spinal cord

14. Positron Emission tomography (PET) - is a unique noninvasive technique that produces three-dimensional images within inside the human body. Compounds like glucose, oxygen, and carbon, which are found naturally in body chemistry, are labeled with signal-emitting tracers and injected into the body. All cells use this tracer, and cells with increased metabolism use more glucose. Because cancer cells are highly metabolic and use
more glucose than normal cells, they are easily seen on a PET scan.

15. Radioisotopes - substance administered to patients in order to diagnose disease in which the radioisotopes gather in the infected area emitting gamma rays from within the body which enable the physician to visualize internal abnormalities

16. Salpingography - radiologic study of the uterus and fallopian tubes

17. Sialography - radiologic study of the salivary ducts

18. Thermography - technique for detecting cancer by differentiating regions of hot and cold in the body; the surface temperature is photographically recorded

19. Tomography - a special x-ray technique to show in detail images of structures lying in a predetermined plane of tissue while blurring or eliminating detail in images of structures in other planes; usually performed on the kidneys

20. Upper GI series or Barium Swallow - x-ray studies, following ingestion of barium, of the pharynx, esophagus, stomach, and duodenum

21. Urography - radiologic study of the urinary tract

a. Urogram - x-ray of the kidney and ureter with emphasis on the pelvis of the kidney by intravenous injection of a contrast medium

b. Cystogram - x-ray of the urinary bladder by filling the bladder by catheterization with a contrast medium

c. IVP (intravenous pyelography) - a succession of x-ray films of the urinary tract following the injection into a vein of an iodine-containing substance which is collected by the kidneys, passing into the ureters and subsequently the bladder, allowing the study of urinary tract function

d. Retrograde Urography - examination of the ureter and renal collecting structures by means of instillation of contrast material through a ureteral catheter passed through a cystoscope into the bladder and ureter

22. Ultrasound - high-frequency sound waves; waves can be bounced off of tissues using special devices. The echoes are then converted into a picture called a sonogram. Ultrasound imaging, referred to as ultrasonography, allows physicians and patients to get an inside view of soft tissues and body cavities, without using invasive techniques.

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CANCER STAGING

SEER SUMMARY STAGE

Directly coded SEER Summary Stage is a required data item for ALL facility types by the Michigan Cancer Surveillance Program for cases diagnosed on or after January 1, 2001. Refer to the SEER Summary Staging Manual − 2000 http://seer.cancer.gov/tools/ssm/.

The summary stage should include all information available through completion of surgery(ies) in the **first course of treatment or within four months from the date of initial diagnosis**.

Summary staging is a method of organizing extent of disease data into groups which have prognostic significance. A staging system is a reference or chart which indicates the category into which a specific piece of information about a case fits.

Summary stage refers to the primary site ONLY.

Directly coded SEER Summary Stage is required for ALL cases submitted to the Michigan Cancer Surveillance Program.

Summary stage consists of the following categories:

0 In situ, Intraepithelial, Noninvasive, Non-infiltrating

1 Localized ONLY (within organ)

2 Regional by direct extension ONLY (to adjacent organs or tissues)
3 Regional lymph node(s) involved ONLY
4 Regional by BOTH direct extension AND regional lymph node(s) involved
5 Regional, NOS (not otherwise specified)

7 Distant site(s)/lymph node(s) involved or Systemic Disease

8 BENIGN: benign brain tumors and central nervous system tumors

9 Unknown if extension or metastasis (unstaged, unknown or unspecified)
Unknown primary site

Summary stage for all sites is based on pathologic, operative and clinical assessments with the pathologic examination taking precedence. It is important to read the pathology and operative reports for evidence of spread, microscopic extension and metastasis, as well as diagnostic imaging reports for mention of distant disease.

Exclude metastasis or disease progression that develops after the **four month interval**.

Apply the same rules when autopsy reports are used to stage the disease.

If it is not definitively known whether the tumor is in-situ or invasive, the suspected or probable status should be reported.

If the primary site is unknown, the SEER Summary Stage must be coded as "9 - unknown."

DO NOT leave this data item blank.

The following definitions may be helpful in determining the most appropriate stage.

1. **In Situ ONLY (Code 0)**
   a. in situ means "in place"

   b. presence of malignant cells within the cell group from which they arose

   c. no penetration of the basement membrane of the tissue; no stromal invasion

   d. applies to epithelial tissue only (no such thing as "sarcoma in situ")

   e. if shown to be micro invasive, case is considered localized

   f. the following terms are to be interpreted as in situ:

      Bowen's Disease (not skin)
      CIN III
      Clark's Level I for melanoma
      Hutchinson's melanotic freckle, NOS
      intracystic non-infiltrating
      intraductal
      intra-epithelial
      no penetration of basement membrane of the tissue
      lobular neoplasia
      lobular, non-infiltrating
      non-infiltrating
      non-invasive
      no stromal invasion
      precancerous melanosis
      Queyrat's erythroplasia
      VAIN III
      VIN III

      Examples Left breast mastectomy - intraductal carcinoma in LIQ, lymph nodes negative. *Code stage as:0 - in situ*

      Bladder, transurethral resection - noninvasive papillary transitional cell carcinoma, Grade II. There is no invasion seen in the sections examined. *Code stage as:0 - in situ*

2. **Localized ONLY (Code 1)**
   a. malignancy limited to organ of origin

   b. no spread beyond organ of origin

   c. infiltration past basement membrane of epithelium into the functional part of the organ, but no spread beyond the boundaries of the organ

d. tumor can be widely invasive or even show metastasis within the organ itself and still be considered ”confined to organ of origin” or localized

e. usually straightforward stage determination for organs which have definite boundaries (prostate, testis, stomach, etc.) or sites where there is a clear line between the organ of origin and the surrounding region (EXCEPTION: skin)

f. for internal organs - it is generally impossible to determine whether the tumor is localized without exploratory surgery

g. if the pathology report, operative report and other investigations show no evidence of spread, tumor may be assumed to be localized

h. when staging cases diagnosed clinically, it is better to record stage as “stage not recorded” rather than “localized” when there is no other evidence of spread

i. recognize the names of different structures within the organ (such as lamina propria, myometrium, muscularis) so that reference to invasion of such structures will not be interpreted as regional spread

*Example*s Subtotal colectomy - ascending colon, moderately differentiated adenocarcinoma invasion through the muscularis propria; no invasion of the pericolic fat; fifteen paracolic lymph nodes negative. *Code stage as:1 – localized*

Laryngectomy - squamous cell carcinoma of the glottis invading the true vocal cords, false vocal cords and intrinsic muscles. *Code stage as:1 - localized*

NOTE: When the primary site is bone marrow (C42.1) or blood (C42.0), the SEER Summary Stage is either “localized” or “distant” depending upon the histology. Refer to the Hematopoietic and Lymphoid Neoplasm section in the Collaborative Staging manual for assistance. As this will include changes in the behavior code for specific diagnoses and alter the stage.

3. Regionalized (Codes 2, 3, 4, & 5)

a. tumor extension beyond the limits of the organ of origin

b. area extending from the periphery of an involved organ that lends itself to removal en bloc with a portion of - or an entire - organ with outer limits to include at least the first level nodal basin

c. delineation of the outer limit between regional and distant spread is not always clear

d. en bloc resection may not always be feasible or may have been shown not to be necessary

e. regional stage has several subcategories, each of which is described in detail below along with examples

i. regional by direct extension only (code 2): invasion through entire wall of organ into surrounding organ and/or adjacent tissues (direct extension or contiguous spread)

Examples Radical prostatectomy - invasive adenocarcinoma of the prostate; adenocarcinoma invades into and involves the left seminal vesicle; iliac lymph nodes negative. *Code stage as:2 - regional, direct extension*

Radical cystectomy - invasive papillary transitional cell carcinoma of the bladder; carcinoma invading the ureter and prostate; iliac lymph nodes negative. *Code stage as:2 - regional, direct extension*

ii. regional lymph node(s) involved only (code 3): tumor invasion of walls of lymphatic where cells can travel through lymphatic vessels to regional lymph nodes where they are filtered out and begin to grow in the nodes

NOTE: Refer to SEER Summary Staging Manual for a list of Lymph Node Synonyms.

Examples Radical mastectomy - invasive ductal carcinoma of the breast; metastatic adenocarcinoma in one of eleven axillary lymph nodes. *Code stage as:3 - regional, lymph nodes*

Radical nephrectomy - invasive renal cell carcinoma; metastatic carcinoma in three of seven renal hilar lymph nodes; biopsy of diaphragm negative. *Code stage as:3 - regional, lymph nodes*

iii. regional by both direct extension and regional lymph node(s) involved (code 4): a combination of direct extension and lymph node involvement; Code 2 + Code 3 = Code 4

Examples Resection of right colon - moderate to poorly differentiated Grade III/III adenocarcinoma arising from the muscosa, invading into pericolic fat; one of twenty pericolic and mesenteric lymph nodes positive for adenocarcinoma. *Code stage as: 4 - regional by BOTH direct extension AND lymph node involvement*

Left pneumonectomy - invasive squamous cell carcinoma of the left lung invading the pleura; metastatic carcinoma in two of nine carinal lymph nodes. *Code stage as: 4 - regional by BOTH direct extension AND lymph node involvement*

iv. regional, NOS (code 5): may be used when it is unclear whether the tissues are involved by direct extension or lymph nodes, or when the other categories are not applicable, such as for staging Non-Hodgkin and Hodgkin Lymphoma of more than one lymph node chain

Example Diffuse, large cell, non-cleaved lymphoma involving the mesenteric and ileocolic lymph nodes. *Code stage as:5 - regional, NOS*

NOTE: Refer to the SEER Summary Staging Manual for a list of the lymph nodes and lymphatic structures above and below the diaphragm.

Clinicians and pathologists use some terms interchangeably which may make it difficult when determining the stage. It is important to understand the words used to describe the spread of cancer.

"Local" as in carcinoma of the stomach with involvement of the local lymph nodes. Local nodes are the first group of nodes to drain the primary. Unless evidence of distant spread is present, such a case should be staged as regional, NOT local.

"Metastasis" as in carcinoma of lung with peribronchial lymph node metastasis. Metastasis in this sense means involvement by tumor. Such a case would still be regionalized, NOT distant. Learn the regional nodes for each primary site.

4. **Distant site(s)/lymph node(s) or Systemic Disease (Code 7)**
   a. tumor cells which have been broken away from the primary tumor, traveled to other parts of the body and have begun to grow at the new location

   b. distant stage is also called:
      - remote
      - disseminated
      - diffuse
      - metastatic (be careful, this may be regional metastasis)
      - secondary disease

   c. cancer cells can travel from the primary site in any of four ways:
      i. Extension from primary organ beyond adjacent tissue into next organ.

         For example: lung → pleura → bone

      ii. Travel in lymph channels beyond the first (regional) drainage area. Tumor cells can be filtered, trapped and begin to grow in any lymph nodes in the body.

         For example: lung → scalene lymph nodes

      iii. Hematogenous or blood-borne metastases. Invasion of blood vessels within the primary tumor (veins are more susceptible to invasion than thicker-walled arteries) allows escape of tumor cells or tumor emboli which are transported through the blood stream to another part of the body where it lodges in a capillary or arteriole. At that point the tumor penetrates the vessel wall and grows back into the surrounding tissue.

      iv. Spread through fluids in a body cavity. Malignant cells rupture the surface of the primary tumor and are released into the thoracic or peritoneal cavity. They float in the fluid and can land on and begin to grow on any tissue reached by the fluid. This type of spread is also called implantation or seeding metastases. Some tumors form large quantities of fluid called ascites that can be removed, but the fluid rapidly re-accumulates.

         NOTE: The presence of fluid or ascites does not automatically indicate dissemination. There MUST be cytologic evidence of malignant cells.

   d. common sites of spread include brain, bone, liver and lung; these organs receive blood flow from all parts of the body. Review the staging scheme for the specific site to make sure disease is not regional extension.

      Examples Right hemi colectomy - moderately differentiated, Grade I-II/III colonic adenocarcinoma invading into the pericolic fat; eight out of eight pericolic lymph nodes showing reactive lymphoid hyperplasia with no evidence of malignancy; biopsy of a mass on the left ovary shows metastatic moderately differentiated Grade II/III adenocarcinoma consistent with colon primary. *Code stage as:7 – distant*

      Radical prostatectomy - invasive adenocarcinoma of the prostate; metastatic adenocarcinoma in four of six inguinal lymph nodes. *Code stage as:7 - distant*

NOTE: When the primary site is bone marrow (C42.1) or blood (C42.0), refer to the SEER Summary Staging Manual to determine whether the tumor is to be coded "localized" or "distant" depending upon the histology.

5. **Unknown if extension or metastasis or Unstaged (Code 9)**
   a. for an unknown primary site (C80.9), the summary stage must be "9 - Unknown."

   b. there will be cases for which sufficient evidence is not available to adequately assign a stage.

      Examples When a patient expires before workup is completed.
      When a patient refuses a diagnostic or treatment procedure.
      When there is limited workup due to the patient's age or a simultaneous condition.

   c. if sufficient information does not exist, the case cannot be staged

   d. use unknown stage sparingly - contact the physician to see if there is more information about the case which is not in the record.

   e. if sufficient information does not exist, DO NOT guess; there is no choice but to mark the case as unknown.

   f. death certificate only cases are coded to "9 - Unknown"

COLLABORATIVE STAGING

Effective with cases diagnosed in 2016, CDC requires directly assigned SEER Summary Stage 2000 and AJCC TNM 7th Edition Clinical and Pathologic Stage in lieu of CSv2. The Collaborative Stage Data Collection System Version 02.05 will continue to be used for cases diagnosed 2004-2015 and for the collection of Site-Specific Factors (SSFs) for cases diagnosed 1/1/2016 and forward. In addition to the SSFs, Regional Node Positive and Examined and Lymph-vascular Invasion will continue to be required. All other CS input data items are no longer required.

For Schema-specific SSF data requirements, refer to CS Version 02.05
http://cancerstaging.org/cstage/schema/Pages/version0205.aspx

AJCC TNM STAGING

Directly assigned AJCC TNM Clinical and Pathologic Staging is required for ALL facility types by the Michigan Cancer Surveillance Program for all cases diagnosed in 2016 and forward. Refer to the AJCC Cancer Staging Manual, 7th Edition, for TNM staging instructions https://cancerstaging.org/references-tools/deskreferences/pages/default.aspx

Physicians are responsible for documenting physician-assigned clinical and pathologic stage in the patient medical record. Hospital registrars are responsible for recording the physician-assigned stage in the registry database. HOWEVER,

   a. If the stage assigned by the physician is inconsistent with the documentation in the medical record, the registrar should assign the stage and record the registrar-assigned stage in the registry database. The registrar should verify the case information with the physician, as he or she may

have additional information that would aid in the assignment of stage. However, it is outside the realm of the responsibility of the registrar to educate the physician. **The registrar should inform the registry physician advisor and refer identified coding issues to the Cancer Committee for quality improvement activities.**

b. If no physician-assigned stage can be found in the medical record, the registrar should assign the stage and record it in the registry database. **The registrar should inform the registry physician advisor and refer identified documentation issues to the Cancer Committee for quality improvement activities.**

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QUALITY CONTROL

Quality control measures are essential to establish accuracy, completeness and consistency of reporting within the registry. Internal quality control relates to the process that is established to check for errors and discrepancies as reports come into the registry from the reporting facilities. External quality control is a method that checks for errors and discrepancies at the reporting facility.

NOTE: Some of the edit checks are prompts to review unusual data such as a prostate gland cancer in a man less than 45 years of age. If it is something rare, please review it with your pathologist.

INTERNAL QUALITY CONTROL

Proper Completion

As the reports are received, they are reviewed for consistency and completeness. Whenever a case is incomplete or inconsistent relative to an essential data item or items the department will query the reporting facility to clarify the case. A copy of the report in question is sent to the reporting facility with a request to clarify or complete the essential data item or items. However, it is customary to make a telephone call rather send out a letter requesting clarification. Those essential data items and the more common problems that are routinely queried are:

Patient's first name	if blank or inconsistent, unknown or illegible
Patient's last name	if blank or unknown or illegible
Complete address	if blank, illegible or inconsistent
Sex	if blank or inconsistent with name or site
Date of Birth	if blank or inconsistent with site, report date, or date of diagnosis
Social Security Number	if blank
Primary site	if blank or inconsistent with histology
Laterality	if blank and a paired organ is reported for the primary site
Histology	if blank, if inconsistent with the primary site or it indicates the condition may not be reportable
Stage	if inconsistent with histology, blank, or, for TNM values, not consistent with the AJCC staging system
Method of diagnosis	if blank or inconsistent as in an in situ diagnosis not based upon a microscopic method of diagnosis
Non-diagnostic method	if method of diagnosis is reported as cytology and the case is in-situ, VIN III or CIN III, or a Pap smear, the case will be queried, to determine if a histological confirmation was obtained
Treatment	if blank and if the report is from a hospital with a cancer treatment center

If the reporting facility cannot supply the needed data items requested, the next step is to query the attending physician. For such cases, the complete name and office address of the physician are requested from the reporting facility.

For independent laboratories that do not have access to necessary patient demographic information to complete the report, adding the name and office address of the doctor to the report is extremely helpful. This reference information on the physician should be added to the **bottom** of the cancer report form for any case with missing information. Be sure to supply the doctor's full name and complete mailing address.

1. Manual checks of new reports

   Routine checking of incoming reports identifies problems early in the processing. Letters are prepared to survey the hospital, laboratory or doctor to obtain information or clarification on identified problems.

   The situations that will result in a letter of inquiry include when:

   a. important information on the patient is missing
   b. the diagnosis is vague or not clearly a malignancy
   c. the diagnosis is an in situ lesion based upon a cytological diagnosis
   d. diagnostic information is missing
   e. logical inconsistencies are evident, such as date of birth that is the same as the date of the report, cancer sites that disagree with the patient's sex or sites and histologies that are not compatible

   If reporting a case that will likely generate a query, such as a CIN III pap smear or a patient with an unknown residence, record the physician's name and address in the lower margin of the report. This information will allow the MCSP staff to contact the doctor directly.

2. Computer edit checks

   A series of edit checks are employed to scan incoming data. Many of these checks are basic screens of the data to insure all codes are valid. Other edits are more complex. These include the standard edit checks for sex and site, site and histology, histology and stage and other edits patterned after those employed at the National Cancer Institute and as recommended by NAACCR. Problems identified by these edits may result in additional inquiries concerning a cancer report.

EXTERNAL QUALITY CONTROL

A quality control field representative will visit each contributing facility to conduct a review of the quality of the cancer reporting at that facility. The field representative will help the facility identify and solve problems associated with casefinding, timeliness, abstracting, reporting, etc. Facility staff responsible for submitting reports are encouraged to contact their quality control field representative with questions about cancer reports.

FACILITY AUDIT PROCEDURE

The reporting of cancer cases by Michigan licensed hospitals and laboratories are required by Act No. 82 of 1984. Administrative Rule 325.9053 provides the Michigan Cancer Surveillance Program (MCSP) with the authority to conduct quality assurance reviews within each reporting entity to ensure consistency and completeness of the statewide cancer incidence registry

Selecting Cases for Audit
Cases are selected and re-abstracted without reference to the original abstract. Discrepancies between abstract and re-abstract are discussed by the original abstractor and the field representative. The re-abstracting study is a tool by which the abstractor and the MCSP staff can identify areas of inconsistency and improve the overall reliability of the registry database.

1. Using codes assigned to each case by the MCSP staff, a report is generated by diagnosis year for the facility that is being audited. The report should contain the following information:

   a. patient state file number
   b. patient full name
   c. social security number
   d. medical record number
   e. topography code
   f. year of diagnosis

2. The total number of reportable cases from the reporting facility for a specific diagnosis year may be utilized to determine the number of cases to be audited.

3. The facility is mailed a list of the selected cases for review. The list will include at a minimum the following:

   a. patient's full name
   b. social security number
   c. medical record number
   d. primary anatomical site
   e. month of diagnosis
   f. year of diagnosis

4. During the audit, the facility will provide the following:

   If conducted remotely (MCSP preferred method):
   - Remote access to the requested medical records and all information contained in them, as well as any additional medical records that may include further information.

   If an on-site audit is required:
   - Requested medical records pulled and available prior to the day of the audit,

     OR

     Electronic access to the requested medical records and all information contained in them, as well as any additional medical records that may include further information.
   - Adequate space where the medical records can be reviewed.
   - Access to an outside phone line and power source for a laptop computer.

5. Data items that may be reviewed during the audit process include:

Name of Patient	Medical Record Number	SEER Summary Stage
Street Address, City, Zip	Primary Site	Tumor Size
County	Paired Organ	AJCC – TNM Values
Social Security Number	Clinical/Histological Diagnosis	AJCC – Stage Group
Date of Birth	Cell Behavior	Date Therapy Began
Sex	Tumor Grade	Reason No Surgery
Race	Date of Diagnosis	Surgery Dates and Codes
Hispanic Origin	Method of Diagnosis	First Course of Treatment

Results of Data Items Reviewed

The data items reviewed having a discrepancy are categorized as either a major or minor discrepancy. The major and minor discrepancies are based upon the standards set forth by the North American Association of Central Cancer Registrars (NAACCR). For further information on the standards, refer to Standards for Cancer Registries (Vol. III) Standards for Completeness, Quality, Analysis, and Management of Data.

The number of major and minor discrepancies, are entered into a weighted error discrepancy rate table. Weighting the rate acts as if each and every record submitted was reviewed during the audit. The following is a statistical summary of the weighted error rates along with the major and minor discrepancies identified for each data item reviewed.

The following table represents those data items that are reviewed during audit and which category (major vs minor) they are assigned to. In addition, the required percentage of accuracy is identified which entitles the facility to obtain a Gold or Silver certificate from the Michigan Cancer Surveillance Program.

Level of Accuracy Required			
Data Item	**Gold**	**Silver**	**MCSP Certification**
Completeness (major discrepancy)	95%	90-94%	X
Name of Patient Major (incorrect name submitted) Minor (incorrect spelling)			Not Established
Patient Demographics Major (county, state) Minor (street address, city, zip)	 99% 95%	 98% 90%	 X X
Marital Status (minor discrepancy)			Not Established
Social Security Number (major discrepancy)			Not Established
Date of Birth (major discrepancy)	99%	98%	X
Sex (major discrepancy)	99%	98%	X
Race (major discrepancy)	99%	98%	X
Hispanic Origin (minor discrepancy)			Future Certification
Medical Record Number (minor discrepancy)			Not Established
Primary Site Major (difference in first three digits) Minor (difference in third digit)	 98% 90%	 95-97% 85-89%	 X X
Paired Organs (minor discrepancy)	99%	98%	X

Level of Accuracy Required			
Data Item	**Gold**	**Silver**	**MCSP Certification**
Histology			
Major (difference in first three digits)	96%	92-95%	X
Minor (difference in fourth digit)	85%	80-84%	X
Cell Behavior (major discrepancy)	99%	98%	X
Tumor Grade (minor discrepancy)	95%	90-94%	
Date of Diagnosis			
Major (different year, difference > 1 month)	99%	98%	X
Minor (same calendar year, but difference of 1 month)	93%	90-92%	X
Method of Diagnosis			
Major (1-4 versus 5-9)	99%	98%	X
Minor (difference in code within 1-4 or 5-9)	97%	96%	X
General Summary Stage (major discrepancy)	85%	75%	Future Certification
Tumor Size (minor discrepancy)			Future Certification
AJCC - TNM Values (major discrepancy)			Not Established
AJCC - Stage Group (major discrepancy)			Not Established
Date Therapy Began			
Major difference > 1 month, no date versus date, unknown versus know month or year)	98%	97%	
Minor (difference < 1 month)	96%	95%	
Reason No Surgery			Not Established
Major (0,8,9 versus 1-7)			
Minor (0 versus 8-9 or difference in code 1-7)			
Surgery Code			
Major (no code versus code)	98%	97%	
Minor (difference in code)	96%	95%	
Treatment Summary			
Biological Response Modifier			
Major (no code or unknown versus code)	95%	94%	
Minor (difference in code)	93%	92%	
Chemotherapy			
Major (no code or unknown versus code)	95%	94%	
Minor (difference in code)	93%	92%	
Immunotherapy			
Major (no code or unknown versus code)	95%	94%	
Minor (difference in code)	93%	92%	
Radiation			
Major (no code or unknown versus code)	95%	94%	
Minor (difference in code)	93%	92%	

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DATA SERVICES PROVIDED TO FACILITIES

A variety of services are available to Michigan facilities providing cancer patient information to the Michigan Cancer Surveillance Program. These services are made available to support the research and planning efforts that facility staff determine are necessary and are particularly intended to aid in hospital cancer registry management and associated activities.

The key services available include:

- Hospital Specific Data or Listings
- Ad Hoc Statistical Data
- Death Searches - Death Certificates
- Death Indexes
- Microfiche - from 1985 - 1995 (135mm)
- Data Files - from 1996 to current
- Death Notices when Reported Patients Die (includes deaths in Michigan and for many other states.)

For more information on these special services contact:

Glenn Copeland, State Registrar
Division for Vital Records and Health Statistics
P.O. Box 30691,
Lansing, MI 48909
Phone (517) 335-8677
Fax (517) 335-9513
E-Mail: CopelandG@michigan.gov

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ABBREVIATIONS

ACoS	American College of Surgeons
ACS	American Cancer Society
CA	Carcinoma/cancer
CAP	College of American Pathologists
CNS	Central nervous system
CoC	Commission on Cancer
CS	Collaborative Stage Data Collection System Manual
DX, Dx	Diagnosis
F/U	Follow-up
FORDS	Facility Oncology Registry Data Standards
H&P	History & physical
H/O	History of
HX, Hx	History
ICD-9-CM	International Classification of Diseases – 9th revision Clinical Modification
ICD-10-CM	International Classification of Diseases – 10th revision Clinical Modification
ICD-O-3	International Classification of Diseases for Oncology, 3rd Edition
INPT	Inpatient
MCSP	Michigan Cancer Surveillance Program
MDHHS	Michigan Department of Health and Human Services
N/A	Not applicable
N/R	Not reportable
NAACCR	North American Association of Central Cancer Registries
NED	No evidence of disease
NCI	National Cancer Institute
NOS	Not otherwise specified
NR	Not reported
Opt	Outpatient
PE	Physical examination

QC	Quality control
R/O	Rule out
REP	Reportable
REQ	Required
ROADS	Registry Operations and Data Standards Documents for Historical Reference
RX, Rx	Treatment
SEER	Surveillance, Epidemiology and End Results
Surg	Surgery, surgical
TNM	Tumor, Node, Metastases (staging system of American Joint Committee for Cancer
TR	Tumor Registry
UNK	Unknown
WHO	World Health Organization

GLOSSARY OF TERMS

Abstract	A summary of a medical case history containing pertinent portions of the medical record.
Anatomic Site	Pertaining to anatomy, or to the structure of the organism.
Autopsy	The post mortem examination of a body.
Basal Cell	The predominant cell of the deepest layer of the epidermis.
Benign	Not malignant; not recurrent; favorable for recovery.
Bilateral Organs	Anatomic organs that exist on both sides of the body.
Biopsy	The removal and examination, usually microscopic, of tissue, performed to establish the characteristics of the neoplasm.
Blastoma	A neoplasm composed of embryonic cells.
Cancer	A malignant tumor.
Carcinoma	A malignant new growth made up of epithelial cells tending to infiltrate the surrounding tissues and give rise to metastases.
Case-Finding	Systematic identification of all reportable neoplasm cases in a facility.
Clinical Cases	Cancer cases not microscopically confirmed through biopsy.
Cytology	The microscopic examination of cells obtained by aspirations, washings, scrapings, and smears (such as pap smears).
Date of Diagnosis	Refers to the first diagnosis of the cancer by a recognized medical practitioner. This is usually the date of first positive tissue specimen.
Demography	The study of populations, especially with reference to size and density, fertility, mortality, growth, age distribution, migration and vital statistics, and the interaction of all these with social and economic conditions.
Diagnosis	The determination of the nature of disease.
Diagnosis Index	A listing of cases by date of discharge from the hospital arranged in diagnostic groupings according to a specific coding system.
Endothelium	The layer of epithelial cells that lines the cavities of the heart and of the blood and lymph vessels, and the serous cavities of the body.
Epidemiology	The study of the occurrence and distribution of disease.
Epithelium	The covering of internal and external surfaces of the body.

Exfoliative Cytology	Microscopic examination of cells shed from a body surface as a means of detecting malignant change.
Frozen Section	A slice cut by a special instrument, the microtome, from tissue that has been frozen.
Gross Anatomy	That which deals with structures that can be distinguished with the naked eye, also called macroscopic anatomy.
Gross Observation	Observations seen with the naked eye (see gross anatomy).
Hematology	The science of blood, its nature, functions, and diseases.
Histology	The specialty of anatomy which deals with minute structures.
Laterality	A relationship to one side, denoting a position from the midline of the body.
Lesion	Any pathological or traumatic discontinuity of tissue or loss of function of a part.
Leukemia	A progressive, malignant disease of the blood-forming organs.
Lymphoma	A term used to describe any neoplastic disorder of the lymphoid tissue, including Hodgkin's disease.
Malignant	An uncontrolled, invasive growth capable of metastasizing, spreading to tumor a distant part of the body. Opposite of benign.
Microscopic	The process of confirming the diagnosis of a neoplasm by examination Confirmation of tissue through a microscope.
Morbidity	Any departure from a state of physiologic or psychological well-being.
Morphology	The science of the forms and structure of organized beings.
Myeloma	A tumor composed of cells of the type normally found in the bone marrow.
Neoplasm	A new growth.
Oncology	The sum of knowledge concerning tumors; the study of tumors.
Paired Site	See bilateral organs.
Papillary	Pertaining to or resembling a papilla, or nipple.
Pathology	That branch of medicine which treats the essential nature of disease, especially of the structural and functional changes in tissues and organs of the body which cause or are caused by disease.
Peritoneal Fluid	Fluid from the serous membrane lining the abdominopelvic walls and the viscera.
Pleural Fluid	Fluid from the serous membrane enveloping the lungs and lining the thoracic cavity, completely enclosing a potential space known as the pleural cavity.

Primary Site	The anatomic organ or tissue of the body where a cancer originates.
Rates	
Incidence Rate	The number of new cases of a disease occurring in a period of time divided by the number of persons at risk of becoming a case during that time. The result is frequently multiplied by a base number such as 1,000 or 100,000.
Death Rate	Computed in the same manner as an incidence rate except that deaths during the time period are used instead of new cases. The deaths may be for a specific cause or causes.
Mortality Rate	See death rate.
Specific Rates	
Age	An incidence or death rate calculated using data (cases, deaths, persons at risk) for a specific age group rather than for all ages.
Sex	An incidence or death rate calculated using data for one sex only.
Resection	Removal of a portion of an organ or other structure.
Sarcoma	A tumor made up of a substance like embryonic connective tissue.
Smear	A specimen for microscopic study prepared by spreading the material across a glass slide.
Tissue Specimen	A preparation of tissue for pathological examination.
Tumor	Classically means a swelling or mass; in current usage means a new growth of tissue or cells.
Validity	The closeness with which a measured value agrees with the "true" value which one desires to know.

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FIPS COUNTY CODES FOR MICHIGAN COUNTIES

Reference Appendix A, NAACCR Data Standards & Data Dictionary (Volume II)
(http://www.naaccr.org/Applications/ContentReader/Default.aspx?c=11)

Alcona	001
Alger	003
Allegan	005
Alpena	007
Antrim	009
Arenac	011
Baraga	013
Barry	015
Bay	017
Benzie	019
Berrien	021
Branch	023
Calhoun	025
Cass	027
Charlevoix	029
Cheboygan	031
Chippewa	033
Clare	035
Clinton	037
Crawford	039
Delta	041
Dickinson	043
Eaton	045
Emmet	047
Genesee	049
Gladwin	051
Gogebic	053
Grand Traverse	055
Gratiot	057
Hillsdale	059
Houghton	061
Huron	063
Ingham	065
Ionia	067
Iosco	069
Iron	071
Isabella	073
Jackson	075
Keweenaw	083
Kalamazoo	077
Kalkaska	079
Kent	081
Lake	085
Lapeer	087
Leelanau	089
Lenawee	091
Livingston	093
Luce	095
Mackinac	097
Macomb	099
Manistee	101
Marquette	103
Mason	105
Mecosta	107
Menominee	109
Midland	111
Missaukee	113
Monroe	115
Montcalm	117
Montmorency	119
Muskegon	121
Newaygo	123
Oakland	125
Oceana	127
Ogemaw	129
Ontonagon	131
Osceola	133
Oscoda	135
Otsego	137
Ottawa	139
Presque Isle	141
Roscommon	143
Saginaw	145
St. Clair	147
St. Joseph	149
Sanilac	151
Schoolcraft	153
Shiawassee	155
Tuscola	157
Van Buren	159
Washtenaw	161
Wayne	163
Wexford	165
Out of State	998
Unknown	999

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U.S. STATE, TERRITORY, COMMONWEALTH, U.S. POSSESSION, AND CANADIAN PROVINCE OR TERRITORY CODES

Reference Appendix B of the SEER Program Coding and Staging Manual 2013
(http://www.seer.cancer.gov/tools/codingmanuals/index.html)

Alabama	AL
Alaska	AK
Alberta	AB
Arizona	AZ
Arkansas	AR
British Columbia	BC
California	CA
Canada	CD
Colorado	CO
Connecticut	CT
Delaware	DE
District of Columbia	DC
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY
Louisiana	LA
Maine	ME
Manitoba	MB
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Brunswick	NB
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
Newfoundland and Labrador	NL
North Carolina	NC
North Dakota	ND
Northwest Territories	NT
Nova Scotia	NS
Nunavut	NU
Ohio	OH
Oklahoma	OK
Ontario	ON
Oregon	OR
Pennsylvania	PA
Prince Edward Island	PE
Puerto Rico	PR
Quebec	QC
Rhode Island	RI
Saskatchewan	SK
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
U.S. Virgin Islands	VI
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY
Yukon Territory	YT
Rest of the World	XX
Unknown	ZZ

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ALPHABETICAL LISTING OF COUNTRY CODES TO BE USED WITH NAACCR VERSION 16

Reference SEER Program Code Manual Appendix B seer.cancer.gov/tools/codingmanuals/index.html

Afghanistan ..... AFG
Africa NOS ..... ZZF
Aland Islands ..... ALA
Albania ..... ALB
Algeria ..... DZA
American Samoa ..... ASM
Andorra ..... AND
Angola ..... AGO
Anguilla ..... AIA
Antarctica ..... ATA
Antigua and Barbuda ..... ATG
Argentina ..... ARG
Armenia ..... ARM
Aruba ..... ABW
Asia NOS ..... ZZA
Australia ..... AUS
Austria ..... AUT
Azerbaijan ..... AZE
Bahamas ..... BHS
Bahrain ..... BHR
Bangladesh ..... BGD
Barbados ..... BRB
Belarus ..... BLR
Belgium ..... BEL
Belize ..... BLZ
Benin ..... BEN
Bermuda ..... BMU
Bhutan ..... BTN
Bolivia ..... BOL
Bonaire, Saint Eustatius and Saba ..... BES
Bosnia and Herzogovina ..... BIH
Botswana ..... BWA
Bouvet Island ..... BVT
Brazil ..... BRA
British Indian Ocean Territory ..... IOT
Brunei Darussalam ..... BND
Bulgaria ..... BGR
Burkina Faso ..... BFA
Burma ..... MMR
Burundi ..... BDI
Cambodia ..... KHM
Cameroon ..... CMR
Canada ..... CAN
Cape Verde ..... CPV
Cayman Islands ..... CYM
Central African Republic ..... CAF
Central America NOS ..... ZZC
Chad ..... TCD
Chile ..... CHL
China ..... CHN
Christmas Island ..... CXR
Cocos (Keeling) Islands ..... CCK
Colombia ..... COL
Comoros ..... COM
Congo, Democratic Republic of ..... COG
Cook Islands ..... COK
Costa Rica ..... CRI
Cote d'Ivoire CIV
Croatia ..... HRV
Cuba ..... CUB
Curacao ..... CUW
Cyprus ..... CYP
Czech Republic ..... CZE
Denmark ..... DNK
Djibouti ..... DJI
Dominica ..... DMA
Dominican Republic ..... DOM
Ecuador ..... ECU
Egypt ..... EGY
El Salvador ..... SLV
England ..... ENG
Equatorial Guinea ..... GNQ
Eritrea ..... ERI
Estonia ..... EST
Ethiopia ..... ETH
Europe NOS ..... ZZE
Falkland Islands ..... FLK
Faroe Islands ..... FRO
Fiji ..... FJI
Finland ..... FIN
France ..... FRA
French Guiana ..... GUF
French Polynesia ..... PYF
French Southern Territories ..... ATF
Gabon ..... GAB
Gambia ..... GMB
Georgia ..... GEO
Germany ..... DEU
Ghana ..... GHA
Gibraltar ..... GIB
Greece ..... GRC
Greenland ..... GRL
Grenada ..... GRD
Guadeloupe ..... GLP
Guam ..... GUM
Guatemala ..... GTM

Guernsey ..... GGY
Guinea ..... GIN
Guinea Bissau ..... GNB
Guyana ..... GUY
Haiti ..... HTI
Heard Island and McDonald Islands ..... HMD
Honduras ..... HND
Hong Kong ..... HKG
Hungary ..... HUN
Iceland ..... ISL
India ..... IND
Indonesia (Dutch East Indies) ..... IDN
Iran ..... IRN
Iraq ..... IRQ
Ireland ..... IRL
Isle of Man ..... IMN
Israel and former Jewish Palestine ..... ISR
Italy ..... ITA
Jamaica ..... JAM
Japan ..... JPN
Jersey ..... JEY
Jordan ..... JOR
Kazakhstan ..... KAZ
Kenya ..... KEN
Kiribati ..... KIR
Kuwait ..... KWT
Kyrgyzstan ..... KGZ
Laos ..... LAO
Latvia ..... LVA
Lebanon ..... LBN
Lesotho ..... LSO
Liberia ..... LBR
Libya ..... LBY
Liechtenstein ..... LIE
Lithuania ..... LTU
Luxembourg ..... LUX
Macao ..... MAC
Macedonia ..... MKD
Madagascar ..... MDG
Malawi ..... MWI
Malaysia ..... MYS
Maldives ..... MDV
Mali ..... MLI
Malta ..... MLT
Marshall Islands ..... MHL
Martinique ..... MTQ
Mauritania ..... MRT
Mauritius ..... MUS
Mayotte ..... MYT
Mexico ..... MEX
Micronesia ..... FSM
Moldova, Republic of ..... MDA
Monaco ..... MCO
Mongolia ..... MNG
Montenegro ..... MNE
Montserrat ..... MSR
Morocco ..... MAR
Mozambique ..... MOZ
Myanmar ..... MMR
Namibia ..... NAM
Nauru ..... NRU
Nepal ..... NPL
Netherlands ..... NLD
New Caledonia ..... NCL
New Zealand ..... NZL
Nicaragua ..... NIC
Niger ..... NER
Nigeria ..... NGA
Niue ..... NIU
Non-US/Canada NOS ..... ZZX
Norfolk Island ..... NFK
North America NOS ..... ZZN
North Korea ..... PRK
Northern Ireland (Ulster) ..... NIR
Northern Mariana Islands ..... MNP
Norway ..... NOR
Oman ..... OMN
Pacific NOS ..... ZZP
Pakistan ..... PAK
Palau (Trust Territory of Pacific Islands) PLW
Palestine ..... PSE
Panama ..... PAN
Panama ..... PAN
Papua New Guinea ..... PNG
Paraguay ..... PRY
Peru ..... PER
Philippines ..... PHL
Pitcairn Islands ..... PCN
Poland ..... POL
Portugal ..... PRT
Puerto Rico ..... PRI
Qatar ..... QAT
Republic of South Africa ..... ZAF
Réunion ..... REU
Romania ..... ROU
Russia ..... RUS
Rwanda ..... RWA
Samoa ..... WSM
San Marino ..... SMR
Sao Tome & Principe ..... STP
Saudi Arabia ..... SAU
Scotland ..... SCT
Senegal ..... SEN
Serbia ..... SRB
Seychelles ..... SYC
Sierra Leone ..... SLE

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Singapore ..... SGP
Saint-Maarten ..... SXM
Slovakia ..... SVK
Slovenia ..... SVN
Solomon Islands ..... SLB
Somalia ..... SOM
South America NOS ..... ZZS
South Georgia and
the South Sandwich Islands ..... SGS
South Korea ..... KOR
South Sudan ..... SSD
Spain ..... ESP
Sri Lanka ..... LKA
St Pierre and Miquelon ..... SPM
St. Barthelemy ..... BLM
St. Helena ..... SHN
St. Kitts and Nevis ..... KNA
St. Lucia ..... LCA
St. Vincent and the Grenadines ..... VCT
Sudan ..... SDN
Suriname ..... SUR
Svalbard and Jan Mayen ..... SJM
Swaziland ..... SWZ
Sweden ..... SWE
Switzerland ..... CHE
Syrian Arab Republic (Syria) ..... SYR
Taiwan ..... TWN
Tajikistan ..... TJK
Tanzania ..... TZA
Thailand ..... THA
Timor-Leste ..... TLS
Togo ..... TGO
Tokelau Islands (New Zealand) ..... TKL
Tonga ..... TON
Trinidad and Tobago ..... TTO
Tunisia ..... TUN
Turkey ..... TUR
Turkmenistan ..... TKM
Turks and Caicos ..... TCA
Tuvalu ..... TUV
Uganda ..... UGA
Ukraine ..... UKR
United Arab Emirates ..... ARE
United Kingdom, NOS ..... GBR
United States ..... USA
Uruguay ..... URY
U.S. Minor Outlying Islands ..... UMI
Uzbekistan ..... UZB
Vanuatu ..... VUT
Vatican City ..... VAT
Venezuela ..... VEN
Vietnam ..... VNM
Virgin Islands, British ..... VGB
Virgin Islands, U.S. ..... VIR
Wales ..... WLS
Wallis and Fotuna ..... WLF
Western Sahara ..... ESH
Yemen ..... YEM
Zambia ..... ZMB
Zimbabwe ..... ZWE
Unknown ..... ZZU

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MICHIGAN CANCER SURVEILLANCE PROGRAM
CANCER PROGRAM MANUAL

Michigan Department of Health and Human Services
Michigan Cancer Surveillance Program
DCH-0916 Rev. 2/9/2016
By Authority of Act 82, P.A. 1984

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