Return to Data Items Table

Reporting Requirements by Data Item and Facility Type

Data reporting requirements are determined by data item and facility type.

Registry Types

Specific reporting requirements for hospitals with a registry, hospitals without a registry, and independent laboratories are summarized in the chart below. The need to report an item has been assigned to the following levels:

- Required
- Reportable
- 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 in the case record.**

- **Hospital with a Registry** - an entity that has an approved cancer program by the American College of Surgeons (ACoS) or is working towards ACoS approval or is 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.
- **Cancer Reporting and Meaningful Use** - Eligible physicians and dentists enrolled in the Medicare and Medicaid Incentive Program and the Merit-based Incentive Payment System (MIPS) may elect to report cancer case information to the MCSP, and thereby fulfilling the Public Health Objective Specialized Registry Measure. Hospitals are not eligible at this time to select cancer reporting as a specialized registry measure and should continue to report in accordance with the MCSP guidelines.

Not all facilities are required to meet the same level of effort to collect and report specific cancer-related data items. Refer to the chart below to determine level of effort associated with collecting and reporting of cancer data based on facility type and specific data item.

Note: If there is no information available for a particular data item, and inquiries have been made, do not leave the item blank (unless specifically noted in the individual data item instructions, e.g., Name--Alias.) Instead, record the appropriate unknown or default code. This note applies to all facility types.

Levels of Effort Requirements Based on Facility Type

Level of Effort	Description
[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. **NOTE: A "Reportable" designation does not mean that the field may be left blank. An appropriate unknown or default value must be reported for all Reportable items.**
[N/R] Not Required/Non-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. **Note: An "N/R" designation does not mean that the field may be left blank. An appropriate unknown or default value must be reported for N/R items.**

Examples:

Data item: Primary Site

All facilities are required to report appropriate primary site ICD-O-3 code for the tumor.

Data item: Name--Alias

Facilities may enter appropriate information if available or leave field blank if unknown/not applicable.

Data item: Grade (Clinical, Pathological or Post Therapy)

Hospitals with registries are required to ascertain and report the correct value for this item.

Laboratories and Hospitals without registries are to enter the correct grade if it is available, but these facilities are not required to determine the tumor grade if information is not available in chart. If the value is unknown, they may record the appropriate unknown or default value for this item. In all cases, a value must be entered regardless of facility type or level of follow-back effort – this field must not be left blank.

Data item: Text--Place of Diagnosis

All facilities must enter 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 information is missing from the record, state that it is missing.

How to Use This Document

This document is comprised of two sections:

- Data Items Table Section - Lists data items in alpha order based on NAACCR item name. Includes NAACCR item number, reportability based on facility type, indication if M record is required and default/unknown value. Also contains link to data item in the Data Items Descriptions & Instructions section.

- Data Items Description & Instructions Section - Lists data items in alpha order based on NAACCR item name. Includes reporting instructions as well as links to standard-setter resource documents containing data item description, rationale, and coding instructions for that data item.

Use the information in these sections to determine data reportability and to assist in correct coding.

- For example, Column 7 in the Data Items Table indicates default codes to use when the value is unknown. If a value is required for an item (REQ VALUE), use the link in Column 1 to go to that item in the Data Items Description & Instructions Section. Here you will find a link to the standard-setter responsible for the item. Use the link to locate required documents containing instructions for correct coding of the item.

- Column 7 may also indicate "Per AJCC requirements" or "Per SEER requirements." In those cases, use the link in the Data Items Description & Instructions Section to connect you to the standard-setter coding instructions for the data item.

Data Items Table Section

Notations Used in Data Items Table

Notation	Used in Column:	Description
² (superscript 2)	Columns 3, 4 & 5	Reporting required by Metropolitan Detroit Cancer Surveillance System (MDCSS) only.
AUTO	Columns 3, 4 & 5	Data is auto populated by software at facility or central registry. Other NAACCR data items may not appear on this list if values are auto generated for electronic reporting of cases
†	Column 7	Value per "Site-Specific Data Item (SSDI) Manual" Effective with Cases Diagnosed 1/1/2018 and Later. Published September 2019. Version 1.7. https://www.naaccr.org/SSDI/SSDI-Manual.pdf?v=1568653063
††	Column 7	Value per EOD Data SEER*RSA - Prostate
REQ VALUE	Column 7	A true value must be entered in this field. An unknown or default value is unavailable. Field cannot be left blank.
<BLANK>	Column 7	Data field may be left blank
X	Column 6	Indicates an M Record submission is required if a change has been made to data item code or text since previously submitted case report.
Bold face text	Column 1	Bold face indicates a Site-Specific Data Item (SSDI). Each SSDI applies only to selected primary sites, histologies, and years of diagnosis. Note: For paper reporting, SSDI data is recorded in the "SSDI Field" section on page 2 of the paper reporting form.
NA	Column 2	State reserved field within the NAACCR record layout for collection of a state-specific data item. Reporting requirements, coding instructions and codes are defined by MCSP.
(Paper form field XXX)	Column 1	Directs paper form users to a corresponding data field on the Cancer Report Form.

Return to Data Items Table

Data Items Table

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
Abstracted By (Paper form field 76)	570	REQ	REQ	REQ		REQ VALUE
Accession Number--Hosp (Paper form field 21)	550	REQ	N/R	N/R	X	REQ VALUE
Addr at DX--City (Paper form field 5b)	70	REQ	REQ	REQ	X	"UNKNOWN"
Addr at DX--Country (Paper form field 5g)	102	REQ	REQ	REQ		ZZU
Addr at DX--No & Street (Paper form field 5a)	2330	REQ	REQ	REQ	X	"UNKNOWN"
Addr at DX--Postal Code (Paper form field 5e)	100	REQ	REQ	REQ	X	999999999
Addr at DX--State (Paper form field 5d)	80	REQ	REQ	REQ	X	ZZ
Addr at DX--Supplementl (May be left blank) (Paper form field 5c)	2335	REP	REP	REP	X	<BLANK>
Addr Current--City (Paper form field 6	1810	REQ	REQ	REQ		"UNKNOWN"
Addr Current--Country (Paper form field 6)	1832	REQ	REQ	REQ		ZZU
Addr Current--No & Street (Paper form field 6)	2350	REQ	REQ	REQ		"UNKNOWN"
Addr Current--Postal Code (Paper form field 6)	1830	REQ	REQ	REQ		999999999
Addr Current--State (Paper form field 6)	1820	REQ	REQ	REQ		ZZ
Addr Current--Supplementl (May be left blank) (Paper form field 6)	2355	REP	REP	REP		<BLANK>
Adenoid Cystic Basaloid Pattern (Paper form field **SSDI**)	3803	REP	REP	N/R		XXX.9†
Adenopathy (Paper form field **SSDI**)	3804	REP	REP	N/R		9†
AFP Post-Orchiectomy Lab Value (Paper form field **SSDI**)	3805	REP	REP	N/R		XXXXX.9†

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
AFP Post-Orchiectomy Range (Paper form field **SSDI**)	3806	REP	REP	N/R		9†
AFP Pre-Orchiectomy Lab Value (Paper form field **SSDI**)	3807	REP	REP	N/R		XXXXX.9†
AFP Pre-Orchiectomy Range (Paper form field **SSDI**)	3808	REP	REP	N/R		9†
AFP Pretreatment Interpretation (Paper form field **SSDI**)	3809	REP	REP	N/R		9†
AFP Pretreatment Lab Value (Paper form field **SSDI**)	3810	REP	REP	N/R		XXXX.9†
Age at Diagnosis	230	AUTO	AUTO	AUTO		REQ VALUE
AJCC API Version Current (2021 cases and later)	2156	AUTO	AUTO	AUTO		AUTO
AJCC API Version Original (2021 cases and later)	2157	AUTO	AUTO	AUTO		AUTO
AJCC Cancer Surveillance API Version Current (2021 cases and later)	2158	AUTO	AUTO	AUTO		AUTO
AJCC Cancer Surveillance API Version Original (2021 cases and later)	2159	AUTO	AUTO	AUTO		AUTO
AJCC ID (2018 cases and later)	995	REQ	REP	N/R	X	REQ VALUE
AJCC TNM Clin M 8th Ed 2018 cases and later (Paper form field 37)	1003	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Clin N 8th Ed 2018 cases and later (Paper form field 37)	1002	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Clin N Suffix 8th Ed 2018 cases and later (Paper form field 37)	1034	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Clin Stage Group 8th Ed 2018 cases and later (Paper form field 37)	1004	REQ (ACOS only)	REP	N/R	X	Per AJCC requirements

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Ind Lab	Change Triggers M Record	If Unknown, Enter…
AJCC TNM Clin T 8th Ed 2018 cases and later (Paper form field 37)	1001	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Clin T Suffix 8th Ed 2018 cases and later (Paper form field 37)	1031	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Path M 8th Ed 2018 cases and later (Paper form field 37)	1013	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Path N 8th Ed 2018 cases and later (Paper form field 37)	1012	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Path N Suffix 8th Ed 2018 cases and later (Paper form field 37)	1035	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Path Stage Group 8th Ed 2018 cases and later (Paper form field 37)	1014	REQ (ACOS only)	REP	N/R	X	Per AJCC requirements
AJCC TNM Path T 8th Ed 2018 cases and later (Paper form field 37)	1011	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Path T Suffix 8th Ed 2018 cases and later (Paper form field 37)	1032	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Post Therapy M 8th Ed 2018 cases and later (Paper form field 37)	1023	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Post Therapy N 8th Ed 2018 cases and later (Paper form field 37)	1022	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Post Therapy N Suffix 8th Ed 2018 cases and later (Paper form field 37)	1036	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Post Therapy Stage Group 8th Ed 2018 cases and later (Paper form field 37)	1024	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Post Therapy T 8th Ed 2018 cases and later (Paper form field 37)	1021	REQ (ACOS only)	REP	N/R		Per AJCC requirements

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
AJCC TNM Post Therapy T Suffix 8th Ed 2018 cases and later (Paper form field 37)	1033	REQ (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Post Therapy Clin (yc) M 8th Ed 2021 cases and later (Paper form field 37)	1066	REP (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Post Therapy Clin (yc) N 8th Ed 2021 cases and later (Paper form field 37)	1064	REP (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Post Therapy Clin (yc) N Suffix 8th Ed 2021 cases and later (Paper form field 37)	1065	REP (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Post Therapy Clin (yc) Stage Group 8th Ed 2021 cases and later (Paper form field 37)	1067	REP (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Post Therapy Clin (yc) T 8th Ed 2021 cases and later (Paper form field 37)	1062	REP (ACOS only)	REP	N/R		Per AJCC requirements
AJCC TNM Post Therapy Clin (yc) T Suffix 8th Ed 2021 cases and later (Paper form field 37)	1063	REP (ACOS only)	REP	N/R		Per AJCC requirements
Alcohol Use (State-specific item 9521) (Paper form field 17)	NA	REP	REP	N/R	X	9
ALK Rearrangement 2021 cases and later (Paper form field **SSDI**)	3938	REP	REP	N/R		9†
Anemia (Paper form field **SSDI**)	3811	REP	REP	N/R		9†
B symptoms (Paper form field **SSDI**)	3812	REP	REP	N/R		9†
Behavior Code ICD-O-3 (Paper form field 32)	523	REQ	REQ	REQ	X	9

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
Bilirubin Pretreatment Total Lab Value (Paper form field **SSDI**)	3813	REP	REP	N/R		XXX.9†
Bilirubin Pretreatment Unit of Measure (Paper form field **SSDI**)	3814	REP	REP	N/R		9†
Birthplace--Country (Paper form field 8b)	254	REP	REP	N/R	X	ZZU
Birthplace--State (Paper form field 8a)	252	REP	REP	N/R	X	ZZ
Bone Invasion (Paper form field **SSDI**)	3815	REP	REP	N/R		9†
BRAF Mutational Analysis 2021 cases and later (Paper form field **SSDI**)	3940	REP	REP	N/R		9†
Brain Molecular Markers (Paper form field **SSDI**)	3816	REP	REP	N/R	X	99†
Breslow Tumor Thickness (Paper form field **SSDI**)	3817	REP	REP	REP	X	XX.9†
CA 19-9 Pre TX Lab Value (Paper form field **SSDI**)	3742	REP	REP	N/R		XXXX.9†
CA-125 Pretreatment Interpretation (Paper form field **SSDI**)	3818	REP	REP	N/R	X	9†
Casefinding Source (Paper form field 23)	501	REQ	REQ	REQ		REQ VALUE
Cause of Death (Paper form field 79)	1910	REP	REP	N/R		0000 (patient alive)
CEA Pretreatment Interpretation (Paper form field **SSDI**)	3819	REP	REP	N/R		9†
CEA Pretreatment Lab Value (Paper form field **SSDI**)	3820	REP	REP	N/R		XXXX.9†
Census Tr Poverty Indictr	145	AUTO	AUTO	N/R		9
Chromosome 19q: Loss of Heterozygosity (LOH) (Paper form field **SSDI**)	3802	REP	REP	N/R		9†
Chromosome 1p: Loss of Heterozygosity (LOH) (Paper form field **SSDI**)	3801	REP	REP	N/R		9†

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Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
Chromosome 3 Status (Paper form field **SSDI**)	3821	REP	REP	N/R		9†
Chromosome 8q Status (Paper form field **SSDI**)	3822	REP	REP	N/R		9†
Circumferential Resection Margin (CRM) (Paper form field **SSDI**)	3823	REP	REP	REP	X	XX.9†
Class of Case (Paper form field 26)	610	REQ	REQ	REQ	X	REQ VALUE
CoC Accredited Flag	2152	REQ	N/R	N/R	X	REQ VALUE
Comorbid/Complication 1 (ICD-9-CM codes only) (Paper form field 14a)	3110	REP	REP	N/R		<BLANK>
Comorbid/Complication 2 (ICD-9-CM codes only) (Paper form field 14a)	3120	REP	REP	N/R		<BLANK>
Comorbid/Complication 3 (ICD-9-CM codes only) (Paper form field 14a	3130	REP	REP	N/R		<BLANK>
Comorbid/Complication 4 (ICD-9-CM codes only) (Paper form field 14a)	3140	REP	REP	N/R		<BLANK>
Comorbid/Complication 5 (ICD-9-CM codes only) (Paper form field 14a)	3150	REP	REP	N/R		<BLANK>
Comorbid/Complication 6 (ICD-9-CM codes only) (Paper form field 14a)	3160	REP	REP	N/R		<BLANK>
Comorbid/Complication 7 (ICD-9-CM codes only) (Paper form field 14a)	3161	REP	REP	N/R		<BLANK>
Comorbid/Complication 8 (ICD-9-CM codes only) (Paper form field 14a)	3162	REP	REP	N/R		<BLANK>
Comorbid/Complication 9 (ICD-9-CM codes only) (Paper form field 14a)	3163	REP	REP	N/R		<BLANK>
Comorbid/Complication 10 (ICD-9-CM codes only) (Paper form field 14a)	3164	REP	REP	N/R		<BLANK>
County at DX (Paper form field 5f)	90	REQ	REQ	REQ	X	999

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
County--Current (Paper form field 6)	1840	REQ	REQ	REQ		999
Creatinine Pretreatment Lab Value (Paper form field **SSDI**)	3824	REP	REP	N/R		XX.9†
Creatinine Pretreatment Unit of Measure (Paper form field **SSDI**)	3825	REP	REP	N/R		9†
CS Extension (DX 2004 - 2015 only) (Paper form field **SSDI**)	2810	REP	REP	N/R	X	Dependent on schema
CS Lymph Nodes (DX 2004 - 2015 only) (Paper form field **SSDI**)	2830	REP	REP	N/R	X	Dependent on schema
CS Lymph Nodes Eval (DX 2004 - 2015 only) (Paper form field **SSDI**)	2840	REP	REP	N/R	X	Dependent on schema
CS Mets at Diagnosis (DX 2004 - 2015 only) (Paper form field **SSDI**)	2850	REP	REP	N/R	X	Dependent on schema
CS Mets at DX - Bone (DX 2004 - 2015 only) (Paper form field **SSDI**)	2851	REP	REP	N/R	X	Dependent on schema
CS Mets at DX - Brain (DX 2004 - 2015 only) (Paper form field **SSDI**)	2852	REP	REP	N/R	X	Dependent on schema
CS Mets at DX - Liver (DX 2004 - 2015 only) (Paper form field **SSDI**)	2853	REP	REP	N/R	X	Dependent on schema
CS Mets at DX - Lung (DX 2004 - 2015 only) (Paper form field **SSDI**)	2854	REP	REP	N/R	X	Dependent on schema
CS Mets Eval (DX 2004 - 2015 only) (Paper form field **SSDI**)	2860	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 1 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2880	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 10 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2864	REP	REP	N/R	X	Dependent on schema

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Ind Lab	Change Triggers M Record	If Unknown, Enter…
CS Site-Specific Factor 11 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2865	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 12 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2866	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 13 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2867	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 14 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2868	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 15 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2869	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 16 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2870	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 17 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2871	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 18 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2872	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 19 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2873	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 2 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2890	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 20 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2874	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 21 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2875	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 22 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2876	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 23 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2877	REP	REP	N/R	X	Dependent on schema

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Ind Lab	Change Triggers M Record	If Unknown, Enter…
CS Site-Specific Factor 24 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2878	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 25 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2879	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 3 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2900	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 4 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2910	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 5 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2920	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 6 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2930	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 7 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2861	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 8 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2862	REP	REP	N/R	X	Dependent on schema
CS Site-Specific Factor 9 (DX 2004 - 2017 only) (Paper form field **SSDI**)	2863	REP	REP	N/R	X	Dependent on schema
CS Tumor Size (DX 2004 - 2015 only) (Paper form field **SSDI**)	2800	REP	REP	N/R	X	Dependent on schema
CS Tumor Size/Ext Eval (DX 2004 - 2015 only) (Paper form field **SSDI**)	2820	REP	REP	N/R	X	Dependent on schema
CS Version Input Current	2937	AUTO	AUTO	AUTO	X	AUTO
CS Version Input Original	2935	AUTO	AUTO	AUTO	X	AUTO
Date 1st Crs RX CoC (Paper form field 49a)	1270	REQ	REP	N/R	X	<BLANK>
Date 1st Crs RX CoC Flag (Paper form field 49b)	1271	REQ	REP	N/R	X	10
Date Case Completed (Paper form field 81)	2090	REQ	REQ	REQ		REQ VALUE
Date Case Report Exported	2110	REQ	REQ	REQ		REQ VALUE

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
Date Initial RX SEER - SEER ONLY	1260	REQ[2]	REP[2]	REP[2]	X	<BLANK>
Date Initial RX SEER Flag - SEER ONLY	1261	REQ[2]	REP[2]	REP[2]	X	10
Date of 1st Contact (Paper form field 27)	580	REQ	REP	REP	X	<BLANK>
Date of 1st Contact Flag	581	REQ	REP	REP	X	12
Date of Birth (Paper form field 7)	240	REQ	REQ	REQ	X	REQ VALUE
Date of Death (Applies to paper reporting form only. Use form field 78)	1750	REP	REP	N/R		<BLANK>
Date of Diagnosis (Paper form field 28)	390	REQ	REQ	REQ	X	REQ VALUE
Date of Last Contact (Paper form field 70a)	1750	REP	REP	N/R		<BLANK>
Date of Last Contact Flag (Paper form field 70b)	1751	REP	REP	N/R		12
Date of Sentinel Lymph Node Biopsy (Paper form field **SSDI**)	832	REP	REP	REP		<BLANK>
Date of Sentinel Lymph Node Biopsy Flag (Paper form field **SSDI**)	833	REP	REP	REP		10
Date Regional Lymph Node Dissection	682	REP	REP	REP		<BLANK>
Date Regional Lymph Node Dissection Flag	683	REP	REP	REP		10
DC State File Number	2380	REP	REP	REP		<BLANK>
Derived EOD 2018 M - SEER ONLY (2018 cases and later)	795	REQ[2]	REP[2]	N/R	X	Per SEER requirements
Derived EOD 2018 N - SEER ONLY (2018 cases and later)	815	REQ[2]	REP[2]	N/R	X	Per SEER requirements
Derived EOD 2018 Stage Group - SEER ONLY (2018 cases and later)	818	REQ[2]	REP[2]	N/R	X	Per SEER requirements
Derived EOD 2018 T - SEER ONLY (2018 cases and later)	785	REQ[2]	REP[2]	N/R	X	Per SEER requirements

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
Diagnostic Confirmation (Paper form field 35)	490	REQ	REQ	REQ	X	9
EGFR Mutational Analysis 2021 cases and later (Paper form field **SSDI**)	3939	REP	REP	N/R		9†
EOD--Mets - SEER ONLY (Paper form field 47)	776	REQ[2]	REP[2]	N/R	X	Per SEER requirements
EOD--Primary Tumor - SEER ONLY (Paper form field 47)	772	REQ[2]	REP[2]	N/R	X	Per SEER requirements
EOD Prostate Pathological Extension (Paper form field **SSDI**)	3919	REP	REP	N/R		999††
EOD--Regional Nodes - SEER ONLY (Paper form field 47)	774	REQ[2]	REP[2]	N/R	X	Per SEER requirements
Esophagus and EGJ Tumor Epicenter (Paper form field **SSDI**)	3829	REP	REP	N/R		9†
Estrogen Receptor Percent Positive or Range (Paper form field **SSDI**)	3826	REP	REP	REP		XX9†
Estrogen Receptor Summary (Paper form field **SSDI**)	3827	REP	REP	N/R	X	9†
Estrogen Receptor Total Allred Score (Paper form field **SSDI**)	3828	REP	REP	N/R		X9†
Extranodal Extension Clin (non-Head and Neck) (Paper form field **SSDI**)	3830	REP	REP	N/R		9†
Extranodal Extension Head and Neck Clinical (Paper form field **SSDI**)	3831	REP	REP	N/R		9†
Extranodal Extension Head and Neck Pathological (Paper form field **SSDI**)	3832	REP	REP	N/R		X.9†
Extranodal Extension Path (Non-Head and Neck) (Paper form field **SSDI**)	3833	REP	REP	N/R		9†

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
Extravascular Matrix Patterns (Paper form field **SSDI**)	3834	REP	REP	N/R		9†
Family History of Cancer (State-specific item 9520) (Paper form field 16a-c)	NA	REP	REP	N/R	X	9
Fibrosis Score (Paper form field **SSDI**)	3835	REP	REP	N/R		9†
FIGO Stage (Paper form field **SSDI**)	3836	REP	REP	N/R		99†
Follow-Up Source	1790	REP	REP	REP		9
Gestational Trophoblastic Prognostic Scoring Index (Paper form field **SSDI**)	3837	REP	REP	N/R		X9†
Gleason Patterns Clinical (Paper form field **SSDI**)	3838	REP	REP	REP	X	X9†
Gleason Patterns Pathological (Paper form field **SSDI**)	3839	REP	REP	N/R	X	X9†
Gleason Score Clinical (Paper form field **SSDI**)	3840	REP	REP	REP	X	X9†
Gleason Score Pathological (Paper form field **SSDI**)	3841	REP	REP	N/R	X	X9†
Gleason Tertiary Pattern (Paper form field **SSDI**)	3842	REP	REP	N/R	X	X9†
Grade (Cases prior to 2018 only) (Paper form field 33)	440	REQ	REP	REP	X	9
Grade Clinical (2018 cases and later) (Paper form field 33)	3843	REQ	REP	REP	X	9
Grade Pathological (2018 cases and later) (Paper form field 33)	3844	REQ	REP	REP	X	9
Grade Post Therapy Clin (yc) (2021 cases and later) (Paper form field 33)	1068	REQ	REP	N/R	X	<BLANK>
Grade Post Therapy Path (yp) (2018 cases and later) (Paper form field 33)	3845	REQ	REP	N/R	X	<BLANK>

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Ind Lab	Change Triggers M Record	If Unknown, Enter…
hCG Post-orchiectomy Lab Value (Paper form field **SSDI**)	3846	REP	REP	N/R		XXXXX.9†
hCG Post-orchiectomy Range (Paper form field **SSDI**)	3847	REP	REP	N/R		9†
hCG Pre-orchiectomy Lab Value (Paper form field **SSDI**)	3848	REP	REP	N/R		XXXXX.9†
hCG Pre-orchiectomy Range (Paper form field **SSDI**)	3849	REP	REP	N/R		9†
HER2 IHC Summary (Paper form field **SSDI**)	3850	REP	REP	N/R		9†
HER2 ISH Dual Probe Copy Number (Paper form field **SSDI**)	3851	REP	REP	N/R		XX.9†
HER2 ISH Dual Probe Ratio (Paper form field **SSDI**)	3852	REP	REP	N/R		XX.9†
HER2 ISH Single Probe Copy Number (Paper form field **SSDI**)	3853	REP	REP	N/R		XX.9†
HER2 ISH Summary (Paper form field **SSDI**)	3854	REP	REP	N/R		9†
HER2 Overall Summary (Paper form field **SSDI**)	3855	REP	REP	N/R	X	9†
Heritable Trait (Paper form field **SSDI**)	3856	REP	REP	N/R	X	9†
High Risk Cytogenetics (Paper form field **SSDI**)	3857	REP	REP	N/R	X	9†
High Risk Histologic Features (Paper form field **SSDI**)	3858	REP	REP	N/R	X	9†
Histologic Type ICD-O-3 (Paper form field 31)	522	REQ	REQ	REQ	X	8000
HIV Status (Paper form field **SSDI**)	3859	REP	REP	N/R		9†
ICD Revision Number	1920	REQ	REQ	REP		REQ VALUE
International Normalized Ratio Prothrombin Time (Paper form field **SSDI**)	3860	REP	REP	N/R		X.9†

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Ind Lab	Change Triggers M Record	If Unknown, Enter…
Invasion Beyond Capsule (Paper form field **SSDI**)	3864	REP	REP	REP		9†
Ipsilateral Adrenal Gland Involvement (Paper form field **SSDI**)	3861	REP	REP	N/R		9†
JAK2 (Paper form field **SSDI**)	3862	REP	REP	N/R	X	9†
Ki-67 (Paper form field **SSDI**)	3863	REP	REP	REP	X	XXX.9†
KIT Gene Immunohistochemistry (Paper form field **SSDI**)	3865	REP	REP	REP	X	9†
KRAS (Paper form field **SSDI**)	3866	REP	REP	REP	X	9†
Laboratory Report Number (State-specific item 9507) (Paper form field 20)	NA	REP	REP	REQ	X	"UNKNOWN"
Laterality (Paper form field 30)	410	REQ	REQ	REQ	X	9
Latitude	2352	REP	REP	REP		<BLANK>
LDH Post-Orchiectomy Range (Paper form field **SSDI**)	3867	REP	REP	N/R		9†
LDH Pre-Orchiectomy Range (Paper form field **SSDI**)	3868	REP	REP	N/R		9†
LDH (Pretreatment) Lab Value (Paper form field **SSDI**)	3932	REP	REP	N/R		XXXXX.9†
LDH (Pretreatment) Level (Paper form field **SSDI**)	3869	REP	REP	N/R		9†
LDH Upper Limits of Normal (Paper form field **SSDI**)	3870	REP	REP	N/R		XX9†
LN Assessment Method Femoral-Inguinal (Paper form field **SSDI**)	3871	REP	REP	N/R		9†
LN Assessment Method Para-aortic (Paper form field **SSDI**)	3872	REP	REP	N/R		9†

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Ind Lab	Change Triggers M Record	If Unknown, Enter…
LN Assessment Method Pelvic (Paper form field **SSDI**)	3873	REP	REP	N/R		9†
LN Distant Assessment Method (Paper form field **SSDI**)	3874	REP	REP	N/R		9†
LN Distant: Mediastinal, Scalene (Paper form field **SSDI**)	3875	REP	REP	N/R		9†
LN Head and Neck Levels I-III (Paper form field **SSDI**)	3876	REP	REP	N/R		9†
LN Head and Neck Levels IV-V (Paper form field **SSDI**)	3877	REP	REP	N/R		9†
LN Head and Neck Levels VI-VII (Paper form field **SSDI**)	3878	REP	REP	N/R		9†
LN Head and Neck Other (Paper form field **SSDI**)	3879	REP	REP	N/R		9†
LN Isolated Tumor Cells (ITC) (Paper form field **SSDI**)	3880	REP	REP	N/R		9†
LN Laterality (Paper form field **SSDI**)	3881	REP	REP	N/R		9†
LN Positive Axillary Level I-II (Paper form field **SSDI**)	3882	REP	REP	N/R		X9†
LN Size (Paper form field **SSDI**)	3883	REP	REP	N/R		XX.9†
LN Status Femoral-Inguinal, Para-aortic, Pelvic (Paper form field **SSDI**)	3884	REP	REP	N/R		9†
Longitude	2354	REP	REP	N/R		<BLANK>
Lymphocytosis (Paper form field **SSDI**)	3885	REP	REP	REP		9†
Lymphovascular Invasion (Paper form field 34)	1182	REP	REP	REP	X	9
Major Vein Involvement (Paper form field **SSDI**)	3886	REP	REP	N/R		9†

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
Marital Status at DX (Paper form field 12)	150	REP	REP	REP		9
Measured Basal Diameter (Paper form field **SSDI**)	3887	REP	REP	REP	X	XX.9†
Measured Thickness (Paper form field **SSDI**)	3888	REP	REP	REP	X	XX.9†
Medical Record Number (Paper form field 19)	2300	REQ	REQ	N/R	X	"UNKNOWN"
Methylation of O6-Methylguanine-Methyltransferase (Paper form field **SSDI**)	3889	REP	REP	REP		9†
Mets at DX-Bone (2016 cases and later) (Paper form field 41)	1112	REP	REP	N/R	X	9
Mets at DX-Brain (2016 cases and later) (Paper form field 42)	1113	REP	REP	N/R	X	9
Mets at DX-Distant LN (2016 cases and later) (Paper form field 43)	1114	REP	REP	N/R	X	9
Mets at DX-Liver (2016 cases and later) (Paper form field 44)	1115	REP	REP	N/R	X	9
Mets at DX-Lung (2016 cases and later) (Paper form field 45)	1116	REP	REP	N/R	X	9
Mets at DX-Other (2016 cases and later) (Paper form field 46)	1117	REP	REP	N/R	X	9
Michigan Facility Number (State-specific item 9508) (Paper form field 25)	NA	REQ	REQ	REQ	X	REQ VALUE
Microsatellite Instability (MSI) (Paper form field **SSDI**)	3890	REP	REP	REP	X	9†
Microvascular Density (Paper form field **SSDI**)	3891	REP	REP	REP		X9†
Mitotic Count Uveal Melanoma (Paper form field **SSDI**)	3892	REP	REP	REP		XX.9†

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
Mitotic Rate Melanoma (Paper form field **SSDI**)	3893	REP	REP	REP	X	X9†
Multigene Signature Method (Paper form field **SSDI**)	3894	REP	REP	N/R	X	9†
Multigene Signature Results (Paper form field **SSDI**)	3895	REP	REP	N/R	X	X9†
Name--Alias (May be left blank) (Paper form field 3)	2280	REP	REP	REP		<BLANK>
Name--Birth Surname 2021 cases and later (Paper form field 2)	2232	REP	REP	N/R	X	<BLANK>
Name--First (Paper form field 1b)	2240	REQ	REQ	REQ	X	REQ VALUE
Name--Last (Paper form field 1a)	2230	REQ	REQ	REQ	X	REQ VALUE
Name--Maiden (May be left blank) (Paper form field 2)	2390	REP	REP	N/R		<BLANK>
Name--Middle (May be left blank) (Paper form field 1c)	2250	REP	REP	REP	X	<BLANK>
NCCN International Prognostic Index (IPI) (Paper form field **SSDI**)	3896	REP	REP	N/R	X	X9†
NCDB--COVID19--Tx Impact 2021 cases and later	3946	REQ	REP	N/R	X	9 or <BLANK>
NCDB--SARSCoV2--Pos 2021 cases and later	3944	REQ	REP	N/R	X	9 or <BLANK>
NCDB--SARSCoV2--Pos Date 2021 cases and later	3945	REQ	REP	N/R	X	<BLANK>
NCDB--SARSCoV2--Test 2021 cases and later	3943	REQ	REP	N/R	X	9 or <BLANK>
NPCR Derived AJCC 8 TNM Clin Stg Grp	3645	REQ	REP	N/R	X	Per AJCC requirements
NPCR Derived AJCC 8 TNM Path Stg Grp	3646	REQ	REP	N/R	X	Per AJCC requirements
NPCR Derived AJCC 8 TNM Post Therapy Stg Grp	3647	REP	REP	N/R	X	Per AJCC requirements

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Ind Lab	Change Triggers M Record	If Unknown, Enter…
NPCR Derived Clin Stg Grp	3650	REQ	REP	N/R	X	Per AJCC requirements
NPCR Derived Path Stg Grp	3655	REQ	REP	N/R	X	Per AJCC requirements
NPCR Specific Field	3720	REQ	REP	N/R		<BLANK>
NPI--Reporting Facility	545	REQ	REP	REP		REQ VALUE
NRAS Mutational Analysis 2021 cases and later (Paper form field **SSDI**)	3941	REP	REP	N/R		9†
Number of Cores Examined (Paper form field **SSDI**)	3897	REP	REP	REP		X9†
Number of Cores Positive (Paper form field **SSDI**)	3898	REP	REP	REP		X9†
Number of Examined Para-Aortic Nodes (Paper form field **SSDI**)	3899	REP	REP	N/R		X9†
Number of Examined Pelvic Nodes (Paper form field **SSDI**)	3900	REP	REP	N/R		X9†
Number of Phases of Rad Treatment to this Volume	1532	REP	REP	N/R		99
Number of Positive Para-Aortic Nodes (Paper form field **SSDI**)	3901	REP	REP	N/R		X9†
Number of Positive Pelvic Nodes (Paper form field **SSDI**)	3902	REP	REP	N/R		X9†
Oncotype Dx Recurrence Score-DCIS (Paper form field **SSDI**)	3903	REP	REP	REP	X	XX9†
Oncotype Dx Recurrence Score-Invasive (Paper form field **SSDI**)	3904	REP	REP	REP	X	XX9†
Oncotype Dx Risk Level-DCIS (Paper form field **SSDI**)	3905	REP	REP	REP	X	9†
Oncotype Dx Risk Level-Invasive (Paper form field **SSDI**)	3906	REP	REP	REP	X	9†
Organomegaly (Paper form field **SSDI**)	3907	REP	REP	N/R		9†

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
Percent Necrosis Post Neoadjuvant (Paper form field **SSDI**)	3908	REP	REP	N/R		XXX.9†
Perineural Invasion (Paper form field **SSDI**)	3909	REP	REP	REP	X	9†
Peripheral Blood Involvement (Paper form field **SSDI**)	3910	REP	REP	REP	X	9†
Peritoneal Cytology (Paper form field **SSDI**)	3911	REP	REP	REP		9†
Phase I Dose per Fraction	1501	REP	REP	N/R		99999
Phase I Number of Fractions	1503	REP	REP	N/R		999
Phase I Radiation External Beam Planning Tech	1502	REP	REP	N/R		99
Phase I Radiation Primary Treatment Volume	1504	REP	REP	N/R		99
Phase I Radiation to Draining Lymph Nodes	1505	REP	REP	N/R		99
Phase I Radiation Treatment Modality	1506	REQ	REP	N/R	X	99
Phase I Total Dose	1507	REP	REP	N/R		999999
Phase II Dose per Fraction	1511	REP	REP	N/R		<BLANK> or 99999
Phase II Number of Fractions	1513	REP	REP	N/R		<BLANK> or 999
Phase II Radiation External Beam Planning Tech	1512	REP	REP	N/R		<BLANK> or 99
Phase II Radiation Primary Treatment Volume	1514	REP	REP	N/R		<BLANK> or 99
Phase II Radiation to Draining Lymph Nodes	1515	REP	REP	N/R		<BLANK> or 99
Phase II Radiation Treatment Modality	1516	REP	REP	N/R		<BLANK> or 99
Phase II Total Dose	1517	REP	REP	N/R		<BLANK> or 999999
Phase III Dose per Fraction	1521	REP	REP	N/R		<BLANK> or 99999
Phase III Number of Fractions	1523	REP	REP	N/R		<BLANK> or 999
Phase III Radiation External Beam Planning Tech	1522	REP	REP	N/R		<BLANK> or 99

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Ind Lab	Change Triggers M Record	If Unknown, Enter…
Phase III Radiation Primary Treatment Volume	1524	REP	REP	N/R		00 or 99
Phase III Radiation to Draining Lymph Nodes	1525	REP	REP	N/R		<BLANK> or 99
Phase III Radiation Treatment Modality	1526	REP	REP	N/R		<BLANK> or 99
Phase III Total Dose	1527	REP	REP	N/R		<BLANK> or 999999
Place of Death--Country (Paper form field 80b)	1944	REP	REP	N/R		ZZU
Place of Death--State (Paper form field 80a)	1942	REQ	REQ	N/R		ZZ
Pleural Effusion (Paper form field **SSDI**)	3913	REP	REP	REP		9†
Primary Payer at DX (Paper form field 13)	630	REP	REP	REP		99
Primary Sclerosing Cholangitis (Paper form field **SSDI**)	3917	REP	REP	REP		9†
Primary Site (Primary form field 29)	400	REQ	REQ	REQ	X	REQ VALUE
Profound Immune Suppression (Paper form field **SSDI**)	3918	REP	REP	N/R		9†
Progesterone Receptor Percent Positive or Range (Paper form field **SSDI**)	3914	REP	REP	REP		XX9†
Progesterone Receptor Summary (Paper form field **SSDI**)	3915	REP	REP	REP	X	9†
Progesterone Receptor Total Allred Score (Paper form field **SSDI**)	3916	REP	REP	REP		X9†
PSA (Prostatic Specific Antigen) Lab Value (Paper form field **SSDI**)	3920	REP	REP	REP	X	XXX.9†
Race 1 (Paper form field 11)	160	REQ	REQ	REQ	X	99
Race 2 (Paper form field 11)	161	REQ	REQ	REQ	X	99
Race 3 (Paper form field 11)	162	REQ	REQ	REQ	X	99

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Ind Lab	Change Triggers M Record	If Unknown, Enter…
Race 4 (Paper form field 11)	163	REQ	REQ	REQ	X	99
Race 5 (Paper form field 11)	164	REQ	REQ	REQ	X	99
Radiation Treatment Discontinued Early	1531	REP	REP	N/R		99
Reason for No Radiation (Paper form field 59)	1430	REQ	REP	N/R	X	99
Reason for No Surgery (Paper form field 51)	1340	REQ	REP	N/R	X	99
Regional Nodes Examined (Paper form field 40)	830	REQ	REQ	N/R	X	99
Regional Nodes Positive (Paper form field 39)	820	REQ	REQ	N/R	X	99
Reporting Facility (Paper form field 24a)	540	REQ	REQ	REQ	X	REQ VALUE
Residual Tumor Volume Post Cytoreduction (Paper form field **SSDI**)	3921	REP	REP	N/R		99†
Response to Neoadjuvant Therapy (Paper form field **SSDI**)	3922	REP	REP	N/R		9†
RQRS NCDB Submission Flag	2155	REQ	N/R	N/R		Per CoC requirements
RX Coding System--Current	1460	REQ	REP	N/R		REQ VALUE
RX Date BRM (Paper form field 66a)	1240	REQ	REP	N/R	X	Use Item Flag Field
RX Date BRM Flag (Paper form field 66b)	1241	REQ	REP	N/R	X	10
RX Date Chemo (Paper form field 61a)	1220	REQ	REP	N/R	X	Use Item Flag Field
RX Date Chemo Flag (Paper form field 61b)	1221	REQ	REP	N/R	X	10
RX Date Hormone (Paper form field 64a)	1230	REQ	REP	N/R	X	Use Item Flag Field
RX Date Hormone Flag (Paper form field 64b)	1231	REQ	REP	N/R	X	10
RX Date Mst Defn Srg (Paper form field 54a)	3170	REQ	REP	N/R	X	Use Item Flag Field
RX Date Mst Defn Srg Flag (Paper form field 54b)	3171	REQ	REP	N/R	X	10

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Ind Lab	Change Triggers M Record	If Unknown, Enter…
RX Date Other (Paper form field 68a)	1250	REQ	REP	N/R	X	Use Item Flag Field
RX Date Other Flag (Paper form field 68b)	1251	REQ	REP	N/R	X	10
RX Date Radiation (Paper form field 58a)	1210	REQ	REP	N/R	X	Use Item Flag Field
RX Date Radiation Flag (Paper form field 58b)	1211	REQ	REP	N/R	X	10
RX Date Surgery (Paper form field 52a)	1200	REQ	REP	N/R	X	Use Item Flag Field
RX Date Surgery Flag (Paper form field 52b)	1201	REQ	REP	N/R	X	10
RX Date Systemic	3230	REQ	REP	N/R	X	Use Item Flag Field
RX Date Systemic Flag	3231	REQ	REP	N/R	X	10
RX Summ--BRM (Paper form field 67)	1410	REQ	REP	N/R	X	99
RX Summ--Chemo (Paper form field 62)	1390	REQ	REP	N/R	X	99
RX Summ--Hormone (Paper form field 65)	1400	REQ	REP	N/R	X	99
RX Summ--Other (Paper form field 69)	1420	REQ	REQ	REQ	X	9
RX Summ--Radiation (Paper form field 60)	1360	REQ	REP	N/R	X	9
RX Summ--Scope Reg NL Sur (Paper form field 56)	1292	REQ	REP	N/R	X	9
RX Summ--Surg Oth Reg/Dis (Paper form field 55)	1294	REQ	REP	N/R	X	9
RX Summ--Surg Prim Site (Code the most definitive surgical procedure of primary site) (Paper form field 53)	1290	REQ	REP	REP	X	99
RX Summ--Surg/Rad Seq (Paper form field 57)	1380	REQ	REP	N/R	X	9
RX Summ--Systemic/Sur Seq (Paper form field 50)	1639	REQ	REQ	REQ	X	9

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
RX Summ--Transplnt/Endocr (Paper form field 63)	3250	REQ	REP	N/R		99†
RX Summ--Treatment Status (Paper form field 48)	1285	REQ	REP	N/R		9†
RX Text--BRM (Paper form field 74)	2660	REQ	REP	N/R		"None" or "N/A"
RX Text--Chemo (Paper form field 74)	2640	REQ	REP	N/R		"None" or "N/A"
RX Text--Hormone (Paper form field 74)	2650	REQ	REP	N/R		"None" or "N/A"
RX Text--Other (Paper form field 74)	2670	REP	REP	N/R		"None" or "N/A"
RX Text--Radiation (Beam) (Paper form field 75)	2620	REQ	REP	N/R		"None" or "N/A"
RX Text--Radiation Other (Paper form field 75)	2630	REP	REP	N/R		"None" or "N/A"
RX Text--Surgery (Paper form field 53)	2610	REQ	REP	REP		"None" or "N/A"
S Category Clinical (Paper form field **SSDI**)	3923	REP	REP	REP		9†
S Category Pathological (Paper form field **SSDI**)	3924	REP	REP	REP		9†
Sarcomatoid Features (Paper form field **SSDI**)	3925	REP	REP	REP		XX9†
Schema Discriminator 1 (Paper form field **SSDI**)	3926	REQ	REP	REP	X	Dependent on schema†
Schema Discriminator 2 (Paper form field **SSDI**)	3927	REQ	REP	REP	X	Dependent on schema†
Schema Discriminator 3 (Paper form field **SSDI**)	3928	REP	REP	REP		Dependent on schema†
Schema ID	3800	REQ	REQ	N/R		REQ VALUE
Schema ID Version Current 2021 cases and later	2117	AUTO	AUTO	AUTO		AUTO
Schema ID Version Original 2021 cases and later	2118	AUTO	AUTO	AUTO		AUTO
Secondary Diagnosis 1 (ICD-10-CM codes only) (Paper form field 14b)	3780	REP	REP	N/R		<BLANK>

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	NAACCR Item	Hospital with Registry	Hospital without Registry	Ind Lab	Change Triggers M Record	If Unknown, Enter…
Secondary Diagnosis 10 (ICD-10-CM codes only) (Paper form field 14b)	3798	REP	REP	N/R		<BLANK>
Secondary Diagnosis 2 (ICD-10-CM codes only) (Paper form field 14b)	3782	REP	REP	N/R		<BLANK>
Secondary Diagnosis 3 (ICD-10-CM codes only) (Paper form field 14b)	3784	REP	REP	N/R		<BLANK>
Secondary Diagnosis 4 (ICD-10-CM codes only) (Paper form field 14b)	3786	REP	REP	N/R		<BLANK>
Secondary Diagnosis 5 (ICD-10-CM codes only) (Paper form field 14b)	3788	REP	REP	N/R		<BLANK>
Secondary Diagnosis 6 (ICD-10-CM codes only) (Paper form field 14b)	3790	REP	REP	N/R		<BLANK>
Secondary Diagnosis 7 (ICD-10-CM codes only) (Paper form field 14b)	3792	REP	REP	N/R		<BLANK>
Secondary Diagnosis 8 (ICD-10-CM codes only) (Paper form field 14b)	3794	REP	REP	N/R		<BLANK>
Secondary Diagnosis 9 (ICD-10-CM codes only) (Paper form field 14b)	3796	REP	REP	N/R		<BLANK>
SEER Cause Specific COD - SEER ONLY	1914	REP[2]	REP[2]	REP[2]	X	Per SEER requirements
SEER Other COD - SEER ONLY	1915	REP[2]	REP[2]	REP[2]	X	Per SEER requirements
SEER Summary Staging 2000 (Directly coded. Applies to cases diagnosed prior to 2018 only) (Paper form field 36)	759	REQ	REP	REP	X	9
Sentinel Lymph Nodes Examined (Paper form field **SSDI**)	834	REQ	REP	REP		99†
Sentinel Lymph Nodes Positive (Paper form field **SSDI**)	835	REQ	REP	REP		99†

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
Separate Tumor Nodules (Paper form field **SSDI**)	3929	REP	REP	REP		9†
Sequence Number--Hospital (Paper form field 21)	560	REQ	REP	REP		REQ VALUE
Serum Albumin Pretreatment Level (Paper form field **SSDI**)	3930	REP	REP	N/R		9†
Serum Beta-2 Microglobulin Pretreatment Level (Paper form field **SSDI**)	3931	REP	REP	N/R		9†
Sex (Paper form field 9)	220	REQ	REQ	REQ	X	9
Social Security Number (Paper form field 4)	2320	REQ	REQ	REQ	X	999999999
Spanish/Hispanic Origin (Paper form field 10)	190	REP	REP	REP	X	9
Summary Stage 2018 - Directly assigned (2018 cases and later) (Paper form field 36)	764	REQ	REP	REP	X	REQ VALUE
Text--DX Proc--Lab Tests (Paper form field 71)	2550	REP	REP	N/R		"None" or "N/A"
Text--DX Proc--OP (Paper form field 53)	2560	REP	REP	N/R		"None" or "N/A"
Text--DX Proc--Path (Paper form fields 31 and 73)	2570	REP	REP	N/R		"None" or "N/A"
Text--DX Proc--PE (Paper form field 71)	2520	REP	REP	REP		"None" or "N/A"
Text--DX Proc--Scopes (Paper form field 73)	2540	REP	REP	REP		"None" or "N/A"
Text--DX Proc--X-ray/Scan (Paper form field 72)	2530	REP	REP	N/R		"None" or "N/A"
Text--Histology Title (Paper form field 31)	2590	REP	REP	REP		"None" or "N/A"
Text--Place of Diagnosis (Paper form field 24b)	2690	REP	REP	N/R		"UNKNOWN"
Text--Primary Site Title (Paper form field 31)	2580	REP	REP	REP		"UNKNOWN PRIMARY"

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
Text--Remarks (Paper form field 75)	2680	REP	REP	N/R		"None" or "N/A"
Text--Staging (Paper form field 73)	2600	REP	REP	REP		"None" or "N/A"
Text--Usual Industry (Paper form field 15b)	320	REP	REP	REP		"UNKNOWN"
Text--Usual Occupation (Paper form field 15a)	310	REP	REP	REP		"UNKNOWN"
Thrombocytopenia (Paper form field **SSDI**)	3933	REP	REP	N/R		9†
TNM Clin Descriptor 7th ed., cases 1/1/2010 – 12/31/2017 (Paper form field 37)	980	REQ	REP	N/R	X	Per AJCC requirements
TNM Clin M 7th ed., cases diagnosed 1/1/2010 – 12/31/2017 (Paper form field 37)	960	REQ	REP	N/R	X	Per AJCC requirements
TNM Clin N 7th ed., cases 1/1/2010 – 12/31/2017 (Paper form field 37)	950	REQ	REP	N/R	X	Per AJCC requirements
TNM Clin Stage Group 7th ed., cases 1/1/2010 – 12/31/2017 (Paper form field 37)	970	REQ	REP	N/R	X	Per AJCC requirements
TNM Clin T 7th ed., cases 1/1/2010 – 12/31/2017 (Paper form field 37)	940	REQ	REP	N/R	X	Per AJCC requirements
TNM Edition Number (Paper form field 37)	1060	REQ	REP	N/R	X	99
TNM Path Descriptor 7th ed., cases 1/1/2010 – 12/31/2017 (Paper form field 37)	920	REQ	REP	N/R	X	Per AJCC requirements
TNM Path M 7th ed., cases 1/1/2010 – 12/31/2017 (Paper form field 37)	900	REQ	REP	N/R	X	Per AJCC requirements

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
NAACCR Item Name	**NAACCR Item**	**Hospital with Registry**	**Hospital without Registry**	**Ind Lab**	**Change Triggers M Record**	**If Unknown, Enter…**
TNM Path N 7th ed., cases 1/1/2010 – 12/31/2017 (Paper form field 37)	890	REQ	REP	N/R	X	Per AJCC requirements
TNM Path Stage Group 7th ed., cases 1/1/2010 – 12/31/2017 (Paper form field 37)	910	REQ	REP	N/R	X	Per AJCC requirements
TNM Path T 7th ed., cases 1/1/2010 – 12/31/2017 (Paper form field 37)	880	REQ	REP	N/R	X	Per AJCC requirements
Tobacco Type (State-specific item 9519) (Paper form field 18)	NA	REP	REP	REP	X	9
Tobacco Use (State-specific item 9522) (Paper form field 18)	NA	REP	REP	REP	X	9
Total Dose	1533	REP	REP	N/R		999999
Tumor Deposits (Paper form field **SSDI**)	3934	REP	REP	REP	X	X9†
Tumor Growth Pattern (Paper form field **SSDI**)	3935	REP	REP	REP		9†
Tumor Size Clinical (2016 cases and later) (Paper form field 38)	752	REP	REP	REP		999
Tumor Size Pathologic (2016 cases and later) (Paper form field 38)	754	REP	REP	REP		999
Tumor Size Summary (2016 cases and later) (Paper form field 38)	756	REQ	REQ	REQ	X	999
Type of Reporting Source (Paper form field 22)	500	REQ	REQ	REQ	X	REQ VALUE
Ulceration (Paper form field **SSDI**)	3936	REP	REP	REP	X	9†
Visceral and Parietal Pleural Invasion (Paper form field **SSDI**)	3937	REP	REP	REP		9†
Vital Status (Paper form field 77)	1760	REP	REP	REP		REQ VALUE

Return to Data Items Table

Data Items Description & Instructions Section

In describing the proper reporting of cancer patient information, frequent reference is made to standard-setting organizations and source materials. Links to these references can be found within the data item descriptions. Reference sources are abbreviated within the instructions as follows:

Reference Abbreviations and Links

Code	Reference Source
ACoS	American College of Surgeons
AJCC	American Joint Committee on Cancer
CMS	Centers for Medicare & Medicaid Services
CoC	Commission on Cancer within the American College of Surgeons
CS	Collaborative Stage Data Collection System Manual
ICD-O-3	International Classification of Diseases for Oncology, 3rd Ed.
MCSP	Michigan Cancer Surveillance Program (State of Michigan central cancer registry)
NAACCR	North American Association of Central Cancer Registries
NPCR	National Program of Cancer Registries
SEER	Surveillance, Epidemiology and End Results NCI/SEER
SSDI	Identifies fields that are Site Specific Data Items. These items apply only to selected primary sites, histologies, and years of diagnosis. Consult the SSDI Manual.
STORE	STandards for Oncology Registry Entry manual produced by the CoC

Data field names used in the MCSP Cancer Program Manual match those used in the NAACCR Data Dictionary and are presented in alphabetic order. The paper form field numbers that correspond to the NAACCR items are shown in the item headings below.

Regardless of facility type of reporting entity, only approved abbreviations may be used when entering information into data fields. For approved abbreviations, see NAACCR Data Standards & Data Dictionary, Appendix G

Item: ABSTRACTED BY (Paper form field 76)

NAACCR Item 570 Source of Standard: CoC

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ACCESSION NUMBER--HOSP (Paper form field 21)

NAACCR Item 550 Source of Standard: CoC

The **Accession Number** is **required only for hospitals with a registry**, (i.e., approved by CoC with an approved cancer program) in which case, the number would be assigned as the patient is enrolled into the system.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR AT DX--CITY (Paper form field 5b)

NAACCR Item 70 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR AT DX--COUNTRY (Paper form field 5g)

NAACCR Item 102 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

For ISO alpha-3 Country Codes, refer to Appendix B of the SEER Program Code Manual.

Item: ADDR AT DX--NO & STREET (Paper form field 5a)

NAACCR Item 2330 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR AT DX--POSTAL CODE (Paper form field 5e)

NAACCR Item 100 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR AT DX--STATE (Paper form field 5d)

NAACCR Item 80 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

For a complete list of state, territory, commonwealth, U.S. possession, or Canadian province or territory codes, refer to Appendix B of the SEER Program Code Manual.

Item: ADDR AT DX--SUPPLEMENTL (Paper form field 5c)

NAACCR Item 2335 Source of Standard: CoC
This data item may be left blank if not applicable or unknown.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR CURRENT--CITY (Paper form field 6)

NAACCR Item 1810 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR CURRENT--COUNTRY (Paper form field 6)

NAACCR Item 1832 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

For ISO alpha-3 Country Codes, refer to Appendix B of the SEER Program Code Manual.

Item: ADDR CURRENT--NO & STREET (Paper form field 6)

NAACCR Item 2350 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR CURRENT--POSTAL CODE (Paper form field 6)

NAACCR Item 1830 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: ADDR CURRENT--STATE (Paper form field 6)

NAACCR Item 1820 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

For a complete list of state, territory, commonwealth, U.S. possession, or Canadian province or territory codes, refer to Appendix B of the SEER Program Code Manual.

Item: ADDR CURRENT--SUPPLEMENTL (Paper form field 6)

NAACCR Item 2355 Source of Standard: CoC
This data item may be left blank if not applicable or unknown.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **ADENOID CYSTIC BASALOID PATTERN** (Paper form field SSDI)

NAACCR Item 3803 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **ADENOPATHY** (Paper form field SSDI)

NAACCR Item 3804 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **AFP POST-ORCHIECTOMY LAB VALUE** (Paper form field SSDI)

NAACCR Item 3805 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **AFP POST-ORCHIECTOMY RANGE** (Paper form field SSDI)

NAACCR Item 3806 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **AFP PRE-ORCHIECTOMY LAB VALUE** (Paper form field SSDI)

NAACCR Item 3807 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **AFP PRE-ORCHIECTOMY RANGE** (Paper form field SSDI)

NAACCR Item 3808 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **AFP PRETREATMENT INTERPRETATION** (Paper form field SSDI)

NAACCR Item 3809 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **AFP PRETREATMENT LAB VALUE** (Paper form field SSDI)

NAACCR Item 3810 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: AGE AT DIAGNOSIS

NAACCR Item 230 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: AJCC API VERSION CURRENT

NAACCR Item 2156 Source of Standard: AJCC
Over time the definitions and other content contained in the AJCC's API may change. This value indicates the most recent release used to modify at least one of the related input items. Refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Note: This data item will be generated by registry software. Blank is allowable in the case that no AJCC or related input items are coded.

Refer to American Joint Committee on Cancer (AJCC) web site.

Item: AJCC API VERSION ORIGINAL

NAACCR Item 2157 Source of Standard: AJCC

Over time the definitions and other content contained in the AJCC's API may change. This item identifies the original API content used to code the TNM data. Refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Note: Blank is allowable in the case that no AJCC or related input items are coded.

Refer to American Joint Committee on Cancer (AJCC) web site.

Item: AJCC CANCER SURVEILLANCE API VERSION CURRENT

NAACCR Item 2158 Source of Standard: AJCC

Over time, the definitions and other content contained in the .dll may change. This item identifies the current API content used to code the items. Refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Note: This data item will be generated by registry software.

Refer to American Joint Committee on Cancer (AJCC) web site.

Item: AJCC CANCER SURVEILLANCE API VERSION ORIGINAL

NAACCR Item 2159 Source of Standard: AJCC

Over time, the definitions and other content contained in the .dll may change. This item identifies the original content used to code the items. Refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Refer to American Joint Committee on Cancer (AJCC) web site.

Item: AJCC ID

NAACCR Item 995 Source of Standard: NAACCR

The values for this data item are based on the chapters of the AJCC manual and will be derived primarily from the site/histology fields and other data items as required. IDs are assigned to cases for which AJCC staging is applicable. When staging is not applicable, code 'XX' is used. Refer to American Joint Committee on Cancer (AJCC) web site.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: AJCC TNM CLIN M (Paper form field 37)

NAACCR Item 1003 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM CLIN N (Paper form field 37)

NAACCR Item 1002 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM CLIN N SUFFIX (Paper form field 37)

NAACCR Item 1034 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM CLIN STAGE GROUP (Paper form field 37)

NAACCR Item 1004 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM CLIN T (Paper form field 37)

NAACCR Item 1001 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM CLIN T SUFFIX (Paper form field 37)

NAACCR Item 1031 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM PATH M (Paper form field 37)

NAACCR Item 1013 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM PATH N (Paper form field 37)

NAACCR Item 1012 Source of Standard: AJCC
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM PATH N SUFFIX (Paper form field 37)

NAACCR Item 1035 Source of Standard: AJCC
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM PATH STAGE GROUP (Paper form field 37)

NAACCR Item 1014 Source of Standard: AJCC
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM PATH T (Paper form field 37)

NAACCR Item 1011 Source of Standard: AJCC
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM PATH T SUFFIX (Paper form field 37)

NAACCR Item 1032 Source of Standard: AJCC
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY M (Paper form field 37)

NAACCR Item 1023 Source of Standard: AJCC
CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY N (Paper form field 37)

NAACCR Item 1022 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY N SUFFIX (Paper form field 37)

NAACCR Item 1036 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY STAGE GROUP (Paper form field 37)

NAACCR Item 1024 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY T (Paper form field 37)

NAACCR Item 1021 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY T SUFFIX (Paper form field 37)

NAACCR Item 1033 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a “Hospitals without registry”. These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY CLIN (YC) M

NAACCR Item 1066 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY CLIN (YC) N

NAACCR Item 1064 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY CLIN (YC) N SUFFIX

NAACCR Item 1065 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY CLIN (YC) STAGE GROUP

NAACCR Item 1067 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY CLIN (YC) T

NAACCR Item 1062 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: AJCC TNM POST THERAPY CLIN (YC) T SUFFIX

NAACCR Item 1063 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to American Joint Committee on Cancer (AJCC) web site.

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: ALCOHOL USE (Paper form field 17)

State-Specific Item 9521 Source of Standard: MCSP

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

Note: Prior Use means patient has not ingested alcohol in over 1 year.

Paper form submission:

Paper Form Item 17: Mark appropriate value:

- Current use
- Prior use (not used for more than 1 year)
- Never used
- Unknown

Do not leave this data item blank. If unknown, enter "9" or "Unknown."
Supporting text documentation for selected data value must be entered in Paper Form Field 95: TEXT - PHYSICAL EXAM even when value is "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 this data value is recorded in NAACCR record layout. Abstracts submitted with incorrect format or missing values will be rejected by MCSP.

Do not leave this data item blank. If unknown, enter "9."

Alcohol History Data Values

Code	USAGE
1	Current use
2	Prior use (not used for more than 1 year)
3	Never used
9	Blank (Unknown)

Item: **ALK REARRANGEMENT** (Paper form field SSDI)

NAACCR Item 3938 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **ANEMIA** (Paper form field SSDI)

NAACCR Item 3811 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **B SYMPTOMS** (Paper form field SSDI)

NAACCR Item 3812 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: BEHAVIOR CODE ICD-O-3 (Paper form field 32)

NAACCR Item 523 Source of Standard: SEER/CoC

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

- 2018 Solid Tumor Rules
- International Classification of Diseases for Oncology, Third Edition (ICD-O-3) coding book. This book can be purchased through any bookstore or ordered from online sources. Electronic CSV database files or print copies of the classifications are available from the World Health Organization. Valid behavior codes are 0-3. See ICD-O-3, page 66, for behavior codes and definitions. Additionally, the ICD-O-3 Implementation Task Force has approved new codes, changes in behavior codes, and new terms associated with current codes. See ICD-O-3 Implementation Guidelines.
- Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual to assist with coding these primaries. These references apply only to cases diagnosed January 1, 2010 and later. 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 later.** 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.
- For 2021, standard setters have agreed to implement new histology terms and codes for ICD-O-3 based on the current versions of the World Health Organization Classification of Tumors. The update, referred to as ICD-O-3.2, includes comprehensive tables listing histology codes and behavior codes in effect beginning with cases diagnosed in 2021. The new codes, new terms, and codes with changes to behavior are available at the NAACCR website.

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).

Behavior Codes, Labels and Definitions

Code	Label	Definition
0	Benign	Benign (Reportable for intracranial and CNS sites only)

Code	Label	Definition
1	Borderline	Uncertain whether benign or malignant, borderline malignancy, low malignant potential, and uncertain malignant potential (Reportable for intracranial and CNS sites only)
2	In situ and/or carcinoma in situ	Carcinoma in situ; intraepithelial; noninfiltrating; non-invasive (carcinoma) Synonyms for in situ behavior: Behavior code '2' Bowen disease (not reportable for C440-C449) Clark level I for melanoma (limited to epithelium) Confined to epithelium Hutchinson melanotic freckle, NOS (C44_) Intracystic, noninfiltrating (carcinoma) Intraductal (carcinoma) Intraepidermal, NOS (carcinoma) Intraepithelial neoplasia, Grade III (e.g., AIN III, CIN III, VAIN III, VIN III) Intraepithelial, NOS (carcinoma) Involvement up to, but not including the basement membrane Lentigo maligna (C44_) Lobular, noninfiltrating (C50_) (carcinoma) Noninfiltrating (carcinoma) Non-invasive (carcinoma) No stromal invasion/involvement Papillary, noninfiltrating or intraductal (carcinoma) Precancerous melanosis (C44_) Queyrat erythroplasia (C60_) Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria)
3	Invasive	Malignant, primary site (invasive or micro-invasive)

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **BILIRUBIN PRETREATMENT TOTAL LAB VALUE** (Paper form field SSDI)

NAACCR Item 3813 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **BILIRUBIN PRETREATMENT UNIT OF MEASURE** (Paper form field SSDI)

NAACCR Item 3814 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: BIRTHPLACE--COUNTRY (Paper form field 8b)

NAACCR Item 254 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

For ISO alpha-3 Country Codes, refer to Appendix B of the SEER Program Code Manual.

Item: BIRTHPLACE--STATE (Paper form field 8a)

NAACCR Item 252 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

For a complete list of state, territory, commonwealth, U.S. possession, or Canadian province or territory codes, refer to Appendix B of the SEER Program Code Manual.

Item: **BONE INVASION** (Paper form field SSDI)

NAACCR Item 3815 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **BRAF MUTATIONAL ANALYSIS** (Paper form field SSDI)

NAACCR Item 3940 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **BRAIN MOLECULAR MARKERS** (Paper form field SSDI)

NAACCR Item 3816 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **BRESLOW TUMOR THICKNESS** (Paper form field SSDI)

NAACCR Item 3817 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **CA-19-9 PRETX LAB VALUE** (Paper form field SSDI)

NAACCR Item 3742 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **CA-125 PRETREATMENT INTERPRETATION** (Paper form field SSDI)

NAACCR Item 3818 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CASEFINDING SOURCE (Paper form field 23)

NAACCR Items 501 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Do not leave this item blank if case was diagnosed in 2006 or later. Leave field blank if the case was diagnosed prior to 2006.

Item: CAUSE OF DEATH (Paper form field 79)

NAACCR Items 1910 Source of Standard: SEER
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: **CEA PRETREATMENT INTERPRETATION** (Paper form field SSDI)

NAACCR Item 3819 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **CEA PRETREATMENT LAB VALUE** (Paper form field SSDI)

NAACCR Item 3820 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CENSUS TR POVERTY INDICTR

NAACCR Item 145 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **CHROMOSOME 19q: LOSS OF HETEROZYGOSITY (LOH)** (Paper form field SSDI)

NAACCR Item 3802 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **CHROMOSOME 1p: LOSS OF HETEROZYGOSITY (LOH)** (Paper form field SSDI)

NAACCR Item 3801 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **CHROMOSOME 3 STATUS** (Paper form field SSDI)

NAACCR Item 3821 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **CHROMOSOME 8q STATUS** (Paper form field SSDI)

NAACCR Item 3822 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **CIRCUMFERENTIAL RESECTION MARGIN (CRM)** (Paper form field SSDI)

NAACCR Item 3823 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CLASS OF CASE (Paper form field 26)

NAACCR Items 610 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Report CIN3, VIN3, VAIN3 and AIN3 cases as required reportable conditions using the applicable class of case code depending upon location of diagnosis and/or first course of treatment of the reportable condition.

Class of Case code **43**: Pathology or laboratory specimens only are required by MCSP.

Class of Case codes **34** (if required by MCSP), **35**, **36** (if required by MCSP), **37**, **38** and **40-42** are also considered reportable conditions when there is sufficient information within the patient's medical record to report information regarding the patient's initial diagnosis and/or first course of treatment. Sufficient information regarding initial diagnosis would include:

- At a minimum:
  - Patient demographic information (including SSN, Race and full Date of Birth)
  - Year of date of initial diagnosis
  - Primary site
  - Histology
  - Method of diagnosis
  - Text fields: Record all applicable information known regarding patient's initial diagnosis and/or first course of treatment in the appropriate text fields. If a text field cannot be left blank, record applicable text to support omission such as, "information not known," "not applicable," etc.

- If known, complete all other applicable NAACCR and MI state-specific data items as documented within the patient's medical record. If the information is not known/not applicable for a data item that cannot be left blank, record applicable default value.

We hope to provide clarification regarding reportability of Class of Case codes 30-33 soon: however, in the meantime, please feel free to contact Jetty Alverson at AlversonG@michigan.gov if you have any questions regarding reportability of these types of cases.

Item: CoC ACCREDITED FLAG

NAACCR Item 2152 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: COMORBID/COMPLICATION (1-10) (Paper form field 14a)

NAACCR Items 3110-3164 Source of Standard: CoC
For cases using ICD-9-CM codes only. ICD-9-CM coding allowed prior to 10/1/2015 only.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

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

Item: COUNTY AT DX REPORTED (Paper form field 5f)

NAACCR Item 90 Source of Standard: FIPS/SEER
For description, rationale, and coding instructions for this data item, refer to NCI SEER

For a complete listing of county names and FIPS codes, refer to NAACCR Appendix A: FIPS Codes for Counties and Equivalent Entities.

Item: COUNTY--CURRENT (Paper form field 6)

NAACCR Item 1840 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

For a complete listing of county names and FIPS codes, refer to NAACCR Appendix A: FIPS Codes for Counties and Equivalent Entities.

Item: **CREATININE PRETREATMENT LAB VALUE** (Paper form field SSDI)

NAACCR Item 3824 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **CREATININE PRETREATMENT UNIT OF MEASURE** (Paper form field SSDI)

NAACCR Item 3825 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: CS EXTENSION

NAACCR Item 2810 Source of Standard: AJCC
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS LYMPH NODES

NAACCR Item 2830 Source of Standard: AJCC
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS LYMPH NODES EVAL

NAACCR Item 2840 Source of Standard: AJCC

This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS METS AT DX

NAACCR Item 2850 Source of Standard: AJCC

This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS METS AT DX - BONE

NAACCR Item 2851 Source of Standard: AJCC

This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS METS AT DX - BRAIN

NAACCR Item 2852 Source of Standard: AJCC

This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS METS AT DX - LIVER

NAACCR Item 2853 Source of Standard: AJCC

This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS METS AT DX - LUNG

NAACCR Item 2854 Source of Standard: AJCC

This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS METS EVAL

NAACCR Item 2860 Source of Standard: AJCC

This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS SITE-SPECIFIC FACTORS (1-25)

NAACCR Items 2861-2880, 2890, 2900, 2910, 2920, 2930 Source of Standard: AJCC

This data item applies to cases diagnosed 1/1/2004 through 12/31/2017.

The parameter and allowable values for each Site-Specific Factor are determined by anatomic site.
For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS TUMOR SIZE

NAACCR Item 2800 Source of Standard: AJCC
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS TUMOR SIZE/EXT EVAL

NAACCR Item 2820 Source of Standard: AJCC
This data item applies to cases diagnosed 1/1/2004 through 12/31/2015 only.

For information on this data item, refer to AJCC CS Collaborative Stage Data Collection System

Item: CS VERSION INPUT CURRENT

NAACCR Item 2937 Source of Standard: AJCC
Data item auto-populated by registry software

Item: CS VERSION INPUT ORIGINAL

NAACCR Item 2935 Source of Standard: AJCC
Data item auto-populated by registry software

Item: DATE 1ST CRS RX COC (Paper form field 49a)

NAACCR Item 1270 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: DATE 1ST CRS RX COC FLAG (Paper form field 49b)

NAACCR Item 1271 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: DATE CASE COMPLETED (Paper form field 81)

NAACCR Item 2090 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Return to Data Items Table

Item: DATE CASE REPORT EXPORTED

NAACCR Item 2110 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: DATE INITIAL RX SEER

NAACCR Item 1260 Source of Standard: SEER
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: DATE INITIAL RX SEER FLAG

NAACCR Item 1261 Source of Standard: NAACCR
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: DATE OF 1ST CONTACT (Paper form field 27)

NAACCR Item 580 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: DATE OF 1ST CONTACT FLAG

NAACCR Item 581 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: DATE OF BIRTH (Paper form field 7)

NAACCR Item 240 Source of Standard: SEER/CoC
Enter the date of birth of the patient using **YYYYMMDD** format (for example 19580912). Be sure to omit slashes or hyphens between date components. If only year of birth know, enter in **YYYY** format (for example 1951).

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. Estimate may be entered in **YYYY**, **YYYYMM**, or **YYYYMMDD** format.

Do not leave this data item blank.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: DATE OF DEATH (Paper form field 78)

NAACCR Item 1750 Source of Standard: SEER/CoC
Applies to paper reporting form only.

Item: DATE OF DIAGNOSIS (Paper form field 28)

NAACCR Item 390 Source of Standard: SEER/CoC
Enter the year, month and day (**YYYYMMDD**) for the date of diagnosis, for example 19580912. Be sure to omit slashes or hyphens between date components.

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 collected** (date of biopsy or surgery), **not the date the specimen was received or 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. These physician statements must be documented in abstract text.

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, 2016. The radiologist read the report as suspicious for cancer, recommending biopsy. The patient does not get a biopsy until February 4, 2017 which reveals an infiltrating ductal adenocarcinoma.
Record the date of diagnosis as August 25, 2016.

Ambiguous terminology must be taken into consideration when determining the initial date of diagnosis. Refer to the ***Ambiguous Terminology*** section of MCSP Cancer Program Manual for a list of specific terms and further instructions.

Common Formats

YYYYMMDD	Complete date is known.
YYYYMM	Year and month are known/estimated; day is unknown.
YYYY	Year is known/estimated; month and day cannot be estimated or are unknown.

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 Date of Diagnosis is an estimate only, a statement to that effect must be entered in the TEXT--REMARKS field.**

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.

Examples:

Spring of 2016
Code date of diagnosis as April 2016

Middle of 2016
Code date of diagnosis as July 2016

Fall of 2016
Code date of diagnosis as October 2016

Winter of 2016
Code date of diagnosis as December 2016 or January 2017 (further investigation may need to be done to determine the year of diagnosis.)

Do not leave this data item blank.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: DATE OF LAST CONTACT (Paper form field 70a)

NAACCR Item 1750 Source of Standard: SEER/CoC

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: DATE OF LAST CONTACT FLAG (Paper form field 70b)

NAACCR Item 1751 Source of Standard: NAACCR

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

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **DATE OF SENTINEL LYMPH NODE BIOPSY** (Paper form field SSDI)

NAACCR Item 832 Source of Standard: CoC

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **DATE OF SENTINEL LYMPH NODE BIOPSY FLAG** (Paper form field SSDI)

NAACCR Item 833 Source of Standard: SEER
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: DATE REGIONAL LYMPH NODE DISSECTION

NAACCR Item 682 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: DATE REGIONAL LYMPH NODE DISSECTION FLAG

NAACCR Item 683 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: DC STATE FILE NUMBER

NAACCR Item 2380 Source of Standard: MCSP
Death certificate identification number as assigned by the vital statistics office in the place recorded in Place of Death [1940].

Item: DERIVED EOD 2018 M (Paper form field 47)

NAACCR Item 795 Source of Standard: SEER
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: DERIVED EOD 2018 N (Paper form field 47)

NAACCR Item 815 Source of Standard: SEER
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: DERIVED EOD 2018 STAGE GROUP (Paper form field 47)

NAACCR Item 818 Source of Standard: SEER
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: DERIVED EOD 2018 T (Paper form field 47)

NAACCR Item 785 Source of Standard: SEER
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: DIAGNOSTIC CONFIRMATION (Paper form field 35)

NAACCR Item 490 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **EGFR MUTATIONAL ANALYSIS** (Paper form field SSDI)

NAACCR Item 3939 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: EOD--METS (Paper form field 47)

NAACCR Item 776 Source of Standard: SEER
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: EOD--PRIMARY TUMOR (Paper form field 47)

NAACCR Item 772 Source of Standard: SEER
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: EOD PROSTATE PATHOLOGICAL EXTENSION (Paper form field 48)

NAACCR Item 3919 Source of Standard: SEER
It was previously collected as Prostate Pathological Extension, and Prostate, CS SSF# 3

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: EOD--REGIONAL NODES (Paper form field 47)

NAACCR Item 774 Source of Standard: SEER
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: **ESOPHAGUS AND EGJ TUMOR EPICENTER** (Paper form field SSDI)

NAACCR Item 3829 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **ESTROGEN RECEPTOR PERCENT POSITIVE OR RANGE** (Paper form field SSDI)

NAACCR Item 3826 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **ESTROGEN RECEPTOR SUMMARY** (Paper form field SSDI)

NAACCR Item 3827 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **ESTROGEN RECEPTOR TOTAL ALLRED SCORE** (Paper form field SSDI)

NAACCR Item 3828 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **EXTRANODAL EXTENSION CLIN (NON-HEAD AND NECK)** (Paper form field SSDI)

NAACCR Item 3830 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **EXTRANODAL EXTENSION HEAD AND NECK CLINICAL** (Paper form field SSDI)

NAACCR Item 3831 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **EXTRANODAL EXTENSION HEAD AND NECK PATH** (Paper form field SSDI)

NAACCR Item 3832 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **EXTRANODAL EXTENSION PATH (NON-HEAD/NECK)** (Paper form field SSDI)

NAACCR Item 3833 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **EXTRAVASCULAR MATRIX PATTERNS** (Paper form field SSDI)

NAACCR Item 3834 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: FAMILY HISTORY OF CANCER (Paper form field 16a-c)

State-specific Item 9520 Source of Standard: MCSP
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 (first degree) family member": mother, father, brother, sister, son, daughter.

"Non-Immediate (second degree) family member": aunt, uncle, niece, nephew, cousin, half-brother, and half-sister.

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

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

Example 1:

Patient is diagnosed with breast cancer. Father has history of colon cancer; maternal aunt has history of breast cancer.
Provided she is a blood-relative, 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.
Since no relative shares the patient's primary site, refer to the father's cancer history since he is the immediate (first degree) family member.

Supporting text documentation for patient and family history of cancer must be recorded in TEXT--DX PROC--PE field even when value is "9" or "Unknown."

Example 1:

Family Medical History negative [or FMH (-)] Personal Medical History negative [or PMH (-)]

Example 2:

FMH (-) PMH (+) STAGE 1 DUCTAL CA, RT BREAST 1999, TX'D WITH LUMPECTOMY

Example 3:

FMH UNK, PMH (-)

Paper form submission:

Item 16a. Family History of Cancer

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

Item 16b. If yes, Immediate Family Member

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

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.

Do not leave items 16a, 16b, or 16c blank. If unknown, enter "9" or "Unknown."
Supporting text documentation for selected data value must be entered in **Paper Form Field 95: TEXT - PHYSICAL EXAM** even when value is "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. Abstracts submitted with incorrect format or missing values will be rejected by MCSP.

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)

Do not leave this data item blank. If unknown, enter "9."

Item: **FIBROSIS SCORE** (Paper form field SSDI)

NAACCR Item 3835 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **FIGO STAGE** (Paper form field SSDI)

NAACCR Item 3836 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: FOLLOW-UP SOURCE

NAACCR Item 1790 Source of Standard: CoC

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **GESTATIONAL TROPHOBLASTIC PROG SCORING INDEX** (Paper form field SSDI)

NAACCR Item 3837 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **GLEASON PATTERNS CLINICAL** (Paper form field SSDI)

NAACCR Item 3838 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **GLEASON PATTERNS PATHOLOGICAL** (Paper form field SSDI)

NAACCR Item 3839 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **GLEASON SCORE CLINICAL** (Paper form field SSDI)

NAACCR Item 3840 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **GLEASON SCORE PATHOLOGICAL** (Paper form field SSDI)

NAACCR Item 3841 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **GLEASON TERTIARY PATTERN** (Paper form field SSDI)

NAACCR Item 3842 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: GRADE (Paper form field 33)

NAACCR Item 440 Source of Standard: SEER/CoC
Applies to cases diagnosed prior to 2018 only.

Refer to SEER Instructions for Coding Grade for 2014+ for complete instructions to determine grade, differentiation or cell indicator for tumors diagnosed prior to 2018.

Refer to the Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual to assist with coding these primaries. These references apply only to cases diagnosed between and including January 1, 2010 and December 31, 2017.

Item: GRADE CLINICAL (Paper form field 33)

NAACCR Item 3843 Source of Standard: NAACCR

Applies to cases diagnosed in 2018 and later only. For description, rationale, and coding instructions for this data item, refer to NAACCR Grade Coding Instructions and Tables

Item: GRADE PATHOLOGICAL (Paper form field 33)

NAACCR Item 3844 Source of Standard: NAACCR

Applies to cases diagnosed in 2018 and later only. For description, rationale, and coding instructions for this data item, refer to NAACCR Grade Coding Instructions and Tables

Item: GRADE POST THERAPY CLIN (YC) (Paper form field 33)

NAACCR Item 1068 Source of Standard: NAACCR

Applies to cases diagnosed in 2021 and later only. For description, rationale, and coding instructions for this data item, refer to NAACCR Grade Coding Instructions and Tables

Item: GRADE POST THERAPY PATH (YP) (Paper form field 33)

NAACCR Item 3845 Source of Standard: NAACCR

Applies to cases diagnosed in 2018 and later only. For description, rationale, and coding instructions for this data item, refer to NAACCR Grade Coding Instructions and Tables

Item: **hCG POST-ORCHIECTOMY LAB VALUE** (Paper form field SSDI)

NAACCR Item 3846 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **hCG POST-ORCHIECTOMY RANGE** (Paper form field SSDI)

NAACCR Item 3847 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **hCG PRE-ORCHIECTOMY LAB VALUE** (Paper form field SSDI)

NAACCR Item 3848 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **hCG PRE-ORCHIECTOMY RANGE** (Paper form field SSDI)

NAACCR Item 3849 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **HER2 IHC SUMMARY** (Paper form field SSDI)

NAACCR Item 3850 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **HER2 ISH DUAL PROBE COPY NUMBER** (Paper form field SSDI)

NAACCR Item 3851 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **HER2 ISH DUAL PROBE RATIO** (Paper form field SSDI)

NAACCR Item 3852 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **HER2 ISH SINGLE PROBE COPY NUMBER** (Paper form field SSDI)

NAACCR Item 3853 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **HER2 ISH SUMMARY** (Paper form field SSDI)

NAACCR Item 3854 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **HER2 OVERALL SUMMARY** (Paper form field SSDI)

NAACCR Item 3855 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **HERITABLE TRAIT** (Paper form field SSDI)

NAACCR Item 3856 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **HIGH RISK CYTOGENETICS** (Paper form field SSDI)

NAACCR Item 3857 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **HIGH RISK HISTOLOGIC FEATURES** (Paper form field SSDI)

NAACCR Item 3858 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: HISTOLOGIC TYPE ICD-O-3 (Paper form field 31)

NAACCR Item 522 Source of Standard: SEER/CoC

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

- 2018 Solid Tumor Rules
- International Classification of Diseases for Oncology, Third Edition (ICD-O-3) coding book. This book can be purchased through any bookstore or ordered from online sources. Electronic CSV database files or print copies of the classifications are available from the World Health Organization. Additionally, the ICD-O-3 Implementation Task Force has approved new codes, changes in behavior codes, and new terms associated with current codes. See ICD-O-3 Implementation Guidelines as well as the 2018 ICD-O-3 Update Table.
- Hematopoietic and Lymphoid Neoplasm Database and the Hematopoietic and Lymphoid Neoplasm Coding Manual to assist with coding these primaries. These references apply only to cases diagnosed January 1, 2010 and later. 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 later.** 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.
- For 2021, standard setters have agreed to implement new histology terms and codes for ICD-O-3 based on the current versions of the World Health Organization Classification of Tumors. The update, referred to as ICD-O-3.2, includes comprehensive tables listing histology codes and behavior codes in effect beginning with cases diagnosed in 2021. The new codes, new terms, and codes with changes to behavior are available at the NAACCR website.

For description, rationale, and coding instructions for this data item, refer to NCI SEER and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **HIV STATUS** (Paper form field SSDI)

NAACCR Item 3859 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: ICD REVISION NUMBER

NAACCR Item 1920 Source of Standard: SEER

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: **INTERNATIONAL NORMALIZED RATIO PROTHROMBIN TIME** (Paper form field SSDI)

NAACCR Item 3860 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **INVASION BEYOND CAPSULE** (Paper form field SSDI)

NAACCR Item 3864 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **IPSILATERAL ADRENAL GLAND INVOLVEMENT** (Paper form field SSDI)

NAACCR Item 3861 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **JAK2** (Paper form field SSDI)

NAACCR Item 3862 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **Ki-67** (Paper form field SSDI)

NAACCR Item 3863 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **KIT GENE IMMUNOHISTOCHEMISTRY** (Paper form field SSDI)

NAACCR Item 3865 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **KRAS** (Paper form field SSDI)

NAACCR Item 3866 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LABORATORY REPORT NUMBER (Paper form field 20)

State-specific Item 9507 Source of Standard: MCSP
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.”

Item: LATERALITY (Paper form field 30)

NAACCR Item 410 Source of Standard: SEER/CoC
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).

NOTE: Laterality reporting rules vary depending upon standard-setter. MCSP and other central cancer registries have not adopted the revision to laterality rules found in FORDS (STORE). MCSP reporting requirements for laterality follow current SEER Program Coding and Staging Manual.

Note: Table 10 on Page 31 of the Head and Neck Equivalent Terms and Definitions section of the December 2020 Update of the Solid Tumor Rules manual states that sites C090 and C091 are paired organs. According to Ask SEER CTR, this is incorrect and will be changed in a future update. Paired organs are correctly listed in the SEER Program Coding and Staging Manual 2021.

Do not leave this data item blank. 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.**

Laterality Codes and Description

Code	Pairing Description
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. Code 5 - Midline is an allowable value for the following sites only: C700, C710-C714, C722-C725, C443, and C445.
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.

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: The prostate and thyroid are made up of lobes, which are represented by left and right - Do not code as a paired organ.

NOTE: 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.

The chart below lists sites for which laterality codes must be recorded: Laterality must be recorded for the following paired organs as 1-5 or 9.

Paired Organs Requiring Laterality Codes

Primary Site Description	Topography Code
Parotid gland	C079
Submandibular gland	C080
Sublingual gland	C081
Tonsil, overlapping lesion	C098
Tonsil, NOS (faucial tonsil, palatine tonsil)	C099
Nasal cavity (excluding nasal cartilage and nasal septum - code 0)	C300
Middle ear	C301
Maxillary sinus	C310
Frontal sinus	C312
Main bronchus (excluding carina - code 0)	C340
Lung	C341 – C349
Pleura	C384
Long bones of upper limb, scapula and associated joints	C400
Short bones of upper limb and associated joints	C401
Long bones of lower limb and associated joints	C402
Short bones of lower limb and associated joints	C403
Rib and clavicle (excluding sternum - code 0)	C413
Pelvic bones (excluding sacrum, coccyx and symphysis pubis - code “0’)	C414
Skin of eyelid	C441
Skin of external ear	C442
*Skin of other unspecified parts of face	C443
*Skin of trunk	C445
Skin of upper limb and shoulder	C446
Skin of lower limb and hip	C447
Peripheral nerves and autonomic nervous system of upper limb and shoulder	C471
Peripheral nerves and autonomic nervous system of lower limb and hip	C472
Connective, subcutaneous and other soft tissue of upper limb and shoulder	C491
Connective, subcutaneous, and other soft tissue of lower limb and hip	C492
Breast	C500 - C509
Ovary	C569
Fallopian tube	C570
Testis	C620 – C629
Epididymis	C630
Spermatic cord	C631
Kidney, NOS	C649

Primary Site Description	Topography Code
Renal pelvis	C659
Ureter	C669
Eye and lacrimal gland	C690 – C699
*Cerebral meninges, NOS (excluding diagnoses prior to 2004)	C700
*Cerebrum (excluding diagnoses prior to 2004)	C710
Frontal lobe (excluding diagnoses prior to 2004)	C711
Temporal lobe (excluding diagnoses prior to 2004)	C712
Parietal lobe (excluding diagnoses prior to 2004)	C713
*Occipital lobe (excluding diagnoses prior to 2004)	C714
*Olfactory nerve (excluding diagnoses prior to 2004)	C722
*Optic nerve (excluding diagnoses prior to 2004)	C723
*Acoustic nerve (excluding diagnoses prior to 2004)	C724
*Cranial Nerve, NOS (excluding diagnoses prior to 2004)	C725
Adrenal gland	C740 – C749
Carotid body	C754

*Site includes code 5 - midline tumor

Item: LATITUDE

NAACCR Item 2352 Source of Standard: NAACCR

Paired with Longitude [2354], this represents the point location of the individual's residence on the earth's surface. It is typically determined by matching an address to a reference file or by identifying the residence using satellite imagery.

This item is coded at the central registry, not by the reporting facility.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LDH POST-ORCHIECTOMY RANGE** (Paper form field SSDI)

NAACCR Item 3867 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LDH PRE-ORCHIECTOMY RANGE** (Paper form field SSDI)

NAACCR Item 3868 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LDH (PRETREATMENT) LAB VALUE** (Paper form field SSDI)

NAACCR Item 3932 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LDH (PRETREATMENT) LEVEL** (Paper form field SSDI)

NAACCR Item 3869 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LDH UPPER LIMITS OF NORMAL** (Paper form field SSDI)

NAACCR Item 3870 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LN ASSESSMENT METHOD FEMORAL-INGUINAL** (Paper form field SSDI)

NAACCR Item 3871 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LN ASSESSMENT METHOD PARA-AORTIC** (Paper form field SSDI)

NAACCR Item 3872 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LN ASSESSMENT METHOD PELVIC** (Paper form field SSDI)

NAACCR Item 3873 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LN DISTANT ASSESSMENT METHOD** (Paper form field SSDI)

NAACCR Item 3874 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LN DISTANT: MEDIASTINAL, SCALENE** (Paper form field SSDI)

NAACCR Item 3875 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LN HEAD AND NECK LEVELS I-III** (Paper form field SSDI)

NAACCR Item 3876 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LN HEAD AND NECK LEVELS IV-V** (Paper form field SSDI)

NAACCR Item 3877 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LN HEAD AND NECK LEVELS VI-VII** (Paper form field SSDI)

NAACCR Item 3878 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LN HEAD AND NECK OTHER** (Paper form field SSDI)

NAACCR Item 3879 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LN ISOLATED TUMOR CELLS (ITC)** (Paper form field SSDI)

NAACCR Item 3880 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LN LATERALITY** (Paper form field SSDI)

NAACCR Item 3881 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LN POSITIVE AXILLARY LEVEL I-II** (Paper form field SSDI)

NAACCR Item 3882 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LN SIZE** (Paper form field SSDI)

NAACCR Item 3883 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LN STATUS FEMORAL-INGUINAL, PARA-AORTIC, PELVIC** (Paper form field SSDI)

NAACCR Item 3884 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LONGITUDE

NAACCR Item 2354 Source of Standard: NAACCR
Paired with Latitude [2352], this represents the point location of the individual's residence on the earth's surface. It is typically determined by matching an address to a reference file or by identifying the residence using satellite imagery.

This item is coded at the central registry, not by the reporting facility.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **LYMPHOCYTOSIS** (Paper form field SSDI)

NAACCR Item 3885 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: LYMPHOVASCULAR INVASION (Paper form field 34)

NAACCR Item 1182 Source of Standard: AJCC
For description, rationale, and coding instructions for this data item, refer to AJCC

Item: **MAJOR VEIN INVOLVEMENT** (Paper form field SSDI)

NAACCR Item 3886 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: MARITAL STATUS AT DX (Paper form field 12)

NAACCR Item 150 Source of Standard: SEER
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: **MEASURED BASAL DIAMETER** (Paper form field SSDI)

NAACCR Item 3887 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **MEASURED THICKNESS** (Paper form field SSDI)

NAACCR Item 3888 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: MEDICAL RECORD NUMBER (Paper form field 19)

NAACCR Item 2300 Source of Standard: CoC
Records medical record number used by the facility to identify the patient. The CoC STORE manual instructs registrars to record numbers assigned by the facility's Health Information Management (HIM) Department only, not department-specific numbers.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **METHYLATION OF O6-METHYLGUANINE-METHYLTRANSFERA** (Paper form field SSDI)

NAACCR Item 3889 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: METS AT DX-BONE (Paper form field 41)

NAACCR Item 1112 Source of Standard: SEER
This data item applies to cases diagnosed 1/1/2016 and later.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: METS AT DX-BRAIN (Paper form field 42)

NAACCR Item 1113 Source of Standard: SEER
This data item applies to cases diagnosed 1/1/2016 and later.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: METS AT DX-DISTANT LN (Paper form field 43)

NAACCR Item 1114 Source of Standard: SEER
This data item applies to cases diagnosed 1/1/2016 and later only.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: METS AT DX-LIVER (Paper form field 44)

NAACCR Item 1115 Source of Standard: SEER
This data item applies to cases diagnosed 1/1/2016 and later.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: METS AT DX-LUNG (Paper form field 45)

NAACCR Item 1116 Source of Standard: SEER
This data item applies to cases diagnosed 1/1/2016 and later.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: METS AT DX-OTHER (Paper form field 46)

NAACCR Item 1117 Source of Standard: SEER
This data item applies to cases diagnosed 1/1/2016 and later.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: MICHIGAN FACILITY NUMBER (Paper form field 25)

State-specific Item 9508 Source of Standard: MCSP
Enter the 5-digit Michigan Facility Number that has been assigned to your institution by the Michigan Cancer Surveillance Program. Note: This number may have a leading zero, e.g., 01234.

If you do not know your Michigan Facility Number, contact MDHHS-MCSP-WebPlus@michigan.gov

Do not leave this data item blank.

Item: **MICROSATELLITE INSTABILITY (MSI)** (Paper form field SSDI)

NAACCR Item 3890 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **MICROVASCULAR DENSITY** (Paper form field SSDI)

NAACCR Item 3891 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **MITOTIC COUNT UVEAL MELANOMA** (Paper form field SSDI)

NAACCR Item 3892 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **MITOTIC RATE MELANOMA** (Paper form field SSDI)

NAACCR Item 3893 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **MULTIGENE SIGNATURE METHOD** (Paper form field SSDI)

NAACCR Item 3894 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **MULTIGENE SIGNATURE RESULTS** (Paper form field SSDI)

NAACCR Item 3895 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: NAME--ALIAS (Paper form field 3)

NAACCR Item 2280 Source of Standard: NAACCR
This data item may be left blank if not applicable or unknown.

Enter the alternate name or “AKA” (also known as) used by the patient.

Note: Maiden name is entered in BIRTH SURNAME field.

Item: NAME--BIRTH SURNAME (Paper form field 2)

NAACCR Item 2232 Source of Standard: NAACCR

Note: This data item was introduced to be a gender-neutral birth-surname data item, analogous to Name--Maiden [2390].

The field should be left blank if the birth surname is not known or not applicable. Since a value in this field may be used by linkage software or other computer algorithms, only legitimate surnames are allowable, and any variation of "unknown" or "not applicable" is not allowable.

Item: NAME--FIRST (Paper form field 1b)

NAACCR Item 2240 Source of Standard: SEER/CoC

Type the legal First Name of the patient. Truncate if more than 40 letters long, but do not abbreviate, e.g., do not use "Robt" for "Robert." Blank spaces or hyphens between multiple-word names are allowed. Do not use other punctuation such as apostrophes. 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 last name changes. For information on how to submit corrections, refer to ***Submitting Updates (Corrections)*** in the MCSP Cancer Program Manual.

Do not leave this data item blank.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: NAME--LAST (Paper form field 1a)

NAACCR Item 2230 Source of Standard: SEER/CoC

Type the legal Last Name of the patient. Truncate name if more than 40 letters long. Blank spaces or hyphens between multiple-word names are allowed. Do not use other punctuation such as apostrophes. Include JR (junior), SR (senior), III (3rd), etc. 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 Updates (Corrections)*** in the MCSP Cancer Program Manual.

Do not leave this data item blank.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: NAME--MAIDEN (Paper form field 2)

NAACCR Item 2390 Source of Standard: NAACCR

This data item may be left blank if not applicable or unknown.

Enter the Maiden Name of female patients who are or have been married. Do not abbreviate. Blank spaces or hyphens between multiple-word names are allowed. Do not use other punctuation such as apostrophes. Leave this item blank for any of the following: a) if it is not appropriate for the patient being reported; b)

maiden name is not available in the records; or c) if maiden name is not a reportable data item per facility's cancer reporting rules.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: NAME--MIDDLE (Paper form field 1c)

NAACCR Item 2250 Source of Standard: SEER/CoC

This data item may be left blank if not applicable or unknown.

Type the legal Middle Name or Middle Initial of the patient. If only an initial is available for the middle name, enter the initial. Blank spaces or hyphens between multiple-word names are allowed. Do not use other punctuation such as apostrophes. If no middle name or initial, leave field blank.

This field may be updated if the last name changes. For information on how to submit corrections, refer to ***Submitting Updates (Corrections)*** in the MCSP Cancer Program Manual.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **NCCN INTERNATIONAL PROGNOSTIC INDEX (IPI)** (Paper form field SSDI)

NAACCR Item 3896 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: NCDB--COVID19--TX IMPACT

NAACCR Item 3946 Source of Standard: CoC

Was the first course of treatment (diagnosis, staging, treatment or other cancer management events) impacted by hospital availability (limited access to facilities or postponement of non-essential procedures) due to COVID-19 pandemic? (No; First Course Delayed; First Course Altered; First Course Cancelled). Collection based on diagnosis years 2020 and 2021.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: NCDB--SARSCOV2--POS

NAACCR Item 3944 Source of Standard: CoC

Data item is designed to track whether patient received a POSITIVE SARS-CoV-2 test or not. Collection based on diagnosis years 2020 and 2021.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: NCDB--SARSCOV2--POS DATE

NAACCR Item 3945 Source of Standard: CoC

What was the date of the first positive test? Collection based on diagnosis years 2020 and 2021.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: NCDB--SARSCOV2--TEST

NAACCR Item 3943 Source of Standard: CoC

Data item is designed to track whether patient received a SARS-CoV-2 test or not. Collection based on diagnosis years 2020 and 2021.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: NPCR DERIVED AJCC 8 TNM CLIN STG GRP

NAACCR Item 3645 Source of Standard: NPCR

For description, rationale, and coding instructions for this data item, refer to AJCC and National Program of Cancer Registries (NPCR)

Item: NPCR DERIVED AJCC 8 TNM PATH STG GRP

NAACCR Item 3646 Source of Standard: NPCR

For description, rationale, and coding instructions for this data item, refer to AJCC and National Program of Cancer Registries (NPCR)

Item: NPCR DERIVED AJCC 8 TNM POST THERAPY STG GRP

NAACCR Item 3647 Source of Standard: NPCR

For description, rationale, and coding instructions for this data item, refer to AJCC and National Program of Cancer Registries (NPCR)

Item: NPCR DERIVED CLIN STG GRP

NAACCR Item 3650 Source of Standard: NPCR

For description, rationale, and coding instructions for this data item, refer to AJCC and National Program of Cancer Registries (NPCR)

Item: NPCR DERIVED PATH STG GRP

NAACCR Item 3655 Source of Standard: NPCR

For description, rationale, and coding instructions for this data item, refer to AJCC and National Program of Cancer Registries (NPCR)

Item: NPCR SPECIFIC FIELD

NAACCR Item 3720 Source of Standard: NPCR

Field not coded. Leave blank.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: NPI--REPORTING FACILITY (Paper form field 24a)

NAACCR Item 545 Source of Standard: CMS

The National Provider Identifier (NPI) is a unique 10-digit number used to identify health care providers. All health care providers who are HIPAA-covered entities, whether individuals or organizations, must obtain an NPI.

For more information on the National Provider Identifier (NPI), refer to CMS.gov

Item: **NRAS MUTATIONAL ANALYSIS** (Paper form field SSDI)

NAACCR Item 3941 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **NUMBER OF CORES EXAMINED** (Paper form field SSDI)

NAACCR Item 3897 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **NUMBER OF CORES POSITIVE** (Paper form field SSDI)

NAACCR Item 3898 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **NUMBER OF EXAMINED PARA-AORTIC NODES** (Paper form field SSDI)

NAACCR Item 3899 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **NUMBER OF EXAMINED PELVIC NODES** (Paper form field SSDI)

NAACCR Item 3900 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: NUMBER OF PHASES OF RAD TREATMENT TO THIS VOLUME

NAACCR Item 1532 Source of Standard: CoC

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **NUMBER OF POSITIVE PARA-AORTIC NODES** (Paper form field SSDI)

NAACCR Item 3901 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **NUMBER OF POSITIVE PELVIC NODES** (Paper form field SSDI)

NAACCR Item 3902 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **ONCOTYPE DX RECURRENCE SCORE-DCIS** (Paper form field SSDI)

NAACCR Item 3903 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **ONCOTYPE DX RECURRENCE SCORE-INVASIVE** (Paper form field SSDI)

NAACCR Item 3904 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **ONCOTYPE DX RISK LEVEL-DCIS** (Paper form field SSDI)

NAACCR Item 3905 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **ONCOTYPE DX RISK LEVEL-INVASIVE** (Paper form field SSDI)

NAACCR Item 3906 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **ORGANOMEGALY** (Paper form field SSDI)

NAACCR Item 3907 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **PERCENT NECROSIS POST NEOADJUVANT** (Paper form field SSDI)

NAACCR Item 3908 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **PERINEURAL INVASION** (Paper form field SSDI)

NAACCR Item 3909 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **PERIPHERAL BLOOD INVOLVEMENT** (Paper form field SSDI)

NAACCR Item 3910 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **PERITONEAL CYTOLOGY** (Paper form field SSDI)

NAACCR Item 3911 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PHASE I DOSE PER FRACTION

NAACCR Item 1501 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE I NUMBER OF FRACTIONS

NAACCR Item 1503 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE I RADIATION EXTERNAL BEAM PLANNING TECH

NAACCR Item 1502 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE I RADIATION PRIMARY TREATMENT VOLUME

NAACCR Item 1504 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE I RADIATION TO DRAINING LYMPH NODES

NAACCR Item 1505 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE I RADIATION TREATMENT MODALITY

NAACCR Item 1506 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE I TOTAL DOSE

NAACCR Item 1507 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE II DOSE PER FRACTION

NAACCR Item 1511 Source of Standard: CoC
Blanks allowed if no Phase II radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE II NUMBER OF FRACTIONS

NAACCR Item 1513 Source of Standard: CoC
Blanks allowed if no Phase II radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE II RADIATION EXTERNAL BEAM PLANNING TECH

NAACCR Item 1512 Source of Standard: CoC
Blanks allowed if no Phase II radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE II RADIATION PRIMARY TREATMENT VOLUME

NAACCR Item 1514 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE II RADIATION TO DRAINING LYMPH NODES

NAACCR Item 1515 Source of Standard: CoC
Blanks allowed if no Phase II radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE II RADIATION TREATMENT MODALITY

NAACCR Item 1516 Source of Standard: CoC
Blanks allowed if no Phase II radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE II TOTAL DOSE

NAACCR Item 1517 Source of Standard: CoC
Blanks allowed if no Phase II radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE III DOSE PER FRACTION

NAACCR Item 1521 Source of Standard: CoC
Blanks allowed if no Phase III radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE III NUMBER OF FRACTIONS

NAACCR Item 1523 Source of Standard: CoC
Blanks allowed if no Phase III radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE III RADIATION EXTERNAL BEAM PLANNING TECH

NAACCR Item 1522 Source of Standard: CoC
Blanks allowed if no Phase III radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE III RADIATION PRIMARY TREATMENT VOLUME

NAACCR Item 1524 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE III RADIATION TO DRAINING LYMPH NODES

NAACCR Item 1525 Source of Standard: CoC
Blanks allowed if no Phase III radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE III RADIATION TREATMENT MODALITY

NAACCR Item 1526 Source of Standard: CoC
Blanks allowed if no Phase III radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PHASE III TOTAL DOSE

NAACCR Item 1527 Source of Standard: CoC
Blanks allowed if no Phase III radiation treatment administered.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: PLACE OF DEATH--COUNTRY (Paper form field 80b)

NAACCR Item 1944 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

For ISO alpha-3 Country Codes, refer to Appendix B of the SEER Program Code Manual.

Item: PLACE OF DEATH--STATE (Paper form field 80a)

NAACCR Item 1942 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

For a complete list of state, territory, commonwealth, U.S. possession, or Canadian province or territory codes, refer to Appendix B of the SEER Program Code Manual.

Item: **PLEURAL EFFUSION** (Paper form field SSDI)

NAACCR Item 3913 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PRIMARY PAYER AT DX (Paper form field 13)

NAACCR Item 630 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **PRIMARY SCLEROSING CHOLAGITIS** (Paper form field SSDI)

NAACCR Item 3917 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: PRIMARY SITE (Paper form field 29)

NAACCR Item 400 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **PROFOUND IMMUNE SUPPRESSION** (Paper form field SSDI)

NAACCR Item 3918 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **PROGESTERONE RECEPTOR PERCENT POSITIVE OR RANGE** (Paper form field SSDI)

NAACCR Item 3914 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **PROGESTERONE RECEPTOR SUMMARY** (Paper form field SSDI)

NAACCR Item 3915 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **PROGESTERONE RECEPTOR TOTAL ALLRED SCORE** (Paper form field SSDI)

NAACCR Item 1316 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **PSA (PROSTATIC SPECIFIC ANTIGEN) LAB VALUE** (Paper form field SSDI)

NAACCR Item 3920 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: RACE (1-5) (Paper form field 11)

NAACCR Item 160-164 Source of Standard: SEER/CoC
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.

Examples:

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 (unknown):
Then Race 2 through Race 5 must all be coded 99.

Do not leave this data item blank. 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. Record race description in TEXT--DX PROC--PE field. If unknown, and if follow-back has been conducted, record as such in this field so it is clear that follow-back has been attempted.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RADIATION TREATMENT DISCONTINUED EARLY

NAACCR Item 1531 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: REASON FOR NO RADIATION (Paper form field 59)

NAACCR Item 1430 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: REASON FOR NO SURGERY (Paper form field 51)

NAACCR Item 1340 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: REGIONAL NODES EXAMINED (Paper form field 40)

NAACCR Item 830 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: REGIONAL NODES POSITIVE (Paper form field 39)

NAACCR Item 820 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: REPORTING FACILITY (Paper form field 24a)

NAACCR Item 540 Source of Standard: CoC
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 compilation of valid FINs can be found here: American College of Surgeons Facility Identification Number (FIN) List

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **RESIDUAL TUMOR VOLUME POST CYTOREDUCTION** (Paper form field SSDI)

NAACCR Item 3921 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **RESPONSE TO NEOADJUVANT THERAPY** (Paper form field SSDI)

NAACCR Item 3922 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: RQRS NCDB SUBMISSION FLAG

NAACCR Item 2155 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX CODING SYSTEM--CURRENT

NAACCR Item 1460 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: RX DATE BRM (Paper form field 66a)

NAACCR Item 1240 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE BRM FLAG (Paper form field 66b)

NAACCR Item 1241 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX DATE CHEMO (Paper form field 61a)

NAACCR Item 1220 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE CHEMO FLAG (Paper form field 61b)

NAACCR Item 1221 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX DATE HORMONE (Paper form field 64a)

NAACCR Item 1230 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE HORMONE FLAG (Paper form field 64b)

NAACCR Item 1231 Source of Standard: NAACCR
This flag explains why there is no appropriate value in the corresponding date field.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX DATE MST DEFN SRG (Paper form field 54a)

NAACCR Item 3170 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE MST DEFN SRG FLAG (Paper form field 54b)

NAACCR Item 3171 Source of Standard: NAACCR
This flag explains why there is no appropriate value in the corresponding date field.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX DATE OTHER (Paper form field 68a)

NAACCR Item 1250 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE OTHER FLAG (Paper form field 68b)

NAACCR Item 1251 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX DATE RADIATION (Paper form field 58a)

NAACCR Item 1210 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE RADIATION FLAG (Paper form field 58b)

NAACCR Item 1211 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX DATE SURGERY (Paper form field 52a)

NAACCR Item 1200 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE SURGERY FLAG (Paper form field 52b)

NAACCR Item 1201 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX DATE SYSTEMIC

NAACCR Item 3230 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

An allowable value must be in this Date field or its corresponding Flag field. Both fields cannot be blank.

Item: RX DATE SYSTEMIC FLAG

NAACCR Item 3231 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

An allowable value must be in this Flag field or its corresponding Date field. Both fields cannot be blank.

Item: RX SUMM--BRM (Paper form field 67)

NAACCR Item 1410 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--CHEMO (Paper form field 62)

NAACCR Item 1390 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--HORMONE (Paper form field 65)

NAACCR Item 1400 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--OTHER (Paper form field 69)

NAACCR Item 1420 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--RADIATION (Paper form field 60)

NAACCR Item 1360 Source of Standard: SEER
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: RX SUMM--SCOPE REG NL SUR (Paper form field 56)

NAACCR Item 1292 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--SURG OTH REG/DIS (Paper form field 55)

NAACCR Item 1294 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--SURG PRIM SITE (Paper form field 53)

NAACCR Item 1290 Source of Standard: SEER/CoC

Code the most definitive surgical procedure of primary site.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--SURG/RAD SEQ (Paper form field 57)

NAACCR Item 1380 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--SYSTEMIC/SUR SEQ (Paper form field 50)

NAACCR Item 1639 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--TRANSPLNT/ENDOCR (Paper form field 63)

NAACCR Item 3250 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: RX SUMM--TREATMENT STATUS (Paper form field 48)

NAACCR Item 1285 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

IMPORTANT NOTICE:
Text documentation is required regardless of facility type. An abstract submitted with codes that lack supporting text data will be rejected in its entirety.

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 independent of 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 produce the same codes as the original abstract.

- For additional information on text documentation rationale, consult NAACCR Data Standards & Data Dictionary

Do not leave text data items blank. If there is no information to record in the text field, type "N/A" or "None" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Only use standard abbreviations in text fields. For a list of recommended abbreviations, refer to NAACCR Data Dictionary Appendix G: Recommended Abbreviations for Abstractors.

Item: RX TEXT--BRM (Paper form field 74)

NAACCR Items 2660 Source of Standard: NPCR

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

Do not leave this data item blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: RX TEXT--CHEMO (Paper form field 74)

NAACCR Items 2640 Source of Standard: NPCR

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.

Do not leave this data item blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: RX TEXT--HORMONE (Paper form field 74)

NAACCR Items 2650 Source of Standard: NPCR

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.

Do not leave this data item blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: RX TEXT--OTHER (Paper form field 74)

NAACCR Items 2670 Source of Standard: NPCR

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.

Do not leave this data item blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: RX TEXT--RADIATION (BEAM) (Paper form field 75)

NAACCR Items 2620 Source of Standard: NPCR

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.

Do not leave this data item blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: RX TEXT--RADIATION OTHER (Paper form field 75)

NAACCR Items 2630 Source of Standard: NPCR

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.

Do not leave this data item blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: RX TEXT--SURGERY (Paper form field 53)

NAACCR Items 2610 Source of Standard: NPCR

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.

Do not leave this data item blank. If there is no information to record in the text field, type "NR" (Not Reported) or "No Info" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: **S CATEGORY CLINICAL** (Paper form field SSDI)

NAACCR Item 3923 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **S CATEGORY PATHOLOGICAL** (Paper form field SSDI)

NAACCR Item 3924 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **SARCOMATOID FEATURES** (Paper form field SSDI)

NAACCR Item 3925 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **SCHEMA DISCRIMINATOR 1** (Paper form field SSDI)

NAACCR Item 3926 Source of Standard: NAACCR

Codes (The information recorded in Schema Discriminator differs for each anatomic site. See the SSDI manual for most current version of the site-specific codes and coding structures.)

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **SCHEMA DISCRIMINATOR 2** (Paper form field SSDI)

NAACCR Item 3927 Source of Standard: NAACCR

Codes (The information recorded in Schema Discriminator differs for each anatomic site. See the SSDI manual for most current version of the site-specific codes and coding structures.)

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **SCHEMA DISCRIMINATOR 3** (Paper form field SSDI)

NAACCR Item 3928 Source of Standard: NAACCR

Codes (The information recorded in Schema Discriminator differs for each anatomic site. See the SSDI manual for most current version of the site-specific codes and coding structures.)

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: SCHEMA ID

NAACCR Item 3800 Source of Standard: NAACCR

See NAACCR website for complete Cancer Schema List. This site generates all required Site Specific Data Items (SSDI) by schema.

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: SCHEMA ID VERSION CURRENT

NAACCR Item 2117 Source of Standard: SEER
This data item will be generated by registry software. No coding instructions are required.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual.

Item: SCHEMA ID VERSION ORIGINAL

NAACCR Item 2118 Source of Standard: SEER
This data item will be generated by registry software. No coding instructions are required.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual.

Item: SECONDARY DIAGNOSIS (1-10) (Paper form field 14b)

NAACCR Items 3780-3798 Source of Standard: CoC
For cases using ICD-10-CM codes only. ICD-10-CM coding required beginning 10/1/2015.

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: SEER CAUSE SPECIFIC COD

NAACCR Item 1914 Source of Standard: SEER
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: SEER OTHER COD

NAACCR Item 1915 Source of Standard: SEER
Reporting required by Metropolitan Detroit Cancer System (MDCSS) only.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: SEER SUMMARY STAGE 2000 (Directly Assigned/Coded) (Paper form field 36)

NAACCR Items 759 Source of Standard: SEER
Must be directly assigned/coded. Applies to cases diagnosed prior to 2018 only. MCSP will always require directly assigned/coded SEER Summary Stage to be reported from all facilities regardless of type.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: **SENTINEL LYMPH NODES EXAMINED** (Paper form field SSDI)

NAACCR Item 834 Source of Standard: CoC

This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later. **This data item is required for breast and melanoma cases.**

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **SENTINEL LYMPH NODES POSITIVE** (Paper form field SSDI)

NAACCR Item 835 Source of Standard: CoC

This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later. **This data item is required for breast and melanoma cases.**

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **SEPARATE TUMOR NODULES** (Paper form field SSDI)

NAACCR Item 3929 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: SEQUENCE NUMBER--HOSPITAL (Paper form field 21)

NAACCR Item 560 Source of Standard: CoC

For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Important: Michigan requires reporting of non-invasive (pre-cancerous) intraepithelial neoplasia grade III tumors of the cervix (CIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III). Sequence numbers 00-59 must be used for these tumors -- do not use sequence number “99” or the 60-87 sequence range which is reserved for benign/borderline CNS tumors.

Item: **SERUM ALBUMIN PRETREATMENT LEVEL** (Paper form field SSDI)

NAACCR Item 3930 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **SERUM BETA-2 MICROGLOBULIN PRETREATMENT LEVEL** (Paper form field SSDI)

NAACCR Item 3931 Source of Standard: NAACCR

For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: SEX (Paper form field 9)

NAACCR Item 220 Source of Standard: SEER/CoC

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).”

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

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 (Paper form field 4)

NAACCR Item 2320 Source of Standard: SEER/CoC

Do not leave this data item blank. Social Security Number 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 unknown, enter 99999999.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: SPANISH/HISPANIC ORIGIN (Paper form field 10)

NAACCR Item 190 Source of Standard: SEER/CoC
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: SUMMARY STAGE 2018 - Directly Assigned (Paper form field 36)

NAACCR Item 764 Source of Standard: SEER
Must be directly assigned/coded. Applies to cases diagnosed in 2018 and later. MCSP will always require directly assigned/coded SEER Summary Stage to be reported from all facilities regardless of type.

For description, rationale, and coding instructions for this data item, refer to SEER Summary Stage 2018

IMPORTANT NOTICE:
Text documentation is required regardless of facility type. An abstract submitted with codes that lack supporting text data will be rejected in its entirety.

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.
- For additional information on text documentation rationale, consult NAACCR Data Standards & Data Dictionary

Do not leave text data items blank. If there is no information to record in the text field, type "N/A" or "None" to indicate that there is no information, otherwise it will be assumed that the information is actually missing.

Only use standard abbreviations in text fields. For a list of recommended abbreviations, refer to NAACCR Data Dictionary Appendix G: Recommended Abbreviations for Abstractors.

Item: TEXT--DX PROC--LAB TESTS (Paper form field 71)

NAACCR Item 2550 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--DX PROC--OP (Paper form field 53)

NAACCR Item 2560 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--DX PROC--PATH (Paper form fields 31 and 73)

NAACCR Item 2570 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--DX PROC--PE (Paper form field 71)

NAACCR Item 2520 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--DX PROC--SCOPES (Paper form field 73)

NAACCR Item 2540 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--DX PROC--X-RAY/SCAN (Paper form field 72)

NAACCR Item 2530 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--HISTOLOGY TITLE (Paper form field 31)

NAACCR Item 2590 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--PLACE OF DIAGNOSIS (Paper form field 24b)

NAACCR Item 2690 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR) 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 information is missing from the record, state that it is missing.

Item: TEXT--PRIMARY SITE TITLE (Paper form field 31)

NAACCR Item 2580 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--REMARKS (Paper form field 75)

NAACCR Item 2680 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--STAGING (Paper form field 73)

NAACCR Item 2600 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--USUAL INDUSTRY (Paper form field 15b)

NAACCR Item 320 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: TEXT--USUAL OCCUPATION (Paper form field 15a)

NAACCR Item 310 Source of Standard: NPCR
For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR)

Item: **THROMBOCYTOPENIA** (Paper form field SSDI)

NAACCR Item 3933 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: TNM CLIN DESCRIPTOR (Paper form field 37)

NAACCR Item 980 Source of Standard: CoC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM CLIN M (Paper form field 37)

NAACCR Item 960 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM CLIN N (Paper form field 37)

NAACCR Item 950 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM CLIN STAGE GROUP (Paper form field 37)

NAACCR Item 970 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM CLIN T (Paper form field 37)

NAACCR Item 940 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM EDITION NUMBER (Paper form field 37)

NAACCR Item 1060 Source of Standard: CoC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM PATH DESCRIPTOR (Paper form field 37)

NAACCR Item 920 Source of Standard: CoC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM PATH M (Paper form field 37)

NAACCR Item 900 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM PATH N (Paper form field 37)

NAACCR Item 890 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM PATH STAGE GROUP (Paper form field 37)

NAACCR Item 910 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TNM PATH T (Paper form field 37)

NAACCR Item 880 Source of Standard: AJCC

CoC requires that AJCC TNM staging be used in its approved cancer programs. For description, rationale, and coding instructions for this data item, refer to AJCC

MCSP has defined some facilities as a "Hospitals without registry". These facilities should report this value only when it is documented in the medical record; otherwise leave blank.

Item: TOBACCO TYPE (Paper form field 18)

State-specific Item 9519 Source of Standard: MCSP

Records type of tobacco use (cigarettes, pipe, cigars, snuff, chew, vaping, etc.) Marijuana use is not included in this data item, although its use should be recorded in the TEXT--DX Proc-PE text field.

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

Paper form submission:

Paper Form Item 18: Mark appropriate value based on chart below.

Do not leave this data item blank. If unknown, enter "9" or "Unknown."
Supporting text documentation for selected data value must be entered in Paper Form Field 95 even when value is "9" 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. Abstracts submitted with incorrect format or missing values will be rejected by MCSP.

Do not leave this data item blank. If unknown, enter "9."
Supporting text documentation for selected data value must be entered in TEXT--DX Proc-PE text field even when value is "9."

Tobacco Type Data Values

Code	Description	Text documentation to support use of coded value
1	Cigarettes	Pack per day times number of years
2	Cigars	Per day times number of years
3	Smokeless Tobacco Products (chewing tobacco, moist snuff)	Type and number of years
4	Electronic Cigarettes (Vape Pen, Hookah Pen)	Type and number of months/years
5	Waterpipes (hookah, Shisha)	Type and number of months/years
6	Multiple Types (code 1, 2 and/or 3)	Type and number of months/years
7	Multiple Types (code 1, 2, and/or 3, plus 4 and/or 5)	Type and number of months/years
8	Never Used	Never used any form
9	Unknown/Not Documented	Medical record reviewed, unknown/not documented

Item: TOBACCO USE (Paper form field 18)

State-specific Item 9522 Source of Standard: MCSP

Records whether or not the patient has a history of tobacco use (cigarettes, pipe, cigars, snuff, chew). Marijuana use is not included in this data item, although its use should be recorded in the TEXT--DX Proc-PE text field.

Note: 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:

Paper Form Item 18: Mark appropriate value per chart below.

Do not leave this data item blank. If unknown, enter "9" or "Unknown."
Supporting text documentation for selected data value must be entered in Paper Form Field 95 even when value is "9" 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. Abstracts submitted with incorrect format or missing values will be rejected by MCSP.

Do not leave this data item blank. If unknown, enter "9."
Supporting text documentation for selected data value must be entered in TEXT--DX PROC--PE field even when value is "9."

Tobacco Use 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: TOTAL DOSE

NAACCR Item 1533 Source of Standard: CoC
For description, rationale, and coding instructions for this data item, refer to CoC STandards for Oncology Registry Entry (STORE) Manual

Item: **TUMOR DEPOSITS** (Paper form field SSDI)

NAACCR Item 3934 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **TUMOR GROWTH PATTERN** (Paper form field SSDI)

NAACCR Item 3935 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: TUMOR SIZE CLINICAL (Paper form field 38)

NAACCR Item 752 Source of Standard: SEER
This data item applies to cases diagnosed 1/1/2016 and later only.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: TUMOR SIZE PATHOLOGIC (Paper form field 38)

NAACCR Item 754 Source of Standard: SEER
This data item applies to cases diagnosed 1/1/2016 and later only.

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Item: TUMOR SIZE SUMMARY (Paper form field 38)

NAACCR Item 756 Source of Standard: NPCR/CoC
This data item applies to cases diagnosed 1/1/2016 and later only.
This refers to size measured on the surgical resection specimen, when surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered. If neoadjuvant therapy is followed by surgery, do not record the size from the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size as 999.

For description, rationale, and coding instructions for this data item, refer to National Program of Cancer Registries (NPCR) and CoC STandards for Oncology Registry Entry (STORE) Manual

Item: TYPE OF REPORTING SOURCE (Paper form field 22)

NAACCR Item 500 Source of Standard: SEER
For description, rationale, and coding instructions for this data item, refer to SEER Program Manual

Do not leave this text data item blank.

Item: **ULCERATION** (Paper form field SSDI)

NAACCR Item 3936 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: **VISCERAL AND PARIETAL PLEURAL INVASION** (Paper form field SSDI)

NAACCR Item 3937 Source of Standard: NAACCR
For description, rationale, and coding instructions for this data item, refer to NAACCR Data Standards and Data Dictionary, Chapter X: Data Dictionary

Item: VITAL STATUS (Paper form field 77)

NAACCR Item 1760 Source of Standard: SEER/CoC

For description, rationale, and coding instructions for this data item, refer to SEER Program Manual and CoC STandards for Oncology Registry Entry (STORE) Manual