



Cancer Reporting Standards Volume 1

REPORTING PROCEDURES
FOR
HOSPITALS
AMBULATORY SURGERY CENTERS



Oregon State Cancer Registry

Cancer Reporting Standards Volume I

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I. Introduction

OREGON STATE CANCER REGISTRY MISSION STATEMENT

"The purpose of the registry shall be to provide information to design, target, monitor, facilitate, and evaluate efforts to determine the causes or sources of cancer among the residents of Oregon and to reduce the burden of cancer and benign tumors in Oregon."

BACKGROUND

Cancer registries play an important role in the effort to reduce the burden of cancer by identifying and quantifying the problem. In 1993, the Oregon Health Division began a cancer control program with the start of the Breast and Cervical Cancer Early Detection Program. As part of the state's cancer control efforts, the planning of an Oregon State Cancer Registry (OSCaR) began in 1994 with the hopes of developing and implementing a comprehensive statewide, population-based surveillance system.

The Oregon Legislature unanimously passed legislation in 1995 that made cancer a reportable disease. All cancer cases diagnosed on or after January 1, 1996, are reportable. The legislation authorized the Oregon Department of Human Services to establish a statewide cancer registry. Funding from the National Program of Cancer Registries (NPCR), Centers for Disease Control and Prevention (CDC), support the development and maintenance of the Oregon State Cancer Registry.

OREGON DEMOGRAPHICS

Population

Over 3.6 million people live in Oregon's 36 counties. The major population concentrations are in the Portland Metropolitan Area and the Interstate-5 corridor in the Willamette Valley. Forty-three percent of the population lives in three Portland Metropolitan Area counties: Multnomah, Washington, and Clackamas counties. Several smaller population clusters are found in the central Cascade Mountains, the Pendleton/LaGrande area in the northeastern region of the state, and along the Oregon coast.

Race and Ethnicity

According to Portland State University Population Research Center data, 87% of Oregon's population are White (non-Hispanic), 8% are of Hispanic origin, 3% are Asian or Pacific Islander, 2% are African American, and 1.4% are American Indian.

HEALTHCARE IN OREGON

There are 53 general acute care hospitals in Oregon with 23 operating cancer programs, 67 ambulatory surgery centers, numerous freestanding cancer treatment centers, and hundreds of private clinics and physician offices. Oregon hospitals are following the national trend of expanding into outpatient services. Other healthcare changes in Oregon include the establishment of contractual agreements with physicians, and the consolidation of hospitals into multi-hospital systems.

CANCER AS A PUBLIC HEALTH ISSUE

The primary purpose of cancer registry data is to support cancer control by targeting, monitoring, and evaluating programs that promote early detection, diagnosis and treatment of cancer. The central cancer registry provides summary statistics on the distribution of cancer cases by type and treatment, which supports efforts by community hospitals and health systems to evaluate their cancer patient care. The medical community is able to use central cancer registry data to evaluate cancer care and preventive health screening programs.

The central registry supports local health agencies in the following ways by:

- following cancer incidence and treatment trends in the state;
- allowing state or local health officials to assess suspected cancer clusters or suspected cancer hazards in local communities; and by
- providing accurate cancer data for cancer-related reports to legislative bodies.

The Oregon State Cancer Registry, as a statewide population-based registry, provides data for epidemiological research related to cancer control efforts in Oregon.

CANCER REGISTRATION

Twenty hospital cancer registries in Oregon are accredited by the American College of Surgeons Commission on Cancer (CoC). These accredited registries report over three-fourths of the cancer cases in the state. Other reporting sources include non-CoC accredited hospitals, ambulatory surgery centers, freestanding cancer treatment centers, outpatient clinics, physicians, and registries in bordering states.

OSCaR follows national reporting standards. These standards include completeness of reporting, accuracy of data, and timeliness in submitting cases to the central registry.

II. Confidentiality and Data Security

CONFIDENTIAL DATA

The Oregon State Cancer Registry is mandated by law to collect cancer incidence data, and as such, must act as custodian of these data. This is to ensure these records are held in trust, and that the privacy of individual patients, reporting facilities, and physicians is protected. Confidentiality of the data is protected under statutory authority (see ORS 432.500 in Appendix A), and is detailed under the Cancer Reporting Regulations (see OAR 333-010-0050 in Appendix A).

Any item used to identify a patient, reporting facility, or practitioner is considered confidential. These items include patient names, addresses, social security numbers, birth dates, telephone numbers, names of physicians, and names of reporting facilities. In addition, any combination of data items that could be used to identify a patient are considered confidential. For example, certain combinations of age and race could breach the confidentiality of a patient who lives in a small population area.

OSCaR and HIPAA

There is a “public health exemption” to the federal Health Insurance Portability and Accountability Act (HIPAA) that applies to state cancer registries.

Consistent with HIPAA Privacy Rules and state statute, OSCaR staff may collect or receive individually identifiable health information as a Public Health Authority for the purpose of preventing or controlling cancer, and to conduct public health surveillance, public health investigations, and public health interventions. The minimum necessary information required for cancer reporting will be requested.

OSCaR POLICY

OSCaR recognizes the importance of maintaining confidentiality and data security, and has developed policies and procedures that address these issues. All OSCaR staff engaged in the collection, processing, and/or the dissemination of data are informed of their responsibility to protect such data, and are aware of the consequences of failing to do so. OSCaR staff members are required to sign an annual confidentiality statement, and access to data is password-protected and restricted to staff members who require access to perform their assigned duties.

RELEASE OF DATA

Non-Confidential Data

OSCaR disseminates data through electronic Internet access and printed reports. Such information includes descriptive statistics regarding the cancer experience in Oregon as a state, as well as individual county data. In addition, reporting facilities, practitioners, and other health professionals are encouraged to request data from OSCaR. Data requests that do not require more than a minimal amount of staff time to fulfill are provided at no charge. A charge to cover staff time is imposed for requests involving extensive staff time.

Confidential Data

Only the following facilities and individuals may receive confidential data.

1. Reporting facilities: each facility is required to designate 1-3 individuals as recipients of the data reported by that facility. A confidentiality statement is required.
2. County Health Officers (or her/his designee): for the purpose of safeguarding public health. Data will be provided only for the county/counties covered by the requesting County Health Officer's jurisdiction.
3. Health care facilities with shared patients: such information is provided only if all parties have signed a data-sharing agreement.
4. DHS staff for purposes as stated in ORS 432.500.
5. Researchers after approval from the DHS Institutional Review Board.

Disclosure of information will be permitted only if the following conditions are met.

- ✓ The minimum number of confidential data items necessary are requested.
- ✓ Use of the data for other than the stated purpose is prohibited.
- ✓ Re-disclosure of confidential data to any other party is not permitted.
- ✓ The data must be destroyed in a manner that maintains confidentiality after the stated need has been fulfilled.

PATIENT NOTIFICATION

OSCaR is required to notify patients that information about them has been reported to the central Registry (see AR 333-010-0035 in Appendix A). OSCaR is the only central registry in the country that informs patients of their inclusion in the Registry. On a monthly basis, OSCaR sends patient notification letters to each patient reported to the Registry (see Appendix E for a sample letter). This letter notifies the patient of their inclusion in the Registry, gives a brief history of the Registry, informs the patient that their personal information will be kept highly confidential, and notifies them of their option to voluntarily participate in research.

III. Reporting Requirements

Cancer is a reportable disease under the Oregon Revised Statutes for all patients diagnosed on, or after, January 1, 1996 (see Appendix A). Oregon physicians, and other health care providers, are required to report patients newly diagnosed with cancer or a closely related condition to the Oregon State Cancer Registry on an ongoing basis in accordance with the reportable conditions list (see pages III-9 and III-10 for the list of required and optional reportable conditions).

REPORTING SOURCES

Completeness in cancer reporting requires the participation of many reporting sources. Reporting sources include cancer registry hospitals, non-registry hospitals, ambulatory surgery centers, out-of-state registries, practitioners, and pathology laboratories.

Cancer Registry Hospitals

This is any hospital with an active cancer registry, whether or not the registry is accredited by the American College of Surgeons (ACoS) Commission on Cancer (CoC) (see Appendix D for a list of reporting facilities). Hospitals with cancer registries are required to report all reportable cancer cases to the central registry. Additionally, cancer registry hospitals are required to report follow-up information to the central registry on an annual basis. All cancer cases diagnosed from the time of the reference date must be submitted to the central registry in electronic format.

Non-Registry Hospitals

This is any Oregon hospital not currently operating a cancer registry (see Appendix D). Such hospitals must report the cancer cases diagnosed and/or treated in their facility to the central registry. All cancer cases diagnosed from the time of the reference date must be submitted to the central registry in electronic format.

Non-registry hospitals have several options for meeting OSCaR's reporting requirements, including contracting with OSCaR to perform casefinding and abstracting at the hospital's expense. Hospitals designated as small rural hospitals (hospitals with 50 or fewer beds) may elect to perform their own casefinding and mail copies of the appropriate portions of the medical record for each case to the central registry. OSCaR staff will abstract and submit the cases at the hospital's expense. Hospitals may also hire an independent contractor to perform casefinding and abstracting activities at the hospital's expense.

Ambulatory Surgery Centers

This is any outpatient surgery center performing cancer diagnostic or treatment procedures (see Appendix D). Ambulatory surgery centers are considered cancer reporting facilities and are required to report all cancer cases diagnosed or treated in their facility to the central cancer registry. All cancer cases diagnosed from the time of the reference date must be submitted to the central registry in electronic format. Ambulatory surgery centers may elect to contract with a cancer registry hospital, OSCaR, or an independent contractor to meet their reporting requirements.

Out-of-State Cancer Registries

OSCaR has agreements with other state cancer registries to allow data sharing of resident cases. This allows the registry to obtain reports on Oregon resident cases diagnosed or treated in other states.

Practitioners

A practitioner is defined as a physician, an outpatient facility operating under the license of a physician, or any person whose professional license allows her/him to diagnose or treat cancer patients. Practitioners are required to report all cancer cases not reported by a cancer reporting facility (hospital or ambulatory surgery center). Practitioners do not need to report cases admitted to an Oregon reporting facility for a cancer diagnosis, or for all or any part of the first course of therapy for that case, within 180 days of diagnosis. Practitioners may meet their reporting requirements by submitting a Cancer Notification Form (CNF) to OSCaR. This form may be found at the following web site: <http://www.oregon.gov/DHS/ph/oscar/docs/cnf.pdf>.

Pathology Laboratories

Any clinical laboratory that diagnoses cancer cases and reportable conditions must report to the state cancer registry. Per ORS 432.520(4) OSCaR requires electronic reporting.

CASEFINDING

Casefinding is a method of identifying new cancer cases. All facilities are responsible for complete casefinding. In some facilities, all records may be housed in one location, such as the Health Information Management Department or medical records. In other facilities, records may be maintained by multiple patient services, including clinics and the radiation oncology department. Procedures for identifying new cases from multiple service areas may be necessary to ensure complete casefinding.

The following areas and departments should be reviewed and regularly monitored to identify new cancer cases.

- HIM/Medical Records Disease Index (inpatient and outpatient)
- Billing information
- Pathology (surgical pathology, bone marrow biopsy, needle biopsy, cytology, autopsy reports)
- Radiation Therapy Department
- Outpatient Departments (including cancer specialty clinics, chemotherapy clinics, day surgery, emergency room)

OVERVIEW OF REPORTING RULES

General Coding Requirements

The Oregon State Cancer Registry uses *the Facility Oncology Registry Data Standards Revised for 2009 manual (FORDS)* for complete coding instructions on all cases diagnosed January 1, 2009, and later. The complete FORDS manual and historical manuals can be downloaded at: www.facs.org/cancer/coc/fordsmanual.html.

In addition, the *SEER Program Coding and Staging Manual 2007*, for cases diagnosed January 1, 2007, or later, may be consulted for additional coding information. This manual, and historical manuals for cases diagnosed prior to January 1, 2007, can be downloaded at: <http://seer.cancer.gov/registrars/>.

Included in this overview of reporting rules are items that are of particular importance to the quality of submitted data. Refer to *FORDS* for complete coding instructions.

Reference Date

The reference date is defined as the date after which all eligible cases must be included in the registry. The reference date for the Oregon State Cancer Registry is January 1, 1996. All cases diagnosed on or after January 1, 1996, are reportable.

Reportable Cases

All cancer cases are reportable that meet the criteria of the reportable list: diagnosed on or after the reference date and diagnosed or treated in an Oregon resident or a non-Oregon resident who is diagnosed or treated in Oregon. Please note the following:

- High-grade dysplasia or severe dysplasia of the colon or esophagus is reportable as carcinoma in situ only when this terminology has been verified with the pathologist and/or cancer committee that these terms are considered synonymous. This information must be transmitted in text with the abstract. This information should also be documented in the hospital procedure manual.

Residency

For population-based cancer registries, data must include the occurrence of specific types of cancer by geographical location. The patient's residency at the time of diagnosis should be recorded as the patient's "usual" address. The U.S. Census Bureau defines "usual" address as the place where a person lives and sleeps most of the time. The *FORDS Manual* provides a list of residency rules as defined by the U.S. Census Bureau and includes the following classifications.

- Vacation or Business
- People without Housing
- People with Multiple Residences
- Students
- Military Personnel

- People in Hospitals, Prisons, or Other Institutions
- People in Non-Institutional Group Quarters
- Foreign Citizens

Date of Diagnosis

OSCaR and the American College of Surgeons, Commission on Cancer define date of diagnosis as the date of initial cancer diagnosis by a recognized medical practitioner, whether the cancer was diagnosed clinically, pathologically, or by imaging.

Diagnostic Confirmation

Diagnostic confirmation is the method of confirming that the patient has cancer. The most conclusive method for confirming cancer is by histology (microscopic analysis of tissue) followed by cytology (examination of cells rather than tissue), laboratory tests, radiography and other imaging technologies, direct visualization, and clinical diagnosis. Some cases are only confirmed clinically for a variety of reasons, including patients with advanced age or comorbid conditions.

Primary Site

Use instructions found in ICD-O-3 section “Coding Guidelines for Topography and Morphology” for coding all primary sites. Pay particular attention to the following:

- Use the following medical records in priority order to determine primary site:
 - Pathology report
 - Surgical reports
 - Imaging reports (X-ray, CT scans, etc.)
 - Physician statement in medical record
- Code the site in which the primary tumor originated not a metastatic site.
- Code the last digit of the primary site to ‘8’ when a single tumor overlaps an adjacent subsite of an organ and the point of origin cannot be determined.
- Code the last digit of the primary site to ‘9’ for single primaries, when multiple tumors arise in different subsites of the same anatomic site and the point of origin cannot be determined.
- Make every effort to determine and code the specific subsite.
- Code leukemia primaries to bone marrow (C421).
- The Breast Guide (See Reference Guide Section) may be used to code breast primary site.

Laterality

Laterality refers to the side of a paired organ or side of the body on which the reportable tumor originated. Determine laterality for each primary abstract. See *FORDS Manual, Cancer Identification Section* for codes and coding instructions. The Laterality Guide (See Reference Guide Section) may be used to code laterality.

Histology and Behavior

Histology, or morphology, refers to the cell type of tumor. Behavior refers to how a tumor acts within the body. ICD-O-3 is used for coding histology and behavior of all cancers and benign or borderline intracranial and CNS tumors.

- For cases diagnosed January 1, 2007, or later, use SEER 2007 Multiple Primary and Histology Coding Rules to code multiple or mixed histologies in one primary.
- For behavior, use code 3 if any invasion is present no matter how limited.
- For behavior, use code 3 if a pathology specimen is from a metastatic site.
- For behavior, code 6 is *not used* by cancer registries.

Grade

Grade, or differentiation refers to how much or little a tumor resembles the normal tissue of the primary site. ICD-O-3 Rule G is used for coding tumor grade.

- Use site-specific coding guidelines.
- Code the grade only from the primary site, not a metastatic site.
- Code the grade from the final pathology diagnosis. If there are multiple pathology reports, code the highest grade from any pathology report.
- Code grade from an unknown primary to 9 (unknown grade).
- The Grade Guide (See Reference Guide Section) to interpret scores and assign grade. Use the priority order to assign grade.
- The Breast Guide (See Reference Guide Section) may be used to code breast grade.
- Document in text the grading basis.

Ambiguous Terms

A pathologist or physician may use vague or ambiguous terms to describe a cancer that does not have a clear diagnosis. Some terms are more indicative of a cancer diagnosis than others. CoC and SEER have a list of ambiguous terms used by medical practitioners that are considered diagnostic of cancer and a list of terms that are not considered diagnostic of cancer. The tables below outline the most common ambiguous terms.

Ambiguous Terms Considered Diagnostic of Cancer
Apparent(ly)
Appears
Comparable with
Compatible with
Consistent with
Favors
Malignant appearing
Most likely
Neoplasm** (beginning with 2004 diagnosis and only for C70.0 – C72.9, C75.1 – 75.3)
Presumed
Probable
Suspect(ed)
Suspicious (for)
Tumor ** (beginning with 2004 diagnosis and only for C70.0 – C72.9, C75.1 – 75.3)
Typical of

** Additional terms for non-malignant primary intracranial and central nervous system tumors only

Ambiguous Terms NOT Considered Diagnostic of Cancer <i>without additional information</i>
Cannot be ruled out
Equivocal
Possible
Potentially malignant
Questionable
Rule out
Suggests
Worrisome

EXCEPTION: If a cytology is reported as *suspicious*, do not interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician’s clinical impression of cancer supports the cytology findings.

Text Documentation

Text documentation of the cancer abstract is heavily used for quality control and to facilitate consolidation of records from multiple facilities. Text is used to validate coded values and provide supplemental information not included with coded values. Keep the following general principles in mind:

- Prioritize information included in the text fields; avoid extraneous information that does not support the coded values.
- Avoid “cutting and pasting” from the medical record.
- Use approved abbreviations in Appendix G.
- Use abbreviations in context.
- The Text Guide (See Reference Guide Section) may be used to document text.

Stage at Diagnosis

Stage refers to how far the cancer has spread from the organ of origin. For cases diagnosed on January 1, 2004, or later OSCaR utilizes the SEER Collaborative Staging (CS) Manual. The CS data items are used to derive Summary Stage 1977 and Summary Stage 2000 as well as derive AJCC T, N, M stage. See Appendix B for required CS data items and Appendix J for a link to download the Collaborative Staging Manual. Keep the following general principals in mind:

- CS records the greatest extent of disease based on combined clinical and operative/pathological assessment.
- Take care to read CS notes included with specific data items.
- CS permits registrars to code distant metastasis clinically as none, rather than unknown, based on clinical evaluation when the clinician proceeds with usual treatment to the primary site.
- Use all information available to code staging elements including imaging reports, dictated reports and radiation oncology reports.
- In the absence of additional information, a statement of “remainder of examination negative” is sufficient to code regional lymph nodes as clinically negative.

Sequence Number

Sequence number represents the number of primary malignancies, and non-malignant CNS tumors, a patient has during his or her lifetime.

- Codes 00-59 and 99 are used for in situ or malignant neoplasms (behavior code /2 or /3)
 - Use code 00 if the patient has a single neoplasm.
 - If a patient develops a subsequent neoplasm, change 00 to 01 and sequentially assign codes to subsequent neoplasms.
 - Any tumor in the patient’s past which is reportable or reportable-by-agreement must be taken into account when assigning sequence number.
- Codes 60-88 are used for non-malignant CNS tumors (behavior code /0 or /1)
 - Use code 60 if the patient has a single neoplasm.
 - If a patient develops a subsequent neoplasm, change 60 to 61 and sequentially assign codes to subsequent neoplasms.

Race

Race identifies the primary race of the patient and is important information used for research and cancer control activities. Every effort should be made to correctly assign an appropriate race code. Registrars are encouraged to review the entire medical record for race information including: registration face sheet, history and physical exam information, consult notes, nursing notes, imaging reports, photographs, and discharge summaries.

MULTIPLE PRIMARY AND HISTOLOGY CODING RULES UPDATED

For cases diagnosed on or after January 1, 2007, OSCaR utilizes the SEER 2007 Multiple Primary and Histology Coding Rules to standardize the process of determining the number of primary tumors to be abstracted. The histology rules contain detailed histology coding instructions and guidance for identifying histologic lineages, differentiating between general (NOS) terms and specific histologic types and correctly assigning mixed and combination codes. The complete Multiple Primary and Histology Coding rules may be downloaded from the SEER Web site:

<http://seer.cancer.gov/registrars/>

Use the Multiple Primary rules to make a decision on the number of primary malignancies to be abstracted for reportable solid malignant tumors. Each module is an independent, complete, set of coding rules.

For cases diagnosed prior to January 1, 2007, OSCaR uses the SEER Program rules in effect at that time.

Site-specific Rules are available for the following primary site groups (excluding leukemia and lymphoma (M9590–9989) and Kaposi sarcoma (M9140) for any site):

- Intracranial and CNS, malignant (C70.0, C70.1, C70.9, C71.0–C71.9, C72.0–C72.5, C72.8, C72.9, C75.1–C75.3)
- Intracranial and CNS, benign and borderline (C70.0, C70.1, C70.9, C71.0–C71.9, C72.0–C72.5, C72.8, C72.9, C75.1–C75.3)
- Breast (C50.0–C50.9)
- Colon (C18.0–C18.9)
- Head and neck (C00.0–C14.8, C30.0–C32.9)
- Kidney (C64.9)
- Lung (C34.0–C34.9)
- Malignant melanoma of the skin (C44.0–C44.9 with Histology 8720–8780)
- Renal pelvis, ureter, bladder, and other urinary (C65.9, C66.9, C67.0–C67.9, C68.0–C68.9)

Use the Other Sites Rules for solid malignant tumors that occur in primary sites not covered by site-specific rules.

CASEFINDING CODES FOR REPORTABLE CONDITIONS (Required)

ICD-9-CM Diagnosis Code (with Preferred ICD-0-3 Terminology)**

Reportable cases (with diagnosis date 2004 or later) include specified benign neoplasms of the brain and CNS and all invasive and in situ* malignant neoplasms as listed below:

ICD-9-CM	Terminology (ICD-0-3)
140.0 – 208.9	Malignant neoplasms (primary and secondary diagnosis)
209.0 – 209.69 #	Neuroendocrine/carcinoid tumors
225.0 – 225.9	Benign neoplasm of brain and spinal cord neoplasm
227.3 – 227.4	Benign neoplasm of pituitary, craniopharyngeal duct, craniobuccal pouch, hypophysis, Rathke’s pouch, sella turcica, pineal gland, pineal body
230.0 – 234.9	Carcinoma <i>in situ</i> (includes vagina, vulva, anus) and (excludes 232-skin* and 233.1-cervix uteri*)
236.0 #	Endometrial stroma, low grade sarcoma, endolymphatic stromal myosis, endometrial stromatosis, stromal endometriosis, stromal myosis, NOS (8931/3)
237.0 –	Neoplasm of uncertain behavior (borderline) of pituitary gland/craniopharyngeal duct
237.1	Neoplasm of uncertain behavior of pineal gland
237.5	Neoplasm of uncertain behavior of brain and spinal cord
237.6	Neoplasm of uncertain behavior of meninges; NOS, cerebral, spinal
237.70	Neurofibromatosis, Unspecified von Recklinghausen’s Disease
237.71	Neurofibromatosis, Type 1 von Recklinghausen’s Disease
237.72	Neurofibromatosis, Type 2 von Recklinghausen’s Disease
237.9	Neoplasm of uncertain behavior of other and unspecified parts of the nervous system; cranial nerves
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3) extramedullary plasmacytoma (9734/3)
238.71	Essential thrombocythemia (9962/3)
238.72	Low grade myelodysplastic syndrome lesions (includes 9980/3, 9982/3, 9985/3) includes: refractory anemia w/o sideroblasts, refractory anemia with ringed sideroblasts, refractory cytopenia with multilineage dysplasia, refractory cytopenia with multilineage dysplasia and ringed sideroblasts
238.73	High grade myelodysplastic syndrome lesions (includes 9983/3) : refractory anemia w/excess blasts-1, refractory anemia w/excess blasts-2
238.74	Myelodysplastic syndrome with 5q deletion (9986/3)
238.75	Myelodysplastic syndrome, unspecified (9989/3)
238.76	Myelofibrosis with myeloid metaplasia (9961/3)
238.79	Other lymphatic and hematopoietic tissues (incl. 9960/3, 9961/3, 9931/3)
273.2	Gamma Heavy chain disease, Franklin disease (9762/3)
273.3	Waldenstrom’s macroglobulinemia (9761/3)
288.3	Hypereosinophilic syndrome (9964/3) includes: chronic eosinophilic leukemia
289.83	Myelofibrosis (NOS) (9961/3)

Revised and/or added code with this revision-3/2009

* **Exclusions:** Basal / squamous cell carcinoma of skin, except of the genitalia, and *in situ* carcinoma of uteri and PIN III are not reportable

Note: VIN 3, VAIN 3, AIN 3 (squamous intraepithelial neoplasia Grade 3) and, juvenile astrocytoma, pilocytic astrocytoma, and piloid astrocytoma are reportable to the Oregon State Cancer Registry.

** International Classification of Diseases, Ninth Revision, Clinical Modification. U.S. Dept of Health and Human Services, Public Health Service- Health Care Finance Administration; DHHS Publication No. (PHS) 80-1260.

CASEFINDING CODES FOR REPORTABLE CONDITIONS (Optional*)

*ICD-9-CM** Diagnosis Code/Terminology*

***NOTE:** Cases with these codes should be screened only as registry time allows and to the discretion of the cancer registry. These are neoplasm-related secondary conditions for which there should also be a primary diagnosis of a reportable neoplasm.

ICD-9-CM	Terminology
042	AIDS (review for AIDS-related malignancies)
235.0 – 238.9	Neoplasms of uncertain behavior
239.0 – 239.9	Neoplasms of unspecified nature
259.2	Carcinoid Syndrome
338.3	Neoplasm related pain (acute)(chronic)- cancer associated pain, pain due to malignancy, tumor associated pain
528.01	Mucositis due to anti-neoplastic therapy
795.16	Pap Smear of vagina w/cytologic evidence of malignancy
796.76	Pap Smear of anus w/cytologic evidence of malignancy
V07.3	Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
V10.0 – V10.9	Personal history of malignancy (review these for recurrences, subsequent/multiple primaries and/or subsequent treatment)
V58.0	Admission for radiotherapy
V58.11	Admission for antineoplastic chemotherapy
V58.12	Admission for antineoplastic immunotherapy
V66.1	Convalescence following radiotherapy and palliative care
V66.2	Convalescence following chemotherapy
V67.1	Follow-up exam following Radiation therapy
V67.2	Cancer Chemotherapy follow-up
V71.1	Observation for suspected malignant neoplasm
V76.0 – V76.9	Special screening for malignant neoplasms
V86.0	Estrogen receptor positive status [ER+]
V86.1	Estrogen receptor negative status [ER-]

*THE ABOVE CODES ARE **OPTIONAL** FOR USE IN CASEFINDING PRACTICES

** International Classification of Diseases, Ninth Revision, Clinical Modification. U.S. Dept of Health and Human Services, Public Health Service- Health Care Finance Administration; DHHS Publication No. (PHS) 80-1260.

IV. Data Transmission Procedures

DATA SUBMISSION SCHEDULE

To better manage the flow of cases entering the central registry system, the Oregon State Cancer Registry has designed a submission schedule based on the annual number of reported cases per facility. This submission schedule was designed for the convenience of cancer reporting facilities, and to ensure consistent flow of data to OSCaR. Reporting facilities should refer to the following table to determine how frequently to submit cases. Each file should include no more than 100 cases.

Total Number of Annual Cases	BI-monthly Submissions	Monthly Submissions	Quarterly Submissions
< 100			X
> 100 - < 500		X	
> 500 - < 1,000		X	
> 1,000	X		

In order to assist cancer registries with determining how current their facilities are in data submission, OSCaR has implemented a tracking system that allows data monitoring by comparing the expected number of cases with the actual number of submitted cases. The registry also actively monitors data timeliness and accuracy.

GUIDELINES FOR TRANSMISSION

All cases that meet the reporting requirements in ORS 432.500 (see Appendix A) must be sent electronically. Electronic reporting is defined as sending data through e-mail, or through web-based reporting. The preferred method of data reporting is via Web Plus, which is a secure, web-based reporting system. Any case updates, changes in records, and follow-up information should be sent electronically.

Your vendor software should provide selection criteria for downloading files. If you do not have an automated transmission program in your software, please contact OSCaR for assistance.

File Format

NAACCR has designed guidelines for a common standard record layout to use for transmission of files and sharing of cases between registries. For consistency in reporting, transmission of files, and sharing of cases between registries, OSCaR has adopted the NAACCR Version 11 data exchange file format. All new cases, future updates, follow-up, or changes in records should also be transmitted in this NAACCR file format.

File Names

In order to track data files, OSCaR requests that reporting hospitals name each file with the hospital abbreviation (see Appendix D), transmission date, and XAA extension.

Example: File Name: GH020109.XAA
Hospital Abbreviation: GH (General Hospital)
Transmission Date: 04/01/09
File Extension: XAA

Multiple files transmitted on the same day should follow a sequential file extension lettering system, i.e., XAA, XAB, XAC.

REPORTING TRANSMISSION OPTIONS

There are currently two data transmission options available:

- ✓ Submitting files through WebPlus, and
- ✓ Submitting files through secure e-mail.

Web Plus is the preferred method of data transmission.

Submitting Files Via Web Plus

File Upload Instructions:

1. Access the Web Plus Login screen through the following link:
<https://oscarwebplus.hr.state.or.us/>
2. Enter your assigned **User ID** and **Password**
Note: You will be assigned a user ID and initial password. If you do not have a user ID or password, or if you need a password reset, email the OSCaR database specialist at oscar.ohd@state.or.us
3. Click the **Login** button.
4. Once you have successfully logged in, choose the **New Upload** option. This will take you to a page that allows you to upload a file to send to the registry
5. Under *Select a file to upload:* click the **Browse** button. Select the file you would like to send to the registry, and add your name, facility name, and number of cases in the file under *Comment*.
Note: The files do not need to be encrypted.
6. Click **Upload**.

7. You should receive a message stating *File was successfully uploaded and has been submitted for edits processing*. At this point, you have the option to wait for the edit report, or you may log out of Web Plus and access the report at a later time.
8. Once the complete file is uploaded, the EDIT Report will open in a separate window.
9. You may check the status of your upload(s), view abstracts and view the edit report under **Previous Uploads**.
10. If you receive a message stating *file was not uploaded successfully*, or if the status shows the file was rejected, please review the edit report and the file, make corrections to the cases, and resubmit the file.

Submitting Files Via E-Mail

An additional method of data submission is secure email. This option should only be used as a backup method for data submission, with WebPlus being the primary method of submission. Please send an email to oscar.ohd@state.or.us, requesting a secure email. The database specialist will respond to your request with a link to a highly secure website where you will be able to download (unencrypted) files. Once you attach the file or files through the secure site and send the message, you will receive an email confirmation from the database specialist noting your files were received.

FEEDBACK REPORTS

In an effort to ensure consistent and accurate reporting, OSCaR has developed and implemented procedures for providing feedback to reporting facilities. Feedback reports currently consist of monthly letters to the specific reporting facilities that indicate the number of cases successfully added to the OSCaR database (See Appendix E for sample letter). This helps facilities ensure they are sending all appropriate cases. The database specialist maintains regular communication with reporting facilities for various data quality issues, and provides immediate feedback on file transmission and downloads via email. This feedback not only ensures that the central cancer registry maintains quality data, but it also helps the central cancer registry and cancer reporting facilities maintain mutual working relationships.

V. Quality Assurance

OVERVIEW

The Oregon State Cancer Registry (OSCaR) is legislatively charged with the systematic and standardized collection of information of Oregon residents diagnosed with cancer or a closely related reportable condition. Success in achieving these goals is dependent upon the availability of timely, complete, and accurate data. In order to accomplish this, OSCaR has implemented quality control procedures. These procedures make up a large part of program operations and consist of clearly defined reporting expectations for health care facilities and central registry quality assurance procedures.

This chapter is divided into two sections. Section 1 focuses on the quality control responsibilities of cancer reporting facilities in Oregon, and Section 2 addresses procedures followed at the central registry to assure high quality, population-based cancer data. We are confident that all partners in cancer registration strive to provide timely, complete, and accurate data to maximize the usefulness of Oregon cancer information to cancer control programs, the medical community, researchers, and the citizens of Oregon.

An overview of this coordinated process between health care facilities and the central cancer registry is depicted in Figure A at the end of this chapter.

SECTION 1

QUALITY ASSURANCE GUIDE FOR REPORTING FACILITIES

This section provides a summary of the quality control responsibilities that OSCaR requires *before* data is transmitted to OSCaR. This section is a guide to achieving quality data that is required to be reported to OSCaR.

The Oregon legislature included mandatory control mechanisms in the cancer reporting statute to ensure high quality data. Following is an excerpt and interpretation of an Oregon Administrative Rule supporting the state statute:

Administrative Rule (excerpt): OAR 333-010-0040(4)-(6)
(see Appendix A for complete statute)

- A cancer reporting facility must report a minimum of 98% of the cases reportable by the facility for any calendar year in order to meet the requirements of these rules.
- The item-specific agreement of reported data from a reporting facility with the information in the facilities medical record shall not be less than 95% for those data items identified in the OSCaR Reportable Data Items listing as quality control items.
- A cancer reporting facility must submit 98% of reportable cases to the central registry within 180 days of either: a) the date of diagnosis; or b) the date of admission for receipt of any part of the first course of therapy provided in that facility, whichever is later.

Interpretation of OAR 333-010-0040(4)-(6)

Completeness – Data must be assessed for completeness and accuracy prior to being transmitted to OSCaR. The data must meet rigid data quality standards for acceptance by OSCaR into the central registry database. Numerous quality control mechanisms are available to the health care reporting facility to meet expectations for data quality prior to submission to the central registry.

The validity of reported statistics depends on the completeness of cancer reporting, i.e. the degree to which all required cases are reported to OSCaR. To achieve data completeness, data are assessed by various methods. It is ultimately OSCaR's responsibility to verify that all facilities are reporting all appropriate cases, and to take corrective action when problems are discovered.

Accuracy - The purpose of OSCaR is to provide accurate cancer data to cancer control programs, the medical community, researchers, and the citizens of Oregon. Data accuracy is the extent to which the submitted data have been appropriately coded and match with the information contained in the patient’s health record. Even the most experienced cancer registrar can make mistakes; random errors are expected in any large data collection system. With the implementation of effective quality assurance tools, OSCaR seeks to maximize accuracy in cancer data reporting. OSCaR encourages each staff member involved in cancer data collection to be a certified cancer registrar (CTR) through the National Cancer Registrars Association. (see Appendix J for contact information)

Timeliness - Timeliness of data depends upon timely reporting. Timeliness is determined by the time it takes each reporting facility to submit reportable cases to the registry. Oregon Administrative Rules address the need for timely reporting by requiring that each case be submitted to the central registry within 180 days of either the date of diagnosis, or the date of admission for receipt of any part of the first course of therapy provided in that facility, whichever is later. In order to ensure timely reporting, please consult the case submission schedule:

CASE SUBMISSION SCHEDULE

DATE OF DIAGNOSIS OR ADMISSION FOR TREATMENT	MONTH TO SUBMIT CASE BY
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

Quality Assurance Representative

Each reporting facility is assigned a Quality Assurance Representative from the OSCaR quality control team. This representative acts as a liaison between the reporting facility and central registry. The OSCaR representative is available to assist the cancer reporting facility with quality control issues through consultation, training, and problem resolution. This OSCaR representative also reviews all submitted data files from the assigned facility. The flow of data and the quality control process is detailed in **Figure A** at the end of this section.

Electronic Data Edits

Electronic data edits are valuable tools used to improve data quality by standardizing the way coded data are checked for validity. It is imperative to incorporate an electronic data-editing program into registry software in each facility. The edit programs should use current standard NAACCR edit metafiles. OSCaR maintains a customized edit set that detects errors, edits failures, and discrepancies. These edits identify many coding issues that must be corrected before data are incorporated into the central registry database. The “Oregon Edit Set” is available from software vendors for use with facility cancer reporting software systems.

Submitted data that do not pass required edits will be withheld from incorporation into the OSCaR database and may be returned to the reporting facility for corrections and re-submission.

Visual Review

Abstracted data should be visually reviewed by the reporting facility before data is submitted to the central registry. Visual review consists of comparing assigned codes with text documentation. Reporting facilities should review 10% or more of their total abstracts for accuracy on a continual basis. The following are examples of visual review comparisons: birth date to age; sex to first name; sex to gender-specific primary site; and primary site and histology to text documentation to verify the new primary. Dates of diagnosis, admission, and treatment should be compared to ensure the appropriate chronology. Text documentation should be compared to codes for site, histology, stage of disease, and treatment to ensure accuracy of codes.

Continuing Education

A necessary element of the quality assurance plan includes staying informed of requirements, regulations, and guidelines. Cancer data reporters must stay current with the requirements of four major standard setters; National Program of Cancer Registries (NPCR), American College of Surgeons (ACoS), North American Association of Central Cancer Registries (NAACCR), and Surveillance Epidemiology and End Results (SEER). The standards for data collection undergo changes over time. To ensure that data items are collected correctly, awareness of the official implementation dates for various coding references is needed. New requirements call for proper planning for implementation and evaluation. Instituting an internal and/or external mentoring program for new and

experienced registrars is good quality control practice. Other ways to stay current and plan for future changes include participating in state and national workshops and web-based educational programs, and accessing current professional publications. The central registry is always willing to assist, advise, and provide education to reporting facilities in appropriate quality assurance procedures.

Feedback Reports

Reporting facilities receive regular feedback reports that contain resolved edits and errors that have been identified and corrected. It is important for facilities to thoroughly review these reports on a regular basis. By reviewing these reports, reporting facilities can often avoid future data issues. Facilities can use feedback reports as peer review on abstracted data in their internal quality control program, and as a tool for ongoing staff education and training.

Each reporting health facility should design, document, and implement procedures to assure that high quality data is being submitted to the central registry. The central registry staff is always willing to assist and advise reporting facilities on appropriate quality assurance procedures and ongoing changes.

SECTION 2

QUALITY ASSURANCE GUIDE FOR OSCaR

This section provides a summary of the quality control measures OSCaR performs *after* the data is received at the central registry. This section will develop a further understanding of the processes utilized by the OSCaR quality control staff to assure quality data.

The Oregon legislature included mandatory control mechanisms in the cancer reporting statute to ensure high quality data. Following is an excerpt and interpretation of an Oregon Administrative Rule supporting the state statute:

***Administrative Rule (excerpt): OAR 333-010-0040
(see Appendix A for complete Rule)***

Quality Standards

- *The usefulness of central registry data is directly dependent upon the accuracy, completeness, and timeliness of the data available in its database. ORS 432.500 – 432.990 directs the Division to establish a quality control program for the data reported to the state registry. In order to assess these aspects of quality for cancer reporting, the central registry will institute a program of continuous quality improvement.*
- *(1) The continuous quality improvement system shall include, but is not limited to, coding edits, completeness audits or checks, reabstracting audits, and statistical mechanisms to estimate data accuracy, validity, and reliability.*

Section 2 of the quality assurance chapter explains the continuous quality improvement procedures for OSCaR. The OSCaR quality assurance system incorporates guidelines and recommendations from CoC, NAACCR and NPCR.

One way to organize this overview of the quality assurance system is to follow submitted data as they are processed in the central registry and to explain the quality assurance activities that take part at each step along the way.

DATA FLOW AND QUALITY ASSURANCE REVIEW

Initial File Receipt

In the first step of the process, OSCaR receives data files from reporting facilities via email or disk. After receiving the files, the Database Specialist downloads each file, checks for downloading errors or file corruption problems, and adds the cases to a facility-specific subsystem in Rocky Mountain Cancer Data System (RMCDs). RMCDs

is the central registry oncology database that houses OSCaR cancer data. Once a file is added to the appropriate subsystem, the Oregon Edit Set is run on the newly received cases to check for data errors and inconsistencies. All files in facility-specific subsystems are kept in those subsystems until the Database Specialist forwards the files to the Cancer Data Specialist assigned to that facility.

The Database Specialist provides immediate feedback on file transmission and downloads through regular email communication. The Oregon Hospital Edit Set is run on incoming files, and the edit report is sent to the submitting facility for correction. Additionally, each facility receives a monthly feedback letter from the Database Specialist stating what files were received and how many cases were added to the database.

QA PROCEDURES ON SUBMITTED DATA

Computer Edits

Computer data edits are logical rules that are applied to all records to check for item validity, internal consistency, and inter-record consistency. They are based on single-field and multifield data items. The “Oregon customized Edit Program” is a detailed computer edit set that is run on submitted files to detect errors and discrepancies. The error messages are important for those people correcting errors and interpreting data. Edits are based on the NAACCR Metafile and subsequent logic. When the error summary report has finished running, the summary is reviewed and assessed by the cancer data specialist. If the percentage of errors is outside of the acceptable error threshold, the file may be returned to the reporting facility for error resolution and re-submission. For detailed information on computer edits, see NAACCR Standards for Cancer Registries, Volume III, Section II.A4: Edits and Data Processing Capabilities for Data Quality; and Section II.B1.b (3): Standards for Data Edits.

Visual Review of Sample

The visual review process occurs on all cases submitted to OSCaR. The computer edits can identify the majority of coding discrepancies; however, a computer is unable to compare codes to text. The codes on the abstract for a specific data item may be one of the allowable choices, but the code must be visually compared with the accompanying text to verify the correctness of the submitted data. OSCaR performs either a random sample or 100% visual review of all cases in the file. The percentage of cases selected for visual review depends on various factors. These factors include, but are not limited to, reporter experience, previous reporting history, and rule and guideline changes. Cases are reviewed for adequate demographic information, site/histology validity, grade, and staging and treatment data. OSCaR also incorporates mechanisms to review documentary text with the coded data. The central registry QA team has implemented an ongoing plan that focuses on problem areas, and the registry may choose cases to review that have the greatest impact on data quality. New rule and guideline changes can also dictate percentage of cases chosen for visual review.

Feedback Reports

Cancer data specialists prepare “feedback reports” that consist of resolved edits, and errors that have been identified and corrected. These reports may also include the Oregon Edit Set Summary report inquiries to the facility, and requests for additional information needed to correct discrepancies.

Reconciliation and Editing Discrepancies

As noted in the feedback report summary, facilities may be requested to obtain additional data to resolve edits or errors. After files have been cleared of all errors and discrepancies, they are given to the OSCaR Program Coordinator who moves files out of the hospital subsystem and merges the data into the main OSCaR database. OSCaR cancer data specialists are available to all reporting facilities to answer and research questions related to the quality control process.

QA Procedures on Consolidated (Merged) Data

Many different reports are generated from the merged data files. All generated reports are fully reviewed. When a case is merged into the Main database, registry software checks for duplicate case submissions and/or new primaries that are being reported on a previously reported patient. Any patients that have previous primaries in the database or have cases that have merged with another hospital case will be printed on a report for the OSCaR CTR to review. Visual review of these cases helps to determine primary site differences, which may verify a second primary. When another primary is identified these cases need to meet the criteria of a new primary and not a progression of disease. This has an effect on the correct coding of sequence numbers, so that field will also need to be verified or changed if necessary on multiple reports. If the first case identifies the primary site as the left lung and the second case identifies the primary site as the prostate, visual review of the case reports may confirm two primary sites; however, review might reveal that a metastatic site was submitted as a second primary and should not be added to the central registry database.

When the central registry verifies treatment data from multiple reports, it is important to compare diagnosis dates and treatment dates. The differences in dates may indicate the treatment recorded was not first course treatment and should not be added to the consolidated file. But usually, we consolidate all treatment information into one case so that we have a full summary of the patient’s diagnosis, treatment, and most current follow-up information.

Visual editing of multiple case reports is a critical function and is performed when manual review consolidation is required. Caution is taken to prevent duplicate records, so if a case on the same patient is submitted from two different reporting facilities, the two cases will be merged into one consolidated record. The consolidated case will include all information from both reporting facilities. This enables OSCaR to obtain information on cases from multiple sources, which furthers our goal of having accurate and complete data.

Other Quality Assurance Activities

The OSCaR Quality Assurance Program encompasses many other areas in addition to case review. They include:

- Reabstracting Audits in the reporting facility to assess quality of submitted data;
- Casefinding Audits in the reporting facility to review source documents for evaluating completeness of reporting;
- Monthly linkage with Death Certificate Database;
- Other linkage, analysis, and research projects;
- Preparation for NAACCR and NPCR-CSS data submissions, including missing and unknown data;
- Protocol for identifying and resolving duplicate records;
- Evaluation of missing or unknown data;
- Training workshops, including new regulations and guidelines, and the most common discrepancies.

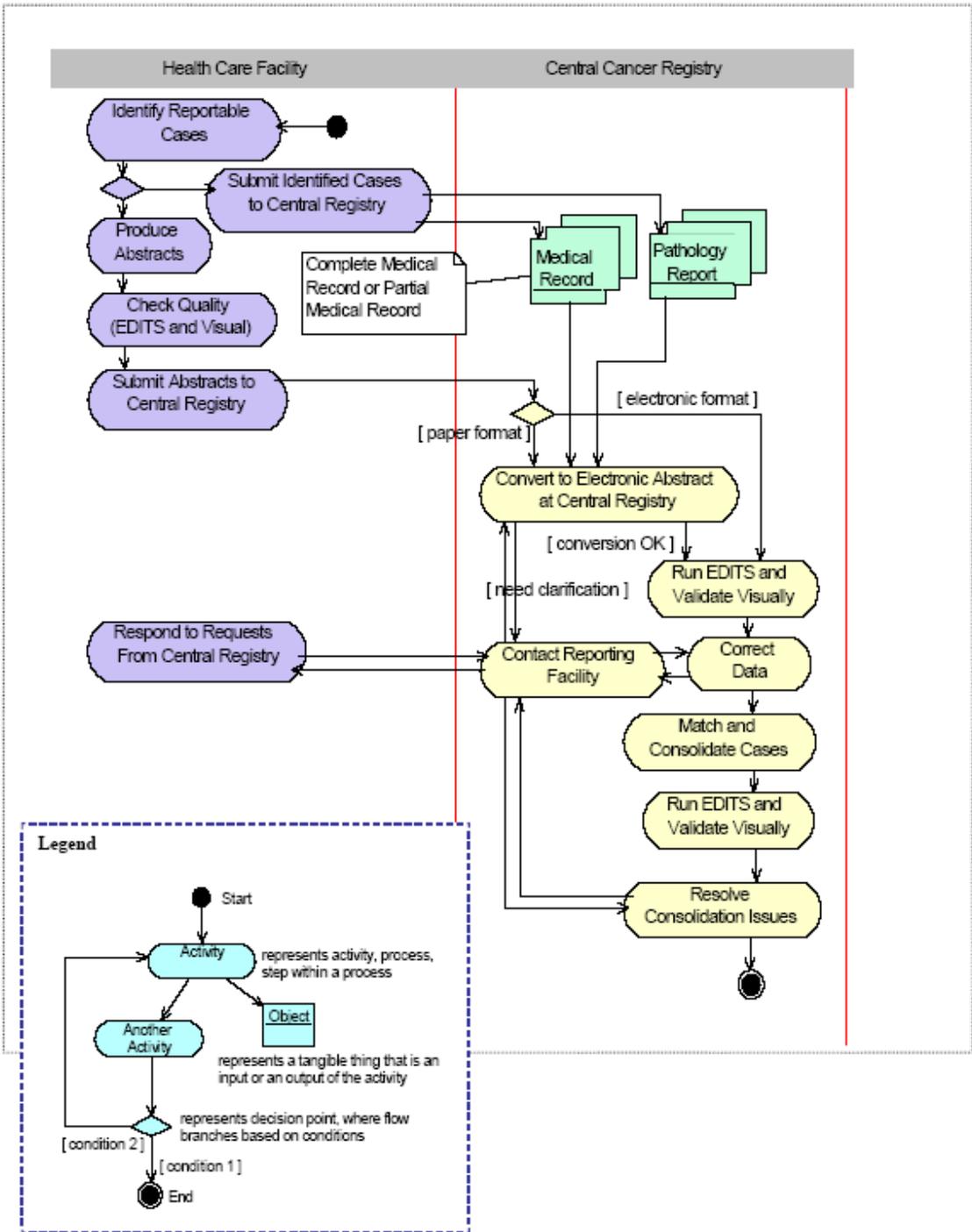
Continuing Education for OSCaR Staff

Regular training is an important component of cancer data collection. OSCaR participates in continuing education opportunities in order to remain current in the cancer registry field, and to enhance the skills of OSCaR staff.

OSCaR CTRs are required to complete 20 continuing education credits every 2 years to maintain their CTR certification, and they meet this requirement by attending trainings throughout the year. This continuing education includes NCRA trainings, CDC webinars, and any relevant trainings that are available. At least one OSCaR staff member attends the annual NCRA conference, and the entire staff attends the OCRA/OSCaR Fall Workshop. OSCaR staff has recently attended the CDC-NPCR Education and Training Sessions about collecting high quality cancer surveillance data.

Additionally, our Education Training Coordinator attends “Train the Trainer” sessions, which include updates and issues relevant to the field. The Coordinator then trains OSCaR staff members who in turn train hospital staff. OSCaR staff members meet weekly to discuss issues that are pertinent to our work in the registry.

Figure A: NAACCR Data Reporting Flow Chart



VI. Data Dictionary

DATA DICTIONARY OVERVIEW

This section provides information on the data items collected in the OSCaR data set. The OSCaR data set follows nationally accepted protocols as described in the **NAACCR Standards for Cancer Registries, Volumes I and II**. A summarized list of OSCaR required data items, and the NAACCR Required Status Table, is in Appendix B. Data items included in the data set are used by both central registries and hospital registries, and ensure that definitions and codes used are standard and consistent with those used by national databases.

In an effort to eliminate duplication of the *FORDS Manual*, this section will not include all codes; rather it will provide reference to relevant pages in the *FORDS Manual* and other resource materials for each data item. Accurate coding of data items according to codes and coding instructions in resource manuals will provide Oregon's cancer registries and OSCaR with meaningful data that can be compared to data from other local, state, and national databases.

In a central registry, supporting text is often needed to resolve any coding discrepancies, and is most useful when consolidating multiple abstracts from different facilities on an individual patient.

A written description of procedures and staging provides a complete picture of the cancer from the primary site to any extension or metastatic involvement of other sites. A precise documentation of pertinent examinations, radiologic tests, operative and pathological findings will support the summary stage. Standard abbreviations are recommended in recording data and are located in Appendix G. Due to limited space, be sure to document only information that is pertinent to the cancer.

NAACCR CASE RECORD LAYOUT, VERSION 11

Appendix H provides the complete NAACCR record layout, version 11. This record layout is to be used for cases diagnosed on or after January 1, 2006. NAACCR case record layout, version 10.2 is to be used for cases diagnosed prior to January 1, 2006.

DATA DICTIONARY INDEX, ALPHABETICAL BY DATA ITEM

Abstracted by	VI-3	Primary Site	VI-23
Accession Number-Hosp	VI-3	Race 1	VI-23
Addr at DX-City	VI-3	Race 2	VI-24
Addr at DX-No & Street	VI-4	Race 3	VI-24
Addr at DX-Postal Code	VI-4	Race 4	VI-24
Addr at DX-State	VI-5	Race 5	VI-24
Addr at DX-Supplemental	VI-5	RAD-Regional RX Modality	VI-25
Addr Current-No & Street	VI-6	Reason for No Surgery	VI-25
Age at Diagnosis	VI-7	Reporting Facility	VI-26
Behavior Code ICD-O-3	VI-7	RX Coding System-Current	VI-26
Birth Date	VI-7	RX Summ-BRM	VI-26
Birthplace	VI-7	RX Summ-Chemo	VI-27
Casefinding Source	VI-8	RX Summ-Hormone	VI-27
Class of Case	VI-9	RX Summ-Other	VI-28
County at DX	VI-10	RX Summ-Scope REG LN SUR	VI-28
CS Extension	VI-10	RX Summ-SURG OTH REG/DIS	VI-28
CS Lymph Nodes	VI-11	RX Summ-SURG PRIM SITE	VI-29
CS Mets at DX	VI-11	RX Summ-SURG/RAD SEQ	VI-29
CS Reg Node Eval	VI-12	RX Summ-Systemic SUR SEQ	VI-29
CS Site-Specific Factor 1	VI-13	RX Summ-TRANSPLNT/ENDOCR	VI-30
CS Site-Specific Factor 3	VI-13	RX Text-BRM	VI-30
CS Tumor Size	VI-14	RX Text-Chemo	VI-31
CS Tumor Size/Ext Eval	VI-14	RX Text-Hormone	VI-33
CS Version 1st	VI-15	RX Text-Other	VI-34
CS Version Latest	VI-16	RX Text-Radiation (Beam)	VI-35
Date of 1st Contact	VI-16	RX Text-Radiation Other	VI-37
Date of 1st CRS RX-COC	VI-17	RX Text-Surgery	VI-38
Date of Diagnosis	VI-17	Sequence Number-Hospital	VI-40
Date of Last Contact	VI-17	Sex	VI-40
Diagnostic Confirmation	VI-17	Social Security Number	VI-40
Grade	VI-18	Spanish/Hispanic Origin	VI-41
Histologic Type ICD-O-3	VI-18	Text-DX Proc-Lab Tests	VI-41
Laterality	VI-19	Text-DX Proc-OP	VI-43
Medical Record Number	VI-19	Text-DX Proc-Path	VI-44
Name-Alias	VI-19	Text-DX Proc-PE	VI-45
Name-First	VI-20	Text-DX Proc-Scopes	VI-47
Name-Last	VI-20	Text-DX Proc-X-Ray/Scan	VI-48
Name-Maiden	VI-20	Text-Histology Title	VI-50
Name-Middle	VI-21	Text-Primary Site Title	VI-51
NPI-Physician-Follow-Up	VI-21	Text-Staging	VI-52
NPI-Reporting Facility	VI-21	Text-Usual Industry	VI-53
Patient ID Number	VI-22	Text-Usual Occupation	VI-54
Physician-Follow-Up	VI-22	Type of Reporting Source	VI-55
Primary Payer at DX	VI-22	Vital Status	VI-56

E ABSTRACTED BY

Alternate Name	Item #	Length	Source of Standard	Column #
	570	3	COC	413-415

Description

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

Coding Instructions

See *FORDS Manual, Case Administration Section*, for coding instructions.

ACCESSION NUMBER-HOSP

Alternate Name	Item #	Length	Source of Standard	Column #
Accession Number	550	9	COC	402-410

Description

Unique number assigned by the hospital registry to identify the patient. The first four digits identify the year (in the format CCYY) the patient was first seen at the institution for the diagnosis or treatment of cancer. The first four digits must be greater than or equal to 1944.

The last five numbers are the numeric order in which the registry entered the case into the database. Within a registry, all primaries for an individual must have the same accession number.

Rationale

Hospitals use this number to identify cases. If the central registry preserves this number, they can refer to it when communicating with the hospital. It also provides a way to link computerized follow-up reports from hospitals into the central database.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for coding instructions.

ADDR AT DX—CITY

Alternate Name	Item #	Length	Source of Standard	Column #
City or Town (pre-96)	70	20	COC	52-71
City/Town at Diagnosis				

Description

Name of the city in which the patient resides at the time the reportable tumor was diagnosed. If the patient resides in a rural area, record the name of the city used in their mailing address. If the patient has multiple primaries, the city of residence may be different for each primary.

Codes (in addition to valid street address)

UNKNOWN Patient's address is unknown

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

ADDR AT DX—NO & STREET

Alternate Name	Item #	Length	Source of Standard	Column #
Patient Address (Number and Street) at Diagnosis Number and Street (pre-96)	2330	40	COC	2108-2147

Description

The number and street address or the rural mailing address of the patient's residence at the time the reportable tumor was diagnosed. If the patient has multiple tumors, address at diagnosis may be different for each tumor. Additional address information such as facility, nursing home, or name of apartment complex should be entered in item (2335) Addr at DX-Supplemental.

U.S. addresses should conform to the USPS Postal Addressing Standards. These standards are referenced in USPS Publication 28, November 2000, *Postal Addressing Standards* (located at <http://pe.usps.gov/text/pub28/welcome.htm>). Canadian addresses should conform to the *Canada Postal Guide* (located at <http://www.canadapost.ca/tools/pg/manual/b03-e.asp>).

Rationale

Addresses that are formatted to conform to U.S. Postal Service (USPS) Postal Addressing Standards can be more properly geocoded by geographic information systems (GIS) software and vendors to the correct census tract, which is required by NPCR and SEER registries. The USPS Standards also address a number of issues that are problematic in producing precise addresses, including the use of punctuation, abbreviations, and proper placement of address elements, such as street direction, apartment and suite numbers, and unusual addressing situations.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

ADDR AT DX—POSTAL CODE

Alternate Name	Item #	Length	Source of Standard	Column #
Postal Code at Diagnosis Zip Code (pre-COC)	100	9	COC	74-82

Description

Postal code for the address of the patient's residence at the time the reportable tumor is diagnosed. If the patient has multiple tumors, the postal code may be different for each tumor.

For U.S. residents, use either the five-digit or the extended nine-digit ZIP code. Blanks follow the five-digit code.

For Canadian residents, use the six-character alphanumeric postal code. Blanks follow the six-character code.

When available, enter the postal code for other countries.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

ADDR AT DX—STATE

Alternate Name	Item #	Length	Source of Standard	Column #
State (pre-96) State at Diagnosis	80	2	COC	72-73

Description

USPS abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory in which the patient resides at the time the reportable tumor is diagnosed. If the patient has multiple primaries, the state of residence may be different for each tumor.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

ADDR AT DX—SUPPLEMENTAL

Alternate Name	Item #	Length	Source of Standard	Column #
Patient Address at Diagnosis-Supplemental	2335	40	COC	2148-2187

Description

This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex.

U.S. addresses should conform to the USPS Postal Addressing Standards. These standards are referenced in USPS Publication 28, November 2000, *Postal Addressing Standards* (located at <http://pe.usps.gov/text/pub28/welcome.htm>). Canadian addresses should conform to the *Canada Postal Guide* (located at <http://www.canadapost.ca/tools/pg/manual/b03-e.asp>).

Rationale

Sometimes the registry receives the name of a facility instead of a proper street address containing the street number, name, direction, and other elements necessary to locate an address on a street file for the purpose of geocoding. By having a second street address field to hold address information, the registry can look up and store the street address and not lose the facility name due to a shortage of space.

Addresses that are formatted to conform to USPS Postal Addressing Standards can be more properly geocoded by GIS software and vendors to the correct census tract, which is required by NPCR and SEER registries. The USPS Standards also address a number of issues that are problematic in

producing precise addresses, including the use of punctuation, abbreviations, and proper placement of address elements, such as street direction, apartment and suite numbers, and unusual addressing situations. Upper case recommended. Mixed case allowed.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for coding instructions.

ADDR CURRENT—NO & STREET

Alternate Name	Item #	Length	Source of Standard	Column #
Patient Address (Number and Street)--Current	2350	40	COC	2188-2227

Description

The number and street address or the rural mailing address of the patient's current usual residence. This can be used to generate a follow-up inquiry, and must correspond to other fields in the current address. If the patient has multiple tumors, the current address should be the same. Additional address information such as the facility, nursing home, or name of apartment complex should be entered in item (2355) Addr Current-Supplemental.

U.S. addresses should conform to the USPS Postal Addressing Standards. These standards are referenced in USPS Publication 28, November 2000, *Postal Addressing Standards* (located at <http://pe.usps.gov/text/pub28/welcome.htm>). Canadian addresses should conform to the *Canada Postal Guide* (located at <http://www.canadapost.ca/tools/pg/manual/b03-e.asp>).

Rationale

“Current address” can be used to measure the regional cancer burden, especially in major retirements regions. Sometimes central registries can carry out follow-up by contacting the patients via letter or telephone calls to ascertain their vital status. This information is also useful for conducting interview studies. Specific to OSCaR, the patient's current address is used for the patient notification process.

Addresses that are formatted to conform to USPS Postal Addressing Standards can be more properly geocoded by GIS software and vendors to the correct census tract, which is required by NPCR and SEER registries. The USPS Standards also address a number of issues that are problematic in producing precise addresses, including the use of punctuation, abbreviations, and proper placement of address elements, such as street direction, apartment and suite numbers, and unusual addressing situations.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for coding instructions.

AGE AT DIAGNOSIS

Alternate Name	Item #	Length	Source of Standard	Column #
	230	3	SEER/COC	119-121

Description

Age of the patient at diagnosis in complete years. Different tumors for the same patient may have different values.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

BEHAVIOR CODE ICD-O-3

Alternate Name	Item #	Length	Source of Standard	Column #
Behavior Code	523	1	SEER/COC	305-305

Description

Code for the behavior of the tumor being reported using ICD-O-3. NAACCR adopted ICD-O-3 as the standard coding system for cases diagnosed beginning January 1, 2001.

Coding Instructions

See ICD-O-3, page 66, for codes and coding instructions.

BIRTH DATE

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Birth	240	8	SEER/COC	122-129

Description

Date of birth of the patient. The birthdate is recorded in month, day, year format (MMDDYYYY). A zero must precede single-digit months and days. Estimate date of birth when information is not available. It is better to estimate than to code as an unknown value.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for coding instructions.

BIRTHPLACE

Alternate Name	Item #	Length	Source of Standard	Column #
Place of Birth	250	3	SEER/COC	130-132

Description

Code the place of birth of the patient. If a patient has multiple tumors, all records should contain the same code.

Rationale

Place of birth is helpful for patient matching and can be used when reviewing race and ethnicity. In addition, adding birthplace data to race and ethnicity allows for more specific definition of the population being reported. Careful descriptions of ancestry, birthplace, and immigration history of populations studied are needed to make the basis for classification into ethnic groups clear. Birthplace has been associated with variation in genetic, socioeconomic, cultural, and nutritional characteristics that affect patterns of disease. A better understanding of the differences within racial and ethnic categories also can help states develop effective, culturally sensitive public health prevention programs to decrease the prevalence of high-risk behaviors and increase the use of preventive services.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for coding instructions.

Note: This item is not required for cases diagnosed January 1, 2004 or later (see derived)

CASEFINDING SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
	501	2	NAACCR	322-323

Description

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

Rationale

This data item will help reporting facilities as well as regional and central registries in prioritizing their casefinding activities. It will identify reportable tumors that were first found through death clearance or sources other than traditional reporting facilities. It provides more detail than “Type of Reporting Source.”

Coding Instructions

This variable is intended to code the source that first identified the tumor. Determine where the case was first identified and enter the appropriate code. At the regional or central level, if a hospital and non-hospital source identified the case independently of each other, enter the code for the non-hospital source (i.e., codes 30-95 have priority over codes 10-29). If the case was first identified at a reporting facility (codes 10-29), code the earliest source (based on patient or specimen contact at the facility) or identifying information.

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

abstracted. If a regional or central registry identifies a case and asks a reporting facility to abstract it, enter the code that corresponds to the initial source, not the code that corresponds to the eventual reporting facility.

Codes

Case first identified at a reporting facility:

- 10 Reporting Hospital, NOS
- 20 Pathology Department Review (surgical pathology reports, autopsies, or cytology reports)
- 21 Daily Discharge Review (daily screening of charts of discharged patients in the medical records department)
- 22 Disease Index Review (review of disease index in the medical records department)
- 23 Radiation Therapy Department/Center
- 24 Laboratory Reports (other than pathology reports, code 20)
- 25 Outpatient Chemotherapy
- 26 Diagnostic Imaging/Radiology (other than radiation therapy, codes 23; includes nuclear medicine)
- 27 Tumor Board
- 28 Hospital Rehabilitation Service or Clinic
- 29 Other Hospital Source (including clinic, NOS or outpatient department, NOS)
- 30 Physician-Initiated Case
- 40 Consultation-only or Pathology-only Report (not abstracted by reporting hospital)
- 50 Independent (non-hospital) Pathology-Laboratory Report
- 60 Nursing Home-Initiated Case
- 70 Coroner's Office Records Review
- 75 Managed Care Organization (MCO) or Insurance Record
- 80 Death Certificate (case identified through death clearance)
- 85 Out-of-State Case Sharing
- 90 Other Non-Reporting Hospital Source
- 95 Quality Control Review (case initially identified through quality control activities such as casefinding audit of a regional or central registry)
- 99 Unknown

CLASS OF CASE

Alternate Name	Item #	Length	Source of Standard	Column #
	610	1	COC	440-440

Description

For a hospital registry, cases divide into two groups: analytic cases are those included in reports on patient treatment and outcomes; non-analytic cases are those not included in such reports. Class of Case codes 0-2 identify cases that are analytic (i.e., cases that were first diagnosed and/or received all or part of their first course of treatment or had treatment planned at the reporting hospital). Class of Case 3-5, 7, 8, and 9 identify cases that are non-analytic (i.e., were first diagnosed and received all of their first part of treatment at a facility other than the reporting institution, or were diagnosed at

autopsy or by death certificate only). Class of Case 6 identifies cases that were first diagnosed and received their entire first course of treatment in a staff physician's office. For diagnosis dates on or after January 1, 2000, these cases are considered non-analytic.

Class of Case can be used in conjunction with item 500 (Type of Reporting Source). Type of Reporting Source is used to document the source of documents used to abstract the cancer being reported.

Coding Instructions

See *FORDS Manual, Cancer Identification Section*, for codes and coding instructions.

COUNTY AT DX

Alternate Name	Item #	Length	Source of Standard	Column #
County at Diagnosis	90	3	FIPS/SEER	83-85

Description

Code for the county of the patient's residence at the time the tumor was diagnosed. For U.S. residents, standard codes are those of the FIPS publication, "Counties and Equivalent Entities of the United States, It's Possessions, and Associated Areas." If the patient has multiple tumors, the county codes may be different for each tumor.

COC uses the geocodes for residents of other countries. Detailed standards have not been set for Canadian provinces/territories. Use code 998 for non-Oregon residents.

Note: See Appendix F for standard FIPS county codes.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

CS EXTENSION

Alternate Name	Item #	Length	Source of Standard	Column #
	2810	2	AJCC	632-633

Description

This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. It is based on and replaces EOD—Extension (790) and EOD—Extension Prost Path (800). This modification for CS is collapsible into AJCC T code according to the sixth edition of *AJCC Cancer Staging Manual*. "CS Extension" identifies the primary tumor growth within the organ of origin or its extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in the CS Extension field.

Site-specific codes provide extensive detail describing disease extent. "CS Extension" is used to derive the Derived AJCC T [2940], Derived AJCC Stage Group [3000], Derived SS1977 [3010], and Derived SS2000 [3020] codes.

Rationale

CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all the participating standard setters. CS incorporates all the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR records for these outputs.

CS LYMPH NODES

Alternate Name	Item #	Length	Source of Standard	Column #
	2830	2	AJCC	635-636

Description

This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. It is based on and replaces EOD—Lymph Node Involv [810]. This modification for CS is collapsible into AJCC N code according to the sixth edition of *AJCC Cancer Staging Manual*. “CS Lymph Nodes” is site-specific and identifies the regional lymph nodes involved with cancer at the time of diagnosis.

Site-specific codes provide extensive detail describing disease extent. “CS Lymph Nodes” is used to derive the Derived AJCC N [2960], Derived AJCC Stage Group [3000], Derived SS1977 [3010], and Derived SS2000 [3020] codes.

Rationale

CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all the participating standard setters. CS incorporates all the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR records for these outputs.

Codes

See the *Collaborative Staging Manual and Coding Instructions*, Version 1.0, for site-specific codes and coding rules.

CS METS AT DX

Alternate Name	Item #	Length	Source of Standard	Column #
CS Metastasis at Diagnosis	2850	2	AJCC	638-639

Description

This belongs to the set of Collaborative Staging (CS) data items and is part of the detailed site-specific codes for anatomic EOD effective with 2004 diagnosis. It replaces data items 1090, 1100, and 1110 (Site of Distant Met 1-3). This modification for CS is collapsible into AJCC M code according to the

sixth edition of *AJCC Cancer Staging Manual*. “CS Metastasis at Diagnosis” identifies the site(s) of metastatic involvement at time of diagnosis.

Site-specific codes provide extensive detail describing disease extent. “CS Mets at DX” is used to derive the Derived AJCC M [2980], Derived AJCC Stage Group [3000], Derived SS1977 [3010], and Derived SS2000 [3020] codes.

Rationale

CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all the participating standard setters. CS incorporates all the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR records for these outputs.

Codes

See the *Collaborative Staging Manual and Coding Instructions*, Version 1.0, for site-specific codes and coding rules.

CS REG NODE EVAL

Alternate Name	Item #	Length	Source of Standard	Column #
CS Regional Nodes Evaluation	2840	1	AJCC	637-637

Description

This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. “CS Reg Node Eval” records how the code for the item “CS Lymph Nodes” [2830] was determined based on the diagnostic methods employed.

This data item is used in CS to identify whether the N (of AJCC TNM) was clinically or pathologically diagnosed and by what method “CS Reg Nodes Eval” is used to derive the Derived AJCC N Descriptor [2970].

Rationale

CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all the participating standard setters. CS incorporates all the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR records for these outputs.

Codes

See the *Collaborative Staging Manual and Coding Instructions*, Version 1.0, for site-specific codes and coding rules.

CS SITE-SPECIFIC FACTOR 1

Alternate Name	Item #	Length	Source of Standard	Column #
	2880	3	AJCC	641-643

Description

This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. The “CS Site-Specific Factor” items (1-6) are used to code additional site-specific information needed to derive TNM or AJCC stage, or to code prognostic factors that have an effect on stage or survival. Some site-specific information that was formerly recorded in “EOD—Tumor Size” [780] (Breslow’s Thickness for melanoma; HIV/AIDS status for lymphoma) is now also in “CS Site-Specific Factor” items. Many site-specific schemas do not use any of the Site-Specific Factors; other schemas use from 1 to all 6 of the factors.

Rationale

CS Site Specific Factors provide an optional area for coding information needed for stage. CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all the participating standard setters. CS incorporates all the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR records for these outputs.

Codes

See the *Collaborative Staging Manual and Coding Instructions*, Version 1.0, for site-specific codes and coding rules.

CS SITE-SPECIFIC FACTOR 3

Alternate Name	Item #	Length	Source of Standard	Column #
	2900	3	AJCC	647-649

Description

This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. The “CS Site-Specific Factor” items (1-6) are used to code additional site-specific information needed to derive TNM or AJCC stage, or to code prognostic factors that have an effect on stage or survival. Some site-specific information that was formerly recorded in “EOD—Tumor Size” [780] (Breslow’s Thickness for melanoma; HIV/AIDS status for lymphoma) is now also in “CS Site-Specific Factor” items. Many site-specific schemas do not use any of the Site-Specific Factors; other schemas use from 1 to all 6 of the factors.

Rationale

CS Site Specific Factors provide an optional area for coding information needed for stage. CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all the participating standard setters. CS incorporates all

the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR records for these outputs.

Codes

See the *Collaborative Staging Manual and Coding Instructions*, Version 1.0, for site-specific codes and coding rules.

CS TUMOR SIZE

Alternate Name	Item #	Length	Source of Standard	Column #
	2800	3	AJCC	629-631

Description

This item belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. It is based on and replaces EOD—Tumor size [780]. For most cities, CS Tumor Size is used to record the largest dimension, or the diameter of the primary tumor in millimeters (for example: 1 mm = 001, 1 cm = 010). See the CS schemes for site-specific variants. For many sites, the CS algorithm uses this data item to derive the Derived AJCC T [2940] according to the sixth edition of *AJCC Cancer Staging Manual*.

Rationale

CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all the participating standard setters. CS incorporates all the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR records for these outputs.

Codes

See the *Collaborative Staging Manual and Coding Instructions*, Version 1.0, for site-specific codes and coding rules.

CS TUMOR SIZE/EXT EVAL

Alternate Name	Item #	Length	Source of Standard	Column #
CS Tumor Size/Extension Evaluation	2820	1	AJCC	634-634

Description

This belongs to the set of Collaborative Staging (CS) data items effective with 2004 diagnosis. “CS Tumor Site/Ext Eval” records how the codes for “CS Tumor Size” [2800] and “CS Extension” [2810] were determined based on the diagnostic methods employed. This data item is used in CS to identify

whether the T (of AJCC TNM) was clinically or pathologically diagnosed and by what method, “CS Tumor Size/Ext Eval” is used to derive the Derived AJCC T Descriptor [2950].

Rationale

CS is a group of data items set up by a joint task force including representatives from SEER, ACoS, CDC, NAACCR, NCRA, and AJCC, designed to provide a single uniform set of codes and rules for coding EOD/stage information to meet the needs of all the participating standard setters. CS incorporates all the fields from SEER 10-digit EOD, in a modified form, and adds several additional fields. When CS data items are coded, a computer algorithm allows generation of AJCC Sixth Edition TNM stage, SEER Summary Stage 1977, and SEER Summary Stage 2000. Separate CS fields are provided in the NAACCR records for these outputs.

Codes

See the *Collaborative Staging Manual and Coding Instructions*, Version 1.0, for site-specific codes and coding rules.

CS VERSION 1ST

Alternate Name	Item #	Length	Source of Standard	Column #
	2935	6	AJCC	705-710

Description

This item indicates the number of the version used to initially code CS fields. The CS version number is returned as part of the output of the CS algorithm. As long as the CS algorithm is run and the output values stored at the time of initial abstracting, the returned values from the program should be automatically stored as CS Version 1st. This item may be blank if the CS algorithm has not been run or if this field has not been implemented. When it is implemented, this data item should be entered at the time of the CS fields are first coded and the algorithm first applied. If the calculation algorithm is not called at the time of the initial abstracting, the CS Version 1st could also be entered manually by the abstractor.

It is not expected that this field would be updated every time a coded value is changed. However, the field should be available for future updating if, for example, the CS fields for certain records were to be systematically recoded for a special study using a later version, the CS Version 1st could be appropriately updated with the new version. The meaning and interpretation of CS Version 1st will be dependent on vendor implementation and local practices. This field should be interpreted with caution in a dataset where the actual coding procedures are unknown.

Codes

CS Version 1st is a 6-digit code. The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results (e.g., 010100).

CS VERSION LATEST

Alternate Name	Item #	Length	Source of Standard	Column #
	2936	6	AJCC	711-716

Description

This item indicates the number of the version of the CS used most recently to derive the CS output fields. This data item is recorded the first time the CS output fields are derived and should be updated each time the CS Derived items are re-computed. The CS version number is returned as part of the output of the CS algorithm. The returned value from the program should be automatically stored as CS Version Latest. This item should not be updated manually.

Codes

CS Version Latest is a 6-digit code. The first two digits represent the major version number; the second two digits represent minor version changes; and the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results (e.g., 010100).

This item should not be blank if the CS Derived items contain stored values. This item should be blank if the CS Derived items are empty or the CS algorithm has not been applied.

DATE OF 1ST CONTACT

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Adm/1 st Contact	580	8	COC	416-423

Description

Date of first patient contact, as inpatient or outpatient, with the reporting facility for the diagnosis and/or treatment of the tumor. The date may represent the date of an outpatient visit for a biopsy, x-ray, scan, or laboratory test.

Rationale

This item is used to assess and monitor the timeliness of reporting. Timeliness of abstracting (and reporting) is a concern for all standard-setting organizations and consequently, timeliness standards have been established. This item can be used in conjunction with the Date Case Report Received (2111) to measure timeliness of reporting by individual facilities to central cancer registries.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

DATE OF 1st CRS RX-COC

Alternate Name	Item #	Length	Source of Standard	Column #
Date of First Course Treatment Dat Started (pre-96)	1270	8	COC	843-850

Description

Date of initiation of the first cancer-directed therapy for the cancer being reported, using the COC definition of first course. The date of first treatment includes the date a decision was made not to treat the patient.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

DATE OF DIAGNOSIS

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Initial Diagnosis	390	8	SEER/COC	283-290

Description

Date of initial diagnosis by a recognized medical practitioner for the cancer being reported. For more discussion on determining date of diagnosis, consult the *FORDS Manual, Cancer Identification Section*.

DATE OF LAST CONTACT

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Last Contact or Death	1750	8	SEER/COC	1294-1301

Description

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

Rationale

Used for Date of Last Contact from active or passive follow-up. Used to record the date of death.

Coding Instructions

See *FORDS Manual, Outcomes Section*, for codes and coding instructions.

DIAGNOSTIC CONFIRMATION

Alternate Name	Item #	Length	Source of Standard	Column #
	490	1	SEER/COC	311-311

Description

Code for the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history.

Rationale

Diagnostic confirmation is useful to calculate rates based on microscopically confirmed cancers. Full incidence calculations must also include cases that are only confirmed clinically. The percentage of cases that are clinically diagnosed only is an indication of whether case finding is including sources outside of pathology reports.

Coding Instructions

See *FORDS Manual, Cancer Identification Section*, for codes and coding instructions.

GRADE

Alternate Name	Item #	Length	Source of Standard	Column #
Grade, Differentiation, or Cell Indicator Grade/Differentiation	440	1	SEER/COC	306-306

Description

Code for the grade or degree of differentiation of the reportable tumor. For lymphomas and leukemias, field also is used to indicate T-, B-, Null-, or NK-cell origin.

Note: Code 8 was adopted for use with lymphoma cases diagnosed in 1995 and later.

Codes

See the grade tables on page 67 of ICD-O-3. See also the *COC FORDS Manual* and the *SEER Program Code Manual*, Third Edition, for site-specific coding rules and conversions.

- 1 Grade I
- 2 Grade II
- 3 Grade III
- 4 Grade IV
- 5 T-cell
- 6 B-cell
- 7 Null cell
- 8 NK (natural killer) cell
- 9 Grade/differentiation unknown, not stated, or not applicable

HISTOLOGIC TYPE ICD-O-3

Alternate Name	Item #	Length	Source of Standard	Column #
	522	4	SEER/COC	301-304

Description

Codes for the histologic type of the tumor being reported using ICD-O-3. NAACCR adopted ICD-O-3 as the standard coding system for cases diagnosed in 2001 and later, and recommended that prior tumors be converted from ICD-O-2.

Coding Instructions

See ICD-O-3, Morphology Section, for histology codes.

LATERALITY

Alternate Name	Item #	Length	Source of Standard	Column #
Laterality at Diagnosis	410	1	SEER/COC	295-295

Description

Code for the side of a paired organ, or side of the body on which the reportable tumor originated. This applies to primary site only.

Coding Instructions

See *FORDS Manual, Cancer Identification Section*, for codes and coding instructions.

MEDICAL RECORD NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	2300	11	NAACCR	2086-2096

Data Type: Numeric

Status: Required (when available)

Description

Records medical record number used by the facility to identify the patient. The *FORDS Manual* instructs registrars to record numbers assigned by the facility's Health Information Management (HIM) Department.

Rationale

This number identifies the patient in a facility. It can be used by a central registry to point back to the patient record, and it helps identify multiple reports on the same patient.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for coding instructions.

NAME—ALIAS

Alternate Name	Item #	Length	Source of Standard	Column #
Alias	2280	15	SEER	2006-2020

Data Type: Alpha

Status: Required (when available)

Description

Records an alternate name or "AKA" (also known as) used by the patient, if known. Note that maiden name is entered in Name-Maiden [2390].

NAME—FIRST

Alternate Name	Item #	Length	Source of Standard	Column #
First Name	2240	14	NAACCR	1972-1985

Data Type: Alpha
Status: Required

Description

First name of the patient.

NAME—LAST

Alternate Name	Item #	Length	Source of Standard	Column #
Last Name	2230	25	NAACCR	1947-1971

Data Type: Alpha
Status: Required

Description

Last name of the patient.

Note: Last Name is required. The last name of the patient must be entered left justified with trailing blanks. Mixed case is allowed. Blanks, spaces, hyphens, apostrophes, and punctuation marks are allowed. The field may not be completely blank. If the last name is unknown, enter Unknown.

NAME—MAIDEN

Alternate Name	Item #	Length	Source of Standard	Column #
Maiden Name	2390	15	SEER	2021-2035

Data Type: Alpha
Status: Required (when available)

Description

Maiden name of female patients who have or have not been married.

Rationale

This is used to link reports on a woman who changed her name between reports. It is also critical when using Spanish surname algorithms to categorize ethnicity.

This field should be left blank if the maiden name 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.

NAME—MIDDLE

Alternate Name	Item #	Length	Source of Standard	Column #
Middle Name	2250	14	COC	1986-1999

Data Type: Alpha
Status: Required

Description

Middle name or, if middle name is unavailable, middle initial of the patient.

NPI—PHYSICIAN—FOLLOW-UP

Alternate Name	Item #	Length	Source of Standard	Column #
	2475	10	NAACCR	2605-2614

Description

The NPI (National Provider Identifier) code for the physician currently responsible for the patient's medical care.

NPI, a unique identification number for health care providers, is scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes large practices and large group providers will be required to use NPI codes by May 2007; small health plans will be required to use NPI codes by May 2008. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items.

Rationale

The NPI equivalent of Physician—Follow-Up [2470].

Codes

Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at:

<http://new.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIcheckdigit.pdf>

NPI—REPORTING FACILITY

Alternate Name	Item #	Length	Source of Standard	Column #
	545	10	NAACCR	372-381

Description

The NPI (National Provider Identifier) code for the facility submitting the data in the record.

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

required to use NPI codes by May 2008. When a facility starts to use the NPI codes, that information should be transmitted in the appropriate NPI data items.

Rationale

The NPI equivalent of Reporting Facility [540].

Codes

Only valid NPI assigned 10-digit numeric codes (9-digit number plus 1 check digit). The check digit algorithm is available at:

<http://new.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIcheckdigit.pdf>

PATIENT ID NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	20	8	OSCaR	2-9

Description

Unique number assigned to an individual patient by the central registry. The central registry will assign this same number to all of the patient's subsequent tumors (records).

Rationale

Provides the central registry with a unique identification number that will link all records for the same patient. The unique number also allows the central registry to identify the patient when there are multiple reports from different hospitals.

PHYSICIAN—FOLLOW-UP

Alternate Name	Item #	Length	Source of Standard	Column #
Following Physician	2470	8	COC	2563-2570

Description

Code for the physician currently responsible for the patient's medical care. OSCaR requires the use of the physician's medical license as prescribed by the Oregon Board of Medical Examiners.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

PRIMARY PAYER AT DX

Alternate Name	Item #	Length	Source of Standard	Column #
Primary Payer at Diagnosis	630	2	COC	445-446

Description

Primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

Rationale

This is used in financial analysis and as an indicator for quality and outcome analyses. The Joint Commission on Accreditation of Healthcare Organizations requires the patient admission page document the type of insurance or payment structure that will cover the patient while being cared for at the hospital.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

PRIMARY SITE

Alternate Name	Item #	Length	Source of Standard	Column #
	400	4	SEER/COC	291-294

Description

Code for the primary site of the tumor being reported using ICD-O-3.

Coding Instructions

See ICD-O-3, Topography Section, for the codes for primary site.

RACE 1

Alternate Name	Item #	Length	Source of Standard	Column #
Race	160	2	SEER/COC	103-104

Description

Code the patient's race. Race is coded separately from item 190 (Spanish/Hispanic Origin). All tumors for the same patient should have the same race code. If the patient is multiracial, code all races using items 161 (RACE 2) through item 164 (RACE 5).

Reference to Census 2000 definitions for ethnicity and race:

<http://www.census.gov/prod/cen2000/doc/sf2.pdf>

Rationale

Because race has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration, even if the state population does not include many of the race categories.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

RACE 2

Alternate Name	Item #	Length	Source of Standard	Column #
	161	2	SEER/COC	105-106

Note: If any race code (Race 2, 3, 4, and 5) is blank, all subsequent race codes must be blank. If more than the Race 1 code is entered, and if any race equals 99, then all race codes (Race 1, 2, 3, 4, and 5) must be 99. If more than the Race 1 code is entered, and if any race codes (for Race 2, 3, 4, and 5) are 88 (no further race documented), then all subsequent race codes also must be 88.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

RACE 3

Alternate Name	Item #	Length	Source of Standard	Column #
	162	2	SEER/COC	107-108

Note: If any race code (Race 2, 3, 4, and 5) is blank, all subsequent race codes must be blank. If more than the Race 1 code is entered, and if any race equals 99, then all race codes (Race 1, 2, 3, 4, and 5) must be 99. If more than the Race 1 code is entered, and if any race codes (for Race 2, 3, 4, and 5) are 88 (no further race documented), then all subsequent race codes also must be 88.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

RACE 4

Alternate Name	Item #	Length	Source of Standard	Column #
	163	2	SEER/COC	109-110

Note: If any race code (Race 2, 3, 4, and 5) is blank, all subsequent race codes must be blank. If more than the Race 1 code is entered, and if any race equals 99, then all race codes (Race 1, 2, 3, 4, and 5) must be 99. If more than the Race 1 code is entered, and if any race codes (for Race 2, 3, 4, and 5) are 88 (no further race documented), then all subsequent race codes also must be 88.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

RACE 5

Alternate Name	Item #	Length	Source of Standard	Column #
	164	2	SEER/COC	111-112

Note: If any race code (Race 2, 3, 4, and 5) is blank, all subsequent race codes must be blank. If more than the Race 1 code is entered, and if any race equals 99, then all race codes (Race 1, 2, 3, 4, and 5)

must be 99. If more than the Race 1 code is entered, and if any race codes (for Race 2, 3, 4, and 5) are 88 (no further race documented), then all subsequent race codes also must be 88.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

RAD—REGIONAL RX MODALITY

Alternate Name	Item #	Length	Source of Standard	Column #
Regional Treatment Modality	1570	2	COC	909-910

Description

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

Rationale

Radiation treatment frequently is delivered in two or more phases that can be summarized as regional and boost treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Coding Instructions

See *FORDS Manual, First Course of Treatment Section*, for codes and coding instructions.

REASON FOR NO SURGERY

Alternate Name	Item #	Length	Source of Standard	Column #
Reason for No Cancer-Directed Surgery	1340	1	SEER/COC	868-868
Reason for No CA Dir Surgery				
Reason for No Surgery to Primary Site				

Description

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

Rationale

This data item provides information related to the quality of care and describes why primary site surgery was not performed.

Coding Instructions

See *FORDS Manual, First Course of Treatment Section*, for codes and coding instructions.

REPORTING FACILITY

Alternate Name	Item #	Length	Source of Standard	Column #
Facility Identification Number (FIN) Reporting Hospital	540	10	COC	382-391

Description

Code for the facility reporting the case.

Rationale

Each facility's FIN is unique. The number is used to identify a reporting facility in the central registry database and is useful in monitoring data submission, ensuring the accuracy of data and identifying areas for special studies. The codes for this item are assigned by COC.

Coding Instructions

COC maintains the codes and are available on the American College of Surgeons web site at: <http://www.facs.org>.

Coding instructions are outlined in the *FORDS Manual, Case Administration Section*.

RX CODING SYSTEM—CURRENT

Alternate Name	Item #	Length	Source of Standard	Column #
	1460	2	NAACCR	888-889

Description

Code describing how treatment for the case now is coded.

Coding Instructions

See *FORDS Manual, Case Administration Section*, for codes and coding instructions.

RX SUMM—BRM

Alternate Name	Item #	Length	Source of Standard	Column #
Immunotherapy Biological Response Modifiers	1410	2	SEER/COC	882-883

Description

Records whether immunotherapeutic (biologic response modifiers) agents were administered as first-course treatment at this facility or the reason they were not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of immunotherapeutic agents as part of the first course of therapy.

Coding Instructions

See *FORDS Manual, First Course of Treatment Section*, for codes and coding instructions.

Note: For cases diagnosed on or after January 1, 2003, information on bone marrow transplants and stem cell transplants should be coded in the new field, item 3250 (RX Summ—Transplnt/Endocr). The COC standards for hospitals do not allow use of codes 02-06 in cases diagnosed on or after January 1, 2003.

RX SUMM—CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
Chemotherapy	1390	2	SEER/COC	878-879

Description

Codes for chemotherapy given as part of the first course of treatment or the reason chemotherapy was not given. Includes treatment given at all facilities as part of the first course.

Coding Instructions

See *FORDS Manual, First Course of Treatment Section*, for codes and coding instructions.

RX SUMM—HORMONE

Alternate Name	Item #	Length	Source of Standard	Column #
Hormone Therapy	1400	2	SEER/COC	880-881

Description

Records whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer growth. It is not usually used as a curative treatment.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy.

Coding Instructions

See *FORDS Manual, First Course of Treatment Section*, for codes and coding instructions.

Note: For cases diagnosed on or after January 1, 2003, information on endocrine surgery and/or endocrine radiation should be coded in the new field, item 3250 (RX SUMM—Transplnt/Endocr). The COC standards for hospitals do not allow use of codes 02-03 in cases diagnosed on or after January 1, 2003.

RX SUMM—OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
Other Treatment	1420	1	SEER/COC	884-884

Description

Identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual. Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment modifies, controls, removes, or destroys proliferating cancer tissue. Such treatments include phlebotomy, transfusions, and aspirin.

Rationale

Information of other therapy is used to describe and evaluate the quality of care and treatment practices.

Coding Instructions

See *FORDS Manual, First Course of Treatment Section*, for codes and coding instructions.

RX SUMM—SCOPE REG LN SUR

Alternate Name	Item #	Length	Source of Standard	Column #
Scope of Regional Lymph Node Surgery	1292	1	SEER/COC	861-861

Description

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

Rationale

In evaluating quality-of-care and treatment practices it is important to identify the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

Coding Instructions

See *FORDS Manual, First Course of Treatment Section*, for codes and coding instructions.

RX SUMM—SURG OTH REG/DIS

Alternate Name	Item #	Length	Source of Standard	Column #
Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes	1294	1	SEER/COC	862-862

Description

Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

Rationale

The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Coding Instructions

See *FORDS Manual, First Course of Treatment Section*, for codes and coding instructions.

RX SUMM—SURG PRIM SITE

Alternate Name	Item #	Length	Source of Standard	Column #
Surgery of Primary Site	1290	2	SEER/COC	859-860

Description

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

Coding Instructions

See *FORDS Manual, First Course of Treatment Section*, for codes and coding instructions.

RX SUMM—SURG/RAD SEQ

Alternate Name	Item #	Length	Source of Standard	Column #
Radiation/Surgery Sequence	1380	1	SEER/COC	875-875

Description

Codes for the sequencing of radiation and cancer-directed surgery given as part of the first course of treatment. Includes treatment given at all facilities as part of the first course.

Coding Instructions

See *FORDS Manual, First Course of Treatment Section*, for codes and coding instructions.

RX SUMM—SYSTEMIC SUR SEQ

Alternate Name	Item #	Length	Source of Standard	Column #
Systemic/Surgery Sequence	1639	1	COC	931-931

Description

Records the sequencing of systemic therapy (RX Summ-Chemo [1390], RX Summ-Hormone [1400], and RX Summ-Transplnt/Endocr [3250]), and surgical procedures given as part of the first course of treatment.

Rationale

The sequence of systemic therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or preformed. This data item can be used to more precisely evaluate the time of delivery of treatment to the patient.

Coding Instructions

- 0 No systemic therapy and/or surgical procedures
- 2 Systemic therapy before surgery
- 3 Systemic therapy after surgery
- 4 Systemic therapy both before and after surgery
- 5 Intraoperative systemic therapy
- 6 Intraoperative systemic therapy with other therapy administered before or after surgery
- 9 Sequence unknown

RX SUMM—TRANSPLNT/ENDOCR

Alternate Name	Item #	Length	Source of Standard	Column #
Hematologic Transplant and Endocrine Procedures	3250	2	COC	876-877

Description

Identifies systemic therapeutic procedures administered as part of the first course of treatment at this facility and all other facilities or the reason they were not used. These include bone marrow transplants, stem cell harvests, and surgical and radiation endocrine therapy.

Rationale

This data item allows the evaluation of patterns of treatment, which involve the alteration of the immune system or change the patient's response to tumor cells but do not involve the administration of antineoplastic agents.

Coding Instructions

See *FORDS Manual, First Course of Treatment Section*, for codes and coding instructions.

RX TEXT—BRM

Alternate Name	Item #	Length	Source of Standard	Column #
	2660	100	NPCR	5325-5424

Description

Text area for manual documentation of information regarding treatment of the tumor being reported with biological response modifiers or immunotherapy.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions 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

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item Name	Item Number
Date of Initial RX-SEER	1260
Date of 1 st Crs RX-COC	1270
RX Hosp-BRM	720
RX Date Systemic	3230
RX Summ-Transplnt/Endocr	3250
RX Summ-BRM	1410
RX Date-BRM	1240

RX TEXT—CHEMO

Alternate Name	Item #	Length	Source of Standard	Column #
	2640	200	NPCR	4925-5124

Description

Text area for manual documentation of information regarding chemotherapy treatment of the reported tumor.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date when chemotherapy began
- Where treatment was given, e.g., at this facility, at another facility
- Type of chemotherapy, e.g., name of agent(s) or protocol
- Other treatment information, e.g., treatment cycle incomplete, unknown if chemotherapy was given

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item Name	Item Number
Date of Initial RX-SEER	1260
Date of 1 st Crs RX-COC	1270
RX Summ-Chemo	1390
RX Hosp-Chemo	700
RX Date-Systemic	3230
RX Date-Chemo	1220
Reason for No Chemo	1440 (Retired in Version 11)

RX TEXT—HORMONE

Alternate Name	Item #	Length	Source of Standard	Column #
	2650	200	NPCR	5125-5324

Description

Text area for information about hormonal treatment.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions 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., orchiectomy
- Other treatment information, e.g., treatment cycle incomplete; unknown if hormones were given

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Initial RX-SEER	1260
Date of 1 st Crs RX-COC	1270
RX Summ-Hormone	1400
RX Hosp-Hormone	710
RX Date-Systemic	3230
RX Date-Hormone	1230
Reason for No Hormone	1450 (Retired in Version 11)

RX TEXT—OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
	2670	100	NPCR	5425-5524

Description

Text area for manual documentation of information regarding 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.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.

- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions 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

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Initial RX-SEER	1260
Date of 1 st Crs RX-COC	1270
RX Summ-Other	1420
RX Date-Other	1250
RX Hosp-Other	730

RX TEXT—RADIATION (BEAM)

Alternate Name	Item #	Length	Source of Standard	Column #
	2620	150	NPCR	4625-4774

Description

Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date when 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

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Initial RX-SEER	1260
Date of 1 st Crs RX-COC	1270
RX Summ-Radiation	1360
RX Summ-Surg/Rad Seq	1380
Reason For No Radiation	1430
RX Date-Radiation	1210
Rad Regional RX Modality	1570
RX Hosp-Radiation	690
RX Date Radiation Ended	3220
RX Summ-Rad to CNS	1370
Rad-No of Treatment Vol	1520
Rad-Regional Dose cGy	1510
Rad Elapsed RX Days	1530 (Retired in Version 11)
Rad Treatment Volume	1540
Rad Location of RX	1550
Rad Intent of Treatment	1560 (Retired in Version 11)
Rad Boost RX Modality	3200

Rad Boost Dose cGy	3210
Rad RX Completion Status	1580 (Retired in Version 11)
Rad Local Control Status	1590 (Retired in Version 11)

RX TEXT—RADIATION OTHER

Alternate Name	Item #	Length	Source of Standard	Column #
	2630	150	NPCR	4775-4924

Description

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.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date when treatment started
- Where treatment was given, e.g., at this facility, at another facility
- Type(s) of nonbeam radiation, e.g., High Dose rate brachytherapy, seed implant, Radioisotopes (I-131)
- Other treatment information, e.g., unknown if radiation was given

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Initial RX-SEER	1260
Date of 1 st Crs RX-COC	1270
RX Summ-Radiation	1360
RX Summ-Surg/Rad Seq	1380
Reason For No Radiation	1430
RX Date-Radiation	1210
Rad Regional RX Modality	1570
RX Hosp-Radiation	690
RX Date Radiation Ended	3220
RX Summ-Rad to CNS	1370
Rad-No of Treatment Vol	1520
Rad-Regional Dose cGy	1510
Rad Elapsed Days	1530 (Retired in Version 11)
Rad Treatment Volume	1540
Rad Location of RX	1550
Rad Intent of Treatment	1560 (Retired in Version 11)
Rad Boost RX Modality	3200
Rad Boost Dose cGy	3210
Rad RX Completion Status	1580 (Retired in Version 11)
Rad Local Control Status	1590 (Retired in Version 11)

RX TEXT--SURGERY

Alternate Name	Item #	Length	Source of Standard	Column #
	2610	150	NPCR	4475-4624

Description

Text area for information describing all surgical procedures performed as part of treatment.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions 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.

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
RX Date Surgery	1200
RX Summ-Surg Prim Site	1290
RX Hosp-Surg Prim Site	670
RX Summ-Scope Reg LN Sur	1292
RX Hosp-Scope Reg Ln Sur	672
RX Summ-Surg Oth Reg/Dis	1294
RX Hosp-Surg Oth Reg/Dis	674
Date of Initial RX—SEER	1260
Date of 1 st Crs RX__COC	1270
EOD-Extension	790
Site of Distant Met 1-3	1090-1110
Reason for No Surgery	1340
RX Summ-Surgical Margins	1320

RX Hosp-Palliative Proc	3280
RX Summ-Palliative Proc	3270
Text-Place of Diagnosis	2690

SEQUENCE NUMBER—HOSPITAL

Alternate Name	Item #	Length	Source of Standard	Column #
Sequence Number	560	2	COC	411-412

Description

Indicates the sequence of all reportable neoplasms over the lifetime of the patient.

Rationale

This data item is used to distinguish among cases having the same accession numbers, to select patients with only one primary tumor for certain follow-up studies, and to analyze factors involved in the development of multiple tumors.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions.

SEX

Alternate Name	Item #	Length	Source of Standard	Column #
	220	1	SEER/COC	118-118

Description

Code for the sex of the patient.

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes.

SOCIAL SECURITY NUMBER

Alternate Name	Item #	Length	Source of Standard	Column #
	2320	9	COC	2099-2107

Data Type: Numeric

Status: Required

Description

Records the patient's social security number. The number is entered without dashes and without any letter suffix. This is not always identical to the Medicare claim number.

Codes (in addition to social security number)

999999999 Unknown

SPANISH/HISPANIC ORIGIN

Alternate Name	Item #	Length	Source of Standard	Column #
Spanish Origin-All Sources	190	1	SEER/COC	115-115

Description

Code identifying persons of Spanish or Hispanic origin. This code is used by hospital and central registries to show the best guess as to whether or not the person should be classified as Hispanic for purposes of calculating cancer rates. If the patient has multiple tumors, all records should have the same code.

All information resources should be used to determine the correct code, including:

- Stated ethnicity in the medical record,
- State Hispanic origin on the death certificate,
- Birthplace,
- Information about life history and/or language spoken found during the abstracting process, and
- Patient's last name or maiden name found on a list of Hispanic names.

If a patient has a Hispanic name, but there is reason to believe they are not Hispanic (i.e., the patient is Filipino, or the patient is a woman known to be non-Hispanic who has a Hispanic married name), the code in this field should be 0 (non-Spanish, non-Hispanic).

Rationale

Ethnic origin has a significant association with cancer rates and outcomes. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the white category of item 160 (Race).

Coding Instructions

See *FORDS Manual, Patient Identification Section*, for codes and coding instructions. Appendix I provides a list of the most common Spanish surnames to assist in coding the patient's Spanish origin.

TEXT—DX PROC—LAB TESTS

Alternate Name	Item #	Length	Source of Standard	Column #
	2250	250	NPCR	3345-3594

Description

Text area for manual information from laboratory examinations other than cytology or histopathology.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Type of lab test/issue specimen(s)
- Record both positive and negative findings. Record positive test results first.
- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Date(s) of lab test(s)
- Tumor markers included, but are not limited to:
 - Breast Cancer – Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu.
 - Prostate Cancer – Prostatic Specific Antigen (PSA)
 - Testicular Cancer – Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH)

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Primary Site	400
Grade	440
Diagnostic Confirmation	490
Laterality	410
Collaborative Stage variables	2800-2930
Date of Diagnosis	390

TEXT—DX PROC—OP

Alternate Name	Item #	Length	Source of Standard	Column #
	2560	250	NPCR	3595-3844

Description

Text area for manual documentation of all surgical procedures that provide information for staging.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived.
- Number of lymph nodes removed
- Size of tumor removed
- Documentation of residual tumor
- Evidence of invasion of surrounding areas

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of 1 st Positive Bx	1080
Date of Diagnosis	390
RX Summ—Dx/Stg Proc	1350
Diagnostic Confirmation	490
Primary Site	400
RX Hosp—Dx/Stg Proc	740
RX Summ—Surg Prim Site	1290
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759

TEXT—DX PROC—PATH

Alternate Name	Item #	Length	Source of Standard	Column #
	2570	250	NPCR	3845-4094

Description

Text area for information from cytology and histopathology reports.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.

- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date(s) of procedure(s)
- Type of tissue specimen(s)
- Tumor type and grade (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.)
- Gross tumor size
- Extent of tumor spread
- Involvement of resection margins
- Number of lymph nodes involved and examined
- Record both positive and negative findings. Record positive test results first.
- Note if pathology report is a slide review or a second opinion from an outside source, i.e., AFIP, Mayo, etc.
- Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of diagnosis	390
Primary Site	400
Laterality	410
Histological Type ICD-O-3	522
Histology (92-00) ICD-O-2	420
Grade	440
Collaborative Stage variables	2800-2930
Diagnostic confirmation	490

TEXT—DX PROC—PE

Alternate Name	Item #	Length	Source of Standard	Column #
	2520	200	NPCR	2645-2844

Description

Text area for manual documentation from the history and physical examination about the history of the current tumor and the clinical description of the tumor.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date of physical exam
- Age, sex, race/ethnicity
- History that relates to cancer diagnosis
- Primary site
- Histology (if diagnosis prior to this admission)
- Tumor location
- Tumor size
- Palpable lymph nodes
- Record positive and negative clinical findings. Record positive results first
- Impression (when stated and pertains to cancer diagnosis)
- Treatment plan

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of 1 st Contact	580
Date of Diagnosis	390
Age at Diagnosis	230
Race 1 – 5	160-164
Spanish Hispanic Origin	190
Sex	220
Primary Site	400
Laterality	410
Histology (92-00) ICD-O-2	420
Histology ICD-O-3	522
Sequence Number-Central	380
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759

TEXT—DX PROC—SCOPES

Alternate Name	Item #	Length	Source of Standard	Column #
	2540	250	NPCR	3095-3344

Description

Text area for information from endoscopic examinations.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.

- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date(s) of endoscopic exam(s)
- Primary site
- Histology (if given)
- Tumor location
- Tumor size
- Lymph nodes
- Record positive and negative clinical findings. Record positive results first

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Diagnosis	390
Date of 1 st Positive Bx	1080
RX Summ-Dx/Stg Proc	1350
Diagnostic Confirmation	490
Primary Site	400
Laterality	410
Histology (92-00) ICD-O-2	420
Histology ICD-O-3	522
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759

TEXT—DX PROC—X-RAY/SCAN

Alternate Name	Item #	Length	Source of Standard	Column #
	2530	250	NPCR	2845-3094

Description

Text area for manual documentation from all X-rays, scan, and/or other imaging examinations that provide information about staging.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date(s) of X-ray/Scan(s)
- Age, sex, race/ethnicity (when given)
- Primary site
- Histology (if given)
- Tumor location
- Tumor size
- Lymph nodes
- Record positive and negative clinical findings. Record positive results first
- Distant disease or metastasis

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Date of Diagnosis	390
Sex	220

Birth Date	240
RX Summ-Dx/Stg Proc	1350
Primary Site	400
Laterality	410
Histology (92-00) ICD-O-2	420
Histology ICD-O-3	522
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759

TEXT—HISTOLOGY TITLE

Alternate Name	Item #	Length	Source of Standard	Column #
	2590	40	NPCR	4135-4174

Description

Text area for manual documentation of information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Information on histologic type and behavior
- Information on differentiation from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc.

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Histology (92-00) ICD-O-2	420
Behavior (92-00) ICD-O-2	430
Histologic Type ICD-O-3	522
Behavior Code ICD-O-3	523
Grade	440

TEXT—PRIMARY SITE TITLE

Alternate Name	Item #	Length	Source of Standard	Column #
	2580	40	NPCR	4095-4134

Description

Text area for manual documentation of information regarding the primary site and laterality of the tumor being reported.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.
- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.

- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Include information on the location of the primary site of the tumor
- Include available information on tumor laterality

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
Primary site	400
Laterality	410

TEXT—STAGING

Alternate Name	Item #	Length	Source of Standard	Column #
	2600	300	NPCR	4175-4474

Description

Additional text area for staging information not already entered in the Text—DX Proc areas.

Rationale

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.

Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR-approved abbreviations should be utilized (See appendix G).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields.

- Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Note: For abstracting software that allows unlimited text, NAACCR recommends that the software indicate to the abstractor the portion of the text that will be transmitted to the central registry.

Suggestions for text:

- Date(s) of procedure(s), including clinical procedures that provided information for assigning stage
- Organs involved by direct extension
- Size of tumor
- Status of margins
- Number and sites of positive lymph nodes
- Site(s) of distant metastasis
- Physician's specialty and comments

Data Item(s) to be verified/validated using the text entered in this field

After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item name	Item number
RX Date—DX/Stg Proc	1280
Collaborative Stage variables	2800-2930
SEER Summary Stage 1977	760
SEER Summary Stage 2000	759
EOD—Tumor Size	780
EOD—Lymph Node Involv	810
Regional Nodes Examined	830
Behavior Code ICD-O-3	523
Behavior (92-00) ICD-O-2	430
Site of Distant Met 1-3	1090-1110

TEXT—USUAL INDUSTRY

Alternate Name	Item #	Length	Source of Standard	Column #
	320	40	NPCR	183-222

Description

Text area for information about the patient's usual industry, also known as usual kind of business/industry.

Rationale

Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

Abstracting Instructions

Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among manufacturing, wholesale, retail, and service components of an industry that performs more than one of these components.

If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient for facility registrars to record the name of the company (with city or town) in which the patient performed his/her usual industry. In these situations, if resources permit, a central registry may be able to use the employer name and city/town to determine the type of activity conducted at that location.

As noted in the Text—Usual Occupation (310) section, in those situations where the usual occupation is not available or unknown, the patient's current or most recent occupation is recorded, if available. The information for industry should be based upon the information in occupation. Therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient's current or most recent business/industry.

If later documentation in the patient's record provides an industry that is more likely to be the usual industry than what was originally recorded, facility registrars are encouraged to update the case abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with industry information provided on death certificates. Comparison with death certificate information is a function of a central registry.

There should be an entry for Text—Usual Industry if any occupation is recorded. If no information is available regarding the industry in which the reported occupation was carried out, record unknown. If the patient was not a student or housewife and had never worked, record never worked as the usual industry. This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

TEXT—USUAL OCCUPATION

Alternate Name	Item #	Length	Source of Standard	Column #
	310	40	NPCR	143-182

Description

Text area for information about the patient's usual occupation, also known as usual type of job or work.

Rationale

Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

Abstracting Instructions

Record the patient's usual occupation (i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor). Do **not** record retired. If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation.

If later documentation in the patient's record provides an occupation that is more likely to be the usual occupation than what was originally recorded, facility registrars are encouraged to update the case abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with industry information provided on death certificates. Comparison with death certificate information should be the function of a central registry.

If the patient was a househusband/housewife and also worked outside the home during most of his/her adult life, record the usual occupation outside the home; if the patient was a househusband/housewife and did not work outside the home for most of his/her adult life, record househusband or housewife. If the patient was not a student or housewife and had never worked, record never worked as the usual occupation.

If no information is available, record unknown. This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

TYPE OF REPORTING SOURCE

Alternate Name	Item #	Length	Source of Standard	Column #
	500	1	SEER	312-312

Description

Code identifying source documents used to abstract the cancer being reported. This may not be the source of original casefinding (for example, if a case is identified through pathology laboratory report review and all source documents used to abstract the case are from the physician's office, code this item 4).

Type of Reporting Source can be used in conjunction with item 610 (Class of Case). Class of Case is designed to differentiate between analytic and non-analytic cases at the hospital level.

Rationale

The code in this field can be used to explain why information may be incomplete on a case. The field also is used to monitor the success of non-hospital case reporting and follow-back mechanisms. All population-based registries should have some death certificate-only cases where no hospital admission was involved, but too high a percentage can imply that follow-back to uncover missed hospital reports was not complete.

Codes

- 1 Hospital inpatient/outpatient or clinic
- 3 Laboratory only (hospital or private)
- 4 Physician's office/private medical practitioner
- 5 Nursing/convalescent home/hospice
- 6 Autopsy only
- 7 Death certificate only

Note: Coding is hierarchical. Within codes 1-5, assign codes in the following priority: 1, 4, 5, 3.

VITAL STATUS

Alternate Name	Item #	Length	Source of Standard	Column #
	1760	1	SEER/COC	1302-1302

Description

Vital status of the patient as of the date entered in item 1750 (Date of Last Contact). If the patient has multiple tumors, vital status should be the same for all tumors.

Codes

- 0 Dead (COC)
- 1 Alive
- 4 Dead (SEER)

Appendix A

OREGON REVISED STATUTES

CANCER AND TUMOR REGISTRY SYSTEM

432.500 Definitions. As used in ORS 432.510 to 432.550 and 432.900:

(1) "Clinical laboratory" means a facility where microbiological, serological, chemical, hematological, immunohematological, immunological, toxicological, cytogenetical, exfoliative cytological, histological, pathological or other examinations are performed on material derived from the human body, for the purpose of diagnosis, prevention of disease or treatment of patients by physicians, dentists and other persons who are authorized by license to diagnose or treat humans.

(2) "Department" means the Department of Human Services or its authorized representative.

(3) "Health care facility" means a hospital, as defined in ORS 442.015 (19), or an ambulatory surgical center, as defined in ORS 442.015.

(4) "Practitioner" means any person whose professional license allows the person to diagnose or treat cancer in patients. [1995 c.585 §1; 2001 c.104 §154; 2003 c.14 §243; 2003 c.269 §1]

Note: 432.500 to 432.570 and 432.900 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 432 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

432.510 Cancer and tumor registry system; purpose; rulemaking; duties of Department of Human Services. (1) The Department of Human Services shall establish a uniform, statewide, population-based registry system for the collection of information determining the incidence of cancer and benign tumors of the brain and central nervous system and related data. The purpose of the registry shall be to provide information to design, target, monitor, facilitate and evaluate efforts to determine the causes or sources of cancer and benign tumors among the residents of Oregon and to reduce the burden of cancer and benign tumors in Oregon. Such efforts may include but are not limited to:

(a) Targeting populations in need of cancer screening services or evaluating screening or other cancer control services;

(b) Supporting the operation of hospital registries in monitoring and upgrading the care and the end results of treatment for cancer and benign tumors;

(c) Investigating suspected clusters or excesses of cancer and benign tumors both in occupational settings and in the state's environment generally;

(d) Conducting studies to identify cancer hazards to the public health and cancer hazard remedies; and

(e) Projecting the benefits or costs of alternative policies regarding the prevention or treatment of cancer and benign tumors.

(2) The department shall adopt rules necessary to carry out the purposes of ORS 432.510 to 432.550 and 432.900, including but not limited to designating which types of cancer and benign tumors of the brain and central nervous system are reportable to the statewide registry, the data to be reported, the data reporting standards and format and the effective date after which reporting by health care facilities, clinical laboratories and practitioners shall be required. When adopting rules under this subsection, the department shall, to the greatest extent practicable, conform the rules to the standards and procedures established by the American College of Surgeons Commission on Cancer, with the goal of achieving uniformity in the collection and reporting of data.

(3) The department shall:

(a) Conduct a program of epidemiologic analyses of registry data collected under subsection (1) of this section to assess control, prevention, treatment and causation of cancer and benign tumors in Oregon; and

(b) Utilize the data to promote, facilitate and evaluate programs designed to reduce the burden of cancer and benign tumors among the residents of Oregon.

(4) The department shall:

(a) Collaborate in studies of cancer and benign tumors with clinicians and epidemiologists and publish reports on the results of such studies; and

(b) Cooperate with the National Institutes of Health and the Centers for Disease Control in providing incidence data for cancer and benign tumors.

(5) The department shall establish a training program for the personnel of participating health care facilities and a quality control program for data for cancer and benign tumors reported to the state registry. [1995 c.585 §2; 2003 c.269 §2]

Note: See note under 432.500.

432.520 Reporting requirement; review of records; special studies. (1) Except as provided in subsection (2) of this section, any health care facility in which patients are diagnosed or provided treatment for cancer or benign tumors of the brain and central nervous system shall report each case of cancer or benign tumors of the brain and central nervous system to the Department of Human Services within a time period and in a format prescribed by the department. The department shall provide, at cost, reporting services to any health care facility at the option of the health care facility. Health care facilities may also purchase reporting services from another facility or commercial vendor. If a health care facility is unable to report in conformance with the format and standards prescribed by the department, the department may, after consultation with the health care facility, elect to activate its reporting service for the facility. When activated, the department may enter the facility, obtain the information and report it in conformance with the appropriate format and standards. In these instances, the facility shall reimburse the department or its authorized representative for the cost of obtaining and reporting the information.

(2) Upon application to the department by a health care facility, the department shall grant to the health care facility an extension of time in which to meet the reporting requirements of this section. In no event shall the extension of time exceed two years from the date of application.

(3) Any practitioner diagnosing or providing treatment to patients with cancer or benign tumors of the brain and central nervous system shall report each case to the department or its authorized representative within a time period and in a format prescribed by the department. Those cases diagnosed or treated at an Oregon health care facility or previously admitted to an Oregon health care facility for diagnosis or treatment of that instance of cancer or benign tumors of the brain and central nervous system shall be considered by the department to have been reported by the health care practitioner.

(4) Any clinical laboratory diagnosing cases of cancer or benign tumors of the brain and central nervous system shall report each case to the department or its authorized representative within a time period and in a format prescribed by the department.

(5) For the purpose of assuring the accuracy and completeness of reported data, the department shall have the right to periodically review all records that would:

(a) Identify cases of cancer and benign tumors, the treatment of the cancer or benign tumors or the medical status of any patient identified as being treated for cancer or benign tumors; or

(b) Establish characteristics of the cancer or benign tumors.

(6) The department may conduct special studies of cancer morbidity and mortality. As part of such studies, registry personnel may obtain additional information that applies to a patient's cancer or benign tumors and that may be in the medical record of the patient. The record holder may either provide the requested information to the registry personnel or provide the registry personnel access to the relevant portions of the patient's medical record. Neither the department nor the record holder shall bill the other for the cost of providing or obtaining this information. [1995 c.585 §3; 2003 c.269 §3]

Note: See note under 432.500.

432.530 Confidentiality of information. (1) All identifying information regarding individual patients, health care facilities and practitioners reported pursuant to ORS 432.520 shall be confidential and privileged. Except as required in connection with the administration or enforcement of public health laws or rules, no public health official, employee or agent shall be examined in an administrative or judicial proceeding as to the existence or contents of data collected under the registry system for cancer and benign tumors of the brain and central nervous system.

(2) All additional information reported in connection with a special study shall be confidential and privileged and shall be used solely for the purposes of the study, as provided by ORS 432.060. Nothing in this section shall prevent the Department of Human Services from publishing statistical compilations relating to morbidity and mortality studies that do not identify individual cases or prevent use of this data by third parties to conduct research as provided by ORS 432.540 (1). [1995 c.585 §5; 2003 c.269 §4]

Note: See note under 432.500.

432.540 Use of confidential data; rules. (1) The Department of Human Services shall adopt rules under which confidential data may be used by third parties to conduct research and studies for the public good. Research and studies conducted using confidential data from the statewide registry must be reviewed and approved by the Committee for the Protection of Human Research Subjects established in accordance with 45 C.F.R. 46.

(2) The department may enter into agreements to exchange information with other registries for cancer and benign tumors of the brain and central nervous system in order to obtain complete reports of Oregon residents diagnosed or treated in other states and to provide information to other states regarding the residents of other states diagnosed or treated in Oregon. Prior to providing information to any other registry, the department shall ensure that the recipient registry has comparable confidentiality protections. [1995 c.585 §6; 2003 c.269 §6]

Note: See note under 432.500.

432.550 Action for damages; license; disciplinary action prohibited for good faith participation in reporting of data. (1) No action for damages arising from the disclosure of confidential or privileged information may be maintained against any person, or the employer or employee of any person, who participates in good faith in the reporting of registry data for cancer or benign tumors of the brain and central nervous system or data for cancer morbidity or mortality studies in accordance with ORS 432.510 to 432.540 and 432.900.

(2) No license of a health care facility or practitioner may be denied, suspended or revoked for the good faith disclosure of confidential or privileged information in the reporting of registry data for cancer or benign tumors of the brain and central nervous system or data for cancer morbidity or mortality studies in accordance with ORS 432.510 to 432.540 and 432.900.

(3) Nothing in this section shall be construed to apply to the unauthorized disclosure of confidential or privileged information when such disclosure is due to gross negligence or willful misconduct. [1995 c.585 §7; 2003 c.269 §5]

Note: See note under 432.500.

432.560 [1995 c.585 §8; repealed by 2001 c.900 §261]

432.570 No requirement or prohibition regarding operation of separate cancer and tumor registry. Nothing in ORS 432.510 to 432.550 and 432.900 shall prohibit a health care facility from operating its own registry for cancer and benign tumors of the brain and central nervous system or require a health care facility to operate its own registry for cancer and benign tumors. [1995 c.585 §9; 2003 c.269 §7]

Note: See note under 432.500.

432.900 Civil penalty. (1) In addition to any other liability or penalty provided by law, the Director of Human Services may impose a civil penalty on any person for willful failure to comply with any part of ORS 432.520. A civil penalty may be imposed against a health care facility for each day compliance is refused. The penalty shall be \$50 per day for the first 30 days and \$500 per day thereafter. A civil penalty of \$50 may be imposed against a practitioner for each day compliance is refused.

(2) Any fines collected pursuant to subsection (1) of this section shall be paid into the State Treasury and deposited in the General Fund.

(3) Civil penalties described in subsection (1) of this section shall be imposed in the manner provided in ORS 183.745. [1995 c.585 §4]

Note: See note under 432.500.

432.990 [Amended by 1963 c.200 §5; 1971 c.743 §369; repealed by 1997 c.783 §48]

OREGON ADMINISTRATIVE RULES

CANCER REPORTING REGULATIONS

333-010-0000 Definitions

(1) "Active follow-up program" means a program for contacting a caregiver or cancer patient to determine, at least annually, information including but not limited to the vital status of each case.

(2) "Admitted" means a rendering of any service by the reporting facility to a patient under the authority or auspices of the facility's license under ORS 442.015(14)(a) or (c) including but not limited to routine admission to the hospital, admission to the Emergency Room, or receiving services in an out-patient clinic.

(3) "Cancer reporting facility" means a hospital or other facility in which cancer is diagnosed or treated and is also one of the following:

(a) A facility currently licensed as a health care facility under the provisions of ORS 442.015(14)(a); or

(b) An ambulatory surgical center licensed under ORS 442.015(14)(c).

(4) "Case" means a reportable cancer in an individual who is either a resident of Oregon, regardless of where the individual was treated or diagnosed, or a nonresident diagnosed or treated in Oregon.

(5) "Central cancer registry" means the Oregon Health Division program authorized to collect, receive, and maintain cancer data for the entire state and which maintains the system by which the collected information is reported to the Division.

(6) "Certified tumor registrar" means an individual who passes the certification examination and is currently certified by the National Board for Certification of Registrars.

(7) "Date of diagnosis" means the date of initial diagnosis by a recognized medical practitioner for the cancer being reported.

(8) "Division" means the Health Division of the Department of Human Resources.

(9) "First course of therapy" means the first cancer directed therapy, including all modalities, provided to a reportable case, as defined in the American College of Surgeons Commission on Cancer Registry Operating and Data System's Manual, 1996.

(10) "Health system cancer registry" means a cancer registry that includes all reportable cases of cancer occurring in the population served by a health system, whether or not the cases are diagnosed or treated in a cancer reporting facility.

(11) "OSCaR" means the Oregon State Cancer Registry, Oregon's central cancer registry.

(12) "Practitioner" means any person whose professional license allows him/her to diagnose or treat cancer patients.

(13) "Quality control system" means operational procedures by which the accuracy, completeness, and timeliness of the information reported to the Division can be determined and improved.

(14) "Reportable cancer" means all malignant neoplasms including carcinoma in situ, except basal and squamous cell carcinoma of the skin, and carcinoma in situ of the cervix uteri diagnosed on or after January 1, 1996. The International Classification of Diseases, 9th Revision, Clinical Modification, (ICD-9-CM), Third Edition codes for reportable cancers are: 140 - 208.9, 230 - 233.0, and 233.2 - 234.9.

(15) "Special study" means a Division-sponsored project, which explores a particular facet of cancer incidence, morbidity, or mortality including, but not limited to, exploring a hypothesis of disease risk or treatment options authorized under ORS 432.500.

Stat. Auth.: ORS 432.500

Stats. Implemented: ORS 432.500 - ORS 432.990

Hist.: HD 2-1996, f. & cert. ef. 2-29-96; OHD 7-1998, f. 7-14-98, cert. ef. 8-1-98

333-010-0010 General Authority

According to ORS 432.500 - 432.990, the Health Division shall establish a uniform, statewide, population-based cancer registry system for the collection of information determining the incidence of cancer and related data. The purpose of the registry shall be to provide information to design, target, monitor, facilitate, and evaluate efforts to reduce the burden of cancer in Oregon.

Stat. Auth.: ORS 432.500

Stats. Implemented: ORS 432.500 - ORS 432.990

Hist.: HD 2-1996, f. & cert. ef. 2-29 -96

333-010-0020 Reporting Requirements for Cancer Reporting Facilities

This section describes the specific requirements for cancer reporting facilities. Such facilities include inpatient facilities, outpatient facilities acting under the license of a hospital, ambulatory surgical centers, and privately owned treatment or diagnostic centers contracted to and acting as a department of a cancer reporting facility.

(1) Cancer reporting facilities must report to the central cancer registry each case of reportable cancer, as defined in 333-010-0000(2), in patients admitted for diagnosis and/or any part of the first course of therapy for that cancer.

(2) Cancer reporting facilities shall report the required data items for each case to the central cancer registry. Required data items are available through OSCaR. Codes for each data item shall follow the recommendations of the American College of Surgeons Commission on Cancer and are further defined by the North American Association of Central Cancer Registries (NAACCR). Copies of the NAACCR Standards for Data Reporting are available upon request from the Oregon State Cancer Registry, Oregon Health Division, 800 NE Oregon Street, Portland, OR 97232.

(3) Cancer reporting facilities shall report data to the central cancer registry as stipulated in 333-010-0020(2) within 180 days of the date the case first receives cancer diagnostic or treatment services at the facility.

(4) Cancer reporting facilities with an active follow-up program shall annually report vital status, date of last patient contact, and, if available, cancer status, to the central cancer registry.

(5) Cancer reporting facilities shall report their cancer cases and any follow-up information to the central cancer registry in the electronic data exchange format and codes, Record Type A: Case Abstract, as specified by NAACCR.

(6) Cancer reporting facilities reporting cases to a health system cancer registry have discharged their reporting responsibilities provided that the health system registry reports those cases to the Division according to the requirements for cancer reporting facilities.

(7) Cancer reporting facilities may elect to:

(a) Allow the central cancer registry staff to do their cancer data collection. They may do so by authorizing the central cancer registry to identify and report their cancer cases. The reporting facilities shall reimburse the Division for these reporting services; or

(b) Contract with a private vendor or contractor to report cases to the Division as outlined above in 333-010-0020(2).

(8) Any cancer reporting facility designated as a Type A or Type B rural hospital by the Oregon Office of Rural Health, may elect to meet the cancer reporting requirements by conducting their own identification of reportable cases and mailing a copy of the relevant portions of the medical record for each case to the central registry. The central registry staff will abstract and report such cases and bill the hospital for this service at its cost. Type A or Type B rural hospitals which authorize the central registry to abstract and report cases have fulfilled their abstracting and reporting requirements under these rules.

(9) Upon application to the Division by a cancer reporting facility, the Division shall grant to the facility an extension of time, not to exceed two years, in which to meet the reporting requirements. Such requests shall be in writing and directed to the Medical Director of OSCaR. On request, the central registry staff shall provide technical assistance to facilities to meet the reporting requirements.

(10)(a) If cancer reports from a reporting facility do not meet reporting requirements, the Division shall inform the facility in writing of the disparity between the facility's reports and the reporting standards. The Division will then consult with the facility regarding its options for meeting the reporting standards, as defined in 333-010-0020(2). Options shall include, but are not limited to:

(A) Further consultation and training;

(B) Reference to contractors for reporting services;

(C) Provision, at cost, of reporting services by the Division. By selecting this option, cancer reporting facilities will fulfill all reporting requirements.

(b) If, after a minimum of 30 days from the receipt of the written notification, the facility cannot meet the reporting requirements, the Division may activate its reporting service for the facility. When activated, the Division may enter the facility, obtain the information and report it in conformance with the appropriate format and standards. In these instances, the facility shall reimburse the Division or its authorized representative for the cost of obtaining and reporting the information.

Stat. Auth.: ORS 432.500

Stats. Implemented: ORS 432.500 - ORS 432.990

Hist.: HD 2-1996, f. & cert. ef. 2-29-96; OHD 7-1998, f. 7-14-98, cert. ef. 8-1-98

333-010-0030 Reporting Requirements for Practitioners

This section describes the reporting requirements for practitioners. Statute ORS 432.500-432.990 establishes a dual reporting responsibility for cancer cases; one is for cancer reporting facilities and the other for practitioners. Practitioners need not report any case admitted to an Oregon reporting facility for the purpose of a cancer diagnosis or for all or any part of the first course of therapy providing that the admission to the facility occurs within 180 days of diagnosis. The practitioner reporting requirement is fulfilled by filing a Practitioner Cancer Notification Form or equivalent, as described in 333-010-0030(3), and by providing access to additional data, if necessary, as described in 333-010-0030(7).

(1) Any practitioner diagnosing a reportable case of cancer, as defined in 333-001-0000, must notify the central cancer registry of each such case within 180 days of the diagnosis of the case.

(2) Data items required for reporting a case include patient name, address, gender, birth date, primary site and type of cancer, date of diagnosis, and the name of the diagnosing practitioner.

(3) Practitioners may elect any of the following options to comply with the notification requirement:

(a) completion and submission of the Practitioner Cancer Notification Form. Copies of this form are available at the Oregon State Cancer Registry, Oregon Health Division, 800 NE Oregon Street, Portland, Oregon 97232.

(b) A written communication containing the information required by notification of the Practitioner Cancer Notification Form and directed to the Medical Director, Oregon State Cancer Registry.

(c) An electronic communication containing the information required by the Practitioner Cancer Notification Form and directed to the Medical Director, Oregon State Cancer Registry, at a confidential electronic mailbox established by the Division, or

(d) A FAX containing the information required by the Practitioner Cancer Notification Form and directed to the Medical Director of the Oregon State Cancer Registry at a confidential receiver established by the Division.

(4) Practitioners need not report any case admitted to an Oregon reporting facility for:

(a) A cancer diagnosis; or

(b) All or part of the first course of therapy for that case, providing that admission occurs within 180 days of diagnosis.

(5) Practitioners reporting cases to a health system cancer registry have discharged their reporting responsibilities provided that the health system cancer registry reports those cases to the Division according to the requirements for cancer reporting facilities.

(6) If a practitioner fails to notify the central registry of reportable cases according to the standards and format prescribed for practitioners, the Division shall inform the practitioner in writing of the disparity between the practitioner's reporting performance and the reporting standards. The Division will consult with the practitioner regarding methods for bringing the practitioner's reporting performance into compliance with the reporting standards.

(7) If the Division does not receive information from another source completing the information required for a reportable case submitted by a practitioner, or if the Division learns of an unreported case for which the practitioner has reporting responsibility but of which the central registry has not been notified by the practitioner, the Division will contact the practitioner to schedule a time to abstract the necessary data from the practitioner's records. The practitioner shall provide access to those portions of a patient's medical record which provide data for the items specified in the list of OSCaR Reportable Data Items.

(8) The Division shall establish a system of confirmation of receipt of cases submitted by practitioners.

[ED. NOTE: The Appendices referenced in this rule are not printed in the OAR Compilation. Copies are available from the agency.]

Stat. Auth.: ORS 432.500

Stats. Implemented: ORS 432.500 - ORS 432.990

Hist.: HD 2-1996, f. & cert. ef. 2-29-96; OHD 7-1998, f. 7-14-98, cert. ef. 8-1-98

333-010-0035 Patient Notification Requirement

This section describes the requirements for notifying patients that information about them has been reported to OSCaR.

(1) Responsibility for notifying patients.

(a) Each person reported to the Oregon State Cancer Registry shall be informed that information about them has been included in the Registry. In the absence of extenuating circumstances, this notification shall occur within one month of the report being received by OSCaR.

(b) OSCaR shall assume the responsibility for notifying the patient unless the facility or practitioner notifies OSCaR that they will routinely take on the notification responsibility of all patients themselves. OSCaR shall reconfirm annually that the facility or practitioner wants to continue to assume the responsibility for notification of all patients.

(c) If the facility or practitioner elects to inform the patient themselves, they shall choose one of the following options:

(A) The facility or practitioner may elect to have OSCaR provide patient notification information to the facility or practitioner for forwarding on to the patient;

(B) the facility or practitioner may elect to develop their own patient notification materials; or

(C) The facility or practitioner may arrange with a third party to carry out the notification process. The facility or practitioner shall: inform OSCaR of the name of the third party that will be carrying out the patient notification requirements, and specify how the third party will know to inform the patient. If either option (B) or (C) is elected, the facility or practitioner shall allow OSCaR to review and approve the materials to ensure that they meet the requirements for information outlined below in 333-010-0035(2).

(2) Information to be provided to patients. The notification to the patient shall include the following information about the purposes of the Registry and the protection of confidentiality:

(a) That Oregon statute requires that every cancer newly diagnosed in Oregon, or in an Oregon resident, be reported to the Oregon State Cancer Registry maintained by the Oregon Health Division;

(b) That information reported to the Division includes: the type and characteristics of the cancer; details of the diagnosis; the patient's name, address, age, and sex; and the treatment given;

(c) That the information is used to understand how cancer affects the population in Oregon, to design and implement prevention and control programs, and for research;

(d) That the information is confidential and the patient's name cannot be released to anyone unless very strict requirements, as provided by law, are met;

(e) If those specific requirements, as provided by law, are met, researchers may be allowed to contact patients to offer them the opportunity to participate in research projects. Any invitation to participate in research is always voluntary and may be freely declined; and

(f) That the researcher shall first consult with the patient's physician regarding participation in a research project, unless the patient specifies to OSCaR either of the following: that their name never be released for any research purpose; or that researcher may contact them directly about participation in research projects.

Stat. Auth.: ORS 432.500

Stats. Implemented: ORS 432.500 - ORS 432.990

Hist.: OHD 7-1998, f. 7-14-98, cert. ef. 8-1-98

333-010-0040 Quality Standards

The usefulness of central registry data is directly dependent upon the accuracy, completeness, and timeliness of the data available in its database. ORS 432.500 - 432.990 directs the Division to establish a quality control program for the data reported to the state registry. In order to assess these aspects of quality for cancer reporting, the central registry will institute a program of continuous quality improvement.

(1) The continuous quality improvement system shall include, but is not limited to, coding edits, completeness audits or checks, reabstracting audits, and statistical mechanisms to estimate data accuracy, validity, and reliability.

(2) For the purpose of assuring the accuracy and completeness of reported data, the Division shall have the right to periodically review all records that would identify cases of cancer or would establish characteristics of the cancer, treatment of the cancer or the medical status of any identified cancer patient. The central registry will provide advance notification of a minimum of 30 days, to allow for the reporting sources to prepare records for review.

(3) The collection of cancer data from cancer reporting facilities, including data collection performed by the central cancer registry staff, shall be performed either by Certified Tumor Registrars or by staff knowledgeable about the following, as recommended by the American College of Surgeons, Commission on Cancer:

- (a) Cancer as a disease process;
- (b) General anatomy and physiology;
- (c) Cancer epidemiology and statistics;
- (d) Casefinding procedures; and
- (e) Basic coding and staging schemes.

(4) A cancer reporting facility must report a minimum of 98 percent of the cases reportable by that facility for any calendar year in order to meet the requirement of these rules.

(5) The item-specific agreement rate of reported data from a reporting facility with the information in the facility's medical record shall not be less than 95% for those data items identified in the OSCaR Reportable Data Items list as *quality control* items.

(6) A cancer reporting facility must submit 98% of reportable cases to the central cancer registry within 180 days of either:

(a) The date of diagnosis; or

(b) The date of admission for receipt of any part of the first course of therapy provided in that facility, whichever is later.

(7) A practitioner must submit a minimum of 95% of reportable cases to the central cancer registry within 180 days of the date of diagnosis.

Stat. Auth.: ORS 432.500

Stats. Implemented: ORS 432.500 - ORS 432.990

Hist.: HD 2-1996, f. & cert. ef. 2-29-96

333-010-0050 Confidentiality and Access to Data

(1) All identifying information regarding individual patients, cancer reporting facilities, and practitioners reported pursuant to OAR 333-010-0020 and ORS 432.500-432.990 shall be confidential and privileged. Except as required in connection with the administration or enforcement of public health laws or rules, no public health official, employee, or agent shall be examined in an administrative or judicial proceeding as to the existence or contents of data collected under the cancer registry system.

(2) The information collected and maintained by the central cancer registry shall be stored in secure locations, shall be used solely for the purposes stated in ORS 432.500 - 432.990 and shall not be further disclosed unless required by law, with the following exceptions:

(a) When the Division has entered into reciprocal cooperative agreements with other states to exchange information on resident cases, as provided for in ORS 432.500 - 432.990. Such agreements shall provide for obtaining data on Oregon resident cases diagnosed or treated out of state, and for reciprocal rights of other states to receive information on residents of those states diagnosed or treated in Oregon. Before entering into an agreement with any other state, the Division shall determine that the other state has comparable confidentiality protections;

(b) When disclosure to officers or employees of federal, state, or local government public health agencies is necessary to investigate or avoid a clear and immediate danger to other individuals or to the public generally;

(c) When the Division elects to contract with another agency for performance of a registry function the Division will require the contractor to agree to use the information only for the purposes of the central cancer registry, to maintain the information securely, and to protect the information from unauthorized disclosure as referred to in 333-010-0050(1). Before entering into any contract with another agency the Division shall determine the agency has comparable confidentiality protections; and

(d) When the Division deems that the information is necessary for others to conduct research in conformance with the purposes for which the data are collected.

(3) Cancer reporting facilities shall have access to confidential and privileged data on any case submitted by that facility. When a patient has been seen for care of a case of cancer by multiple cancer reporting facilities, the Division may share information on treatment and follow-up among the facilities, provided that all participating facilities have signed agreements with the Division to do so.

(4) Practitioners shall have access to confidential and privileged data on any case submitted by that practitioner. When a patient has been seen for care of a case of cancer by multiple practitioners, the Division may share information on treatment and follow-up among the practitioners, (provided that all participating practitioners have signed agreements with the Division to do so).

Stat. Auth.: ORS 432.500

Stats. Implemented: ORS 432.500 - ORS 432.990

Hist.: HD 2-1996, f. & cert. ef. 2-29-96; OHD 7-1998, f. 7-14-98, cert. ef. 8-1-98

333-010-0055 Research Studies

(1) Requirements for Research Studies. Before any confidential data may be disclosed to a researcher, the Division shall:

(a) Approve a submitted protocol for the proposed research, which describes how the research will be used to determine the sources of cancer among the residents of Oregon or to reduce the burden of cancer in Oregon, in accordance with 333-010-0010 of ORS 432.500 - 432.990;

(b) Agree that the data requested are necessary for the efficient conduct of the study;

(c) Approve the researcher's submitted protocol and procedures for: identifying patients to be contacted; protecting against inadvertent disclosure of confidential and privileged data; providing secure conditions to use and store the data; assuring that the data will only be used for the purposes of the study; and assuring that confidential and privileged data will be destroyed upon conclusion of the research;

(d) Determine that the researcher has access to sufficient resources to carry out the proposed research before releasing any confidential data;

(e) Require that the proposed research be reviewed and approved by the body used by the Division as the Committee for the Protection of Human Research Subjects and established in accordance with 45 C.F.R. 46;

(f) Determine the need for and require the researcher to implement other safeguards which, in the judgment of the Division, may be necessary for protecting confidential and privileged data from inadvertent disclosure due to unique or special characteristics of the proposed research;

(g) Determine whether the research methodology has been reviewed for scientific excellence by a nationally recognized peer review group and, if it is determined that no such review has taken place, the Division shall convene an ad hoc peer review subcommittee of the advisory committee containing appropriately qualified scientists to perform a peer review of the research. The central registry shall not release confidential and privileged information to the researcher unless and until the proposed research is judged to be scientifically meritorious by the peer review group.

(2) Contacting Patients for Research. As outlined in OAR 333-010-0035(2)(e,f), participation in research is voluntary and patients may choose whether or not they want to be contacted regarding research studies.

(a) Before disclosing confidential patient information to a researcher, the Division shall:

(A) Determine whether any of the patients identified have previously informed the OSCaR that information regarding their cancer may not be disclosed under any circumstances, as described in 333-010-0035(2)(f). Such patients will be excluded from those provided to the researcher.

(B) For those patients to be contacted, determine whether they have previously informed OSCaR that they wish to be contacted about their participation in research programs directly by the researcher, or after consulting with the patient's treating physician as described in 333-010-0035(2)(f).

(b) For those patients who have indicated that researchers may contact them directly, the researcher shall make a good faith effort to identify and contact the patient's current treating physician to inform them of the study prior to any contact with a patient.

(c) In attempting to consult with the patient's physician prior to contacting the patient, the researcher shall first attempt to contact the patient's treating physician of record. In situations where the treating physician of record is no longer the patient's physician, the researcher shall make a good faith effort to find the patient's current physician. This effort would include determining if the treating physician had record of a referral physician, contacting other physicians in the patient's OSCaR record, and contacting any health system cancer registry that might contain additional physician information. Only in the case where no current physician of record could be identified would patient contact without prior physician contact be initiated.

(d) The contacted physician shall be informed of the study and of the identity of the eligible patient. Within three weeks that physician shall do one of the following:

(A) Contact the patient and determine the patient's interest in participating in the study. If the physician chooses this option, the physician must inform the researcher of the patient's decision within one week; or

(B) Agree that direct contact by the researcher would be appropriate; or

(C) Indicate the presence of a medical, psychological or social situation in the patient's life that would make contact inappropriate at that time. The physician would be under no obligation to disclose the specifics of the medical, psychological or social situation. When the presence of such situations are identified by the patient's treating physician, the researcher shall not attempt to contact the patient. However, a researcher may recontact the physician at a future time to determine whether or not the situation still exists.

(e) If a researcher does not receive a response from the physician within one month, the researcher may contact the patient directly.

(f) Researchers are strictly prohibited from redisclosing patient names or other confidential information to other researchers, individuals, or institutions not specifically identified in the approved study protocol as outlined above.

Stat. Auth.: ORS 432.500

Stats. Implemented: ORS 432.500 - ORS 432.990

Hist.: OHD 7-1998, f. 7-14-98, cert. ef. 8-1-98

333-010-0060 Special Studies

(1) From time to time, the Division may elect to conduct special studies of cancer mortality and morbidity. The Division is specifically authorized to obtain any information which applies to a patient's cancer and which may be found in the medical record of the patient under ORS 432.500 - 432.990. Upon request, the practitioner or health care facility shall provide the requested information to the central cancer registry or provide the central cancer registry personnel access to the relevant portions of the medical records.

(2) If the Division seeks additional data on cancer cases which may be contained in a practitioner's medical records, for the conduct of a special study, the Division shall make the request of the practitioner. If asked, the Division shall provide the request in writing. Cancer registry personnel may obtain additional information which applies to a patient's cancer and which may be in the patient's medical record. The record holder may either provide the requested information to the cancer registry personnel or provide the cancer registry personnel access to the relevant portions of the patient's medical record. Neither the Division nor the record holder shall bill the other for the cost of providing or obtaining this information.

Stat. Auth.: ORS 432.500

Stats. Implemented: ORS 432.500 - ORS 432.990

Hist.: HD 2-1996, f. & cert. ef. 2-29-96

333-010-0070 Advisory Committee

The Division shall appoint an advisory committee to review the operations of the central registry and to make recommendations regarding registry policy and review research protocols for which confidential and privileged data are requested. The composition of the advisory committee shall generally represent those with a professional or personal interest in cancer.

Stat. Auth.: ORS 432.500

Stats. Implemented: ORS 432.500 - ORS 432.990

Hist.: HD 2-1996, f. & cert. ef. 2-29-96

333-010-0080 Training and Consultation

The Division shall provide annual continuing education for interested persons involved in cancer registry reporting. Continuing education content shall include, but is not limited to, cancer diagnosis and management, epidemiology and statistics, and hardware and software registry applications. The central registry staff shall supplement the continuing education with one-on-one consultations to assist cancer reporting facilities and practitioners as needed in meeting the reporting requirements.

Stat. Auth.: ORS 432.500

Stats. Implemented: ORS 432.500 - ORS 432.990

Hist.: HD 2-1996, f. & cert. ef. 2-29-96

333-010-0090 Fees

OSCaR may establish fees, reasonably calculated, to reimburse for its actual cost in making OSCaR records and data available to researchers. Such costs include, but are not limited to, costs for computer programming; consultation; and for summarizing, compiling, analyzing, or tailoring records and data to a researchers' needs.

Stat. Auth.: ORS 432.560

Stats. Implemented: ORS 432.500 - ORS 432.990

Hist.: OHD 11-1999, f. & cert. ef. 12-8-99

Appendix B

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
0												
10	Record Type	R	.	R	.	R	T	T		.	NAACCR	
20	Patient ID Number	R	.	.	R	R	.	T		.	Reporting Registry	
21	Patient System ID-Hosp	.	.	.	.	.	T	.	.	.	NAACCR	
30	Registry Type	.	.	.	.	.	.	T		.	NAACCR	
35	FIN Coding System	.	.	.	.	.	.	.		.	NAACCR	
37	Reserved 00	.	.	.	.	.	.	.		.
40	Registry ID	R	.	.	R	R	T	T		.	NAACCR	
45	NPI--Registry ID	.	.	.	R*	.	.	.		.	CMS	Revised
50	NAACCR Record Version	R	.	R	.	.	T	T		.	NAACCR	
60	Tumor Record Number	.	.	.	S	S	T	T		.	NAACCR	
70	Addr at DX--City	R	R	R	R	.	T	T		.	CoC	
80	Addr at DX--State	R	R	R	R	.	T	T		.	CoC	
90	County at DX	R	R	R	R	R	T	T		.	FIPS/SEER	
100	Addr at DX--Postal Code	R	R	R	R	.	T	T	R	R	CoC	
110	Census Tract 1970/80/90	RH*	.	.	RH	RH	.	T*		.	SEER	
120	Census Cod Sys 1970/80/90	RH*	.	.	RH	RH	.	T*		.	SEER	
130	Census Tract 2000	R	.	.	R	R	.	T*		.	NAACCR	
140	Census Tract Cod Sys--Alt									.		Retired
150	Marital Status at DX	.	.	.	R	R	.	.		.	SEER	
160	Race 1	R	R	R	R	R	T	T		.	SEER/CoC	
161	Race 2	R	R	R	R	R	T	T		.	SEER/CoC	
162	Race 3	R	R	R	R	R	T	T		.	SEER/CoC	
163	Race 4	R	R	R	R	R	T	T		.	SEER/CoC	
164	Race 5	R	R	R	R	R	T	T		.	SEER/CoC	
170	Race Coding Sys--Current	.	R	R	.	.	T	T		.	NAACCR	
180	Race Coding Sys--Original	.	R	R	.	.	T	T		.	NAACCR	
190	Spanish/Hispanic Origin	R	R	R	R	R	T	T	.	.	SEER/CoC	
191	NHIA Derived Hisp Origin	D	.	.	D	R	.	.	.	.	NAACCR	

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
192	IHS Link	R*	.	.	.	R	.	.	.	.	NPCR	
193	Race--NAPIIA	.	.	.	D	R	.	.	.	.	NAACCR	New
200	Computed Ethnicity	R	.	.	D	R	.	.	.	.	SEER	
210	Computed Ethnicity Source	R	.	.	R	R	.	.	.	.	SEER	
220	Sex	R	R	R	R	R	T	T	R	R	SEER/CoC	Revised
230	Age at Diagnosis	R	R	R	R	R	.	.	.	.	SEER/CoC	
240	Birth Date	R	R	R	R	R	T	T	R	R	SEER/CoC	
250	Birthplace	R*	R	R	R	R	T*	T	.	.	SEER/CoC	
260	Religion	.	.	.	.	.	.	.	.	.	Varies	
270	Occupation Code--Census	R*	.	.	.	.	.	.	.	.	Census/NPCR	
280	Industry Code--Census	R*	.	.	.	.	.	.	.	.	Census/NPCR	
290	Occupation Source	R*	.	.	.	.	.	.	.	.	NPCR	
300	Industry Source	R*	.	.	.	.	.	.	.	.	NPCR	
310	Text--Usual Occupation	R*	.	.	.	.	T*	T*	.	.	NPCR	
320	Text--Usual Industry	R*	.	.	.	.	T*	T*	.	.	NPCR	
330	Occup/Ind Coding System	R*	.	.	.	.	.	.	.	.	NPCR	
340	Tobacco History	.	.	.	.	.	.	.	.	.	Varies	
350	Alcohol History	.	.	.	.	.	.	.	.	.	Varies	
360	Family History of Cancer	.	.	.	.	.	.	.	.	.	Varies	
362	Census Block Group 2000	.	.	.	S	.	.	.	.	.	Census	
364	Census Tr Cert 1970/80/90	RH*	.	.	RH	RH	.	.	.	.	SEER	
365	Census Tr Certainty 2000	R	.	.	R	R	.	.	.	.	NAACCR	
366	GIS Coordinate Quality	R*	.	.	S	.	.	.	.	.	NAACCR	
368	CensusBlockGroup 70/80/90	.	.	.	S	.	.	.	.	.	Census	
370	Reserved 01	.	.	.	.	.	.	.	.	.
380	Sequence Number--Central	R	.	.	R	R	.	T	.	.	SEER	
390	Date of Diagnosis	R	R	R	R	R	T	T	.	.	SEER/CoC	
400	Primary Site	R	R	R	R	R	T	T	.	.	SEER/CoC	
410	Laterality	R	R	R	R	R	T	T	R	R	SEER/CoC	Revised
419	Morph--Type&Behav ICD-O-2									.		

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
420	Histology (92-00) ICD-O-2	RH	RH.	RH	RH	RH	TH	TH	RH	RH	SEER/CoC	
430	Behavior (92-00) ICD-O-2	RH	RH	RH	RH	RH	TH	TH	RH	RH	SEER/CoC	
440	Grade	R	R	R	R	R	T	T	R	R	SEER/CoC	
442	Ambiguous Terminology DX	.	R	R	R	R	.	.	S	S	SEER	Revised
443	Date of Conclusive DX	.	R	R	R	R	.	.	S	S	SEER	Revised
444	Mult Tum Rpt as One Prim	.	R	R	R	R	.	.	S	S	SEER	Revised
445	Date of Multiple Tumors	.	R	R	R	R	.	.	S	S	SEER	Revised
446	Multiplicity Counter	.	R	R	R	R	.	.	S	S	SEER	Revised
447	Number of Tumors/Hist	.	.	.	.	.	.	.	.	.	NAACCR	Retired
450	Site Coding Sys--Current	R	R	R	.	.	T	T	.	.	NAACCR	
460	Site Coding Sys--Original	.	R	R	.	.	T	T	.	.	NAACCR	
470	Morph Coding Sys--Current	R	R	R	.	.	T	T	.	.	NAACCR	
480	Morph Coding Sys--Originl	.	R	R	.	.	T	T	.	.	NAACCR	
490	Diagnostic Confirmation	R	R	R	R	R	T	T	.	.	SEER/CoC	
500	Type of Reporting Source	R	.	.	R	R	T	T	.	.	SEER	
501	Casefinding Source	.	.	.	.	.	T*	T*	.	.	NAACCR	Revised
510	Screening Date	.	.	.	.	.	.	.	.	.	NAACCR	
520	Screening Result	.	.	.	.	.	.	.	.	.	NAACCR	
521	Morph--Type&Behav ICD-O-3									.		
522	Histologic Type ICD-O-3	R	R	R	R	R	T	T	R	R	SEER/CoC	
523	Behavior Code ICD-O-3	R	R	R	R	R	T	T	R	R	SEER/CoC	
530	Reserved 02	.	.	.	.	.	.	.	.	.
535	Reserved 25	.	.	.	.	.	.	.	.	.		Retired
538	Reporting Hospital FAN									.		Retired
540	Reporting Facility	R	R	R	R	.	T	.	.	.	CoC	
545	NPI--Reporting Facility	R*	R	R	R*	.	.	.	.	.	CMS	Revised
550	Accession Number--Hosp	.	R	R	R	.	T*	.	.	.	CoC	
560	Sequence Number--Hospital	.	R	R	R	.	T	.	.	.	CoC	
570	Abstracted By	.	R	R	R	.	.	.	.	.	CoC	
580	Date of 1st Contact	R	R	R	.	.	T	.	.	.	CoC	
590	Date of Inpatient Adm	.	.	.	.	.	.	.	.	.	NAACCR	

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
600	Date of Inpatient Disch	.	.	.	.	.	.	.	.	.	NAACCR	
610	Class of Case	R	R	R	RC	.	T	.	.	.	CoC	
615	Reserved 26	.	.	.	.	.	.	.	.	.
620	Year First Seen This CA											Retired
630	Primary Payer at DX	R*	R	R	R	R	.	.	.	.	CoC	
635	Reserved 27	.	.	.	.	.	.	.	.	.		Retired
640	Inpatient/Outpt Status											Retired
650	Presentation at CA Conf								.			Retired
660	Date of CA Conference								.			Retired
670	RX Hosp--Surg Prim Site	.	R	R	R	.	T*	.	.	.	CoC	
672	RX Hosp--Scope Reg LN Sur	.	R	R	R	.	T*	.	.	.	CoC	
674	RX Hosp--Surg Oth Reg/Dis	.	R	R	R	.	T*	.	.	.	CoC	
676	RX Hosp--Reg LN Removed	.	.	RH	.	.	T*	.	.	.	CoC	
680	Reserved 03	.	.	.	.	.	.	.	.	.
690	RX Hosp--Radiation	.	.	.	RH	.	TH*	.	.	.	SEER/CoC	
700	RX Hosp--Chemo	.	R	R	R	.	T*	.	.	.	CoC	
710	RX Hosp--Hormone	.	R	R	R	.	T*	.	.	.	CoC	
720	RX Hosp--BRM	.	R	R	R	.	T*	.	.	.	CoC	
730	RX Hosp--Other	.	R	R	R	.	T*	.	.	.	CoC	
740	RX Hosp--DX/Stg Proc	.	R	R	.	.	.	.	.	.	CoC	
741	Reserved 28	.	.	.	.	.	.	.	.	.
742	RX Hosp--Screen/BX Proc1											Retired
743	RX Hosp--Screen/BX Proc2											Retired
744	RX Hosp--Screen/BX Proc3											Retired
745	RX Hosp--Screen/BX Proc4											Retired
746	RX Hosp--Surg Site 98-02	.	.	RH	RH	.	TH*	.	.	.	CoC	
747	RX Hosp--Scope Reg 98-02	.	.	RH	RH	.	TH*	.	.	.	CoC	
748	RX Hosp--Surg Oth 98-02	.	.	RH	RH	.	TH*	.	.	.	CoC	
750	Reserved 04	.	.	.	.	.	.	.	.	.
759	SEER Summary Stage 2000	RH	RH	RH	.	S	TH*	TH*	.	.	SEER	
760	SEER Summary Stage 1977	RH	RH	RH	.	S	TH*	TH*	.	.	SEER	
765	Reserved 29	.	.	.	.	.	.	.	.	.

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
770	Loc/Reg/Distant Stage									.		Retired
779	Extent of Disease 10-Dig									.		
780	EOD--Tumor Size	.	RH	RH	RH	RH	TH*	TH*		.	SEER/CoC	
790	EOD--Extension	.	.	.	RH	RH	TH*	TH*		.	SEER	
800	EOD--Extension Prost Path	.	.	.	RH	RH	TH*	TH*		.	SEER	
810	EOD--Lymph Node Involv	.	.	.	RH	RH	TH*	TH*		.	SEER	
820	Regional Nodes Positive	.	R	R	R	R	T*	T*	R*	R*	SEER/CoC	
830	Regional Nodes Examined	.	R	R	R	R	T*	T*	R*	R*	SEER/CoC	
840	EOD--Old 13 Digit	.	.	.	RH	RH	.	.		.	SEER	
850	EOD--Old 2 Digit	.	.	.	RH	RH	.	.		.	SEER	
860	EOD--Old 4 Digit	.	.	.	RH	RH	.	.		.	SEER	
870	Coding System for EOD	.	.	.	RH	RH	.	TH*		.	SEER	
880	TNM Path T	.	R*	R*	.	.	T*	T*	.	.	AJCC	
890	TNM Path N	.	R*	R*	.	.	T*	T*	.	.	AJCC	
900	TNM Path M	.	R*	R*	.	.	T*	T*	.	.	AJCC	
910	TNM Path Stage Group	.	R*	R*	.	.	T*	T*	.	.	AJCC	
920	TNM Path Descriptor	.	R*	R*	.	.	T*	T*	.	.	CoC	
930	TNM Path Staged By	.	R*	R*	.	.	T*	T*	.	.	CoC	
940	TNM Clin T	.	R	R	.	.	T*	T*	.	.	AJCC	
950	TNM Clin N	.	R	R	.	.	T*	T*	.	.	AJCC	
960	TNM Clin M	.	R	R	.	.	T*	T*	.	.	AJCC	
970	TNM Clin Stage Group	.	R	R	.	.	T*	T*	.	.	AJCC	
980	TNM Clin Descriptor	.	R	R	.	.	T*	T*	.	.	CoC	
990	TNM Clin Staged By	.	R	R	.	.	T*	T*	.	.	CoC	
995	Reserved 30	.	.	.	.	.	.	.		.
1000	TNM Other T											Retired
1010	TNM Other N											Retired
1020	TNM Other M											Retired
1030	TNM Other Stage Group											Retired
1040	TNM Other Staged By											Retired
1050	TNM Other Descriptor											Retired

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
1060	TNM Edition Number	.	R	R	.	.	T*	T*	.	.	CoC	
1065	Reserved 31	.	.	.	.	.	.	.	.	.
1070	Other Staging System									.		Retired
1080	Date of 1st Positive BX	.	.	.	.	.	.	.	.	.	NAACCR	
1090	Site of Distant Met 1	.	.	RH	.	.	.	.	.	.	CoC	
1100	Site of Distant Met 2	.	.	RH	.	.	.	.	.	.	CoC	
1110	Site of Distant Met 3	.	.	RH	.	.	.	.	.	.	CoC	
1120	Pediatric Stage	.	.	.	.	.	.	.	.	.	CoC	
1130	Pediatric Staging System	.	.	.	.	.	.	.	.	.	CoC	
1140	Pediatric Staged By	.	.	.	.	.	.	.	.	.	CoC	
1150	Tumor Marker 1	.	.	RH	RH	RH	TH*	TH*	.	.	SEER	
1160	Tumor Marker 2	.	.	RH	RH	RH	TH*	TH*	.	.	SEER	
1170	Tumor Marker 3	.	.	RH	RH	RH	TH*	TH*	.	.	SEER	
1180	Reserved 05	.	.	.	.	.	.	.	.	.
1190	Reserved 06	.	.	.	.	.	.	.	.	.
1200	RX Date--Surgery	.	R	R	S	.	T*	T*	.	.	CoC	
1210	RX Date--Radiation	.	R	R	S	.	T*	T*	.	.	CoC	
1220	RX Date--Chemo	.	.	R*	.	.	TH*	TH*	.	.	NAACCR	Revised
1230	RX Date--Hormone	.	.	R*	.	.	TH*	TH*	.	.	NAACCR	Revised
1240	RX Date--BRM	.	.	R*	S	.	TH*	TH*	.	.	NAACCR	Revised
1250	RX Date--Other	.	R	R	S	.	T*	T*	.	.	CoC	
1260	Date of Initial RX--SEER	R#	.	.	R	R	T*	T*			SEER	
1270	Date of 1st Crs RX--COC	R#	R	R	.	.	T*	T*			CoC	
1280	RX Date--DX/Stg Proc	.	R	R	.	.	.	.	.	.	CoC	
1290	RX Summ--Surg Prim Site	R	R	R	R	R	T	T*	.	.	SEER/CoC	
1292	RX Summ--Scope Reg LN Sur	R	R	R	R	R	T	T*	.	.	SEER/CoC	
1294	RX Summ--Surg Oth Reg/Dis	R	R	R	R	R	T	T*	.	.	SEER/CoC	
1296	RX Summ--Reg LN Examined	.	.	RH	RH	RH	TH*	TH*	.	.	SEER/CoC	
1300	Reserved 07	.	.	.	.	.	.	.	.	.
1310	RX Summ--Surgical Approch	.	.	RH	.	.	.	.	.	.	CoC	
1320	RX Summ--Surgical Margins	.	R	R	.	.	.	.	.	.	CoC	

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
1330	RX Summ--Reconstruct 1st	.	.	.	RH	RH	.	.	.	.	SEER	
1340	Reason for No Surgery	R	R	R	R	R	T	T*	.	.	SEER/CoC	
1350	RX Summ--DX/Stg Proc	.	R	R	.	.	.	.	.	.	CoC	
1355	Reserved 22	.	.	.	.	.	.	.	.	.
1360	RX Summ--Radiation	D	.	.	R	R	TH*	TH*	.	.	SEER	
1370	RX Summ--Rad to CNS	.	.	.	R	R	.	.	.	.	SEER/CoC	
1380	RX Summ--Surg/Rad Seq	R	R	R	R	R	T	T*	.	.	SEER/CoC	
1390	RX Summ--Chemo	R	R	R	R	R	T*	T*	.	.	SEER/CoC	
1400	RX Summ--Hormone	R	R	R	R	R	T*	T*	.	.	SEER/CoC	
1410	RX Summ--BRM	R	R	R	R	R	T*	T*	.	.	SEER/CoC	
1420	RX Summ--Other	R	R	R	R	R	T*	T*	.	.	SEER/CoC	
1430	Reason for No Radiation	.	R	R	.	.	.	.	.	.	CoC	
1435	Reserved 32	.	.	.	.	.	.	.	.	.
1440	Reason for No Chemo									.		Retired
1450	Reason for No Hormone									.		Retired
1460	RX Coding System--Current	R	R	R	.	RH	T*	T*	.	.	NAACCR	
1465	Reserved 33	.	.	.	.	.	.	.	.	.
1470	Protocol Eligibility Stat									.		Retired
1480	Protocol Participation									.		Retired
1490	Referral to Support Serv									.		Retired
1500	First Course Calc Method	.	.	.	.	.	.	.	.	.	NAACCR	
1510	Rad--Regional Dose: CGY	.	R	R	.	.	T	.	.	.	CoC	
1520	Rad--No of Treatment Vol	.	R	R	.	.	T	.	.	.	CoC	
1530	Rad--Elapsed RX Days									.		Retired
1535	Reserved 34	.	.	.	.	.	.	.	.	.
1540	Rad--Treatment Volume	.	R	R	.	.	T	.	.	.	CoC	
1550	Rad--Location of RX	.	R	R	.	.	T	.	.	.	CoC	
1555	Reserved 35	.	.	.	.	.	.	.	.	.
1560	Rad--Intent of Treatment									.		Retired
1570	Rad--Regional RX Modality	R	R	R	RC	.	T	T*	.	.	CoC	
1580	Rad--RX Completion Status									.		Retired
1590	Rad--Local Control Status									.		Retired

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
1600	Chemotherapy Field 1									.		Retired
1610	Chemotherapy Field 2									.		Retired
1620	Chemotherapy Field 3									.		Retired
1630	Chemotherapy Field 4									.		Retired
1635	Reserved 23	.	.	.	.	.	.	.	.	.	.
1639	RX Summ--Systemic/Sur Seq	R	R	R	R	R	T	T	.	.	CoC	
1640	RX Summ--Surgery Type	.	.	.	RH	RH	TH*	TH*	.	.	SEER	
1641	Reserved 36	.	.	.	.	.	.	.	.	.
1642	RX Summ--Screen/BX Proc1											Retired
1643	RX Summ--Screen/BX Proc2											Retired
1644	RX Summ--Screen/BX Proc3											Retired
1645	RX Summ--Screen/BX Proc4											Retired
1646	RX Summ--Surg Site 98-02	.	RH	RH	RH	RH	TH*	TH*	.	.	SEER/CoC	
1647	RX Summ--Scope Reg 98-02	.	RH	RH	RH	RH	TH*	TH*	.	.	SEER/CoC	
1648	RX Summ--Surg Oth 98-02	.	RH	RH	RH	RH	TH*	TH*	.	.	SEER/CoC	
1650	Reserved 08	.	.	.	.	.	.	.	.	.
1660	Subsq RX 2nd Course Date	.	.	.	.	.	.	.	.	.	CoC	
1670	Subsq RX 2nd Course Codes											
1671	Subsq RX 2nd Course Surg	.	.	.	.	.	.	.	.	.	CoC	
1672	Subsq RX 2nd Course Rad	.	.	.	.	.	.	.	.	.	CoC	
1673	Subsq RX 2nd Course Chemo	.	.	.	.	.	.	.	.	.	CoC	
1674	Subsq RX 2nd Course Horm	.	.	.	.	.	.	.	.	.	CoC	
1675	Subsq RX 2nd Course BRM	.	.	.	.	.	.	.	.	.	CoC	
1676	Subsq RX 2nd Course Oth	.	.	.	.	.	.	.	.	.	CoC	
1677	Subsq RX 2nd--Scope LN SU	.	.	.	.	.	.	.	.	.	CoC	
1678	Subsq RX 2nd--Surg Oth	.	.	.	.	.	.	.	.	.	CoC	
1679	Subsq RX 2nd--Reg LN Rem	.	.	.	.	.	.	.	.	.	CoC	
1680	Subsq RX 3rd Course Date	.	.	.	.	.	.	.	.	.	CoC	
1690	Subsq RX 3rd Course Codes											
1691	Subsq RX 3rd Course Surg	.	.	.	.	.	.	.	.	.	CoC	
1692	Subsq RX 3rd Course Rad	.	.	.	.	.	.	.	.	.	CoC	

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
1693	Subsq RX 3rd Course Chemo	.	.	.	.	.	.	.	.	.	CoC	
1694	Subsq RX 3rd Course Horm	.	.	.	.	.	.	.	.	.	CoC	
1695	Subsq RX 3rd Course BRM	.	.	.	.	.	.	.	.	.	CoC	
1696	Subsq RX 3rd Course Oth	.	.	.	.	.	.	.	.	.	CoC	
1697	Subsq RX 3rd--Scope LN Su	.	.	.	.	.	.	.	.	.	CoC	
1698	Subsq RX 3rd--Surg Oth	.	.	.	.	.	.	.	.	.	CoC	
1699	Subsq RX 3rd--Reg LN Rem	.	.	.	.	.	.	.	.	.	CoC	
1700	Subsq RX 4th Course Date	.	.	.	.	.	.	.	.	.	CoC	
1710	Subsq RX 4th Course Codes											
1711	Subsq RX 4th Course Surg	.	.	.	.	.	.	.	.	.	CoC	
1712	Subsq RX 4th Course Rad	.	.	.	.	.	.	.	.	.	CoC	
1713	Subsq RX 4th Course Chemo	.	.	.	.	.	.	.	.	.	CoC	
1714	Subsq RX 4th Course Horm	.	.	.	.	.	.	.	.	.	CoC	
1715	Subsq RX 4th Course BRM	.	.	.	.	.	.	.	.	.	CoC	
1716	Subsq RX 4th Course Oth	.	.	.	.	.	.	.	.	.	CoC	
1717	Subsq RX 4th--Scope LN Su	.	.	.	.	.	.	.	.	.	CoC	
1718	Subsq RX 4th--Surg Oth	.	.	.	.	.	.	.	.	.	CoC	
1719	Subsq RX 4th--Reg LN Rem	.	.	.	.	.	.	.	.	.	CoC	
1720	Subsq RX 5th Course Date											Retired
1725	Reserved 37	.	.	.	.	.	.	.	.	.
1726	Reserved 38	.	.	.	.	.	.	.	.	.
1730	Subsq RX 5th Course Codes											Retired
1731	Subsq RX 5th Course Surg											Retired
1732	Subsq RX 5th Course Rad											Retired
1733	Subsq RX 5th Course Chemo											Retired
1734	Subsq RX 5th Course Horm											Retired
1735	Subsq RX 5th Course BRM											Retired
1736	Subsq RX 5th Course Oth											Retired
1737	Subsq RX 5th--Scope LN Su											Retired
1738	Subsq RX 5th--Surg Oth											Retired
1739	Subsq RX 5th--Reg LN Rem											Retired
1740	Reserved 09	.	.	.	.	.	.	.	.	.

Required Status Table

Item #	Item Name	<u>NPCR/</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		<u>OSCaR</u>	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
1741	Subsq RX--Reconstruct Del	.	.	.	.	.	.	.	.	.	CoC	
1750	Date of Last Contact	R	R	R	R	R	T	T			SEER/CoC	
1755	Date of Death--Canada	.	.	.	.	.	.	.	.	.	CCCR	New
1760	Vital Status	R	R	R	R	R	T	T	.	.	SEER/CoC	
1770	Cancer Status	.	R	R	.	.	.	.	.	.	CoC	
1780	Quality of Survival	.	.	.	.	.	.	.	.	.	CoC	
1790	Follow-Up Source	R*	R	.	.	.	T*	.	.	.	CoC	Revised
1791	Follow-up Source Central	R	.	.	.	.	.	T*	.	.	NAACCR	
1800	Next Follow-Up Source	.	R	.	.	.	.	.	.	.	CoC	
1810	Addr Current--City	.	R	.	R	.	T*	.	.	.	CoC	
1820	Addr Current--State	.	R	.	R	.	T*	.	.	.	CoC	
1830	Addr Current--Postal Code	.	R	.	R	.	T*	.	.	.	CoC	
1835	Reserved 10	.	.	.	.	.	.	.	.	.
1840	County--Current	.	.	.	.	.	.	.	.	.	NAACCR	
1842	Follow-Up Contact--City	.	.	.	R	.	T*	.	.	.	SEER	
1844	Follow-Up Contact--State	.	.	.	R	.	T*	.	.	.	SEER	
1846	Follow-Up Contact--Postal	.	.	.	R	.	T*	.	.	.	SEER	
1850	Unusual Follow-Up Method	.	.	.	.	.	.	.	.	.	CoC	
1860	Recurrence Date--1st	.	R	R	RC	.	T*	.	.	.	CoC	
1870	Recurrence Distant Sites									.		Retired
1871	Recurrence Distant Site 1	.	.	.	.	.	.	.	.	.	NAACCR	
1872	Recurrence Distant Site 2	.	.	.	.	.	.	.	.	.	NAACCR	
1873	Recurrence Distant Site 3	.	.	.	.	.	.	.	.	.	NAACCR	
1880	Recurrence Type--1st	.	R	R	RC	.	T*	.	.	.	CoC	
1890	Recurrence Type--1st--Oth									.		Retired
1895	Reserved 39	.	.	.	.	.	.	.	.	.
1900	Reserved 11	.	.	.	.	.	.	.	.	.
1910	Cause of Death	R	.	.	R	R	.	T	.	.	SEER	
1920	ICD Revision Number	R	.	.	R	R	.	T	.	.	SEER	
1930	Autopsy	.	.	.	.	.	.	.	.	.	NAACCR	
1940	Place of Death	R	.	.	.	.	T*	T*	.	.	NPCR	

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
1950	Reserved 12	.	.	.	.	.	.	.	.	.		Retired
1960	Site (73-91) ICD-O-1	.	.	.	RH	RH	.	.	.	.	SEER	
1970	Morph (73-91) ICD-O-1	.	.	.								
1971	Histology (73-91) ICD-O-1	.	.	.	RH	RH	.	.	.	.	SEER	
1972	Behavior (73-91) ICD-O-1	.	.	.	RH	RH	.	.	.	.	SEER	
1973	Grade (73-91) ICD-O-1	.	.	.	RH	RH	.	.	.	.	SEER	
1980	ICD-O-2 Conversion Flag	.	R	R	R	R	T*	T*			SEER	
1981	Over-ride SS/NodesPos	.	.	.	.	.	T*	T*			NAACCR	
1982	Over-ride SS/TNM-N	.	.	.	.	.	T*	T*		.	NAACCR	
1983	Over-ride SS/TNM-M	.	.	.	.	.	T*	T*		.	NAACCR	
1984	Over-ride SS/DisMet1	.	.	.	.	.	T*	T*		.	NAACCR	
1985	Over-ride Acsn/Class/Seq	.	R	R	.	.	T*	T*		.	CoC	
1986	Over-ride HospSeq/DxConf	.	R	R	.	.	T*	T*		.	CoC	
1987	Over-ride COC-Site/Type	.	R	R	.	.	T*	T*		.	CoC	
1988	Over-ride HospSeq/Site	.	R	R	.	.	T*	T*		.	CoC	
1989	Over-ride Site/TNM-StgGrp	.	R	R	.	.	T*	T*		.	CoC	
1990	Over-ride Age/Site/Morph	R	R	R	R	R	T*	T*		.	SEER	
2000	Over-ride SeqNo/DxConf	R	.	.	R	R	T*	T*		.	SEER	
2010	Over-ride Site/Lat/SeqNo	R	.	.	R	R	T*	T*		.	SEER	
2020	Over-ride Surg/DxConf	R	R	R	R	R	T*	T*		.	SEER	
2030	Over-ride Site/Type	R	R	R	R	R	T*	T*		.	SEER	
2040	Over-ride Histology	R	R	R	R	R	T*	T*		.	SEER	
2050	Over-ride Report Source	R	.	.	R	R	T*	T*		.	SEER	
2060	Over-ride Ill-define Site	R	.	.	R	R	T*	T*		.	SEER	
2070	Over-ride Leuk, Lymphoma	R	R	R	R	R	T*	T*		.	SEER	
2071	Over-ride Site/Behavior	R	R	R	R	R	T*	T*		.	SEER	
2072	Over-ride Site/EOD/DX Dt	.	.	.	R	R	T*	T*		.	SEER	
2073	Over-ride Site/Lat/EOD	.	.	.	R	R	T*	T*		.	SEER	
2074	Over-ride Site/Lat/Morph	R	R	R	R	R	T*	T*		.	SEER	
2080	Reserved 13									.		Retired
2081	CRC CHECKSUM	.	.	.	S	S	.	.		.	NAACCR	

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
2082	Reserved 24	.	.	.	.	.	.	.	.	.
2090	Date Case Completed	.	.	R*	.	.	.	.	.	.	NAACCR	Revised
2100	Date Case Last Changed	.	.	.	.	.	.	.	.	.	NAACCR	
2110	Date Case Report Exported	R	.	.	.	.	T	.	.	.	NPCR	Revised
2111	Date Case Report Received	R	.	.	.	.	.	.	.	.	NPCR	
2112	Date Case Report Loaded	R	.	.	.	.	.	.	.	.	NPCR	
2113	Date Tumor Record Availbl	R	.	.	.	.	.	.	.	.	NPCR	
2114	Future Use Timeliness 1									.		Retired
2115	Future Use Timeliness 2									.		Retired
2116	ICD-O-3 Conversion Flag	R	R	R	R	R	T	T		.	SEER/CoC	
2120	SEER Coding Sys--Current	.	.	.	.	R	T*	T*	.	.	NAACCR	
2130	SEER Coding Sys--Original	.	.	.	.	R	T*	T*	.	.	NAACCR	
2140	COC Coding Sys--Current	.	R	R	.	.	T*	T*		.	CoC	
2150	COC Coding Sys--Original	.	R	R	.	.	T*	T*		.	CoC	
2160	Subsq Report for Primary											Retired
2161	Reserved 20									.		Retired
2170	Vendor Name	.	.	R	.	.	T	T	.	.	NAACCR	
2180	SEER Type of Follow-Up	.	.	.	R	R	.	.	.	.	SEER	
2190	SEER Record Number	.	.	.	.	R	.	.	.	.	SEER	
2200	Diagnostic Proc 73-87	.	.	.	RH	RH	.	.		.	SEER	
2210	Reserved 14									.		Retired
2220	State/Requestor Items	.	.	.	.	.	.	.	.	.	Varies	
2230	Name--Last	R	R	.	R	.	T	T		.	NAACCR	
2240	Name--First	R	R	.	R	.	T	T		.	NAACCR	
2250	Name--Middle	R	R	.	R	.	T*	T*		.	CoC	
2260	Name--Prefix	.	.	.	.	.	.	.		.	SEER	
2270	Name--Suffix	.	.	.	R	.	T*	T*		.	SEER	
2280	Name--Alias	R	.	.	R	.	T*	T*		.	SEER	
2290	Name--Spouse/Parent	.	.	.	.	.	.	.		.	NAACCR	
2300	Medical Record Number	R	R	.	R	.	T	.		.	CoC	
2310	Military Record No Suffix	.	R	.	.	.	.	.		.	CoC	

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
2320	Social Security Number	R	R	.	R	.	T	T	.	.	CoC	
2330	Addr at DX--No & Street	R	R	.	R	.	T	T	.	.	CoC	
2335	Addr at DX--Supplementl	R	R	.	R	.	T*	T*	.	.	CoC	
2350	Addr Current--No & Street	.	R	.	R	.	T*	T*	.	.	CoC	
2352	Latitude	R*	.	.	S	.	.	.	.	.	NAACCR	
2354	Longitude	R*	.	.	S	.	.	.	.	.	NAACCR	
2355	Addr Current--Supplementl	.	R	.	R	.	T*	.	.	.	CoC	
2360	Telephone	.	R	.	R	.	T*	T*	.	.	CoC	
2370	DC State									.		Retired
2371	Reserved 21									.		Retired
2380	DC State File Number	R	.	.	R*	.	.	T*	.	.	State	
2390	Name--Maiden	R	.	.	R	.	T*	T*	.	.	SEER	
2392	Follow-Up Contact--No&St	.	.	.	R	.	.	.	.	.	SEER	
2393	Follow-Up Contact--Suppl	.	.	.	R	.	.	.	.	.	SEER	
2394	Follow-Up Contact--Name	.	.	.	R	.	.	.	.	.	SEER	
2400	Reserved 16									.		Retired
2410	Institution Referred From	.	R	.	.	.	T*	.	.	.	CoC	
2415	NPI--Inst Referred From	.	R	.	.	.	.	.	.	.	CMS	Revised
2420	Institution Referred To	.	R	.	.	.	T*	.	.	.	CoC	
2425	NPI--Inst Referred To	.	R	.	.	.	.	.	.	.	CMS	Revised
2430	Last Follow-Up Hospital											Retired
2435	Reserved 40	.	.	.	.	.	.	.	.	.
2440	Following Registry	.	R	.	R	.	.	.	.	.	CoC	
2445	NPI--Following Registry	.	.	.	R*	.	.	.	.	.	CMS	Revised
2450	Reserved 17									.		Retired
2460	Physician--Managing	.	.	.	.	.	.	.	.	.	NAACCR	
2465	NPI--Physician--Managing	.	R	R	.	.	.	.	.	.	CMS	Revised
2470	Physician--Follow-Up	.	R	.	R	.	T*	T*	.	.	CoC	
2475	NPI--Physician--Follow-Up	.	R	R	R*	.	.	.	.	.	CMS	Revised
2480	Physician--Primary Surg	.	R	.	.	.	.	.	.	.	CoC	
2485	NPI--Physician--Primary Surg	.	R	R	.	.	.	.	.	.	CMS	Revised

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
2490	Physician 3	.	R	.	.	.	.	.	.	.	CoC	
2495	NPI--Physician 3	.	R	R	.	.	.	.	.	.	CMS	Revised
2500	Physician 4	.	R	.	.	.	.	.	.	.	CoC	
2505	NPI--Physician 4	.	R	R	.	.	.	.	.	.	CMS	Revised
2520	Text--DX Proc--PE	R^	.	.	R	.	T*	T*	.	.	NPCR	
2530	Text--DX Proc--X-ray/Scan	R^	.	.	R	.	T*	T*	.	.	NPCR	
2540	Text--DX Proc--Scopes	R^	.	.	R	.	T*	T*	.	.	NPCR	
2550	Text--DX Proc--Lab Tests	R^	.	.	R	.	T*	T*	.	.	NPCR	
2560	Text--DX Proc--Op	R^	.	.	R	.	T*	T*	.	.	NPCR	
2570	Text--DX Proc--Path	R^	.	.	R	.	T*	T*	.	.	NPCR	
2580	Text--Primary Site Title	R^	.	.	R	.	T*	T*	.	.	NPCR	
2590	Text--Histology Title	R^	.	.	R	.	T*	T*	.	.	NPCR	
2600	Text--Staging	R^	.	.	R	.	T*	T*	.	.	NPCR	
2610	RX Text--Surgery	R^	.	.	R	.	T*	T*	.	.	NPCR	
2620	RX Text--Radiation (Beam)	R^	.	.	R	.	T*	T*	.	.	NPCR	
2630	RX Text--Radiation Other	R^	.	.	R	.	T*	T*	.	.	NPCR	
2640	RX Text--Chemo	R^	.	.	R	.	T*	T*	.	.	NPCR	
2650	RX Text--Hormone	R^	.	.	R	.	T*	T*	.	.	NPCR	
2660	RX Text--BRM	R^	.	.	R	.	T*	T*	.	.	NPCR	
2670	RX Text--Other	R^	.	.	R	.	T*	T*	.	.	NPCR	
2680	Text--Remarks	.	.	.	R	.	T*	T*	.	.	NPCR	
2690	Text--Place of Diagnosis	.	.	.	.	.	.	.	.	.	NPCR	
2700	Reserved 19	.	.	.	.	.	.	.	.	.
2800	CS Tumor Size	R	R	R	R	R	T	T	R*	R*	AJCC	
2810	CS Extension	R	R	R	R	R	T	T	R*	R*	AJCC	
2820	CS Tumor Size/Ext Eval	R	R	R	R	R	T*	T*	R*	R*	AJCC	Revised
2830	CS Lymph Nodes	R	R	R	R	R	T	T	R*	R*	AJCC	
2840	CS Reg Node Eval	.	R	R	R	R	T*	T*	R*	R*	AJCC	Revised
2850	CS Mets at DX	R	R	R	R	R	T	T	R*	R*	AJCC	
2860	CS Mets Eval	.	R	R	R	R	T*	T*	R*	R*	AJCC	Revised

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
2880	CS Site-Specific Factor 1	RS	R	R	R	R	T	T	R*	R*	AJCC	
2890	CS Site-Specific Factor 2	.	R	R	R	R	T	T	R*	R*	AJCC	
2900	CS Site-Specific Factor 3	RS	R	R	R	R	T	T	R*	R*	AJCC	
2910	CS Site-Specific Factor 4	.	R	R	R	R	T	T	R*	R*	AJCC	
2920	CS Site-Specific Factor 5	.	R	R	R	R	T	T	R*	R*	AJCC	
2930	CS Site-Specific Factor 6	.	R	R	R	R	T	T	R*	R*	AJCC	
2935	CS Version 1st	R	D	R	D	R	.	.	R*	R*	AJCC	Revised
2936	CS Version Latest	R	D	R	D	R	.	.	R*	R*	AJCC	Revised
2940	Derived AJCC T	.	D	R	D	R	T*	T*	R*	R*	AJCC	Revised
2950	Derived AJCC T Descriptor	.	D	R	D	R	T*	T*	R*	R*	AJCC	Revised
2960	Derived AJCC N	.	D	R	D	R	T*	T*	R*	R*	AJCC	Revised
2970	Derived AJCC N Descriptor	.	D	R	D	R	T*	T*	R*	R*	AJCC	Revised
2980	Derived AJCC M	.	D	R	D	R	T*	T*	R*	R*	AJCC	Revised
2990	Derived AJCC M Descriptor	.	D	R	D	R	T*	T*	R*	R*	AJCC	Revised
3000	Derived AJCC Stage Group	.	D	R	D	R	T*	T*	R*	R*	AJCC	Revised
3010	Derived SS1977	.	D	R	D	R	T*	T*	R*	R*	AJCC	Revised
3020	Derived SS2000	D	D	R	D	R	T*	T*	R*	R*	AJCC	Revised
3030	Derived AJCC--Flag	.	R	R	D	R	T*	T*	R*	R*	AJCC	Revised
3040	Derived SS1977--Flag	.	R	R	D	R	T*	T*	R*	R*	AJCC	Revised
3050	Derived SS2000--Flag	D	R	R	D	R	T*	T*	R*	R*	AJCC	Revised
3100	Archive FIN	.	R	R	.	.	.	.	.	.	CoC	
3105	NPI--Archive FIN	.	R	R	.	.	.	.	.	.	CMS	Revised
3110	Comorbid/Complication 1	.	R	R	.	.	T*	.	.	.	CoC	
3120	Comorbid/Complication 2	.	R	R	.	.	T*	.	.	.	CoC	
3130	Comorbid/Complication 3	.	R	R	.	.	T*	.	.	.	CoC	
3140	Comorbid/Complication 4	.	R	R	.	.	T*	.	.	.	CoC	
3150	Comorbid/Complication 5	.	R	R	.	.	T*	.	.	.	CoC	
3160	Comorbid/Complication 6	.	R	R	.	.	T*	.	.	.	CoC	
3161	Comorbid/Complication 7	.	R	R	.	.	T*	.	.	.	CoC	
3162	Comorbid/Complication 8	.	R	R	.	.	T*	.	.	.	CoC	

Required Status Table

Item #	Item Name	<u>NPCR/ OSCaR</u>	<u>CoC</u>		<u>SEER</u>		<u>Exchange Elements</u>		<u>CCCR</u>		Source of Standard	Status
		Collect	Collect	Transmit	Collect	Transmit	Hospital->Central	Central->Central	Collect	Transmit		
3163	Comorbid/Complication 9	.	R	R	.	.	T*	.	.	.	CoC	
3164	Comorbid/Complication 10	.	R	R	.	.	T*	.	.	.	CoC	
3165	ICD Revision Comorbid	.	R	R	.	.	T*	.	.	.	CoC	
3170	RX Date--Most Defin Surg	.	R	R	.	.	T*	.	.	.	CoC	
3180	RX Date--Surgical Disch	.	R	R	.	.	.	.	.	.	CoC	
3190	Readm Same Hosp 30 Days	.	R	R	.	.	.	.	.	.	CoC	
3200	Rad--Boost RX Modality	.	R	R	RC	.	T*	T*	.	.	CoC	
3210	Rad--Boost Dose cGy	.	R	R	.	.	.	.	.	.	CoC	
3220	RX Date--Radiation Ended	.	R	R	.	.	.	.	.	.	CoC	
3230	RX Date--Systemic	.	R	R	S	.	T*	T*	.	.	CoC	
3250	RX Summ--Transplnt/Endocr	R	R	R	R	R	T*	T*	.	.	CoC	
3260	Pain Assessment								.			Retired
3270	RX Summ--Palliative Proc	.	R	R	.	.	T*	.	.	.	CoC	
3280	RX Hosp--Palliative Proc	.	R	R	.	.	T*	.	.	.	CoC	
3300	RuralUrban Continuum 1993	D	.	.	.	.	.	.	.	.	NAACCR	
3310	RuralUrban Continuum 2003	D	.	.	.	.	.	.	.	.	NAACCR	

TH = cases diagnosed before 2004, transmit data if available in exchange record.

= Central registries may code available data using either SEER or CoC data items and associated rules.

RC = Collected by SEER from CoC approved hospitals.

T = data is vital to complete exchange record.

D = Derived.

RH = Historically collected and currently transmitted.

RH* = Historically collected and currently transmitted when available.

. = No recommendations.

R = Required.

RS = Required, site specific.

R^ = Required, these text requirements may be met with one or several text block fields.

R* = Required, when available.

R\$ = Requirements differ by year.

S = Supplementary/recommended.

Appendix C

Definitions of Single and Subsequent Primaries for Hematologic Malignancies based on ICD-O-3 reportable malignancies, effective with diagnoses 01/01/2001 and after

Cancer registrars are often faced with multiple pathology reports in patients with hematologic malignancies, and the diagnoses reported may require different morphology codes. This is due in part to the fact that more intensive diagnostic study may yield a more specific diagnosis, and in part due to the natural histories of hematopoietic diseases, which may progress from one diagnosis into another.

The following chart, provided to aid the registrar in determining single versus subsequent primaries, employs the following guidelines:

1. "Lymphoma" is a general term for hematopoietic solid malignancies of the lymphoid series. "Leukemia" is a general term for liquid malignancies of either the lymphoid or the myeloid series. While it is recognized that some malignancies occur predominantly (or even exclusively) in liquid or solid form, because so many malignancies can potentially arise as either leukemias or lymphomas (or both), all hematopoietic malignancies are assumed to have this potential.
2. Malignancies of the lymphoid series are considered to be different from those of the myeloid series. Therefore, a lymphoid malignancy arising after diagnosis of a myeloid malignancy (or myelodysplastic or myeloproliferative disorder) would be considered a subsequent primary; however, a myeloid malignancy diagnosed after a previous myeloid malignancy would not count as a subsequent primary. Histiocytic malignancies are considered different from both lymphoid and myeloid malignancies.
3. Hodgkin lymphoma is considered to be different from non-Hodgkin lymphoma (NHL). Among the NHLs, B-cell malignancies are considered different from T-cell/NK cell malignancies. Therefore, a B-cell malignancy arising later in the course of a patient previously diagnosed with a T-cell malignancy would be considered a subsequent primary; however, a T-cell malignancy diagnosed later in the same patient would not be considered a subsequent primary.
4. The sequence of diagnoses affects whether a diagnosis represents a subsequent primary. In some cases, the order of occurrence of the two diagnoses being compared is a factor in the decision whether the second diagnosis is a new primary.

We gratefully acknowledge the assistance of Drs. Charles Lynch, Charles Platz, and Fred Dick of the University of Iowa, Dr. Tim Cote of the SEER Program, Jennifer Seiffert, MLIS, CTR, and Annette Hurlbut, RHIT, CTR, for their assistance with this project.

To use the table, assign the ICD-O-3 code to the first diagnosis and find the row containing that code. Assign the ICD-O-3 code for the second diagnosis and find the column containing that code. In the cell at the intersection of the first diagnosis row and the second diagnosis column, a "**S**" symbol indicates that the two diagnoses are most likely the **same** disease process (prepare/update a single abstract), and a "**D**" indicates that they are most likely **different** disease processes (prepare more than one abstract).

Note 1: If one of the two diagnoses is an NOS (not otherwise specified) term and the other is more specific and determined to be the same disease process, code the more specific diagnosis regardless of the sequence. For example, if a diagnosis of non-Hodgkin lymphoma, NOS is followed by a diagnosis of follicular lymphoma, assign the morphology code for the follicular lymphoma.

Note 2: The table "Single versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases" (pages 2-6) and the "Complete Diagnostic Terms for Table (based on ICD-O-3)" (page 7) display only the ICD-O-3 primary (boldfaced) term associated with the code. Refer to the *International Classification of Diseases, Third Edition* (ICD-O-3) for a complete list of related terms and synonyms.

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02/28/2001

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 1		SECOND DX ACROSS FIRST DX DOWN										
		1. 9590 Malignant lymphoma, NOS	2. 9591 NHL, NOS	3. 9596 Composite HD/NHL	4. 9650-9667 Hodgkin lymphoma	5. 9670-9671 ML, small B lymph	6. 9673 Mantle cell lymph	7. 9675-9684 ML, diff large B-cell	8. 9687 Burkitt lymphoma	9. 9689,9699 Marg zn, B-cl lym	10. 9690-9698 Follicular lymphoma	
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	D	D	S	S	S	S	S	S	S
3. Composite HD/NHL	9596	S	S	S	S	S	S	S	S	S	S	S
4. Hodgkin lymphoma	9650-9667	S	D	D	S	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	S	D	D	S	D	S	D	D	D	D
6. Mantle cell lymphoma	9673	S	S	D	D	D	S	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	S	D	D	S	D	S	S	D	D	S
8. Burkitt lymphoma	9687	S	S	D	D	D	D	D	S	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	S	S	D	D	D	D	D	D	S	D	D
10. Follicular lymphoma	9690-9698	S	S	D	D	D	D	S	D	D	D	S
11. Mycos fung, Sezary disease	9700-9701	S	S	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	S	S	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	S	S	D	D	D	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	S	S	D	D	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	S	S	D	D	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	S	S	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	S	S	D	D	S	D	S	D	D	D	D
21. Waldenstrom macroglob	9761	S	S	D	D	S	D	S	D	D	D	D
22. Heavy chain disease, NOS	9762	S	S	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	S	S	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	S	S	D	D	D	D	D	S	D	D	D
25. Acute biphenotypic leukem	9805	S	S	D	D	S	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	D	D	D	D	D	S	D	D	S
27. BCLL/SLL	9823	S	S	D	D	S	D	S	D	D	D	D
28. Burkitt cell leukemia	9826	S	S	D	D	D	D	D	S	D	D	D
29. Adult T-cell leuk/lymph	9827	S	S	D	D	D	D	D	D	D	D	D
30. Polym'cyt leuk, NOS	9832	D	D	D	D	S	D	D	D	D	D	D
31. Polym'cyt leuk, B-cell	9833	D	D	D	D	S	D	D	D	D	D	D
32. Polym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	S	S	D	D	D	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	S	S	D	D	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	S	S	D	D	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	D	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	9948	S	S	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	D	D	D	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	D	D	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	D	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 2 SECOND DX ACROSS FIRST DX DOWN		11. 9700-9701 MF, Sezary disease	12. 9702-9719 T/NK-cell lymphoma	13. 9727 Precurs lym'blas lymph NOS	14. 9728 Precurs lym'blas lymph B-cl	15. 9729 Precurs lym'blas lymph T-cl	16. 9731-9734 Plasma cell tumors	17. 9740-9742 Mast cell tumors	18. 9750-9756 Histiocytos; LCH	19. 9757-9758 Dendritic cell sarc	20. 9760 Immunoprolif dis
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	S	S	S	D	D	D	S	S
3. Composite HD/NHL	9596	S	S	S	S	S	D	D	D	D	S
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D	D	D	S
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	S	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	S	D	D	D	D	D	D	D	S
13. Precurs lym'blas lymph NOS	9727	D	D	S	S	S	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	S	S	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	S	D	S	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	S	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	S	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	S	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	S	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	S	D	D	D	S
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	S
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	S
23. Immun sm intest disease	9764	D	D	D	D	D	S	D	D	D	S
24. Leuk/Acute leuk, NOS	9800-9801	D	S	S	S	S	D	D	D	D	D
25. Acute biphenotypic leukem	9805	S	S	S	S	S	D	D	D	D	D
26. Lymphocytic leukem, NOS	9820	S	S	S	S	S	D	D	D	D	S
27. BCLL/SLL	9823	D	D	D	D	D	D	D	D	D	S
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	S	S	S	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	S	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	S	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	9948	D	S	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	D	D	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	D	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 3 SECOND DX ACROSS FIRST DX DOWN		21. 9761 Waldenstrom	22. 9762 Heavy chain dis	23. 9764 Imm sm intest dis	24. 9800-9801 Leuk/Acu leuk NOS	25. 9805 Acute biphenotypic leuk	26. 9820 Lym'cyt leuk, NOS	27. 9823 BCLL/SLL	28. 9826 Burkitt leukemia	29. 9827 Adult T-cell leuk/lym	30. 9832 Prolym leuk, NOS
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	S	S	S	S	S	S	S	D
3. Composite HD/NHL	9596	S	S	S	S	D	S	S	S	S	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	D	D	D	S	S	S	D	D	S
6. Mantle cell lymphoma	9673	D	D	D	D	S	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	S	S	D	S	S	S	D	D	S
8. Burkitt lymphoma	9687	D	D	D	S	S	S	D	S	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	S	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	S	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	S	S	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	S	S	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	D	S	S	S	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	D	S	S	S	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	D	S	S	S	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	S	S	S	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	S	D	D	D	D	S	S	D	D	D
22. Heavy chain disease, NOS	9762	D	S	S	D	D	S	S	D	D	D
23. Immun sm intest disease	9764	D	S	S	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	D	D	D	S	S	S	D	S	S	D
25. Acute biphenotypic leukem	9805	D	D	D	S	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	D	S	S	S	S	S	S	S
27. BCLL/SLL	9823	D	D	D	D	S	S	S	D	D	S
28. Burkitt cell leukemia	9826	D	D	D	S	S	S	D	S	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	S	S	D	D	S	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	S	S	S	D	D	S
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	S	S	S	D	D	S
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	S	S	D	D	S	S
33. Precurs lym'cyt leuk, NOS	9835	D	D	D	S	S	S	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	D	S	S	S	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	D	S	S	S	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	S	S	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	S	S	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	S	S	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	S	S	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	S	S	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	S	S	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	S	S	D	D	D	D	D
43. NK-cell leukemia	9948	D	D	D	S	S	S	D	D	D	D
44. Polycythemia vera	9950	D	D	D	S	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	S	S	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	S	S	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	S	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	S	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	S	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	S	S	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	S	S	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	S	S	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 4 SECOND DX ACROSS FIRST DX DOWN		31. 9833 Polym leuk, B-cell	32. 9834 Polym leuk, T-cell	33. 9835 Precurs leuk, NOS	34. 9836 Precurs leuk, B-cell	35. 9837 Precurs leuk, T-cell	36. 9840-9910 Myeloid leukemias	37. 9920 Therapy rel AML	38. 9930 Myeloid sarcoma	39. 9931 Acute panmyelosis	40. 9940 Hairy cell leukemia	41. 9945 Chr myelomono leu
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	D	D	S	S	S	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	S	S	S	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	D	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	S	S	S	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	S	S	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	S	D	S	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	D	D	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	D	D	S	S	S	S	S	S	D	D	S
25. Acute biphenotypic leukem	9805	S	S	S	S	S	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	S	S	S	D	D	D	D	S	D
27. BCLL/SLL	9823	S	D	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D	D
30. Polym'cyt leuk, NOS	9832	S	S	D	D	D	D	D	D	D	D	D
31. Polym'cyt leuk, B-cell	9833	S	D	D	D	D	D	D	D	D	D	D
32. Polym'cyt leuk, T-cell	9834	D	S	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	S	S	S	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	S	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	S	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	S	S	S	S	D	S
37. Therapy related AML	9920	D	D	D	D	D	S	S	S	S	D	S
38. Myeloid sarcoma	9930	D	D	D	D	D	S	S	S	S	D	S
39. Acute panmyelosis	9931	D	D	D	D	D	S	S	S	S	D	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	S	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	S	S	S	S	D	S
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	S	S	S	S	D	S
43. NK-cell leukemia	9948	D	D	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	S	S	S	S	D	S
46. Myelosclerosis	9961	D	D	D	D	D	S	S	S	S	D	S
47. Essen thrombocythem	9962	D	D	D	D	D	S	S	S	S	D	S
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	S	S	S	S	D	S
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	S	S	S	S	D	S
50. Refractory anemias	9980-9986	D	D	D	D	D	S	S	S	S	D	S
51. Therapy related MDS	9987	D	D	D	D	D	S	S	S	S	D	S
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	S	S	S	S	D	S

Codes: S--one primary only; D--presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 5 SECOND DX ACROSS FIRST DX DOWN		42. 9946 Juv myelomono leu	43. 9948 NK-cell leukemia	44. 9950 Polycythemia vera	45. 9960 Chr myeloprolif dis	46. 9961 Myelosclerosis	47. 9962 Ess thrombocythem	48. 9963 Chr neutrophil leu	49. 9964 Hyper eosin syndr	50. 9980-9986 Refract anemias	51. 9987 Therapy rel MDS	52. 9989 Myelodys syn NOS
1. Malignant lymphoma, NOS	9590	S	S	D	D	D	D	D	D	D	D	D
2. NHL, NOS	9591	D	D	D	D	D	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	D	D	D	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	D	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	D	D	D	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	D	D	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	D	D	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	D	D	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	S	D	D	S	S	D	S	S	D	S	S
25. Acute biphenotypic leukem	9805	S	S	D	S	S	D	D	D	S	S	S
26. Lymphocytic leukem, NOS	9820	D	S	D	D	D	D	D	D	D	D	D
27. BCLL/SLL	9823	D	D	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D	D
30. Polym'cyt leuk, NOS	9832	D	D	D	D	D	D	D	D	D	D	D
31. Polym'cyt leuk, B-cell	9833	D	D	D	D	D	D	D	D	D	D	D
32. Polym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	D	D	D	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	D	D	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	D	D	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	S	D	D	S	S	S	S	S	D	S	S
37. Therapy related AML	9920	S	D	D	D	S	D	D	D	D	S	S
38. Myeloid sarcoma	9930	S	D	D	S	S	S	S	D	D	S	S
39. Acute panmyelosis	9931	S	D	D	D	S	D	D	D	D	S	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	S	D	D	S	S	D	S	D	D	S	S
42. Juvenile myelomonocy leuk	9946	S	D	D	D	S	D	D	D	D	S	S
43. NK-cell leukemia	9948	D	S	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	S	S	S	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	S	S	S	S	D	D	D	D
46. Myelosclerosis	9961	S	D	D	S	S	S	S	D	D	S	S
47. Essen thrombocythem	9962	D	D	D	S	S	S	S	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	S	S	S	S	D	D	D	D
49. Hyper eosinophilic syndrome	9964	S	D	D	S	S	D	D	S	D	D	D
50. Refractory anemias	9980-9986	S	D	D	S	S	D	D	D	S	S	S
51. Therapy related MDS	9987	S	D	D	S	S	D	D	D	S	S	S
52. Myelodysplastic syndr, NOS	9989	S	D	D	S	S	D	D	D	S	S	S

Codes: S--one primary only; D--presumably a subsequent primary SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

COMPLETE DIAGNOSTIC TERMS FOR TABLE (BASED ON ICD-O-3)

- 1 9590 Malignant lymphoma, NOS
- 2 9591 Malignant lymphoma, non-Hodgkin, NOS
- 3 9596 Composite Hodgkin and non-Hodgkin lymphoma
- 4 9650-9667 Hodgkin lymphoma (all subtypes)
- 5 9670-9671 Malignant lymphoma, small B lymphocytic
- 6 9673 Mantle cell lymphoma
- 7 9675-9684 Malignant lymphoma, diffuse large B-cell
- 8 9687 Burkitt lymphoma
- 9 9689, 9699 Marginal zone B-cell lymphoma
- 10 9690-9698 Follicular lymphoma
- 11 9700-9701 Mycosis fungoides and Sezary syndrome
- 12 9702-9719 T/NK-cell non-Hodgkin lymphoma
- 13 9727 Precursor cell lymphoblastic lymphoma, NOS
- 14 9728 Precursor B-cell lymphoblastic lymphoma
- 15 9729 Precursor T-cell lymphoblastic lymphoma
- 16 9731-9734 Plasma cell tumors
- 17 9740-9742 Mast cell tumors
- 18 9750-9756 Histiocytosis/Langerhans cell histiocytosis
- 19 9757-9758 Dendritic cell sarcoma
- 20 9760 Immunoproliferative disease, NOS
- 21 9761 Waldenstrom macroglobulinemia
- 22 9762 Heavy chain disease, NOS
- 23 9764 Immunoproliferative small intestinal disease
- 24 9800-9801 Leukemia, NOS/Acute leukemia, NOS
- 25 9805 Acute biphenotypic leukemia
- 26 9820 Lymphoid leukemia, NOS
- 27 9823 B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma
- 28 9826 Burkitt cell leukemia
- 29 9827 Adult T-cell leukemia/lymphoma (HTLV-1 positive)
- 30 9832 Prolymphocytic leukemia, NOS
- 31 9833 Prolymphocytic leukemia, B-cell type
- 32 9834 Prolymphocytic leukemia, T-cell type
- 33 9835 Precursor cell lymphoblastic leukemia, NOS
- 34 9836 Precursor B-cell lymphoblastic leukemia
- 35 9837 Precursor T-cell lymphoblastic leukemia
- 36 9840-9910 Myeloid leukemias
- 37 9920 Therapy related acute myelogenous leukemia
- 38 9930 Myeloid sarcoma
- 39 9931 Acute panmyelosis with myelofibrosis
- 40 9940 Hairy cell leukemia
- 41 9945 Chronic myelomonocytic leukemia, NOS
- 42 9946 Juvenile myelomonocytic leukemia
- 43 9948 Aggressive NK-cell leukemia
- 44 9950 Polycythemia vera
- 45 9960 Chronic myeloproliferative disease, NOS
- 46 9961 Myelosclerosis with myeloid metaplasia
- 47 9962 Essential thrombocythemia
- 48 9963 Chronic neutrophilic leukemia
- 49 9964 Hypereosinophilic syndrome
- 50 9980-9986 Refractory anemias
- 51 9987 Therapy related myelodysplastic syndrome, NOS
- 52 9989 Myelodysplastic syndrome, NOS

Version 1.01. Codes corrected for terms in rows 7 and 9 on pages 2-5.

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02/28/2001

Appendix D

Reporting Facilities

<u>FacilityNumber</u>	<u>FacilityName</u>	<u>FacilityAbbreviation</u>
920510	Adventist Medical Center	AM
920010	Albany General Hospital	AG
920025	Ashland Community Hospital	AC
920327	Bay Area Hospital	BA
920195	Blue Mountain Hospital	BM
920015	Columbia Memorial Hospital	CM
920270	Columbia Willamette Valley Medical Ctr.	CW
920105	Coquille Valley Hospital	CV
920165	Curry General Hospital	CU
920175	Good Shepherd Medical Center	GO
920210	Grande Ronde Hospital	GR
920075	Harney District Hospital	HD
920340	Holy Rosary Medical Center	HR
920190	Hood River Memorial Hospital	HM
920445	Kaiser Sunnyside Medical Center	KS
920231	Lake District Hospital	LD
920241	Lebanon Community Hospital	LC
000034	Legacy Health System	LS
920614	Lower Umpqua Hospital	LU
920741	McKenzie-Willamette Hospital	MC
920620	Mercy Medical Center	MM
920770	Mid-Columbia Medical Center	MI
920242	Mountain View Hospital	MT
920570	OHSU--OP17A	OH
920163	Peace Harbor Hospital	PH
920610	Pioneer Memorial Hospital	PI
920590	Portland VA Medical Center	VA
920290	Providence Medford Med Center	PF
920296	Providence Milwaukie Hospital	PM
920315	Providence Newberg Hospital	PN
920520	Providence Portland Medical Center	PP
920725	Providence Seaside Hospital	PS
920540	Providence St. Vincent Medical Center	PV
920280	Rogue Valley Medical Center	RV
920630	Roseburg VA Medical Center	RS
920160	Sacred Heart Medical Center	SH
920708	Salem Hospital	SL
920110	Samaritan Regional	GS
920243	Samaritan North Lincoln Hospital	NL
920325	Samaritan Pac. Comm. Hospital	PC
920743	Santiam Memorial Hospital	SM

Reporting Facilities

920740	Silverton Hospital	SI
920207	Sky Lakes Medical Center	SK
920065	Southern Coos Hospital	SO
920380	St. Anthony Hospital	SA
920070	St. Charles Medical Center	SB
920612	St. Charles-Redmond	SR
920060	St. Elizabeth Hospital & Health Care Ctr.	SE
920171	Three Rivers -- Washington	TW
920780	Tillamook County General Hospital	TC
920180	Tuality Community Hospital	TU
920140	Wallowa Memorial Hospital	WM
920350	Willamette Falls Hospital	WF

Ambulatory Surgery Centers

<u>FacilityName</u>	<u>FacilityNumber</u>	<u>State Number*</u>
Aesthetic Breast Care Center	001438	licensed in OR only
Aesthetic Surgery Center of Eugene		001052
Ashland Surgical Center		001061
Bend Surgery Center	001027	001027
Cascade Endoscopy Center		001058
Cascade Spine Center, LLC		001054
Cascade Surgicenter		001068
Center for Cosmetic & Plastic Surgery	001441	001018
Center for Specialty Surgery		001056
Croisan Ridge Surger Center		001062
Day Surgery Center of Corvallis		001055
Doctors Park Surgery Center, LLC	001504	001048
East Oregon Surgery Center, LLC	001505	001047
East Portland Surgery Center		001050
Eastern Oregon Regional Surgery Center		001053
Endoscopy Ctr at West Hills Gastroenterology		001064
Eugene Surgery Center	001035	001035
Eye Health Eastside Surgery Center		no lic. number listed
Eye Surgery Center (Albany)	001500	001009
Eye Surgery Center (Medford)	001430	001004
Futures Outpatient Surgery Center, Inc.	001440	001017
Gastroenterology Endoscopy Center (Tualatin)	001012	001012
Gastroenterology Endoscopy Center (Oregon City)		001049
Gateway Medical Center		001066
GI Endoscopy Center	001432	001011
Grants Pass Surgery Center	001028	001028
Gresham Station Surgery Center		001069
Healthsouth Northbank Surgery Center	001315	001002
Interstate Med Ofc S Ambulatory Surg Ctr	001030	001030
Klamath Surgery Center	001503	001029
Lane Surgery Center, LLC	001506	001040
Laser and Surgical Eye Center	001022	001022
Lovejoy Surgicenter, Inc.	000978	001000
McKenzie Surgery Center	001020	001020
McMinnville Surgical Center	001042	001042
Medford Plastic Surgeons ASC	001019	not on list
Native American Rehabilitation Assoc.	001510	not on list
NGC Endoscopy Services		001046
North Bend Medical Ctr Ambulatory Surgical Ctr	001333	001006
Northwest ASC		001067
Northwest Center for Plastic Surgery		001071
Northwest Surgery Centers, Inc.	001003	not on list

Ambulatory Surgery Centers

NW Eye Center	001511	not on list
Ontario Surgery Center	001021	001021
Oregon Endoscopy Center, LLC	001044	001044
Oregon Eye Surgery Center	001428	001007
Oregon Outpatient Surgery Center		001060
Oregon Plastic Surgeons		licensed in OR only
Oregon Surgery Center	001436	001051
Oregon Surgicenter		001064
Pacific Cataract & Laser Institute	001038	001038
Pacific Digestive Endoscopy Center		001065
Pacific Surgery Center, LLC	001034	001034
Parrish Cosmetic & Plastic Surgery Ctr	001033	001033
Pearl Surgicenter		001070
Petroff Center		001057
Redmond Surgery Center		"38-initial"
River Road Surgery Center	001037	001037
Salem Laser & Surgery Center, LLC	001036	001036
Skyline Medical Office Ambulatory Surg Ctr	001032	001032
South Coast Surgery Center, LLC	001025	001025
South Eugene Surgi-Center	001039	001039
Surgery Center of Southern Oregon	001502	001024
The Eye Surgery Institute	001023	001023
The Oregon Clinic Endoscopy Center	001045	001045
The Oregon Clinic, GI Division	001439	not on list
The Portland Clinic Surgical Center	001329	001005
Tigard Surgery Center	001434	not on list
Vision Surgery & Laser Center	001041	001041
Westside Surgery Center		001013
Willamette Ambulatory Surgery Center, LLC	001031	001031
Willamette Spine Ctr Ambulatory Surgery, LLC	001043	001043
Willamette Valley Cancer Center	400001	not on list
Willamette Valley Eye Surgicenter	001431	001010

Appendix E



Oregon
Ted Kulongoski, Governor

Department of Human Services
Health Services
Oregon State Cancer Registry
800 NE Oregon Street, Suite 730
Portland, OR 97232-2162
(971) 673-0986 Telephone
(971) 673-0996 Fax
(971) 673-0372 TTY-Nonvoice

Date

Patient Name
Patient Address

Dear Patient:

In 1995, the Oregon State Legislature established the Oregon State Cancer Registry (OSCaR). At the time, Oregon was one of only a few states without a statewide cancer registry. Today, every state has one. The purpose of the registry is to understand how cancer affects Oregonians and what can be done to fight it. Information from the registry is used to target early detection of cancer and prevention efforts, develop screening and treatment programs, and evaluate cancer clusters. Registry information is also used in academic research studying the causes and/or treatment of specific cancer types.

Sometime in the last couple of years, you had a medical evaluation that showed cancer or a closely related condition. This letter is to inform you that your case has been reported to OSCaR, in compliance with Oregon law (statute ORS 432.520). Information such as your name, address, age, sex, characteristics/type of cancer, and details of diagnosis/treatment are included in this highly confidential record. Information in the registry is granted legal protection under Oregon law and cannot be accessed even by court subpoena (statute ORS 432.530).

So that this information can help in future cancer research, we are enclosing a form on which you can indicate your willingness to participate in research studies. Before the release of any confidential data, all research studies must be reviewed for compliance with strict criteria as provided by law (statute 432.540). If you do not return the research participation form, researchers will consult with your physician if you qualify for a study. Regardless of how you are contacted, your participation in any research project is strictly voluntary and you may decline at any time.

Please visit OSCaR's website www.healthoregon.org/oscar for general information about the Registry and to view the latest annual report, *Cancer in Oregon*; a list of current research activities can be found there as well. Contact OSCaR's Program Manager at (971) 673-0986 or by email oscar.ohd@state.or.us with any questions.

Sincerely yours,

Katrina Hedberg, MD, MPH
Interim State Epidemiologist & Office Administrator

Research Participation Reply Form

Regarding participation in research, if you do not return this form, OSCaR's standard procedure will be to contact patients only after consulting with the patient's physician. However, you may choose to be contacted directly or to never be contacted for research. If you want to choose one of these options, please make your selection, sign and date, update any name and address changes, and return this form in the envelope provide.

For more information or questions, you may contact OSCaR.

Oregon State Cancer Registry
800 NE Oregon Street, Suite 730
Portland, OR 97232
Tel: (971) 673-0986 Fax (971) 673-0996
Email: OSCaR.ohd@state.or.us

Patient Name _____
Patient Address _____

- Be contacted directly by researchers if there is an opportunity to be a participant in a research project; there is no need to consult with my physician. The researchers can explain the project to me directly, and I will decide whether or not to participate.
- Never be contacted through OSCaR for any research purpose.
- Be contacted after consulting with my physician.

Patient Signature

Date

Have you had a name or address change? If any of your patient information is different than what we have listed above, please update any changes below so we can have accurate and up-to-date records. Thank you.

Please Print

First Name _____ Middle Name _____

Last Name _____ Tel No. _____

Address _____

City _____ State _____ Zip _____



Oregon

Theodore R. Kulongoski, Governor
Oregon State Cancer Registry

Department of Human
Services
Health Services
800 NE Oregon Street, Suite
730
Portland, OR 97232-2162
(971) 673-0986 Telephone
(971) 673-0996 Fax
(503) 731-4031 TTY Nonvoice

TO: (Name of CTR)
DATE: (Today's Date)
FROM Alyssa Elting McGuire
Research Analyst - Database Specialist
SUBJECT: File Transmission Status Report

Thank you for your recent cancer case submissions. This memo is your verification that OSCaR has received and downloaded the following files with the number of cancer cases listed below into the central registry database during the past month.

XY Hospital **MM/DD/YY**(Date entered in OSCaR Database), File **XYMMDDYY.xaa** (# of cases)
XZ Hospital **MM/DD/YY**(Date entered in OSCaR Database), File **XZMMDDYY.xaa** (# of cases)

Total cases received for the month: (total # of cases)

If your records do not agree with this number, please contact us.

Thank you.



Oregon

Theodore Kulongoski, Governor

Department of Human Services
Health Services
Oregon State Cancer Registry
800 NE Oregon Street, Suite 730
Portland, OR 97232-2162
971.673.0986 Telephone
971.673.0996 Fax

NOTICE TO COVERED ENTITIES OF AUTHORITY TO COLLECT OR RECEIVE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION AS A PUBLIC HEALTH AUTHORITY

TO:

FAX:

RE: DOB:

Copies of the above-named patient's medical record are being requested as part of the Department of Human Services, Health Service's Oregon State Cancer Registry (OSCaR).

The specific information required to be provided is:

- (Specific information to be released)

Authorization to collect or receive individually identifiable health information in these records is covered under ORS 432.500.

Consistent with the HIPAA Privacy Rules, 45 CFR § 164.512(b), the Department of Human Services staff and/or representatives identified below are authorized to collect or receive individually identifiable health information as a Public Health Authority for the purpose of preventing or controlling disease, injury or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions.

The information requested constitutes the minimum necessary information for the public health purpose, function or activity described above.

This statement provides the authority for the Department of Human Services staff and/or representatives identified below to collect or receive this information, pursuant to applicable state or federal law and the HIPAA Privacy Rule, 45 § 164.514(h)(1).

Name: _____
Donald Shipley, Program Manager

Name: _____
(Cancer Data Specialist's Name)

Appendix F

COUNTY CODES

001	Baker
003	Benton
005	Clackamas
007	Clatsop
009	Columbia
011	Coos
013	Crook
015	Curry
017	Deschutes
019	Douglas
021	Gilliam
023	Grant
025	Harney
027	Hood River
029	Jackson
031	Jefferson
033	Josephine
035	Klamath
037	Lake
039	Lane
041	Lincoln
043	Linn
045	Malheur
047	Marion
049	Morrow
051	Multnomah
053	Polk
055	Sherman
057	Tillamook
059	Umatilla
061	Union
063	Wallowa
065	Wasco
067	Washington
069	Wheeler
071	Yamhill
998	Out of State
999	Unknown

Appendix G

SELECTED STANDARD ABBREVIATIONS

See the "NAACCR Recommended Abbreviation List Ordered by Word/Term(s)" for a full list of abbreviations

ABD	Abdomen
AK	Above knee
ACID PHOS	Acid phosphatase
AIDS	Acquired Immunodeficiency Syndrome
AGL	Acute Granulocytic Leukemia
AIN	Anal Intraepithelial Neoplasia
ALL	Acute Lymphocytic Leukemia
AML	Acute Myelocytic Leukemia
ADENOCA	Adenocarcinoma
ADJ	Adjacent
ADM	Admission, admit
AMA	Against medical advice
ARC	AIDS Related Complex
ETOH	Alcohol
ALK PHOS	Alkaline Phosphatase
AFP	Alpha-fetoprotein
AKA	Also known as
AMB	Ambulatory
ANAP	Anaplastic
ANGIO	Angioplasty; Angiography
ANT	Anterior
AP	Abdomino perineal; Anteroposterior
APPROX	Approximately
ASP	Aspiration
A&P	Auscultation and percussion
AUT	Autopsy
AX	Axillary
BE	Barium enema
BUS	Bartholin's, Urethral & Skene's Gland
BOT	Base of tongue
BPH	Benign prostatic hypertrophy/hyperplasia
BIL	Bilateral
BSO	Bilateral Salpingo-oophorectomy
BD	Bile duct
BRM	Biological response modifier
BX	Biopsy
BUN	Blood urea nitrogen

BM	Bone marrow; Bowel movement
BS	Bone scan
BRS	Breath sounds
BRB(PR)	Bright red blood (per rectum)
CA	Carcinoma
CEA	Carcinoembryonic Antigen
CIS	Carcinoma in situ
CUPS	Carcinoma of unknown primary site
CT	CAT scan
CM	Centimeter; Costal margin
CNS	Central nervous system
CSF	Cerebrospinal fluid
CIN	Cervical intraepithelial neoplasia
C1-C7	Cervical vertebrae
CX	Cervix
CS	Cesium
CHEMO	Chemotherapy
CXR	Chest x-ray
CC	Chief complaint
CGL	Chronic granulocytic leukemia
CLL	Chronic lymphocytic leukemia
CML	Chronic myelogenous leukemia
CIG	Cigarettes
A-COLON	Ascending colon
D-COLON	Descending colon
S-COLON	Sigmoid colon
T-COLON	Transverse colon
CBD	Common bile duct
C/O	Complaining of
CBC	Complete Blood Count
CT/CAT SCAN	Computerized Axial Tomography Scan
C/W	Consistent with
CONT	Continue
CC	Cubic centimeter
CYSTO	Cystoscopy
CYTO	Cytology
CMV	Cytomegalovirus
DOB	Date of birth
DOA	Dead on arrival
DECR	Decreased

DERM	Dermatology
DX	Diagnosis
DIAM	Diameter
DIFF	Differentiated
DRE	Digital rectal exam
D&C	Dilation and curettage
DISCH	Discharge
DC	Discontinue(d)
DZ	Disease
DR, MD	Doctor
EEG	Electroencephalogram
EMG	Electromyogram
ENLGD	Enlarged
ENT	Ear, nose, throat
ERCP	Endoscopic Retrograde Cholangiopancreatography
ER	Emergency room
ER, ERA	Estrogen receptor (assay)
EXAM	Examination
EUA	Exam under anesthesia
EXC(D)	Excision/excised
EXP LAP	Exploratory laparotomy
EXT	Extension, Extremity, External
ECF	Extended care facility
EOD	Extent of disease
EVAL	Evaluation
FH	Family history
FUO	Fever of unknown origin
FB	Fingerbreadth
FOM	Floor of mouth
FU	Follow-up
FX	Fracture
FS	Frozen section
GB	Gallbladder
GE	Gastroenterostomy
GE	Gastroesophageal
GI	Gastrointestinal
GU	Genitourinary
GM	Gram
HOP	Head of pancreas
HCT	Hematocrit

HGB	Hemoglobin
HCG	Human Chorionic Gondadotropin
HEENT	Head, eyes, ears, nose, throat
H&P	History and physical
HPI	History of present illness
HORM	Hormone
HOSP	Hospital
HR, HRS	Hour, hours
HX	History
HYST	Hysterectomy
INCL	Includes, including
INCR	Increase
INF	Inferior
INFILT	Infiltrating
IDCA	Infiltrating ductal carcinoma
IQ	Inner quadrant
IP	Inpatient
IMA	Internal mammary artery
IV	Intravenous
IVP	Intravenous pyelogram
IG	Immunoglobulin
IMP	Impression
KUB	Kidney, ureter, bladder
KG	Kilogram
KS	Kaposi's Sarcoma
LAP	Laparotomy
LG	Large
LMP	Last menstrual period
LAT	Lateral
L	Left
LCM	Left costal margin
LLE	Left lower extremity
LLL	Left lower lobe
LLQ	Left lower quadrant
LSO	Left salpingo-oophorectomy
LUL	Left upper lobe
LUQ	Left upper quadrant
LKS(B)	Liver, kidneys, spleen (bladder)
LMD	Local M.D.
LVNI	Local vessel and/or nerve involvement

LIQ	Lower inner quadrant
LP	Lumbar puncture
L5-S1	Lumbar 5th, Sacral 1st vertebrae
LS, L-SP	Lumbosacral
LN, LNS	Lymph node(s)
LAD (LNA)	Lymphadenopathy
MRI	Magnetic resonance imaging
MAL, MALIG	Malignant
MM	Malignant melanoma
MAND	Mandible
MAST	Mastectomy
MAX	Maximum
MED	Medicine, media
METS	Metastasis, metastases
MICRO	Microscopic
MCL	Mid clavicular line
ML	Middle lobe; Millileter
MC (H)	Millicurie (hours)
MG	Milligram
MM	Millimeter
MEV	Million electron volts
MIN	Minimum
MOD	Moderate
MRM	Modified radical mastectomy
MD	Moderately differentiated
N&V	Nausea and vomiting
NEG or -	Negative
NEM	No evidence of malignancy
NEURO	Neurology
NED	No evidence of disease
NL	Normal
NSF	No significant findings
NA	Not applicable, not available
NOS	Not otherwise specified
NR	Not recorded
OBST	Obstruct -ed, -ing, -ion
OR	Operating room
OP	Operation
OP REPORT	Operative report
OZ	Ounce

OP	Outpatient
PPD	Packs per day
PAP	Papanicolaou Smear
PMH	Past medical history
PATH	Pathology
PT	Patient
PID	Pelvic inflammatory disease
P&A	Percussion and auscultation
PERC	Percutaneous
PMD	Primary M.D
PE	Physical examination
PLT	Platelets
PD, POOR DIFF	Poorly differentiated
POS or +	Positive
POSS	Possible
POST	Posterior; Postmortem examination
PA	Posterior anterior
POD	Postoperative day
PO, POSTOP	Postoperative
PI	Present illness
PTA	Prior to admission
PROB	Probable, probably
PR, PRA	Progesterone receptor (assay)
PULM, PA	Pulmonary, pulmonary artery
RAD	Radiation; Radio immuno assay
RT	Radiation therapy
RA	Radium
RBC	Red blood cells
RESEC	Resection
RESP	Respiratory
ROF	Review of outside films
ROS	Review of outside slides
ROS	Review of systems
R	Right
RLE	Right lower extremity
RLL	Right lower lobe
RLQ	Right lower quadrant
RML	Right middle lobe
RSO	Right salpingo-oophorectomy
RUE	Right upper extremity

RUL	Right upper lobe
RUQ	Right upper quadrant
RO, R/O	Rule out
S1-S5	Sacral vertebrae
SO	Salpingo-oophorectomy
SMA	sequential multiple analysis
SGOT	Serum Glutamic Oxaloacetic Transaminase
SGPT	Serum Glutamic Pyruvic Transaminase
SOB	Short of breath
SIL	Squamous intraepithelial lesion
SPEC	Specimen
STSG	Split thickness skin graft
SM, SML	Small
SB, SML BWL	Small bowel
SQ, SQUAM	Squamous
SCC, SCCA	Squamous cell carcinoma
S/P	Status post
SUBQ, SQ	Subcutaneous
SUGG	Suggested
SVC	Superior vena cava
SURG	Surgery, surgical
SUSP	Suspicious
SX	Symptoms
T	Thoracic
T1-T12	Thoracic vertebrae
T-spine	Thoracic spine
TAH	Total abdominal hysterectomy
TUR	Transurethral resection
TURB	Transurethral resection bladder
TURP	Transurethral resection prostate
TX,RX,TMT	Treatment
TS	Tumor size
TURBT	Transurethral resection bladder tumor
US	Ultrasound
UNDIFF	Undifferentiated
UE	Upper extremity
UGI	Upper gastrointestinal
UIQ	Upper inner quadrant
UOQ	Upper outer quadrant
UA	Urinalysis

VAG	Vaginal, vagina
VAG HYST	Vaginal hysterectomy
VAIN	Vaginal intraepithelial neoplasia
VIN	Vulvar intraepithelial neoplasia
VASC	Vascular
VCR	Vincristine
WD	Well differentiated
WBC	White blood cells
W/, W/O	With, without
W/U	Workup
XR	X-ray
YR	Year
SYMBOLS	
=	Is equal to
>	Increase, more than
<	Decrease, less than
X	Times
#	Pounds
@	At
/	Comparison, ex: 6/12 (six of twelve)

Appendix H

CHAPTER VII

RECORD LAYOUT TABLE (COLUMN # ORDER)

The following table presents Version 11.3 of the NAACCR record layout. The table has column number, length, item number, item name, section, and note fields. Differences from Version 11.2 are marked "Revised" or "New" in the "Note" column of the table. Revised and new items are summarized in Appendix F. Please note that "Retired" items are not reflected in this table.

Column #	Length	Item #	Item Name	Section	Note
1-1	1	10	Record Type	Record ID	
2-9	8	20	Patient ID Number	Record ID	
10-10	1	30	Registry Type	Record ID	
11-11	1	35	FIN Coding System	Record ID	
12-18	7	37	Reserved 00	Record ID	
19-19	1	50	NAACCR Record Version	Record ID	
20-29	10	40	Registry ID	Record ID	
30-31	2	60	Tumor Record Number	Record ID	
32-39	8	21	Patient System ID-Hosp	Record ID	
40-49	10	45	NPI--Registry ID	Record ID	
50-51	2	370	Reserved 01	Record ID	
52-71	20	70	Addr at DX--City	Demographic	
72-73	2	80	Addr at DX--State	Demographic	
74-82	9	100	Addr at DX--Postal Code	Demographic	
83-85	3	90	Country at DX	Demographic	
86-91	6	110	Census Tract 1970/80/90	Demographic	
92-92	1	120	Census Cod Sys 1970/80/90	Demographic	
93-98	6	130	Census Tract 2000	Demographic	
99-99	1	362	Census Block Group 2000	Demographic	
100-100	1	364	Census Tr Cert 1970/80/90	Demographic	
101-101	1	365	Census Tr Certainty 2000	Demographic	
102-102	1	150	Marital Status at DX	Demographic	
103-104	2	160	Race 1	Demographic	
105-106	2	161	Race 2	Demographic	
107-108	2	162	Race 3	Demographic	
109-110	2	163	Race 4	Demographic	
111-112	2	164	Race 5	Demographic	
113-113	1	170	Race Coding Sys--Current	Demographic	
114-114	1	180	Race Coding Sys--Original	Demographic	
115-115	1	190	Spanish/Hispanic Origin	Demographic	
116-116	1	200	Computed Ethnicity	Demographic	
117-117	1	210	Computed Ethnicity Source	Demographic	
118-118	1	220	Sex	Demographic	
119-121	3	230	Age at Diagnosis	Demographic	
122-129	8	240	Birth Date	Demographic	
130-132	3	250	Birthplace	Demographic	

Column #	Length	Item #	Item Name	Section	Note
133-134	2	260	Religion	Demographic	
135-137	3	270	Occupation Code--Census	Demographic	
138-140	3	280	Industry Code--Census	Demographic	
141-141	1	290	Occupation Source	Demographic	
142-142	1	300	Industry Source	Demographic	
143-182	40	310	Text--Usual Occupation	Demographic	
183-222	40	320	Text--Usual Industry	Demographic	
223-223	1	330	Occup/Ind Coding System	Demographic	
224-224	1	340	Tobacco History	Demographic	
225-225	1	350	Alcohol History	Demographic	
226-226	1	360	Family History of Cancer	Demographic	
227-228	2	3300	RuralUrban Continuum 1993	Demographic	
229-230	2	3310	RuralUrban Continuum 2003	Demographic	
231-231	1	191	NHIA Derived Hisp Origin	Demographic	
232-232	1	192	IHS Link	Demographic	
233-234	2	366	GIS Coordinate Quality	Demographic	
235-235	1	368	CensusBlockGroup 70/80/90	Demographic	
236-237	2	193	Race--NAPILA	Demographic	New
238-280	43	530	Reserved 02	Demographic	Revised
281-282	2	380	Sequence Number--Central	Cancer Identification	
283-290	8	390	Date of Diagnosis	Cancer Identification	
291-294	4	400	Primary Site	Cancer Identification	
295-295	1	410	Laterality	Cancer Identification	
296-300	5	419	Morph--Type&Behav ICD-O-2	Cancer Identification	Group
296-299	4	420	Histology (92-00) ICD-O-2	Cancer Identification	Subfield
300-300	1	430	Behavior (92-00) ICD-O-2	Cancer Identification	Subfield
301-305	5	521	Morph--Type&Behav ICD-O-3	Cancer Identification	Group
301-304	4	522	Histologic Type ICD-O-3	Cancer Identification	Subfield
305-305	1	523	Behavior Code ICD-O-3	Cancer Identification	Subfield
306-306	1	440	Grade	Cancer Identification	
307-307	1	450	Site Coding Sys--Current	Cancer Identification	
308-308	1	460	Site Coding Sys--Original	Cancer Identification	
309-309	1	470	Morph Coding Sys--Current	Cancer Identification	
310-310	1	480	Morph Coding Sys--Original	Cancer Identification	
311-311	1	490	Diagnostic Confirmation	Cancer Identification	
312-312	1	500	Type of Reporting Source	Cancer Identification	

Column #	Length	Item #	Item Name	Section	Note
313-320	8	510	Screening Date	Cancer Identification	
321-321	1	520	Screening Result	Cancer Identification	
322-323	2	501	Casefinding Source	Cancer Identification	
324-324	1	442	Ambiguous Terminology DX	Cancer Identification	
325-332	8	443	Date of Conclusive DX	Cancer Identification	
333-334	2	444	Mult Tum Rpt as One Prim	Cancer Identification	
335-342	8	445	Date of Multiple Tumors	Cancer Identification	
343-344	2	446	Multiplicity Counter	Cancer Identification	
345-371	27	680	Reserved 03	Cancer Identification	
372-381	10	545	NPI--Reporting Facility	Hospital-Specific	
382-391	10	540	Reporting Facility	Hospital-Specific	
392-401	10	3100	Archive FIN	Hospital-Specific	
402-410	9	550	Accession Number--Hosp	Hospital-Specific	
411-412	2	560	Sequence Number--Hospital	Hospital-Specific	
413-415	3	570	Abstracted By	Hospital-Specific	
416-423	8	580	Date of 1st Contact	Hospital-Specific	
424-431	8	590	Date of Inpatient Adm	Hospital-Specific	
432-439	8	600	Date of Inpatient Disch	Hospital-Specific	
440-440	1	610	Class of Case	Hospital-Specific	
441-444	4	615	Reserved 26	Hospital-Specific	
445-446	2	630	Primary Payer at DX	Hospital-Specific	
447-456	10	3105	NPI--Archive FIN	Hospital-Specific	
457-458	2	670	RX Hosp--Surg Prim Site	Hospital-Specific	
459-459	1	672	RX Hosp--Scope Reg LN Sur	Hospital-Specific	
460-460	1	674	RX Hosp--Surg Oth Reg/Dis	Hospital-Specific	
461-462	2	676	RX Hosp--Reg LN Removed	Hospital-Specific	
463-463	1	690	RX Hosp--Radiation	Hospital-Specific	
464-465	2	700	RX Hosp--Chemo	Hospital-Specific	
466-467	2	710	RX Hosp--Hormone	Hospital-Specific	
468-469	2	720	RX Hosp--BRM	Hospital-Specific	
470-470	1	730	RX Hosp--Other	Hospital-Specific	
471-472	2	740	RX Hosp--DX/Stg Proc	Hospital-Specific	
473-473	1	3280	RX Hosp--Palliative Proc	Hospital-Specific	
474-477	4	741	Reserved 28	Hospital-Specific	
478-479	2	746	RX Hosp--Surg Site 98-02	Hospital-Specific	
480-480	1	747	RX Hosp--Scope Reg 98-02	Hospital-Specific	

Column #	Length	Item #	Item Name	Section	Note
481-481	1	748	RX Hosp--Surg Oth 98-02	Hospital-Specific	
482-527	46	750	Reserved 04	Hospital-Specific	
528-528	1	759	SEER Summary Stage 2000	Stage/Prognostic Factors	
529-529	1	760	SEER Summary Stage 1977	Stage/Prognostic Factors	
530-530	1	765	Reserved 29	Stage/Prognostic Factors	
531-542	12	779	Extent of Disease 10-Dig	Stage/Prognostic Factors	Group
531-533	3	780	EOD--Tumor Size	Stage/Prognostic Factors	Subfield
534-535	2	790	EOD--Extension	Stage/Prognostic Factors	Subfield
536-537	2	800	EOD--Extension Prost Path	Stage/Prognostic Factors	Subfield
538-538	1	810	EOD--Lymph Node Involv	Stage/Prognostic Factors	Subfield
539-540	2	820	Regional Nodes Positive	Stage/Prognostic Factors	Subfield
541-542	2	830	Regional Nodes Examined	Stage/Prognostic Factors	Subfield
543-555	13	840	EOD--Old 13 Digit	Stage/Prognostic Factors	
556-557	2	850	EOD--Old 2 Digit	Stage/Prognostic Factors	
558-561	4	860	EOD--Old 4 Digit	Stage/Prognostic Factors	
562-562	1	870	Coding System for EOD	Stage/Prognostic Factors	
563-564	2	880	TNM Path T	Stage/Prognostic Factors	
565-566	2	890	TNM Path N	Stage/Prognostic Factors	
567-568	2	900	TNM Path M	Stage/Prognostic Factors	
569-570	2	910	TNM Path Stage Group	Stage/Prognostic Factors	
571-571	1	920	TNM Path Descriptor	Stage/Prognostic Factors	
572-572	1	930	TNM Path Staged By	Stage/Prognostic Factors	
573-574	2	940	TNM Clin T	Stage/Prognostic Factors	
575-576	2	950	TNM Clin N	Stage/Prognostic Factors	
577-578	2	960	TNM Clin M	Stage/Prognostic Factors	
579-580	2	970	TNM Clin Stage Group	Stage/Prognostic Factors	
581-581	1	980	TNM Clin Descriptor	Stage/Prognostic Factors	
582-582	1	990	TNM Clin Staged By	Stage/Prognostic Factors	
583-592	10	995	Reserved 30	Stage/Prognostic Factors	
593-594	2	1060	TNM Edition Number	Stage/Prognostic Factors	
595-609	15	1065	Reserved 31	Stage/Prognostic Factors	
610-617	8	1080	Date of 1st Positive BX	Stage/Prognostic Factors	
618-618	1	1090	Site of Distant Met 1	Stage/Prognostic Factors	
619-619	1	1100	Site of Distant Met 2	Stage/Prognostic Factors	
620-620	1	1110	Site of Distant Met 3	Stage/Prognostic Factors	
621-622	2	1120	Pediatric Stage	Stage/Prognostic Factors	

Column #	Length	Item #	Item Name	Section	Note
623-624	2	1130	Pediatric Staging System	Stage/Prognostic Factors	
625-625	1	1140	Pediatric Staged By	Stage/Prognostic Factors	
626-626	1	1150	Tumor Marker 1	Stage/Prognostic Factors	
627-627	1	1160	Tumor Marker 2	Stage/Prognostic Factors	
628-628	1	1170	Tumor Marker 3	Stage/Prognostic Factors	
629-631	3	2800	CS Tumor Size	Stage/Prognostic Factors	
632-633	2	2810	CS Extension	Stage/Prognostic Factors	
634-634	1	2820	CS Tumor Size/Ext Eval	Stage/Prognostic Factors	
635-636	2	2830	CS Lymph Nodes	Stage/Prognostic Factors	
637-637	1	2840	CS Reg Node Eval	Stage/Prognostic Factors	
638-639	2	2850	CS Mets at DX	Stage/Prognostic Factors	
640-640	1	2860	CS Mets Eval	Stage/Prognostic Factors	
641-643	3	2880	CS Site-Specific Factor 1	Stage/Prognostic Factors	
644-646	3	2890	CS Site-Specific Factor 2	Stage/Prognostic Factors	
647-649	3	2900	CS Site-Specific Factor 3	Stage/Prognostic Factors	
650-652	3	2910	CS Site-Specific Factor 4	Stage/Prognostic Factors	
653-655	3	2920	CS Site-Specific Factor 5	Stage/Prognostic Factors	
656-658	3	2930	CS Site-Specific Factor 6	Stage/Prognostic Factors	
659-660	2	2940	Derived AJCC T	Stage/Prognostic Factors	
661-661	1	2950	Derived AJCC T Descriptor	Stage/Prognostic Factors	
662-663	2	2960	Derived AJCC N	Stage/Prognostic Factors	
664-664	1	2970	Derived AJCC N Descriptor	Stage/Prognostic Factors	
665-666	2	2980	Derived AJCC M	Stage/Prognostic Factors	
667-667	1	2990	Derived AJCC M Descriptor	Stage/Prognostic Factors	
668-669	2	3000	Derived AJCC Stage Group	Stage/Prognostic Factors	
670-670	1	3010	Derived SS1977	Stage/Prognostic Factors	
671-671	1	3020	Derived SS2000	Stage/Prognostic Factors	
672-672	1	3030	Derived AJCC--Flag	Stage/Prognostic Factors	
673-673	1	3040	Derived SS1977--Flag	Stage/Prognostic Factors	
674-674	1	3050	Derived SS2000--Flag	Stage/Prognostic Factors	
675-679	5	3110	Comorbid/Complication 1	Stage/Prognostic Factors	
680-684	5	3120	Comorbid/Complication 2	Stage/Prognostic Factors	
685-689	5	3130	Comorbid/Complication 3	Stage/Prognostic Factors	
690-694	5	3140	Comorbid/Complication 4	Stage/Prognostic Factors	
695-699	5	3150	Comorbid/Complication 5	Stage/Prognostic Factors	
700-704	5	3160	Comorbid/Complication 6	Stage/Prognostic Factors	

Column #	Length	Item #	Item Name	Section	Note
705-710	6	2935	CS Version 1st	Stage/Prognostic Factors	
711-716	6	2936	CS Version Latest	Stage/Prognostic Factors	
717-721	5	3161	Comorbid/Complication 7	Stage/Prognostic Factors	
722-726	5	3162	Comorbid/Complication 8	Stage/Prognostic Factors	
727-731	5	3163	Comorbid/Complication 9	Stage/Prognostic Factors	
732-736	5	3164	Comorbid/Complication 10	Stage/Prognostic Factors	
737-737	1	3165	ICD Revision Comorbid	Stage/Prognostic Factors	
738-754	17	1180	Reserved 05	Stage/Prognostic Factors	
755-762	8	1200	RX Date--Surgery	Treatment-1st Course	
763-770	8	3170	RX Date--Most Defin Surg	Treatment-1st Course	
771-778	8	3180	RX Date--Surgical Disch	Treatment-1st Course	
779-786	8	1210	RX Date--Radiation	Treatment-1st Course	
787-794	8	3220	RX Date--Radiation Ended	Treatment-1st Course	
795-802	8	3230	RX Date--Systemic	Treatment-1st Course	
803-810	8	1220	RX Date--Chemo	Treatment-1st Course	
811-818	8	1230	RX Date--Hormone	Treatment-1st Course	
819-826	8	1240	RX Date--BRM	Treatment-1st Course	
827-834	8	1250	RX Date--Other	Treatment-1st Course	
835-842	8	1260	Date of Initial RX--SEER	Treatment-1st Course	
843-850	8	1270	Date of 1st Crs RX--CoC	Treatment-1st Course	
851-858	8	1280	RX Date--DX/Stg Proc	Treatment-1st Course	
859-860	2	1290	RX Summ--Surg Prim Site	Treatment-1st Course	
861-861	1	1292	RX Summ--Scope Reg LN Sur	Treatment-1st Course	
862-862	1	1294	RX Summ--Surg Oth Reg/Dis	Treatment-1st Course	
863-864	2	1296	RX Summ--Reg LN Examined	Treatment-1st Course	
865-865	1	1310	RX Summ--Surgical Approach	Treatment-1st Course	
866-866	1	1320	RX Summ--Surgical Margins	Treatment-1st Course	
867-867	1	1330	RX Summ--Reconstruct 1st	Treatment-1st Course	
868-868	1	1340	Reason for No Surgery	Treatment-1st Course	
869-870	2	1350	RX Summ--DX/Stg Proc	Treatment-1st Course	
871-871	1	3270	RX Summ--Palliative Proc	Treatment-1st Course	
872-872	1	1355	Reserved 22	Treatment-1st Course	
873-873	1	1360	RX Summ--Radiation	Treatment-1st Course	
874-874	1	1370	RX Summ--Rad to CNS	Treatment-1st Course	
875-875	1	1380	RX Summ--Surg/Rad Seq	Treatment-1st Course	
876-877	2	3250	RX Summ--Transplnt/Endocr	Treatment-1st Course	

Column #	Length	Item #	Item Name	Section	Note
878-879	2	1390	RX Summ--Chemo	Treatment-1st Course	
880-881	2	1400	RX Summ--Hormone	Treatment-1st Course	
882-883	2	1410	RX Summ--BRM	Treatment-1st Course	
884-884	1	1420	RX Summ--Other	Treatment-1st Course	
885-885	1	1430	Reason for No Radiation	Treatment-1st Course	
886-887	2	1435	Reserved 32	Treatment-1st Course	
888-889	2	1460	RX Coding System--Current	Treatment-1st Course	
890-893	4	1465	Reserved 33	Treatment-1st Course	
894-894	1	1500	First Course Calc Method	Treatment-1st Course	
895-899	5	1510	Rad--Regional Dose: CGY	Treatment-1st Course	
900-901	2	1520	Rad--No of Treatment Vol	Treatment-1st Course	
902-904	3	1535	Reserved 34	Treatment-1st Course	
905-906	2	1540	Rad--Treatment Volume	Treatment-1st Course	
907-907	1	1550	Rad--Location of RX	Treatment-1st Course	
908-908	1	1555	Reserved 35	Treatment-1st Course	
909-910	2	1570	Rad--Regional RX Modality	Treatment-1st Course	
911-912	2	3200	Rad--Boost RX Modality	Treatment-1st Course	
913-917	5	3210	Rad--Boost Dose cGy	Treatment-1st Course	
918-930	13	1635	Reserved 23	Treatment-1st Course	
931-931	1	1639	RX Summ--Systemic/Sur Seq	Treatment-1st Course	
932-933	2	1640	RX Summ--Surgery Type	Treatment-1st Course	
934-937	4	1641	Reserved 36	Treatment-1st Course	
938-938	1	3190	Readm Same Hosp 30 Days	Treatment-1st Course	
939-940	2	1646	RX Summ--Surg Site 98-02	Treatment-1st Course	
941-941	1	1647	RX Summ--Scope Reg 98-02	Treatment-1st Course	
942-942	1	1648	RX Summ--Surg Oth 98-02	Treatment-1st Course	
943-987	45	1190	Reserved 06	Treatment-1st Course	
988-995	8	1660	Subsq RX 2nd Course Date	Treatment-Subsequent & Other	
996-1002	7	1670	Subsq RX 2nd Course Codes	Treatment-Subsequent & Other	Group
996-997	2	1671	Subsq RX 2nd Course Surg	Treatment-Subsequent & Other	Subfield
998-998	1	1672	Subsq RX 2nd Course Rad	Treatment-Subsequent & Other	Subfield
999-999	1	1673	Subsq RX 2nd Course Chemo	Treatment-Subsequent & Other	Subfield
1000-1000	1	1674	Subsq RX 2nd Course Horm	Treatment-Subsequent & Other	Subfield
1001-1001	1	1675	Subsq RX 2nd Course BRM	Treatment-Subsequent & Other	Subfield
1002-1002	1	1676	Subsq RX 2nd Course Oth	Treatment-Subsequent & Other	Subfield
1003-1010	8	1680	Subsq RX 3rd Course Date	Treatment-Subsequent & Other	

Column #	Length	Item #	Item Name	Section	Note
1011-1017	7	1690	Subsq RX 3rd Course Codes	Treatment-Subsequent & Other	Group
1011-1012	2	1691	Subsq RX 3rd Course Surg	Treatment-Subsequent & Other	Subfield
1013-1013	1	1692	Subsq RX 3rd Course Rad	Treatment-Subsequent & Other	Subfield
1014-1014	1	1693	Subsq RX 3rd Course Chemo	Treatment-Subsequent & Other	Subfield
1015-1015	1	1694	Subsq RX 3rd Course Horm	Treatment-Subsequent & Other	Subfield
1016-1016	1	1695	Subsq RX 3rd Course BRM	Treatment-Subsequent & Other	Subfield
1017-1017	1	1696	Subsq RX 3rd Course Orth	Treatment-Subsequent & Other	Subfield
1018-1025	8	1700	Subsq RX 4th Course Date	Treatment-Subsequent & Other	
1026-1032	7	1710	Subsq RX 4th Course Codes	Treatment-Subsequent & Other	Group
1026-1027	2	1711	Subsq RX 4th Course Surg	Treatment-Subsequent & Other	Subfield
1028-1028	1	1712	Subsq RX 4th Course Rad	Treatment-Subsequent & Other	Subfield
1029-1029	1	1713	Subsq RX 4th Course Chemo	Treatment-Subsequent & Other	Subfield
1030-1030	1	1714	Subsq RX 4th Course Horm	Treatment-Subsequent & Other	Subfield
1031-1031	1	1715	Subsq RX 4th Course BRM	Treatment-Subsequent & Other	Subfield
1032-1032	1	1716	Subsq RX 4th Course Orth	Treatment-Subsequent & Other	Subfield
1033-1047	15	1725	Reserved 37	Treatment-Subsequent & Other	
1048-1048	1	1677	Subsq RX 2nd--Scope LN SU	Treatment-Subsequent & Other	
1049-1049	1	1678	Subsq RX 2nd--Surg Oth	Treatment-Subsequent & Other	
1050-1051	2	1679	Subsq RX 2nd--Reg LN Rem	Treatment-Subsequent & Other	
1052-1052	1	1697	Subsq RX 3rd--Scope LN Su	Treatment-Subsequent & Other	
1053-1053	1	1698	Subsq RX 3rd--Surg Oth	Treatment-Subsequent & Other	
1054-1055	2	1699	Subsq RX 3rd--Reg LN Rem	Treatment-Subsequent & Other	
1056-1056	1	1717	Subsq RX 4th--Scope LN Su	Treatment-Subsequent & Other	
1057-1057	1	1718	Subsq RX 4th--Surg Oth	Treatment-Subsequent & Other	
1058-1059	2	1719	Subsq RX 4th--Reg LN Rem	Treatment-Subsequent & Other	
1060-1063	4	1726	Reserved 38	Treatment-Subsequent & Other	
1064-1064	1	1741	Subsq RX--Reconstruct Del	Treatment-Subsequent & Other	
1065-1114	50	1300	Reserved 07	Treatment-Subsequent & Other	
1115-1115	1	1981	Over-ride SS/NodesPos	Edit Overrides/Conversion History/System Admin	
1116-1116	1	1982	Over-ride SS/TNM-N	Edit Overrides/Conversion History/System Admin	
1117-1117	1	1983	Over-ride SS/TNM-M	Edit Overrides/Conversion History/System Admin	
1118-1118	1	1984	Over-ride SS/DisMet1	Edit Overrides/Conversion History/System Admin	
1119-1119	1	1985	Over-ride Acscn/Class/Seq	Edit Overrides/Conversion History/System Admin	
1120-1120	1	1986	Over-ride HospSeq/DxConf	Edit Overrides/Conversion History/System Admin	

Column #	Length	Item #	Item Name	Section	Note
1121-1121	1	1987	Over-ride CoC-Site/Type	Edit Overrides/Conversion History/System Admin	
1122-1122	1	1988	Over-ride HospSeq/Site	Edit Overrides/Conversion History/System Admin	
1123-1123	1	1989	Over-ride Site/TNM-StgGrp	Edit Overrides/Conversion History/System Admin	
1124-1124	1	1990	Over-ride Age/Site/Morph	Edit Overrides/Conversion History/System Admin	
1125-1125	1	2000	Over-ride SeqNo/DxConf	Edit Overrides/Conversion History/System Admin	
1126-1126	1	2010	Over-ride Site/Lat/SeqNo	Edit Overrides/Conversion History/System Admin	
1127-1127	1	2020	Over-ride Surg/DxConf	Edit Overrides/Conversion History/System Admin	
1128-1128	1	2030	Over-ride Site/Type	Edit Overrides/Conversion History/System Admin	
1129-1129	1	2040	Over-ride Histology	Edit Overrides/Conversion History/System Admin	
1130-1130	1	2050	Over-ride Report Source	Edit Overrides/Conversion History/System Admin	
1131-1131	1	2060	Over-ride Ill-define Site	Edit Overrides/Conversion History/System Admin	
1132-1132	1	2070	Over-ride Leuk- Lymphoma	Edit Overrides/Conversion History/System Admin	
1133-1133	1	2071	Over-ride Site/Behavior	Edit Overrides/Conversion History/System Admin	
1134-1134	1	2072	Over-ride Site/EOD/DX Dt	Edit Overrides/Conversion History/System Admin	
1135-1135	1	2073	Over-ride Site/Lat/EOD	Edit Overrides/Conversion History/System Admin	
1136-1136	1	2074	Over-ride Site/Lat/Morph	Edit Overrides/Conversion History/System Admin	
1137-1140	4	1960	Site (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	
1141-1146	6	1970	Morph (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	Group
1141-1144	4	1971	Histology (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	Subfield
1145-1145	1	1972	Behavior (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	Subfield
1146-1146	1	1973	Grade (73-91) ICD-O-1	Edit Overrides/Conversion History/System Admin	Subfield
1147-1147	1	1980	ICD-O-2 Conversion Flag	Edit Overrides/Conversion History/System Admin	
1148-1163	16	2082	Reserved 24	Edit Overrides/Conversion History/System Admin	
1164-1173	10	2081	CRC CHECKSUM	Edit Overrides/Conversion History/System Admin	
1174-1181	8	2090	Date Case Completed	Edit Overrides/Conversion History/System Admin	
1182-1189	8	2100	Date Case Last Changed	Edit Overrides/Conversion History/System Admin	

Column #	Length	Item #	Item Name	Section	Note
1190-1197	8	2110	Date Case Report Exported	Edit Overrides/Conversion History/System Admin	
1198-1198	1	2120	SEER Coding Sys--Current	Edit Overrides/Conversion History/System Admin	
1199-1199	1	2130	SEER Coding Sys--Original	Edit Overrides/Conversion History/System Admin	
1200-1201	2	2140	CoC Coding Sys--Current	Edit Overrides/Conversion History/System Admin	
1202-1203	2	2150	CoC Coding Sys--Original	Edit Overrides/Conversion History/System Admin	
1204-1213	10	2170	Vendor Name	Edit Overrides/Conversion History/System Admin	
1214-1214	1	2180	SEER Type of Follow-Up	Edit Overrides/Conversion History/System Admin	
1215-1216	2	2190	SEER Record Number	Edit Overrides/Conversion History/System Admin	
1217-1218	2	2200	Diagnostic Proc 73-87	Edit Overrides/Conversion History/System Admin	
1219-1226	8	2111	Date Case Report Received	Edit Overrides/Conversion History/System Admin	
1227-1234	8	2112	Date Case Report Loaded	Edit Overrides/Conversion History/System Admin	
1235-1242	8	2113	Date Tumor Record Availbl	Edit Overrides/Conversion History/System Admin	
1243-1243	1	2116	ICD-O-3 Conversion Flag	Edit Overrides/Conversion History/System Admin	
1244-1293	50	1650	Reserved 08	Edit Overrides/Conversion History/System Admin	
1294-1301	8	1750	Date of Last Contact	Follow-up/Recurrence/Death	
1302-1302	1	1760	Vital Status	Follow-up/Recurrence/Death	
1303-1303	1	1770	Cancer Status	Follow-up/Recurrence/Death	
1304-1304	1	1780	Quality of Survival	Follow-up/Recurrence/Death	
1305-1305	1	1790	Follow-Up Source	Follow-up/Recurrence/Death	
1306-1306	1	1800	Next Follow-Up Source	Follow-up/Recurrence/Death	
1307-1326	20	1810	Addr Current--City	Follow-up/Recurrence/Death	
1327-1328	2	1820	Addr Current--State	Follow-up/Recurrence/Death	
1329-1337	9	1830	Addr Current--Postal Code	Follow-up/Recurrence/Death	
1338-1340	3	1840	Country--Current	Follow-up/Recurrence/Death	
1341-1341	1	1850	Unusual Follow-Up Method	Follow-up/Recurrence/Death	
1342-1349	8	1860	Recurrence Date--1st	Follow-up/Recurrence/Death	
1350-1350	1	1871	Recurrence Distant Site 1	Follow-up/Recurrence/Death	
1351-1351	1	1872	Recurrence Distant Site 2	Follow-up/Recurrence/Death	
1352-1352	1	1873	Recurrence Distant Site 3	Follow-up/Recurrence/Death	
1353-1354	2	1880	Recurrence Type--1st	Follow-up/Recurrence/Death	
1355-1356	2	1895	Reserved 39	Follow-up/Recurrence/Death	

Column #	Length	Item #	Item Name	Section	Note
1357-1376	20	1842	Follow-Up Contact--City	Follow-up/Recurrence/Death	
1377-1378	2	1844	Follow-Up Contact--State	Follow-up/Recurrence/Death	
1379-1387	9	1846	Follow-Up Contact--Postal	Follow-up/Recurrence/Death	
1388-1391	4	1910	Cause of Death	Follow-up/Recurrence/Death	
1392-1392	1	1920	ICD Revision Number	Follow-up/Recurrence/Death	
1393-1393	1	1930	Autopsy	Follow-up/Recurrence/Death	
1394-1396	3	1940	Place of Death	Follow-up/Recurrence/Death	
1397-1398	2	1791	Follow-up Source Central	Follow-up/Recurrence/Death	
1399-1406	8	1755	Date of Death--Canada	Follow-up/Recurrence/Death	New
1407-1446	40	1740	Reserved 09	Follow-up/Recurrence/Death	Revised
1447-1946	500	2220	State/Requestor Items	Special Use	
1947-1971	25	2230	Name--Last	Patient-Confidential	
1972-1985	14	2240	Name--First	Patient-Confidential	
1986-1999	14	2250	Name--Middle	Patient-Confidential	
2000-2002	3	2260	Name--Prefix	Patient-Confidential	
2003-2005	3	2270	Name--Suffix	Patient-Confidential	
2006-2020	15	2280	Name--Alias	Patient-Confidential	
2021-2035	15	2390	Name--Maiden	Patient-Confidential	
2036-2085	50	2290	Name--Spouse/Parent	Patient-Confidential	
2086-2096	11	2300	Medical Record Number	Patient-Confidential	
2097-2098	2	2310	Military Record No Suffix	Patient-Confidential	
2099-2107	9	2320	Social Security Number	Patient-Confidential	
2108-2147	40	2330	Addr at DX--No & Street	Patient-Confidential	
2148-2187	40	2335	Addr at DX--Supplementl	Patient-Confidential	
2188-2227	40	2350	Addr Current--No & Street	Patient-Confidential	
2228-2267	40	2355	Addr Current--Supplementl	Patient-Confidential	
2268-2277	10	2360	Telephone	Patient-Confidential	
2278-2283	6	2380	DC State File Number	Patient-Confidential	
2284-2313	30	2394	Follow-Up Contact--Name	Patient-Confidential	
2314-2353	40	2392	Follow-Up Contact--No&St	Patient-Confidential	
2354-2393	40	2393	Follow-Up Contact--Suppl	Patient-Confidential	
2394-2403	10	2352	Latitude	Patient-Confidential	
2404-2414	11	2354	Longitude	Patient-Confidential	
2415-2464	50	1835	Reserved 10	Patient-Confidential	
2465-2474	10	2435	Reserved 40	Hospital-Confidential	
2475-2484	10	2440	Following Registry	Hospital-Confidential	

Column #	Length	Item #	Item Name	Section	Note
2485-2494	10	2410	Institution Referred From	Hospital-Confidential	
2495-2504	10	2420	Institution Referred To	Hospital-Confidential	
2505-2514	10	2415	NPI--Inst Referred From	Hospital-Confidential	
2515-2524	10	2425	NPI--Inst Referred To	Hospital-Confidential	
2525-2534	10	2445	NPI--Following Registry	Hospital-Confidential	
2535-2554	20	1900	Reserved 11	Hospital-Confidential	
2555-2562	8	2460	Physician--Managing	Other-Confidential	
2563-2570	8	2470	Physician--Follow-Up	Other-Confidential	
2571-2578	8	2480	Physician--Primary Surg	Other-Confidential	
2579-2586	8	2490	Physician 3	Other-Confidential	
2587-2594	8	2500	Physician 4	Other-Confidential	
2595-2604	10	2465	NPI--Physician--Managing	Other-Confidential	
2605-2614	10	2475	NPI--Physician--Follow-Up	Other-Confidential	
2615-2624	10	2485	NPI--Physician--Primary Surg	Other-Confidential	
2625-2634	10	2495	NPI--Physician 3	Other-Confidential	
2635-2644	10	2505	NPI--Physician 4	Other-Confidential	
2645-2844	200	2520	Text--DX Proc--PE	Text-Diagnosis	
2845-3094	250	2530	Text--DX Proc--X-ray/Scan	Text-Diagnosis	
3095-3344	250	2540	Text--DX Proc--Scopes	Text-Diagnosis	
3345-3594	250	2550	Text--DX Proc--Lab Tests	Text-Diagnosis	
3595-3844	250	2560	Text--DX Proc--Op	Text-Diagnosis	
3845-4094	250	2570	Text--DX Proc--Path	Text-Diagnosis	
4095-4134	40	2580	Text--Primary Site Title	Text-Diagnosis	
4135-4174	40	2590	Text--Histology Title	Text-Diagnosis	
4175-4474	300	2600	Text--Staging	Text-Diagnosis	
4475-4624	150	2610	RX Text--Surgery	Text-Treatment	
4625-4774	150	2620	RX Text--Radiation (Beam)	Text-Treatment	
4775-4924	150	2630	RX Text--Radiation Other	Text-Treatment	
4925-5124	200	2640	RX Text--Chemo	Text-Treatment	
5125-5324	200	2650	RX Text--Hormone	Text-Treatment	
5325-5424	100	2660	RX Text--BRM	Text-Treatment	
5425-5524	100	2670	RX Text--Other	Text-Treatment	
5525-5874	350	2680	Text--Remarks	Text-Miscellaneous	
5875-5924	50	2690	Text--Place of Diagnosis	Text-Miscellaneous	
5925-6694	770	2700	Reserved 19	Text-Miscellaneous	

Appendix I

APPENDIX TABLE A: 639 MOST FREQUENTLY OCCURRING HEAVILY HISPANIC SURNAMES

(Number to right of surname indicates relative ranking among Spanish surnames)

Abeyta	476	Baca	157	Carrion	340	Dominguez	63	Guardado	587
Abrego	534	Badillo	515	Carvajal	478	Dominquez	448	Guerra	85
Abreu	416	Baez	193	Casanova	419	Duarte	201	Guerrero	54
Acevedo	112	Baeza	456	Casares	600	Duenas	499	Guevara	211
Acosta	60	Bahena	616	Casarez	458	Duran	76	Guillen	311
Acuna	370	Balderas	359	Casas	341	Echevarria	394	Gurule	539
Adame	326	Ballesteros	552	Casillas	271	Elizondo	379	Gutierrez	24
Adorno	549	Banda	339	Castaneda	123	Enriquez	173	Guzman	43
Agosto	597	Banuelos	378	Castellanos	261	Escalante	349	Haro	471
Aguayo	409	Barajas	220	Castillo	25	Escamilla	275	Henriquez	480
Aguilar	45	Barela	405	Castro	37	Escobar	139	Heredia	336
Aguilera	243	Barragan	526	Cavazos	228	Escobedo	244	Hernandez	528
Aguirre	104	Baraza	381	Cazares	406	Esparza	169	Hernandes	520
Alanis	598	Barrera	111	Ceballos	498	Espinal	500	Hernandez	5
Alaniz	267	Barreto	497	Cedillo	571	Espino	469	Herrera	33
Alarcon	364	Barrientos	432	Ceja	410	Espinosa	143	Hidalgo	282
Alba	404	Barrios	200	Centeno	459	Espinoza	68	Hinojosa	229
Alcala	424	Batista	418	Cepeda	467	Esquibel	460	Holguin	372
Alcantar	567	Becerra	226	Cerda	296	Esquivel	231	Huerta	188
Alcaraz	599	Beltran	158	Cervantes	99	Estevez	619	Hurtado	253
Alejandro	550	Benavides	208	Cervantez	479	Estrada	52	Ibarra	114
Aleman	347	Benavidez	310	Chacon	213	Fajardo	382	Iglesias	489
Alfaro	207	Benitez	172	Chapa	247	Farias	428	Inizarry	233
Alicea	303	Bermudez	227	Chavarria	306	Feliciano	205	Jaime	442
Almanza	387	Bernal	168	Chavez	22	Fernandez	29	Jaimes	588
Almaraz	551	Berrios	299	Cintron	348	Ferrer	360	Jaquez	553
Almonte	614	Betancourt	290	Cisneros	135	Fierro	395	Jaramillo	171
Alonso	238	Bianco	163	Collado	536	Figueroa	59	Jasso	472
Alonzo	264	Bonilla	153	Collazo	318	Flores	13	Jimenez	35
Altamirano	466	Borrego	398	Colon	53	Florez	429	Jiminez	490
Alva	568	Botello	516	Colunga	434	Fonseca	335	Juarez	78
Alvarado	56	Bravo	194	Concepcion	426	Franco	116	Jurado	603
Alvarez	27	Briones	457	Contreras	71	Frias	461	Laboy	540
Amador	281	Briseno	433	Cordero	180	Fuentes	97	Lara	94
Amaya	265	Brito	333	Cordova	142	Gaitan	573	Laureano	604
Anaya	195	Bueno	316	Comejo	441	Galarza	449	Leal	176
Anguiano	477	Burgos	209	Corona	186	Galindo	179	Lebron	400
Angulo	438	Bustamante	274	Coronado	221	Gallardo	232	Ledesma	300
Aparicio	535	Bustos	399	Corral	353	Gallegos	73	Leiva	622
Apodaca	273	Caballero	268	Corrales	601	Galvan	125	Lemus	297
Apointe	236	Caban	439	Correa	159	Galvez	307	Leon	95
Aragon	230	Cabrera	105	Cortes	175	Gamboia	354	Lerma	322
Arana	581	Cadena	440	Cortez	64	Gamez	302	Leyva	258
Aranda	285	Caldera	582	Cotto	468	Gaona	501	Limon	383
Arce	288	Calderon	107	Covarrubias	518	Garay	538	Linares	368
Archuleta	289	Calvillo	617	Crespo	278	Garcia	1	Lira	401
Arellano	190	Camacho	98	Cruz	17	Garibay	527	Llamas	554
Arenas	525	Camarillo	425	Cuellar	246	Garica	620	Loera	412
Arevalo	321	Campos	84	Curiel	572	Garrido	430	Lomeli	555
Arguello	569	Canales	260	Davila	129	Garza	26	Longoria	192
Arias	166	Candelaria	366	Deanda	584	Gastelum	586	Lopez	4
Armas	615	Cano	167	Dejesus	131	Gaytan	462	Lovato	502
Armendariz	447	Cantu	102	Delacruz	151	Gi	262	Loya	420
Armenta	417	Caraballo	317	Delafuente	585	Giron	411	Lozada	541
Armijo	377	Carbajal	367	Delagarza	371	Godinez	388	Lozano	122
Arredondo	212	Cardenas	106	Delao	602	Godoy	621	Lucero	124
Arreola	365	Cardona	214	Delapaz	537	Gomez	15	Lucio	481
Arriaga	397	Carmona	252	Delarosa	164	Gonzales	12	Luevano	491
Arroyo	132	Carranza	269	Delatorre	237	Gonzalez	6	Lugo	137
Arteaga	332	Carrasco	210	Deleon	81	Gracia	389	Lujan	215
Atencio	496	Carrasquillo	570	Delgadillo	427	Granado	519	Luna	66
Avalos	250	Carreon	583	Delgado	46	Granados	350	Macias	115
Avila	86	Carrera	517	Delrio	393	Griego	435	Madera	542
Aviles	245	Carrero	618	Delvalle	334	Grijalva	470	Madrid	185
Ayala	65	Carrillo	77	Diaz	14	Guajardo	308	Madrigal	270

APPENDIX TABLE A: 639 MOST FREQUENTLY OCCURRING HEAVILY HISPANIC SURNAMES

(Number to right of surname indicates relative ranking among Spanish surnames)

Maestas	304	Nazario	545	Posada	593	Salcedo	532	Vaca	636
Magana	248	Negrete	324	Prado	294	Salcido	309	Valadez	330
Malave	521	Negron	216	Preciado	531	Saldana	219	Valdes	240
Maldonado	51	Nevarez	369	Prieto	313	Saldivar	445	Valdez	47
Manzanares	623	Nieto	251	Puente	358	Salgado	184	Valdivia	524
Mares	402	Nieves	120	Puga	609	Salinas	80	Valencia	127
Marin	177	Nino	626	Pulido	444	Samaniego	511	Valentin	257
Marquez	61	Noriega	344	Quesada	484	Sanabria	454	Valenzuela	110
Marrero	178	Nunez	58	Quezada	292	Sanches	431	Valladares	577
Marroquin	312	Ocampo	355	Quinones	146	Sanchez	8	Valle	235
Martinez	2	Ocasio	361	Quinonez	413	Sandoval	55	Vallejo	386
Mascarenas	589	Ochoa	91	Quintana	140	Santacruz	631	Valles	396
Mata	138	Ojeda	255	Quintanilla	277	Santana	117	Valverde	548
Mateo	503	Olivares	272	Quintero	162	Santiago	41	Vanegas	637
Matias	529	Olivarez	305	Quiroz	218	Santillan	562	Varela	223
Matos	202	Olivas	291	Rael	463	Sarabia	632	Vargas	36
Maya	556	Olivera	558	Ramirez	10	Sauceda	512	Vasquez	23
Mayorga	605	Olivo	475	Ramon	407	Saucedo	239	Vazquez	62
Medina	30	Olmos	507	Ramos	20	Sedillo	594	Vega	49
Medrano	191	Olvera	276	Rangel	133	Segovia	523	Vela	182
Mejia	93	Ontiveros	301	Rascon	610	Segura	241	Velasco	293
Melendez	109	Oquendo	530	Raya	561	Sepulveda	280	Velasquez	96
Melgar	624	Ordonez	421	Razo	492	Serna	249	Velazquez	130
Mena	323	Orellana	443	Regalado	403	Serrano	89	Velez	83
Menchaca	482	Omelas	283	Rendon	287	Serrato	612	Veliz	578
Mendez	39	Orosco	452	Renteria	256	Sevilla	613	Venegas	375
Mendoza	32	Orozco	147	Resendez	485	Sierra	187	Vera	197
Menendez	337	Orta	436	Reyes	19	Sisneros	563	Verdugo	579
Meraz	543	Ortega	50	Reyna	149	Solano	315	Verduzco	638
Mercado	103	Ortiz	16	Reynoso	325	Solis	90	Vergara	495
Merino	557	Osorio	338	Rico	295	Soliz	385	Viera	415
Mesa	342	Otero	174	Rincon	522	Solorio	446	Vigil	136
Meza	156	Ozuna	559	Riojas	574	Solorzano	564	Villa	134
Miramontes	606	Pabon	590	Rios	48	Soria	437	Villagomez	465
Miranda	79	Pacheco	92	Rivas	88	Sosa	118	Villalobos	225
Mireles	298	Padilla	57	Rivera	9	Sotelo	328	Villalpando	596
Mojica	343	Padron	508	Rivero	373	Soto	34	Villanueva	145
Molina	67	Paez	607	Robledo	509	Suarez	101	Villareal	423
Mondragon	450	Pagan	148	Robles	82	Tafoya	455	Villarreal	87
Monroy	544	Palacios	181	Rocha	121	Tamayo	414	Villasenor	392
Montalvo	254	Palomino	627	Rodarte	493	Tamez	595	Villegas	165
Montanez	286	Palomo	591	Rodriguez	629	Tapia	141	Yanez	266
Montano	203	Pantoja	356	Rodriguez	3	Tejada	513	Ybarra	189
Montemayor	504	Paredes	357	Rodriquez	38	Tejeda	464	Zambrano	488
Montenegro	505	Parra	217	Rojas	74	Tellez	352	Zamora	108
Montero	351	Partida	453	Rojo	510	Tello	565	Zamudio	639
Montes	154	Patino	345	Roldan	391	Teran	633	Zapata	224
Montez	451	Paz	327	Rolon	611	Terrazas	533	Zaragoza	376
Montoya	70	Pedraza	592	Romero	28	Tijerina	362	Zarate	331
Mora	119	Pedroza	422	Romo	222	Tirado	329	Zavala	170
Morales	18	Pelayo	546	Roque	486	Toledo	363	Zayas	514
Moreno	31	Pena	42	Rosado	144	Toro	346	Zelaya	580
Mota	483	Peralas	384	Rosales	113	Torres	11	Zepeda	234
Moya	279	Peralta	263	Rosario	126	Torrez	242	Zuniga	155
Munguia	506	Perea	390	Rosas	152	Tovar	204		
Muniz	160	Peres	560	Roybal	408	Trejo	206		
Munoz	40	Perez	7	Rubio	128	Trevino	72		
Munillo	183	Pichardo	608	Ruelas	630	Trujillo	69		
Muro	625	Pina	196	Ruiz	21	Ulibarri	566		
Najera	319	Pineda	161	Ruvalcaba	575	Ulloa	494		
Naranjo	473	Pizarro	628	Saavedra	314	Urbina	374		
Narvaez	474	Polanco	320	Saenz	199	Urena	634		
Nava	198	Ponce	150	Saiz	487	Urias	576		
Navarrete	380	Porras	547	Salas	100	Uribe	284		
Navarro	75	Portillo	259	Salazar	44	Urrutia	635		

Appendix J

Cancer Reporting Resources

Standard-setting organizations

North American Association of Central Cancer Registries (NAACCR)

2121 W. White Oaks Drive, Suite C
Springfield, IL 62704
Tel: (217) 698-0800 Fax: (217) 698-0188
Email: info@naaccr.org
www.naaccr.org

Centers for Disease Control and Prevention (CDC)

Division of Cancer Prevention and Control
Mail stop K-64, 4770 Buford Hwy. NE
Atlanta, GA 30341-3717
CDC Public Inquiries: (800) 232-4636 Fax: (770) 488-4760
Email: cdcinfo@dcd.gov
www.cdc.gov

American College of Surgeons (ACoS)

Commission on Cancer
633 North Saint Clair Street
Chicago, IL 60611-3211
Tel: (312) 202-5085 Fax (312) 202-5009
Email: coc@facs.org
www.facs.org

National Cancer Institute (NCI)

SEER Program (SEER)
6116 Executive Blvd.-MSC 8316, Suite 504
Bethesda, MD 20892
Tel: (301) 496-8510 Fax: (301) 496-9949
Email: cancer.gov_staff@mail.nih.gov
www.seer.cancer.gov

National Cancer Registrars Association (NCRA)

1340 Braddock Place, Suite 203
Alexandria, VA 22314
Tel: (703) 299-6640 Fax: (703) 299-6620
Email: info@ncra-usa.org
www.ncra-usa.org

American Cancer Society (ACS), Oregon Division

0330 SW Curry Street
Portland, OR 97239
Tel: (503) 795-3911 or Toll Free 1-800-227-2345
www.cancer.org

Cancer Reporting Resources

Basic OSCaR Registrar References

Manual or Reference	Used for:
FORDS (<i>Commission on Cancer</i>)	Field definitions & detailed coding instructions for: <ul style="list-style-type: none"> • Reportability (also see state specific reportability list) • Patient demographics • Cancer diagnosis • First course of treatment • Outcomes Download @ http://www.facs.org/cancer/coc/fordsmanual.html Note: updated manual available in 2009
Multiple Primary & Histology Coding Manual (<i>SEER</i>)	Site specific rules to: <ul style="list-style-type: none"> • Determine number of primaries • Promote consistent coding of histology (<i>especially complex or mixed histologies</i>) Used in conjunction with ICDO-3 Download @ http://seer.cancer.gov/tools/mphrules/
SEER Program Coding Manual (<i>SEER</i>)	Field definitions & detailed coding instructions for: <ul style="list-style-type: none"> • Similar to FORDS but more detailed and comprehensive • Integrates site-specific information such as surgery codes and staging information Download @ http://seer.cancer.gov/tools/codingmanuals/index.html
Collaborative Staging & Coding Manual (<i>AJCC</i>)	Combines clinical and pathological data to derive a best stage. <ul style="list-style-type: none"> • Part I – General instructions and principles. Read before reading Part II. • Part II – contains site specific coding instructions for all primary sites. Download @ http://www.cancerstaging.org/cstage/manuals.html
ICDO-3 (<i>World Health Organization</i>)	Universal coding system used throughout the world for: <ul style="list-style-type: none"> • Primary site • Histology Electronic version not available but purchase info can be found @ http://www.who.int/classifications/icd/adaptations/oncology/en/ Updates and Errata can be downloaded @ http://seer.cancer.gov/icd-o-3/index.html
Cancer Program and Data Standards	http://www.facs.org/cancer/coc/programstandards.html
NCHS ICD-9-CM	Assure codes on reportable list and codes accessed fro hospital disease index are up-to-date http://www.cdc.gov/nchs/datawh/ftpser/ftpicd9/ftpicd9.htm#guidelines
SEER *Rx	Interactive Antineoplastic Drugs Database <ul style="list-style-type: none"> • One-step lookup for coding oncology drugs and regimens Download free @ http://seer.cancer.gov/tools/seerrx/index.html

Cancer Reporting Resources

Recommended Reference	Ordering/Download Information
<i>Abstracting and Coding Guide for the Hematopoietic Diseases</i>	National Cancer Institute SEER Program 6166 Executive Blvd., Suite 504 Bethesda, MD 20892-0001 1-800-4-CANCER www.seer.cancer.gov
AJCC Cancer Staging Manual, Sixth Edition	American College of Surgeons, AJCC Executive Office 633 N. Saint Clair Chicago, IL 60611 312-202-5420 www.cancerstaging.org
<i>Clinical Oncology</i> , second edition	American Cancer Society Oregon Division 0330 SW Curry Street Portland, OR 97239 503-795-3911 www.cancer.org
<i>Facility Oncology Registry Data Standards (FORDS)</i> , 2004	American College of Surgeons, Commission on Cancer 633 N. Saint Clair Chicago, IL 60611 1-800-621-4111 www.facs.org
<i>International Classification of Diseases for Oncology</i> , third edition, 2000	WHO Publications Center, USA 49 Sheridan Ave Albany, NY 12210 518-436-9686 Email: bookorders@who.int www.who.int/bookorders
<i>NAACCR Data Exchange Standards and Record Descriptions Volume I</i> , 2004	National Association of Central Cancer Registries Cancer Surveillance and Control Program 2121 West White Oaks Drive, Suite C Springfield, IL 62704 217-698-0800 www.naacr.org
<i>NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary</i> , 2004	National Association of Central Cancer Registries Cancer Surveillance and Control Program 2121 West White Oaks Drive, Suite C Springfield, IL 62704 217-698-0800 www.naacr.org

Cancer Reporting Resources

<p><i>SEER Comparative Staging Guide for Cancer</i></p>	<p>National Institutes of Health National Cancer Institute SEER Program Bethesda, MD 20893-0001 1-800-4-CANCER www.seer.cancer.gov</p>
<p><i>SEER Program Code Manual 2007</i></p>	<p>National Institutes of Health National Cancer Institute SEER Program Bethesda, MD 20893-0001 1-800-4-CANCER www.seer.cancer.gov/manuals/codeman/pdf</p>
<p><i>SEER Self Instructional Manuals, 1-5, 7, 8</i></p>	<p>National Institutes of Health National Cancer Institute SEER Program Bethesda, MD 20893-0001 1-800-4-CANCER www.seer.cancer.gov/training/manuals</p>
<p><i>SEER Summary Staging Manual 2000: Codes and Coding Instructions</i></p>	<p>National Institutes of Health National Cancer Institute SEER Program Bethesda, MD 20893-0001 1-800-4-CANCER www.seer.cancer.gov/tools/ssm</p>
<p><i>Collaborative Staging Manual and Coding Instructions</i> NIH Pub. No. 04-5496</p>	<p>Jointly published by: American Joint Committee on Cancer Chicago IL and U.S. Department of Health and Human Services Bethesda MD www.cancerstaging.org/cstage/index.html</p>
<p>Seer*Rx Interactive Drug Database</p>	<p>http://seer.cancer.gov/tools/seerrx/index.html</p>
<p><i>Postal Addressing Standards</i> U.S.P.S. Pub 28, November 2000</p>	<p>http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf</p>

Reference Guides:

Laterality Guide

Breast Guide

Grade Guide

Text Guide

Laterality Coding Guide

Paired Organ Sites	
ICDO-3	Site
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1 – C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bones of upper limb
C40.2	Long bones of upper limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum)
C41.4	Pelvic bones (excluding sacrum, coccyx and symphysis pubis)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves & autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves & autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous and other soft tissues of upper limb & shoulder
C49.2	Connective, subcutaneous and other soft tissues of lower limb & hip
C50.0 – C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube

Paired Organ Sites, continued	
ICDO-3	Site
C62.0 – C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0 – C69.9	Eye & Lacrimal gland
C74.0 – C74.9	Adrenal gland
C75.4	Carotid body

Central Nervous System	
ICDO-3	Site
C70.0	Cerebral Meninges, NOS **
C71.0	Cerebrum
C71.1	Frontal lobe **
C71.2	Temporal lobe **
C71.3	Parietal lobe **
C71.4	Occipital lobe **
C72.2	Olfactory nerve **
C72.3	Optic nerve **
C72.4	Acoustic nerve **
C72.5	Cranial nerve, NOS **

** Effective with cases diagnosed 1/1/2004

Note: A laterality code of 1-4 or 9 **must** be assigned for the above sites except as noted. If the site is not listed on the table, assign code 0 for laterality.

Laterality Guide NAACCR Item # 410

Laterality describes the side of a paired organ or side of the body on which the reportable tumor originated. For each primary you need to determine whether laterality should be coded.

Starting with cases diagnosed January 1, 2004 and later, laterality is coded for select invasive, benign, and borderline primary intracranial and CNS tumors.

Codes

- 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, lateral origin unknown; stated to be single primary
- 9 Paired site, but no information concerning laterality; midline tumor

Coding Instructions

1. Code laterality using codes 1-9 for all of the sites listed in the *Paired Organ Sites* table.
2. Code the side where the primary tumor originated
 - a. Assign **code 3** if the laterality is not known but the tumor is confined to a single side of the paired organ.

Example: Pathology report: Patient has a 2 cm carcinoma in the upper pole of the kidney. Code laterality as 3 because there is documentation that the disease exists in only one kidney, but it is unknown if the disease originated in the right or left kidney.

- b. **Code 4** is seldom used EXCEPT for the following diseases:
 - i. Both ovaries involved simultaneously, single histology
 - ii. Bilateral retinoblastomas
 - iii. Bilateral Wilms tumors
 - iv.

Note: Laterality **may** be coded for sites other than those required above.

3. Assign **code 9** when there is a midline tumor or when the disease originated in a paired site, but the laterality is unknown.

Example 1: Admitting history says patient was diagnosed with lung cancer based on positive sputum cytology. Patient is treated for painful bony metastases. There is no information about laterality in the diagnosis of this lung cancer.

Example 2: Patient has an excision of a melanoma located just above the umbilicus. Assign code 9 for a midline tumor.

BREAST- Primary Site & Grade

Primary Site

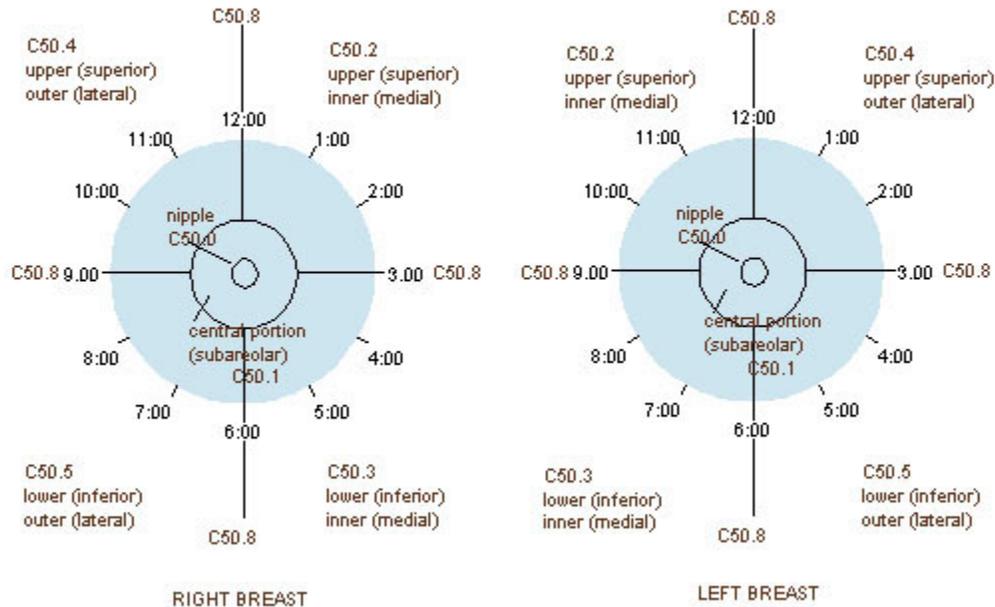
- | | |
|---|--|
| <p>C500</p> <ul style="list-style-type: none">• Nipple (areolar)• Paget disease without underlying tumor <p>C501</p> <ul style="list-style-type: none">• Central portion of breast (subareolar) area extending 1 cm around areolar complex• Retroareolar• Infraareolar• Next to areola, NOS• Behind, beneath, under, underneath, next to, above, cephalad to, or below nipple• Paget disease with underlying tumor <p>C502</p> <ul style="list-style-type: none">• Upper inner quadrant (UIQ) of breast• Superior medial• Upper medial• Superior inner <p>C503</p> <ul style="list-style-type: none">• Lower inner quadrant (LIQ) of breast• Inferior medial• Lower medial• Inferior inner <p>C504</p> <ul style="list-style-type: none">• Upper outer quadrant (UOQ) of breast• Superior lateral• Superior outer• Upper lateral | <p>C505</p> <ul style="list-style-type: none">• Lower outer quadrant (LOQ) of breast• Inferior lateral• Inferior outer• Lower lateral <p>C506</p> <ul style="list-style-type: none">• Axillary tail of breast• Tail of breast, NOS• Tail of Spence <p>C508</p> <ul style="list-style-type: none">• Overlapping lesion of breast• Inferior breast, NOS• Inner breast, NOS• Lateral breast, NOS• Lower breast, NOS• Medial breast, NOS• Midline breast NOS• Outer breast NOS• Superior breast, NOS• Upper breast, NOS• 3:00, 6:00, 9:00, 12:00 o'clock <p>C509</p> <ul style="list-style-type: none">• Breast, NOS• Entire breast• Multiple tumors in different subsites within breast• Inflammatory without palpable mass• $\frac{3}{4}$ or more of breast involved with tumor• Diffuse (tumor size 998) |
|---|--|

When to Use Subsites 8 and 9

1. Code the primary site to C508 when there is a single tumor that overlaps two or more subsites, and the subsite in which the tumor originated is unknown
2. Code the primary site to C508 when there is a single tumor located at the 12, 3, 6, or 9 o'clock position on the breast
3. Code the primary site to C509 when there are multiple tumors (two or more) in at least two quadrants of the breast

BREAST- Primary Site & Grade

"Clock" Positions, Quadrants and ICD-O Codes of the Breast



Grade

Code grade in the following priority order:

1 st BR Score	2 nd BR Grade	3 rd Nuclear Grade	4 th Terminology or differentiation	5 th Histologic Grade	6 th Grade	CODE
3, 4, 5 points	Low grade	1/2 or 1/3	Well Differentiated	I/III or 1/3	Grade i	1
6, 7 points	Medium grade	2/3	Moderately differentiated	II/III or 2/3	Grade ii	2
8, 9 points	High grade	2/2 or 3/3	Poorly differentiated	III/III or 3/3	Grade iii	3

Bloom Richardson (BR) may also be called:

- Modified Bloom-Richardson (MBR)
- Scarff-Bloom-Richardson (SBR), SBR grading
- BR grading
- Elston-Ellis modification of Bloom Richardson score
- Nottingham modification of Bloom Richardson score, Nottingham-Tenovus
- Nottingham grade

Grading basis must be documented in text field.

REFERENCE: SEER Program Coding and Staging Manual 2007

Grade Coding Guide

Terminology Conversion Table*		
Description	Grade	Code
Differentiated, NOS	I	1
Well differentiated	I	1
Fairly well differentiated	II	2
Intermediate differentiation	II	2
Low grade	I-II	2
Mid differentiated	II	2
Moderately differentiated	II	2
Moderately well differentiated	II	2
Partially differentiated	II	2
Partially well differentiated	I-II	2
Relatively or generally well differentiated	II	2
Medium grade, intermediate grade	II-III	3
Moderately poorly differentiated	III	3
Moderately undifferentiated	III	3
Poorly differentiated	III	3
Relatively poorly differentiated	III	3
Relatively undifferentiated	III	3
Slightly differentiated	III	3
Dedifferentiated	III	3
High grade	III-IV	4
Undifferentiated, anaplastic, not differentiated	IV	4
Non-high grade		9

**From SEER Program Code Manual 2007*

TWO GRADE Systems		
Terminology	Histologic grade	Code
Low grade	1/2 or I/II	2
High grade	2/2 or II/III	4

Adapted from SEER Program Coding and Staging Manual 2007 and FORDS

Oregon State Cancer Registry April 2009

Grade Coding Guide

THREE GRADE Systems Code in following priority order:			
1 st	2 nd	3 rd	
Terminology	Histologic grade	Nuclear grade	Code
Low grade, well to moderately differentiated	1/3 or I/III	1/3, 1/2	2
Medium grade, moderately undifferentiated, relatively undifferentiated	2/3 or II/III	2/3	3
High grade, poorly differentiated to undifferentiated	3/3 or III/III	3/3	4

BREAST cancer Code in following order:					
1 st	2 nd	3 rd	4 th	5 th	
Bloom-Richardson (Nottingham) scores	Bloom-Richardson grade	Nuclear grade	Terminology	Histologic grade	Code
3 – 5 points	Low grade	1/3 or 1/2	Well differentiated	I/III or 1/3	1
3, 7 points	Intermediate grade	2/3	Moderately differentiated	II/III or 2/3	2
8,9 points	High grade	2/2 or 3/3	Poorly differentiated	III/III or 3/3	3
Note: Bloom-Richardson must be documented in pathology report for conversion to be applied when coding grade.					

PROSTATE grade Code in following priority order:			
1 st	2 nd	3 rd	
Gleason's Score (sum of primary and secondary patterns)	Terminology	Histologic grade	Code
2, 3, 4	Well differentiated	I	1
5, 6	Moderately differentiated	II	2
7, 8, 9, 10	Poorly differentiated	III	3

KIDNEY (renal) grade (does not apply to Wilm's tumor) Code in following priority order:				
1 st	2 nd	3 rd	4 th	
Fuhrman's grade	Nuclear grade	Terminology	Histologic grade	Code
I	1/3,1/2	Well differentiated, differentiated NOS	I	1
II	2/3	Moderately differentiated, intermediate differentiation, moderately well differentiated	II	2
III	2/2, 3/3	Poorly differentiated, dedifferentiated	III	3
IV	4/4	Undifferentiated, anaplastic	IV	4

Adapted from SEER Program Coding and Staging Manual 2007 and FORDS

Oregon State Cancer Registry April 2009

OSCaR Text Fields Guide

From: *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Thirteenth Edition Version 11.3 – Chapter III: Standards for Tumor Inclusion and Reportability.*

NAACCR Text Field	Suggestions for text	Data Item(s) verified/validated with text*
		Item name / Item number
TEXT--PRIMARY SITE TITLE #2580	<ul style="list-style-type: none"> • Include information on the location of the primary site of the tumor • Include available information on tumor laterality 	Primary site #400 Laterality #410
TEXT--DX PROC--PATH #2570	<ul style="list-style-type: none"> • Date(s) of procedure(s) • Type of tissue specimen(s) • Tumor histologic type (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.) • Information on differentiation from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc. • Gross tumor size • Extent of tumor spread • Involvement of resection margins • Number of lymph nodes involved and examined • Record both positive and negative findings. <i>Record positive test results first</i> • Note if pathology report is a slide review or a second opinion from an outside source, i.e., AFIP, Mayo, etc. • Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored 	Date of Diagnosis #390 Primary Site #400 Laterality #410 Histologic Type ICD-O-3 #522 Grade #440 Collaborative Stage variables #2800-2930 Diagnostic confirmation #490
TEXT--STAGING #2600	<ul style="list-style-type: none"> • Date(s) of procedure(s), including clinical procedures, that provided information for assigning stage • Organs involved by direct extension • Size of tumor • Status of margins • Number and sites of positive lymph nodes • Site(s) of distant metastasis • Physician's specialty and comments 	RX Date--DX/Stg Proc #1280 Collaborative Stage variables #2800-2930 Regional Nodes Positive #820 Regional Nodes Examined #830 Behavior Code ICD-O-3 #523 Site of Distant Met 1-3 #1090-1110

*Ensure that text entered both agrees with the coded values and clearly justifies the selected codes.

OSCaR Text Fields Guide

NAACCR Text Field	Suggestions for text	Data Item(s) verified/validated with text*
		Item name / Item number
TEXT--DX PROC--LAB TESTS #2550	<ul style="list-style-type: none"> • Type of lab test/tissue specimen(s) • Record both positive and negative findings. <i>Record positive test results first</i> • Information can include tumor markers, serum and urine electrophoresis, special studies, etc. • Date(s) of lab test(s) • Tumor markers included, but are not limited to: <ul style="list-style-type: none"> • Breast Cancer – Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu • Prostate Cancer – Prostatic Specific Antigen (PSA) • Testicular Cancer – Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH) 	Primary Site #400 Grade #440 Diagnostic Confirmation #490 Laterality #410 Collaborative Stage variables #2800-2930 Date of Diagnosis #390
TEXT--DX PROC--OP #2560	<ul style="list-style-type: none"> • Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived • Number of lymph nodes removed • Size of tumor removed • Documentation of residual tumor • Evidence of invasion of surrounding areas 	Date of 1st Positive Bx #1080 Date of Diagnosis #390 RX Summ--Dx/Stg Proc #1350 Diagnostic Confirmation #490 Primary Site #400 RX Hosp--Dx/Stg Proc #740 RX Summ--Surg Prim Site #1290 Collaborative Stage variables #2800-2930
TEXT--DX PROC--PE #2520	<ul style="list-style-type: none"> • Date of physical exam • Age, sex, race/ethnicity • History that relates to cancer diagnosis. • Primary site • Histology (if diagnosis prior to this admission) • Tumor location • Tumor size • Palpable lymph nodes • Record positive and negative clinical findings. <i>Record positive results first</i> • Impression (when stated and pertains to cancer diagnosis) • Treatment plan 	Date of 1st Contact #580 Date of Diagnosis #390 Age at Diagnosis #230 Race 1 - 5 #160-164 Spanish Hispanic Origin #190 Sex #220 Primary Site #400 Laterality #410 Histology ICD-O-3 #522 Sequence Number-Central #380 Collaborative Stage variables #2800-2930
TEXT--DX PROC--SCOPES #2540	<ul style="list-style-type: none"> • Date(s) of endoscopic exam(s) • Primary site • Histology (if given) • Tumor location • Tumor size • Lymph nodes • Record positive and negative clinical findings. <i>Record positive results first</i> 	Date of Diagnosis #390 Date of 1st Positive Bx #1080 RX Summ-Dx/Stg Proc #1350 Diagnostic Confirmation #490 Primary Site #400 Laterality #410 Histology ICD-O-3 #522 Collaborative Stage variables #2800-2930

*Ensure that text entered both agrees with the coded values and clearly justifies the selected codes.

OSCaR Text Fields Guide

NAACCR Text Field	Suggestions for text	Data Item(s) verified/validated with text*
		Item name / Item number
TEXT--DX PROC--X-RAY/SCAN #2530	<ul style="list-style-type: none"> • Date(s) of X-ray/Scan(s) • Age, sex, race/ethnicity (when given) • Primary site • Histology (if given) • Tumor location • Tumor size • Lymph nodes • Record positive and negative clinical findings. <i>Record positive results first</i> • Distant disease or metastasis 	Date of Diagnosis #390 Sex #220 Birth Date #240 RxSumm-Dx/Stg Proc #1350 Primary Site #400 Laterality #410 Histology ICD-O-3 #522 Collaborative Stage variables #2800-2930
RX TEXT – SURGERY #2610	<ul style="list-style-type: none"> • 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. <i>Record positive findings first</i> 	RX Date Surgery #1200 RX Summ-Surg Prim Site #1290 RX Hosp-Surg Prim Site #670 RX Summ-Scope Reg LN Sur #1292 RX Hosp-Scope Reg LN Sur #672 RX Summ-Surg Oth Reg/Dis #1294 RX Hosp-Surg Oth Reg/Dis #674 Date of Initial RX--SEER #1260 Date of 1st Crs RX__CoC #1270 Reason for No Surgery #1340 RX Summ-Surgical Margins #1320 RX Hosp-Palliative Proc #3280 RX Summ-Palliative Proc #3270 Text-Place of Diagnosis #2690
RX Text – RADIATION (BEAM) #2620	<ul style="list-style-type: none"> • Date when 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 	Date of Initial RX-SEER #1260 Date of 1st Crs RX-CoC #1270 RX Summ-Radiation #1360 RX Summ-Surg/Rad Seq #1380 Reason For No Radiation #1430 RX Date-Radiation #1210 Rad Regional RX Modality #1570 RX Hosp-Radiation #690 RX Date Radiation Ended #3220 RX Summ-Rad to CNS #1370 Rad-No of Treatment Vol #1520 Rad-Regional Dose cGy #1510 Rad Treatment Volume #1540 Rad Location of RX #1550 Rad Boost RX Modality #3200 Rad Boost Dose cGy #3210

*Ensure that text entered both agrees with the coded values and clearly justifies the selected codes.

OSCaR Text Fields Guide

NAACCR Text Field	Suggestions for text	Data Item(s) verified/validated with text*
		Item name / Item number
RX Text – CHEMO #2640	<ul style="list-style-type: none"> • Date when chemotherapy began • Where treatment was given, e.g., at this facility, at another facility • Type of chemotherapy, e.g., name of agent(s) or protocol • Other treatment information, e.g., treatment cycle incomplete, unknown if chemotherapy was given 	Date of Initial RX-SEER #1260 Date of 1st Crs RX-CoC #1270 RX Summ-Chemo #1390 RX Hosp-Chemo #700 RX Date-Systemic #3230 RX Date-Chemo #1220
RX Text – Hormone #2650	<ul style="list-style-type: none"> • 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., orchiectomy • Other treatment information, e.g., treatment cycle incomplete; unknown if hormones were given 	Date of Initial RX-SEER #1260 Date of 1st Crs RX-CoC #1270 RX Summ-Hormone #1400 RX Hosp-Hormone #710 RX Date-Systemic #3230 RX Date-Hormone #1230
TEXT--REMARKS #2680	<ul style="list-style-type: none"> • Smoking history • Family and personal history of cancer • Comorbidities • Information on sequence numbers if a person was diagnosed with another cancer out-of-state or before the registry's reference date • Place of birth • Justification of over-ride flags 	

*Ensure that text entered both agrees with the coded values and clearly justifies the selected codes.