The SEER Program Code Manual

SEER

Cancer Statistics Branch
Surveillance Program
Division of Cancer Prevention and Control
National Cancer Institute

U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES
Public Health Service
National Institutes of Health

THE SEER PROGRAM CODE MANUAL

CANCER STATISTICS BRANCH
SURVEILLANCE PROGRAM
DIVISION OF CANCER PREVENTION AND CONTROL
NATIONAL CANCER INSTITUTE

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The SEER Program Code Manual -- 1988

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The *SEER Program Code Manual* is a limited explanation of the format and definitions of the computerized record routinely submitted by each SEER Participant to the National Cancer Institute (NCI). It is, therefore, concerned only with providing description in detail sufficient to achieve consensus in coding the routinely required data. In no way does this code manual imply any restriction on the type or degree of detailed information collected, classified, or studied at the local level.

The SEER Program is a continuation of two preceding NCI programs, the End Results Group and the Third National Cancer Survey. The working or operational definitions in these two large studies were not identical in all respects. One of the purposes of this manual is to clarify the definitions in areas where the traditions are different. Whether or not there is theoretical agreement regarding the best or proper interpretation of a particular concept, there should be a clear understanding of what has been agreed upon as a basis for common data. The interpretations presented here represent the decisions in force at this time.

"What is a Diagnosis of Cancer?"

The simplest way to state the answer is that a patient has cancer if a *recognized medical practitioner* says so. Then the question changes to "How can one tell from the medical record that the physician has stated a cancer diagnosis?" In most cases the patient's record clearly presents the diagnosis by use of specific terms which are synonymous with cancer. However, not always is the physician certain or the recorded language definitive. SEER rules concerning the usage of vague or inconclusive diagnostic language are as follows:

> The ambiguous terms "probable," "suspect," "suspicious," "compatible with," or "consistent with" *ARE* considered to be diagnostic of cancer.
>
> The ambiguous terms "questionable," "possible," "suggests," "worrisome," or "equivocal," *ARE NOT* considered to be diagnostic of cancer.

"How Changeable are the Diagnostic Items?"

Most of the diagnostic information items are restricted to information available or procedures performed within the time limits defined for each item. However, with the passage of time the patient's medical record gets more complete in regard to information originally missing or uncertain. It is therefore established practice to accept the thinking and information about the case at the time of the latest submission, or the most complete or detailed information. Thus, there may be changes in the coding of primary site, histology, extent of disease, residence, etc., as the information becomes more certain.

"How Changeable are the Diagnostic Items?" (cont'd)

There may be cases reported originally as cancer, especially if the initial report was a death certificate or one with the ambiguous terms, listed previously, which later information indicates never was a malignancy. These cases must be deleted from the file and the sequence number of any remaining cases for the same person adjusted accordingly.

"What is Cancer so far as Reporting to SEER is Concerned?"

All cases with a behavior code of '2' or '3' in the *International Classification of Diseases for Oncology, Field Trial Edition, March, 1988*, (ICD-O, FT, 1988) are reportable neoplasms. The following are exclusions:

8000-8004	Neoplasms, malignant, NOS of the skin (173.0-173.9)
8010-8045	Epithelial carcinomas of the skin (173.0-173.9)
8050-8082	Papillary and Squamous cell carcinomas of the skin (173.0-173.9)
8090-8110	Basal cell carcinomas of any site except genital sites

Note: The above lesions ARE reportable for skin of the genital sites: vagina, clitoris, vulva, prepuce, penis, and scrotum (sites 184.0, 184.1, 184.2, 184.3, 184.4, 187.1, 187.4, 187.7).

Note: If a '0' or '1' behavior code term in ICD-O, FT, 1988 is verified as in situ, '2', or malignant, '3', by a pathologist, these cases are reportable.

"What Dates of Diagnoses are Included in the SEER Program?"

Cases diagnosed as of January 1973 forward are included in the SEER Program. For exceptions, see list of SEER Participants with "Year Reporting Started" in Section I.01.

"Does residency of patient affect reportability to SEER?"

All cancers diagnosed in persons who are residents of the SEER reporting area at time of diagnosis are reportable to SEER.

"What is the Policy When There is More Than One Cancer?"

The determination of how many primary cancers a patient has is, of course, a medical decision, but operational rules are needed in order to ensure consistency of reporting by all participants. Basic factors include the site of origin, the date of diagnosis, the histologic type, the behavior of the neoplasm (i.e., in situ versus malignant), and laterality.

"What is the Policy When There is More Than One Cancer?" (cont'd)

In general, if there is a difference in the site where the cancer originates, it is fairly easy to determine whether it is a separate primary, regardless of dates of detection and of differences in histology.

Likewise, if there is a clear-cut difference in histology, other data such as site and time of detection are not essential. In some neoplasms, however, one must be careful since different histologic terms are used to describe progressive stages or phases of the same disease process.

"How Are Multiple Primary Cancers Determined?"

Definitions:

1. Site differences: For colon, rectum, bone, connective tissue, and melanoma of skin, each *subcategory* (4-digits) as delineated in the *International Classification of Diseases for Oncology, Field Trial Edition, March, 1988* (ICD-O, FT, 1988) is considered to be a separate site. For all other sites, each *category* (3-digits) as delineated in ICD-O, FT, 1988, is considered to be a separate site.

   For example: Transverse colon (ICD-O code 153.1) and descending colon (153.2) are each considered to be separate sites while trigone of urinary bladder (188.0) and lateral wall of urinary bladder (188.2) are considered to be subsites of the urinary bladder and would be coded as one primary -- bladder (188.9).

2. Histologic type differences: Differences in histologic type refer to differences in the *FIRST THREE* digits of the morphology code, except for lymphatic and hematopoietic diseases.

3. Simultaneous/Synchronous: Diagnoses within two months of each other.

Rules for Determining Multiple Primary Cancers (except for lymphatic and hematopoietic diseases) (See pages 10-35):

1. A single lesion of one histologic type is considered a single primary even if the lesion crosses site boundaries.

2. A single lesion with multiple histologic types is to be considered as a single primary.

Rules for Determining Multiple Primary Cancers (except for lymphatic and hematopoietic diseases): (cont'd)

3. If a new cancer of the same histology as an earlier one is diagnosed in the same site within two months, consider this to be the same primary cancer. If a new cancer of the same histology is diagnosed in the same site after two months, consider this new cancer a separate primary unless stated to be recurrent or metastatic.

   EXCEPTION: Bladder cancers, site codes 188.0-188.9, with histology codes 8120-8130, are the only exception to the above rule. For these bladder cancers, a single abstract is required for the first lesion only.

4. Multiple lesions of the same histologic type:

   a. Simultaneous multiple lesions of the same histologic type within the same site will be considered a single primary. Further, if one lesion has a behavior code of in situ and another a behavior code of malignant, still consider this to be a single primary whose behavior is malignant.

   b. Multiple lesions of the same histologic type occurring in different sites are considered to be separate primaries unless stated to be metastatic.

5. Multiple lesions of different histologic types:

   a. Multiple lesions of different histologic types within a single site are to be considered separate primaries whether occurring simultaneously or at different times. The following are exceptions to this rule:

      1) For multiple lesions within a single site occurring within two months, if one lesion is stated to be carcinoma NOS, adenocarcinoma NOS, or sarcoma NOS and the second lesion is a more specific term, such as large cell carcinoma, mucinous adenocarcinoma, or spindle cell sarcoma, consider this to be a single primary and code to the more specific term.

         Exception: When both an adenocarcinoma (8140/3) and an adenocarcinoma (in situ) in a(n) (adenomatous) polyp (8210) or an adenocarcinoma (in situ) in a (tubulo)villous adenoma (8261, 8263) arise in the same segment of the colon or of the rectum, code as adenocarcinoma (8140/3).

         When both a carcinoma (8010/3) and a carcinoma (in situ) in a(n) (adenomatous) polyp (8210) arise in the same segment of the colon or of the rectum, code as carcinoma (8010/3).

Rules for Determining Multiple Primary Cancers (except for lymphatic and hematopoietic diseases): (cont'd)

2) Within each breast, combinations of ductal and lobular carcinoma occurring within two months of each other are to be considered a single primary and the histology coded according to the ICD-O, FT, 1988.

Note: If the ductal and lobular lesions for the female breast are reported to occur in different quadrants of the same breast, the appropriate site code is '174.9'. If the ductal lesion occurs in one breast and the lobular lesion occurs in the opposite breast, these are considered to be two primaries whether diagnosed within two months or not.

3) Some tumors have more than one histologic pattern. The most frequent combinations are listed in ICD-O, FT, 1988, under the term "mixed" in the alphabetic index. In addition combination terms such as "adenosquamous carcinoma (8560/3)" or "small cell-large cell carcinoma (8045/3)" are included. Any of these mixed histologies are to be considered one primary. Refer to the rule on "Compound Morphologic Diagnoses" (pg. xviii, *International Classification of Diseases for Oncology, 1976* (ICD-O, 1976)) for rules on coding compound morphologic diagnoses or diagnoses including modifying adjectives which have different code numbers. For a diagnosis with more than one modifying adjective, consider this to be one primary and code to the highest histology.

b. Multiple lesions of different histologic types occurring in different sites are considered separate primaries whether occurring simultaneously or at different times.

6. If only one histologic type is reported and if both sides of a paired site are involved within two months of diagnosis, a determination must be made as to whether the patient has one or two independent primaries. If it is determined that there are two independent primaries, two records are to be submitted, each with the appropriate laterality and extent of disease information. If it is determined that there is only one primary, laterality should be coded according to the side in which the single primary originated and a single record submitted. If it is impossible to tell in which of the pair the single primary originated, laterality should be coded as a '4' and a single record submitted.

There are *THREE EXCEPTIONS* to this rule. Simultaneous bilateral involvement of the ovaries in which there is only a single histology is to be considered one primary and laterality is to be coded '4'. Bilateral retinoblastomas and bilateral Wilms's tumor are always considered single primaries (whether simultaneous or not), and laterality is coded as '4'.

Rules for Determining Multiple Primary Cancers (except for lymphatic and hematopoietic diseases): (cont'd)

7. Kaposi's sarcoma (9140/3) is reported only once. Kaposi's sarcoma is coded to the site in which it arises. If Kaposi's sarcoma arises in skin and another site simultaneously, code to skin (173._). If no primary site is stated, code to skin (173._).

Rules for Determining Multiple Primaries for Lymphatic and Hematopoietic Diseases:

The table on pages 11-35 is to be used to help determine multiple primaries of the lymphatic and hematopoietic diseases. To use this table locate the first diagnosis in the left column of the table, then locate the second diagnosis in the other columns. If the second primary appears in the middle column, the two diagnoses are usually considered two separate primaries. If the second diagnosis appears in the right hand column, then the two diagnoses are usually considered one primary. Select the disease mentioned in the first column unless there is an indication in the right hand column to do otherwise. If the pathology report specifically states differently, use the pathology report. Consult your medical advisor or pathologist if questions remain.

For example,

1) a. first diagnosis: small cleaved cell, diffuse lymphoma
   b. second diagnosis: Hodgkin's disease, mixed cellularity

   This case would be considered two primaries.

2) a. first diagnosis: small cleaved cell, diffuse lymphoma
   b. second diagnosis: acute lymphocytic leukemia

   This case would be considered one primary.

RULES:

1. No topography (site) is to be considered in determining multiple primaries of lymphatic and hematopoietic diseases.

2. The interval between diagnoses is NOT to enter into the decision.

   Example: A lymphocytic lymphoma (M-9670/3) diagnosed in March, 1987 and an unspecified non-Hodgkin's lymphoma (M-9590/3) diagnosed in April, 1988 would be considered one primary, a lymphocytic lymphoma diagnosed in March, 1987 (the earlier diagnosis).

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Hodgkin's disease (9650-9667)	Non-Hodgkin's lymphoma (9591-9594,9670-9686, 9690-9698,9702-9704) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700-9701) Malignant histiocytosis or Letterer-Siwe's disease (9720,9722) True histiocytic lymphoma (9723) Multiple myeloma or plasmacytoma (9730,9731) Mast cell tumor (9740-9741) Any leukemia (9800-9940) Waldenstrom's macroglobulinemia (9761)	Hodgkin's disease* (9650-9667) Malignant lymphoma, NOS (9590)

*Code to the term with the higher histology code.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Malignant lymphoma, NOS (9590)***	Burkitt's lymphoma (9687)	Non-Hodgkin's lymphoma** (9590-9594, 9670-9686, 9690-9698, 9702-9704)
	Mycosis fungoides or Sezary's disease (9700,9701)	
	Malignant histiocytosis or Letterer-Siwe's disease (9720,9722)	Hodgkin's disease** (9650-9667)
	Mast cell tumor (9740,9741)	True histiocytic lymphoma (9723)
	Acute leukemia, NOS (9801)	Multiple myeloma or plasmacytoma** (9730,9731)
	Mast cell tumor (9740,9741)	Leukemia, NOS (9800)
	Non-lymphocytic leukemias (9840-9842,9860-9910)	Chronic leukemia, NOS (9803)
	Myeloid sarcoma (9930)	Lymphoid or lymphocytic leukemia (9820-9825)
	Acute panmyelosis (9931)	Plasma cell leukemia (9830)

**Presumably this is the correct diagnosis. Code the case to this histology.

***If the diagnosis includes "can"t rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis; then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Malignant lymphoma, NOS (9590) *** (cont'd)	Acute myelofibrosis (9932) Hairy cell leukemia (9940)	Lymphosarcoma cell leukemia (9850) Waldenstrom's macroglobulinemia (9761)

**Presumably this is the correct diagnosis. Code the case to this histology.

***If the diagnosis includes "can"t rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis; then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Non-Hodgkin's lymphoma*** (9591-9594,9670-9686, 9690-9698)	Hodgkin's disease (9650-9667)	Non-Hodgkin's lymphoma* (9590-9594, 9670-9686, 9690-9698, 9702-9704)
	Burkitt's lymphoma (9687)	
	Mycosis fungoides or Sezary's disease (9700,9701)	Multiple myeloma or plasmacytoma** (9730,9731)
	Malignant histiocytosis or Letterer-Siwe's disease (9720,9722)	True histiocytic lymphoma (9723)
	Mast cell tumor (9740-9741)	Leukemia, NOS (9800)
	Acute leukemia, NOS (9801)	Chronic leukemia, NOS (9803)
	Non-lymphocytic leukemias (9840-9842,9860-9910)	Lymphoid or lymphocytic leukemia (9820-9825)
	Myeloid sarcoma (9930)	Plasma cell leukemia (9830)
	Acute panmyelosis (9931)	Lymphosarcoma cell leukemia (9850)

*Code to the term with the higher histology code.

**Presumably this is the correct diagnosis. Code the case to this histology.

***If the diagnosis includes "can"t rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis; then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Non-Hodgkin's lymphoma*** (9591-9594,9670-9686, 9690-9698) (cont'd)	Acute myelofibrosis (9932) Hairy cell leukemia (9940)	Waldenstrom's macroglobulinemia (9761)

*Code to the term with the higher histology code.

**Presumably this is the correct diagnosis. Code the case to this histology.

***If the diagnosis includes "can"t rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis; then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Burkitt's lymphoma (9687)	Specific non-Hodgkin's lymphoma (9593-9594, 9670-9686,9690-9698, 9702-9704) Hodgkin's disease (9650-9667) Mycosis fungoides or Sezary's disease (9700,9701) Malignant histiocytosis or Letterer-Siwe's disease (9720,9722) Multiple myeloma or plasmacytoma (9730,9731) True histiocytic lymphoma (9723) Mast cell tumor (9740,9741) Acute leukemia, NOS unless specified as Burkitt's type (9801) Chronic leukemia, NOS (9803) Non-lymphocytic leukemias (9840-9842,9860-9910) Chronic lymphocytic leukemia (9823)	Malignant lymphoma, NOS (9590-9591) Burkitt's lymphoma (9687) Lymphosarcoma (9592) Acute leukemia, NOS specified as Burkitt's type (9801) Lymphoid or lymphocytic leukemia (9820,9821,9825)

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Burkitt's lymphoma (9687) (cont'd)	Plasma cell leukemia (9830)	
	Lymphosarcoma cell leukemia (9850)	
	Myeloid sarcoma (9930)	
	Acute panmyelosis (9931)	
	Acute myelofibrosis (9932)	
	Hairy cell leukemia (9940)	
	Waldenstrom's macroglobulinemia (9761)	

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Cutaneous and peripheral T-cell lymphomas (9700-9704)	Specific non-Hodgkin's lymphoma (9593-9594, 9670-9687,9690-9698)	Malignant lymphoma, NOS (9590-9591)
	Hodgkin's disease (9650-9667)	Lymphosarcoma (9592)
	Malignant histiocytosis or Letterer-Siwe's disease (9720,9722)	Cutaneous and peripheral T-cell lymphomas (9700-9704)
	True histiocytic lymphoma (9723)	Leukemia, NOS (9800)
	Multiple myeloma or plasmacytoma (9730,9731)	Acute leukemia, NOS (9801)
	Mast cell tumor (9740,9741)	Chronic leukemia, NOS (9803)
	Lymphoid or lymphocytic leukemia specified as B-cell (9820-9825)	Lymphoid or lymphocytic leukemia unless specifically identified as B-cell (9820-9825)
	Non-lymphocytic leukemia (9840-9842,9860-9910)	
	Plasma cell leukemia (9830)	
	Lymphosarcoma cell leukemia (9850)	
	Myeloid sarcoma (9930)	
	Acute panmyelosis (9931)	
	Acute myelofibrosis (9932)	

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Cutaneous and peripheral T-cell lymphomas (9700-9704) (cont'd)	Hairy cell leukemia (9940) Waldenstrom's macroglobulinemia (9761)	

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Malignant histiocytosis or Letterer-Siwe's disease (9720,9722,9723)	Specific non-Hodgkin's lymphoma (9592-9594, 9670-9686,9690-9698, 9702-9704) Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700,9701) Multiple myeloma or plasmacytoma (9730,9731) Mast cell tumor (9740,9741) Leukemia except hairy cell (9800-9932) Waldenstrom's macroglobulinemia (9761)	Non-Hodgkin's lymphoma, NOS (9590-9591) Malignant histiocytosis or Letterer-Siwe's disease (9720,9722,9723) Hairy cell leukemia (9940)

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Multiple myeloma or plasmacytoma (9730,9731)	Non-Hodgkin's lymphoma except immunoblastic or large-cell lymphoma (9592-9594, 9670,9672-9676,9683, 9685-9686,9690-9697, 9702-9704) Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700,9701) Malignant histiocytosis or Letterer-Siwe's disease (9720,9722) True histiocytic lymphoma (9723) Mast cell tumor (9740,9741) Leukemia except plasma cell (9800-9825, 9840-9940)	Malignant lymphoma, NOS (9590,9591) Immunoblastic or large cell lymphoma* (9761,9680-9682, 9684,9698) Multiple myeloma or plasmacytoma (9730,9731) Plasma cell leukemia (9830) Waldenstrom's macroglobulinemia (9761)

*Occasionally multiple myeloma develops an immunoblastic or large cell lymphoma phase. This is to be considered one primary, multiple myeloma. Consult your medical advisor or pathologist if questions remain.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Mast cell tumor (9740,9741)	Non-Hodgkin's lymphoma (9590-9594,9670-9687, 9690-9698,9702-9704) Hodgkin's disease (9650-9667) Mycosis fungoides or Sezary's disease (9700,9701) Malignant histiocytosis or Letterer-Siwe's disease (9720,9722) True histiocytic lymphoma (9723) Multiple myeloma or plasmacytoma (9730,9731) Non-lymphocytic leukemias (9840-9842,9860-9880, 9910) Chronic lymphocytic leukemia (9823) Plasma cell leukemia (9830) Lymphosarcoma cell leukemia (9850) Myeloid sarcoma (9930)	Mast cell tumor (9740,9741) Leukemia, NOS (9800) Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Monocytic leukemia (9890-9893) Mast cell leukemia (9900)

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Mast cell tumor (9740,9741) (cont'd)	Acute panmyelosis (9931)	
	Acute myelofibrosis (9932)	
	Hairy cell leukemia (9940)	
	Waldenstrom's macroglobulinemia (9761)	

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Waldenstrom's macroglobulinemia (9761)	Non-Hodgkin's lymphoma except immunoblastic or large cell lymphoma (9593-9594,9673-9676, 9683,9685-9686, 9690-9697,9702-9704)	Malignant lymphoma, NOS (9590,9591)
		Lymphosarcoma (9592)
		Immunoblastic or large cell lymphoma (9761,9680,9682, 9684,9698)
	Hodgkin's disease (9650-9667)	
		Malignant lymphoma, lymphocytic (9670,9672)
	Burkitt's lymphoma (9687)	
	Mycosis fungoides or Sezary's disease (9700,9701)	Multiple myeloma or plasmacytoma (9730,9731)
	Malignant histiocytosis or Letterer-Siwe's disease (9720,9722)	Plasma cell leukemia (9830)
		Waldenstrom's macroglobulinemia (9761)
	True histiocytic lymphoma (9723)	
	Mast cell tumor (9740,9741)	
	Leukemia except plasma cell (9800-9825,9840-9940)	

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Leukemia, NOS (9800)	Non-Hodgkin's lymphoma*** (9590-9594,9670-9687, 9690-9698,9702-9704) Hodgkin's disease (9650-9667) Mycosis fungoides (9700) Malignant histiocytosis or Letterer-Siwe's disease (9720,9722) True histiocytic lymphoma (9723) Multiple myeloma or plasmacytoma (9730,9731) Mast cell tumor (9740,9741) Waldenstrom's macroglobulinemia (9761)	Any leukemia* (9800-9940) Sezary's disease** (9701)

*Note: Leukemia, NOS (9800) should be upgraded to a more specific leukemia diagnosis (higher number) when it is found but not considered a second primary.

**Presumably this is the correct diagnosis. Code the case to this histology.

***If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis; then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Acute leukemia, NOS (9801)	Non-Hodgkin's lymphoma (9590-9594,9670-9687, 9690-9698,9702-9704) Hodgkin's disease (9650-9667) Mycosis fungoides (9700) Malignant histiocytosis Letterer-Siwe's disease (9720,9722) True histiocytic lymphoma (9723) Multiple myeloma or plasmacytoma (9730,9731) Mast cell tumor (9740,9741) Waldenstrom's macroglobulinemia (9761)	Any leukemia* (9800-9940) Sezary's disease** (9701)

*Note: Acute leukemia, NOS (9801) should be upgraded to a more specific type of acute leukemia (higher number) when it is found, but not considered a second primary.

**Presumably this is the correct diagnosis. Code the case to this histology.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Chronic leukemia, NOS (9803)	Hodgkin's disease (9650-9667)	Non-Hodgkin's lymphoma*** (9590-9594, 9670-9686, 9690-9698, 9702-9704)
	Malignant histiocytosis or Letterer-Siwe's disease (9720,9722)	Burkitt's lymphoma (9867)
	Mast cell tumor (9740,9741)	Mycosis fungoides or Sezary's disease (9700,9701)
		True histiocytic lymphoma (9723)
		Multiple myeloma or plasmacytoma (9730,9731)
		Any leukemia* (9800-9940)
		Waldenstrom's macroglobulinemia (9761)

*Note: Chronic leukemia, NOS (9803) should be upgraded to a more specific type of chronic leukemia (higher number) when it is found, but not considered a second primary.

***If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis; then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Lymphocytic leukemia (9820-9825)	Hodgkin's disease (9650-9667)	Non-Hodgkin's lymphoma* +++ (9592-9594, 9670-9687, 9690-9698, 9702-9704)
	Malignant histiocytosis or Letterer-Siwe's disease (9720,9722)	Malignant lymphoma, NOS+++ (9590-9591)
	Multiple myeloma or plasmacytoma (9730,9731)	Mycosis fungoides or Sezary's disease* (9700,9701)
	Mast cell tumor (9740,9741)	True histiocytic lymphoma (9723)
	Non-lymphocytic leukemias** (9840-9842,9860-9910)	Leukemia, NOS (9800)
	Myeloid sarcoma**(9930)	Acute leukemia, NOS (9801)
	Acute panmyelosis** (9931)	Chronic leukemia, NOS (9803)
	Acute myelofibrosis** (9932)	

*Note: Lymphocytic leukemia, NOS (9820) should be upgraded to a more specific diagnosis that is not considered a second primary.

**If any of these diagnoses are made within 4 months of lymphocytic leukemia, NOS (9820) or acute lymphocytic leukemia (9821), one of the two diagnoses probably is wrong. The case should be reviewed.

+++If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis; then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Lymphocytic leukemia (9820-9825) (cont'd)	Waldenstrom's macroglobulinemia (9761)	Lymphocytic leukemia* (9820-9825) Plasma cell leukemia* (9830) Lymphosarcoma cell leukemia* (9850) Hairy cell leukemia* (9940)

*Note: Lymphocytic leukemia, NOS (9820) should be upgraded to a more specific diagnosis that is not considered a second primary.

**If any of these diagnoses are made within 4 months of lymphocytic leukemia, NOS (9820) or acute lymphocytic leukemia (9821), one of the two diagnoses probably is wrong. The case should be reviewed.

+++If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis; then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Plasma cell leukemia (9830)	Non-Hodgkin's lymphoma (9590-9594,9670-9686, 9690-9698,9702-9704)	Multiple myeloma or plasmacytoma (9730,9731)
	Hodgkin's disease (9650-9667)	Leukemia, NOS (9800)
	Burkitt's lymphoma (9687)	Acute leukemia, NOS (9801)
	Mycosis fungoides or Sezary's disease (9700,9701)	Chronic leukemia, NOS (9803)
	Malignant histiocytosis or Letterer-Siwe's disease (9720,9722)	Lymphocytic leukemia (9820-9825)
	True histiocytic lymphoma (9723)	Plasma cell leukemia (9830)
	Mast cell tumor (9740,9741)	Lymphosarcoma cell leukemia (9850)
	Non-lymphocytic leukemia (9840-9842,9860-9910)	Hairy cell leukemia (9940)
	Myeloid sarcoma (9930)	Waldenstrom's macroglobulinemia (9761)
	Acute panmyelosis (9931)	
	Acute myelofibrosis (9932)	

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Lymphosarcoma cell leukemia (9850)	Hodgkin's disease (9650-9667) Mycosis fungoides or Sezary's disease (9700,9701) Malignant histiocytosis or Letterer-Siwe's disease (9720,9722) Mast cell tumor (9740,9741) Non-lymphocytic leukemia (9840-9842,9860-9940)	Non-Hodgkin's lymphoma (9590-9594, 9670-9687, 9690-9698, 9702-9704) True histiocytic lymphoma (9723) Lymphosarcoma cell leukemia (9850) Multiple myeloma or plasmacytoma (9730-9731) Leukemia, NOS (9800) Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Lymphocytic leukemias (9820-9825) Plasma cell leukemia (9830) Waldenstrom's macroglobulinemia (9761)

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Non-lymphocytic leukemias (9840-9842, 9860-9893,9910, 9930-9932)	Non-Hodgkin's lymphoma (9590-9594,9670-9686, 9690-9698,9702-9704)	Leukemia, NOS (9800)
	Hodgkin's disease (9650-9667)	Acute leukemia, NOS (9801)
	Burkitt's lymphoma (9687)	Chronic leukemia, NOS (9803)
	Mycosis fungoides or Sezary's disease (9700,9701)	Non-lymphocytic leukemias* (9840-9842, 9860-9893,9910, 9930-9932)
	Malignant histiocytosis or Letterer-Siwe's disease (9720,9722)	
	True histiocytic lymphoma (9723)	
	Multiple myeloma or plasmacytoma (9730,9731)	
	Mast cell tumor (9740,9741)	
	Lymphocytic leukemia (9820-9825)	
	Plasma cell leukemia (9830)	
	Lymphosarcoma cell leukemia (9850)	

*Code to the term with the higher histology code.

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Non-lymphocytic leukemias (9840-9842,9860-9893, 9910,9930-9932) (cont'd)	Mast cell leukemia (9900) Hairy cell leukemia (9940) Waldenstrom's macroglobulinemia (9761)	

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Mast cell leukemia (9900)	Non-Hodgkin's lymphoma (9590-9594,9670-9686, 9690-9698,9702-9704) Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700,9701) Malignant histiocytosis or Letterer-Siwe's disease (9720,9722) True histiocytic lymphoma (9723) Multiple myeloma or plasmacytoma (9730,9731) Any other leukemia (9820-9893,9910-9932) Waldenstrom's macroglobulinemia (9761)	Mast cell tumor (9740,9741) Leukemia, NOS (9800) Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Mast cell leukemia (9900)

DETERMINATION OF SUBSEQUENT PRIMARIES OF LYMPHATIC (NODAL AND EXTRANODAL) AND HEMATOPOIETIC DISEASES

First Primary	Presumably a Second Subsequent Primary	Presumably NOT a Subsequent Primary (only One Primary)
Hairy cell leukemia (9940)	Hodgkin's disease (9650-9667) Non-Hodgkin's lymphoma (9590-9594,9670-9686, 9690-9698,9702-9704) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700,9701) True histiocytic lymphoma (9723) Multiple myeloma or plasmacytoma (9730,9731) Mast cell tumor (9740,9741) Any non-lymphocytic leukemia (9800-9803,9830-9932) Lymphocytic leukemia (9821-9825) Waldenstrom's macroglobulinemia (9761)	Malignant histiocytosis or Letterer-Siwe's (9720,9722) Lymphocytic leukemia, NOS (9820) Hairy cell leukemia (9940)

REFERENCES

1. *SEER Program, Abstracting Instructions; Extent of Disease and Surgical Procedures for Major Sites.*

2. *SEER Program, SEER Extent of Disease Codes -- 1988, Codes and Coding Instructions,* (1988 schemes), Revised January 1989.

3. *SEER Program, Extent of Disease Codes and Coding Instructions,* (New 4-digit schemes), Revised March 1984.

4. *SEER Program, Extent of Disease Codes and Coding Instructions* Cancer Surveillance and Epidemiology and End Results Reporting, April 1977.

5. *International Classification of Diseases for Oncology,* World Health Organization, Geneva, 1976.

6. *International Classification of Diseases for Oncology, Field Trial Edition,* IARC, March, 1988.

7. *International Classification of Diseases, 1975 Revision* World Health Organization, Geneva, 1977.

8. *International Classification of Diseases, 9th Revision, Clinical Modification,* PHS Pub. No. 80-1260, United States Department of Health and Human Services, 1980.

9. *International Classification of Diseases Adapted for use in the United States, 8th Revision,* PHS Pub. No. 1693, United States Department of Health, Education, and Welfare, 1967.

10. *Self-instructional Manual for Tumor Registrars, Book 8, Antineoplastic Drugs,* United States Department of Health and Human Services, NIH Pub. No. 86-2441, Revised October, 1986.

The SEER Code Summary is intended to be a quick reference to the valid codes for each field. See complete description of each field for specific coding rules.

Section, Field Number	Code	Description	Character Position
I. Basic Record Identification			
I.01		SEER Participant	01-02
		A specific two-digit identification of each participant in the SEER Program	
	01	San Francisco-Oakland SMSA	
	02	Connecticut	
	20	Metropolitan Detroit	
	21	Hawaii	
	22	Iowa	
	23	New Mexico	
	25	Seattle-Puget Sound	
	26	Utah	
	27	Metropolitan Atlanta	
	28	Puerto Rico	
	33	Arizona Indians	
	34	Newark Area	
	37	Rural Georgia	
I.02		Case Number	03-10
		A unique number assigned to the patient by the SEER participant	
I.03		Record Number	11-12
		A unique sequential number assigned by the SEER participant to this record for the patient	

Section, Field Number	Code	Description	Character Position
II. Information source			
II.01		Type of Reporting Source	13
	1	Hospital Inpatient/Outpatient or Clinic	
	3	Laboratory (Hospital or Private)	
	4	Private Medical Practitioner (LMD)	
	5	Nursing/Convalescent Home/Hospice	
	6	Autopsy Only	
	7	Death Certificate Only	
II.02		Field Not Used	14-23

Section, Field Number	Code	Description	Character Position
III. Demographic Information			
III.01		Place of Residence at Diagnosis	
III.01.A		County	24-26
III.01.B		Census Tract	27-32
III.01.C		Coding System for Census Tract	33
	0	Not tracted	
	1	1970 Census Tract Definitions (1973-77)	
	2	1980 Census Tract Definitions (1978-87)	
	3	1990 Census Tract Definitions (1988+)	
III.02		Field Not Used	34
III.03		Place of Birth	35-37
		See Appendix B for numeric and alphabetic lists of places and codes.	
III.04		Date of Birth	
		Month	38-39
	01-12	Month	
	99	Unknown	
		Year	40-43
		All four digits of year	
	9999	Unknown	
III.05		Age at Diagnosis	44-46
	000	Less than one year old	
	001	One year old, but less than two years	
	002	Two years old	
	...		
	...	(Show actual age.)	
	...		
	101	One hundred one years old	
	...		
	...		
	...		
	120	One hundred twenty years old	
	...		
	...		
	...		
	999	Unknown Age	

Section, Field Number	Code	Description	Character Position
III. Demographic Information (cont'd)			
III.06		Race	47-48
	01	White	
	02	Black	
	03	American Indian, Aleutian, or Eskimo	
	04	Chinese	
	05	Japanese	
	06	Filipino	
	07	Hawaiian	
	08	Korean	
	09	Asian Indian, Pakistani	
	10	Vietnamese	
	11	Laotian	
	12	Hmong	
	13	Kampuchean	
	98	Other	
	99	Unknown	
III.07		Spanish Surname or Origin	49
	0	Non-Spanish	
	1	Mexican	
	2	Puerto Rican	
	3	Cuban	
	4	South or Central American (except Brazil)	
	5	Other Spanish (includes European)	
	6	Spanish, NOS	
	9	Unknown whether Spanish or not	
III.08		Sex	50
	1	Male	
	2	Female	
	3	Other (Hermaphrodite)	
	4	Transsexual	
	9	Not Stated	

Section, Field Number	Code	Description	Character Position
III. Demographic Information (cont'd)			
III.09		Marital Status at Diagnosis	51
	1	Single (never married)	
	2	Married (including common law)	
	3	Separated	
	4	Divorced	
	5	Widowed	
	9	Unknown	
III.10		Field Not Used	52-71

Section, Field Number	Code	Description	Character Position
IV. Description of This Neoplasm			
IV.01		Date of Diagnosis	
		Month	72-73
	01-12	Month	
	99	Unknown	
		Year	74-77
		All four digits of year	
IV.02		Sequence Number	78-79
	00	One primary only	
	01	First of two or more primaries	
	02	Second of two or more primaries	
	..		
	..	(Actual number of this primary)	
	..		
	10	Tenth of ten or more primaries	
	11	Eleventh of eleven or more primaries	
	..		
	..		
	..		
	99	Unspecified sequence number	
IV.03		Primary Site	80-82
		See the *International Classification of Diseases for Oncology, Field Trial Edition, March, 1988* (ICD-O, FT, 1988), Topography Section for the primary site.	
IV.04		Field Not Used	83
IV.05		Laterality at Diagnosis	84
	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, Both ovaries involved simultaneously, single histology Bilateral retinoblastomas Bilateral Wilms's tumors	
	9	Paired site, but no information concerning laterality; midline tumor	

Section, Field Number	Code	Description	Character Position
IV. Description of This Neoplasm (cont'd)			
IV.06		Morphology	85-90
		See the *International Classification of Diseases for Oncology, Field Trial Edition, March, 1988* (ICD-O, FT, 1988), Morphology Section for histologic type, behavior and grading.	
IV.06.A		Histologic Type	85-88
IV.06.B		Behavior code	89
IV.06.C		Grade, Differentiation, or Cell Indicator	90
IV.07		Field Not Used	91-92
IV.08		Diagnostic Confirmation	93
	1	Positive histology	
	2	Positive exfoliative cytology, no positive histology	
	4	Positive microscopic confirmation, method not specified	
	5	Positive laboratory test/marker study	
	6	Direct visualization without microscopic confirmation	
	7	Radiography and other imaging techniques without microscopic confirmation	
	8	Clinical diagnosis only (other than 5, 6, or 7)	
	9	Unknown whether or not microscopically confirmed	
IV.09		Field Not Used	94
IV.10		Diagnostic Procedures (1973-87)	95-96
		See site-specific detail in Appendix D.	
IV.11		Field Not Used	97
IV.12		Coding System for Extent of Disease	98
	0	SEER Nonspecific (1973-82)	
	1	SEER Two-Digit Site-Specific (1973-82)	
	2	SEER Expanded (13-digit) Site-Specific (1973-82)	
	3	SEER 4-digit Extent of Disease (1983-87)	
	4	SEER 10-digit Extent of Disease, 1988 (1988+)	

Section, Field Number	Code	Description	Character Position
IV. Description of This Neoplasm (cont'd)			
IV.13		Extent of Disease	
IV.13.A,B	SEER	Nonspecific/Two-Digit (1973-82)	99-100
IV.13.C	SEER	Expanded (13-digit) Site-Specific (1973-82)	101-113
IV.13.D	SEER	4-digit Extent of Disease (1983-87)	114-117
IV.13.E	SEER	10-digit Extent of Disease, 1988 (1988+)	118-127
IV.14		Field Not Used	128-137

Section, Field Number	Code	Description	Character Position
V. First Course of Cancer-Directed Therapy			
V.01		Date Therapy Initiated	
	000000	No cancer-directed therapy	
	999999	Unknown if any cancer-directed therapy was administered	
		Month	138-139
		01-12 Month	
		99 Unknown	
		Year	140-143
		All four digits of year	
		9999 Unknown	
V.02		Surgery	
V.02.A		Site-Specific Surgery	144-145
		See two-digit code for surgery detail in Appendix C of this manual.	
V.02.B		Reason for No Cancer-Directed Surgery	146
	0	Cancer-directed surgery performed	
	1	Cancer-directed surgery not recommended	
	2	Contraindicated due to other conditions; Autopsy Only case	
	6	Unknown reason for no cancer-directed surgery	
	7	Patient or patient's guardian refused	
	8	Recommended, unknown if done	
	9	Unknown if cancer-directed surgery performed; Death Certificate Only case	
V.03		Radiation	147
	0	None	
	1	Beam radiation	
	2	Radioactive implants	
	3	Radioisotopes	
	4	Combination of 1 with 2 or 3	
	5	Radiation, NOS -- method or source not specified	
	7	Patient or patient's guardian refused	
	8	Radiation recommended, unknown if administered	
	9	Unknown	

Section, Field Number	Code	Description	Character Position
V. First Course of Cancer-Directed Therapy			
V.04		Radiation to the Brain and/or Central Nervous System	148
		For Lung and Leukemia Cases Only	
	0	No radiation to the brain and/or central nervous system	
	1	Radiation	
	7	Patient or patient's guardian refused	
	8	Radiation recommended, unknown if administered	
	9	Unknown	
		For All Other Cases	
	9	Not applicable	
V.05		Radiation Sequence with Surgery	149
	0	No radiation and/or cancer-directed surgery	
	2	Radiation before surgery	
	3	Radiation after surgery	
	4	Radiation both before and after surgery	
	5	Intraoperative radiation	
	6	Intraoperative radiation with other radiation given before or after surgery	
	9	Sequence unknown, but both surgery and radiation were given	
V.06		Chemotherapy	150
	0	None	
	1	Chemotherapy, NOS	
	2	Chemotherapy, single agent	
	3	Chemotherapy, multiple agents (combination regimen)	
	7	Patient or patient's guardian refused	
	8	Chemotherapy recommended, unknown if administered	
	9	Unknown	

Section, Field Number	Code	Description	Character Position
V. First Course of Cancer-Directed Therapy (cont'd)			
V.07		Endocrine (Hormone/Steroid) Therapy	151
	0	None	
	1	Hormones (including NOS and antihormones)	
	2	Endocrine surgery and/or endocrine radiation (if cancer is of another site)	
	3	Combination of 1 and 2	
	7	Patient or patient's guardian refused	
	8	Hormonal therapy recommended, unknown if administered	
	9	Unknown	
V.08		Biological Response Modifiers	152
	0	None	
	1	Biological response modifier	
	7	Patient or patient's guardian refused	
	8	Biological response modifier recommended, unknown if administered	
	9	Unknown	
V.09		Other Cancer-Directed Therapy	153
	0	No other cancer-directed therapy except as coded elsewhere	
	1	Other cancer-directed therapy	
	2	Other experimental cancer-directed therapy (not included elsewhere)	
	3	Double-blind study, code not yet broken	
	6	Unproven therapy (including laetrile, krebiozen, etc.)	
	7	Patient or patient's guardian refused therapy which would have been coded 1-3 above	
	8	Other cancer-directed therapy recommended, unknown if administered	
	9	Unknown	
V.10		Field Not Used	154-171

Section, Field Number	Code	Description	Character Position
VI. Follow-up Information			
VI.01		Date of Last Follow-Up or of Death	
		Month	172-173
	01-12	Month	
	99	Unknown	
		Year	174-177
		All four digits of year	
VI.02		Vital Status	178
	1	Alive	
	4	Dead	
VI.03		ICD Code Revision Used for Cause of Death	179
	0	Patient Alive at Last Follow-Up	
	8	ICDA-8	
	9	ICD-9	
VI.04		Underlying Cause of Death	180-184
	0000	Patient alive at last contact	
	7777	State death certificate not available	
	7797	State death certificate available but underlying cause of death is not coded	
		All other cases: ICDA-8 or ICD-9 underlying cause of death code	
VI.05		Type of Follow-Up	185
	1	"Autopsy Only" and "Death Certificate Only" case	
	2	Active follow-up case	
	3	In situ cancer of the cervix uteri only	
	4	Case not originally in active follow-up, but in active follow-up now (San Francisco-Oakland only)	
VI.06		Field Not Used	186-205

Section, Field Number	Code	Description	Character Position
VII. Administrative Codes			
VII.01		Site/Type Interfield Review	206
	blank	Not reviewed	
	1	Reviewed: The coding of an unusual combination of primary site and histologic type has been reviewed.	
VII.02		Histology/Behavior Interfield Review	207
	blank	Not reviewed	
	1	Reviewed: The behavior code of the histology is designated as benign or uncertain in ICD-O, FT, 1988, but the pathologist states the primary to be "in situ" or "malignant."	
VII.03		Age/Site/Histology Interfield Review	208
	blank	Not reviewed	
	1	Reviewed: An unusual occurrence of a particular site/histology combination for a given age group has been reviewed.	
VII.04		Sequence Number/Diagnostic Confirmation Interfield Review	209
	blank	Not reviewed	
	1	Reviewed: Multiple primaries of special sites in which at least one diagnosis has not been microscopically confirmed have been reviewed.	
VII.05		Site/Histology/Laterality/Sequence Number Interrecord Review	210
	blank	Not reviewed	
	1	Reviewed: Multiple primaries of the same histology (3-digit) in the same primary site group have been reviewed.	
VII.06		Surgery/Diagnostic Confirmation Interfield Review	211
	blank	Not reviewed	
	1	Reviewed: Record(s) have been reviewed for a patient who had cancer-directed surgery; but the tissue removed was not sufficient for microscopic confirmation.	

Section, Field Number	Code	Description	Character Position
VII. Administrative Codes (cont'd)			
VII.07		Type of Reporting Source/Sequence Number Interfield Review	212
	blank	Not reviewed	
	1	Reviewed: A second or subsequent primary with a reporting source of Death Certificate Only has been reviewed and is indeed an independent primary.	
VII.08		Sequence Number/Ill-defined Site Interfield Review	213
	blank	Not reviewed	
	1	Reviewed: A second or subsequent primary reported with an ill-defined primary site (195.0-195.8, 199.9) has been reviewed and is indeed an independent primary.	
VII.09		Leukemia or Lymphoma/Diagnostic Confirmation Interfield Review	214
	blank	Not reviewed	
	1	Reviewed: Record(s) have been reviewed for a patient who was diagnosed with leukemia or lymphoma and the diagnosis was not microscopically confirmed.	
VII.10		Field Not Used	215-250

The records submitted by each SEER participant, the record(s) for the same person, and each separate record need to be identified. The Basic Record Identification section includes coded identifiers for the SEER participant, the person, and the record. The use of coded identifiers preserves the confidentiality of the data, yet allows the identification of individual records or a set of records for a person. Together the fields in the Basic Record Identification section provide a unique identifier for each record.

SEER PARTICIPANT

Section I, Field 01

A specific two-digit has been assigned to each participant in the SEER Program.

Code	Contractor	Area Covered* Year Reporting Started	Name
01	Northern California Cancer Center	5 counties 1973	San Francisco-Oakland SMSA
02	Connecticut State Department of Health Services	Entire state 1973	Connecticut
20	Michigan Cancer Foundation	3 counties 1973	Metropolitan Detroit
21	Research Corporation of Hawaii	Entire state 1973	Hawaii
22	University of Iowa	Entire state 1973	Iowa
23	University of New Mexico	Entire state 1973	New Mexico
25	Fred Hutchinson Cancer Research Center	13 counties 1974	Seattle-Puget Sound
26	University of Utah	Entire state 1973	Utah
27	Emory University	5 counties 1975	Metropolitan Atlanta
28	Commonwealth of Puerto Rico Department of Health	Entire commonwealth 1973	Puerto Rico
33	University of New Mexico	Arizona 1973	Arizona Indians
34	New Jersey State Department of Health	4 counties 1979	Newark Area
37	Emory University	10 counties 1978	Rural Georgia

**NOTE:* See list of counties for each area in Appendix A.

CASE NUMBER

Section I, Field 02

The case number is issued by the SEER participant to identify the person.

Each computer record pertaining to the same person must have an identical case number.

Code:

Case Number

If the case number is less than 8 digits, enter leading zeros to create an 8-digit number. *For example:* Case #7034 will be coded as '00007034'.

RECORD NUMBER

Section I, Field 03

A unique sequential number is assigned by the SEER participant to this record for the person.

Code:

Record Number	
01	One or first of more than one record for person
02	Second record for person
..	
..	
..	
nn	Last of nn records for person

All records submitted to SEER must have continuous record numbers beginning with 01 with the highest number assigned representing the total number of records submitted for that person.

TYPE OF REPORTING SOURCE

Section II, Field 01

Code:

Type of Reporting Source

1 Hospital Inpatient/Outpatient or Clinic
3 Laboratory (Hospital or Private)
4 Private Medical Practitioner (LMD)
5 Nursing/Convalescent Home/Hospice
6 Autopsy Only
7 Death Certificate Only

The hospital record for an inpatient with a cancer diagnosis (before death) takes precedence over other types of reports.

Code '6', Autopsy Only, means that the cancer was not diagnosed even as a clinical diagnosis while the patient was alive. If the patient was an inpatient with another admitting diagnosis and an autopsy disclosed the cancer for the first time, code '6' is proper. Autopsy findings take precedence over death certificate information, i.e., code '6' takes precedence over code '7'. However, a clinical diagnosis of cancer at any of the sources coded '1'-'5' has priority over confirmation at autopsy.

For Autopsy Only cases:

1. Date of Diagnosis (IV.01) must be the date of death.
2. Code Date Therapy Initiated (V.01) to '000000'.
3. For lung and leukemia diagnoses, code Radiation to the Brain and Central Nervous System (V.04) to '0'; for all other cases code '9'.
4. Code Reason for No Cancer-directed Surgery (V.02B) to '2'.
5. Code all remaining treatment fields (V.02A,V.03,V.05-V.09) to zero.

Code '7', Death Certificate Only (including Coroners' case), is used only when "follow-back" activities have produced no other medical reports -- the death certificate is truly the only source of information. Often a case is reported first via the death certificate, but later registry action yields missing or additional medical reports. Such additional reports take precedence.

For Death Certificate cases:

1. Date of Diagnosis (IV.01) must be the date of death.
2. Code Diagnostic Confirmation (IV.08) to '9'.
3. Code Date Therapy Initiated (V.01) to '999999'.
4. Code Site-specific Surgery (V.02A) to '09'.
5. Code Reason for No Cancer-directed Surgery (V.02B) to '9'.
6. Code Radiation Sequence with Surgery (V.05) to '0'.
7. Code all remaining treatment fields (V.03,V.04,V.06-V.09) to '9'.

FIELD NOT USED

Section II, Field 02

Blanks should be submitted in this field.

DEMOGRAPHIC INFORMATION

Section III, Field 01, Introduction

Demographic Information section includes the basic characteristics of the person with this cancer, such as, place of residence, place and date of birth, age, race, ethnicity, sex, and marital status. These characteristics are used to describe the cancer population, to compute incidence and survival rates, and to assess risk.

PLACE OF RESIDENCE AT DIAGNOSIS

Section III, Field 01, Introduction

The residence at diagnosis is the place of usual residence as stated by the patient. However, if the patient is a college student who resides at college, then the ususal residence is the college even though the patient states his parents' address as usual residence. If no usual residence is stated and the person is a resident of a college, military installation, nursing home, other institution or prison, consider that person a resident of the area in which the college, military installation, other institution or prison is located.

In like manner, long-term residents of Veterans Administration (VA) or military hositals are considered residents of the area in which the VA or military hospital in located.

COUNTY

Section III, Field 01.A

Valid county codes for county of residence at diagnosis can be found in Appendix A.

CENSUS TRACT

Section III, Field 01.B

For cases diagnosed 1988 forward, 1990 definitions must be used.

If area is not census tracted, code as '000000'.

If area is census tracted and census tract is not available, code as '999999'.

For purposes of coding census tract, assume that the decimal point is located between the fourth and fifth positions of this field. Census tract should then be zero filled so that all six positions have a code entered. Thus, census tract ' 409.6 ' would be coded '040960' and census tract ' 516.21' would be coded '051621'.

Code:

Coding System for Census Tract

0 Not tracted
1 1970 Census Tract Definitions (1973-77)
2 1980 Census Tract Definitions (1978-87)
3 1990 Census Tract Definitions (1988+)

A census tract is a small statistical subdivision of a county with (generally) between 2,500 and 8,000 residents. The boundaries of census tracts are established cooperatively by local committees and the Census Bureau. An attempt is made to keep the same boundaries from census to census so that historical comparability will be maintained. This goal is not always achieved; old tracts may be subdivided due to population growth, disappear entirely, or have their boundaries changed. Between 1970 and 1980 the number of tracts increased by over 20 percent. Thus it is important to know which definitions were used for the coding of the census tracts -- the 1970 definitions, the 1980 definitions, or starting with 1988 diagnoses, the 1990 definitions.

FIELD NOT USED

Section III, Field 02

Blanks should be submitted in this field.

Code:

Place of Birth

See Appendix B in this manual for numeric and alphabetic lists of places and codes.

When the SEER Geocodes were originally assigned during the 1970's, the United States owned or controlled islands in the Pacific. Since then many of these islands have either been given their independence or have had control turned over to another country. However, in order to maintain information over time, these islands are still to be coded to the original code. The names have been annotated to indicate the new political designation. The alphabetic list indicates the correct code.

DATE OF BIRTH

Section III, Field 04

Date of Birth is a six-digit field. The first two digits indicate the month; the last four digits identify the year.

Code:

Month:

01 January
02 February
03 March
04 April
05 May
06 June
07 July
08 August
09 September
10 October
11 November
12 December
99 Unknown

Year:

All four digits of year
9999 Unknown

If age at diagnosis and year of diagnosis are known, but year of birth is unknown, then year of birth should be calculated and so coded. Month would be coded as '99'.

AGE AT DIAGNOSIS

Section III, Field 05

The age of the patient at diagnosis is measured in completed years of life, i.e., age at LAST birthday.

Code:

Age at Diagnosis	
000	Less than one year old
001	One year old, but less than two years old
002	Two years old
...	
...	(actual age in years)
...	
101	One hundred one years old
...	
...	
...	
120	One hundred twenty years old
...	
...	
...	
999	Unknown age

If year of birth and year of diagnosis are known, but age is unknown, calculate age at diagnosis.

Code:

	Race
01	White
02	Black
03	American Indian, Aleutian, or Eskimo
04	Chinese
05	Japanese
06	Filipino
07	Hawaiian
08	Korean
09	Asian Indian, Pakistani
10	Vietnamese
11	Laotian
12	Hmong
13	Kampuchean
98	Other
99	Unknown

This field is used to code the race of the person and is to be used in conjunction with III.07, Spanish Surname or Origin.

Persons of Mexican, Puerto Rican, or Cuban origin are usually white.

If a person's race is recorded as a combination of white and any other race, code to the appropriate other race.

If a person's race is recorded as a combination of Hawaiian and any other race(s), code the person's race as Hawaiian.

Otherwise, code to the first stated non-white race ('02'-'98').

When the race is recorded as "Colored," "Negro," or "Afro-American," code race as '02'.

When the race is recorded as "Yellow," "Oriental," "Mongolian," or "Asian" and the place of birth is recorded as China, Japan or the Philippines, code the race based on birthplace information. *For example:* If the person's race is recorded as "Oriental" and the place of birth is recorded as "Japan," code race as '05'.

Code:

	Spanish Surname or Origin
0	Non-Spanish
1	Mexican
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other Spanish (includes European)
6	Spanish, NOS
9	Unknown whether Spanish or not

This field is used to denote those persons of Spanish surname or origin. Persons of Spanish surname/origin may be of any race.

Portuguese and Brazilians are not considered Spanish and should be coded '0'.

Code:

	Sex
1	Male
2	Female
3	Other (Hermaphrodite)
4	Transsexual
9	Not stated

Code:

Marital Status at Diagnosis

1 Single (never married)
2 Married (including common law)
3 Separated
4 Divorced
5 Widowed
9 Unknown

FIELD NOT USED

Section III, Field 10

Blanks should be submitted in this field.

DATE OF DIAGNOSIS

Section IV, Field 01

Date of Diagnosis is a six-digit field representing date of the first diagnosis of this cancer. The first two digits indicate the month; the last four digits identify the year.

Code:

Month:

01 January
02 February
03 March
04 April
05 May
06 June
07 July
08 August
09 September
10 October
11 November
12 December
99 Unknown

Year:

All four digits of year

The diagnosis date refers to the first diagnosis of this cancer by any *recognized medical practitioner*. This is often a clinical diagnosis and may not ever be confirmed histologically. Even if confirmed later, the diagnosis date refers to the date of the first clinical diagnosis and not to the date of confirmation. If upon medical and/or pathological review of a previous condition the patient is deemed to have had cancer at an earlier date, then the earlier date is the date of diagnosis, i.e., the date of diagnosis is back-dated.

The date of diagnosis for "Death Certificate Only" cases is the date of death.

The date of diagnosis for "Autopsy Only" cases is the date of death.

In the absence of an exact date of diagnosis, make the best approximation:

1. If the only information is "Spring of," "Middle of the year," "Fall," approximate these as April, July, and October, respectively. For "Winter of" it is important to determine whether the beginning or end of the year is meant before approximating the month.

2. If there is no basis for an approximation, code the month of diagnosis as '99'.

3. If necessary, approximate the year.

4. Date of first cancer-directed therapy may be used as the date of diagnosis if the cancer-directed therapy has been initiated and cancer is later confirmed, but prior to therapy the diagnosis was not definitive.

Code:

Sequence Number

00 One primary only
01 First of two or more primaries
02 Second of two or more primaries
..
.. (Actual number of this primary)
..
10 Tenth of ten or more primaries
11 Eleventh of eleven or more primaries
..
..
..
99 Unspecified sequence number

Sequence Number describes the chronology of diagnoses of all primary malignant and/or in situ cancers (as defined on pages 5-35) over the entire lifetime of the person. However when the ICD-O, FT, 1988 was developed, additional terms were included as malignancies, thus making these diagnoses reportable to SEER. If one of these had been diagnosed before it became reportable to SEER, it is not to be included in the assignment of sequence number.

For example:

1. For a person with
   a. Breast cancer diagnosed in 1968
   b. Colon cancer diagnosed in 1988

   Only one record would be submitted -- the colon cancer with a sequence of '02'.

2. For a person with
   a. Waldenstrom's macroglobulinemia diagnosed April 1978
   b. Breast cancer diagnosed September 1988

   Only one record would be submitted -- the breast cancer with a Sequence Number of '00'.

3. For a person with
   a. Waldenstrom's macroglobulinemia diagnosed April 1988
   b. Breast cancer diagnosed September 1988

   Two records would be submitted. The Waldenstrom's macroglobulinemia with a Sequence Number of '01' and the breast cancer with a Sequence Number of '02'.

If two or more independent primaries are diagnosed at the same time, the lowest sequence number will be assigned to the diagnosis with the worst prognosis. This means extent of disease and morphology must be considered. If no difference in prognosis is evident, the decision must be arbitrary.

Whenever diagnoses are added or deleted, sequence number(s) must be updated as necessary.

Example: If a person has a breast cancer diagnosed in 1975 with a sequence number of '00' and a colon cancer diagnosed in 1988, the sequence number of the colon cancer is coded '02'; the sequence number of the breast cancer is changed to '01'.

Code:

The Topography section of the *International Classification of Diseases for Oncology* (ICD-O, FT, 1988) is used for coding the Primary Site of all cancers reported to SEER.

Site codes may be found in the Topography, Numeric Section (pages 1-22) in ICD-O, FT, 1988 or in the Alphabetic Index (pages 57-153) of ICD-O, FT, 1988 which includes both Topography and Morphology terms. In the Alphabetic Index all site (Topography) codes are indicated by a 'T-' preceding the code number. The 'T-' should not be coded. For all site codes in ICD-O, FT, 1988, the SEER Program drops the first digit, '1', and the decimal point.

For example: A patient's record states the primary site is "cardia of stomach." This site is looked up in the Alphabetic Index, either under "cardia" or "stomach" and is found to be T-151.0. In coding for SEER, drop the T-, the first 1, and the decimal point; then enter the three-digit code, '510'.

In the Introduction of ICD-O, 1976 (page xvii), the topic of "Site-Specific Morphology Terms" is discussed. If the patient record has a morphologic term with a "T-" number listed in ICD-O, FT, 1988, use this "T-" number if no definite site is given or if only a metastatic site is given.

For example: If the diagnosis is hepatoma (8170/3) with no other statement about topography, code primary site as '550' (liver) since this morphology is always indicative of a primary malignancy in the liver.

Leukemia is coded to bone marrow ('691') since blood cells originate in the bone marrow.

Lymphomas originating in lymph nodes are coded to lymph nodes. If an extranodal site is designated as the primary, code to this site. For example, a malignant lymphoma of the stomach is coded to stomach. Be sure this is the primary site of origin and not just a site where the biopsy was taken. If no primary is stated, code to lymph nodes ('96_'). For lymphomas, a mass specified only as "retroperitoneal", "inguinal", "mediastinal", or "mesentery" (with no specific information as to tissue involved) is to be coded as nodal.

Kaposi's sarcoma is coded to the site in which it arises. If Kaposi's sarcoma arises in skin and another site simultaneously, code to skin ('73_'). If no primary site is stated, code to skin ('73_').

Definitions:

Primary versus Secondary (Metastatic) Sites:

The SEER Program identifies cases only according to the primary site and NOT a metastatic site. If the site of origin cannot be determined exactly, it may be possible to use the NOS category of an organ system or the Ill-Defined Sites ('950'-'958'). (See page ix of ICD-O, 1976.) If the primary site is unknown or if the only information available pertains to a secondary site, code '999'.

Where the record is not entirely explicit, it is suggested that a physician determine whether the cancer site is primary or secondary and which site would be the most definitive one.

Multiple Subsites:

The rules on pages 5-35 should be used in determining the number of primary cancers to be reported and the appropriate site code for each.

FIELD NOT USED

Section IV, Field 04

A blank should be submitted in this field.

LATERALITY AT DIAGNOSIS

Section IV, Field 05

Laterality at diagnosis describes this primary site only.

Code:

Laterality at Diagnosis

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
  Both ovaries involved simultaneously, single histology
  Bilateral retinoblastomas
  Bilateral Wilms's tumors
9 Paired site, but no information concerning laterality; midline tumor

Laterality codes of '1'-'9' must be used for the following sites except as noted. Only *major headings* are listed. However, laterality should be coded for all subheadings included in ICD-O, FT, 1988 unless specifically excluded. Such exclusions must be coded '0'.

142.0 Parotid gland
142.1 Submandibular gland
142.2 Sublingual gland
146.0 Tonsil, NOS
146.1 Tonsillar fossa
146.2 Tonsillar pillar
160.0 Nasal cavity (excluding nasal cartilage, nasal septum)
160.1 Middle ear
160.2 Maxillary sinus
160.4 Frontal sinus
162.2 Main bronchus (excluding carina)
162.3-162.9 Lung
163.0-163.9 Pleura
170.3 Rib, Clavicle (excluding sternum)
170.4 Long bones of upper limb, scapula
170.5 Short bones of upper limb
170.6 Pelvic Bones (excluding sacrum, coccyx, and symphysis pubis)
170.7 Long bones of lower limb
170.8 Short bones of lower limb
171.2 Connective, subcutaneous, and other soft tissues of upper limb and shoulder
171.3 Connective, subcutaneous, and other soft tissues of lower limb and hip
173.1 Skin of eyelid

173.2 Skin of external ear
173.3 Skin of other and unspecified parts of face (midline code '9')
173.5 Skin of trunk (midline code '9')
173.6 Skin of arm and shoulder
173.7 Skin of leg and hip
174.0-174.9 Female breast
175.9 Male breast
183.0 Ovary
183.2 Fallopian tube
186.0-186.9 Testis
187.5 Epididymis
187.6 Spermatic cord
189.0 Kidney, NOS
189.1 Renal pelvis
189.2 Ureter
190.0-190.9 Eye
194.0 Suprarenal gland
194.5 Carotid body

NOTE: Laterality may be submitted for sites other than those required above.

Code:

The *International Classification Diseases for Oncology, Field Trial Edition, March, 1988*, (ICD-O, FT, 1988) is used for morphology of all cancers. In the Alphabetic Index all morphology codes are indicated by a 'M-' preceding the code number. The 'M-' should not be coded. The '/' appearing between the histology and behavior codes is also not coded.

Morphology is a six-digit code consisting of three parts:

A Histologic type (4 digits)
B Behavior (1 digit)
C Grading or differentiation; or for lymphomas and leukemias, designation of T-cell, B-cell, and null cell (1 digit)

Determine the primary site using the criteria on pages 5-35 of the introduction to this manual, then apply the following rules for lesions with more than one histologic type reported:

Single lesion - same behavior

1. Histologies with the same behavior code are coded to the higher histologic type code in ICD-O, FT, 1988 unless a mixed histologic type code is available.

   Example: Transitional cell (8120/3) and Epidermoid carcinoma (8070/3) would be coded to the higher number (8120/3).

2. If a mixed histologic type code is available code to that code.

   Example: Mixed adenocarcinoma and squamous cell carcinoma coded to the mixed histologic type code, adenosquamous carcinoma (8560/3).

Single lesion - different behavior

1. Histologies with different behavior codes are coded to the histologic type associated with the malignant behavior.

   Example: Squamous cell carcinoma in situ (8070/2) and papillary squamous cell carcinoma (8052/3) would be coded the papillary squamous cell carcinoma (8052/3).

Multiple lesions - considered a single primary

1. If one lesion is stated to be a general 'NOS' term (carcinoma, adenocarcinoma, sarcoma) and the second lesion is a more specific term (large cell carcinoma, mucinous adenocarcinoma, spindle cell sarcoma) code to the more specific term.

2. For colon and rectum primaries:

   When both an adenocarcinoma (8140/3) and an adenocarcinoma (in situ) in a(n) (adenomatous) polyp (8210) or an adenocarcinoma (in situ) in (tubulo)villous adenoma (8261, 8263) arise in same segment of the colon or of the rectum, code as adenocarcinoma (8140/3).

   When both a carcinoma (8010/3) and a carcinoma (in situ) in a(n) (adenomatous) polyp (8210) arise in the same segment of the colon or of the rectum, code as carcinoma (8010/3).

3. For breast primaries with combinations of ductal and lobular carcinoma code to the appropriate mixed histology codes in ICD-O, FT, 1988.

In coding histology, all pathology reports for the case for a particular site should be used. Although the material from the most representative tissue is usually the best, sometimes all of the positive material may be removed at biopsy. *For example:*

Skin biopsy: Superficial malignant melanoma
Wide excision: No residual cancer

This should be coded Superficial malignant melanoma (8720/39).

Usually the *FINAL* pathologic diagnosis is coded. However, if the final diagnosis is carcinoma, NOS, melanoma, NOS, sarcoma, NOS, lymphoma, NOS, or malignant tumor, NOS, *AND* a more specific detailed histology is found in the microscopic description or in a comment, the more specific histologic diagnosis should be coded.

For example:

1. The final pathologic diagnosis is carcinoma of the prostate. The microscopic diagnosis states adenocarcinoma of the prostate, grade III. Code the more specific diagnosis, adenocarcinoma of the prostate.

2. The final pathologic diagnosis is histiocytic lymphoma. The comment states either diffuse large cell or large cell immunoblastic. Since the final diagnosis is specific, code it, histiocytic lymphoma (9680/3). Ignore the specific diagnosis of immunoblastic in the comment.

Do not use the ICD-O, FT, 1988, histology code '9990', "no microscopic confirmation, clinically malignant tumor (cancer)."

The usual behavior codes are listed in both the numeric and alphabetic indices of ICD-O, FT, 1988, following the histology code. If a pathologist calls a cancer in situ ('2') or malignant ('3') when it is not listed as such in ICD-O, FT, 1988, code the stated behavior. (See Table 1, pages xiv and xv, in ICD-O, 1976.)

SEER does not accept behavior codes 0, 1, 6, or 9. If the only specimen was from a metastatic site, code the histologic type of the metastatic site and code a '3' for the behavior code. The primary site is assumed to have the same histology as the metastatic site.

Synonymous terms for in situ (behavior code '2') are:

(adeno)carcinoma in an adenomatous polyp with NO invasion of stalk
Bowen's disease
CIN Grade III (T-180._)
Clark's level 1 for melanoma (limited to epithelium)
comedocarcinoma, noninfiltrating (T-174._)
confined to epithelium
Hutchinson's melanotic freckle, NOS (T-173._)
intracystic, noninfiltrating
intraductal
intraepidermal, NOS
intraepithelial, NOS
involvement up to but not including the basement membrane
lentigo maligna (T-173._)
lobular neoplasia (T-174._)
lobular, noninfiltrating (T-174._)
noninfiltrating
noninvasive
no stromal invasion
papillary, noninfiltrating or intraductal
precancerous melanosis (T-173._)
Queyrat's erythroplasia (T-187._)
Stage 0 (T-180._)

Note that "in situ" is a concept based upon histologic evidence. Therefore, clinical evidence alone cannot justify the usage of this term. In addition, any pathological diagnosis qualified as "micro-invasive" is not acceptable as "carcinoma in situ"; for such a diagnosis the behavior must be coded malignant, '3'.

The grading or differentiation; or for lymphomas and leukemias, designation of T-cell, B-cell, and null cell is described on page 24 of ICD-O, FT, 1988.

Grade, differentiation

If a diagnosis indicates two different degrees of grade or differentiation (e.g., "well and poorly differentiated"; or "grade II-III"; or "well differentiated grade II"), code to the higher grade code (Rule 10, page xxiii in ICD-O, 1976).

Code the degree of differentiation or grade stated in the FINAL pathologic diagnosis only.

For example:

Microscopic Description: Moderately differentiated squamous cell carcinoma with poorly differentiated areas
Final Pathologic Diagnosis: Moderately differentiated squamous cell carcinoma

Code to the final diagnosis: Moderately differentiated '2'.

Usually there will be no statement as to grade for in situ lesions. However, if a grade is stated, it should be coded.

When there is variation in the usual terms for degree of differentiation, code to the higher grade as specified below:

Term	Grade	Code
Low grade	I-II	2
Medium grade	II-III	3
High grade	III-IV	4
Partially well differentiated	I-II	2
Moderately undifferentiated	III	3
Relatively undifferentiated	III	3

Note: Where there is no tissue diagnosis, it may still be possible to establish the grade of a tumor through Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET). In particular, it is now possible to grade brain tumors by this method. Thus, if there is no tissue diagnosis, but there is a grade/differentiation available from an MRI or PET report, code grade based on those reports. If there is a tissue diagnosis, grade should be from the pathology report only.

According to the *Manual for Staging Cancer, Third Edition*, from the American Joint Committee on Cancer, grade of tumor is required for the following sites to be staged:

170.0-170.9	Bone
171.0-171.0	Connective, subcutaneous and other soft tissue
185.9	Prostate gland
191.0-191.9	Brain
192.1	Cerebral meninges

Grade coding for prostate cases using Gleason's score or pattern:

1. If Gleason's score (2-10) is given, code as follows:

Gleason's score	Grading	
2, 3, 4	I	Well Differentiated
5, 6, 7	II	Moderately Differentiated
8, 9, 10	III	Poorly Differentiated

2. If Gleason's pattern (1-5) is given, code as follows:

Gleason's pattern	Grading	
1,2	I	Well Differentiated
3	II	Moderately Differentiated
4,5	III	Poorly Differentiated

For lymphomas and leukemias, designation of T-cell, B-cell, and null cell

Code the final pathologic diagnosis of T-cell, B-cell or null cell whether or not marker studies are documented in the patient record. (See page 24 of ICD-O, FT, 1988.)

For lymphomas and leukemias, information on T-cell, B-cell or null cell has precedence over information on grading or differentiation.

FIELD NOT USED

Section IV, Field 07

Blanks should be submitted in this field.

DIAGNOSTIC CONFIRMATION

Section IV, Field 08

Diagnostic Confirmation indicates whether *AT ANY TIME* during the patient's medical history there was microscopic confirmation of the morphology of this cancer. It indicates not only the fact of microscopic confirmation but the nature of the best evidence available. Thus, this is a priority series with code '1' taking precedence. Each number takes priority over all higher numbers.

Code:

Diagnostic Confirmation

Microscopically Confirmed

1 Positive histology
2 Positive exfoliative cytology, no positive histology
4 Positive microscopic confirmation, method not specified

Not Microscopically Confirmed

5 Positive laboratory test/marker study
6 Direct visualization without microscopic confirmation
7 Radiography and other imaging techniques without microscopic confirmation
8 Clinical diagnosis only (other than 5, 6, or 7)

Confirmation unknown

9 Unknown whether or not microscopically confirmed

Specific:

Code 1: Microscopic diagnoses based upon tissue specimens from biopsy, frozen section, surgery, autopsy, or D and C. Positive hematologic findings relative to leukemia are also included. Bone marrow specimens (including aspiration biopsies) are coded as '1'.

Code 2: Cytologic diagnoses based on microscopic examination of cells as contrasted with tissues. Included are smears from sputum, bronchial brushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, and urinary sediment. Cervical and vaginal smears are common examples. Also included are diagnoses based upon paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.

Code 4: Diagnoses stated to be microscopically confirmed but with no detailed information on method.

Code 5: Clinical diagnosis of cancer based on certain laboratory tests or marker studies which are clinically diagnostic for cancer. Examples are the presence of fetal alpha protein for liver cancer and an abnormal electrophoretic spike for multiple myeloma and Waldenstrom's macroglobulinemia.

Code 6: Visualization includes diagnosis made at surgical exploration or by use of the various endoscopes (including colposcope, mediastinoperitoneoscope). However, use only if such visualization is not supplemented by positive histology or positive cytology reports. Also use when gross autopsy findings are the only positive information.

Code 7: Cases with diagnostic radiology for which there is neither a positive histology nor a positive cytology report. "Other imaging techniques" include procedures such as ultrasound, computerized axial tomography (CAT) scans, and magnetic resonance imaging (MRI).

Code 8: Cases diagnosed by clinical methods not mentioned above and for which there were no positive microscopic findings.

Code 9: Cases for which it is unknown whether or not it has been microscopically confirmed. Also included are all "Death Certificate Only" cases.

FIELD NOT USED

Section IV, Field 09

A blank should be submitted in this field.

DIAGNOSTIC PROCEDURES

Section IV, Field 10

Diagnostic Procedures were collected for certain cases diagnosed between 1973 and 1987. See Appendix D for description of codes and coding rules.

FIELD NOT USED

Section IV, Field 11

A blank will be submitted in this field.

Code:

Coding System for Extent of Disease

0 SEER Nonspecific (1973-82)
(See Appendix D for details.)
1 SEER Two-Digit Site-Specific (1973-82)
(See Appendix D for details.)
2 SEER Expanded (13-digit) Site-Specific (1973-82)
(See Appendix D for details.)
3 SEER 4-digit Extent of Disease (1983-87)
(See Appendix D for details.)
4 SEER 10-digit Extent of Disease, 1988 (1988+)

Use code '4' for all cases diagnosed as of January 1, 1988 and later.

Discussion:

SEER collects extent of disease data and not a summarization or stage per se. This allows collapsibility to different staging schemes and flexibility for consistency over time even if a staging scheme is changed. The major components of extent of disease are size of tumor, extension of the tumor, metastases, and lymph node involvement. Extent of disease codes are site-specific.

EXTENT OF DISEASE

Section IV, Field 13.A-E

The five extent of disease schemes are:

13A	Nonspecific - 1973-82 as appropriate
13B	Two-digit site-specific - 1973-82 as appropriate
13C	Expanded (13-digit) site-specific -- 1973-82 as appropriate
13D	SEER 4-digit Extent of Disease (all sites) -- 1983-87
13E	SEER 10-digit Extent of Disease -- 1988

Schemes 13A-13D were used for cases diagnosed between 1973-87. See Appendix D for information on coding these fields.

The Extent of Disease scheme used for cases diagnosed 1988 forward is

13E, SEER 10-digit Extent of Disease -- 1988. It is composed of:

- Size of Primary Tumor (3 digits)
- Extension (2 digits)
- Lymph Nodes (1 digit)
- Number of Positive Regional Lymph Nodes (2 digits)
- Number of Regional Lymph Nodes Examined (2 digits)

The codes and coding instructions for the SEER Extent of Disease -- 1988 are detailed in *SEER Extent of Disease Codes -- 1988, Codes and Coding Instructions.*

Extent of Disease should be limited to all information available within two months of diagnosis. However, metastasis known to have developed after the original diagnosis was made should be excluded.

The priority for using information is pathologic, operative and clinical findings.

Autopsy reports are used in coding extent of disease applying the same rules for inclusion and exclusion.

In coding size of the tumor, code the size given prior to radiation therapy for surgical patients pretreated by radiation therapy. Do NOT code size after radiation therapy is given.

For "Death Certificate Only" cases, field 13E is to be coded '9999999999'.

FIELD NOT USED

Section IV, Field 14

Blanks should be submitted in this field.

For the SEER Program the concept of definitive treatment is limited to procedures directed toward cancer tissues whether of the primary site or metastases. If a specific therapy normally affects, controls, changes, removes, or destroys cancer tissue, it is classified as definitive treatment even if it cannot be considered curative for a particular patient in view of the extent of disease, incompleteness of treatment, lack of apparent response, size of dose, operative mortality, or other criteria. The first course of cancer-directed therapy may begin any time at or after diagnosis.

Definition of "First Course" for all Malignancies Except Leukemias:

For all cases, the first course of therapy includes all cancer-directed treatment administered to the patient within four months after the initiation of therapy. All modalities of treatment are included regardless of sequence or the degree of completion of any component method.

Exceptions:

1. If it is documented that the planned first course of therapy continued beyond or began after four months of initiation, include all as first course.

2. Should there be a change of therapy due to apparent failure of the original planned and administered treatment or because of progression of the disease, the later therapy should be *EXCLUDED* from the first course and considered part of a SECOND course of therapy.

Definitions of "First Course" for Leukemias:

The basic time period is two months after the date of initiation of therapy. When precise information permits, the first course of definitive treatment is to be related to the first "remission" as follows -- even if in violation of the two-month rule:

A. If a remission, complete or partial, is achieved during the first course of chemotherapy for the leukemic process, include:

   1. All definitive therapy considered as "remission-inducing" for the first remission, and

   2. All definitive therapy considered as "remission-maintaining" for the first remission, i.e., irradiation to the central nervous system.

   3. Disregard all treatment administered to the patient after the lapse of the first remission.

B. If no remission is attained during the first course of chemotherapy, use the two-month rule.

No Cancer-Directed Therapy:

"Cancer tissue" means proliferating malignant cells or an area of active production of malignant cells such as adjacent tissues or distant sites. In some instances, malignant cells are found in tissues where they did not originate and where they do not reproduce, such as malignant cells found at thoracentesis or paracentesis. A procedure removing malignant cells but not treating a site of proliferation of such cells is NOT to be considered cancer therapy for the purpose of this program.

If patient receives ONLY symptomatic or supportive therapy, this is classified as "no cancer-directed therapy."

The term "palliative" is normally used in two senses: (a) as meaning non-curative and (b) as meaning the alleviation of symptoms. Thus, some treatments termed palliative fall within the definition of cancer-directed treatment and some are excluded as treating the patient but not the cancer.

Autopsy Only and Death Certificate Only Cases:

For Autopsy Only cases:

1. Code Date Therapy Initiated (V.01) to '000000'.
2. For lung and leukemia diagnoses, code Radiation to the Brain and Central Nervous System (V.04) to '0'; for all other cases code '9'.
3. Code Reason for No Cancer-directed Surgery (V.02B) to '2'.
4. Code all remaining treatment fields to zero.

For Death Certificate Only cases:

1. Code Date Therapy Initiated (V.01) to '999999'.
2. Code Site-specific Surgery (V.02A) to '09'.
3. Code Reason for No Cancer-directed Surgery (V.02B) to '9'.
4. Code Radiation Sequence with Surgery (V.05) to '0'.
5. Code all remaining treatment fields to '9'.

DATE THERAPY INITIATED

Section V, Field 01

Date Therapy Initiated is a six-digit field representing the date of initiation of the patient's first cancer-directed treatment for this cancer. The first two digits indicate the month; the last four digits identify the year.

Code:

Month:

01 January
02 February
03 March
04 April
05 May
06 June
07 July
08 August
09 September
10 October
11 November
12 December
99 Unknown

Year:

All four digits of year
9999 Unknown

Code '000000' if there was no cancer-directed therapy. This includes when incisional biopsy, exploratory surgery, or -otomy, -ostomy or bypass is the only procedure done and there is no cancer-directed therapy of any kind.

Code '000000' for "Autopsy Only" cases.

Code '999999' for "Death Certificate Only" cases.

Code the date (month/year) that cancer-directed therapy was begun. If cancer-directed treatment was first received on an outpatient basis, code the date (month/year) that cancer directed-therapy was started.

CODE THE DATE OF THE EXCISIONAL BIOPSY as the date of first therapy whether followed by further definitive therapy or not. Code the date of the excisional biopsy whether or not residual cancer is found at time of later resection. If the biopsy is not stated to be excisional, but no residual cancer is found at a later resection, assume the biopsy was excisional.

In the *ABSENCE OF AN EXACT DATE OF TREATMENT*, the date of admission for that hospitalization during which the first cancer-directed therapy was begun is an acceptable entry.

Date therapy initiated is not to be based on the date of an incisional biopsy, exploratory surgery, or -otomy, -ostomy or bypass.

When an unproven therapy (e.g., laetrile) is the first course of therapy, code the date the patient started taking that therapy.

GENERAL INSTRUCTIONS FOR CODING SITE-SPECIFIC SURGERY

The site-specific surgery scheme is composed of a two-digit code for all sites. Individual schemes exist in Appendix C for these sites:

ICD-O	Site
140.0-149.9	Oral Cavity
151.0-151.9	Stomach
153.0-153.9	Colon
154.0-154.1	Rectosigmoid, Rectum
157.0-157.9	Pancreas
161.0-161.9	Larynx
162.2-162.9	Bronchus and Lung
169.2	Spleen
170.0-170.9	Connective tissue
171.0-171.9	Bone
173.0-173.9	Skin
174.0-174.9, 175.9	Breast
180.0-180.9	Cervix Uteri
182.0-182.8	Corpus Uteri
183.0	Ovary
185.9	Prostate
186.0-186.9	Testis
188.0-188.9	Bladder
189.0-189.2	Kidney, Renal Pelvis, Ureter
193.9	Thyroid
196.0-196.9	Lymph nodes

All other sites are coded to the general scheme in Appendix C.

Once it is determined that cancer-directed surgery was performed, use the best information in the operative/pathology reports to determine the operative procedure. Do *NOT* depend on the name of the procedure since it may be incomplete.

If the operative report is unclear as to what was excised or if there is a discrepancy between the operative and pathology reports, use the pathology report, unless there is reason to doubt its accuracy.

If a surgical procedure removes the remaining portion of an organ which had been partially resected previously for any condition, code as total removal of the organ. If none of the primary organ remains, the code should indicate that this is the case.

GENERAL INSTRUCTIONS FOR CODING SITE-SPECIFIC SURGERY (cont'd)

For example:

1. Resection of a stomach which had been partially excised previously is coded as total removal of stomach.
2. Removal of a cervical stump is coded as total removal of uterus.
3. Lobectomy of a lung with a previous wedge resection is coded as total removal of lobe.

For purposes of this program a lymph node dissection is defined as any lymph node dissection done within the first course of cancer-directed therapy. Any lymph node dissection done as a separate procedure within the first course of cancer-directed therapy is to be coded.

In order to code the removal of lymph nodes as "surgery with lymph node dissection", a minimum of four lymph nodes must be removed.

If an excisional biopsy is followed by "re-excision" or "wide excision" within the first course of cancer-directed therapy, include that later information in coding site-specific surgery.

If multiple primaries are excised at the same time, code the appropriate surgery for each site. *For example:* 1) if a total abdominal hysterectomy was done for a patient with two primaries, one of the cervix and one of the endometrium, code each as having had a total abdominal hysterectomy. 2) If a total colectomy was done for a patient with multiple primaries in several segments of the colon, code total colectomy for each of the primary segments.

Surgery for extranodal lymphomas should be coded using the scheme for the extranodal site. *For example:* a lymphoma of the stomach is to be coded using the scheme for stomach.

Ignore surgical approach in coding procedures.

Ignore the use of laser if used only for the initial incision.

Surgical procedures performed solely for the purpose of establishing a diagnosis/stage or for the relief of symptoms are to be coded in the Site-specific Surgery field using codes '01'-'07' but are not considered cancer-directed surgery.

GENERAL INSTRUCTIONS FOR CODING SITE-SPECIFIC SURGERY (cont'd)

Examples of exploratory surgery are:

Celiotomy	Laparotomy
Cystotomy	Nephrotomy
Gastrotomy	Thoracotomy

Examples of bypass surgery are:

Colostomy	Nephrostomy
Esophagostomy	Tracheostomy
Gastrostomy	Urethrostomy

Priority of Codes

In the Site-specific Surgery code schemes, except where otherwise noted, the following priorities hold:

1. Codes '10'-'90' over codes '00'-'09'.
2. Codes '10'-'78' over codes '80'-'90'.
3. In the range '10'-'78' the higher code has priority.
4. Codes '01'-'07' over code '09'.
5. In the range '01'-'06' the higher code has priority.
6. Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
7. Surgery of primary not included in any category should be coded '90'.
8. Codes '01'-'06' have priority over code '07'.

Reconstructive Surgery

Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

REASON FOR NO CANCER-DIRECTED SURGERY

Section V, Field 02.B

Code:

Reason for No Cancer-directed Surgery

0 Cancer-directed surgery performed

1 Cancer-directed surgery not recommended
2 Contraindicated due to other conditions; Autopsy Only case
6 Unknown reason for no cancer-directed surgery
7 Patient or patient's guardian refused
8 Recommended, unknown if done
9 Unknown if cancer-directed surgery performed; Death Certificate Only case

If the Site-specific Surgery is coded '00'-'09', then code the reason using codes '1'-'9'.

If the site-specific surgery is coded '10'-'99', then code the Reason for No Cancer-directed Surgery as '0'.

Code:

Radiation

0 None
1 Beam radiation
2 Radioactive implants
3 Radioisotopes
4 Combination of 1 with 2 or 3
5 Radiation, NOS -- method or source not specified
7 Patient or patient's guardian refused radiation therapy
8 Radiation recommended, unknown if administered
9 Unknown

Code '1' for beam radiation directed to cancer tissue regardless of source of radiation. Included is treatment via:

X-ray
Cobalt
Linear accelerator
Neutron beam
Betatron
Spray radiation.

Code '2' for all interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive material such as cesium, radium, radon, or radioactive gold.

Code '3' for internal use of radioactive isotopes, such as I-131 or P-32, when given orally, intracavitarily, or by intravenous injection.

For lung and leukemia cases only, code radiation to brain and central nervous system in the Radiation to the Brain and Central Nervous System field.

For all cases except lung and leukemia, code radiation to brain and central nervous system in this field.

Code:

Radiation to the Brain and/or Central Nervous System

For Lung and Leukemia Cases Only

0 No radiation to the brain and/or central nervous system
1 Radiation
7 Patient or patient's guardian refused
8 Radiation recommended, unknown if administered
9 Unknown

For All Other Cases

9 Not applicable

For lung and leukemia diagnoses only:
1. code '0' for all "Autopsy Only" cases;
2. code '9' for all "Death Certificate Only" cases;
3. code '0'-'9' for all other cases.

Radiation should be coded whether or not there are known metastases to the brain or central nervous system.

For all sites except lung and leukemia diagnoses, code '9'.

Code:

Radiation Sequence with Surgery

0 No radiation and/or cancer-directed surgery
2 Radiation before surgery
3 Radiation after surgery
4 Radiation both before and after surgery
5 Intraoperative radiation
6 Intraoperative radiation with other radiation given before or after surgery
9 Sequence unknown, but both surgery and radiation were given

If first course of treatment consisted of both cancer-directed surgery and radiation, use codes '2'-'9'. Radiation coded in either of the fields, Radiation and Radiation to Brain and/or Central Nervous System, is to be considered.

All other cases, code '0'. This includes the following combinations of codes:

Surgery	Radiation	Radiation to Brain and/or Central Nervous System
00-09	0-9	0-9
10-99	0,7-9	0,7-9

Code:

Chemotherapy

0 None
1 Chemotherapy, NOS
2 Chemotherapy, single agent
3 Chemotherapy, multiple agents (combination regimen)
7 Patient or patient's guardian refused chemotherapy
8 Chemotherapy recommended, unknown if administered
9 Unknown

Code any chemical which is administered to treat cancer tissue and which is not considered to achieve its effect through change of the hormone balance. Only the agent, not the method of administration, is to be considered in coding.

Two or more single agents given at separate times during the first course of cancer-directed therapy are considered a combination regimen.

Codes '1'-'3' have priority over codes '0', '7'-'9'.

In the range '1'-'3', the higher code has priority.

Refer to *Book 8, Antineoplastic Drugs, Second Edition,* if in doubt as to which agents to include.

Code:

Endocrine (Hormone/Steroid) Therapy

0 None
1 Hormones (including NOS and antihormones)
2 Endocrine surgery and/or endocrine radiation (if cancer is of another site)
3 Combination of 1 and 2
7 Patient or patient's guardian refused hormonal therapy
8 Hormonal therapy recommended, unknown if administered
9 Unknown

Code any therapy which is administered to treat cancer tissue and which is considered to achieve its effect on cancer tissue through change of the hormone balance. Included are the administration of hormones, agents acting via hormonal mechanisms, antihormones, or steroids, surgery for hormonal effect on cancer tissue, and radiation for hormonal effect on cancer tissue.

Hormones, agents acting via hormonal mechanisms, and antihormones (cancer-directed only) are to be coded for all sites (primary and metastatic).

Refer to *Book 8, Antineoplastic Drugs, Second Edition,* if in doubt as to which drugs to include. *For example:* leuprolide and flutamide are both agents acting via hormonal mechanisms and should be coded as hormones.

Adrenocorticotrophic hormones (cancer-directed only) are coded for leukemias, lymphomas, multiple myelomas, breast, prostate. Exception: Prednisone given in combination with chemotherapy, e.g., MOPP or COPP, is coded as hormone therapy for any site unless it is specified that prednisone was given for other reasons.

Endocrine surgery or radiation is to be coded for breast and prostate only:

Breast:	Prostate:
oophorectomy	orchiectomy
adrenalectomy	adrenalectomy
hypophysectomy	hypophysectomy

Both glands or the remaining gland of paired glands must be removed or irradiated for the procedure to be considered endocrine surgery or radiation.

Code:

Biological Response Modifier

0 None
1 Biological response modifier
7 Patient or patient's guardian refused biological response modifier
8 Biological response modifier recommended, unknown if administered
9 Unknown

Biological response modifier is a generic term which covers all chemical or biological agents that alter the immune system or change the host response (defense mechanism) to the cancer. Examples of biological response modifiers are:

Allogeneic cells	Interferon	Thymosin
BCG	Levamisole	Vaccine therapy
Bone marrow transplant	MVE2	Virus Therapy
C-Parvum	Pyran copolymer	

Refer to *Book 8, Antineoplastic Drugs, Second Edition* if in doubt as to which drugs to include.

Code:

Other Cancer-Directed Therapy

0 No other cancer-directed therapy except as coded elsewhere
1 Other cancer-directed therapy
2 Other experimental cancer-directed therapy (not included elsewhere)
3 Double-blind clinical trial, code not yet broken
6 Unproven therapy (including laetrile, krebiozen, etc.)
7 Patient or patient's guardian refused therapy which would have been coded 1-3 above
8 Other cancer-directed therapy recommended, unknown if administered
9 Unknown

Other Cancer-Directed Therapy includes any and all cancer-directed therapy not appropriately assigned to the other specific treatment codes. This includes an experimental or newly developed method of treatment differing greatly from proven types of cancer therapy. Examples are hyperbaric oxygen (as adjunct to definitive treatment), hyperthermia, and arterial block for renal cell carcinoma.

Double-blind clinical trial information: After the code is broken, review and recode therapy, as necessary, according to the treatment actually administered.

FIELD NOT USED

Section V, Field 10

Blanks should be submitted in this field.

Follow-up of cancer patients provides the following data needed for survival analysis: the vital status of the patient, the date the vital status was determined, and the underlying cause of death, if the person is dead. The fields in the Follow-up Information section provide this information. SEER requires that this information be updated annually for living patients.

DATE OF LAST FOLLOW-UP OR OF DEATH

Section VI, Field 01

The date of last follow-up or death consists of six digits, the first two digits indicate the appropriate month and the last four digits identify the year. This field pertains to the date of the actual information and not the date the follow-up inquiry was forwarded or the date the follow-up report was received.

Code:

Month:

01 January
02 February
03 March
04 April
05 May
06 June
07 July
08 August
09 September
10 October
11 November
12 December
99 Unknown

Year:

All four digits of year

If there is no new follow-up information, the entry is the same as that of the previous follow-up for this patient. If no follow-up information is ever received, code the latest date the patient was seen.

This field pertains to the patient and not to the cancer. Thus, for a patient with more than one malignancy, all records for that patient should have the same date in this field.

VITAL STATUS

Section VI, Field 02

Vital status specifies whether the patient was alive or dead at the last follow-up.

Code:

	Vital Status
1	Alive
4	Dead

This field pertains to the patient and not to the cancer. Thus, for a patient with more than one malignancy, all records for that patient should have the same code in this field.

ICD CODE REVISION USED FOR CAUSE OF DEATH

Section VI, Field 03

Code:

ICD Code Revision Used for Cause of Death

0 Patient alive at last follow-up
8 ICDA-8
9 ICD-9

The underlying cause of death as coded by a State Health Department is to be used. Even when the code is believed to be in error, the entry as coded by a State Health Department is to be used.

Code:

Underlying Cause of Death

0000 Patient alive at last contact
7777 State death certificate or listing not available
7797 State death certificate or listing available, but underlying cause of death not coded.

All other cases: ICDA-8 or ICD-9 Underlying Cause of Death Code

Underlying cause of death codes usually have four digits. Some codes may have an optional fifth digit. Ignore the fifth digit.

Ignore any decimal points when transferring codes.

If a fourth digit for the underlying cause of death is "X", "blank", or "-", use '9' for the fourth digit.

All underlying causes of death should be left-justified.

Beginning January 1, 1979, all deaths are coded using the *International Classification of Diseases, 1975 Revision* (ICD-9). In this volume, the "E" code is a supplemental code but will be used as the primary if, and only if, the morbid condition is classifiable to Chapter XVII (Injury and Poisoning). Do not include the "E" in the code submitted to SEER.

It is not necessary to have a copy of the death certificate as long as the official code for the underlying cause of death is available.

If the coded underlying cause is not available, do not attempt to code it; use code '7797'.

For example:

Underlying Cause of Death	ICD-8 or ICD-9	Code
Cancer of the thyroid	193	1939
Acute appendicitis with peritonitis	540.0	5400
Adenocarcinoma of stomach	151.9	1519
Fall on ice	E885	8859

TYPE OF FOLLOW-UP

Section VI, Field 05

Code:

Type of Follow-up	
1	"Autopsy Only" or "Death Certificate Only" case
2	Active follow-up case
3	In situ cancer of the cervix uteri only
4	Case not originally in active follow-up, but in active follow-up now (San Francisco-Oakland only)

All cases other than in situs of the cervix uteri must be followed annually.

If information on persons with an in situ cancer of the cervix uteri is received, the follow-up information should be updated.

FIELD NOT USED

Section VI, Field 06

Blanks should be submitted in this field.

Each calendar year the SEER participants submit to NCI records for all persons/cancers diagnosed since the participant started reporting. Many of these records have been updated with information received by the participant since the prior data submission. At NCI the information is edited to insure correctness and comparability of reporting. Some of these edits reflect conditions that require additional review. To eliminate the need to review the same cases each submission, the Administrative Codes section contains a set of indicators used to specify that the information on a record has already been reviewed.

Code:

Site/Type Interfield Review

blank Not reviewed
1 Reviewed: The coding of an unusual combination of primary site and histologic type has been reviewed.

Code:

Histology/Behavior Interfield Review

blank Not reviewed
1 Reviewed: The behavior code of the histology is designated as benign or uncertain in ICD-O, FT, 1988, and the pathologist states the primary to be "in situ" or "malignant."

Code:

Age/Site/Histology Interfield Review

blank Not reviewed
1 Reviewed: An unusual occurrence of a particular site/histology combination for a given age group has been reviewed.

Code:

Sequence Number/Diagnostic Confirmation Interfield Review

blank Not reviewed
1 Reviewed: Multiple primaries of special sites in which at least one diagnosis has not been microscopically confirmed have been reviewed.

Code:

Site/Histology/Laterality/Sequence Interrecord Review

blank Not reviewed
1 Reviewed: Multiple primaries of the same histology (3-digit) in the same primary site group have been reviewed.

Code:

Surgery/Diagnostic Confirmation Interfield Review

blank Not reviewed
1 Reviewed: Record(s) for a patient who had cancer-directed surgery, but the tissue removed was not sufficient for microscopic confirmation.

TYPE OF REPORTING SOURCE/SEQUENCE NUMBER INTERFIELD REVIEW

Section VII, Field 07

Code:

Type of Reporting Source/Sequence Number Interfield Review

blank	Not reviewed
1	Reviewed: A second or subsequent primary with a reporting source of Death Certificate Only has been reviewed and is indeed an independent primary.

Code:

Sequence Number/Ill-defined Site Interfield Review

blank	Not reviewed
1	Reviewed: A second or subsequent primary reported with an ill-defined primary site (195.0-195.8, 199.9) has been reviewed and is indeed an independent primary.

Code:

Leukemia or Lymphoma/Diagnostic Confirmation Interfield Review

blank	Not reviewed
1	Reviewed: Record(s) have been reviewed for a patient who was diagnosed with leukemia or lymphoma and the diagnosis was not microscopically confirmed.

FIELD NOT USED

Section VII, Field 10

Blanks should be submitted in this field.

APPENDIX A
COUNTY CODES

The following are the valid county codes for coding county of residence at diagnosis:

SEER Area	County Code	County
San Francisco-Oakland SMSA	001	Alameda
	013	Contra Costa
	041	Marin
	075	San Francisco
	081	San Mateo
Connecticut	001	Fairfield
	003	Hartford
	005	Litchfield
	007	Middlesex
	009	New Haven
	011	New London
	013	Tolland
	015	Windham
Metropolitan Detroit	099	Macomb
	125	Oakland
	163	Wayne
Hawaii	001	Hawaii
	003	Honolulu
	005*	Kalawao
	007	Kauai
	009*	Maui
Iowa	001	Adair
	003	Adams
	005	Allamakee
	007	Appanoose
	009	Audubon
	011	Benton
	013	Black Hawk
	015	Boone
	017	Bremer
	019	Buchanan
	021	Buena Vista
	023	Butler
	025	Calhoun
	027	Carroll
	029	Cass
	031	Cedar
	033	Cerro Gordo

**Kalawao was split from Maui during the 1970's.*

SEER Area	County Code	County
Iowa (cont'd)	035	Cherokee
	037	Chickasaw
	039	Clarke
	041	Clay
	043	Clayton
	045	Clinton
	047	Crawford
	049	Dallas
	051	Davis
	053	Decatur
	055	Delaware
	057	Des Moines
	059	Dickinson
	061	Dubuque
	063	Emmet
	065	Fayette
	067	Floyd
	069	Franklin
	071	Fremont
	073	Greene
	075	Grundy
	077	Guthrie
	079	Hamilton
	081	Hancock
	083	Hardin
	085	Harrison
	087	Henry
	089	Howard
	091	Humbolt
	093	Ida
	095	Iowa
	097	Jackson
	099	Jasper
	101	Jefferson
	103	Johnson
	105	Jones
	107	Keokuk
	109	Kossuth
	111	Lee
	113	Linn
	115	Louisa
	117	Lucas
	119	Lyon
	121	Madison
	123	Mahaska
	125	Marion
	127	Marshall
	129	Mills

APPENDIX A
COUNTY CODES

SEER Area	County Code	County
Iowa (cont'd)	131	Mitchell
	133	Monona
	135	Monroe
	137	Montgomery
	139	Muscatine
	141	O'Brien
	143	Osceola
	145	Page
	147	Palo Alto
	149	Plymouth
	151	Pocahontas
	153	Polk
	155	Pottawattamie
	157	Poweshiek
	159	Ringgold
	161	Sac
	163	Scott
	165	Shelby
	167	Sioux
	169	Story
	171	Tama
	173	Taylor
	175	Union
	177	Van Buren
	179	Wapello
	181	Warren
	183	Washington
	185	Wayne
	187	Webster
	189	Winnebago
	191	Winneshiek
	193	Woodbury
	195	Worth
	197	Wright
New Mexico	001	Bernalillo
	003	Catron
	005	Chaves
	006*	Cibola
	007	Colfax
	009	Curry
	011	De Baca
	013	Dona Ana
	015	Eddy
	017	Grant
	019	Guadalupe
	021	Harding
	023	Hidalgo

**Cibola was split from Valencia in 1981.*

APPENDIX A
COUNTY CODES

SEER Area	County Code	County
New Mexico (cont'd)	025	Lea
	027	Lincoln
	028	Los Alamos
	029	Luna
	031	McKinley
	033	Mora
	035	Otero
	037	Quay
	039	Rio Arriba
	041	Roosevelt
	043	Sandoval
	045	San Juan
	047	San Miguel
	049	Santa Fe
	051	Sierra
	053	Socorro
	055	Taos
	057	Torrance
	059	Union
	061*	Valencia
Seattle-Puget Sound	009	Clallam
	027	Grays Harbor
	029	Island
	031	Jefferson
	033	King
	035	Kitsap
	045	Mason
	053	Pierce
	055	San Juan
	057	Skagit
	061	Snohomish
	067	Thurston
	073	Whatcom
Utah	001	Beaver
	003	Box Elder
	005	Cache
	007	Carbon
	009	Daggett
	011	Davis
	013	Duchesne
	015	Emery
	017	Garfield
	019	Grand
	021	Iron

**Cibola was split from Valencia in 1981.*

APPENDIX A
COUNTY CODES

SEER Area	County Code	County
Utah (cont'd)	023	Juab
	025	Kane
	027	Millard
	029	Morgan
	031	Piute
	033	Rich
	035	Salt Lake
	037	San Juan
	039	Sanpete
	041	Sevier
	043	Summit
	045	Tooele
	047	Uintah
	049	Utah
	051	Wasatch
	053	Washington
	055	Wayne
	057	Weber
Metropolitan Atlanta	063	Clayton
	067	Cobb
	089	De Kalb
	121	Fulton
	135	Gwinnett
Puerto Rico	001	Entire Commonwealth
Arizona	001	Apache
	003	Cochise
	005	Coconino
	007	Gila
	009	Graham
	011	Greenlee
	013	Maricopa
	015	Mohave
	017	Navajo
	019	Pina
	021	Pinal
	023	Santa Cruz
	025	Yavapai
	027	Yuma

APPENDIX A
COUNTY CODES

SEER Area	County Code	County
Newark Area	013	Essex
	017	Hudson
	031	Passaic
	039	Union
Rural Georgia	125	Glascock
	133	Greene
	141	Hancock
	159	Jasper
	163	Jefferson
	211	Morgan
	237	Putnam
	265	Taliaferro
	301	Warren
	303	Washington

SEER GEOCODES FOR CODING PLACE OF BIRTH

Use the most specific code possible.

APPENDIX B
SEER GEOCODES FOR CODING PLACE OF BIRTH

CONTINENTAL UNITED STATES AND HAWAII

000 United States

001 New England and New Jersey

002 Maine
003 New Hampshire
004 Vermont
005 Massachusetts
006 Rhode Island
007 Connecticut
008 New Jersey

010 North Mid-Atlantic States

011 New York
014 Pennsylvania
017 Delaware

020 South Mid-Atlantic States

021 Maryland
022 District of Columbia
023 Virginia
024 West Virginia
025 North Carolina
026 South Carolina

030 Southeastern States

031 Tennessee
033 Georgia
035 Florida
037 Alabama
039 Mississippi

040 North Central States

041 Michigan
043 Ohio
045 Indiana
047 Kentucky

CONTINENTAL UNITED STATES AND HAWAII (cont'd)

050 Northern Midwest States

- 051 Wisconsin
- 052 Minnesota
- 053 Iowa
- 054 North Dakota
- 055 South Dakota
- 056 Montana

060 Central Midwest States

- 061 Illinois
- 063 Missouri
- 065 Kansas
- 067 Nebraska

070 Southern Midwest States

- 071 Arkansas
- 073 Louisiana
- 075 Oklahoma
- 077 Texas

080 Mountain States

- 081 Idaho
- 082 Wyoming
- 083 Colorado
- 084 Utah
- 085 Nevada
- 086 New Mexico
- 087 Arizona

090 Pacific Coast States

- 091 Alaska
- 093 Washington
- 095 Oregon
- 097 California
- 099 Hawaii

UNITED STATES POSSESSIONS

When SEER geocodes were originally assigned during the 1970's, the United States owned or controlled islands in the Pacific. Since then many of these islands have either been given their independence or had control turned over to another country. In order to maintain information over time, these islands are still to be coded to the original codes. The names have been annotated to indicate the new political designation.

100 Atlantic/Caribbean Area

- 101 Puerto Rico
- 102 U.S. Virgin Islands
- 109 Other Atlantic/Caribbean Area

110 Canal Zone

120 Pacific Area

- 121 American Samoa
- 122 Canton and Enderbury Islands (Kiribati)
- 123 Caroline Islands (Trust Territory of Pacific Islands)
- 124 Cook Islands (New Zealand)
- 125 Gilbert (Kiribati) and Ellice (Tuvalu) Islands
- 126 Guam
- 127 Johnston Atoll
- 128 Line Islands, Southern (Kiribati)
- 129 Mariana Islands (Trust Territory of Pacific Islands)
- 131 Marshall Islands (Trust Territory Pacific Islands)
- 132 Midway Islands
- 133 Nampo-Shoto, Southern
- 134 Ryukyu Islands (Japan)
- 135 Swan Islands
- 136 Tokelau Islands (New Zealand)
- 137 Wake Island

APPENDIX B
SEER GEOCODES FOR CODING PLACE OF BIRTH

NORTH AND SOUTH AMERICA, EXCLUSIVE OF THE UNITED STATES AND ITS POSSESSIONS

210 Greenland

220 Canada

- 221 Maritime provinces (Newfoundland, Nova Scotia, Prince Edward Island, New Brunswick)
- 222 Quebec
- 223 Ontario
- 224 Prairie provinces (Manitoba, Saskatchewan, Alberta)
- 225 Yukon Territory, Northwest Territories
- 226 British Columbia

230 Mexico

240 North American Islands

- 241 Cuba
- 242 Haiti
- 243 Dominican Republic
- 244 Jamaica
- 245 Other Caribbean Islands
- 246 Bermuda
- 247 Bahamas

250 Central America

- 251 Guatemala
- 252 Belize (British Honduras)
- 253 Honduras
- 254 El Salvador
- 255 Nicaragua
- 256 Costa Rica
- 257 Panama

300 South America

- 311 Colombia
- 321 Venezuela
- 331 Guyana (British Guiana)
- 332 Suriname (Dutch Guiana)
- 333 French Guiana
- 341 Brazil
- 345 Ecuador
- 351 Peru
- 355 Bolivia
- 361 Chile
- 365 Argentina
- 371 Paraguay
- 375 Uruguay

APPENDIX B
SEER GEOCODES FOR CODING PLACE OF BIRTH

EUROPE

400 United Kingdom

- 401 England, Channel Islands
- 402 Wales
- 403 Scotland
- 404 Northern Ireland (Ulster)

410 Ireland (Eire)

420 Scandinavia

- 421 Iceland
- 423 Norway
- 425 Denmark
- 427 Sweden
- 429 Finland

430 Germanic countries

- 431 Germany (East and West)
- 432 Netherlands
- 433 Belgium
- 434 Luxembourg
- 435 Switzerland
- 436 Austria
- 437 Liechtenstein

440 Romance-language countries

- 441 France, (Corsica), Monaco
- 443 Spain, (Canary Islands, Balearic Islands), Andorra
- 445 Portugal (Madeira Islands, Azores, Cape Verde Islands)
- 447 Italy, (Sardinia, Sicily), San Marino
- 449 Romania

450 Slavic countries

- 451 Poland
- 452 Czechoslovakia (Bohemia, Moravia, Slovakia)
- 453 Yugoslavia (Serbia, Croatia, Dalmatia, Montenegro, Macedonia, Slavonia, Slovenia)
- 454 Bulgaria
- 455 Russian S.F.S.R. (Russia)
- 456 Ukranian S.S.R. (The Ukraine) and Moldavian S.S.R. (Bessarabia)
- 457 Byelorussian S.S.R. (White Russia)
- 458 Estonian S.S.R. (Estonia)
- 459 Latvian S.S.R. (Latvia)
- 461 Lithuanian S.S.R. (Lithuania)

EUROPE (cont'd)

470 Other mainland Europe

- 471 Greece
- 475 Hungary
- 481 Albania
- 485 Gibraltar

490 Other Mediterranean islands

- 491 Malta
- 495 Cyprus

APPENDIX B
SEER GEOCODES FOR CODING PLACE OF BIRTH

AFRICA

500 Africa

510 North Africa

511 Morocco
513 Algeria
515 Tunisia
517 Libya (Tripoli, Tripolitania, Cyrenaica)
519 Egypt (United Arab Republic)

520 Sudanese countries (Western (Spanish) Sahara, Mauritania, Mall, Niger, Chad, Sudan, Upper Volta)

530 West Africa

531 Nigeria
539 Senegal, Gambia, Portuguese Guinea, Guinea, Sierra Leone, Liberia, Ivory Coast, Ghana, Togo, Benin (Dahomey), Cameroon (Kameroon), Equatorial Guinea (Fernando Poo, Bioko, Rio Muni), Gabon, Congo-Brazzaville (French Congo), Central African Republic

540 South Africa

541 Congo-Leopoldville (Zaire, Belgian Congo)
543 Angola, Sao Tome, Principe, Cabinda
545 Republic of South Africa (Cape Colony, Orange Free State, Natal, Transvaal), Namibia (South West Africa), Lesotho (Basutoland), Botswana (Bechuanaland), Ciskel, Swaziland, Transkei, Bophuthatswana, Venda
547 Zimbabwe (Rhodesia, Southern Rhodesia)
549 Zambia (Northern Rhodesia)
551 Malawi (Nyasaland)
553 Mozambique
555 Madagascar (Malagasy Republic)

570 East Africa

571 Tanzania (Tanganyika, Tanzanyika, Zanzibar)
573 Uganda
575 Kenya
577 Rwanda (Ruanda)
579 Burundi (Urundi)
581 Somalia (Somali Republic, Somaliland)
583 Afars and Issas (Djibouti, French Somaliland)
585 Ethiopia (Abyssinia, Eritrea)

APPENDIX B
SEER GEOCODES FOR CODING PLACE OF BIRTH

ASIA

610 Near East

611 Turkey

620 Asian Arab countries

621 Syria
623 Lebanon
625 Jordan (Transjordan) and former Arab Palestine
627 Iraq
629 Arabian Peninsula (Saudi Arabia, Yemen, People's Democratic Republic of Yemen (Southern Yemen), United Arab Emirates (Trucial States), Aden, Bahrain, Kuwait, Oman and Muscat, Qatar)

631 Israel and former Jewish Palestine
633 Caucasian Republics of the U.S.S.R. (Georgia, Armenia, Azerbaijan)
634 Other Asian Republics of the U.S.S.R. (Kazakh S.S.R., Kirghiz S.S.R., Tadzhik S.S.R., Turkmen S.S.R., Uzbek S.S.R.)
637 Iran (Persia)
638 Afghanistan
639 Pakistan (West Pakistan)

640 Mid-East

641 India
643 Nepal, Bhutan, Sikkim
645 Bangladesh (East Pakistan)
647 Ceylon (Sri Lanka)
649 Burma

650 Southeast Asia

651 Thailand (Siam)

660 Indochina

661 Laos
663 Cambodia
665 Vietnam (Tonkin, Annam, Cochin China)

671 Malaysia, Singapore, Brunei
673 Indonesia (Dutch East Indies)
675 Philippines (Philippine Islands)

ASIA (cont'd)

680 East Asia

- 681 China (not otherwise specified)
  - 682 China (People's Republic of China)
  - 683 Hong Kong
  - 684 Taiwan (Formosa) (Republic of China)
  - 685 Tibet
  - 686 Macao (Macau)
- 691 Mongolia
- 693 Japan
- 695 Korea (North and South)

AUSTRALIA AND OCEANIA

711 Australia and Australian New Guinea
715 New Zealand

720 Pacific Islands *

- 721 Melanesian Islands *
- 723 Micronesian Islands *
- 725 Polynesian Islands *

** Except possessions of the U.S.A.*

PLACE OF BIRTH UNKNOWN

998 Place of Birth stated not to be in United States, but no other information available
999 Place of Birth unknown

APPENDIX B
SEER GEOCODES FOR CODING PLACE OF BIRTH

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663 Cambodia
539 Cameroon
220 Canada
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545 Cape Colony
445 Cape Verde islands
245 Caribbean islands, other
123 Caroline islands
711 Cartier Islands
633 Caucasian republics of the U.S.S.R.
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539 Central African Republic
250 Central America
060 Central Midwest States
647 Ceylon
520 Chad
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684 China, Republic of
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245 Dominica
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539 Guinea-Bissau
539 Guinea, Equatorial
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APPENDIX B
SEER GEOCODES FOR CODING PLACE OF BIRTH

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723 Nauru
610 Near-East Asia
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054 North Dakota
711 North East New Guinea
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010 North Mid-Atlantic States
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671 Singapore
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721 Solomon Islands
581 Somali Republic
581 Somalia
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300 South America
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020 South Mid-Atlantic States
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650 Southeast Asia
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647 Sri Lanka
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453 Yugoslavia
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Z

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ORAL CAVITY
140.0-149.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Electrocautery, or cryosurgery; laser surgery WITHOUT pathology specimen

20 Laser surgery WITH pathology specimen; excisional biopsy

30 Local surgical excision

40 Radical excision

50 Local/radical excision WITH radical neck dissection

70 Radical neck dissection ONLY

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

ORAL CAVITY (cont'd)

NOTE: Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

STOMACH

151.0-151.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Local surgical excision (includes polypectomy, excision of ulcer, other lesions, or stomach tissue with evidence of cancer)

20 Partial*/subtotal/hemigastrectomy: Upper (proximal) portion (may include part of esophagus, i.e., esophagogastrectomy)

30 Partial*/subtotal/hemigastrectomy: Lower (distal) portion (may include part of duodenum, i.e., gastropylorectomy); Billroth I (indicates anastomosis to duodenum); duodenostomy; Billroth II (indicates anastomosis to jejunum); jejunostomy; antrectomy (resection of pyloric antrum of stomach)

40 Partial*/subtotal/hemigastrectomy, NOS; resection of portion of stomach, NOS

50 Total/near total** gastrectomy (includes resection with pouch left for anastomosis; total gastrectomy following previous partial resection for another cause)

60 Gastrectomy, NOS

70 Gastrectomy (partial, total, radical) PLUS partial or total removal of other organs

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

*Partial gastrectomy includes sleeve resection of stomach.

**Near total gastrectomy means 80 percent or more.

STOMACH (cont'd)

NOTE: Codes 10-70 may include removal of spleen, nodes, omentum, mesentery, or mesocolon.
Ignore incidental removal of gallbladder, bile ducts, appendix, or vagus nerve.
Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

COLON (excludes rectosigmoid, rectum)
153.0-153.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Local cancer destruction WITHOUT pathology specimen (includes laser surgery, cryosurgery, electrocautery, or fulguration)

20 Local surgical excision WITH pathology specimen (includes polypectomy, snare, or laser surgery)

30 Partial/subtotal colectomy, but less than hemicolectomy (includes segmental resection, e.g., cecectomy, appendectomy, sigmoidectomy, partial resection of transverse colon and flexures, ileocolectomy, enterocolectomy, and partial/subtotal colectomy, NOS)

40 Hemicolectomy or greater (but less than total); right/left colectomy (all of right or left colon beginning at mid-transverse)

50 Total colectomy (beginning with cecum and ending with sigmoid/rectum or part of rectum)

60 Colectomy, NOS

70 Colectomy (subtotal, hemicolectomy or total) PLUS partial or total removal of other organs

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

COLON (excludes rectosigmoid, rectum) (cont'd)

NOTE: Codes 30-70 may include removal of lymph nodes, mesentery, mesocolon, peritoneum, a portion of terminal ileum, or omentum.

Ignore incidental removal of appendix, gallbladder, bile ducts, or spleen.

Codes '10'-'90' have priority over codes '00'-'09'.

Codes '10'-'78' have priority over codes '80'-'90'.

Surgery of primary not included in any category should be coded '90'.

In the range '10'-'78', the higher code has priority.

Codes '01'-'07' have priority over code '09'.

In the range '01'-'06', the higher code has priority.

Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.

Codes '01'-'06' have priority over code '07'.

Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

If not clear from either the operative or pathology report what was removed, but the title of the operative report is hemicolectomy, code as hemicolectomy.

RECTOSIGMOID, RECTUM
154.0-154.1

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Local cancer destruction WITHOUT pathology specimen (includes laser surgery, cryosurgery, electrocautery, or fulguration)

20 Local surgical excision WITH pathology specimen (includes polypectomy, snare, or laser surgery)

30 Anterior/posterior resection, wedge or segmental resection, transsacral rectosigmoidectomy, Hartmann's operation, partial proctectomy, rectal resection, NOS

40 Pull-through resection WITH sphincter preservation (e.g., Turnbull's and Swenson's operations, Soave's submucosal resection, Altemeier's operation, and Duhamel's operation)

50 Abdominoperineal resection (e.g., Miles' and Rankin's operations), complete proctectomy

60 Any of codes 30-50 PLUS partial or total removal of other organs

70 Pelvic Exenteration (partial or total)
Posterior exenteration (includes rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes)
Total exenteration (includes removal of all pelvic contents and pelvic lymph nodes)
Extended exenteration (includes pelvic blood vessels or bony pelvis)

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

RECTOSIGMOID, RECTUM (cont'd)

NOTE: Codes 30-70 may include removal of lymph nodes and/or removal of section of colon.

Ignore incidental removal of gallbladder, bile ducts, or appendix.

Codes '10'-'90' have priority over codes '00'-'09'.

Codes '10'-'78' have priority over codes '80'-'90'.

Surgery of primary not included in any category should be coded '90'.

In the range '10'-'78', the higher code has priority.

Codes '01'-'07' have priority over code '09'.

In the range '01'-'06', the higher code has priority.

Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.

Codes '01'-'06' have priority over code '07'.

Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

PANCREAS
157.0-157.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Local or partial surgical excision of pancreas

20 Total pancreatectomy WITH/WITHOUT splenectomy

30 Subtotal gastrectomy, duodenectomy with complete or partial pancreatectomy WITH/WITHOUT splenectomy (Whipple's operation)

40 Radical regional pancreatectomy with lymph node dissection, portal vein, mesocolon and adjacent soft tissue resection

50 Pancreatectomy, NOS

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

PANCREAS (cont'd)

NOTE: Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

LARYNX
161.0-161.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Laser surgery WITHOUT pathology specimen

20 Local surgical excision or destruction of lesion; laser surgery WITH pathology specimen; stripping

30 Partial laryngectomy WITH/WITHOUT node dissection

40 Total laryngectomy WITHOUT dissection of lymph nodes; total laryngectomy, NOS

50 Total laryngectomy WITH dissection of lymph nodes; radical laryngectomy

60 Laryngectomy, NOS

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

LARYNX (cont'd)

NOTE: Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

BRONCHUS AND LUNG
162.2-162.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Local surgical excision or destruction of lesion

20 Partial/wedge/segmental resection, lingulectomy, partial lobectomy, sleeve resection (bronchus only)

30 Lobectomy/bilobectomy (includes lobectomy plus segmental/sleeve resection, radical lobectomy, partial pneumonectomy) WITHOUT dissection of lymph nodes

40 Lobectomy/bilobectomy (includes lobectomy plus segmental/sleeve resection, radical lobectomy, partial pneumonectomy) WITH dissection of lymph nodes

50 Complete/total/standard pneumonectomy (includes hilar and parabronchial lymph nodes); pneumonectomy, NOS

60 Radical pneumonectomy (complete pneumonectomy PLUS dissection of mediastinal lymph nodes)

70 Extended radical pneumonectomy (includes parietal pleura, pericardium and/or chest wall (with diaphragm) plus lymph nodes)

80 Surgery of regional and/or distant site(s)/node(s) ONLY (includes removal of mediastinal mass ONLY)

90 Resection of lung, NOS; surgery, NOS

BRONCHUS AND LUNG (cont'd)

NOTE: Ignore incidental removal of rib(s) (operative approach).
Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

BONE AND CONNECTIVE AND OTHER SOFT TISSUE
170.0-170.9, 171.0, 171.2-171.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Local or wide excision of lesion

20 Resection, partial
Internal hemipelvectomy (pelvis)

30 Radical excision/resection
Limb salvage (arm or leg)

40 Amputation, partial/total of limb

50 Amputation, forequarter (incl. scapula)
Amputation, hindquarter (incl. ilium/hip bone)
Hemipelvectomy

60 Excision/resection, NOS

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

BONE AND CONNECTIVE AND OTHER SOFT TISSUE (cont'd)

NOTE: Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

SKIN
173.0-173.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Local cancer destruction WITHOUT pathology specimen (includes laser surgery, cryosurgery, fulguration, or electrocauterization)

20 Simple excision/excisional biopsy; local surgical excision; wedge resection; laser surgery WITH pathology specimen; excision, NOS

30 Shave/punch biopsy/biopsy, NOS followed by excision of lesion (not a wide excision)

40 Wide/re-excision or minor (local) amputation (includes digits, ear, eyelid, lip, nose) WITHOUT lymph node dissection

45 Radical excision WITHOUT lymph node dissection

50 Codes 10-45 WITH lymph node dissection

60 Amputation (other than code 40) WITHOUT lymph node dissection; amputation, NOS

70 Amputation (other than in code 40) WITH lymph node dissection

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

SKIN (cont'd)

NOTE: Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

BREAST

174.0-174.9 Female; 175.9 Male

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Partial/less than total mastectomy (includes segmental mastectomy, lumpectomy, quadrantectomy, tylectomy, wedge resection, nipple resection, excisional biopsy, or partial mastectomy, NOS) WITHOUT dissection of axillary lymph nodes

20 Partial/less than total mastectomy WITH dissection of axillary lymph nodes

30 Subcutaneous mastectomy WITH/WITHOUT dissection of axillary nodes

40 Total (simple) mastectomy (breast only) WITHOUT dissection of axillary lymph nodes

50 Modified radical/total (simple) mastectomy (may include portion of pectoralis major) WITH dissection of axillary lymph nodes

60 Radical mastectomy WITH dissection of majority of pectoralis major WITH dissection of axillary lymph nodes

70 Extended radical mastectomy (code 60 PLUS internal mammary node dissection; may include chest wall and ribs)

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Mastectomy, NOS; Surgery, NOS

BREAST (cont'd)

Note: Codes '10'-'78' apply to unilateral resection of primary cancer.

Ignore removal of fragments or tags of muscle; removal of pectoralis minor; resection of pectoralis muscles; and resection of fascia with no mention of muscle.

Oophorectomy, adrenalectomy, and hypophysectomy will be coded as Endocrine (Hormone/Steroid) Therapy.

Codes '10'-'90' have priority over codes '00'-'09'.

Codes '10'-'78' have priority over codes '80'-'90'.

Surgery of primary not included in any category should be coded '90'.

In the range '10'-'78', the higher code has priority.

Codes '01'-'07' have priority over code '09'.

In the range '01'-'06', the higher code has priority.

Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.

Codes '01'-'06' have priority over code '07'.

Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

CERVIX UTERI
180.0-180.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Cryosurgery; laser surgery WITHOUT pathology specimen

15 Dilatation and curettage (in situ ONLY); endocervical curettage (in situ ONLY)

20 Local surgical excision; excisional biopsy; trachelectomy; amputation of cervix or cervical stump; laser surgery WITH pathology specimen; conization

30 Total/pan/simple hysterectomy (includes both corpus and cervix uteri) WITHOUT removal of tubes and ovaries WITHOUT dissection of lymph nodes

40 Total/pan/simple hysterectomy WITH removal of tube(s) and ovary(ies) WITHOUT dissection of lymph nodes

50 Modified radical/extended hysterectomy (includes uterus, tube(s), ovary(ies), and para-aortic and pelvic lymph nodes, and may include vaginal cuff); radical hysterectomy (includes uterus, tube(s), ovary(ies), vagina, all parametrial and paravaginal tissue, and para-aortic and pelvic lymph nodes); Wertheim's operation

60 Hysterectomy, NOS

70 Pelvic Exenteration (partial or total)
Anterior exenteration (includes bladder, distal ureters, and genital organs with their ligamentous attachments and pelvic lymph nodes)
Posterior exenteration (includes rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes)
Total exenteration (includes removal of all pelvic contents and pelvic lymph nodes)
Extended exenteration (includes pelvic blood vessels or bony pelvis)

CERVIX UTERI (cont'd)

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

NOTE: Codes 30 and 40 may include a portion of vaginal cuff.
Ignore incidental removal of appendix.
Ignore omentectomy if it was the only surgery performed in addition to hysterectomy.
Ignore surgical approach, i.e., abdominal or vaginal.
For invasive cancers only, dilatation and curettage is to be coded as an incisional biopsy.
Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

CORPUS UTERI
182.0-182.8

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Polypectomy; myomectomy (simple excision); simple excision, NOS

20 Subtotal hysterectomy; supracervical hysterectomy; fundectomy (cervix left in place WITH/WITHOUT removal of tubes and ovaries)

30 Total/pan/simple hysterectomy (includes both corpus and cervix uteri) WITHOUT removal of tubes and ovaries
WITHOUT dissection of lymph nodes

40 Total/pan/simple hysterectomy WITH removal of tube(s) and ovary(ies) WITHOUT dissection of lymph nodes

50 Modified radical/extended hysterectomy (includes uterus, tube(s), ovary(ies), and para-aortic and pelvic lymph nodes, and may include vaginal cuff); radical hysterectomy (includes uterus, tube(s), ovary(ies), vagina, and all parametrial and paravaginal tissue, and para-aortic and pelvic lymph nodes); Wertheim's operation

60 Hysterectomy, NOS

70 Pelvic Exenteration (partial or total)
Anterior exenteration (includes bladder, distal ureters, and genital organs with their ligamentous attachments and pelvic lymph nodes)
Posterior exenteration (includes rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes)
Total exenteration (includes removal of all pelvic contents and pelvic lymph nodes)
Extended exenteration (includes pelvic blood vessels or bony pelvis)

CORPUS UTERI (cont'd)

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

NOTE: Codes 30 and 40 may include a portion of vaginal cuff.
Ignore incidental removal of appendix.
Ignore omentectomy if it is the only surgery performed in addition to hysterectomy.
Ignore surgical approach, i.e., abdominal or vaginal.
For invasive and in situ cancers, dilatation and curettage is to be coded as an incisional biopsy.
Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

OVARY
183.0

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Subtotal/partial or unilateral (salpingo)-oophorectomy; wedge resection WITHOUT hysterectomy

20 Subtotal/partial or unilateral (salpingo)-oophorectomy WITH hysterectomy

30 Bilateral (salpingo)-oophorectomy WITHOUT hysterectomy; (salpingo)-oophorectomy, NOS

40 Bilateral (salpingo)-oophorectomy WITH hysterectomy

50 Omentectomy (partial, total, or NOS) with unilateral or bilateral (salpingo)-oophorectomy, unknown if hysterectomy done

51 Omentectomy (partial, total, or NOS) with unilateral or bilateral (salpingo)-oophorectomy, WITHOUT hysterectomy

52 Omentectomy (partial, total, or NOS) with unilateral or bilateral (salpingo)-oophorectomy, WITH hysterectomy

60 Debulking* of ovarian cancer mass (may include ovarian tissue)

70 Pelvic Exenteration (partial or total)
Anterior exenteration (includes bladder, distal ureters, and genital organs with their ligamentous attachments and pelvic lymph nodes)
Posterior exenteration (includes rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes)
Total exenteration (includes removal of all pelvic contents and pelvic lymph nodes)
Extended exenteration (includes pelvic blood vessels or bony pelvis)

OVARY (cont'd)

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

*Debulking: Partial removal of cancer to reduce cancer volume to levels that can be handled by the host's immune system and is usually followed by other treatment modalities

NOTE: Ignore incidental removal of appendix.
Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

PROSTATE
185.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Transurethral resection of prostate (TURP); cryoprostatectomy; local surgical excision of lesion
WITHOUT lymph node dissection

20 Transurethral resection of prostate (TURP); cryoprostatectomy; local surgical excision of lesion
WITH lymph node dissection

30 Subtotal/simple prostatectomy (segmental resection or enucleation leaving capsule intact)
WITHOUT dissection of lymph nodes

40 Subtotal/simple prostatectomy (segmental resection or enucleation)
WITH dissection of lymph nodes

50 Radical/total prostatectomy (excised prostate, ejaculatory ducts (ductus deferens), and seminal vesicles)
WITHOUT dissection of lymph nodes

60 Radical/total prostatectomy (excised prostate, ejaculatory ducts (ductus deferens), and seminal vesicles)
WITH dissection of lymph nodes

70 Cystoprostatectomy, radical cystectomy, pelvic exenteration
WITH/WITHOUT dissection of lymph nodes

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Prostatectomy, NOS; Surgery, NOS

PROSTATE (cont'd)

NOTE: Orchiectomy will be coded as Endocrine (Hormone/Steroid) Therapy.
Ignore surgical approach, i.e., suprapubic, retropubic, or perineal.
Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

TESTIS
186.0-186.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Local surgical excision or partial resection of testicle

20 Excision of testicle WITHOUT cord

30 Excision of testicle WITH cord (or cord not mentioned)

40 Excision of testicle WITH unilateral lymph node dissection

50 Excision of testicle WITH bilateral lymph node dissection

60 Orchiectomy, NOS

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

TESTIS (cont'd)

NOTE: Codes '10'-'59' take priority over codes '60'-'99'.
Codes '10'-'99' take priority over codes '00'-'09'.
In the range '10'-'58' the higher code has priority.
Codes '01'-'07' take priority over code '09'.
In the range '01'-'06' the higher code has priority.
Surgery of primary not included in any category should be coded '90'.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

BLADDER
188.0-188.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Transurethral resection of bladder (TURB); local destruction (electrocoagulation, fulguration, cryosurgery); excisional biopsy

20 Partial/subtotal cystectomy (includes segmental resection) WITHOUT dissection of pelvic lymph nodes

30 Partial/subtotal cystectomy (includes segmental resection) WITH dissection of pelvic lymph nodes

40 Complete/total/simple cystectomy WITHOUT dissection of lymph nodes

50 Complete/total/simple cystectomy WITH dissection of lymph nodes

60 Cystectomy, NOS

70 Radical cystectomy (in men: removal of bladder, prostate, seminal vesicles, surrounding perivesical tissues and distal ureters; in women: removal of bladder, uterus, ovaries, fallopian tubes, surrounding peritoneum, and sometimes urethra and vaginal wall)

Pelvic Exenteration (partial, total, or extended)
- Anterior exenteration (includes bladder, distal ureters, and genital organs with their ligamentous attachments and pelvic lymph nodes)
- Posterior exenteration (includes rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes)
- Total exenteration (includes removal of all pelvic contents and pelvic lymph nodes)
- Extended exenteration (includes pelvic blood vessels or bony pelvis)

BLADDER (cont'd)

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

NOTE: Ignore partial removal of ureter in coding cystectomy.
Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

KIDNEY, RENAL PELVIS, AND URETER
189.0-189.2

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Partial/subtotal nephrectomy (includes local excision, wedge resection, and segmental resection);
Partial ureterectomy

20 Complete/total/simple nephrectomy -- for kidney parenchyma
Nephroureterectomy (includes bladder cuff) -- for renal pelvis or ureter
WITHOUT dissection of lymph nodes

30 Complete/total/simple nephrectomy -- for kidney parenchyma
Nephroureterectomy (includes bladder cuff) -- for renal pelvis or ureter
WITH dissection of lymph nodes

40 Radical nephrectomy (includes removal of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial ureter)
WITHOUT dissection of lymph nodes

50 Radical nephrectomy (includes removal of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial ureter)
WITH dissection of lymph nodes

60 Nephrectomy, NOS
Ureterectomy, NOS

70 Codes 20-60 PLUS other organs (e.g., bladder, colon)

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

KIDNEY, RENAL PELVIS, AND URETER (cont'd)

NOTE: Ignore incidental removal of rib(s).
Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

THYROID
193.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Local surgical excision or partial removal of lobe

20 Lobectomy WITH/WITHOUT isthmectomy, WITH/WITHOUT dissection of lymph nodes

30 Lobectomy, isthmectomy and partial removal of contralateral lobe (near total thyroidectomy)
WITH/WITHOUT dissection of lymph nodes

40 Total thyroidectomy WITHOUT dissection of lymph nodes

50 Total thyroidectomy WITH limited lymph node dissection (nodal sampling or "berry picking") or lymph node dissection, NOS

60 Total thyroidectomy WITH radical/modified lymph node dissection

70 Thyroidectomy, NOS

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

THYROID (cont'd)

NOTE: Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

LYMPH NODES AND SPLEEN
169.2, 196.0-196.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Excision of localized tumor mass

20 Splenectomy (partial, total, or NOS)

30 Lymph node dissection, one chain

31 Lymph node dissection, one chain PLUS splenectomy

40 Lymph node dissection, 2+ chains and/or adjacent organ(s)

41 Lymph node dissection, 2+ chains and/or adjacent organ(s) PLUS splenectomy

50 Lymph node dissection, NOS

51 Lymph node dissection, NOS PLUS splenectomy

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

LYMPH NODES AND SPLEEN (cont'd)

NOTE: Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

ALL OTHER SITES

150.0-150.9, 152.0-152.9, 154.2-156.9, 158.0-160.9, 162.0, 163.0-165.9, 169.0-169.1, 169.3-169.9, 179.9, 181.9, 183.2-184.9, 187.1-187.9, 189.3-192.9, 194.0-195.8, 199.9

Code:

No Cancer-Directed Surgery/Unknown

00 No surgical procedure
01 Incisional, needle, or aspiration biopsy of other than primary site
02 Incisional, needle, or aspiration biopsy of primary site
03 Exploratory ONLY (no biopsy)
04 Bypass surgery, -ostomy ONLY (no biopsy)
05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
07 Non-cancer directed surgery, NOS
09 Unknown if surgery done

Type of Cancer-Directed Surgery

10 Cryosurgery

20 Cautery, fulguration, laser surgery WITHOUT pathology specimen

30 Laser surgery WITH pathology specimen

35 Excisional biopsy; polypectomy

40 Simple removal of primary site WITHOUT dissection of lymph nodes

50 Simple removal of primary site WITH dissection of lymph nodes

55 Debulking WITH or WITHOUT dissection of lymph nodes

60 Radical surgery (primary site plus partial or total removal of other organs)

80 Surgery of regional and/or distant site(s)/node(s) ONLY

90 Surgery, NOS

ALL OTHER SITES

NOTE: Codes '10'-'90' have priority over codes '00'-'09'.
Codes '10'-'78' have priority over codes '80'-'90'.
Surgery of primary not included in any category should be coded '90'.
In the range '10'-'78', the higher code has priority.
Codes '01'-'07' have priority over code '09'.
In the range '01'-'06', the higher code has priority.
Codes '01-'07' and '09' cannot be used in combination with codes '10'-'90'.
Codes '01'-'06' have priority over code '07'.
Second digit is to be coded '8' when reconstructive surgery of the primary site is done as part of the planned first course of therapy.

APPENDIX D
CODING EXCEPTIONS FOR PRE-1988 CASES

AUTOPSY ONLY CASES

For Autopsy Only cases diagnosed before 1988, Diagnostic Procedures must be coded ' '.

For Autopsy Only cases diagnosed before 1988, the treatment fields must be coded as follows:

1. For all cases, code Radiation to the Brain and Central Nervous System (V.04) to '9'.
2. Code Reason for No Cancer-directed Surgery (V.02B) to '2'.
3. Code all remaining treatment fields (V.02A,V.03,V.05-V.09) to zero.

DEATH CERTIFICATE ONLY CASES

For Death Certificate Only cases diagnosed before 1988,

A. Diagnostic Procedures must be coded ' '.
B. For cases diagnosed before January 1, 1983,
    1. Coding System for Extent of Disease must be coded '0'.
    2. SEER Nonspecific Extent of Disease must be coded '--'.
C. For cases diagnosed after December 31, 1982,
    1. Coding System for Extent of Disease must be coded '3'.
    2. SEER 4-digit Extent of Disease (1983-87) must be coded '9999'.

CENSUS TRACT

For cases diagnosed prior to 1978, 1970 census tract definitions must be used.

For cases diagnosed between 1978-87, 1980 census tract definitions must be used.

CODING SYSTEM FOR CENSUS TRACT

For cases diagnosed prior to 1978, Coding System for Census Tract must be coded '1' if tracted.

For cases diagnosed between 1978-87, Coding System for Census Tract must be coded '2' if tracted.

UNDERLYING CAUSE OF DEATH

Through December 31, 1978, death certificates were coded according to the 8th Revision of the *International Classification of Diseases, Adapted.*

APPENDIX D
CODING EXCEPTIONS FOR PRE-1988 CASES

TYPE OF REPORTING SOURCE

OLD	DEFINITION	NEW	DEFINITION
1	Hospital inpatient	1	Hospital inpatient/outpatient or clinic
2	Outpatient or clinic		
3	Laboratory (hospital or private)	3	Laboratory (hospital or private)
4	Private medical practitioner	4	Private medical practitioner
5	Nursing/convalescent home/ hospice	5	Nursing/convalescent home/ hospice
6	Autopsy only	6	Autopsy only
7	Death certificate only	7	Death certificate only

APPENDIX D
CODING EXCEPTIONS FOR PRE-1988 CASES

RACE/SPANISH ORIGIN

Race OLD DEFINITION		Race NEW DEFINITION
0 Caucasian, NOS	>	01 White
1 Caucasian of Spanish origin		
2 Black		02 Black
3 American Indian or Alaskan Native		03 American Indian, Aleutian, or Eskimo
4 Chinese		04 Chinese
5 Japanese		05 Japanese
6 Filipino		06 Filipino
7 Hawaiian		07 Hawaiian
Not specified individually prior to 1988		08 Korean 09 Asian Indian, Pakistani 10 Vietnamese 11 Laotian 12 Hmong 13 Kampuchean
8 Other		98 Other
9 Unknown		99 Unknown

Race OLD DEFINITION		Spanish Surname or Origin NEW DEFINITION
0 Caucasian, NOS		0 Non-Spanish
Not specified individually prior to 1988		1 Mexican 2 Puerto Rican 3 Cuban 4 South or Central American (except Brazil) 5 Other Spanish (includes European)
1 Caucasian of Spanish origin		6 Spanish, NOS
2 Black 3 American Indian or Alaskan Native 4 Chinese 5 Japanese 6 Filipino 7 Hawaiian 8 Other	>	0 Non-Spanish (Spanish origin not specified prior to 1988)
9 Unknown		9 Unknown

RACE/SPANISH ORIGIN (cont'd)

For cases diagnosed before 1988:

1. The following Race codes are not to be coded separately:

   08 Korean
   09 Asian Indian, Pakistani
   10 Vietnamese
   11 Laotian
   12 Hmong
   13 Kampuchean

   Persons of these races are to be coded to Other '98'.

2. The following Spanish Surname or Origin codes are not to be coded separately:

   1 Mexican
   2 Puerto Rican
   3 Cuban
   4 South or Central American (except Brazil)
   5 Other Spanish (includes European)

   All persons of Spanish origin are to be coded to Spanish, NOS '6'.

3. The Spanish origin of persons of non-White race is not to be coded. These persons are to be coded to non-Spanish '0'.

4. For persons with independent primaries diagnosed before and after January 1, 1988, the new race codes must be used.

5. For persons with independent primaries diagnosed before and after January 1, 1988, the new Spanish origin codes must be used.

APPENDIX D
CODING EXCEPTIONS FOR PRE-1988 CASES

DIAGNOSTIC CONFIRMATION

OLD DEFINITION		NEW DEFINITION	
1	Positive histology	1	Positive histology
2	Positive exfoliative cytology, no positive histology	2	Positive exfoliative cytology, no positive histology
4	Positive microscopic confirmation, method not specified	4	Positive microscopic confirmation, method not specified
	Not specified separately prior to 1988	5	Positive laboratory test/marker study
6	Direct visualization without microscopic confirmation	6	Direct visualization without microscopic confirmation
7	Radiography and other imaging techniques without microscopic confirmation	7	Radiography and other imaging techniques without microscopic confirmation
8	Clinical diagnosis only (other than 6 or 7)	8	Clinical diagnosis only (other than 5, 6, or 7)
9	Unknown whether or not microscopically confirmed	9	Unknown whether or not microscopically confirmed

For cases diagnosed before 1988:

1. The following Diagnostic Confirmation code is not to be used:
   5 Positive laboratory test/marker study

2. Cases with positive laboratory test/marker studies and without microscopic confirmation are to be coded to '6', '7', or '8' as appropriate.

APPENDIX D
CODING EXCEPTIONS FOR PRE-1988 CASES

DIAGNOSTIC PROCEDURES

Code:

Diagnostic Procedures

Prior to 1983, diagnostic procedures were required for any case for which SEER Expanded Site-specific Extent of Disease was coded. Regardless of site diagnostic procedures are to be left blank for "Autopsy Only" and "Death Certificate Only" cases.

Diagnostic Procedures were required for the following sites for 1983-87:

ICD-O	Site
151.0-151.6, 151.8-151.9	Stomach
153.0-153.9	Colon
154.0-154.1	Rectosigmoid, Rectum
162.2-162.5, 162.8-162.9	Bronchus and Lung
173.0-173.9 (Histology: 8720-8790)	Malignant Melanoma of Skin
174.0-174.6, 174.8-174.9, 175.9	Breast
180.0-180.1, 180.8-180.9	Cervix Uteri
182.0-182.1, 182.8	Corpus Uteri
185.9	Prostate
188.0-188.9	Bladder
Histology: 9650-9667 9590-9594, 9600-9642, 9670-9698, 9702-9704, 9710, 9740-9750	Hodgkin's disease and Non-Hodgkin's lymphoma, all sites (1983 forward)

This field evaluates the relative reliability of extent of disease information on the basis of the pathologic examinations. It should be limited, just as is extent of disease, to all pathologic examinations performed by the end of the first hospitalization for definitive *SURGICAL* resection if done within two months of diagnosis, or two months after diagnosis for *ALL OTHER CASES*, both treated and untreated. However, metastasis known to have developed after the original diagnosis was made should be excluded.

If a patient has radiation therapy followed by definitive surgery within two months of diagnosis, include all information available through definitive surgery.

If an excisional biopsy, D and C, cone biopsy, lymphadenectomy, TUR (prostate or bladder), or a polypectomy is followed by further definitive therapy within two months of diagnosis, include all information available through the definitive therapy.

For example: a melanoma excised in the doctor's office is coded '20'. If the patient is then admitted for wide excision and lymphadenectomy within two months of diagnosis, the proper code is '60'.

DIAGNOSTIC PROCEDURES (cont'd)

Historically, diagnostic procedures for lymphomas of extranodal sites have been coded to the schemes for those sites. Beginning 1983 and forward, diagnostic procedures for lymphomas of extranodal sites are coded to the Hodgkin's and Non-Hodgkin's schemes.

Also, diagnostic procedures for the carina and the cardio-esophageal junction were not coded. Beginning 1983 and forward, diagnostic procedures for these sites are coded to the Lung and Stomach schemes, respectively.

Similarly, before 1983 diagnostic procedures for melanomas (histologies 8720-8790) of the vagina (841-844), the penis (871-872, 874), and the scrotum (877) were coded to the scheme for melanomas of the skin. Beginning in 1983 and forward, diagnostic procedures for melanomas of these sites are not coded.

Diagnostic Procedures will *NOT* be collected for any case diagnosed after December 31, 1987.

DIAGNOSTIC PROCEDURES (cont'd)

For 1973-82 diagnoses:
Stomach, excluding cardioesophageal junction
151.0-151.6, 151.8, 151.9
All histologies

For 1983-87 diagnoses:
Stomach
151.0-151.6, 151.8-151.9
Except histologies 9650-9667, 9590-9594, 9600-9642, 9670-9698, 9702-9704, 9710, 9740-9750)

Code:

00 None

10 Cytology of primary site (including brushings and washings)
20 Biopsy of primary site (includes biopsy, incisional and excisional, done during endoscopy or exploratory surgery)
30 Biopsy or resection of direct extension and/or regional node(s)
40 (20) and (30)

50 Resected primary site (partial or total gastrectomy)
60 Resected primary site and regional node(s)

70 Cytology of distant site
80 Biopsy or resection of distant site and/or distant node(s); site or nodes unknown if regional or distant

90 (70 or 80) with any of (20-40)
91 (70 or 80) with (50 or 60)

DIAGNOSTIC PROCEDURES (cont'd)

For 1973-82 diagnoses:
Colon and Rectum
153.0-153.4, 153.6, 153.7, 154.0, 154.1
All histologies

For 1983-87 diagnoses:
Colon and Rectum
153.0-153.9, 154.0-154.1
Except histologies 9650-9667, 9590-9594, 9600-9642, 9670-9698, 9702-9704, 9710, 9740-9750)

Code:

00 None

10 Cytology of primary site (including washings)
20 Biopsy of primary site (includes biopsy, incisional and excisional, done during endoscopy or exploratory surgery)
30 Biopsy or resection of direct extension and/or regional node(s)
40 (20) and (30)

50 Resected primary site
60 Resected primary site and regional node(s)

70 Cytology of distant site
80 Biopsy or resection of distant site and/or distant (node(s): site or nodes unknown if regional or distant

90 (70 or 80) with any of (20-40)
91 (70 or 80) with (50 or 60)

DIAGNOSTIC PROCEDURES (cont'd)

For 1973-82 diagnoses:
Bronchus and Lung, excluding carina
162.2-162.5, 162.8, 162.9
All histologies

For 1983-87 diagnoses:
Bronchus and Lung
162.2-162.5, 162.8-162.9
Except histologies 9650-9667, 9590-9594, 9600-9642, 9670-9698, 9702-9704, 9710, 9740-9750)

Code:

00 None

10 Cytology of primary site (including sputum, brushings, and washings)
20 Biopsy of primary site (includes biopsy done during endoscopy or exploratory surgery); wedge resection, lingulectomy, segmentectomy (less than a lobectomy)
30 Biopsy or resection of direct extension and/or regional node(s): cytology of regional site
40 (20) and (30)

50 Resected primary site
60 Resected primary site and regional node(s)

70 Cytology of distant site
80 Biopsy or resection of distant site and/or distant node(s); site or nodes unknown if regional or distant

90 (70 or 80) with any of (20-40)
91 (70 or 80) with (50 or 60)

NOTE: Removal of ribs is not a diagnostic procedure unless tissue is involved by cancer.

DIAGNOSTIC PROCEDURES (cont'd)

For 1973-82 diagnoses:
Malignant Melanoma of Skin
173.0-173.7, 184.1-184.4, 187.1-187.2, 187.4, 187.7
Histologies: 8720-8790

For 1983-87 diagnoses:
Malignant Melanoma of Skin
173.0-173.9
Histologies: 8720-8790

Code:

00 None

10 Cytology of primary site
20 Biopsy of primary site; excisional biopsy (includes local excision, wedge resection, simple excision, laser surgery)
30 Biopsy or resection of direct extension (including satellite cancers) and/or regional node(s)
40 (20) and (30)

50 Resected primary site (wide excision/re-excisional/resection)
60 Resected primary site (wide excision/resection) and regional nodes(s)

70 Cytology of distant site
80 Biopsy or resection of distant site and/or distant node(s); site or nodes unknown if regional or distant

90 (70 or 80) with any of (20-40)
91 (70 or 80) with (50 or 60)

DIAGNOSTIC PROCEDURES (cont'd)

For 1973-82 diagnoses:
Breast
174.0-174.9, 175.9
All histologies

For 1983-87 diagnoses:
Breast
174.0-174.6, 174.8-174.9 Female; 175.9 Male
Except histologies 9650-9667, 9590-9594, 9600-9642, 9670-9698, 9702-9704, 9710, 9740-9750)

Code:

00 None

10 Cytology of primary site
20 Biopsy of primary site (including aspiration biopsy/frozen section; excisional biopsy; lumpectomy; tylectomy, quadrantectomy, wedge resection, nipple resection, partial mastectomy, segmental resection)
30 Biopsy or resection of direct extension and/or regional node(s)
40 (20) and (30)

50 Resected primary site (total mastectomy includes subcutaneous)
60 Resected primary site and regional node(s)

70 Cytology of distant site
80 Biopsy or resection of distant site and/or distant node(s); site or nodes unknown if regional or distant

90 (70 or 80) with any of (20-40)
91 (70 or 80) with (50 or 60)

DIAGNOSTIC PROCEDURES (cont'd)

For 1973-82 diagnoses:
Cervix Uteri
180.0-180.9
All histologies

For 1983-87 diagnoses:
Cervix Uteri
180.0-180.1, 180.8-180.9
Except histologies 9650-9667, 9590-9594, 9600-9642, 9670-9698, 9702-9704, 9710, 9740-9750

Code:

00 None

10 Cytology of primary site (Pap smear)
20 Biopsy of primary site, conization, D & C of endocervix only
30 Biopsy or resection of direct extension and/or regional node(s); D & C of endometrium only
40 (20) and (30)

50 Resected primary site
60 Resected primary site and regional node(s)

70 Cytology of distant site
80 Biopsy or resection of distant site and/or distant node(s); site or nodes unknown if regional or distant

90 (70 or 80) with any of (20-40)
91 (70 or 80) with (50 or 60)

NOTE: Removal of tube(s) and/or ovary(ies) is not a diagnostic procedure unless tissue is involved by cancer.

DIAGNOSTIC PROCEDURES (cont'd)

For 1973-82 diagnoses:
Corpus Uteri
182.0-182.8
All histologies

For 1983-87 diagnoses:
Corpus Uteri
182.0-182.1, 182.8
Except histologies 9650-9667, 9590-9594, 9600-9642, 9670-9698, 9702-9704, 9710, 9740-9750

Code:

00 None

10 Cytology of primary site (Pap smear)
20 Biopsy of primary site, D & C
30 Biopsy or resection of direct extension and/or regional node(s); conization
40 (20) and (30)

50 Resected primary site
60 Resected primary site and regional node(s)

70 Cytology of distant site
80 Biopsy or resection of distant site and/or distant node(s); site or nodes unknown if regional or distant

90 (70 or 80) with any of (20-40)
91 (70 or 80) with (50 or 60)

NOTE: Removal of tube(s) and/or ovary(ies) is not a diagnostic procedure unless tissue is involved by cancer.

DIAGNOSTIC PROCEDURES (cont'd)

For 1973-82 diagnoses:
Prostate
185.9
All histologies

For 1983-87 diagnoses:
Prostate
185.9
Except histologies 9650-9667, 9590-9594, 9600-9642, 9670-9698, 9702-9704, 9710, 9740-9750

Code:

00 None

10 Cytology of primary site (including urinary sediment and/or prostatic fluid after massage)
20 Biopsy (includes needle biopsy) of primary site and/or TUR*
30 Biopsy or resection of direct extension and/or regional node(s)
40 (20) and (30)

50 Prostatectomy (excluding TUR)
60 Prostatectomy (excluding TUR) and regional node(s)

70 Cytology of distant site
80 Biopsy or resection of distant site and/or distant node(s); site or nodes unknown if regional or distant

90 (70 or 80) with any of (20-40)
91 (70 or 80) with (50 or 60)

NOTE: Orchiectomy is not a diagnostic procedure unless tissue is involved by cancer.

*TUR is also to be coded as treatment in Section V.02A, First Course of Cancer-Directed Therapy -- Site-Specific Surgery.

DIAGNOSTIC PROCEDURES (cont'd)

For 1973-82 diagnoses:
Bladder
188.0-188.6, 188.8, 188.9
All histologies

For 1983-87 diagnoses:
Bladder
188.0-188.9
Except histologies 9650-9667, 9590-9594, 9600-9642, 9670-9698, 9702-9704, 9710, 9740-9750

Code:

00 None

10 Cytology of primary site
20 Biopsy of primary site (including polypectomy) and/or TUR*
30 Biopsy or resection of direct extension and/or regional node(s)
40 (20) and (30)

50 Resected primary site
60 Resected primary site and regional node(s)

70 Cytology of distant site
80 Biopsy or resection of distant site and/or distant node(s); site or nodes unknown if regional or distant

90 (70 or 80) with any of (20-40)
91 (70 or 80) with (50 or 60)

*TUR is also to be coded as treatment in Section V.02A, First Course of Cancer-Directed Therapy -- Site-Specific Surgery.

DIAGNOSTIC PROCEDURES (cont'd)

For 1973-82 diagnoses:
Lymph Nodes and Lymphoid Tissue
196.0-196.9, 141.6, 146.0, 147.1, 149.1, 164.0, 169.2
Histologies 9590-9698, 9750

For 1983-87 diagnoses:
Hodgkin's Disease and Non-Hodgkin's Lymphoma of All Sites
Histologies 9650-9667, 9590-9694, 9600-9642, 9670-9698, 9702-9704, 9710, 9740-9750

Code:

00 Single nodal/site biopsy and/or resection or clinical impression

10 Multiple nodal/site biopsies and/or resections
20 Splenectomy with or without nodal site biopsies and/or resections

30 Bone marrow examination (aspiration and/or biopsy)
31 (30) and (10)
32 (20) and (30)

40 Liver biopsy
41 (40) and (10)
42 (40) and (20)
43 (40) and (30)
44 (40) and (31)
45 (40) and (32)

APPENDIX D
CODING EXCEPTIONS FOR PRE-1988 CASES

CODING SYSTEM FOR EXTENT OF DISEASE

Use codes '0', '1', and '2' for cases diagnosed prior to January 1, 1983. Code '0' is obligatory for "Death Certificate Only" cases diagnosed prior to January 1, 1983.

Use code '3' for all cases diagnosed between January 1, 1983 and December 31, 1987.

EXTENT OF DISEASE

13A SEER Nonspecific (1973-82) scheme

13B SEER Two-digit Site-Specific (1973-82) scheme

13C SEER Expanded (13 digit) Site-Specific (1973-82) scheme

The Extent of Disease scheme used for cases diagnosed 1983 forward and for all cases from New Jersey is:

13D SEER 4-digit Extent of Disease (1983-87). It is composed of:
- Tumor Size (2 digits)
- Extension (1 digit)
- Lymph Nodes (1 digit)

Discussion:

Extent of Disease should be limited to all information available by the end of the first hospitalization for surgical resection if done within two months of diagnosis or two months after diagnosis for all other cases, both treated and untreated. However, metastasis known to have developed after the original diagnosis was made should be excluded.

If a patient has radiation therapy followed by definitive surgery within two months of diagnosis, include all information available through definitive surgery in determining extent of disease.

In coding size of the cancer, code the size given prior to radiation therapy for surgical patients pretreated by radiation therapy.

If an excisional biopsy, D and C, cone biopsy, lymphadenectomy, TUR (prostate or bladder), or a polypectomy is followed by further definitive therapy within two months of diagnosis, include all information available through the definitive surgery in determining extent of disease.

EXTENT OF DISEASE (cont'd)

Autopsy reports are used in coding extent of disease just as pathology reports, applying the same rules for inclusion and exclusion.

Use Field 13D for cases diagnosed from January 1, 1983 to December 31, 1987 and for all cases from New Jersey diagnosed prior to 1988. Use 13A, 13B, and 13C for cases diagnosed prior to 1983 except for cases from New Jersey. Field 13D replaces the other three extent of disease fields (13A, 13B, and 13C).

For Death Certificate cases diagnosed between 1983-87, code '9999' in Field 13D.

Use the *SEER Extent of Disease Codes and Coding Instructions* (New 4-digit schemes) for coding field 13D. When coding field 13D (4-digit extent of disease), the definition of Hodgkin's and Non-Hodgkin's lymphomas in the SEER Extent of Disease Codes has been modified to include the following ICD-O, 76 and ICD-O, FT, 1988 histology codes:

Hodgkin's disease	9650-9667
Non-Hodgkin's lymphoma	9590-9594, 9600-9642, 9670-9698, 9702-9704, 9710, 9740-9750

Appropriate EOD Code for Field 13A, 13B, and 13C for Cases Diagnosed Prior to 1983

This table, given in primary site code order, specifies which EOD field is required for cases diagnosed before January 1, 1983. The table specifies the sites for which A or B must be coded for cases diagnosed between 1973-82. The table also specifies the sites and diagnosis years for which C must be coded. If a site is listed as requiring C but is diagnosed before the range of dates, then schemes B or C may be used.

Exception for fields 13A, 13B, and 13C: If a case is reported via "Death Certificate Only," code '--' (unstaged) in Field 13A.

Primary Site Code	Field 13 Required	Page(s) in 1977 EOD Manual*
140.0-140.4	B	Buff pages
140.5	A	ii
140.6	B	Buff pages
140.8-140.9	A	ii
141.0-141.4	B	Buff pages
141.5	A	ii
141.6 (hist 959-970, 9687)	C (05/77-12/82)	74-77
141.6 (excl. hist 959-970, 9687)	B	Buff pages
141.8-141.9	A	ii

*This column refers to pages or sections of the SEER Program manual *Extent of Disease -- Codes and Coding Instructions,* April 1977.

EXTENT OF DISEASE (cont'd)

Appropriate EOD Code (cont'd)

Primary Site Code	Field 13 Required	Page(s) in 1977 EOD Manual*
142.0-142.1	B	Buff pages
142.2-142.9	A	ii
143.0-143.1	B	Buff pages
143.8-143.9	A	ii
144.0-144.9	B	Buff pages
145.0-145.4	B	Buff pages
145.5	A	ii
145.6	B	Buff pages
145.8-145.9	A	ii
146.0 (hist 959-970, 9687)	C (05/77-12/82)	74-77
146.0 (excl hist 959-970, 9687)	B	Buff pages
146.1-146.9	B	Buff pages
147.0	B	Buff pages
147.1 (hist 959-970, 9687)	C (05/77-12/82)	74-77
147.1 (excl hist 959-970, 9687)	B	Buff pages
147.2-147.9	B	Buff pages
148.0-148.9	B	Buff pages
149.0	A	ii
149.1 (hist 959-970, 9687)	C (05/77-12/82)	74-77
149.1 (excl hist 959-970, 9687)	A	ii
149.8-149.9	A	ii
150.0-150.5	B	Buff pages
150.8-150.9	A	ii
151.0 (cardia only)	C (12/77-12/82)	8-11
151.0 (excluding cardia)	A	ii
151.1-151.9	C (12/77-12/82)	8-11
152.0-152.2	B	Buff pages
152.3-153.9	A	ii
153.0-153.1	C **	20-23
153.2	C **	24-27
153.3	C **	28-31
153.4	C **	12-15
153.5	A	ii
153.6	C **	16-19
153.7	C **	20-23
153.8-153.9	A	ii
154.0	C **	32-35
154.1	C **	36-39
154.2-154.3	B	Buff pages
154.8	A	ii
155.0-155.1	B	Buff pages

*This column refers to pages or sections of the SEER Program manual *Extent of Disease -- Codes and Coding Instructions,* April 1977.
**Used for cases diagnosed 1975-82, except cases diagnosed in 1975 of Alameda, Contra Costa, and Marin counties of the San Francisco/Oakland SMSA.

EXTENT OF DISEASE (cont'd)

Appropriate EOD Code (cont'd)

Primary Site Code	Field 13 Required	Page(s) in 1977 EOD Manual*
156.0-156.2	B	Buff pages
156.8-156.9	A	ii
157.0-157.2	B	Buff pages
157.3-157.9	A	ii
158.0-158.9	A	ii
159.0-159.9	A	ii
160.0-160.9	A	ii
161.0-161.2	B	Buff pages
161.3-161.9	A	ii
162.0	A	ii
162.2 (carina only)	A	ii
162.2 (excluding carina)	C (12/77-12/82)	40-45
162.3-162.9	C (12/77-12/82)	40-45
163.0-163.9	A	ii
164.0 (hist 959-970, 9687)	C (05/77-12/82)	74-77
164.0 (excl hist 959-970, 9687)	A	ii
164.1-164.9	A	ii
165.0-165.9	A	ii
169.0-169.1	A	ii
169.2 (hist 959-970, 9687)	C (05/77-12/82)	74-77
169.2 (excl hist 959-970, 9687)	A	ii
169.3-169.9	A	ii
170.0-170.9	B	Buff pages
171.0-171.9	A	ii
173.0-173.7 (hist 872-879)	C (05/77-12/82)	46-49
173.0-173.7 (excl hist 872-879)	B	Buff pages
173.8-173.9	A	ii
174.0-174.9, 175.9	C **	50-54
179.9	A	ii
180.0-180.9	C (12/77-12/82)	55-59
181.9	A	ii
182.0-182.8	C (12/77-12/82)	60-64
183.0-183.2	B	Buff pages
183.3-183.9	A	ii
184.0	B	Buff pages
184.1-184.4 (hist 872-879)	C (05/77-12/82)	46-49
184.1-184.4 (excl hist 872-879)	B	Buff pages
184.8-184.9	A	ii
185.9	C (12/77-12/82)	65-69
186.0, 186.9	B	Buff pages

*This column refers to pages or sections of the SEER Program manual *Extent of Disease -- Codes and Coding Instructions*, April 1977.

**Used for cases diagnosed 1975-82, except cases diagnosed in 1975 of Alameda, Contra Costa, and Marin counties of the San Francisco/Oakland SMSA.

EXTENT OF DISEASE (cont'd)

Appropriate EOD Code (cont'd)

Primary Site Code	Field 13 Required	Page(s) in 1977 EOD Manual*
187.1-187.2 (hist 872-879)	C (05/77-12/82)	46-49
187.1-187.2, 187.4 (excl hist 872-879)	B	Buff pages
187.3	A	ii
187.5-187.6	A	ii
187.7 (hist 872-879)	C (05/77-12/82)	46-49
187.7 (excl hist 872-879)	A	ii
187.8-187.8	A	ii
188.0-188.6	C (12/77-12/82)	70-73
188.7	A	ii
188.8-188.9	C (12/77-12/82)	70-73
189.0-189.2	B	Buff pages
189.3-189.9	A	ii
190.0-190.9	A	ii
191.0-191.9	A	ii
192.0-192.9	A	ii
193.9	B	Buff pages
194.0-194.9	A	ii
195.0-195.8	A	ii
196.0-196.9 (hist 959-970, 9687)	C (05/77-12/82)	74-77
196.0-196.9 (excl hist 959-970, 9687)	A	ii
199.9	A	ii

*This column refers to pages or sections of the SEER Program manual *Extent of Disease -- Codes and Coding Instructions,* April 1977.

APPENDIX D
CODING EXCEPTIONS FOR PRE-1988 CASES

SURGERY/SITE-SPECIFIC SURGERY

For all cases diagnosed 1973-82 and any case diagnosed 1983-87 for which Site-specific Surgery is not required, the following holds:

Surgery		Site-specific Surgery	
OLD	DEFINITION	NEW	DEFINITION
0	None	09	Unknown if surgery done
1	Given	90	Surgery NOS
8	Recommended	09	Unknown if surgery done
9	Unknown	09	Unknown if surgery done

SITE-SPECIFIC SURGERY

For cases diagnosed 1983-87 requiring detailed site-specific surgery, the following pages (215-238) contain the tables for Site-specific Surgery. The first table shows the codes used for No cancer-directed surgery/unknown. The remaining tables specify for each site the codes used for cancer-directed surgery.

SITE: All sites for which site-specific surgery was required for cases diagnosed prior to 1988

OLD DEFINITION		NEW DEFINITION
Not specified individually prior to 1988	<	01 Incisional, needle or aspiration biopsy of other than primary site
		02 Incisional, needle or aspiration biopsy of primary site
		03 Exploratory ONLY (no biopsy)
		04 Bypass surgery, -ostomy ONLY (no biopsy)
		05 Exploratory ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
		06 Bypass surgery, -ostomy ONLY AND incisional, needle or aspiration biopsy of primary site or other sites
		07 Non-cancer directed surgery, NOS
0 No surgery; unknown if surgery done		09 Unknown if surgery done

SITE-SPECIFIC SURGERY (cont'd)

SITE: Stomach (151.0-151.9)

OLD	DEFINITION	NEW	DEFINITION
1	Local excision (incl. polypectomy, excision of ulcer, other lesions, or stomach tissue with evidence of tumor)	10	Local surgical excision (includes polypectomy, excision of ulcer, other lesions, or stomach tissue with evidence of cancer)
2	Partial/subtotal/hemi-gastrectomy: Upper (proximal) portion (may include part of esophagus, i.e., esophagogastrectomy)	20	Partial/subtotal/ hemigastrectomy: Upper (proximal) portion (may include part of esophagus, i.e., esophagogastrectomy)
3	Partial/subtotal/hemi-gastrectomy: Lower (distal) portion (may include part of duodenum, i.e., gastropylorectomy); Billroth I (indicates anastomosis to duodenum--duodenostomy); Billroth II (includes anastomosis to jejunum--jejunostomy), antrectomy (resection of pyloric antrum of stomach)	30	Partial/subtotal/ hemigastrectomy: Lower (distal) portion (may include part of duodenum, i.e., gastropylorectomy); Billroth I (indicates anastomosis to duodenum); duodenostomy; Billroth II (includes anastomosis to jejunum); jejunostomy; antrectomy (resection of pyloric antrum of stomach)
4	Partial/subtotal/hemi-gastrectomy, NOS or NEC; resection of portion of stomach, NOS	40	Partial/subtotal/ hemigastrectomy, NOS; resection of portion of stomach, NOS
5	Total/near total gastrectomy (incl. resection with pouch left for anastomosis, total gastrectomy following previous partial resection for another cause)	50	Total/near total gastrectomy (includes resection with pouch left for anastomosis; total gastrectomy following previous partial resection for another cause)
6	Gastrectomy, NOS	60	Gastrectomy, NOS
7	Gastrectomy (partial, total, radical) PLUS partial or total removal of other organs	70	Gastrectomy (partial, total, radical) PLUS partial or total removal of other organs

SITE-SPECIFIC SURGERY (cont'd)

SITE: Stomach (151.0-151.9) (cont'd)

OLD	DEFINITION	NEW	DEFINITION
8	Surgery of regional and/or distant site(s)/nodes ONLY	80	Surgery of regional and/or distant site(s)/node(s) ONLY
9	Surgery, NOS	90	Surgery, NOS

SITE-SPECIFIC SURGERY (cont'd)

SITE: Colon (excluding rectosigmoid, rectum) (153.0-153.9)

OLD	DEFINITION	NEW	DEFINITION
1	Local tumor destruction (incl. cryosurgery, electrocautery, fulguration, laser surgery (vaporized--no path specimen))	10	Local cancer destruction WITHOUT pathology specimen (includes laser surgery, cryosurgery, electrocautery, or fulguration)
2	Local excision (incl. polypectomy, snare, laser surgery (with path specimen))	20	Local surgical excision WITH pathology specimen (includes polypectomy, snare, or laser surgery)
3	Partial/subtotal colectomy, but less than hemicolectomy (incl. segmental resection, e.g., cecectomy, appendectomy, sigmoidectomy, transverse colon and flexures, ileocolectomy, enterocolectomy, and partial/subtotal colectomy, NOS)	30	Partial/subtotal colectomy, but less than hemicolectomy (includes segmental resection, e.g., cecectomy, appendectomy, sigmoidectomy, partial resection of transverse colon and flexures, ileocolectomy, enterocolectomy, and partial/subtotal colectomy, NOS)
4	Hemicolectomy or greater (but less than total), right/left colectomy (all of right or left colon beginning at mid-transverse)	40	Hemicolectomy or greater (but less than total); right/left colectomy (all of right or left colon beginning at mid-transverse)
5	Total colectomy (beginning with cecum and ending with sigmoid/rectum or part of rectum)	50	Total colectomy (beginning with cecum and ending with sigmoid/rectum or part of rectum)
6	Colectomy, NOS	60	Colectomy, NOS
7	Colectomy (subtotal, hemicolectomy or total) PLUS partial or total removal of other organs	70	Colectomy (subtotal, hemicolectomy or total) PLUS partial or total removal of other organs
8	Surgery of regional and/or distant site(s)/nodes ONLY	80	Surgery of regional and/or distant site(s)/node(s) ONLY
9	Surgery, NOS	90	Surgery, NOS

SITE-SPECIFIC SURGERY (cont'd)

SITE: Rectosigmoid, Rectum (154.0-154.1)

OLD	DEFINITION	NEW	DEFINITION
1	Local tumor destruction (incl. cryosurgery, electrocautery, fulguration, laser surgery (vaporized--no path specimen))	10	Local cancer destruction WITHOUT pathology specimen (includes laser surgery, cryosurgery, electrocautery, or fulguration)
2	Local excision (incl. polypectomy, snare, laser surgery (with path specimen))	20	Local surgical excision WITH pathology specimen (includes polypectomy, snare, or laser surgery)
3	Anterior/posterior resection, wedge or segmental resection, transsacral rectosigmoidectomy, Hartmann resection, partial proctectomy, rectal resection, NOS	30	Anterior/posterior resection, wedge or segmental resection, transsacral rectosigmoidectomy, Hartmann's operation, partial proctectomy, rectal resection, NOS
4	Pull-through resection WITH sphincter preservation (e.g., Turnbull and Swenson's operations, Soave submucosal resection, Altemeier operation, Duhamel resection)	40	Pull-through resection WITH sphincter preservation (e.g., Turnbull's and Swenson's operations, Soave's submucosal resection, Altemeier's operation, and Duhamel's resection)
5	Abdominal perineal resection (e.g., Miles and Rankin procedures), complete proctectomy.	50	Abdominoperineal resection (e.g., Miles' and Rankin's operations), complete proctectomy
6	Any of codes 3-5 PLUS partial or total removal of other organs	60	Any of codes 30-50 PLUS partial or total removal of other organs

SITE-SPECIFIC SURGERY (cont'd)

SITE: Rectosigmoid, Rectum (154.0-154.1) (cont'd)

OLD	DEFINITION	NEW	DEFINITION
7	Pelvic Exenteration (partial or total) Posterior exenteration (incl. rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes) Total exenteration: all pelvic contents and pelvic lymph nodes Extended exenteration: includes pelvic blood vessels or bony pelvis	70	Pelvic Exenteration (partial or total) Posterior exenteration (includes rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes) Total exenteration (includes removal of all pelvic contents and pelvic lymph nodes) Extended exenteration (includes pelvic blood vessels or bony pelvis
8	Surgery of regional and/or distant site(s)/nodes ONLY	80	Surgery of regional and/or distant site(s)/node(s) ONLY
9	Surgery, NOS	90	Surgery, NOS

SITE-SPECIFIC SURGERY (cont'd)

SITE: Lung and Bronchus (162.2-162.9)

OLD	DEFINITION	NEW	DEFINITION
1	Local excision or destruction of lesion	10	Local surgical excision or destruction of lesion
2	Wedge resection(s), segmental resection(s), lingulectomy, partial lobectomy, sleeve resection (bronchus only)	20	Partial/wedge/segmental resection, lingulectomy, partial lobectomy, sleeve resection (bronchus only)
3	Lobectomy (incl. lobectomy plus segmental/sleeve resection, bilobectomy, radical lobectomy, partial pneumonectomy) WITHOUT dissection of lymph nodes	30	Lobectomy/bilobectomy (includes lobectomy plus segmental/sleeve resection, radical lobectomy, partial pneumonectomy) WITHOUT dissection of lymph nodes
4	Lobectomy WITH dissection of lymph nodes	40	Lobectomy/bilobectomy (includes lobectomy plus segmental/sleeve resection, radical lobectomy, partial pneumonectomy) WITH dissection of lymph nodes
5	Complete/total/standard pneumonectomy; pneumonectomy, NOS	50	Complete/total/standard pneumonectomy (include hilar and parabronchial lymph nodes); pneumonectomy, NOS
6	Radical pneumonectomy (complete pneumonectomy plus dissection of hilar/mediastinal lymph nodes)	60	Radical pneumonectomy (complete pneumonectomy PLUS dissection of mediastinal lymph nodes)
7	Extended radical pneumonectomy (incl. parietal pleura, pericardium and/or chest wall (incl. diaphragm) plus nodes)	70	Extended radical pneumonectomy (includes parietal pleura, pericardium and/or chest wall (with diaphragm) plus lymph nodes)

SITE SPECIFIC SURGERY (cont'd)

SITE: Lung and Bronchus (162.2-162.9) (cont'd)

OLD	DEFINITION	NEW	DEFINITION
8	80 Surgery of regional and/or distant site(s)/nodes ONLY (incl. removal of mediastinal mass ONLY)	80	Surgery of regional and/or distant site(s)/node(s) ONLY (includes removal of mediastinal mass ONLY)
9	Resection of lung, NOS; surgery, NOS	90	Resection of lung, NOS; surgery, NOS

SITE SPECIFIC SURGERY (cont'd)

SITE: Melanoma of Skin (173.0-173.9, histologies 8720-8790)

OLD DEFINITION		NEW DEFINITION	
1	Local tumor destruction (cryosurgery, fulguration, electrocauterization, laser surgery (vaporized--no path specimen))	10	Local cancer destruction WITHOUT pathology specimen (includes laser surgery, cryosurgery, fulguration, or electrocauterization)
2	Excisional biopsy, local excision, wedge resection, simple excision, laser surgery (with path specimen); excision, NOS	20	Simple excision/excisional biopsy; local surgical excision; wedge resection; laser surgery WITH pathology specimen; excision, NOS
3	Shave/punch biopsy followed by excision of lesion (not a wide excision)	30	Shave/punch biopsy/biopsy, NOS followed by excision of lesion (not a wide excision)
Not specified individually prior to 1988		40	Wide/re-excision or minor (local) amputation (includes digits, ear, eyelid, lip, nose) WITHOUT lymph node dissection
		45	Radical excision WITHOUT lymph node dissection
4	Wide/radical excision/re-excision or minor (local) amputation (incl. digits, ear, eyelid, lip, nose)	49	Wide/radical excision/re-excision or minor (local) amputation (incl. digits, ear, eyelid, lip, nose) (Used for cases diagnosed 1983-87 ONLY)
5	1-4 WITH dissection of lymph nodes	50	Codes 10-45 WITH lymph node dissection
6	Amputation (other than in code 4) WITHOUT dissection of lymph nodes, amputation, NOS	60	Amputation (other than code 40) WITHOUT lymph node dissection; amputation, NOS
7	Amputation (other than in code 4) WITH dissection of lymph nodes	70	Amputation (other that code 40) WITH lymph node dissection

SITE SPECIFIC SURGERY (cont'd)

SITE: Melanoma of Skin (173.0-173.9, histologies 8720-8790) (cont'd)

OLD	DEFINITION	NEW	DEFINITION
8	Surgery of regional and/or distant site(s)/nodes ONLY	80	Surgery of regional and/or distant site(s)/node(s) ONLY
9	Surgery, NOS	90	Surgery, NOS

SITE SPECIFIC SURGERY (cont'd)

SITE: Breast (174.0-174.9, 175.9)

OLD	DEFINITION	NEW	DEFINITION
1	Partial/less than total mastectomy (incl. segmental mastectomy, lumpectomy, quadrantectomy, tylectomy, wedge resection, nipple resection, excisional biopsy, or partial mastectomy, NOS) WITHOUT dissection of axillary lymph nodes	10	Partial/less than total mastectomy (includes segmental mastectomy, lumpectomy, quadrantectomy, tylectomy, wedge resection, nipple resection, excisional biopsy, or partial mastectomy, NOS) WITHOUT dissection of axillary lymph nodes
2	Code 1 WITH dissection of axillary lymph nodes	20	Partial/less than total mastectomy WITH dissection of axillary lymph nodes
3	Subcutaneous mastectomy WITH/WITHOUT dissection of axillary lymph nodes	30	Subcutaneous mastectomy WITH/WITHOUT dissection of axillary nodes
4	Total (simple) mastectomy (breast only) WITHOUT dissection of axillary lymph nodes	40	Total (simple) mastectomy (breast only) WITHOUT dissection of axillary lymph nodes
5	Total (simple)/modified radical mastectomy (may include portion of pectoralis major) WITH dissection of axillary lymph nodes	50	Modified radical/total (simple) mastectomy (may include portion of pectoralis major) WITHOUT dissection of axillary lymph nodes
6	Radical mastectomy WITH dissection of all of pectoralis major WITH dissection of axillary lymph nodes	60	Radical mastectomy WITH dissection of majority of pectoralis major WITH dissection of axillary lymph nodes
7	Extended radical mastectomy (code 6 + internal mammary node dissection; may include chest wall and ribs)	70	Extended radical mastectomy (code 60 PLUS internal mammary node dissection; may include chest wall and ribs)

SITE SPECIFIC SURGERY (cont'd)

SITE: Breast (174.0-174.9, 175.9) (cont'd)

OLD	DEFINITION	NEW	DEFINITION
8	Surgery of regional and/or distant site(s)/nodes ONLY	80	Surgery of regional and/or distant site(s)/node(s) ONLY
9	Mastectomy, NOS; Surgery, NOS	90	Mastectomy, NOS; Surgery, NOS

SITE SPECIFIC SURGERY (cont'd)

SITE: Cervix uteri (180.0-180.9)

OLD DEFINITION	NEW DEFINITION
Not specified individually prior to 1988	10 Cryosurgery; laser surgery WITHOUT pathology specimen
	15 Dilatation and curettage (in situ ONLY); endocervical curettage (in situ ONLY)
1 Cryosurgery, laser surgery (vaporized--no path specimen): for cervix D & C (in situ ONLY), polypectomy, myomectomy, simple excision: corpus	19 Cryosurgery, laser surgery (vaporized--no path specimen); D & C (in situ ONLY) (Used for cases diagnosed 1983-87 ONLY)
Not specified individually prior to 1988	20 Local surgical excision; excisional biopsy; trachelectomy; amputation of cervix or cervical stump; laser surgery WITH pathology specimen; conization
2 Local excision and/or conization, excisional biopsy, trachelectomy, amputation of cervix, laser (with path specimen), endocervical curettage (in situ only): cervix uteri Subtotal hysterectomy, supracervical hysterectomy, fundectomy (cervix left in place with/without removal of tubes and ovaries): corpus uteri	29 Local excision and/or conization, excisional biopsy, trachelectomy, amputation of cervix, laser (with path specimen), endocervical curettage (in situ only) (Used for cases diagnosed 1983-87 ONLY)
3 Total/simple hysterectomy (incl. both corpus and cervix uteri) WITHOUT removal of tubes and ovaries WITHOUT dissection of lymph nodes	30 Total/pan/simple hysterectomy (includes both corpus and cervix uteri) WITHOUT removal of tubes and ovaries WITHOUT dissection of lymph nodes

SITE SPECIFIC SURGERY (cont'd)

SITE: Cervix uteri (180.0-180.9) (cont'd)

OLD	DEFINITION	NEW	DEFINITION
4	Total/simple/pan-hysterectomy WITH removal of tube(s) and ovary(ies) WITHOUT dissection of lymph nodes	40	Total/pan/simple hysterectomy WITH removal of tube(s) and ovary(ies) WITHOUT dissection of lymph nodes
5	Modified radical/extended hysterectomy (incl. uterus, tubes and ovaries, and (upper) vaginal cuff and para-aortic/pelvic nodes) Radical hysterectomy (incl. uterus, tubes and ovaries, vagina, and all parametrial and paravaginal tissue and para-aortic and pelvic lymph nodes) Wertheim's operation	50	Modified radical/extended hysterectomy (includes uterus, tube(s), ovary(ies), and para-aortic and pelvic lymph nodes and may include vaginal cuff); radical hysterectomy (includes uterus, tube(s), ovary(ies), vagina, all parametrial and paravaginal tissue, and para-aortic and pelvic lymph nodes); Wertheim's operation
6	Hysterectomy, NOS (abdominal or vaginal)	60	Hysterectomy, NOS
7	Pelvic Exenteration (partial or total) Anterior exenteration (incl. bladder, distal ureters, genital organs with their ligamentous attachments and pelvic lymph nodes) Posterior exenteration (incl. rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes) Total exenteration: all pelvic contents and pelvic lymph nodes Extended exenteration: incl. pelvic blood vessels/bony pelvis	70	Pelvic Exenteration (partial or total) Anterior exenteration (includes bladder, distal ureters, and genital organs with their ligamentous attachments and pelvic lymph nodes) Posterior exenteration (includes rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes) Total exenteration (includes removal of all pelvic contents and pelvic lymph nodes) Extended exenteration (includes pelvic blood vessels or bony pelvis)

SITE SPECIFIC SURGERY (cont'd)

SITE: Cervix uteri (180.0-180.9) (cont'd)

OLD	DEFINITION	NEW	DEFINITION
8	Surgery of regional and/or distant site(s)/nodes ONLY	80	Surgery of regional and/or distant site(s)/node(s) ONLY
9	Surgery, NOS	90	Surgery, NOS

SITE SPECIFIC SURGERY (cont'd)

SITE: Corpus uteri (182.0-182.8)

OLD	DEFINITION	NEW	DEFINITION
1	Cryosurgery, laser surgery (vaporized--no path specimen): for cervix D & C (in situ ONLY), polypectomy, myomectomy, simple excision: corpus	10	Polypectomy, myomectomy (simple excision); simple excision, NOS
2	Local excision and/or conization, excisional biopsy, trachelectomy, amputation of cervix, laser (with path specimen), endocervical curettage (in situ only): cervix uteri Subtotal hysterectomy, supracervical hysterectomy, fundectomy (cervix left in place with/without removal of tubes and ovaries): corpus uteri	20	Subtotal hysterectomy; supracervical hysterectomy; fundectomy (cervix left in place WITH/WITHOUT removal of tubes and ovaries)
3	Total/simple hysterectomy (incl. both corpus and cervix uteri) WITHOUT removal of tubes and ovaries WITHOUT dissection of lymph nodes	30	Total/pan/simple hysterectomy (includes both corpus and cervix uteri) WITHOUT removal of tubes and ovaries WITHOUT dissection of lymph nodes
4	Total/simple/pan-hysterectomy WITH removal of tube(s) and ovary(ies) WITHOUT dissection of lymph nodes	40	Total/pan/simple hysterectomy WITH removal of tube(s) and ovary(ies) WITHOUT dissection of lymph nodes

SITE SPECIFIC SURGERY (cont'd)

SITE: Corpus uteri (182.0-182.8) (cont'd)

OLD	DEFINITION	NEW	DEFINITION
5	Modified radical/extended hysterectomy (incl. uterus, tubes and ovaries, and (upper) vaginal cuff and para-aortic/pelvic nodes) Radical hysterectomy (incl. uterus, tubes and ovaries, vagina, and all parametrial and paravaginal tissue and para-aortic and pelvic lymph nodes) Wertheim's operation	50	Modified radical/extended hysterectomy (includes uterus, tube(s), ovary(ies), and para-aortic and pelvic lymph nodes and may include vaginal cuff); radical hysterectomy (includes uterus, tube(s), ovary(ies), vagina, all parametrial and paravaginal tissue, and para-aortic and pelvic lymph nodes); Wertheim's operation
6	Hysterectomy, NOS (abdominal or vaginal)	60	Hysterectomy, NOS
7	Pelvic Exenteration (partial or total) Anterior exenteration (incl. bladder, distal ureters, genital organs with their ligamentous attachments and pelvic lymph nodes) Posterior exenteration (incl. rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes) Total exenteration: all pelvic contents and pelvic lymph nodes Extended exenteration: incl. pelvic blood vessels/bony pelvis	70	Pelvic Exenteration (partial or total) Anterior exenteration (includes bladder, distal ureters, and genital organs with their ligamentous attachments and pelvic lymph nodes) Posterior exenteration (includes rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes) Total exenteration (includes removal of all pelvic contents and pelvic lymph nodes) Extended exenteration (includes pelvic blood vessels or bony pelvis)
8	Surgery of regional and/or distant site(s)/nodes ONLY	80	Surgery of regional and/or distant site(s)/node(s) ONLY
9	Surgery, NOS	90	Surgery, NOS

SITE SPECIFIC SURGERY (cont'd)

SITE: Ovary (183.0)

OLD DEFINITION		NEW DEFINITION	
1	Subtotal/partial or unilateral (salpingo)-oophorectomy; wedge resection WITHOUT hysterectomy	10	Subtotal/partial or unilateral (salpingo)-oophorectomy; wedge resection WITHOUT hysterectomy
2	Subtotal/partial or unilateral (salpingo)-oophorectomy; WITH hysterectomy	20	Subtotal/partial or unilateral (salpingo)-oophorectomy WITH hysterectomy
3	Bilateral (salpingo)-oophorectomy - WITHOUT hysterectomy; (Salpingo)-oophorectomy, NOS	30	Bilateral (salpingo)-oophorectomy WITHOUT hysterectomy; (salpingo)-oophorectomy, NOS
4	Bilateral (salpingo)-oophorectomy WITH hysterectomy	40	Bilateral (salpingo)-oophorectomy WITH hysterectomy
5	Omentectomy (partial, total, or NOS) with uni-/bi-lateral (salpingo)-oophorectomy with or without hysterectomy	50	Omentectomy (partial, total, or NOS) with unilateral or bilateral (salpingo)-oophorectomy, unknown if hysterectomy done
Not separated individually prior to 1988		51	Omentectomy (partial, total, or NOS) with unilateral or bilateral (salpingo)-oophorectomy, WITHOUT hysterectomy
		52	Omentectomy (partial, total, or NOS) with unilateral or bilateral (salpingo)-oophorectomy, WITH hysterectomy

SITE SPECIFIC SURGERY (cont'd)

SITE: Ovary (183.0) (cont'd)

OLD	DEFINITION	NEW	DEFINITION
6	Debulking of ovarian tumor mass (may include ovarian tissue)	60	Debulking of ovarian cancer mass (may include ovarian tissue)
7	Pelvic Exenteration (partial or total) Anterior exenteration (incl. bladder, distal ureters, genital organs with their ligamentous attachments and pelvic lymph nodes) Posterior exenteration (incl. rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes) Total exenteration: all pelvic contents and pelvic lymph nodes Extended exenteration: includes pelvic blood vessels or bony pelvis.	70	Pelvic Exenteration (partial or total) Anterior exenteration (includes bladder, distal ureters, genital organs with their ligamentous attachments and pelvic lymph nodes) Posterior exenteration (includes rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes) Total exenteration (includes removal of all pelvic contents and pelvic lymph nodes) Extended exenteration
8	Surgery of regional and/or distant site(s)/nodes ONLY	80	Surgery of regional and/or distant site(s)/node(s) ONLY
9	Surgery, NOS	90	Surgery, NOS

SITE SPECIFIC SURGERY (cont'd)

SITE: Prostate (185.9)

OLD	DEFINITION	NEW	DEFINITION
1	Cryoprostatectomy Transurethral resection, local excision of lesion WITHOUT lymph node dissection	10	Transurethral resection of prostate (TURP); cryoprostatectomy; local surgical excision of lesion WITHOUT lymph node dissection
2	Code 1 WITH dissecti lymph nodes	20	Transurethral resection of prostate (TURP); cryoprostatectomy; local surgical excision of lesion WITH lymph node dissection
3	Subtotal/simple prostatectomy (segmental resection or enucleation leaving capsule intact) WITHOUT dissection of lymph nodes	30	Subtotal/simple prostatectomy (segmental resection or enucleation leaving capsule intact) WITHOUT dissection of lymph nodes
4	Subtotal/simple prostatectomy (segmental resection or enucleation) WITH dissection of lymph nodes	40	Subtotal/simple prostatectomy (segmental resection or enucleation) WITH dissection of lymph nodes
5	Radical/total prostatectomy (excised prostate with capsule, ejaculatory ducts (ductus deferens), and seminal vesicles) WITHOUT dissection of lymph nodes	50	Radical/total prostatectomy (excised prostate, ejaculatory ducts (ductus deferens), and seminal vesicles) WITHOUT dissection of lymph nodes
6	Radical/total prostatectomy (excised prostate, ejaculatory ducts (ductus deferens), and seminal vesicles) WITH dissection of lymph nodes	60	Radical/total prostatectomy (excised prostate, ejaculatory ducts (ductus deferens), and seminal vesicles) WITH dissection of lymph nodes
7	Cystoprostatectomy, radical cystectomy, pelvic exenteration WITH or WITHOUT dissection of lymph nodes	70	Cystoprostatectomy, radical cystectomy, pelvic exenteration WITH/WITHOUT dissection of lymph nodes

SITE SPECIFIC SURGERY (cont'd)

SITE: Prostate (185.9) (cont'd)

OLD	DEFINITION	NEW	DEFINITION
8	Surgery of regional and/or distant site(s)/nodes ONLY	80	Surgery of regional and/or distant site(s)/node(s) ONLY
9	Prostatectomy, NOS; Surgery, NOS	90	Prostatectomy, NOS; Surgery, NOS

SITE SPECIFIC SURGERY (cont'd)

SITE: Bladder (188.0-188.9)

OLD	DEFINITION	NEW	DEFINITION
1	Local transurethral destruction (electrocoagulation, fulguration, cryosurgery), transurethral resection; excisional biopsy	10	Transurethral resection of bladder (TURB); local destruction (electrocoagulation, fulguration, cryosurgery); excisional biopsy
2	Partial/subtotal cystectomy (incl. segmental resection) WITHOUT dissection of pelvic lymph nodes	20	Partial/subtotal cystectomy (includes segmental resection) WITHOUT dissection of pelvic lymph nodes
3	Partial/subtotal cystectomy (incl. segmental resection) WITH dissection of pelvic lymph nodes	30	Partial/subtotal cystectomy (includes segmental resection) WITH dissection of pelvic lymph nodes
4	Complete/total/simple cystectomy WITHOUT dissection of lymph nodes	40	Complete/total/simple cystectomy WITHOUT dissection of lymph nodes

SITE SPECIFIC SURGERY (cont'd)

SITE: Bladder (188.0-188.9) (cont'd)

OLD	DEFINITION	NEW	DEFINITION
5	Complete/total/simple cystectomy WITH dissection of lymph nodes	50	Complete/total/simple cystectomy WITH dissection of lymph nodes
6	Cystectomy, NOS	60	Cystectomy, NOS
7	Radical cystectomy (removal of bladder, prostate, seminal vesicles and surrounding perivesical tissues and distal ureters in men; removal of bladder, uterus, ovaries, fallopian tubes and surrounding peritoneum and sometimes urethra and vaginal wall in women) Pelvic Exenteration (partial, total, or extended) Anterior exenteration (incl. bladder, distal ureters, genital organs with their ligamentous attachments and pelvic lymph nodes) Posterior exenteration (incl. rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes) Total exenteration: all pelvic contents and pelvic lymph nodes Extended exenteration: includes pelvic blood vessels or bony pelvis.	70	Radical cystectomy (in men: removal of bladder, prostate, seminal vesicles, surrounding perivesical tissues and distal ureters; in women: removal of bladder, uterus, ovaries, fallopian tubes, surrounding peritoneum, and sometimes urethra and vaginal wall) Pelvic Exenteration (partial, total or extended) Anterior exenteration (includes bladder, distal ureters, genital organs with their ligamentous attachments and pelvic lymph nodes) Posterior exenteration (includes rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes) Total exenteration (includes removal of all pelvic contents and pelvic lymph nodes) Extended exenteration (includes pelvic blood vessels or bony pelvis)
8	Surgery of regional and/or distant site(s)/nodes ONLY	80	Surgery of regional and/or distant site(s)/node(s) ONLY
9	Surgery, NOS	90	Surgery, NOS

SITE SPECIFIC SURGERY (cont'd)

SITE: Kidney, Renal pelvis, Ureter (189.0-189.2)

OLD	DEFINITION	NEW	DEFINITION
1	Partial/subtotal nephrectomy (incl. local excision, wedge resection, and segmental resection) Partial ureterectomy	10	Partial/subtotal nephrectomy (includes local excision, wedge resection, and segmental resection); Partial ureterectomy
2	Complete/total nephrectomy--for kidney parenchyma Nephroureterectomy (incl. bladder cuff)--for renal pelvis and ureter WITHOUT dissection of lymph nodes	20	Complete/total/simple nephrectomy -- for kidney parenchyma Nephroureterectomy (includes bladder cuff) -- for renal pelvis or ureter WITHOUT dissection of lymph nodes
3	Complete/total nephrectomy--for kidney parenchyma Nephroureterectomy (incl. bladder cuff)--for renal pelvis and ureter WITH dissection of lymph nodes	30	Complete/total/simple nephrectomy -- for kidney parenchyma Nephroureterectomy (includes bladder cuff) -- for renal pelvis or ureter WITH dissection of lymph nodes
4	Radical nephrectomy (incl. removal of vena cava or adrenal gland(s), or Gerota's fascia, perinephric fat, partial ureter) WITHOUT dissection of lymph nodes	40	Radical nephrectomy (includes removal of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial ureter) WITHOUT dissection of lymph nodes
5	Radical nephrectomy (incl. removal of vena cava or adrenal gland(s) or Gerota's fascia, perinephric fat, partial ureter) WITH dissection of lymph nodes	50	Radical nephrectomy (includes removal of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial ureter) WITH dissection of lymph nodes
6	Nephrectomy, NOS Ureterectomy, NOS	60	Nephrectomy, NOS Ureterectomy, NOS
7	2-6 PLUS other organs (e.g., bladder, colon)	70	Codes 20-60 PLUS other organs (e.g., bladder, colon)

SITE SPECIFIC SURGERY (cont'd)

SITE: Kidney, renal pelvis, and ureter (189.0-189.2) (cont'd)

OLD	DEFINITION	NEW	DEFINITION
8	Surgery of regional and/or distant site(s)/nodes ONLY	80	Surgery of regional and/or distant site(s)/node(s) ONLY
9	Surgery, NOS	90	Surgery, NOS

SITE SPECIFIC SURGERY (cont'd)

For all cases diagnosed prior to 1988:

1. Non-cancer-directed surgery is not to be coded separately. Thus, the following Site-specific Surgery codes are not to be used:

   00 No surgical procedure
   01 Incisional or needle biopsy of other than primary site
   02 Incisional or needle biopsy of primary site
   03 Exploratory ONLY (no biopsy)
   04 Bypass surgery, -ostomy ONLY (no biopsy)
   05 Exploratory ONLY AND incisional or needle biopsy of primary site or other sites
   06 Bypass surgery, -ostomy ONLY AND incisional or needle biopsy of primary site or other sites
   07 Non-cancer directed surgery, NOS

   All cases having no cancer-directed surgery are to be coded as unknown if surgery done '09'.

2. No reconstructive surgery of the primary site is to be coded separately. Thus no Site-specific Surgery code terminating in a last digit of 8 may be used.

   The surgery information for any case receiving reconstructive surgery of the primary site is to be coded as though no reconstructive surgery was performed.

For all cases diagnosed 1973-82:

All cancer-directed surgery is to be coded as surgery, NOS '90'.

SITE SPECIFIC SURGERY (cont'd)

For cases diagnosed 1983-87:

1. For melanomas of the skin, the following codes are not to be used:
   - 40 Wide/re-excision or minor (local) amputation (includes digits, ear, eyelid, lip, nose) WITHOUT lymph node dissection
   - 45 Radical excision WITHOUT lymph node dissection

   Cases for which the above surgical procedures are performed are to be coded as:
   - 49 Wide/radical excision/re-excision or minor (local) amputation (incl. digits, ear, eyelid, lip, nose)

2. For cervix uteri cases, the following codes are not to be used:
   - 10 Cryosurgery; laser surgery WITHOUT pathology specimen
   - 15 Dilatation and curettage (in situ ONLY); endocervical curettage (in situ ONLY)
   - 20 Local surgical excision; excisional biopsy; trachelectomy; amputation of cervix, laser (with path specimen), endocervical curettage (in situ only)

   Cases for which the above surgical procedures are performed are to be coded using:
   - 19 Cryosurgery, laser surgery (vaporized--no path specimen); D & C (in situ ONLY)
   - 29 Local excision and/or conization, excisional biopsy, trachelectomy, amputation of cervix, laser (with path specimen), endocervical curettage (in situ only)

3. For ovary cases, the following codes are not to be used:
   - 51 Omentectomy (partial, total, or NOS) with unilateral or bilateral (salpingo)-oophorectomy, WITHOUT hysterectomy
   - 52 Omentectomy (partial, total, or NOS) with unilateral or bilateral (salpingo)-oophorectomy, WITH hysterectomy

   Cases for which the above surgical procedures are performed are to be coded as:
   - 50 Omentectomy (partial, total, or NOS) with unilateral or bilateral (salpingo)-oophorectomy, unknown if hysterectomy done

SITE SPECIFIC SURGERY (cont'd)

For cases diagnosed 1983-87 (cont'd):

4. All cancer-directed surgery is to be coded surgery, NOS '90' for any case with a site other than the following:
   - Stomach (151.0-151.9)
   - Colon (excluding rectosigmoid, rectum) (153.0-153.9)
   - Rectosigmoid, rectum (154.1-154.2)
   - Lung and Bronchus (162.2-162.9)
   - Melanoma of Skin (173.0-173.9; histology 8720-8790)
   - Breast (174.0-174.9, 175.9)
   - Cervix uteri (180.0-180.9)
   - Corpus uteri (182.0-182.8)
   - Ovary (183.0)
   - Prostate (185.9)
   - Bladder (188.0-188.9)
   - Kidney, renal pelvis, and ureter (189.0-189.2)

For cases diagnosed 1988+:

1. For melanomas of the skin, the following site-specific surgery code is not to be used:
   - 49 Wide/radical excision/re-excision or minor (local) amputation (incl. digits, ear, eyelid, lip, nose)

2. For cervix uteri cases, the following site-specific surgery codes are not to be used:
   - 19 Cryosurgery, laser surgery (vaporized--no path specimen); D & C (in situ ONLY)
   - 29 Local excision and/or conization, excisional biopsy, trachelectomy, amputation of cervix, laser (with path specimen), endocervical curettage (in situ only)

SURGERY/REASON NO CANCER-DIRECTED SURGERY

Surgery OLD DEFINITION		Reason No Cancer-Directed Surgery NEW DEFINITION	
Not specified individually prior to 1988		1	Cancer-directed surgery not recommended
		2	Contraindicated due to other conditions; Autopsy Only case
0	None	6	Unknown reason for no cancer-directed surgery
1	Given	0	Cancer-directed surgery performed
Not specified individually prior to 1988		7	Patient of patient's guardian refused
8	Recommended, unknown if done	8	Recommended, unknown if done
9	Unknown	9	Unknown if cancer-directed surgery performed; Death Certificate Only case

For all cases diagnosed 1973-87:
The following Reason for No Cancer-directed Surgery codes are not to be used:

1 Cancer-directed surgery not recommended
7 Patient or patient's guardian refused

For Autopsy Only cases, the following Reason for No Cancer-directed Surgery code is to be used:

2 Contraindicated due to other conditions; Autopsy Only case

This code is NOT to be used for any other cases diagnosed before 1988.

All cases known to have had no cancer-directed surgery are to be coded as unknown reason for no cancer-directed surgery '6'.

APPENDIX D
CODING EXCEPTIONS FOR PRE-1988 CASES

RADIATION

OLD DEFINITION		NEW DEFINITION	
0	No radiation	0	No radiation
1	Beam radiation	1	Beam radiation
2	Other radiation	6	Other radiation (Used for cases diagnosed 1973-87 ONLY)
	Not specified individually prior to 1988	2	Radioactive implants
		3	Radioisotopes
3	Combination of 1 and 2	4	Combination of 1 with 2 or 3
7	Radiation, NOS--method or source not specified	5	Radiation, NOS -- method or source not specified
	Not specified individually prior to 1988	7	Patient or patient's guardian refused
8	Radiation recommended, unknown if performed	8	Radiation recommended, unknown if performed
9	Unknown	9	Unknown

For cases diagnosed prior to 1988:
The following Radiation codes are not to be used:

2 Radioactive implants
3 Radioisotopes
7 Patient or patient's guardian refused

All cases treated using radioactive implants or radioisotopes are to be coded as other radiation '6'.

Cases for which radiation was refused by either the patient or the patient's guardian are to be coded as none '0'.

RADIATION TO THE BRAIN AND CENTRAL NERVOUS SYSTEM

All cases diagnosed before 1988 are to be coded unknown or not applicable '9'. This rule applies to Autopsy Only cases as well.

APPENDIX D
CODING EXCEPTIONS FOR PRE-1988 CASES

RADIATION SEQUENCE WITH SURGERY

OLD DEFINITION	NEW DEFINITION
0 No radiation and/or cancer-directed surgery	0 No radiation and/or cancer-directed surgery
2 Radiation before surgery	2 Radiation before surgery
3 Radiation after surgery	3 Radiation after surgery
4 Radiation both before and after surgery	4 Radiation both before and after surgery
Not specified individually prior to 1988	5 Intraoperative radiation 6 Intraoperative radiation with other radiation given before or after surgery
9 Sequence unknown, but both surgery and radiation were given	9 Sequence unknown, but both surgery and radiation were given

For cases diagnosed prior to 1988:

The following Radiation/Sequence with Surgery codes are not to be used:

- 5 intraoperative radiation
- 6 intraoperative radiation with other radiation given before or after surgery

Cases receiving intraoperative radiation are to be coded to sequence unknown, but both surgery and radiation were given '9'.

APPENDIX D
CODING EXCEPTIONS FOR PRE-1988 CASES

CHEMOTHERAPY

OLD DEFINITION		NEW DEFINITION	
0	None	0	None
1	Chemotherapy	1	Chemotherapy, NOS
Not specified individually prior to 1988		2	Chemotherapy, single agent
		3	Chemotherapy, multiple agents (combination regimen)
		7	Patient or patient's guardian refused chemotherapy
8	Chemotherapy recommended, unknown if performed	8	Chemotherapy recommended, unknown if performed
9	Unknown	9	Unknown

For cases diagnosed prior to 1988:

The following Chemotherapy codes are not to used:

- 2 chemotherapy, single agent
- 3 chemotherapy, multiple agents (combination regimen)
- 7 patient or patient's guardian refused chemotherapy

All cases treated with chemotherapy (either single or multiple agent regimens) are to be coded as chemotherapy, NOS '1'.

Cases for which chemotherapy was refused by either the patient or the patient's guardian are to be coded as none '0'.

APPENDIX D
CODING EXCEPTIONS FOR PRE-1988 CASES

ENDOCRINE (HORMONE/STEROID) THERAPY

OLD	DEFINITION	NEW	DEFINITION
0	No endocrine therapy	0	No endocrine therapy
1	Hormones (including NOS and antihormones)	1	Hormones (including NOS and antihormones)
2	Endocrine surgery (if cancer is of another site)	2	Endocrine surgery and/or radiation (if cancer is of another site)
3	Combination of 1 and 2	3	Combination of 1 and 2
4	Endocrine radiation (if cancer is of another site)	2	Endocrine surgery and/or radiation (if cancer is of another site)
5	Combination of 1 and 4	3	Combination of 1 and 2
6	Combination of 2 and 4	2	Endocrine surgery and/or radiation (if cancer is of another site)
7	Combination of 1 and 2 and 4	3	Combination of 1 and 2
	Not specified individually prior to 1988	7	Patient or patient's guardian refused hormonal therapy
8	Hormonal therapy recommended, unknown if administered	8	Hormonal therapy recommended, unknown if administered
9	Unknown	9	Unknown

For cases diagnosed prior to 1988:

The following Endocrine (Hormone/Steroid) Therapy code is not to used:

7 patient or patient's guardian refused hormonal therapy

Cases for which endocrine therapy was refused by either the patient or the patient's guardian are to be coded as none '0'.

APPENDIX D
CODING EXCEPTIONS FOR PRE-1988 CASES

BIOLOGICAL RESPONSE MODIFIERS

OLD DEFINITION		NEW DEFINITION	
0	None	0	None
1	Biological response modifier	1	Biological response modifier
	Not specified individually prior to 1988	7	Patient or patient's guardian refused biological response modifier
8	Biological response modifier recommended, unknown if administered	8	Biological response modifier recommended, unknown if administered
9	Unknown	9	Unknown

For cases diagnosed prior to 1988:

The following Biological response Modifier code is not to used:

7 patient or patient's guardian refused biological response modifier

Cases for which biological response modifier was refused by either the patient or the patient's guardian are to be coded as none '0'.

OTHER CANCER-DIRECTED THERAPY

OLD	DEFINITION	NEW	DEFINITION
0	None	0	None
1	Other cancer-directed therapy (including dermoplaning, hyperbaric oxygen as adjunct, etc.)	1	Other cancer-directed therapy
2	Other experimental cancer-directed therapy (not included elsewhere)	2	Other experimental cancer-directed therapy (not included elsewhere)
3	Double-blind study, code not yet broken	3	Double-blind clinical trial, code not yet broken
7	Unproven cancer-directed therapy	6	Unproven cancer-directed therapy
	Not specified individually prior to 1988	7	Patient or patient's guardian refused therapy which would have been coded 1-3 above
8	Other cancer-directed therapy recommended, unknown if performed	8	Other cancer-directed therapy recommended, unknown if performed
9	Unknown	9	Unknown

For cases diagnosed prior to 1988:

The following Other Cancer-directed Therapy code is not to used:

7 patient or patient's guardian refused therapy that would have been coded 1-3 above

Cases for which other cancer-directed therapy was refused by either the patient or the patient's guardian are to be coded as none '0'.

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