

SEER Program Coding and Staging Manual 2027

Effective with Cases Diagnosed January 1, 2027, and Forward

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Preface to the 2027 SEER Program Coding and Staging Manual

The *2027 Surveillance, Epidemiology and End Results (SEER) Program Coding and Staging Manual* may be downloaded in electronic format from the SEER website: <http://www.seer.cancer.gov/tools/codingmanuals>.

Effective Date

The *2027 SEER Program Coding and Staging Manual* is effective for cases diagnosed January 1, 2027, and forward. Previous editions of this manual are available on the [SEER website](#).

Summary of Changes

The major changes and additions to the *2027 SEER Program Coding and Staging Manual* include

2027 Changes

Reportability:

Appendix E.3, Examples of Reportable and Non-reportable Intraepithelial Neoplasia, Dysplasia, and Hyperplasia Terms, created; terms from the Reportable Diagnosis List removed

Determining reportability using imaging reports section added

Instructions for Reporting Pediatric Cancers added

Cancer PathCHART Site-Morphology Combination Standards updated

Data Items added to manual

Section II: Information Source

Class of Case

Section III: Demographic Information

Geocode Address at Diagnosis--Number and Street

Geocode Address at Diagnosis--City

Geocode Address at Diagnosis--State

Geocode Address at Diagnosis--Postal Code

Section VIII: Follow Up Information

Cancer Status Following First Course of Treatment

Date of Cancer Status Following First Course of Treatment

Section IX: Administrative Codes

Over-ride Flag for Sex Assigned at Birth

Data Items deleted from manual

Section VI: Stage-related Data Items/Site-specific Data Items (SSDIs)

SSDI tables deleted

Section VII: First Course of Therapy

Neoadjuvant Therapy

Neoadjuvant Therapy--Clinical

Neoadjuvant Therapy--Treatment Effect

Codes and/or Description added/modified

- NAACCR Record Version
- Date of Diagnosis
- Laterality
- Behavior Code
- Diagnostic Confirmation
- Tumor Size Summary
- Sentinel Lymph Nodes Examined
- Regional Nodes Examined
- Hematologic Transplant and Endocrine Procedures
- Disease Follow-up or First Recurrence/Progression (name modified)
- Disease Follow-up or First Recurrence/Progression Date (name modified)

Appendices new/modified/deleted

- Appendix A County Codes (references updated)

- Appendix B Country and State Codes

- Appendix C Coding Guidelines

- Colon
- Esophagus
- Thyroid
- Tongue

- Appendix C Neoadjuvant Therapy--Treatment Effect

- All site-specific documents deleted from manual; moved to SSDI Manual

- Appendix C Surgery Codes

- Brain
- Ovary
- Skin

- Appendix D Race and Nationality Descriptions

- Appendix E

- Appendix E.1 Reportable Examples
- Appendix E.2 Non-Reportable Examples
- Appendix E.3 Examples of Reportable and Non-reportable Intraepithelial Neoplasia, Dysplasia, and Hyperplasia Terms (new)

For a more detailed listing of changes to the *2027 SEER Program Coding and Staging Manual*, including updates to coding instructions, refer to the [Summary of Changes](#) document.

2027 Updates

In addition to the changes to the *2027 SEER Program Coding and Staging Manual*, updates related to cancer coding and staging for 2027 include

[Cancer PathCHART ICD-O-3 Site Morphology Validation List \(CPC*SMVL\) and Search \(CPC*Search\) Grade Manual](#)
[ICD-O-3.2 and ICD-O-3 Coding Updates](#)
[NAACCR 2027 Implementation Guidelines and Recommendations](#)
[NAACCR Version 27](#)

[Pediatric Data Collection System and Staging Manual](#)
[SEER Extent of Disease \(EOD\) \(includes updates to SEER*RSA\)](#)
[SEER Hematopoietic and Lymphoid Manual and Database](#)
[SEER Solid Tumor Rules](#)
[Site-Specific Data Items \(SSDI\) Manual](#)
[Summary Stage 2018](#)

Submitting Questions

Submit technical questions, suggestions, and revisions related to this manual to [Ask A SEER Registrar](#) on the SEER website. An appointed staff member from each SEER core registry may also submit technical questions to NCI SEER inquiry system using the web-based [SINQ system](#). Updates to this manual identified after publication will be found in SINQ under the category of ‘Updates to current manual’ until a subsequent revision of this manual is issued. Relevant questions and answers from Ask A SEER Registrar and from the SINQ system will be incorporated into the next edition of the SEER manual.

Note: See the [American College of Surgeons Commission on Cancer CAnswer Forum](#) for questions about AJCC TNM staging, Grade, the **Site-Specific Data Items**, and **data items not required by SEER**. SEER required data items are listed in the [NAACCR Required Status Table](#).

Collection and Storage of Dates

Dates may be collected and stored in any format, including the traditional format (month, day, year [MMDDYYYY]), or the recommended date format (year, month, day [YYYYMMDD]); however, the recommended format must be used for transmission (see Transmission Instructions for Dates below). See the [NAACCR Implementation Guidelines](#) and [NAACCR website](#) for further information regarding the updated data exchange standard.

Transmission Instructions for Dates

Dates must be transmitted in the year, month, day format (YYYYMMDD). The transmission requirements are intended to follow a left-to right- transmission which ensures the minimum allowable information is listed first, allowing only valid portions of the date are transmitted; missing and unknown portions of dates are not transmitted. If there are no known date components, the date data item will be completely blank.

For example,

- YYYYMMDD – when complete date is known and valid.
- YYYYMM – when year and month are known and valid, and day is unknown.
- YYYY – when year is known/estimated, and month and day are unknown.
- Blank – when no known date applies; no spaces should be used.

Note: *Date of Diagnosis* cannot be entirely blank. See the specific coding instructions for each date data item.

Most SEER registries collect the month, day, and year. When the full date (YYYYMMDD) is transmitted for *Date of Diagnosis* and/or *Date of Last Follow-Up or of Death*, the seventh and eighth digits will be held confidentially and only used for survival calculations when received by NCI SEER.

SEER Site-Specific Factors 1 – 6

Six data items have been set aside as place holders. Five of these data items are not in use and must be left blank. SEER Site-Specific Factor 1 is reserved for capturing information on human papilloma virus (HPV) status. See the [SSDI Manual, Appendix A](#) for *SEER Site-Specific Factor 1* coding instructions.

NAACCR Item #	Item Name	Codes/Data Collected
3700	SEER Site-Specific Factor 1	HPV
3702	SEER Site-Specific Factor 2	Blank
3704	SEER Site-Specific Factor 3	Blank
3706	SEER Site-Specific Factor 4	Blank
3708	SEER Site-Specific Factor 5	Blank
3710	SEER Site-Specific Factor 6	Blank

Introduction

SEER Program

Two programs, the End Results Group and the Third National Cancer Survey, were predecessors of the Surveillance, Epidemiology, and End Results (SEER) Program.

SEER publishes the *2027 SEER Program Coding and Staging Manual* to provide instructions and descriptions that are detailed enough to promote consistent abstracting and coding.

SEER Coding and Staging Manual Contents

The *2027 SEER Program Coding and Staging Manual* includes data item descriptions, codes, and coding instructions for cases diagnosed January 1, 2027, and forward as reported by SEER registries. For all cases diagnosed on or after January 1, 2027, the instructions and codes in this manual take precedence over all previous instructions and codes. Updates to this manual identified after publication will be found in SINC under the category of ‘Updates to current manual’ until a subsequent revision of this manual is issued.

The *2027 SEER Program Coding and Staging Manual* explains the format and the definitions of the [data items required by SEER](#). Documentation and codes for historical data items can be found in earlier versions of the SEER Program Code Manual. Earlier versions are available on the [SEER website](#).

This coding manual does not prevent SEER contract registries or other registries that follow SEER rules from collecting additional data items useful for those regions.

Data items that are not required for 2027 diagnoses but were collected in years prior to 2027 must be transmitted to SEER as blanks for cases diagnosed in 2027 and subsequent years. Descriptions of historic data items, allowable codes, and coding rules can be found in historic coding manuals on the [SEER website](#).

Reportability

Dates of Diagnosis/Residency

SEER registries are required to collect data on persons who are diagnosed with cancer and who, at the time of diagnosis, are **residents** of the geographic area covered by the SEER registry. Cases diagnosed on or after January 1, **1973**, are reportable to SEER. Registries that joined the SEER Program after 1973 have different reporting start dates specified in their contracts. All cases meeting these criteria are reportable to SEER, including non-analytic cases.

Reportable Diagnosis List

Definition of Reportable: Meets the criteria for inclusion in a registry. Reportable cases are cases that the registry is required to collect and report. Reporting requirements for SEER registries are established by NCI SEER. A “Reportable List” includes all diagnoses to be reported by the registry to NCI SEER.

Refer to [Appendix E.1](#) and [Appendix E.3](#) for reportable examples and to the ICD-O-3.2 Updates for new/changed behaviors and terms.

1. Malignant Histologies (In Situ and Invasive)

- a. Report all histologies with a behavior code of /2 or /3 in the ICD-O-Third Edition, Second Revision Morphology (ICD-O-3.2), except as noted in section 1.b. below. The following are reportable diagnoses that are either new or are frequently questioned.
 - i. All gastrointestinal stromal tumors (GIST) are reportable as behavior /3 including GIST described with terms such as benign, borderline, indolent, low risk score, NOS, or behavior unknown as of 01/01/2021.
 - ii. Thymomas are reportable as a behavior /3 unless stated to be benign as of 01/01/2021.
 - iii. Post Transplant Lymphoproliferative Disorder (PTLD) 9971/1 is reportable as 9971/3 as of 01/01/2025.
 - iv. High-grade astrocytoma with piloid features (HGAP) (9421/3) as of 01/01/2023.
 - v. Lymphangioleiomyomatosis (9174/3) is reportable as of 01/01/2023; behavior changed from /1 to /3.
 - vi. Mesothelioma in situ (9050/2) is reportable as of 01/01/2023.
 - vii. Diffuse leptomeningeal glioneuronal tumor (9509/3) is reportable as of 01/01/2023.
 - viii. The following diagnoses **are reportable** (not a complete list).
 - Lobular carcinoma in situ (LCIS) of breast
 - Intraepithelial neoplasia (IEN), high grade, grade II, grade III

For a list of IEN, dysplasia, and hyperplasia examples, refer to [Appendix E.3](#).
 - ix. Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive.
 - x. Mature teratoma of the testes in adults is malignant and reportable as 9080/3.
 - xi. **Urine** cytology positive for malignancy is reportable for cases diagnosed 2013 and forward.

Exception: When a subsequent biopsy of a urinary site is negative, do not report.

- Code the primary site to C689 in the absence of any other information.
- Do not implement new/additional casefinding methods to capture these cases.

b. Do not report (Exceptions to reporting requirements):

i. **Skin** primary (C440-C449) with any of the following histologies

Malignant neoplasm (8000-8005)

Epithelial carcinoma (8010-8046)

Papillary and squamous cell carcinoma (SCC) (8050-8086)

Squamous intraepithelial neoplasia III (SIN III) (8077) of skin sites coded to C44_

Basal cell carcinoma (8090-8110)

Note 1: If the registry collects basal or squamous cell carcinoma of **skin** sites (C440-C449), sequence them in the 60-87 range and do not report to SEER.

Note 2: SCC of sites coded to C44 (for example, C442 located in the head or neck) is not reportable. Do not use AJCC staging to determine reportability. Follow cancer registry instructions for reportability.

ii. **In situ** carcinoma of **cervix** (/2), any histology, cervical intraepithelial neoplasia (CIN III), or SIN III of the cervix (C530-C539)

Note: Collection stopped effective with cases diagnosed 01/01/1996, and later. As of the 2018 data submission, cervical in situ cancer is no longer required for any diagnosis year. Sequence all cervix in situ cases in the 60-87 range regardless of diagnosis year.

iii. Adenocarcinoma in situ, HPV-associated (8483/2) (C53)

iv. Non-invasive follicular thyroid neoplasm with papillary-like nuclear features (NIFTP) (8349/1) (C739) as of 01/01/2021

Refer to [Appendix E.2](#) and [Appendix E.3](#) for non-reportable examples.

c. “Carcinomatosis” (8010/9) and “metastatic” tumor or neoplasm (8000/6) indicate malignancy and could be indicative of a reportable neoplasm. Review all of the available information to determine the origin of the carcinomatosis or the origin of the metastases.

2. Benign/Non-Malignant Histologies

a. Report **benign** and **borderline** primary **intracranial** and **central nervous system (CNS)** tumors with a behavior code of /0 or /1 in ICD-O-3 (effective with cases diagnosed 01/01/2004 to 12/31/2020) or ICD-O-3.2 (effective with cases diagnosed 01/01/2021 and later). See the table below for the specific sites.

Note 1: Benign and borderline tumors of the cranial bones (C410) are **not reportable**.

Note 2: Benign and borderline tumors of the peripheral nerves (C47_) are **not reportable**.

b. Report pilocytic astrocytoma/juvenile pilocytic astrocytoma as 9421/1 for **all** CNS sites as of 01/01/2023.

c. Report diffuse astrocytoma, MYB- or MYBL1-altered and diffuse low-grade glioma, MAPK pathway-altered (9421/1) as of 01/01/2023.

d. Report multinodular and vacuolating neuronal tumor (9509/0) as of 01/01/2023.

e. Report juvenile xanthogranuloma (9749/1) as of 01/01/2023 (C715 is the most common site).

- f. **Neoplasm and tumor** are reportable terms for intracranial and CNS because they are listed in ICD-O-3.2 with behavior codes of /0 and /1.
- i. **“Mass” and “lesion”** are **not** reportable terms for intracranial and CNS because they are **not** listed in ICD-O-3.2 with behavior codes of /0 or /1.

Table. Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors

General Term	Specific Sites	ICD-O-3 Topography Code
Meninges	Cerebral meninges	C700
	Spinal meninges	C701
	Meninges, NOS	C709
Brain	Cerebrum	C710
	Frontal lobe	C711
	Temporal lobe	C712
	Parietal lobe	C713
	Occipital lobe	C714
	Ventricle, NOS	C715
	Cerebellum, NOS	C716
	Brain stem	C717
	Overlapping lesion of brain	C718
	Brain, NOS	C719
Spinal cord, cranial nerves, and other parts of the central nervous system	Spinal cord	C720
	Cauda equina	C721
	Olfactory nerve	C722
	Optic nerve	C723
	Acoustic nerve	C724
	Cranial nerve, NOS	C725
	Overlapping lesion of brain and central nervous system	C728
	Nervous system, NOS	C729
Pituitary, craniopharyngeal duct, and pineal gland	Pituitary gland	C751
	Craniopharyngeal duct	C752
	Pineal gland	C753

Diagnosis Prior to Birth

SEER reportability requirements apply to diagnoses made in utero. Diagnoses made in utero are reportable **only when the pregnancy results in a live birth**. In the absence of documentation of stillbirth, abortion, or fetal death, assume there was a live birth and report the case.

Disease Regression

When a reportable diagnosis is confirmed prior to birth and disease is not evident at birth due to regression, accession the case based on the pre-birth diagnosis.

Reportable Examples

Refer to [Appendix E.1](#) and [Appendix E.3](#) for reportable examples.

Non-Reportable Examples

Refer to [Appendix E.2](#) and [Appendix E.3](#) for non-reportable examples.

Instructions for Reporting Solid Tumors

Reportability instructions in this manual apply to solid tumors. For hematopoietic and lymphoid neoplasms, see the Reportability Instructions in the [Hematopoietic and Lymphoid Neoplasm Coding Manual and Database](#).

Documentation of Reportable Diagnoses

A reportable diagnosis made by a recognized physician and/or advanced practice provider (PAPP) may appear on a variety of medical documentation including, but not limited to

- Pathology report
- Cytology report
- Imaging report
- Discharge diagnosis
- History and physical
- Other parts of medical record
- Death certificate
- Autopsy report

PAPP includes physician, physician assistant, nurse practitioner, and nurse midwife. For purposes of this manual, the terms “physician” and “PAPP” are used interchangeably. Both terms refer to a physician and/or advanced practice provider.

Cases diagnosed clinically are reportable. In the absence of a histologic or cytologic confirmation of a reportable neoplasm, accession a case based on the **clinical diagnosis** (when a recognized PAPP says the patient has a cancer, carcinoma, malignant neoplasm, or reportable neoplasm). A clinical diagnosis may be recorded in the discharge diagnosis on the face sheet or other parts of the medical record.

Note: A pathology report normally takes precedence over a clinical diagnosis. If the patient has a negative biopsy, the case would **not** be reported.

Determining reportability using imaging reports

- Prostate Imaging Reporting and Data System (PI-RADS) and Liver Imaging Reporting and Data System (LI-RADS) MRI are radiology reporting classification systems used to communicate the level of suspicion for malignancy on imaging studies. The PI-RADS or LI-RADS score on a radiology report alone does **not** make a case reportable to SEER. A case becomes reportable to SEER only when the radiologic findings are supported by a PAPP statement using approved reportable terminology or a positive pathology result. For reportable cases, the date of diagnosis is the date of the PAPP’s statement using approved reportable terminology or the date of the positive pathology confirmation.
- **Example 1:** Radiologist assigns PI-RADS score category 5 assessment on imaging on 01/2027, with no additional statement indicating cancer. Patient was subsequently evaluated by a urologist and undergoes a needle core biopsy on 03/2027 which confirms intraductal carcinoma. Report the case and record the date of diagnosis as 03/2027.
- **Rationale:** Neither the radiologist nor the urologist confirms prostate cancer based on the PI-RADS report. Reportability and date of diagnosis are based on the needle core biopsy.

- **Example 2:** A PI-RADS category 5 assessment is assigned on imaging on 01/04/2027. No additional information is available. Do not report the case.
- **Rationale:** A PI-RADS category 5 assessment alone does not confirm a diagnosis of prostate cancer and no additional information is available to establish reportability. Therefore, this case is not reportable.
- **Example 3:** A LI-RADS category 5 assessment is assigned on imaging performed on 05/11/2027. Oncologist notes imaging found hepatocellular carcinoma (HCC) in liver as patient had two lesions consistent with HCC on 6/8/2027. Report the case and record the date of diagnosis as 05/11/2027.
- **Rationale:** Oncologist documents that the patient has liver cancer based on the LI-RADS findings. Record the date of diagnosis. If the physician documents the date of diagnosis as the date of LI-RADS imaging, use the date of imaging as the date of diagnosis.

Exceptions

1. Patient receives **treatment** for cancer. Accession the case.
Note: Standard treatments for cancer may be given for non-malignant conditions. Follow back with the physician to clarify if needed.
2. It has been **six months or longer** since the negative biopsy, and the physician continues to call this a reportable disease. Accession the case.

Intracranial or CNS Neoplasms

An intracranial or a CNS neoplasm identified only by diagnostic imaging is reportable.

“**Neoplasm**” and “**tumor**” are **reportable** terms for intracranial and CNS because they are listed in ICD-O-3.2 with behavior codes of /0 and /1.

“**Mass**” and “**lesion**” are **not** reportable terms for intracranial and CNS because they are not listed in ICD-O-3.2 with behavior codes of /0 or /1.

Ambiguous Terminology

Ambiguous terminology may originate in any source document, such as a pathology report, radiology report, or clinical report. The terms listed below are reportable when they are used with a term such as cancer, carcinoma, sarcoma, etc. Ambiguous terms not listed below are not reportable.

Cytology

Do **not** accession a case based **ONLY** on **suspicious** cytology. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended. Accession the case when a reportable diagnosis is confirmed later. The date of diagnosis is the date of the suspicious cytology.

Note 1: “Suspicious cytology” means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable in this manual.

Note 2: This is a change to previous instructions. The date of a suspicious cytology may be used as the date of diagnosis when a definitive diagnosis follows the suspicious cytology. See *Date of Diagnosis* for more information.

Cytology refers to the microscopic examination of cells in body fluids obtained from aspirations, washings, scrapings, and smears, usually a function of the pathology department.

Important: Accession cases with cytology diagnoses that are **positive** for malignant cells.

Urine cytology positive for malignancy is reportable. Code the primary site to C689 in the absence of any other information.

Ambiguous Terms for Reportability

Apparent(ly)
Appears
Comparable with
Compatible with
Consistent with
Favor(s)
Malignant appearing
Most likely
Presumed
Probable
Suspect(ed)
Suspicious (for)
Typical (of)

Report cases that use the words on the list or an equivalent word such as “favored” rather than “favor(s).” Do not substitute synonyms such as “supposed” for presumed or “equal” for comparable. Do not substitute “likely” for “most likely.”

Use **all available information first** and **seek clarification** from clinicians whenever possible.

Equivalent to “Diagnostic for” malignancy or reportable diagnosis. These phrases are reportable when **no other information is available** or there is no information to the contrary.

- Considered to be [malignancy or reportable diagnosis]
- Characteristic of [malignancy or reportable diagnosis]
- Appears to be a [malignancy or reportable diagnosis]
- Most compatible with [malignancy or reportable diagnosis]
- Most certainly [malignancy or reportable diagnosis]
- In keeping with [malignancy or reportable diagnosis]

Equivalent to “Not diagnostic for” malignancy or reportable diagnosis. These phrases are **NOT** reportable when **no other information is available**.

- Highly suspicious for, but not diagnostic of [malignancy or reportable diagnosis]
- Most compatible with a [non-reportable diagnosis] such as a [reportable diagnosis]
- High probability for [malignancy or reportable diagnosis]

Equivalent to “Differential diagnoses”

- Differential considerations

There may be ambiguous terms preceded by a modifier, such as “mildly” suspicious. In general, ignore modifiers or other adjectives and accept the reportable ambiguous term.

If there is no information to the contrary, report a case described as "malignant until proven otherwise." The patient should have further work up to prove or disprove the findings. When additional information becomes available, update, as necessary. Use text fields to describe the details.

Ambiguous Terminology Lists: References of Last Resort

This section clarifies the use of Ambiguous Terminology as listed in *STORE 2018* for case reportability and staging in Commission on Cancer (CoC)-accredited programs. When abstracting, registrars are to use the "Ambiguous Terms at Diagnosis" list with respect to case reportability; however, **these lists need to be used correctly**.

The first and foremost resource for the registrar for questionable cases is the physician who diagnosed and/or staged the tumor. The ideal way to approach abstracting situations when the medical record is not clear is to follow up with the physician. If the physician is not available, the medical record, and any other pertinent reports (e.g., pathology, etc.) should be read closely for the required information. The purpose of the Ambiguous Terminology lists is so that in the case where wording in the patient record is ambiguous with respect to reportability or tumor spread and no further information is available from any resource, registrars will make consistent decisions. When there is a clear statement of malignancy or tumor spread (i.e., the registrar can determine malignancy or tumor spread from the resources available), they should not refer to the Ambiguous Terminology lists. Registrars should only rely on these lists when the situation is not clear, and the case cannot be discussed with the appropriate physician/pathologist.

The CoC recognizes that not every registrar has access to the physician who diagnosed and/or staged the tumor, and as a result, the Ambiguous Terminology lists continue to be used in CoC-accredited programs and maintained by CoC as "references of last resort."

How to Use Ambiguous Terminology for Case Ascertainment

1. In Situ and Invasive (Behavior codes /2 and /3)

- a. If any of the reportable **ambiguous terms precede** a word that is **synonymous** with a reportable in situ or invasive tumor (e.g., cancer, carcinoma, malignant neoplasm, etc.), accession the case.

Example: The pathology report says: Prostate biopsy with markedly abnormal cells that are typical of adenocarcinoma. Accession the case.

Negative Example: The final diagnosis on the outpatient report reads: Rule out pancreatic cancer. Do not accession the case.

b. Discrepancies

- i. Accession the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record.

1. Do **not** accession a case when the original source document used a **non-reportable** ambiguous term and subsequent documents refer to history of cancer.

Example: Report from the dermatologist is "possible melanoma." Patient admitted later for unrelated procedure and physician listed history of melanoma. No further information is available, no evidence of treatment for melanoma. Give priority to the information from the dermatologist and do not report this case. "Possible" is **not** a reportable ambiguous term. The later information is less reliable in this case.

- ii. Accept the reportable term and accession the case when there is a single report in which both reportable and non-reportable terms are used.

- iii. **Example:** Abdominal CT reveals a 1 cm liver lesion. “The lesion is consistent with hepatocellular carcinoma” appears in the discussion section of the report. The final diagnosis is “1 cm liver lesion, possibly hepatocellular carcinoma.” Accession the case. “Consistent with” is a reportable ambiguous term. Accept “consistent with” over the non-reportable term “possibly.”

- c. Do **not** accession a case based **ONLY** on **suspicious** cytology.

Note: “Suspicious cytology” means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable on the preceding page.

Follow back on cytology diagnoses using ambiguous terminology is strongly recommended.

Cytology refers to the microscopic examination of cells in body fluids obtained from aspirations, washings, scrapings, and smears; usually a function of the pathology department.

Important: Accession cases with cytology diagnoses that are **positive** for malignant cells.

- d. Use the reportable ambiguous terms when **screening** diagnoses on pathology reports, operative reports, scans, mammograms, and other diagnostic testing with the exception of tumor markers.

- i. Do not accession a case when resection, excision, biopsy, cytology, or physician’s statement proves the ambiguous diagnosis is not reportable.

Example 1: Mammogram shows calcifications suspicious for intraductal carcinoma. The biopsy of the area surrounding the calcifications is negative for malignancy. Do not accession the case.

Example 2: CT report states “mass in the right kidney, highly suspicious for renal cell carcinoma.” CT-guided needle biopsy with final diagnosis “Neoplasm suggestive of oncocytoma. A malignant neoplasm cannot be excluded.” Discharged back to the nursing home and no other information is available. Do not accession the case. The suspicious CT finding was biopsied and not proven to be malignant. “Suggestive of” is not a reportable ambiguous term.

Example 3: Stereotactic biopsy of the left breast is “focally suspicious for DCIS” and is followed by a negative needle localization excisional biopsy. Do not accession the case. The needle localization excisional biopsy was performed to further evaluate the suspicious stereotactic biopsy finding. The suspicious diagnosis was proven to be false.

Example 4: Esophageal biopsy with diagnosis of “focal areas suspicious for adenocarcinoma in situ.” Diagnosis on partial esophagectomy specimen “with foci of low-grade dysplasia; no invasive carcinoma identified.” Do not accession the case. The esophagectomy proved that the suspicious biopsy result was false.

2. **Benign** and **borderline** primary intracranial and CNS tumors

- a. Use the “Ambiguous terms that are reportable” list above to identify benign and borderline primary intracranial and CNS tumors that are reportable.
- b. “**Neoplasm**” and “**tumor**” are **reportable** terms for intracranial and CNS because they are listed in ICD-O-3.2 with behavior codes of /0 and /1.
- c. Accession the case when any of the reportable **ambiguous terms precede** either the word “**tumor**” or the word “**neoplasm**”.

Example: The mass on the CT scan is consistent with pituitary tumor. Accession the case.

- d. **“Mass” and “lesion”** are **not** reportable terms for intracranial and CNS because they are **not** listed in ICD-O-3.2 with behavior codes of /0 or /1.
- e. **Discrepancies**
 - i. Accession the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record.
 - 1. Do not accession a case when subsequent documents refer to history of tumor and the original source document used a **non-reportable** ambiguous term.
 - ii. Accept the reportable term and accession the case when there is a single report and one section of a report uses a reportable term such as “apparently” and another section of the same report uses a term that is not on the reportable list.

Exception: Do not accession a case based ONLY on ambiguous **cytology** (the reportable term is preceded by an ambiguous term such as apparently, appears, compatible with, etc.).
- f. Use the reportable ambiguous terms when **screening** diagnoses on pathology reports, scans, ultrasounds, and other diagnostic testing other than tumor markers.
 - i. Do not accession the case when resection, excision, biopsy, cytology, or physician’s statement proves the ambiguous diagnosis is not reportable.

Instructions for Hematopoietic and Lymphoid Neoplasms

See the Reportability Instructions in the [Hematopoietic and Lymphoid Neoplasm Coding Manual and Database](#).

Instructions for Reporting Pediatric Cancers

SEER began collecting data items within the Pediatric Data Collection System (PDCS) on 1/1/2024. The PDCS Manual and Appendices can be found here: ([Pediatric Resources](#)). In addition, the online version of the PDCS can be found in [SEER*RSA](#) (schemas only).

Please refer to the table below for SEER requirements of the PDCS data items.

As of 1/1/2027, all applicable pediatric cases ages 0-39 (and occasionally all ages) are required for SEER registries. Contact your central registry for more information on requirements. Please refer to [SEER*RSA](#) for more information on Pediatric Staging or submit a question to [Ask a SEER Registrar](#).

Diagnosis Year	PDCS Data Collection Requirements for SEER
2024	Required, site specific**, when available for ages 0-19; ages 20-39 optional
2025	Required, site specific**, when available for ages 0-19; ages 20-39 optional
2026	Required, site specific**, when available for ages 0-19; ages 20-39 optional
2027	Required, site specific**, for all pediatric cases ages 0-39

**=Not all pediatric tumors are collected in the PDCS. See the Pediatric Manual, Appendix I ([Pediatric Resources](#)), Pediatric ID [NAACCR Data Item #1132] for the complete listing of age/primary site/histology combinations that are included in the PDCS.

Casefinding Lists

Current and previous [casefinding lists](#) are available on the SEER website. Use the casefinding lists to screen prospective cases and identify cancer cases for inclusion in the registry. It is important to include all casefinding sources when searching for reportable cases.

Sources include

- Inpatient/Outpatient Admission/Discharge Documents
- Pathology/Cytology Pathology Reports
- Surgery Logs/Schedules
- Radiology
- Nuclear Medicine
- Radiation Therapy Logs
- Chemotherapy Outpatient Logs
- Emergency Room Records
- Autopsy Reports
- Pain Clinic Logs

A casefinding list is **not** the same as a [reportable list](#). Casefinding lists are intended for searching a variety of cases so as not to miss any reportable cases.

Definition of **Casefinding** (case ascertainment): Process of identifying all reportable cases through review of source documents and case listings. Casefinding covers a range of cases that need to be assessed to determine whether or not they are reportable.

Changing Information on the Abstract

The information originally collected on the abstract should be changed or modified under the following circumstances

1. To **correct** coding or abstracting **errors** (for example, errors found during quality control activities).

2. **When clarifications or rule changes** retroactively affect data item code

Example: SEER adds codes to a data item and asks the registries to review a set of cases and update using the new codes.

3. **When better information** is available later

Example 1: Consults from specialty labs, pathology report addenda or comments or other information have been added to the chart. Reports done during the diagnostic workup and placed on the chart after the registrar abstracted the information may contain valuable information. Whenever these later reports give better information about the histology, grade of tumor, primary site, etc., change the codes to reflect the better information.

Example 2: The primary site was recorded as unknown at the time of diagnosis. At a later date, the physician determines that the cancer is primary to the testis. Change the primary site from unknown to testis.

Example 3: The original diagnosis was in situ. Metastases are diagnosed at a later date. Change the behavior code for the original diagnosis from in situ to invasive when **no new primary has been diagnosed** in the interim.

Example 4: Patient seen in Hospital A. The pathologic diagnosis was negative for malignancy. Patient goes to Hospital B and the slides from Hospital A are re-read. The diagnosis at Hospital B is reportable. Hospital B sends their slide report back to Hospital A. Hospital A reports the case based on the info from Hospital B. Enter supporting documentation in a text field.

4. **When the date of diagnosis is confirmed in retrospect to be earlier than the original date abstracted**

Example: Patient has surgery for a benign argentaffin carcinoid (8240/1) of the sigmoid colon in May 2026. In January 2027, the patient is admitted with widespread metastasis consistent with malignant argentaffin carcinoid. The registrar accessions the malignant argentaffin carcinoid as a 2027 diagnosis. Two months later, the pathologist reviews the slides from the May 2026 surgery and concludes that the carcinoid diagnosed in 2026 was malignant. Change the date of diagnosis to May 2026, histology to 8241, and behavior code to malignant (/3).

Determining Multiple Primaries

Solid Tumors

Apply the General Instructions and site-specific instructions for determining multiple primaries in the current [Solid Tumor Rules](#).

Apply the site-specific multiple primary rules in the current Solid Tumor Rules.

Site-specific multiple primary rules cover the following:

Primary Site	Topography Codes
Head and Neck	C000-C148, C300-C339, C410, C411, C479, C754, C755
Colon, Rectosigmoid, Rectum	C180-C189, C199, C209
Lung	C340-C349
Cutaneous Melanoma	C440-C449 with Histology 8720-8780
Breast	C500-C506, C508-C509
Kidney	C649
Urinary Sites	C659, C669, C670-C679, C680-C681, C688-C689
Non-malignant CNS	C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
Malignant CNS and Peripheral Nerves	C470-C479, C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
Other Sites	Excludes Head and Neck, Colon, Rectosigmoid, Rectum, Lung, Cutaneous Melanoma, Breast, Kidney, Urinary Sites, Peripheral Nerves, CNS

The General rules do not apply to hematopoietic primaries (lymphoma and leukemia) of any site. The head and neck, colon, rectosigmoid and rectum, breast, kidney, urinary sites, and malignant CNS and peripheral nerves rules exclude lymphoma and leukemia (M9590-M9993) and Kaposi sarcoma (M9140). All other sites rules exclude lymphoma and leukemia (M9590-M9993).

Hematopoietic and Lymphoid Neoplasms

Updates were made to the *Hematopoietic and Lymphoid Neoplasm Coding Manual* and *Database* for 2027 cases. Apply the Multiple Primary Rules in the [Hematopoietic and Lymphoid Neoplasm Coding Manual and Database](#).

Transplants

Transplanted organs or tissue may originate from

1. Organs or tissue from the patient's own body (called autograft) or
2. Another human donor (homograft or allograft)

Accession a new primary in the transplanted organ as you would any new primary, applying the current Solid Tumor Rules. Code the primary site to the location of the transplanted organ, i.e., code the malignancy where it resides/lies.

Example: Diagnosis of malignancy in transplanted section of colon serving as esophagus. Code the primary site as esophagus. Document the situation in a text field.

Section I

Basic Record Identification

The Basic Record Identification data items provide a unique identifier for individual records or a set of records for each person and tumor in the SEER data system. The coded identifiers protect data confidentiality.

Note: For San Francisco, Los Angeles, San Jose/Monterey, and Greater California, the patient identifier identifies a unique patient across the entire state.

SEER Participant

Item Length: 10
 NAACCR Item #: 40
 NAACCR Name: Registry ID
 XML NAACCR ID: registryId

SEER Participant is a unique code assigned to each SEER participating registry. The number identifies the registry sending the record and what population the data are based upon.

Table of SEER Core Registries

Code	Participant	Area Covered	Year SEER Reporting Started	Name	Two-Character Abbreviation
0000001501	Cancer Prevention Institute of California	5 counties	1973	San Francisco-Oakland SMSA	SF
0000001502	Connecticut Department of Public Health	Entire state	1973	Connecticut	CT
0000001521	Research Corporation of Hawaii	Entire state	1973	Hawaii	HI
0000001522	University of Iowa	Entire state	1973	Iowa	IA
0000001523	University of New Mexico	Entire state	1973	New Mexico	NM
0000001525	Fred Hutchinson Cancer Research Center	13 counties	1974	Seattle-Puget Sound	SE
0000001526	University of Utah	Entire state	1973	Utah	UT
0000001527	Emory University	5 counties	1975	Metropolitan Atlanta	AT
0000001529	Alaska Native	Native American population of Alaska	1984	Alaska Native	AK
0000001530	California Cancer Registry	Entire state	2018	California	CA
0000001531	Cancer Prevention Institute of California	4 counties	1992	San Jose-Monterey	SJ
0000001532	Greater Bay Area Cancer Registry	9 counties	2018	Greater Bay	GB
0000001533	University of New Mexico	Native American population of Arizona	1973	Arizona Indians	AZ
0000001535	University of Southern California	1 county	1992	Los Angeles	LX
0000001537	Emory University	10 Counties	1978	Rural Georgia	RG
0000001540	Georgia Comprehensive Cancer Registry	Entire state	2018	Georgia	GA

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Code	Participant	Area Covered	Year SEER Reporting Started	Name	Two-Character Abbreviation
0000001541	Public Health Institute, California	California except Los Angeles, San Francisco-Oakland, and San Jose-Monterey	2000	Greater California	GC
0000001542	University of Kentucky Research Foundation	Entire state	2000	Kentucky	KY
0000001543	Louisiana State University HSC	Entire state	2000	Louisiana	LA
0000001544	Rutgers, the State University of New Jersey	Entire state	2000	New Jersey	NJ
0000001547	Emory University	Entire state other than metropolitan Atlanta and rural Georgia	2010	Greater Georgia	GG
0000001551	Cherokee Nation – Oklahoma	Native American population	1997	Cherokee Nation	CN
0000001561	Idaho Cancer Data Registry	Entire state	2018	Idaho	ID
0000001562	New York State Cancer Registry	Entire state	2018	New York	NY
0000001565	Illinois Department of Public Health	Entire state	2021	Illinois	IL
0000001566	Texas Department of State Health Services	Entire state	2021	Texas	TX

Table of SEER Research Support Registries

Code	Participant	Area Covered	Year SEER Reporting Started	Name	Two-Character Abbreviation
0000001520	Wayne State University	3 counties	1973	Metropolitan Detroit	DM
0000001563	Massachusetts Cancer Registry	Entire state	2018	Massachusetts	MA
0000001564	Wisconsin Cancer Reporting System	Entire state	2018	Wisconsin	WI
0000001567	Arkansas Department of Health	Entire state	2021	Arkansas	AR
0000001568	California Department of Public Health	Entire state	2021	California	CA

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Code	Participant	Area Covered	Year SEER Reporting Started	Name	Two- Character Abbreviation
0000001569	Colorado Department of Public Health and Environment	Entire state	2021	Colorado	CO
0000001570	Michigan Department of Health and Human Services	Entire state	2021	Michigan	MI
0000001571	Oregon Health & Science University	Entire state	2021	Oregon	OR
0000001572	Tennessee Department of Health	Entire state	2021	Tennessee	TN
0000001573	The Curators of the University of Missouri	Entire state	2021	Missouri	MO
0000001574	Trustees of Dartmouth College	Entire state	2021	New Hampshire	NH

Patient ID Number

Item Length: 8

NAACCR Item #: 20

NAACCR Name: Patient ID Number

XML NAACCR ID: patientIdNumber

The participating SEER registry generates a unique number and assigns that number to one patient. The SEER registry will assign this same number to all of the patient's subsequent tumors (records). Enter preceding zeros if the number is less than 8 digits.

Example: Patient # 7034 would be entered as 00007034.

Note: For the state of California, the patient ID number is assigned for the entire state, not for the individual registries within the state.

NAACCR Record Version

Item Length: 3**NAACCR Item #: 50****NAACCR Name: NAACCR Record Version****XML NAACCR ID: naaccrRecordVersion**

NAACCR Record Version applies only to record types I, C, A, and M. The correction record (U) has its own record version data item. This data item is the NAACCR version that is used to create the record. The NAACCR layout version is necessary to communicate to the recipient of data in NAACCR format where the various items are found and how they are coded. It should be added to the record when the record is created.

Code	Description
120	2010 Version 12
121	2011 Version 12.1
122	2012 Version 12.2
130	2013 Version 13
140	2014 Version 14
150	2015 Version 15
160	2016 Version 16
180	2018 Version 18
210	2021 Version 21
220	2022 Version 22
230	2023 Version 23
240	2024 Version 24
250	2025 Version 25
260	2026 Version 26
270	2027 Version 27

Section II

Information Source

Type of Reporting Source

Item Length: 1

NAACCR Item #: 500

NAACCR Name: Type of Reporting Source

XML NAACCR ID: typeOfReportingSource

Type of Reporting Source identifies the source documents that provided the most complete information when abstracting the case. This is not necessarily the original document that identified the case; rather, it is the source that provided the most complete information.

Code	Description
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records (new code definition effective with diagnosis on or after 01/01/2006)
2	Radiation Treatment Centers or Medical Oncology Centers (hospital affiliated or independent) (effective with diagnosis on or after 01/01/2006)
3	Laboratory Only (hospital affiliated or independent)
4	Physician's Office/Private Medical Practitioner (LMD)
5	Nursing/Convalescent Home/Hospice
6	Autopsy Only
7	Death Certificate Only
8	Other hospital outpatient units/surgery centers (effective with diagnosis on or after 01/01/2006)

Definitions

Comprehensive, unified medical record

- A hospital or managed health care system that maintains a single record for each patient. That record includes all encounters in affiliated locations.

Stand-alone medical record

- An independent health care facility's record where the facility is not a part of a hospital or managed care system.
- An independent medical record containing only information from encounters with that specific facility or practice

Managed health plan

- Any practice and/or facility where all of the diagnostic and treatment information is maintained in one unit record.
- The abstractor is able to use the unit record when abstracting the case.

Examples of such facilities: HMOs or other health plan such as Kaiser, Veterans Administration, or military facilities

Physician office

- A physician office performs examinations and tests. Physician offices may perform limited surgical procedures.

Note: The category "physician's office" also includes facilities that are called surgery centers when surgical procedures under general anesthesia cannot be performed in these facilities.

Surgery center

- Surgery centers are equipped and staffed to perform surgical procedures under **general anesthesia**.
- The patient usually does not stay overnight.

Note: If the facility cannot perform surgical procedures under general anesthesia, code as physician's office.

Unit record

- All records for the patient from all departments, clinics, offices, etc., in a single file with the same medical record number

Code	Label	Source Documents	Priority
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records	Hospital inpatient Offices/facilities with a comprehensive, unified record • HMO physician office or group • HMO-affiliated freestanding laboratory, surgery, radiation, or oncology clinic Includes outpatient services of HMOs and large multi-specialty physician group practices with unified records.	1
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)	Facilities with a stand-alone medical record • Radiation treatment centers • Medical oncology centers (hospital affiliated or independent) There were no source documents from code 1.	2
3	Laboratory Only (hospital-affiliated or independent)	Laboratory with a stand-alone medical record There were no source documents from codes 1, 2, 8, or 4.	5
4	Physician's Office/Private Medical Practitioner (LMD)	Physician's office that is NOT an HMO or large multi-specialty physician group practice There were no source documents from codes 1, 2, or 8.	4
5	Nursing/Convalescent Home/Hospice	Nursing or convalescent home or a hospice There were no source documents from codes 1, 2, 8, 4, or 3.	6
6	Autopsy Only	Autopsy The cancer was first diagnosed on autopsy. There were no source documents from codes 1, 2, 8, 4, 3, or 5.	7
7	Death Certificate Only	Death certificate Death certificate is the only source of information; follow-back activities did not identify source documents from codes 1, 2, 8, 4, 3, 5 or 6. If another source document is subsequently identified, the Type of Reporting Source code must be changed to the appropriate code in the range of 1, 2, 8, 4, 3, 5, or 6.	8
8	Other hospital outpatient units/surgery centers	Other hospital outpatient units/surgery centers Includes, but not limited to, outpatient surgery and nuclear medicine services. There were no source documents from codes 1 or 2.	3

Priority Order for Assigning Type of Reporting Source

Code the source that provided the best information used to abstract the case.

Example 1: Surgery for primary cancer performed at hospital as outpatient (no overnight stay). Assign code 1 if the hospital is part of a managed health plan with comprehensive, unified medical records – meaning that a single record is maintained for each patient and that record includes all encounters in affiliated locations. Otherwise, assign code 8.

Example 2: The only patient record available for a physician office biopsy is the pathology report identified from a freestanding laboratory. Assign code 3 [Laboratory Only (hospital-affiliated or independent)]. Reporting source should reflect the lab where this case was identified. The MD office added nothing to the case, not even a confirmation of malignancy.

When multiple source documents are used to abstract a case, use the following priority order to assign a code for *Type of Reporting Source*: Codes: 1, 2, 8, 4, 3, 5, 6, 7.

Note: Beginning with cases diagnosed 01/01/2006, the definitions for this data item have been expanded. Codes 2 and 8 were added to identify outpatient sources that were previously grouped under code 1. Laboratory reports now have priority over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.

SEER recommends that you do **not** make changes to this data item for historic cases in the central cancer registry database, i.e., cases diagnosed prior to January 1, 2006. Conversion of the old codes would be problematic and would require extensive and time-consuming review of original source documents.

Class of Case

Item Length: 2
NAACCR Item #: 610
NAACCR Name: Class of Case
XML NAACCR ID: classOfCase

Class of Case, implemented 01/01/2027, is assigned based on the reporting facility's role in diagnosis and/or first course treatment.

Class of Case divides cases into two groups. Analytic cases (codes 00–22) are those that are required by CoC to be abstracted because of the program's primary responsibility in managing the cancer. Analytic cases are grouped according to the location of diagnosis and first course of treatment. Non-analytic cases (codes 30–49 and 99) may be abstracted by the facility to meet central registry requirements or in response to a request by the facility's cancer program. Non-analytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.

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

Initial diagnosis at reporting facility

Code	Description
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10	Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
13	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility

Initial diagnosis elsewhere, facility involved in first course treatment

Code	Description
20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility

Non-analytic Classes of Case (Not required by CoC to be abstracted; may be required by Cancer Committee, state or regional registry, or other entity)**Patient appears in person at reporting facility; both initial diagnosis and treatment elsewhere**

Code	Description
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere)
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement)
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease)

Patient appears in person at reporting facility; both initial diagnosis and treatment elsewhere

Code	Description
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active)
34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility
35	Case diagnosed before the program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility
36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37	Case diagnosed before the program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death

Patient does not appear in person at Reporting Facility

Code	Description
40	Diagnosis AND all first course treatment given at the same staff physician's office
41	Diagnosis and all first course treatment given in two or more different offices of physicians with admitting privileges
42	Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43	Pathology or other lab specimens only
49	Death certificate only

Unknown relationship to reporting facility

Code	Description
99	Non-analytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases)

Coding Instructions

1. Assign the code that most precisely describes the patient's relationship to the facility.
2. Assign code 00 when the reporting facility diagnosed the patient and it is known that the
 - a. Patient went elsewhere for treatment
 - b. Decision not to treat was made elsewhere.
3. Assign code 10 when the reporting facility diagnosed the patient and it is not known that the patient actually received treatment or it is unknown if a decision not to treat was made somewhere else.
4. Assign code 41 for physicians who are not employed by the hospital but are under contract with it or have routine admitting privileges.
 - a. Treatment is "elsewhere" when provided in the office of a physician with admitting privileges outside of the hospital's realm of responsibility.
5. Assign code 31 (in-transit care) when care is given to a patient who is temporarily away from the patient's usual practitioner for continuity of care, e.g., medication administration or monitoring.
6. Assign code 21 (part of first course treatment elsewhere, part of first course of treatment at the reporting facility) when first course radiation or chemotherapy infusion is started elsewhere and continues at the reporting facility (i.e., not in-transit); the case is analytic.
 - a. When diagnosis and treatment is started at another facility as part of the first course treatment plan and continues at the reporting facility, e.g., hormone treatment, there must be documentation of the continuation in the medical record in order to assign code 21, even if there is no longer active disease.
7. Update the code if information for coding *Class of Case* changes during the patient's first course of care.

CoC Accredited Flag

Item Length: 1

NAACCR Item #: 2152

NAACCR Name: COC Accredited Flag

XML NAACCR ID: cocAccreditedFlag

CoC Accredited Flag, effective 01/01/2018, identifies abstracts from CoC-accredited hospitals. Further, for those abstracts, the flag will designate analytic versus non-analytic abstracts.

Code	Description
0	Abstract prepared at a facility WITHOUT CoC accreditation of its cancer program
1	ANALYTIC abstract prepared at facility WITH CoC accreditation of its cancer program (Includes Class of Case codes 10-22)
2	NON-ANALYTIC abstract prepared at facility WITH CoC accreditation of its cancer program (Includes Class of Case codes 30-43 and 99, plus code 00 which is analytic for CoC but not required to be staged)
Blank	Not applicable; DCO

Coding Instructions

Instructions for Hospital Cancer Registries

1. Assign at the time of data abstraction.
2. Assign manually or automatically assign using registry software.

Instructions for Central Cancer Registries

1. Set the flag to **1** when **any** of the facilities who contributed to the consolidated data for a cancer record set the *CoC Accredited Flag* to 1.
2. Set the flag to 2 when all incoming records for the consolidated case have the CoC Accredited Flag set to 2.
3. Set the flag to 0 when all incoming records for the consolidated case have the CoC Accredited Flag set to 0.
4. Set the flag to 2 when incoming records for the consolidated case have the CoC Accredited Flag set to 0 and 2.
5. Flag remains blank for
 - a. DCO cases

Section III

Demographic Information

First Name

Item Length: 40
NAACCR Item #: 2240
NAACCR Name: Name--First
XML NAACCR ID: nameFirst

This data item identifies the first name of the patient. First name may also be referred to as given name. First name is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

1. Truncate first name if longer than 40 characters.
2. Blank spaces, hyphens, and apostrophes are allowed; do not use other punctuation.
3. Leave blank if the patient's first name is unknown.
4. Record the most current name and update this data item if the first name changes. Enter previous names in the Alias data item (not included in this manual).
5. Do not record nicknames in *First Name*.
 - a. Record nicknames in the Alias data item (not included in this manual).

Example: The patient's nickname is Bill and the first name is William. Record William in *First Name*.

Middle Name

Item Length: 40
NAACCR Item #: 2250
NAACCR Name: Name--Middle
XML NAACCR ID: nameMiddle

This data item identifies the middle name of the patient. *Middle Name* is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

1. Truncate middle name if longer than 40 characters.
2. Blank spaces, hyphens, and apostrophes are allowed; do **not** use other punctuation.
3. Record the middle initial if the full middle name is not known.
4. Leave blank if the patient's middle name is unknown or patient has no middle name.
5. Record the most current name and update this data item if the middle name changes. Enter previous names in the *Name--Alias* data item (not included in this manual).

Last Name

Item Length: 40
NAACCR Item #: 2230
NAACCR Name: Name--Last
XML NAACCR ID: nameLast

This data item identifies the last name of the patient. Last name may also be referred to as surname. Last name is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

1. Truncate name if longer than 40 characters.
2. Blank spaces, hyphens, and apostrophes are allowed; do **not** use other punctuation.
3. Code UNKNOWN if the patient's last name is unknown; do not leave blank.
4. Record the most current name and update this data item if the last name changes. Enter previous names in the *Name--Alias* data item (not included in this manual).

Examples:

Mc Donald: Recorded with space as Mc Donald

O'Hara: Recorded with apostrophe as O'Hara

Smith-Jones: Janet Smith marries Fred Jones and changes her last name to Smith-Jones

Birth Surname

Item Length: 40

NAACCR Item #: 2232

NAACCR Name: Name--Birth Surname

XML NAACCR ID: nameBirthSurname

Birth Surname, effective 01/01/2021, is a sex-neutral replacement for the NAACCR data item *Name - Maiden* (NAACCR Item #2390). Birth surname reflects the last name of the patient at birth regardless of sex or marital status. Allowable values for *Birth Surname* are identical to those used for *Name--Maiden*.

Birth surname is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

1. Truncate name if longer than 40 characters.
2. Record when known regardless of value in the *Sex Assigned at Birth* data item.
3. Leave blank if the birth surname is not known or not applicable.
4. Blank spaces, hyphens, and apostrophes are allowed; do **not** use other punctuation.

Examples

Mc Donald: Recorded with space as Mc Donald

O'Hara: Recorded with apostrophe as O'Hara

Social Security Number

Item Length: 9

NAACCR Item #: 2320

NAACCR Name: Social Security Number

XML NAACCR ID: socialSecurityNumber

Social Security Number records the patient's Social Security number (SSN). Social Security number is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Code	Description
(actual SSN)	Record the patient's Social Security number without dashes
999999999	Patient does not have a Social Security number; SSN is not available

Coding Instructions

1. Code the patient's Social Security number.
2. For missing parts of the Social Security number, enter 9s or leave blank depending on what the registry software allows.
3. Do not automatically enter a patient's Medicare claim number; it may not always be identical to the person's Social Security number.
4. See <https://www.ssa.gov> for more information.

Place of Residence

Place of Residence at Diagnosis

SEER registries collect information on place of residence at diagnosis. Information relating to address is not transmitted to SEER. The SEER rules for determining residency at diagnosis are either identical or comparable to rules used by the U.S. Census Bureau, to ensure comparability of definitions of cases (numerator) and the population at risk (denominator).

Coding Priorities/Sources

1. Code the **street address** of usual residence as stated by the patient. Definition: U.S. Census Bureau Instructions: “The place where he or she lives and sleeps most of the time or the place the person says is his or her usual home.” The residency rules of departments of vital statistics may differ from those of the U.S. Census Bureau/SEER.
2. A **post office box** is not a reliable source to identify the residency at diagnosis. Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Use the post office box address only if no street address information is available after follow-back.
3. Use residency information from a **death certificate** only when the residency from other sources is coded as unknown. Review each case carefully and apply the U.S. Census Bureau/SEER rules for determining residence.
 - a. For example, the death certificate may give the person’s previous home address rather than the nursing home address as the place of residence. If the person was a resident of a nursing home at diagnosis, use the nursing home address as the place of residence.
4. Do not use **legal status** or **citizenship** to code residence.

Persons with More than One Residence

1. Code the residence where the patient spends the majority of time (usual residence).
2. If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.

Examples: The above rules should be followed for “snowbirds” who live in the south for the winter months, “sunbirds” who live in the north during the summer months, and people with vacation residences that they occupy for a portion of the year.

Persons with No Usual Residence

Homeless people and transients are examples of persons with no usual residence. Code the patient’s residence at the time of diagnosis such as the shelter or the hospital where diagnosis was confirmed.

Temporary Residents of SEER Area

Code the place of usual residence rather than the temporary address for

Migrant workers

Educators temporarily assigned to a university in the SEER area

Persons **temporarily residing** with family during cancer treatment

Military personnel on **temporary** duty assignments (TDY)

Boarding school students below college level (code the parent's known residence)

Code the residence where the student is living for

College students while attending college

Exchange students temporarily living in the U.S.

Code the address of the institution for **Persons in Institutions**.

Note: Code the physical address of the institution. Do not code the post office box.

U.S. Census Bureau definition: "Persons under formally authorized, supervised care or custody are residents of the institution."

Persons who are incarcerated

Persons who are physically handicapped, mentally challenged, or mentally ill who are residents of homes, schools, hospitals or wards

Residents of nursing, convalescent, and rest homes

Long-term residents of other hospitals such as Veterans Administration (VA) hospitals

Persons in the Armed Forces and on Maritime Ships (including Merchant Marine)

Armed Forces

For military personnel and their family members, code the address of the military installation or surrounding community as stated by the patient.

Personnel Assigned to Navy, Coast Guard, and Maritime Ships

The U.S. Census Bureau has detailed rules for determining residency for personnel assigned to these ships. The rules refer to the ship's deployment, port of departure, destination, and its homeport. Refer to [U.S. Census Bureau Publications](#) for detailed rules.

Address at Diagnosis--Number and Street

Item Length: 60

NAACCR Item #: 2330

NAACCR Name: Addr at Dx--No & Street

XML NAACCR ID: addrAtDxNoStreet

Address at Diagnosis--Number and Street is the patient's street address including the number at the time of diagnosis. This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

1. Record the number and street address or the rural mailing address of the patient's usual residence when the tumor was diagnosed.
2. Record the physical number and street address of the patient at diagnosis. If the patient also has a Post Office (PO) Box address, record the PO Box address in *Address at Diagnosis--Supplemental*.
3. Spell out the address fully with standardized use of abbreviations and punctuation per U.S. Postal Service (USPS) postal addressing standards. The USPS Postal Addressing Standards, Publication 28, October 2024, can be found on the Internet at <http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf>.
4. The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations. Do not use punctuation unless absolutely necessary to clarify an address; leave space between numbers and words.
Example: 103 FIRST AVE SW APT 102
5. Limit abbreviations to those recognized by the Postal Service standard abbreviations. They include, but are not limited to: AVE (avenue), BLVD (boulevard), CIR (circle), CT (court), DR (drive), PLZ (plaza), PARK (park), PKWY (parkway), RD (road), SQ (square), ST (street), APT (apartment), BLDG (building), FL (floor), STE (suite), UNIT (unit), RM (room), DEPT (department), N (north), NE (northeast), NW (northwest), S (south), SE (southeast), SW (southwest), E (east), W (west). A complete list of recognized street abbreviations is provided in Appendix C of USPS Publication 28.
6. Punctuation is normally limited to periods (for example, 39.2 RD), slashes for fractional addresses (101 1/2 MAIN ST), and hyphens when a hyphen carries meaning (289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The referred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (425 FLOWER BLVD # 72).
7. If the patient has multiple tumors, the address may be different for different primaries.
8. Do not update this data item if the patient's address changes.
9. Enter **UNKNOWN** when the patient's street address is unknown.

Address at Diagnosis--Supplemental

Item Length: 60

NAACCR Item #: 2335

NAACCR Name: Addr at Dx--Supplementl

XML NAACCR ID: addrAtDxSupplementl

Address at Diagnosis--Supplemental allows for additional address information such as the name of a place or facility (for example, a nursing home, apartment complex, or other mailing address) at the time of diagnosis. This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

1. Record the name of the place or facility where the patient resided when the tumor was diagnosed.
 - a. For example, the name of an apartment complex or a nursing home
2. If the patient has multiple tumors, the address may be different for different primaries.
3. Do **not** use this data item to record the number and street address of the patient. Record number and street in *Address at Diagnosis--Number and Street*.
4. Do **not** update this data item if the patient's address changes.
5. Leave blank if this data item is not needed.

County

Item Length: 3

NAACCR Item #: 90

NAACCR Name: County at DX Reported

XML NAACCR ID: countyAtDx

Codes for county of residence at the time of diagnosis for each SEER area are listed in [Appendix A](#) of this manual.

Use code 999 when it is known that a person is a resident of a particular SEER region, but the exact county is not known.

County at Diagnosis Geocode 1970/80/90**Item Length: 3****NAACCR Item #: 94****NAACCR Name: County at DX Geocode 1970/80/90****XML NAACCR ID: countyAtDxGeocode1990**

County at Diagnosis Geocode 1970/80/90 stores a computer-generated geocoded value for the county of residence at the time of diagnosis. Codes in this data item are based on the Census Boundary files from the 1990 Decennial Census.

Code	Description
001-997	County at diagnosis. Valid FIPS code
998	Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria). Use this code for Canadian residents.
999	County unknown. The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.

Note: For U.S. residents, historically, standard codes are those of the FIPS publication “Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas.” These FIPS codes (FIPS 6-4) have been replaced by INCITS standard codes, however, there is no impact on this variable as the codes align with the system the Census used for each decennial census and will automatically be accounted for during geocoding.

County at Diagnosis Geocode 2000

Item Length: 3

NAACCR Item #: 95

NAACCR Name: County at DX Geocode2000

XML NAACCR ID: countyAtDxGeocode2000

County at Diagnosis Geocode 2000 stores a computer-generated geocoded value for the county of residence at the time of diagnosis. Codes in this data item are based on the Census Boundary files from the 2000 Decennial Census. This code should be used for county and county-based rates and analysis for all cases diagnosed in 2000-2009.

Code	Description
001-997	County at diagnosis. Valid FIPS code
998	Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria). Use this code for Canadian residents.
999	County unknown. The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.

Note: For U.S. residents, historically, standard codes are those of the FIPS publication “Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas.” FIPS codes (FIPS 6-4) have been replaced by INCITS standard codes, however, there is no impact on this variable as the codes align with the system the Census used for each decennial census and will automatically be accounted for during geocoding.

County at Diagnosis Geocode 2010

Item Length: 3**NAACCR Item #: 96****NAACCR Name: County at DX Geocode2010****XML NAACCR ID: countyAtDxGeocode2010**

County at Diagnosis Geocode 2010 stores a computer-generated geocoded value for the county of residence at the time of diagnosis. Codes in this data item are based on the Census Boundary files from the 2010 Decennial Census. This code should be used for county and county-based rates and analysis for all cases diagnosed in 2010-2019.

Code	Description
001-997	County at diagnosis. Valid FIPS code
998	Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria). Use this code for Canadian residents.
999	County unknown. The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.

Note: For U.S. residents, historically, standard codes are those of the FIPS publication “Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas.” These FIPS codes (FIPS 6-4) have been replaced by INCITS standard codes, however, there is no impact on this variable as the codes align with the system the Census used for each decennial census and will automatically be accounted for during geocoding.

County at Diagnosis Geocode 2020

Item Length: 3

NAACCR Item #: 97

NAACCR Name: County at DX Geocode2020

XML NAACCR ID: countyAtDxGeocode2020

County at Diagnosis Geocode 2020 is a derived variable that stores a computer-generated geocoded value for the county of residence at the time of diagnosis. Codes in this data item are based on the Census Boundary files from the 2020 Decennial Census. This code should be used for county and county-based rates and analysis for all cases diagnosed in 2020-2029.

Code	Description
001-997	County at diagnosis. Valid FIPS code
998	Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria). Use this code for Canadian residents.
999	County unknown. The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.

Note: For U.S. residents, historically, standard codes are those of the FIPS publication “Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas.” These FIPS codes (FIPS 6-4) have been replaced by INCITS standard codes, however, there is no impact on this variable as the codes align with the system the Census used for each decennial census and will automatically be accounted for during geocoding.

County at Diagnosis Analysis

Item Length: 3

NAACCR Item #: 89

NAACCR Name: County at DX Analysis

XML NAACCR ID: countyAtDxAnalysis

County at Diagnosis Analysis, effective 01/01/2018, is a derived variable to be used for county and county-based rates and analyses for all cases regardless of year of diagnosis.

Code	Description
001-997	County at diagnosis. Valid FIPS code
998	Known town, city, state, or country of residence but county code not known AND a resident outside of the state of reporting institution (must meet all criteria). Use this code for Canadian residents.
999	County unknown. The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.

Note: For U.S. residents, historically, standard codes are those of the FIPS publication “Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas.” These FIPS codes (FIPS 6-4) have been replaced by INCITS standard codes, however, there is no impact on this variable as the codes align with the system the Census used for each decennial census and will automatically be accounted for during geocoding.

Address at Diagnosis--City

Item Length: 50

NAACCR Item #: 70

NAACCR Name: Addr at DX--City

XML NAACCR ID: addrAtDxCity

Address at Diagnosis--City captures the name of the city or town of the patient's residence at the time of diagnosis. This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

1. Record the city of the physical number and street address of the patient at diagnosis. If the patient also has a Post Office (PO) Box address, record the PO Box address in *Address at Diagnosis--Supplemental*.
2. Do **not** use punctuation, special characters, or numbers. The use of capital letters is preferred by the United States Postal Service (USPS); use abbreviations when necessary.
3. If the patient has multiple malignancies/tumors, the city or town of residence at diagnosis may be different for different primaries.
4. Do **not** update city/town if the patient's city/town of residence changes.
5. Enter **UNKNOWN** if the patient's city or town is unknown.

Address at Diagnosis--State

Item Length: 2

NAACCR Item #: 80

NAACCR Name: Addr at DX--State

XML NAACCR ID: addrAtDxState

This data item records the state of residence at the time of diagnosis. State is coded according to the United States Postal Service abbreviation for the state.

Coding Instructions

Assign the most specific code possible from [Appendix B](#) of this manual.

Address at Diagnosis--Postal Code (ZIP Code)**Item Length: 9****NAACCR Item #: 100****NAACCR Name: Addr at DX--Postal Code****XML NAACCR ID: addrPostalCode**

Address at Diagnosis--Postal Code (ZIP Code) captures the postal code (ZIP code) of the patient's residence at diagnosis. This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Code	Description
(actual ZIP code)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
60611 _ _ _ _	When the nine-digit extended U.S. ZIP code is not available, record the five-digit postal code, left justified, followed by four blanks
M6G2S8 _ _ _	The patient's six-character Canadian postal code left justified, followed by three blanks
88888 _ _ _ _ or 888888888	Permanent address in a country other than Canada, United States, or U.S. possessions and postal code is unknown
999999999	Permanent address in Canada, United States, or U.S. possession and postal code is unknown

Coding Instructions

1. For U.S. residents, record the patient's nine-digit extended postal code of the patient's residence at the time of diagnosis.
2. For Canadian residents, record the six-character postal code.
3. When available, record the postal code for other countries.
4. If the patient has multiple malignancies/tumors, the postal code may be different for all primaries.
5. Do not update this data item if the patient's postal code changes.

State at Diagnosis Geocode 1970/80/90

Item Length: 2

NAACCR Item #: 81

NAACCR Name: State at DX Geocode 1970/80/90

XML NAACCR ID: stateAtDxGeocode19708090

State at Diagnosis Geocode 1970/80/90, effective 01/01/2018, is the state of residence at the time of diagnosis. It is a derived (geocoded) variable based on Census Boundary files from 1970, 1980, or 1990 Decennial Census.

Codes for state of residence for each SEER area are listed in [Appendix B](#) of this manual.

State at Diagnosis Geocode 2000

Item Length: 2

NAACCR Item #: 82

NAACCR Name: State at DX Geocode 2000

XML NAACCR ID: stateAtDxGeocode2000

State at Diagnosis Geocode 2000, effective 01/01/2018, is the state of residence at the time of diagnosis. It is a derived (geocoded) variable based on Census Boundary files from 2000 Decennial Census.

Codes for state of residence for each SEER area are listed in [Appendix B](#) of this manual.

State at Diagnosis Geocode 2010

Item Length: 2

NAACCR Item #: 83

NAACCR Name: State at DX Geocode 2010

XML NAACCR ID: stateAtDxGeocode2010

State at Diagnosis Geocode 2010, effective 01/01/2018, is the state of residence at the time of diagnosis. It is a derived (geocoded) variable based on Census Boundary files from 2010 Decennial Census.

Codes for state of residence for each SEER area are listed in [Appendix B](#) of this manual.

State at Diagnosis Geocode 2020

Item Length: 2

NAACCR Item #: 84

NAACCR Name: State at DX Geocode 2020

XML NAACCR ID: stateAtDxGeocode2020

State at Diagnosis Geocode 2020, effective 01/01/2018, is the state of residence at the time of diagnosis. It is a derived (geocoded) variable based on Census Boundary files from 2020 Decennial Census.

Codes for state of residence for each SEER area are listed in [Appendix B](#) of this manual.

Geocode Address at Diagnosis--Number and Street

Item Length: 60

NAACCR Item #: 105

NAACCR Name: Geo Addr at DX--No Street

XML NAACCR ID: geoAddrAtDxNoStreet

Geocode Address at Diagnosis--Number and Street, effective 01/01/2027, stores the output geocode address for the number and street as a variable. This derived variable is used to identify significant differences between user input addresses and geocoded output addresses.

Geocode Address at Diagnosis--City

Item Length: 50

NAACCR Item #: 106

NAACCR Name: Geo Addr at DX--City

XML NAACCR ID: geoAddrAtDxCity

Geocode Address at Diagnosis--City, effective 01/01/2027, stores the output geocode address for the city as a variable. This derived variable is used to identify significant differences between user input addresses and geocoded output addresses.

Geocode Address at Diagnosis--State

Item Length: 2

NAACCR Item #: 107

NAACCR Name: Geo Addr at DX--State

XML NAACCR ID: geoAddrAtDxState

Geocode Address at Diagnosis--State, effective 01/01/2027, stores the output geocode address for the state as a variable. This derived variable is used to identify significant differences between user input addresses and geocoded output addresses.

Codes for state of residence for each SEER area are listed in [Appendix B](#) of this manual.

Geocode Address at Diagnosis--Postal Code

Item Length: 9

NAACCR Item #: 108

NAACCR Name: Geocode Addr at DX--Postal Code

XML NAACCR ID: geoAddrAtPostalCode

Geocode Address at Diagnosis--Postal Code, effective 01/01/2027, stores the output geocode address for the postal code as a variable. This derived variable is used to identify significant differences between user input addresses and geocoded output addresses.

Geocoding Quality Code

Item Length: 1

NAACCR Item #: 86

NAACCR Name: Geocoding Quality Code

XML NAACCR ID: geocodingQualityCode

Geocoding Quality Code, effective 01/01/2024, is a derived variable based on the geocoding process for use by researchers and registry staff. This code allows for the selection of geocoded records and the determination of records that need to be reviewed and geocoded again. The code indicates whether an address in NAACCR / AGGIE Geocoder or MI GeoCorrect Tool matched, failed to match, or needs to be reviewed.

Geocoding Quality Code Detail

Item Length: 14

NAACCR Item #: 87

NAACCR Name: Geocoding Quality Code Detail

XML NAACCR ID: geocodingQualityCodeDetail

Geocoding Quality Code Detail, effective 01/01/2024, is a derived variable related to *Geocoding Quality Code* (NAACCR Item #86). It is intended for use by researchers and registry staff when manually reviewing geocoded cases. The codes provide a way to assess input reference data agreement, geographic accuracy, and micro-scale fitness for use at the sub-county level.

Census Tract 2010

Item Length: 6

NAACCR Item #: 135

NAACCR Name: Census Tract 2010

XML NAACCR ID: censusTract2010

Census Tract 2010 is a derived variable. It is computer generated using patient address information. *Census Tract 2010* records the census tract of a patient's residence at the time of diagnosis. The codes are the same codes used by the U.S. Census Bureau for the Year 2010 census. This item is coded for cases diagnosed January 1, 2006, and forward. This data item allows a central registry to add year 2010 Census tracts to cases diagnosed in previous years without losing the codes in the data items *Census Tract 1970/80/90* and *Census Tract 2000* which are only collected historically.

A census tract is a small statistical subdivision of a county that, in general, has between 2,500 and 8,000 residents. Local committees and the U.S. Census Bureau establish census tract boundaries and try to keep the same boundaries from census to census to maintain historical comparability, though this is not always possible. When populations increase or decrease, old tracts may be subdivided, disappear, or have their boundaries changed. Because the census tracts do change, it is important to know which census tract definition is used to code them.

Codes

Census tract codes 000100-999998

Special Codes

Code	Description
000000	Area not census-tracted
999999	Area census-tracted, but census tract is not available
Blank	Census Tract 2010 not coded

Coding Instructions

1. Code the Census tract of the patient's residence at the time of diagnosis.
2. Census tract codes should be assigned based on a computer match (geocoding software).
3. Census tracts are identified by four-digit numbers ranging from 0001 to 9989 and a two-digit suffix.
4. Assign code 999999 when an area does have an assigned census tract but the census tract is not available.
5. Right justify the first four digits and zero fill to the left. Add the suffix as the fifth and sixth digits if it exists; otherwise, use 00 so all six positions are coded.

Example 1: Code census tract 516 and suffix 21 to 051621.

Example 2: Census tract 409 and suffix does not exist should be coded 040900.

Census Tract 2020

Item Length: 6

NAACCR Item #: 125

NAACCR Name: Census Tract 2020

XML NAACCR ID: censusTract2020

Census Tract 2020 is a derived variable. It is computer generated using patient address information. *Census Tract 2020* records the census tract of a patient's residence at the time of diagnosis. The codes are the same codes used by the U.S. Census Bureau for the Year 2020 census. This item is coded for cases diagnosed January 1, 2006, and forward. This data item allows a central registry to add year 2020 Census tracts to cases diagnosed in previous years without losing the codes in the data items *Census Tract 1970/80/90*, *Census Tract 2000*, and *Census Tract 2010* which are only collected historically.

A census tract is a small statistical subdivision of a county that, in general, has between 2,500 and 8,000 residents. Local committees and the U.S. Census Bureau establish census tract boundaries and try to keep the same boundaries from census to census to maintain historical comparability, though this is not always possible. When populations increase or decrease, old tracts may be subdivided, disappear, or have their boundaries changed. Because the census tracts do change, it is important to know which census tract definition is used to code them.

Codes

Census tract codes 000100-999998

Special Codes

Code	Description
000000	Area not census-tracted
999999	Area census-tracted, but census tract is not available
Blank	Census Tract 2010 not coded

Coding Instructions

1. Code the Census tract of the patient's residence at the time of diagnosis.
2. Census tract codes should be assigned based on a computer match (geocoding software).
3. Census tracts are identified by four-digit numbers ranging from 0001 to 9989 and a two-digit suffix.
4. Assign code 999999 when an area does have an assigned census tract but the census tract is not available.
5. Right justify the first four digits and zero fill to the left. Add the suffix as the fifth and sixth digits if it exists; otherwise, use 00 so all six positions are coded.

Example 1: Code census tract 516 and suffix 21 to 051621.

Example 2: Census tract 409 and suffix does not exist should be coded 040900.

Census Tract Certainty 2010

Item Length: 1

NAACCR Item #: 367

NAACCR Name: Census Tr Certainty 2010

XML NAACCR ID: censusTractCertainty2010

Census Tract Certainty 2010 is coded by the central registry. *Census Tract Certainty 2010* records how the 2010 census tract was assigned for an individual record. Most of the time, this information is provided by a geocoding vendor service. Central registry staff should code this data item manually when geocoding is not available through a vendor service. This item is coded for cases diagnosed January 1, 2006, and forward.

Code	Description
1	Census tract based on complete and valid street address of residence
2	Census tract based on residence ZIP + 4
3	Census tract based on residence ZIP + 2
4	Census tract based on residence ZIP code only
5	Census tract based on ZIP code of post office box
6	Census tract/Block Numbering Area (BNA) based on residence city where city has only one census tract, or based on residence ZIP code where ZIP code has only one census tract
9	Not assigned, geocoding attempted
Blank	Not assigned, geocoding not attempted

Coding Priority

The codes are hierarchical with the numerically lower codes having priority except as noted in the following list

1. Code 1 has priority over codes 2-6 and 9.
2. Codes 2 and 6 are of equal priority.
3. Code 2 has priority over codes 3-5 and 9.
4. Code 6 has priority over codes 3-5, and 9.
5. Code 3 has priority over codes 4, 5, and 9.
6. Code 4 has priority over codes 5 and 9.
7. Code 5 has priority over code 9.

Note: Codes 1-5 and 9 are usually assigned by a geocoding vendor, while code 6 is usually assigned through a special effort by the central registry.

Coding Instructions

Note: Avoid using the post office box mailing address to code the census tract whenever possible.

1. Assign code **1** when the census tract is assigned with certainty based on complete and valid street address.

2. Assign codes **2-5** when the census tract is based on residence ZIP code.
 - a. Assign code **2** when
 - i. Street address is incomplete or invalid, but ZIP + 4 code is known OR
 - ii. Only rural route number is available, but ZIP + 4 code is known.
 - b. Assign code **3** when
 - i. Street address is incomplete or invalid, but ZIP + 2 code is known OR
 - ii. Only rural route number is available, but ZIP + 2 code is known.
 - c. Assign code **4** when
 - i. Street address is incomplete or invalid, but ZIP code is known OR
 - ii. Only rural route number is available, but ZIP code is known.
 - d. Assign code **5** when only the **post office box** ZIP code, ZIP +2, or ZIP + 4 is known.
3. Assign code **6** when
 - a. Address is unknown or incomplete and city has only one census tract OR
 - b. Only ZIP code of residence is known, and ZIP code has only one census tract.
4. Assign code **9** when
 - a. ZIP code is missing OR
 - b. The complete address of the patient is unknown or cannot be determined OR
 - c. There is insufficient information to assign a census code.

Census Tract Certainty 2020

Item Length: 1

NAACCR Item #: 369

NAACCR Name: Census Tr Certainty 2020

XML NAACCR ID: censusTractCertainty2020

Census Tract Certainty 2020 is a derived variable. *Census Tract Certainty 2020* records how the 2020 census tract was assigned for an individual record. Most of the time, this information is provided by a geocoding vendor service. Central registry staff should code this data item manually when geocoding is not available through a vendor service. This item is coded for cases diagnosed January 1, 2006, and forward.

Code	Description
1	Census tract based on complete and valid street address of residence
2	Census tract based on residence ZIP + 4
3	Census tract based on residence ZIP + 2
4	Census tract based on residence ZIP code only
5	Census tract based on ZIP code of post office box
6	Census tract/Block Numbering Area (BNA) based on residence city where city has only one census tract, or based on residence ZIP code where ZIP code has only one census tract
9	Not assigned, geocoding attempted
Blank	Not assigned, geocoding not attempted

Coding Priority

The codes are hierarchical with the numerically lower codes having priority except as noted in the following list

1. Code 1 has priority over codes 2-6 and 9.
2. Codes 2 and 6 are of equal priority.
3. Code 2 has priority over codes 3-5 and 9.
4. Code 6 has priority over codes 3-5, and 9.
5. Code 3 has priority over codes 4, 5, and 9.
6. Code 4 has priority over codes 5 and 9.
7. Code 5 has priority over code 9.

Note: Codes 1-5 and 9 are usually assigned by a geocoding vendor, while code 6 is usually assigned through a special effort by the central registry.

Coding Instructions

Note: Avoid using the post office box mailing address to code the census tract whenever possible.

1. Assign code **1** when the census tract is assigned with certainty based on complete and valid street address.

2. Assign codes **2-5** when the census tract is based on residence ZIP code.
 - a. Assign code **2** when
 - i. Street address is incomplete or invalid, but ZIP + 4 code is known OR
 - ii. Only rural route number is available, but ZIP + 4 code is known.
 - b. Assign code **3** when
 - i. Street address is incomplete or invalid, but ZIP + 2 code is known OR
 - ii. Only rural route number is available, but ZIP + 2 code is known.
 - c. Assign code **4** when
 - i. Street address is incomplete or invalid, but ZIP code is known OR
 - ii. Only rural route number is available, but ZIP code is known.
 - d. Assign code **5** when only the **post office box** ZIP code, ZIP +2, or ZIP + 4 is known.
3. Assign code **6** when
 - a. Address is unknown or incomplete and city has only one census tract OR
 - b. Only ZIP code of residence is known, and ZIP code has only one census tract.
4. Assign code **9** when
 - a. ZIP code is missing OR
 - b. The complete address of the patient is unknown or cannot be determined OR
 - c. There is insufficient information to assign a census code.

Current Address--Number and Street**Item Length: 3****NAACCR Item #: 2350****NAACCR Name: Addr Current--No & Street****XML NAACCR ID: addrCurrentNoStreet**

Current Address--Number and Street identifies the patient's current address including both number and street. It is often used for follow-up. This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

1. Record the number and street address or the rural mailing address of the patient's current usual residence.
2. Spell out the address fully with standardized use of abbreviations and punctuation per U.S. Postal Service (USPS) postal addressing standards. The USPS Postal Addressing Standards, Publication 28, October 2024, can be found on the Internet at <http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf>.
3. The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations. Do not use punctuation unless absolutely necessary to clarify an address; leave space between numbers and words.
Example: 103 FIRST AVE SW APT 102
4. Limit abbreviations to those recognized by the Postal Service standard abbreviations. They include, but are not limited to: AVE (avenue), BLVD (boulevard), CIR (circle), CT (court), DR (drive), PLZ (plaza), PARK (park), PKWY (parkway), RD (road), SQ (square), ST (street), APT (apartment), BLDG (building), FL (floor), STE (suite), UNIT (unit), RM (room), DEPT (department), N (north), NE (northeast), NW (northwest), S (south), SE (southeast), SW (southwest), E (east), W (west). A complete list of recognized street abbreviations is provided in Appendix C of USPS Publication 28.
5. Punctuation is normally limited to periods (for example, 39.2 RD), slashes for fractional addresses (101 1/2 MAIN ST), and hyphens when a hyphen carries meaning (289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The referred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (425 FLOWER BLVD # 72).
6. Update this data item if the patient's address changes.
7. Do not update this data item when the patient dies.
8. Enter UNKNOWN when the patient's street address is unknown.

Current Address--Supplemental

Item Length: 3

NAACCR Item #: 2355

NAACCR Name: Addr Current--Supplementl

XML NAACCR ID: addrCurrentSupplementl

Current Address--Supplemental allows for additional address information such as the name of a place or facility (for example, a nursing home, apartment complex, or other mailing address) of current residence. It is often used for follow-up. This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

1. Record the name of the place or facility where the patient currently resides.
 - a. For example, the name of an apartment complex or a nursing home
2. Do **not** use this data item to record the number and street address of the patient. Record number and street in *Current Address--Number and Street*.
3. Leave blank if this data item is not needed.

Current Address--City

Item Length: 50

NAACCR Item #: 1810

NAACCR Name: Addr Current--City

XML NAACCR ID: addrCurrentCity

Current Address--City captures the name of the city or town of the patient's current usual residence. It is often used for follow-up. This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

1. If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.
2. The current city or town of residence should be the same for all tumors when a patient has multiple malignancies/tumors.
3. Update city/town if the patient's city/town of residence changes.
4. Do **not** update this data item when the patient dies.

Current Address--State

Item Length: 50

NAACCR Item #: 1820

NAACCR Name: Addr Current--State

XML NAACCR ID: addrCurrentState

Current Address--State captures the name of the state of the patient's current usual residence. It is often used for follow-up. This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Coding Instructions

1. Assign the most specific code possible from [Appendix B](#) of this manual.
2. The current state of residence should be the same for all tumors when a patient has multiple malignancies/tumors.
3. Code either XX or YY depending on the circumstance when the patient is a foreign resident (See [Appendix B](#)).
4. Update state if the patient's state of residence changes.
5. Do **not** change this data item when the patient dies.

Current Address--Postal Code (ZIP Code)**Item Length: 9****NAACCR Item #: 1830****NAACCR Name: Addr Current--Postal Code****XML NAACCR ID: addrCurrentPostalCode**

Current Address--Postal Code (ZIP Code) captures the postal code (ZIP code) of the patient's current usual residence. It is often used for follow-up. This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Code	Description
(actual ZIP code)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
60611 _ _ _ _	When the nine-digit extended U.S. ZIP code is not available, record the five-digit postal code, left justified, followed by four blanks
M6G2S8 _ _ _	The patient's six-character Canadian postal code left justified, followed by three blanks
88888 _ _ _ _ or 888888888	Permanent address in a country other than Canada, United States, or U.S. possessions and postal code is unknown
999999999	Permanent address in Canada, United States, or U.S. possession and postal code is unknown

Coding Instructions

1. Record the nine-digit extended postal code of the patient's current usual residence for U.S. residents.
2. Record the six-character postal code for Canadian residents.
3. Record the postal code for other countries when available.
4. The postal code should be the same on each abstract for patients with multiple malignancies/tumors.
5. Update this data item if the patient's postal code changes.

Telephone

Item Length: 10
NAACCR Item #: 2360
NAACCR Name: Telephone
XML NAACCR ID: telephone

Telephone records the current telephone number including area code for the patient. This data item is collected by SEER registries for identification and matching purposes; it is not submitted to NCI SEER.

Code	Description
(actual telephone number)	Number entered without dashes
0000000000	Patient does not have a telephone
9999999999	Telephone number unavailable or unknown

Coding Instructions

1. Record the current telephone number including area code of the patient without dashes.
2. Update the telephone number if the telephone number changes.

Birthplace--State

Item Length: 3
NAACCR Item #: 252
NAACCR Name: Birthplace--State
XML NAACCR ID: birthplaceState

For cases diagnosed 01/01/2013 and later, *Birthplace--State* (NAACCR Item #252) and *Birthplace--Country* (NAACCR Item #254) replace *Place of Birth* (NAACCR Item #250). See the [2013 NAACCR Implementation Guidelines](#) for further information.

Coding Instructions

Assign the most specific code possible from [Appendix B](#) of this manual.

Birthplace--Country

Item Length: 3

NAACCR Item #: 254

NAACCR Name: Birthplace--Country

XML NAACCR ID: birthplaceCountry

For cases diagnosed 01/01/2013 and later, *Birthplace--State* (NAACCR Item #252) and *Birthplace--Country* (NAACCR Item #254) replace *Place of Birth* (NAACCR Item #250). See the [2013 NAACCR Implementation Guidelines](#) for further information.

Coding Instructions

Assign the most specific code possible from [Appendix B](#) of this manual.

Date of Birth

Item Length: 8
 NAACCR Item #: 240
 NAACCR Name: Date of Birth
 XML NAACCR ID: dateOfBirth

Date of Birth identifies the month, day, and year of the patient's birth. Transmit date data items in the year, month, day format (YYYYMMDD). Leave the year, month, and/or day blank when they cannot be calculated or are unknown.

Common Formats

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

Transmit Instructions

1. Transmit date data items in the year, month, day format (YYYYMMDD).
2. Leave the year, month, and/or day blank when they cannot be calculated or are unknown.
 - a. Leave the year, month, and day blank for death certificate only (DCO) cases when the date of birth is unknown and cannot be calculated.
3. Most SEER registries collect the month, day, and year. When the full date (YYYYMMDD) is transmitted, the seventh and eighth digits (day) will be deleted when the data are received by SEER.

Codes for Year

Code the four-digit year.

Codes for Month

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

Codes for Day

01
02
03
..
..
31

Coding Instructions

1. Code the date of birth.
2. If the date of birth is **unknown**, but the *Age at Diagnosis* and *Date of Diagnosis* are **known**
 - a. Calculate the year of birth by subtracting the patient's age at diagnosis from the year of diagnosis.
 - b. Leave the month and day blank.

Note: A zero must precede a single-digit month and a single-digit day.

Example: September 5, 1970, would be transmitted as 19700905.

Place of Death--State

Item Length: 2

NAACCR Item #: 1942

NAACCR Name: Place of Death--State

XML NAACCR ID: placeOfDeathState

Place of Death--State, effective 01/01/2018, indicates the state where the patient died and where the certificate of death is filed.

Coding Instructions

Assign the most specific code possible from [Appendix B](#) of this manual.

Place of Death--Country

Item Length: 3

NAACCR Item #: 1944

NAACCR Name: Place of Death--Country

XML NAACCR ID: placeOfDeathCountry

Place of Death--Country, effective 01/01/2018, indicates the country where the patient died and where the certificate of death is filed.

Coding Instructions

Assign the most specific code possible from [Appendix B](#) of this manual.

Age at Diagnosis

Item Length: 3
 NAACCR Item #: 230
 NAACCR Name: Age at Diagnosis
 XML NAACCR ID: ageAtDiagnosis

This data item represents the age of the patient at diagnosis **for this cancer or tumor**. This data item is tumor specific, i.e., the correct value could be different for each tumor diagnosis for a patient.

Code	Description
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

Coding Instructions

1. **Measure** the patient's age in **completed years** of life, i.e., age at the patient's **last** birthday.
2. Generally, the registry software program calculates the *Age at Diagnosis* using the *Date of Birth* and *Date of Diagnosis*.
3. *Age at Diagnosis* can be manually calculated using the *Date of Birth* and the *Date of Diagnosis*.
4. If the patient's age is 100 years or older, check the accuracy of the date of birth and date of diagnosis, and document both in a text field.

Cases Diagnosed In Utero

Record **000**, less than one year old, for cases diagnosed in utero.

Generally, registry software programs calculate *the Age at Diagnosis* using the *Date of Birth* and *Date of Diagnosis*. The calculation may result in a negative number for a case diagnosed in utero – replace the negative number with 000. Code age 000 for all diagnoses within the first year of life or before.

Race 1, 2, 3, 4, 5**Item Length: 2****NAACCR Item #: 160, 161, 162, 163, 164****NAACCR Name: Race 1, Race 2, Race 3, Race 4, Race 5****XML NAACCR ID: race1, race2, race3, race4, race5**

Race and ethnicity are defined by specific physical, hereditary, and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship. 'Origin' is defined by the U.S. Census Bureau as the heritage, nationality group, lineage, or in some cases, the country of birth of the person or the person's parents or ancestors before their arrival in the United States.

The five race data items (*Race 1 – Race 5*) make it possible to code multiple races for one person, consistent with the 2000 Census. All resources in the facility, including the medical record, face sheet, physician and nursing notes, and any other sources, must be used to determine race. If a facility does not print race in the medical record but does maintain it in electronic form, the electronic data must also be reviewed.

Recommendation: Document how the race code(s) was (were) determined in a text field.

Code	Description
01	White
02	Black or African American
03	American Indian or Alaska Native
04	Chinese
05	Japanese
06	Filipino
07	Native Hawaiian
08	Korean
10	Vietnamese
11	Laotian
12	Hmong
13	Cambodian
14	Thai
15	Asian Indian, NOS or Pakistani, NOS
16	Asian Indian (Effective with 01/01/2010 dx)
17	Pakistani (Effective with 01/01/2010 dx)
20	Micronesian, NOS
21	Chamorro
22	Guamanian, NOS
25	Polynesian, NOS
26	Tahitian
27	Samoan
28	Tongan
30	Melanesian, NOS
31	Fiji Islander
32	Papua New Guinean
88	No additional races (Race 2 – Race 5)
96	Other Asian, including Asian, NOS
97	Pacific Islander, NOS
98	Some other race
99	Unknown by patient

Priorities for Coding Multiple Races

List all races for the patient in this priority order.

1. Code **07** takes priority over all other codes.

Example: Patient is described as Japanese and Hawaiian. Code *Race 1* as 07 (Native Hawaiian), *Race 2* as 05 (Japanese).

2. Codes **02-32, 96-97** take priority over code **01 and 98**

Example 1: Patient is described as White and Black. Code *Race 1* as 02 (Black or African American), *Race 2* as 01 (White).

Example 2: Patient is described as White, Chinese, Korean, Black, and Hawaiian. Code *Race 1* as 07 (Native Hawaiian), *Race 2* as 04 (Chinese), *Race 3* as 08 (Korean), *Race 4* as 02 (Black or African American), and *Race 5* as 01 (White).

3. Code the specific race before the non-specific race when both a specific race code and a non-specific race code apply.
 - a. When more than five race fields are needed for specific race codes, omit the non-specific race code.
 - i. Codes 04-06, and 08-17 take priority over code 96
 - ii. Codes 16-17 take priority over code 15
 - iii. Codes 20-32 take priority over code 97
 - iv. Codes 01-32 and 96-97 take priority over code 98
 - v. Code 98 takes priority over code 99

Coding Instructions

1. Do **not** use patient name as the basis for coding race.
 - a. See Coding Instruction 14, Exception, for the only situation in which name is taken into account when coding race.
2. Code race using the highest priority source available according to the list below (a is the highest and c is the lowest) when race is reported differently by two or more sources. Use self-reported information as first priority.
 - a. Self-reported race information takes precedence over genetic testing and over information obtained through linkages. Generally, race information is used from linkages when race data are missing or unknown, or to enhance data. Self-reported information is the highest priority for coding race because the race information for the U.S. population comes from census data and that information is self-reported. For national cancer statistics, in order for the numerator (cancer cases) and the denominator (population) to be comparable, use self-reported race information whenever it is available.

Sources in Priority Order

- a. The patient's self-declared identification
- b. Documentation in the medical record
- c. Death certificate
3. Assign the same race code(s) for all tumors for one patient.

4. Code the race(s) of the patient in data items *Race 1*, *Race 2*, *Race 3*, *Race 4*, and *Race 5*.
 - a. Code **88** for the remaining race data items (*Race 2* – *Race 5*) when at least one race, but fewer than five races, are reported.
5. Use the associated text field to document when no race information is available.
6. Code as **01** (White) when
 - a. The race is described as White or Caucasian regardless of place of birth.
 - b. There is a statement that the patient is Hispanic or Latino(a) and **no further information** is available.
 - i. A person of Spanish origin may be any race; however, for coding race when there is no further information other than “Hispanic” or “Latino(a),” assign race as White as a last resort instead of coding unknown.

Example: Sabrina Fitzsimmons is a Latina. No further information is available. Code race as 01 (White).

Note 1: Do not code 98 (Other) in this situation.

Note 2: Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually White.

7. Code race as **02** (Black or African American) when the stated race is African American or Black.
8. Assign code **03** for any person stated to be
 - a. Native Alaskan (western hemisphere) OR
 - b. American Indian, whether from North, Central, South, or Latin America

Note: Information from IHS linkage can be used to override unknown race. Code 03 can be added based on IHS linkage. Follow the priority rules for recording race above.
9. Code the race based on birthplace information when the race is recorded as Mongolian or Asian and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation.

Example 1: Race is recorded as Asian and the place of birth is recorded as Japan. Code race as 05 (Japanese) because it is more specific than 96.

Example 2: The person describes himself as an Asian-American born in Laos. Code race as 11 (Laotian) because it is more specific than 96.
10. Use the appropriate non-specific code 96 (Other Asian including Asian, NOS), 97 (Pacific Islander, NOS), or 98 (Some other race) when there is no race code for a specific race documented in the patient record.

Note: Document the specified race in a text field.
11. Do not use code 98 (Some other race).
 - a. Alone for “multi-racial.” If multi-racial is the only information available, assign code 99. See Coding Examples below.
 - b. When race is unknown (code 99)

12. All race data items must be coded 99 (Unknown by patient) when *Race 1* is coded 99 (Unknown by patient).

Note: Assign code 99 in *Race 2* – *Race 5* **only when** *Race 1* is coded 99.

13. Assign code 99 for death certificate only (DCO) cases when race is unknown.

14. Refer to [Appendix D](#) “Race and Nationality Descriptions” when race is unknown or not stated in the medical record and birth place is recorded.
 - a. In some cases, race may be inferred from the nationality. Use Appendix D to identify nationalities from which race codes may be inferred.

Example 1: Record states: “this native of Portugal...” Code race as 01 (White) per Appendix D.

Example 2: Record states: “this patient was Nigerian...” Code race as 02 (Black or African American) per Appendix D.

Exception: Code *Race 1* through *Race 5* as 99 (Unknown by patient) when patient’s name is incongruous with the race inferred on the basis of nationality.

Example 1: Patient’s birthplace is listed as England. Patient’s name is Siddhartha Rao. Do not use country of birth to code the patient as White. Use other information to code the race. If no additional information is available, code *Race 1* through *Race 5* as 99 (Unknown).

Example 2: Patient’s birthplace is Ethiopia. Patient’s name is Ping Chen. Do not use country of birth to code the patient as Black. Use other information to code the race. If no additional information is available, code *Race 1* through *Race 5* as 99 (Unknown).
15. When the patient face-sheet indicates “Race Other,” look for other descriptions of the patient’s race. When **no further race information is available, code race as 99 (Unknown by patient)** and document that patient face-sheet indicates “Race Other,” and no further race information is available.
16. Do not use patient photographs or images from social media to code race.
17. Code the race data items in the order stated when no other priority applies.
18. The race of parents, when known, may be used with caution to determine patient’s race in the absence of other more specific information (see coding examples 5 and 7).

Coding Examples

Example 1: Patient is stated to be Japanese. Code as 05 (Japanese).

Example 2: Patient is stated to be German-Irish. Code as 01 (White).

Example 3: Patient is described as Arabian. Code as 01 (White).

Example 4: Patient described as a Black female. Code as 02 (Black or African American).

Example 5: Patient states she has a Polynesian mother and Tahitian father. Code *Race 1* as 25 (Polynesian), *Race 2* as 26 (Tahitian) and *Race 3* through *Race 5* as 88.

Example 6: Patient describes herself as multi-racial (nothing more specific) and nursing notes say “African-American.” Code *Race 1* as 02 (Black or African American). Code *Race 2* as 98 (Some other race). Code *Race 3* through *Race 5* as 88.

Example 7: The patient is described as Asian-American with Korean parents. Code race as 08 (Korean) because it is more specific than 96 (Asian) [-American].

Example 8: *Race 1* through *Race 5* in the cancer record are coded as 99 (Unknown by patient). The death certificate states race as black. Change cancer record for *Race 1* to 02 (Black or African American) and *Race 2* through *Race 5* to 88.

Example 9: *Race 1* is coded in the cancer record as 96 (Asian). Death certificate gives birthplace as China. Change *Race 1* in the cancer record to 04 (Chinese) and code *Race 2* through *Race 5* as 88.

Example 10: Patient is stated to be Chinese and Black. Code *Race 1* as 04 (Chinese), code *Race 2* as 02 (Black or African American). Code in the order stated when no other priority applies.

Example 11: Patient described as Middle Eastern. Code as 01 (White).

Example 12: Patient described as Greek. Code as 01 (White).

Example 13: *Race 1* is coded by one facility as 02 (Black or African American) and *Race 1* is coded by a different facility as 03 (American Indian or Alaska Native); no further documentation is provided. When consolidating records at the central cancer registry, code *Race 1* as 02 (Black or African American) and *Race 2* as 03 (American Indian or Alaska Native). If the patient is identified as Native American via the IHS linkage, follow usual procedures.

Example 14: Patient is from Guyana. Patient's race is coded differently in multiple source records using codes such as 02 (Black or African American) for *Race 1* or 98 (Some other race) or 15 (Asian Indian, NOS or Pakistani, NOS), for example, no further documentation is provided. When consolidating records at the central cancer registry, record all races reported in the appropriate priority order.

Example 15: Electronic medical record indicates patient is "Native Hawaiian or Other Pacific Islander." Look for other descriptions of the patient's race. When no other information is available, assign 07, Native Hawaiian, in *Race 1* and assign 97, Pacific Islander, NOS in *Race 2*.

Example 16: Patient is "Belgian." Medical record indicates "non-Hispanic, other race." Patient appears white on scanned driver's license photo. Assign race code 01 for white. "Belgium" is classified as "European" in Appendix D and European is included under the descriptions for white. Do not use photo to verify race.

History

1. *Race 1* is the data item used to compare with race data on cases diagnosed prior to January 1, 2000
2. Race codes must be identical on each record when the patient has multiple tumors.
 - a. For cases with all diagnoses prior to January 1, 2000, *Race 2* through *Race 5* must be blank.
 - b. For cases that have multiple tumors with at least one primary diagnosed **on or after January 1, 2000**, race codes in *Race 1*, *Race 2*, *Race 3*, *Race 4*, and *Race 5* must be identical on all records.
3. Codes **08-13** became effective with diagnoses on or after January 1, 1988
4. Code **09** was **retired** effective with diagnoses on or after January 1, 2010
5. Code **14** became effective with diagnoses on or after January 1, 1994
6. Codes **15**, **16**, and **17** became effective with diagnoses on or after January 1, 2010
7. Codes **20-97** became effective with diagnoses on or after January 1, 1991
8. San Francisco, San Jose-Monterey, and Los Angeles are permitted to use codes 14 and 20-97 for cases diagnosed after January 1, 1987; Greater California is permitted to use codes 14 and 20-97 for cases diagnosed after January 1, 1988. Other SEER registries may choose to recode cases diagnosed prior to 1991 using 14 and 20-97 if all cases in the following race codes are reviewed: 96 (Other Asian, including Asian, NOS); 97 (Pacific Islander, NOS); 98 (Some other race); and 99 (Unknown by patient).

IHS Link

Item Length: 1
NAACCR Item #: 192
NAACCR Name: IHS Link
XML NAACCR ID: ihsLink

Indian Health Service (IHS) Link reports the result of linkage between the registry database and the Indian Health Service (IHS) patient registration database. This linkage identifies American Indians who were misclassified as non-Indian in the registry. The computer linkage program will automatically assign the code for this data item.

SEER requires *IHS Link* for cases diagnosed January 1, 1988, and forward. *IHS Link* may be submitted for cases diagnosed in earlier years. The data item will be blank unless an attempt was made to link the case with the records from the IHS.

Code	Description
0	Record sent for linkage, no IHS match
1	Record sent for linkage, IHS match
Blank	Record not sent for linkage or linkage result pending

Note: Information from IHS linkage can be used to update race from unknown to code 03. Follow the priority rules for recording race.

Spanish Surname or Origin

Item Length: 1

NAACCR Item #: 190

NAACCR Name: Spanish/Hispanic Origin

XML NAACCR ID: spanishHispanicOrigin

This data item is used to identify patients with Spanish/Hispanic surname or of Spanish origin. Persons of Spanish or Hispanic surname/origin may be of any race. The data item is requested for submission to NAACCR.

Note: Hispanic surname lists are registry-specific.

Code	Description
0	Non-Spanish/Non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil) [See below for lists of countries in Central and South America]
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS There is evidence, other than surname or birth surname (maiden name) , that the person is Hispanic but he/she cannot be assigned to any of the categories 1-5.
7	Spanish surname only (effective with diagnosis on or after 01/01/1994) The only evidence of the person's Hispanic origin is the surname or birth surname (maiden name) and there is no evidence that he/she is not Hispanic .
8	Dominican Republic (effective with diagnosis on or after 01/01/2005)
9	Unknown whether Spanish/Hispanic or not

Coding Instructions

- Coding *Spanish Surname or Origin* is not dependent on race. A person of Spanish descent may be white, black, or any other race.
- Use all information to determine the Spanish/Hispanic origin including
 - The ethnicity stated in the medical record.
 - Self-reported information takes priority over other sources of information.
 - Hispanic origin stated on the death certificate
 - Birthplace
 - Information about life history and/or primary language spoken at home found in the abstracting process
 - A last name or birth surname (maiden name) found on a list of Hispanic/Spanish names
- Assign code 0 for Brazil.
- Assign code 6 when there is more than one ethnicity/origin (multiple codes), such as Mexican (code 1) and Dominican Republic (code 8). There is no hierarchy among the codes 1-4 or 8.

5. Assign code **7** when the only evidence of the patient's Hispanic origin is a surname or birth surname (maiden name) and there is no evidence that the patient is not Hispanic. Code 7 is ordinarily for central registry use only.
6. Portuguese, Brazilians, and Filipinos are not presumed to be Spanish or non-Spanish.
 - a. Assign code **7** when the patient is Portuguese, Brazilian, or Filipino and their name appears on a Hispanic surname list.
 - b. Assign code **0** when the patient is Portuguese, Brazilian, or Filipino and their name does NOT appear on a Hispanic surname list.
7. Assign code **9**
 - a. For death certificate only (DCO) cases when Spanish/Hispanic origin is unknown
 - b. When there is no written or verbal indication of Spanish origin, the patient declined to answer their Spanish origin, or the patient does not know their Spanish origin.

Example: The patient's race is white or black, they were born in the United States, their last name is not on a Spanish surname list, and there is no mention of Spanish origin in the patient record.
8. When consolidating records at the central registry
 - a. Prefer code 1 over code 5 when both are submitted with a birthplace of Mexico.
 - b. Prefer code 2, 3, 4, or 8 over 5

Coding Examples

Example 1: Married female, no married name, Race 99, born in Mexico, married name is not on Spanish surname list. Code as 1 (Mexican) using coding instruction 2.c.

Example 2: Married female, no maiden name (birth surname), Race 01, born in Philippines, married last name not on Spanish surname list and medical record states "Hispanic." Code as 6 (Hispanic, NOS) using coding instruction 2.a.

Example 3: Married female, no maiden name (birth surname), Race 99, born in Peru, married last name is on Spanish surname list, no statement regarding ethnicity available. Code as 4 (South or Central America) using coding instruction 2.c.

Example 4: Patient has two last names, one of the last names is on the Spanish surname list. Code as 7 (Spanish surname only) using coding instruction 5.

Countries in Central America

- Belize
- Costa Rica
- El Salvador
- Guatemala
- Honduras
- Nicaragua
- Panama

Countries in South America

- Argentina
- Bolivia

- Brazil [Not included in code 4].
- Chile
- Colombia
- Ecuador
- Guyana
- Paraguay
- Peru
- Suriname
- Uruguay
- Venezuela

NHIA Derived Hispanic Origin

Item Length: 1

NAACCR Item #: 191

NAACCR Name: NHIA Derived Hisp Origin

XML NAACCR ID: nhiaDerivedHispOrigin

The NAACCR Hispanic Identification Algorithm (NHIA) is a computerized algorithm that uses a combination of variables to directly or indirectly classify cases as Hispanic for analytic purposes.

Note: Surname lists are just one component of the indirect assignment of ethnicity or race by NHIA. A number of filters based on race, ethnicity, birthplace, or county attribute may preclude a patient from ever being indirectly assigned based on surname. Also, if a patient is coded as non-Hispanic, the registry may elect NOT to run the case through NHIA. A female patient's last name could, however, be used to classify the case as Hispanic for the NHIA variable after making it through the filters and exclusions.

Persons are also included as Hispanic/Latino(a) when they are female cases with heavily Hispanic birth surnames (maiden names); female cases with missing maiden names and heavily Hispanic last names; female cases with generally Hispanic, moderately Hispanic, occasionally Hispanic, or indeterminate maiden names and heavily Hispanic last names.

Code	Description
0	Non-Hispanic
1	Mexican, by birthplace or other specific identifier
2	Puerto Rican, by birthplace or other specific identifier
3	Cuban, by birthplace or other specific identifier
4	South or Central American (except Brazil), by birthplace or other specific identifier
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic), by birthplace or other specific identifier
6	Spanish, NOS; Hispanic, NOS; Latino, NOS
7	NHIA surname match only
8	Dominican Republic
Blank	Algorithm has not been run

Sex Assigned at Birth

Item Length: 1

NAACCR Item #: 225

NAACCR Name: Sex Assigned at Birth

XML NAACCR ID: sexAssignedAtBirth

Sex Assigned at Birth, effective 01/01/2026, records the sex designated to a patient at birth, most often based on visual anatomy.

Code	Description
1	Male
2	Female
9	Not stated/Unknown

Coding Instructions

1. Assign the sex of the patient assigned at birth.
2. Assign code 1 or 2 when the patient's sex is documented as male or female, respectively, and there is no other information to indicate the patient was assigned a different sex at birth.
3. When sex is not known
 - a. Assign code 1 when the primary site is C600-C639.
 - b. Assign code 2 when the primary site is C510-C589.
 - c. Assign code 9 for primary sites not included above.
4. Assign code 9
 - a. When sex is unknown (excluding Coding Instructions 3.a and 3.b) or sex is not yet determined
 - i. Do not assign code 9 when sex is documented as male or female and there is no other information about sex assigned at birth.
 - b. If patient is born with Disorders of Sexual Development (DSD) and sex is not clearly defined
 - c. When patient's sex is documented as other than male or female (e.g., non-binary, transsexual), and there is no additional information about sex assigned at birth.

Marital Status at Diagnosis

Item Length: 1

NAACCR Item #: 150

NAACCR Name: Marital Status at DX

XML NAACCR ID: maritalStatusAtDx

Code the patient's marital status at the time of diagnosis for the reportable tumor.

Code	Description
1	Single (never married)
2	Married (including common law)
3	Separated
4	Divorced
5	Widowed
6	Unmarried or Domestic Partner (same sex or opposite sex, registered or unregistered, other than common law marriage) (effective for cases diagnosed 01/01/11 and forward)
9	Unknown

Note: If the patient has multiple tumors, marital status may be different for each tumor.

Definition

Common Law Marriage. A couple living together for a period of time and declaring themselves as married to friends, family, and the community, having never gone through a formal ceremony or obtained a marriage license.

Coding Instructions

1. Assign code **2** [Married (including common law)] when the patient declares him/herself as married. Marriage is self-reported.
2. Assign code **6** when the patient is not married and is in a domestic partner relationship other than common law marriage.
3. Assign code **9** for death certificate only (DCO) cases when marital status at the time of diagnosis is unknown.

Justification for Continued Collection

Marital Status at Diagnosis was evaluated for possible retirement (discontinuation of collection). It will not be retired at this time because it is readily available and provides important information not available from any other data item.

Primary Payer at Diagnosis

Item Length: 2

NAACCR Item # 630

NAACCR Name: Primary Payer at DX

XML NAACCR ID: primaryPayerAtDx

Primary Payer at Diagnosis identifies the patient's primary health insurance carrier or method of payment at the time of initial diagnosis and/or treatment.

Code	Label	Definition
01	Not insured	Patient has no insurance and is declared a charity write-off
02	Not insured, self-pay	Patient has no insurance and is declared responsible for charges
10	Insurance, NOS	Type of insurance is unknown or other than types listed in codes 20, 21, 31, 35, 60-68
20	Private Insurance: Managed care, HMO, or PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network, or a staff model. "Gate-keeper model" is another term for describing this type of insurance.
21	Private Insurance: Fee-for-service	An insurance plan that does not have a negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs Medicaid other than Medicaid described in code 35
35	Medicaid – administered through a Managed Care plan	Patient is enrolled in Medicaid through a Managed Care program (e.g., HMO or PPO). The managed care plan pays for all incurred costs.
60	Medicare/Medicare, NOS	Federal government funded insurance generally for persons who are 65 years of age or older, are chronically disabled (social security insurance eligible), or are dialysis patients. Includes Medicare without supplement. Not described in codes 61, 62, or 63.
61	Medicare with supplement, NOS	Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare. (See also, codes 63 and 64.). Example: Patient is known to have Medicare with a supplement, but the type of Medicare supplement is unknown.
62	Medicare – Administered through a Managed Care Plan	Patient is enrolled in Medicare through a Managed Care plan (e.g., HMO or PPO). The Managed Care plan pays for all incurred costs. Example: Patient has a Medicare managed plan (also known as Medicare C or Medicare Advantage). The Medicare managed care plan takes the place of original Medicare plan and will be listed as the first and usually only insurance as a HMO, PPO, etc.
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare. Example: Patient has Medicare A (inpatient) and B (outpatient and durable medical equipment) with a private supplement to cover costs outside of Medicare A and B. Medicare will be listed on the patient's face sheet as the first insurance with the commercial insurance (Medicare supplement) listed second. If Medicare is listed first with Medicaid listed second, capture under code 64.
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with state-administered Medicaid supplement.

Code	Label	Definition
65	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents Formerly known as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).
66	Military	Military personnel or their dependents treated at a military facility
67	Veterans Affairs	Veterans treated in Department of Veterans Affairs facilities
68	Indian/Public Health Service	Patient receives care at an Indian Health Service facility or at another facility and medical costs are reimbursed by the Indian Health Service Patient receives care at a Public Health Service facility or at another facility, and medical costs are reimbursed by the Public Health Service
99	Insurance status unknown	Patient's medical record does not indicate whether or not the patient is insured

Coding Instructions

1. Code the type of insurance reported on the patient's admission record.
2. Code the **first** insurance mentioned when multiple insurance carriers are listed on one admission record.
3. Code the type of insurance reported **closest to the date of diagnosis** when there are multiple insurance carriers reported for multiple admissions and/or multiple physician encounters.
4. Code the patient's insurance at the time of **initial diagnosis and/or treatment**. Do not change the insurance information based on subsequent information.
 - a. Code the first insurance mentioned when there is more than one type of insurance specified during the initial diagnosis and/or treatment.
5. Use code **02** when the only information available is "self-pay".
6. Use code **10** for prisoners when no further information is available.
7. Assign code **99** for death certificate only (DCO) cases when the primary payer at diagnosis is unknown.

Tobacco Use Smoking Status

Item Length: 1

NAACCR Item #344

NAACCR Name: Tobacco Use Smoking Status

XML NAACCR ID: tobaccoUseSmokingStatus

Tobacco Use Smoking Status, effective 01/01/2022, captures the patient's past or current use of tobacco (cigarette, cigar, and/or pipe).

Tobacco smoking history can be obtained from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats, or Nursing Assessment section, or other available sources from the patient's hospital medical record or physician office record. The information recorded in this data item is not comparable to the information previously collected under the CDC Comparative Effectiveness Research (CER) and Patient Centered Outcomes Research (PCOR) projects.

Code	Description
0	Never smoker
1	Current smoker
2	Former smoker
3	Smoker, current status unknown
9	Unknown if ever smoked

Coding Instructions

- Record the past or current use of tobacco.
 - Tobacco use includes cigarette, cigar, and/or pipe.
- Do not record the patient's past or current use of marijuana, chewing tobacco, e-cigarettes, or vaping devices.
- Assign code **1** when
 - The patient currently smokes.
 - The record only states "current tobacco use".
 - There is evidence in the medical record that the patient quit smoking within 30 days prior to diagnosis. The 30 days prior information is intended to differentiate patients who may have quit recently due to symptoms that led to a cancer diagnosis.
- Assign code **2** when the medical record indicates
 - "Former smoker"
 - "Prior tobacco use"
 - Patient has smoked tobacco in the past but does not smoke now. Patient must have quit 31 or more days prior to cancer diagnosis to be coded as 'former smoker'.
- Assign code **3** when
 - The patient is noted to have smoked, but the current smoking status is not known.
 - It is known that the patient "recently" stopped smoking but it is not known how long ago the patient stopped smoking.
 - It cannot be determined whether the patient currently smokes or formerly smoked.

Example: The medical record only indicates “Yes” for smoking without further information.

6. Assign code **9** rather than code 0 when
 - a. The medical record only indicates “No” for tobacco use.
 - b. Smoking status is not stated or provided.
 - c. The method (cigarette, pipe, cigar) used cannot be verified in the chart.
 - d. The record has no information about smoking status or history (e.g., pathology report only).
 - e. It is documented that the patient uses or used smokeless or chewing tobacco or e-cigarettes or vapes, but tobacco use is not mentioned.
7. Use text fields to explain the code assignment.
8. Leave blank for cases diagnosed prior to 2022.

Section IV

Description of this Neoplasm

Pathology Reports

For the purposes of coding primary site, histologic type, and behavior, SEER recommends that information from consult pathology reports be preferred over the original pathology report. This is because consults are usually requested from a more experienced or specialized pathologist/lab and are generally thought to be more accurate. In this context, a “re-read” is the same as a consult pathology report.

Date of Diagnosis

Item Length: 8

NAACCR Item #: 390

NAACCR Name: Date of Diagnosis

XML NAACCR ID: dateOfDiagnosis

The date of diagnosis is the month, day, and year the reportable neoplasm was first identified, clinically or microscopically, by a physician and/or advanced practice provider (PAPP). PAPP includes physician, physician assistant, nurse practitioner, and nurse midwife.

Date of Diagnosis must be transmitted in the YYYYMMDD format. *Date of Diagnosis* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format. Regardless of the format, at least **Year** of diagnosis must be **known or estimated for cases transmitted to SEER**. Year of diagnosis **cannot be blank or unknown for cases transmitted to SEER**.

Transmitting Dates

Transmit date data items in the year, month, day format (YYYYMMDD). Transmit only known or estimated **year** of diagnosis; blanks will not be accepted for year. Leave the month, day, and/or year¹ blank when they cannot be estimated or are unknown.

Common Formats

YYYYMMDD	Complete date is known
YYYYMM	Year and month are known/estimated; day is unknown
YYYY	Year is known/estimated; month and day cannot be estimated or are unknown
Blank	Year, ¹ month, and day cannot be estimated or are unknown

Transmit Instructions

1. Transmit date data items in the year, month, day format (YYYYMMDD).
2. Transmit only known or estimated year of diagnosis, blanks will not be accepted.
3. Leave the month and/or day blank when they cannot be estimated or are unknown.
4. Most SEER registries collect the month, day, and year of diagnosis. When the full date (YYYYMMDD) is transmitted, the seventh and eighth digits (day) will be held confidentially and only used for survival calculations when received by NCI SEER.

¹ Cases NOT transmitted to SEER only

Instructions

Cases with an unknown year of diagnosis **cannot** be transmitted to NCI SEER. It is very important to do everything possible to determine the year of diagnosis.

Case transmitted to NCI SEER

1. Follow-back must be done to obtain the date of diagnosis. If no information can be found, follow instruction 2.
2. Date of diagnosis must be estimated. See the coding instructions below for estimating date of diagnosis.
 - a. For reports dated December or January of a given year, code the month of the report or the month of admission (Coding Instruction 9.a.viii.). Coding the month of the report or the month of admission results in a better estimate of the date of diagnosis than coding month as 99 and having the computer assign July as the month of diagnosis, for example.
 - b. When the diagnosis date is stated to be spring, summer, fall, or winter, follow coding instructions 9.a.i., ii., iii., and iv.

Case **NOT** transmitted to NCI SEER

1. Code the date of diagnosis when known, even if the case is not transmitted to SEER for other reasons.
2. Code as unknown when there is no information available.

Codes for Year

Code the four-digit year of diagnosis.

Codes for Month

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

Codes for Day

01
02
03
..
..
31

Coding Instructions

1. Code the month, day, and year the tumor was first diagnosed, clinically or microscopically, by a PAPP.
 - a. When the first diagnosis includes reportable ambiguous terminology, record the date of that diagnosis.

Example: Area of microcalcifications in breast suspicious for malignancy on 02/13/2027. Biopsy positive for ductal carcinoma on 02/28/2027. The date of diagnosis is 02/13/2027.
2. When the **only** information available is a positive pathology or cytology report, code the date the procedure was done as the date of diagnosis. Do not code the date the specimen was received, read as positive by the pathologist, or the date the report was dictated or transcribed.

Example: Biopsy was performed on 05/06/2027. The specimen from the biopsy was received and read by the pathologist as positive for cancer on 05/09/2027. The date of diagnosis is 05/06/2027.
3. The first diagnosis of cancer may be **clinical** (i.e., based on clinical findings or physician's documentation).

Note: Do **not** change the date of diagnosis when a clinical diagnosis is subsequently confirmed by positive histology or cytology.

Example: On May 15, 2027, physician states that patient has lung cancer based on clinical findings. The patient has a positive biopsy of the lung on June 3, 2027. The date of diagnosis remains May 15, 2027.
4. Positive **tumor markers** alone are **not** diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.

Example 1: The patient has an elevated PSA, and the physical examination is negative. The physician documents only that the patient is referred for a needle biopsy of the prostate. Biopsy is positive for adenocarcinoma. The date of diagnosis is the date of the biopsy (do not code the date of the PSA or the date the procedure was dictated or transcribed).

Example 2: The patient has an elevated PSA, and the physical examination is negative. The physician documents that he/she suspects that the patient has prostatic cancer and is referring the patient for a needle biopsy. The needle biopsy is positive, confirming the physician's suspicion of cancer. The date of diagnosis is the date the physician documented that he/she **suspects** that the patient has prostatic cancer.

Note: Positive tumor markers alone are never used for case ascertainment.
5. Use the date of suspicious cytology when the diagnosis is proven by subsequent biopsy, excision, or other means.

Example: Cytology suspicious for malignancy 01/12/2027. Diagnosis of carcinoma per biopsy on 02/06/2027. Record 01/12/2027 as the date of diagnosis.

Note 1: “Suspicious” cytology means that the diagnosis is preceded by an [ambiguous term](#) such as apparently, appears, compatible with, etc.

Note 2: Do **not** use ambiguous cytology **alone** for case ascertainment.

6. Code the **earlier date** as the date of diagnosis when

- a. A recognized PAPP says that, in **retrospect**, the patient had cancer at an earlier date, or
- b. The original slides are reviewed and the pathologist documents that cancer was present. Code the date of the original procedure as the diagnosis date.

Example 1: The patient had an excision of a benign fibrous histiocytoma in January 2027. Six months later, a wide re-excision was positive for malignant fibrous histiocytoma. The physician documents in the chart that the previous tumor must have been malignant. Code the diagnosis date as January 2027.

Note: Do **not** back-date the diagnosis when

- The information on the previous tumor is unclear **AND/OR**
- There is **no review** of previous slides **AND/OR**
- There is **no physician’s statement** that, in retrospect, the previous tumor was malignant.

Example 2: The patient had a total hysterectomy and a bilateral salpingo-oophorectomy (BSO) in June 2027, with pathology diagnosis of papillary cystadenoma of the ovaries. In December 2027, the patient is diagnosed with widespread metastatic papillary cystadenocarcinoma. The slides from June 2027 are not reviewed and there is no physician statement saying the previous tumor was malignant. The date of diagnosis is December 2027.

7. Code the **date of death** as the date of diagnosis for autopsy only cases.

8. Death certificate only (DCO) Cases

- a. Use information on the death certificate to estimate the date of diagnosis.
- b. Record the date of death as the date of diagnosis when there is not enough information available to estimate the date of diagnosis; for example, the time from onset to the date of death is described as ‘years’.
- c. If no information is available, record the date of death as the date of diagnosis.

9. **Estimate the date of diagnosis** if an exact date is not available. Use all information available to calculate the month and year of diagnosis.

- a. Estimating the **month**
 - i. Code “spring” to April
 - ii. Code “summer” or “middle of the year” to July.
 - iii. Code “fall” or “autumn” as October.
 - iv. For “winter” try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month of diagnosis.
 - v. Code “early in year” to January.
 - vi. Code “late in year” to December.
 - vii. Use whatever information is available to calculate the month of diagnosis.

Example 1: Admitted October 2027. History states that the patient was diagnosed 7 months ago. Subtract 7 from the month of admission and code date of diagnosis to March 2027.

Example 2: Outpatient bone scan done January 2027 that states history of prostate cancer. The physician says the patient was diagnosed in 2027. Assume bone scan was part of initial work-up and code date of diagnosis to January 2027.

- viii. Code the month of admission when there is no basis for estimation.
- ix. Leave month blank (or convert 99 to blank) if there is no basis for approximation.
- b. Estimating the **year**
 - i. Code “a couple of years” to two years earlier.
 - ii. Code “a few years” to three years earlier.
 - iii. Use whatever information is available to calculate the year of diagnosis.
 - iv. Code the year of admission when there is no basis for estimation.
- 10. If **no information** about the date of diagnosis is available
 - a. Case transmitted to NCI SEER
 - i. Use the date of admission as the date of diagnosis.
 - ii. In the absence of an admission date, code the date of first treatment as the date of diagnosis.
 - b. Case **NOT** transmitted to NCI SEER
 - i. Code month and year as unknown.

Nursing Home and Hospice Residents (Not hospitalized for their cancer; no information other than nursing home or hospice records and/or death certificate)

- 1. Use the **best approximation** for the date of diagnosis when the only information available is that the patient **had cancer while in the nursing home** and it is unknown whether the patient had cancer when admitted.
- 2. Code the **date of admission** to the nursing home as the date of diagnosis when
 - a. The **only information available** is that the patient had cancer when admitted to the nursing home.
 - b. The **only information available** is that the patient had cancer while in the nursing home, it is unknown whether the patient had cancer when admitted, and there is **no basis for approximation**.

Cases Diagnosed Before Birth

Record the actual date of diagnosis for diagnoses made in utero even though this date will precede the date of birth.

Example: Fetal intrahepatic mass consistent with hepatoblastoma diagnosed via ultrasound at 39 weeks gestation (01/30/2027). Live birth by C-section 02/04/2027. Code the date of diagnosis as 01/30/2027.

Note: Prenatal diagnoses are reportable when there is a live birth.

Tumor Record Number

Item Length: 2

NAACCR Item #: 60

NAACCR Name: Tumor Record Number

XML NAACCR ID: tumorRecordNumber

Tumor Record Number is used to uniquely identify a tumor. It is auto-assigned in SEER*DMS when the Consolidated Tumor Case (CTC) is created. It never changes and is not reused if the tumor is deleted or replaced. Since the tumor record never changes, there are cases where the tumor record numbers are not in sequential order according to diagnosis date. *Tumor Record Number* does not change the way the sequence number changes. It is increasingly important to track a specific tumor over time for linkage purposes.

Code	Description
01	First tumor
02	Second tumor
..	..
..	..
99	99 th tumor

Sequence Number--Central

Item Length: 2

NAACCR Item #: 380

NAACCR Name: Sequence Number--Central

XML NAACCR ID: sequenceNumberCentral

Sequence Number--Central describes the number and sequence of all reportable malignant, in situ, benign, and borderline primary tumors that occur over the lifetime of a patient.

This sequence number counts all tumors that were reportable in the year they were diagnosed even if the tumors occurred before the registry existed or before the registry participated in the SEER Program. See coding instructions below.

While the *Sequence Number--Hospital* (NAACCR Item #560) may be useful in determining *Sequence Number--Central*, the two sequence numbers do not have to be identical.

Rules for Determining Multiple Primaries and the reportability requirements for each diagnosis year should be used to decide which primaries need to be sequenced.

In Situ/Malignant as Federally Required based on Diagnosis Year

Code	Description
00	One primary in the patient's lifetime
01	First of two or more primaries
02	Second of two or more primaries
..	..
..	(Actual number of this primary)
..	..
59	Fifty-ninth or higher of fifty-nine or more primaries
99	Unspecified or unknown sequence number of Federally required in situ or malignant tumors. Sequence number 99 can be used if there is a malignant tumor and its sequence number is unknown. (If there is known to be more than one malignant tumor, then the tumors must be sequenced.)

Non-malignant Tumor as Federally Required based on Diagnosis Year

Code	Description
60	Only one non-malignant tumor or central registry-defined neoplasm
61	First of two or more non-malignant tumors or central registry-defined neoplasms
62	Second of two or more non-malignant tumors or central registry-defined neoplasms
..	..
87	Twenty-seventh of twenty-seven
88	Unspecified or unknown sequence number of non-malignant tumor or central-registry defined neoplasms. (Sequence number 88 can be used if there is a non-malignant tumor and its sequence number is unknown. If there is known to be more than one non-malignant tumor, then the tumors must be sequenced.)

Type of Neoplasm/Sequence Number Series

Neoplasm	Sequence Number--Central Numeric Series
Series 1: In situ/malignant as Federally required	00-59, 99
All in situ (behavior code 2) excluding Cervix CIS, CIN III, SIN III of cervix All other in situ including VIN III, VAIN III, AIN III Malignant (behavior code 3) Invasive following in situ – new primary defined by SEER	00-59
Unspecified Federally required sequence number or unknown	99
Series 2: Non-malignant tumor as Federally required or state or regional registry defined*	60-87, 88
Examples	
Non-malignant tumor/benign brain/intracranial	60-87
Borderline ovarian (diagnosis year 2001+)	60-87
Other borderline/benign	60-87
Skin SCC/BCC	60-87
PIN III (diagnosis year 2001+)	60-87
Cervix CIS/CIN III, SIN III of cervix <i>Note:</i> Submission of in situ cervical cancer is no longer required as of 2018 NCI SEER data submission.	60-87
Unspecified non-malignant tumor or central registry-defined sequence number	88

*Series 2 – The only tumors in Series 2 that SEER requires are benign/borderline intracranial and central nervous system (CNS) tumors.

Note: Conversion Guidance

Do **not** change the sequence numbers for neoplasms whose histology codes were associated with behavior codes that changed from in situ/malignant to benign/borderline or vice versa during the conversion from ICD-O-2 to ICD-O-3 or the conversion from ICD-O-3 to ICD-O-3.2.

In situ/Malignant Coding Instructions

- Count all previous and current in situ/malignant reportable primaries which occur(red) over the lifetime of the patient, regardless of where he/she lived at diagnosis.
 - A 'reportable' primary refers to the site/histology/behavior of the tumor and the years when reporting was required. Review of the reportability requirements in effect during the diagnosis year will be needed.
- Code **00** when there is only **one** primary in the patient's lifetime.
- Sequence in situ/malignant primaries chronologically as 01 (first of one or more), 02 (second primary), 03 (third primary), and assign the appropriate sequence number to all primaries in the database when there are multiple primaries.

Example 1: The patient has a history of breast cancer in 1999. She has colon cancer in 2010. Assign sequence number 02 to the colon cancer and change the sequence number on the breast cancer from 00 to 01.

Example 2: In 1987, patient was diagnosed and treated for childhood leukemia in another state. After becoming a resident of a SEER region, the patient develops bladder cancer. The SEER registry assigns a sequence number of 02 to the bladder cancer. Document the first diagnosis in a text field.

- a. Change the sequence number of the first primary from 00 to 01 when one patient has a primary with sequence 00 and then develops another reportable /2 or /3 primary.
- b. **Exception:** There are certain cancers that were only reportable for some years. The following are some examples (not a complete list):
 - Borderline tumors of the ovary were reported for 1992-2000.
 - Sequence 00-59
 - Refractory anemia is reported only for 2001+.
 - Myelodysplastic syndromes are reported only for 2001+.
 - Newly reportable hematopoietic neoplasms as of 01/01/2010
4. Assign the lower sequence number to the primary with the worse prognosis when **two primaries are diagnosed simultaneously**.
 - a. Base the prognosis decision on the primary site, histology, and extent of disease for each of the primaries
 - b. If there is no difference in prognosis, the sequence numbers may be assigned in any order.

Non-Malignant Coding Instructions

1. Include all non-malignant primary intracranial /CNS tumors diagnosed in 2004, and forward regardless of where the patient lived at diagnosis.
2. Assign sequence number **60** when there are no prior or subsequent non-malignant intracranial/CNS tumors.
 - a. The sequence number is 60 when a patient has **only one** reportable non-malignant tumor. If a tumor has a sequence of 60 and there is another reportable non-malignant tumor, change the sequence number of the first primary from 60 to 61.
3. Assign sequence numbers in chronological order according to the order in which they occur(red). Reportable benign and borderline intracranial/CNS tumors are restricted to primary site codes C700-C729, C751-C753 with behavior codes of /0 or /1.
4. Sequence multiple non-malignant tumors chronologically as 61 (first of two or more), 62 (second), etc.
5. Sequence a non-malignant intracranial/CNS tumor and a malignant intracranial/CNS tumor (/2 or /3) independently when one patient has both. The non-malignant tumor has a sequence number of 60 and the malignant (/2 or /3) tumor has a sequence number of 00.
6. Sequence tumors other than those required by SEER in the 60-87 range when a registry chooses to collect non-reportable tumors. These non-reportable tumors are often referred to as "Reportable by agreement."

Example: Cervix in situ was diagnosed in 2003, and lung cancer was diagnosed in 2027. The cervix in situ, if collected by the registry, would be a sequence number 60 and the lung would be assigned a sequence number of 00.

Note: Sequence all cervix in situ cases in the 60-87 range regardless of diagnosis year. Submission of in situ cervical cancer is no longer required as of 2018 NCI SEER data submission.

Primary Site

Item Length: 4
NAACCR Item #: 400
NAACCR Name: Primary Site
XML NAACCR ID: primarySite

For cases diagnosed 01/01/2001 and later, code the primary site using the topography codes listed in the *International Classification of Diseases for Oncology, Third Edition* (ICD-O-3). The current Solid Tumor Rules contain additional coding instructions for some primary sites, including Head and Neck, Lung, and Urinary.

Note: Continue to use ICD-O-3 for assigning topography codes. ICD-O-3.2 did not change any of the topography codes.

The ICD-O-3 has topography codes listed in two sections; the first is a numeric listing by code number, the second is an alphabetic listing by anatomic site. The topography code consists of a lead character (the letter 'C') followed by two numeric digits, a decimal point, and then one additional numeric digit. The decimal point is not entered as part of the code.

Example: The pathology report says the primary site is the cardia of the stomach. The code C16.0 is found in the Alphabetic Index under either "stomach" or "cardia." Enter the code as C160; do not record the decimal point.

Resources for Coding Primary Site for Solid Tumors, in priority order

1. ICD-O
2. SEER Program Manual
 - a. Including Coding Guidelines in Appendix C
3. Solid Tumor Rules

Physician Priority Order for Coding Primary Site for Solid Tumors

As a general rule, the surgeon is usually in a better position to determine the site of origin compared to the pathologist. The surgeon sees the tumor in its anatomic location, while the pathologist is often using information given to him/her by the surgeon and looking at a specimen removed from the anatomic landmarks. However, when a pathologist is looking at an entire organ, such as the pancreas, he/she may be able to pinpoint the site of origin within that organ.

Example: The surgeon states during a pancreatectomy that the primary site is body of pancreas while the pathologist states in the College of American Pathologists (CAP) Synoptic Reports that the primary site is neck of pancreas. In the case of pancreas body vs. neck, the neck is a thin section of the pancreas located between the head and the body. It may be a matter of opinion whether a tumor is located in the "body" vs. the "neck." In this example, we would give preference to the surgeon and assign the code for body of pancreas, C251.

Coding Instructions for Solid Tumors

See the Coding Guidelines for Topography and Morphology in the introduction of the ICD-O-3 for additional details. Refer also to the current [Solid Tumor Rules](#) for selected primary site coding instructions.

1. Unless otherwise instructed, use all available information in the medical record to code the site.

2. Code the site in which the primary tumor **originated**, even if it extends onto/into an adjacent subsite.
 - a. Primary site should always be coded to reflect the site of origin according to the medical opinion on the case. Look for information about where the neoplasm originated. Always code the primary site based on where the tumor arose / site of origin.
 - b. Site of origin may be indicated by terms such as "tumor arose from...", "tumor originated in...", "tumor emanated from..." or similar statements.
 - c. Site of origin is not necessarily the site of a biopsy.
 - d. Tumors may involve many sites. The primary site code should reflect the site where the tumor arose rather than all sites of involvement.

Example 1: Final diagnosis is adenocarcinoma of the upper lobe of the right lung. Code the topography to lung, upper lobe (C341).

Example 2: The patient has a 4 cm tumor in the right breast. The tumor originated in the upper inner quadrant and extends into the lower inner quadrant. Code the primary site to upper inner quadrant of breast (C502).

Example 3: Patient has a right branchial cleft cyst; the pathology report identifies an adenocarcinoma arising in an ectopic focus of thyroid tissue within the branchial cleft cyst. Thyroidectomy pathology is negative. Code the primary site to branchial cleft (C104).

Example 4: The patient had a total hysterectomy with a bilateral salpingo-oophorectomy ten years ago for non-cancer reasons. She now has widespread cystadenocarcinoma in the peritoneum. Code the primary site to peritoneum, NOS (C482). (The chart may or may not state that the patient has extra-ovarian carcinoma.)

Example 5: Pathology report shows adenocarcinoma arising in a patch of endometriosis on the sigmoid colon. Code the primary site to sigmoid colon (C187), the site in which the cancer originated.

Example 6: The patient has a left lower lip wedge excision showing invasive squamous cell carcinoma at the mucocutaneous junction. There is no further information in operative report or pathology report regarding the location of this tumor that would indicate this is a skin primary. Assign C001, external lower lip. C001 includes vermilion border of lower lip. Vermilion border is synonymous with mucocutaneous junction.

3. Do **not** adjust the primary site code to fit staging or any other data items.
4. Code the last digit of the primary site code to '8' when a **single tumor overlaps** an adjacent **subsite(s)** of an organ and the **point of origin cannot be determined**.

Example: The patient has a primary tumor of the cervicothoracic esophagus and the point of origin is unknown. Code the primary site to C158.

Note: **Skin** cancers overlapping sites in the head and neck **ONLY**.

- a. Assign the primary site code for the site where the bulk of the tumor is or where the epicenter is; do **not** use code C448.
- b. Single tumor overlapping a reportable site and a non-reportable site: Determine the site of origin or the site with the greatest involvement.
 - i. If the site of origin/site with greatest involvement is the reportable site, report the case and assign the appropriate topography code.
 - ii. If the site of origin/site with greatest involvement is the non-reportable site, do not report the case.

- iii. If the site of origin/site with greatest involvement cannot be determined, do not report the case because you cannot confirm reportability.

Example: Squamous cell carcinoma overlapping skin and vermillion of upper lip. If the site of origin is the vermillion, report the case. If the site of origin cannot be determined and more than 50% of the lesion is on the vermillion, report the case. If less than 50% of the lesion is on the vermillion, do not report the case. If the site with the greatest involvement cannot be determined, do not report the case.

- 5. Code the site of the invasive tumor when there is an invasive tumor and in situ tumor in different subsites of the same anatomic site.

Example 1: Patient has an invasive breast tumor in the upper-outer quadrant of the left breast and in situ tumor in multiple quadrants of the left breast. Code the primary site to C504 (upper outer quadrant of breast).

Example 2: Patient has in situ Paget disease of the right nipple and invasive duct carcinoma of the lower inner quadrant of the right breast. Code the primary site to C503 (lower inner quadrant).

- 6. Code the last digit of the primary site code to '9' for **single primaries** when **multiple tumors arise in different subsites** of the same anatomic site and the **point of origin cannot be determined**.

Example 1: During a transurethral resection of the bladder (TURB), the physician describes multiple papillary tumors in the bladder neck (C675) and the lateral wall of the bladder (C672). Code the primary site as bladder, NOS (C679).

Example 2: Patient has an infiltrating duct tumor in the upper outer quadrant (C504) of the right breast and another infiltrating duct carcinoma in the lower inner (C503) quadrant of the right breast. Code the primary site as breast, NOS (C509).

- 7. Some histology/behavior terms in ICD-O-3.2 have a **related site code** in parentheses; for example, hepatoma (C220).

- a. Code the site as documented in the medical record and ignore the suggested ICD-O-3.2 code when a primary site is specified in the medical record.

Example: The path report says "infiltrating duct carcinoma of the head of pancreas." The listing in ICD-O-3.2 is infiltrating duct carcinoma 8500/3 (C50_). Code the primary site to head of pancreas (C250), NOT to breast (C50_) as suggested by the ICD-O-3.2.

- b. Use the site code suggested by ICD-O-3.2 when the primary site is the same as the site code suggested or the primary site is unknown.

Example 1: The biopsy is positive for hepatoma, and no information is available about the primary site. Code the primary site to liver (C220) as suggested by ICD-O-3.2.

Example 2: Excision of the right axillary nodes reveals metastatic infiltrating duct carcinoma. The right breast is negative. ICD-O-3.2 shows infiltrating duct carcinoma (8500) with a suggested site of breast (C50_). Code the primary site as breast, NOS (C509).

- c. Use the site code suggested by ICD-O-3.2 when there is no information available indicating a different primary site.

Example: Biopsy of lymph node diagnosed as metastatic non-small cell carcinoma. Patient expired and there is no information available about the primary site. Assign C349 based on the site code suggested in ICD-O-3.2.

8. Code the primary site, not the metastatic site. If a tumor is metastatic and the primary site is unknown, code the primary site as unknown (C809).
 - a. Code primary site using results of the molecular test CancerTYPE ID **only** when there is no other information about the primary site. Document in the text that the site is solely based on results from CancerTYPE ID molecular testing.

Note: CancerTYPE ID tests are a standardized molecular method of determining primary site in tumors initially identified in a metastatic site. The use of CancerTYPE ID to determine primary site is not yet a standard practice and has not received FDA clearance.
9. See the site-specific coding guidelines in [Appendix C](#) for primary site coding guidelines for the following sites.

Anus	Kidney
Bladder	Lung
Brain/CNS, Benign and Borderline	Lymphoma
Brain/CNS, Malignant	Melanoma
Breast	Pancreas
Colon	Rectosigmoid Junction
Esophagus	Renal Pelvis and Ureter
Intracranial Glands	Tongue
Kaposi Sarcoma of All Sites	Urethra
10. See section below for primary site coding guidelines for sarcoma.
11. Angiosarcoma
 - a. Code C422 (spleen) as the primary site for angiosarcoma of spleen.
 - b. Code C50_ (breast) for angiosarcoma of breast. Although angiosarcoma actually originates in the lining of the blood vessels, an angiosarcoma originating in the breast has a poorer prognosis than many other breast tumors.
12. Gastrointestinal Stromal Tumors (GIST): Code the primary site to the location where the GIST originated.
13. Transplants
 - a. Code the primary site to the location of the transplanted organ when a malignancy arises in a transplanted organ, i.e., code the primary site to where the malignancy resides or lies.

Example: There is a diagnosis of malignancy in transplanted section of colon serving as esophagus. Code the primary site as esophagus. Document the situation in a text field.
 - b. For information about organ or tissue transplants, see the section [Determining Multiple Primaries](#).
 - c. For additional information about hematopoietic-related transplants, refer to the [Hematopoietic and Lymphoid Neoplasm Coding Manual and Database](#).
14. Assign primary site code C449, skin NOS, for a Merkel cell carcinoma presenting in a nodal or distant metastatic site and site of origin is **unknown**.
15. When the choice is between ovary, fallopian tube, or primary peritoneal without designation of the site of origin, any indication of fallopian tube involvement indicates the primary tumor is a tubal primary. Fallopian tube primary carcinomas can be confirmed by reviewing the fallopian tube sections as described on the pathology report to document the presence of either serous tubal intraepithelial carcinoma (STIC) and/or tubal mucosal high-grade serous carcinoma (HGSC). In the absence of fallopian tube involvement, refer to the histology and look at the treatment plans for the patient. If all else fails, assign C579 as a last resort. For additional

information, see the CAP Gynecologic protocol, Ovary, Fallopian Tube, or Peritoneum, Table 1: Criteria for Assignment of Primary Site in High-Grade Serous Carcinoma (HGSC).

16. In the ***absence of any additional information*** about the primary site, assign the codes listed for these primary sites/histologies and record in a text field as appropriate.

Primary Site/Histology	Topography Code
Ampullary/peri-ampullary	C241
Anal margin	C445
Anal verge	C211
Angle of the stomach	C162
Angular incisura of stomach	C163
Back of tongue	C019
Book-leaf lesion (mouth)	C068
Clavicular skin	C445
Colored / lipstick portion of upper lip	C000
Cutaneous leiomyosarcoma	C44_
Distal conus	C720
Edge of tongue	C021
Frontoparietal (brain)	C718
Gastric angular notch (incisura)	C163
Gastrohepatic ligament	C481
Genu of pancreas	C250
Glossotonsillar sulcus	C109
Incisura, incisura angularis	C163
Infrahilar area of lung	C349
Interarytenoid space	C329
Interhemispheric fissure (cerebrum)	C710
Intracranial	C719
Lateral tongue	C023
Leptomeninges	C709
Masticator space	C760
Mastoid or mastoid complex	C301
Melanoma, NOS	C449
Nail bed, thumb	C446
Pancreatobiliary	C269
Parapharyngeal space	C139
Periareolar (breast)	C501
Periclitoral	C511
Perihilar bile duct	C240
Porta hepatis	C220
Postauricular region	C444
Preauricular (skin)	C443
Prostatic sinus (urethra)	C680
Pterygomandibular raphe	C069
Septum pellucidum	C719
Testis, descended post orchiopexy	C621
True vocal folds	C320

Primary Site/Histology	Topography Code
Uncinate of pancreas	C250
Ureterovesical junction (UVJ)	C669

17. When the medical record does **not** contain **enough information** to assign a primary
- Consult a physician advisor to assign the site code.
 - Use the NOS category for the organ system or the Ill-Defined Sites (C760-C768) if the physician advisor cannot identify a primary site.
 - Occult Tumors of the Head and Neck
 - Assign primary site C119 (nasopharynx) for occult head and neck tumors with cervical lymph node metastasis in Levels I-VII, and other group lymph nodes positive for Epstein-Barr virus (EBV+) (regardless of p16 status) encoded small RNAs (EBER) identified by in situ hybridization.
 - Assign primary site C109 (oropharynx) for occult head and neck tumors with cervical lymph node metastasis in Levels I-VII, and other group lymph nodes, p16 positive with histology consistent with HPV-associated oropharyngeal carcinoma (OPC).
 - Assign C760 for Occult Head and Neck primaries with positive cervical lymph nodes. Schema Discriminator 1: Occult Head and Neck Lymph Nodes is used to discriminate between these cases and other uses of C760.

For more information about schemas and schema IDs, go to the [SSDI Manual, Appendix A](#).
 - Assign the NOS code for the body system when there are two or more possible primary sites documented and all are within the same system.

Example: Two possible sites are documented in the GI system such as colon and small intestine; code to the GI tract, NOS (C269). Document the possible primary sites in a text field.
 - Code unknown primary site when there is a physician statement of unknown primary site **ONLY** when **none of the above instructions can be applied**.
 - Code unknown primary site (C809) if there is not enough information to assign an NOS or Ill-Defined Site category.

Sarcoma

The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system, which includes the fat, muscles, blood vessels, deep skin tissues, nerves, bones, and cartilage. The default code for sarcomas of unknown primary site is **C499** rather than C809.

Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. **Code the primary site to the organ of origin.**

Example 1: The pathology identifies a carcinosarcoma of the uterine corpus. Code the primary site to corpus uteri (C549).

Example 2: Rhabdomyosarcoma of ethmoid sinus. Code primary site to C311.

Code the organ of origin as the primary site when leiomyosarcoma arises in an organ. Do not code soft tissue as the primary site in this situation.

Example 1: Leiomyosarcoma arises in kidney. Code the primary site to kidney (C649).

Example 2: Leiomyosarcoma arises in prostate. Code primary site to prostate (C619).

Coding Instructions for Hematopoietic and Lymphoid Neoplasms (9590/3-9993/3)

See the [Hematopoietic and Lymphoid Neoplasm Coding Manual and Database](#) for instructions on coding the primary site for hematopoietic and lymphoid neoplasms.

Laterality

Item Length: 1

NAACCR Item #: 410

NAACCR Name: Laterality

XML NAACCR ID: laterality

Laterality describes the side of a paired organ or side of the body on which the reportable tumor originated. Determine whether laterality should be coded for each primary.

Code	Description
0	Not a paired site
1	Right: origin of primary
2	Left: origin of primary
3	Only one side involved, right or left origin unspecified
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5	Paired site: midline tumor (effective with 01/01/2010 dx)
9	Paired site, but no information concerning laterality

Coding Instructions

1. Assign code **0** when
 - a. The primary site is not a paired site.
 - b. Primary site is unknown (C809), or
 - c. Laterality is unknown for a death certificate only (DCO) case and the primary site is **NOT** one of the primary site codes listed in the table below (*Sites for Which Laterality Codes Must Be Recorded*).
2. Code Laterality using codes 1-5, 9 for all sites listed in the table: *Sites for Which Laterality Codes Must Be Recorded*.
 - a. *Laterality* may be coded for sites other than those required, for example, thyroid.
3. Code the side where the primary tumor **originated**.
 - a. Assign code **3** if the laterality is not known but the tumor is confined to a single side of the paired organ.
Example: Pathology report: Patient has a 2 cm carcinoma in the upper pole of the kidney. Code *Laterality* as 3 because there is documentation that the disease exists in only one kidney, but it is unknown if the disease originated in the right or left kidney.
4. Code **4** is seldom used EXCEPT for the following.
 - a. Both ovaries involved simultaneously with a **single histology**; a single primary according to the Solid Tumor Rules
 - b. Diffuse bilateral lung nodules
 - c. Bilateral retinoblastomas
 - d. Bilateral Wilms tumors
 - e. Both breasts when inflammatory carcinoma is bilateral at diagnosis.

- f. Bilateral involvement at time of diagnosis and lateral origin unknown for a site listed in the table *Sites for Which Laterality Must Be Recorded*.
Example: Both arms are involved with Kaposi sarcoma and no other sites are involved. It is not known on which arm the Kaposi sarcoma originated. Assign *Laterality* code 4. Skin of upper limb and shoulder is listed as a paired organ in the table *Sites for Which Laterality Must Be Recorded*.
5. Assign code **5** when the tumor originates in the midline of a site listed in 5.a.
 - a. C700, C710-C714, C722-C725, C443, C444, C445
 - i. Do not assign code 5 to sites not listed in 5.a.
 - ii. **Example 1:** Patient has an excision of a melanoma located just above the umbilicus (C445, laterality code 5).
 - iii. **Example 2:** Patient has a midline meningioma of the cerebral meninges (C700, laterality code 5).
6. Assign code **9** when
 - a. The neoplasm originated in a paired site and
 - i. Laterality is unknown, AND
 - ii. There is no statement that only one side of the paired organ is involved.
Example 1: Admitting history says patient was diagnosed with lung cancer based on positive sputum cytology. Patient is treated for painful bony metastases. There is no information about laterality in the diagnosis of this lung cancer.
Example 2: Widely metastatic ovarian carcinoma surgically debulked. Ovaries could not be identified in the specimen.
 - b. Laterality is unknown for a death certificate only (DCO) case with primary site code listed in the table below (*Sites for Which Laterality Codes Must Be Recorded*).
7. Document the laterality in a text field.

Sites for Which Laterality Codes Must Be Recorded

Starting with cases diagnosed January 1, 2004, and later, laterality is coded for select invasive, benign, and borderline primary intracranial and CNS tumors.

A laterality code other than 0 must be assigned for the sites listed in the table below. There is an effective date for assigning laterality for some of the sites. If the site is not listed on the table, code 0 may be assigned for laterality. *Laterality* may be coded for sites other than those required below. For example, code 2 may be assigned for a tumor originating in the left lobe of thyroid.

ICD-O-3 Code	Site or Subsite
C079	Parotid gland
C080	Submandibular gland
C081	Sublingual gland
C098	Overlapping lesion of tonsil
C099	Tonsil, NOS
C301	Middle ear
C310	Maxillary sinus
C312	Frontal sinus
C341-C349	Lung
C384	Pleura

ICD-O-3 Code	Site or Subsite
C400	Long bones of upper limb, scapula, and associated joints
C401	Short bones of upper limb and associated joints
C402	Long bones of lower limb and associated joints
C403	Short bones of lower limb and associated joints
C441	Skin of the eyelid
C442	Skin of the external ear
C443	Skin of other and unspecific parts of the face
C444	Skin of scalp and neck
C445	Skin of trunk
C446	Skin of upper limb and shoulder
C447	Skin of the lower limb and hip
C471	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C472	Peripheral nerves and autonomic nervous system of the lower limb and hip
C491	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C492	Connective, subcutaneous, and other soft tissues of the lower limb and hip
C500-C509	Breast
C569	Ovary
C570	Fallopian tube
C620-C629	Testis
C630	Epididymis
C631	Spermatic cord
C649	Kidney, NOS
C659	Renal pelvis
C669	Ureter
C690-C699	Eye and adnexa
C700	Cerebral meninges, NOS (Effective with cases diagnosed 01/01/2004)
C710	Cerebrum (Effective with cases diagnosed 01/01/2004)
C711	Frontal lobe (Effective with cases diagnosed 01/01/2004)
C712	Temporal lobe (Effective with cases diagnosed 01/01/2004)
C713	Parietal lobe (Effective with cases diagnosed 01/01/2004)
C714	Occipital lobe (Effective with cases diagnosed 01/01/2004)
C722	Olfactory nerve (Effective with cases diagnosed 01/01/2004)
C723	Optic nerve (Effective with cases diagnosed 01/01/2004)
C724	Acoustic nerve (Effective with cases diagnosed 01/01/2004)
C725	Cranial nerve, NOS (Effective with cases diagnosed 01/01/2004)
C740-C749	Adrenal gland
C754	Carotid body

Diagnostic Confirmation

Item Length: 1

NAACCR Item #: 490

NAACCR Name: Diagnostic Confirmation

XML NAACCR ID: diagnosticConfirmation

This data item records the best method used to confirm the presence of the cancer being reported. The best method could occur at any time during the patient's first course of treatment. It is not limited to the confirmation at the time of initial diagnosis.

Note: The codes and instructions for hematopoietic and lymphoid neoplasms are different from the codes for solid tumors. **Codes and instructions for solid tumors follow.** See the section **Codes for Hematopoietic and Lymphoid Neoplasms** for hematopoietic and lymphoid neoplasms *Diagnostic Confirmation* codes.

Codes for Solid Tumors

Microscopically Confirmed

Code	Description
1	Positive histology
2	Positive cytology
4	Positive microscopic confirmation, method not specified

Not Microscopically Confirmed

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

Confirmation Unknown

Code	Description
9	Unknown whether or not microscopically confirmed; death certificate only

Coding Instructions for Solid Tumors

- The codes are in **priority order**; code **1** has the **highest** priority. Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods.
- Change to a higher-priority code, if at **ANY TIME** during the first course of treatment the patient has a diagnostic confirmation with a **higher priority**.

Example: Benign brain tumor diagnosed on MRI. Assign *Diagnostic Confirmation* as code 7. Patient later becomes symptomatic and the tumor is surgically removed. Change diagnostic confirmation code to 1.

3. Assign code **1** when the microscopic diagnosis is based on
 - a. **Tissue** specimens from fine needle aspirate, biopsy, surgery, autopsy, or D&C
 - b. Bone marrow specimens (aspiration and biopsy)
4. Assign code **2** when the microscopic diagnosis is based on
 - a. Examination of **cells** (rather than tissue) including but not limited to: sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears, or vaginal smears
 - b. Paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid
5. Assign code **4** when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.
6. Assign code **5** when the diagnosis of cancer is based on laboratory tests or tumor marker studies that are clinically diagnostic for that specific cancer and there is no other diagnostic work up (e.g., imaging).

Example: If the workup for a prostate cancer patient is limited to a highly elevated PSA (no DRE and no imaging) and the physician **diagnoses and/or treats** the patient based only on that PSA, code *Diagnostic Confirmation* to 5.

Note: For tests and tumor markers that may be used to help diagnose cancer, see <https://www.cancer.gov/about-cancer/diagnosis-staging/diagnosis>
<https://www.cancer.gov/about-cancer/diagnosis-staging/diagnosis/tumor-markers-fact-sheet>
7. Assign code **6** when the diagnosis is based only on
 - a. The surgeon's operative report from a surgical exploration or endoscopy such as colonoscopy, mediastinoscopy, or peritoneoscopy and no tissue was examined.
 - b. Gross autopsy findings (no tissue or cytologic confirmation)
8. Assign code **7** when the only confirmation of malignancy was diagnostic imaging such as computerized axial tomography (CT scans), magnetic resonance imaging (MRI scans), or ultrasounds/sonography.

Note: Intraductal papillary mucinous neoplasm with high grade dysplasia (8453/2) of the pancreas is reportable based on imaging alone; histologic confirmation is not required.
9. Assign code **8** when the case was diagnosed by any clinical method not mentioned in preceding codes. *Diagnostic Confirmation* is coded 8 when the only confirmation of disease is a physician's clinical diagnosis.

Example: CT diagnosis is possible lung cancer. Patient returns to the nursing home with a Do Not Resuscitate (DNR) order. Physician enters a diagnosis of lung cancer in the medical record. Code *Diagnostic Confirmation* to 8: there is a physician's clinical diagnosis – clinical diagnosis made by the physician using the information available for the case.
10. Assign code **9**
 - a. When it is unknown if the diagnosis was confirmed microscopically
 - b. For death certificate only case
11. Do not include liquid biopsy as a diagnostic confirmation method. Liquid biopsies are not diagnostic. They are used for screening and detection of minimal residual disease.

Codes and Coding Instructions for Hematopoietic and Lymphoid Neoplasms (9590/3-9993/3)

See the [*Hematopoietic and Lymphoid Neoplasm Coding Manual and Database*](#) for coding instructions.

Histologic Type ICD-O-3

Item Length: 4

NAACCR Item #: 522

NAACCR Name: ICD-O-3

XML NAACCR ID: histologicTypeIcdO3

The data item *Histologic Type ICD-O-3* describes the microscopic composition of cells and/or tissue for a specific primary.

The current [Solid Tumor Rules](#), the [Hematopoietic and Lymphoid Neoplasm Coding Manual and Database](#), and the *International Classification of Diseases for Oncology*, Third Edition, Second Revision Morphology (ICD-O-3.2) are the standard references for histology codes.

ICD-O-3.2 Update

The 2027 ICD-O-3.2 Update Guidelines provide the changes to ICD-O-3.2 including new terminology and reportability changes effective for cases diagnosed 01/01/2027 forward.

Standard setters have agreed to implement new histology terms and codes for ICD-O-3 based on the current versions of the *World Health Organization Classification of Tumours*. The update, referred to as ICD-O-3.2, includes comprehensive tables listing histology codes and behavior codes in effect beginning with cases diagnosed in 2021, or as designated. The new codes, new terms, and codes with changes to behavior are available at the [NAACCR website](#).

Histology Coding for Solid Tumors

Apply the general instructions and instructions for coding the histologic type in the current Solid Tumor Rules.

Apply the site-specific histology coding rules in the current Solid Tumor Rules.

Site-specific histology coding rules cover the following sites groups.

Primary Site Group	Topography
Head and Neck	C000-C148, C300-C339, C410, C411, C479, C754, C755
Colon, Rectosigmoid, Rectum	C180-C189, C199, C209
Lung	C340-C343, C348, C349
Cutaneous Melanoma	C440-C449 with Histology 8720-8780
Breast	C500-C506, C508-C509
Kidney	C649
Urinary Sites	C659, C669, C670-C679, C680-C681, C688-C689
Non-malignant CNS Tumors	C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
Malignant CNS and Peripheral Nerves	C470-C479, C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
Other Sites	Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Histology Coding for Hematopoietic and Lymphatic Primaries

Apply the Histology Coding Rules in the [*Hematopoietic and Lymphoid Neoplasm Coding Manual and Database*](#).

Behavior Code

Item Length: 1

NAACCR Item #: 523

NAACCR Name: Behavior Code ICD-O-3

XML NAACCR ID: behaviorCodeIcdO3

The data item *Behavior Code* describes the malignant potential of the tumor, ranging from /0 benign to /3 malignant (invasive).

Code	Description
0	Benign (Reportable for intracranial and CNS sites only)
1	Uncertain whether benign or malignant, borderline malignancy, low malignant potential, and uncertain malignant potential (Reportable for intracranial and CNS sites only)
2	Carcinoma in situ; intraepithelial; noninfiltrating; non-invasive (carcinoma)
3	Malignant, primary site (invasive)

Coding Instructions

General

Code behavior prior to neoadjuvant therapy when given.

Intracranial and CNS Tumors

Intracranial and CNS tumors with behavior codes 0 (benign) and 1 (borderline malignancy) are reportable for diagnoses beginning January 1, 2004.

Code the behavior from CT scan, Magnetic Resonance Imaging (MRI), or Positron Emission Tomography (PET) report when there is no tissue diagnosis (pathology or cytology report). Code the behavior listed on the scan. Do not use the WHO grade to code behavior.

Metastatic or Non-primary Sites

Cases reported to SEER cannot have a metastatic (/6) behavior code. If the only pathologic specimen is from a **metastatic** site, code the appropriate histology code and the malignant behavior code (/3). The primary site and its metastatic site(s) have the same histology.

Code the behavior as malignant (/3) when malignant metastasis is present. Metastasis could be regional, nodal, or distant.

Example: Adenocarcinoma in situ with lymph nodes positive for malignancy. Code the behavior as malignant (/3). When the invasive component cannot be found and there are positive lymph nodes, assign behavior /3 based on the positive lymph nodes.

Exception: For in situ breast cancer; code as non-invasive (/2) in the presence of isolated tumor cells or if cells are artifactually displaced from a previous procedure.

In Situ

Clinical evidence alone cannot identify the behavior as in situ; a behavior code of /2 (in situ) must be based on pathologic examination.

Exception: Intraductal papillary mucinous neoplasm with high grade dysplasia (8453/2) of the pancreas is reportable based on imaging alone; histologic confirmation is not required.

In Situ and Invasive

Code the behavior as malignant (/3) if any portion of the primary tumor is invasive no matter how limited, i.e., microinvasion.

Example: Pathology from mastectomy: Large mass composed of intraductal carcinoma with a single focus of invasion. Code the behavior as malignant (/3).

Exception: For an ovarian mucinous borderline tumor with microinvasion, the term "microinvasion" is not an indication of malignancy. Low malignant potential/borderline ovarian tumors are defined by the pathology of the primary tumor and are not affected by microinvasion or invasion in implants. Though a case may be staged, this does not mean it is reportable.

Re-code the behavior as malignant (/3) when metastases are attributed to a tumor originally thought to be in situ.

Example: Right colon biopsy reveals tubulovillous adenoma with microfocal carcinoma in situ (CIS); right hemicolectomy is negative for residual disease. Later core liver biopsy consistent with metastatic adenocarcinoma of gastrointestinal origin. Oncologist states most likely colon primary. Change the behavior code for the colon primary from /2 to /3. There were no other colon primaries in this case.

ICD-O-3.2 Histology/Behavior Code Listing

Behavior is the fifth digit of the morphology code after the slash (/). The standard reference for coding behavior is the ICD-O-3.2. Pages 27 through 30 in ICD-O-3 discuss behavior. The following general rules are found on pages 29-30 in ICD-O-3.

- Usually, a histologic term carries a clear indication of the likely behavior of the tumor, whether malignant or benign, and this is reflected in the behavior code assigned to it in the ICD-O.
- Although only a few histologic types of in situ neoplasms are actually listed in the ICD-O, the behavior code /2 could be attached to any histology code if an in situ form of the neoplasm is diagnosed.
- If the pathologist disagrees with the ICD-O behavior assignment in a particular case, code the behavior according to the pathologist's description of the behavior even if that histology/behavior combination is not listed in the ICD-O.

The pathologist has the final say on the behavior of the tumor. ICD-O-3 may have only one behavior code, in situ (/2) or malignant (/3), listed for a specific histology. If the pathology report describes the histology as in situ and the ICD-O-3 histology code is listed only with a malignant behavior code (/3), assign the in situ behavior code (/2). If the pathology report describes histology as malignant and the ICD-O-3 histology code is listed only with an in situ behavior code (/2), assign the malignant behavior code (/3). See the Morphology and Behavior Code Matrix discussion on page 29 in ICD-O-3.

Example: The pathology report says large cell carcinoma in situ. The ICD-O-3 lists large cell carcinoma only with a malignant behavior (8012/3). Code the histology and behavior as 8012/2 as specified by the pathologist.

Synonyms for In Situ Behavior

Behavior code '2'

Bowen disease (not reportable for C440-C449)

Clark level I for melanoma (limited to epithelium)

Confined to epithelium

Hutchinson melanotic freckle, NOS (C44_)

Intracystic, noninfiltrating (carcinoma)

Intraductal (carcinoma)

Intraepidermal, NOS (carcinoma)

Intraepithelial neoplasia, Grade III (e.g., AIN III, LIN III, SIN III, VAIN III, VIN III)

Intraepithelial, NOS (carcinoma)

Involvement up to, but not including the basement membrane

Lentigo maligna (C44_)

Lobular, noninfiltrating (C50_) (carcinoma)

Noninfiltrating (carcinoma)

Non-invasive (carcinoma)

No stromal invasion/involvement

Papillary, noninfiltrating or intraductal (carcinoma)

Precancerous melanosis (C44_)

Queyrat erythroplasia (C60_)

Stage 0 (except Paget disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria)

Cancer PathCHART Site-Morphology Combination Standards

About Cancer PathCHART: The Cancer Pathology Coding Histology and Registration Terminology (Cancer PathCHART) initiative is a ground-breaking collaboration of North American and global registrar, registry, pathology, and clinical organizations. The main goal of Cancer PathCHART is to improve cancer surveillance data quality by updating standards for tumor site, histology, and behavior code combinations and associated terminology. This initiative involves a substantial, multifaceted review process of histology and behavior codes (and associated terminology) by tumor site that includes expert pathologists and tumor registrars. The results of these in-depth reviews are incorporated into the Cancer PathCHART database, which serves as the single source of truth standards for tumor site, histology, and behavior coding across all standard setters. See the Cancer PathCHART website for further information: <https://seer.cancer.gov/cancerpathchart/>.

Cancer PathCHART Standards: Each tumor site-morphology combination is designated as valid, unlikely, or impossible. Valid tumor entities can be abstracted without any issues. Impossible tumor entities will trigger an error on the Primary Site, Morphology-Type, Beh ICDO3 2024 (N7040) edit and cannot be abstracted. An alternative site, histology, and behavior combination will need to be coded for the tumor. Unlikely entities will also trigger an error on the N7040 edit. For these combinations, confirm the primary site, histology, and behavior code combination by thoroughly reviewing the medical record. If the information is determined to be correct as coded, set the Site/Type Interfield Review override flag for the abstract. Site-morphology combinations in the Fifth edition *World Health Organization Classification of Tumours* books are considered valid.

Validity Status	Site-Type Edit Errors	Coding in Cancer Registry Database
Valid	Will not generate edit errors	Can be coded
Impossible	Will generate an edit error	Cannot be coded
Unlikely ¹	Will generate an edit error	Requires manual override or correction to site and/or morphology to be coded

¹ Unlikely tumor site-morphology combinations are included in CPC*Search but were not included in the CPC SMVLs (see next section below).

The Cancer PathCHART ICD-O-3 Site Morphology Validation List: Cancer PathCHART ICD-O-3 Site Morphology Validation Lists (CPC SMVL) have been output directly from the Cancer PathCHART database and applies to cases diagnosed in 2024, 2025, 2026, and 2027. The CPC SMVL is a comprehensive table that replaces both the 2023 ICD-O-3 SEER Site/Histology Validation List and the list of impossible site and histology combinations included in the 2023 Primary Site, Morphology-Imposs ICDO3 (SEER IF38) edit. CPC SMVL files are freely available to cancer registration software vendors and any other end users in easily consumed, computer-readable formats (CSV, XLSX, XML, and JSON). **The downloadable file can be found at <https://seer.cancer.gov/cancerpathchart/products.html>. End users should read the release notes before accessing the files.**

CPC SMVL Versioning: The naming convention for versions is V and the year of implementation. Subsequent versions are designated by a letter after the year (A for the second version, B for the third version, C for the fourth version, etc.). Standards for each of the four applicable years (2024 to 2027) are included in separate columns by year.

*Cancer PathCHART CPC*Search Tool:* Launched in April 2024, [CPC*Search](#) is an interactive webtool that allows cancer registrars and other users to search the [most current CPC \(CPC SMVL\)](#) by tumor site, histology and behavior. This tool should not be the primary resource for determining site, histology, and behavior code combinations. Before using CPC*Search, registrars should re-review the medical record to confirm primary site, histology, and behavior code combinations; consult the SEER [Hematopoietic and](#)

[Lymphoid Neoplasm Database](#) for hematolymphoid morphologies and the [Solid Tumor Rules](#) for all other tumors; and then use CPC*Search to confirm site, histology, and behavior code combinations. Registrars are encouraged to take remaining questions to the pathologist or oncologist/hematologist. If the registrar still has a question, they should submit it to [Ask a SEER Registrar](#). An additional use is to explore similar terms that are different entities in another organ system. For example, 8550/3 acinar cell carcinoma is impossible in the prostate, but 8140/3 acinar adenocarcinoma is valid in the prostate.

*Alignment between CPC SMVL, CPC*Search, and NAACCR Edits Metafile:* The latest release of the CPC SMVL is aligned with the content in CPC*Search, and the N7040 edit in the NAACCR Edits Metafile.

Sites Reviewed for Cancer PathCHART: For sites that have not been reviewed for an update in validity standards for 2024, 2025, 2026, or 2027, the 2023 site-morphology combination standards were used. Code combinations included in the 2023 ICD-O-3 SEER Site/Histology Validation List were valid, and those in the 2023 Primary Site, Morphology-Imposs ICDO3 (SEER IF38) edit were impossible. All other site-morphology code combinations were unlikely. Sites that have not been reviewed by the Cancer PathCHART initiative adopted the existing 2023 standards as shown below.

Standard Used for Primary Sites Not Yet Reviewed	CPC SMVL Validity Status
2023 ICD-O-3 SEER Site/Histology Validation List	Valid
2023 Primary Site, Morphology-Imposs ICDO3 (SEER IF38)	Impossible
Combinations not included in 2023 Valid or Impossible standards listed above	Unlikely

For a list of primary sites reviewed by implementation year, see [Cancer PathCHART: Product Downloads](#).

Grade Clinical

Item Length: 1

NAACCR Item #: 3843

NAACCR Name: Grade Clinical

XML NAACCR ID: gradeClinical

Grade Clinical, effective 01/01/2018, records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant). For some sites, grade is required to assign the clinical stage group.

Refer to the most recent version of the [Grade Coding Instructions and Tables](#).

Grade Post Therapy Clin (yc)

Item Length: 1

NAACCR Item #: 1068

NAACCR Name: Grade Post Therapy Clin (yc)

XML NAACCR ID: gradePostTherapyClin

Grade Post Therapy Clin (yc), effective 01/01/2021, records the grade of a solid primary tumor that has been microscopically sampled following neoadjuvant therapy or primary systemic/radiation therapy.

Refer to the most recent version of the [Grade Coding Instructions and Tables](#).

Grade Pathological

Item Length: 1

NAACCR Item #: 3844

NAACCR Name: Grade Pathological

XML NAACCR ID: gradePathological

Grade Pathological, effective 01/01/2018, records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup. For some sites, grade is required to assign the pathological stage group.

Refer to the most recent version of the [Grade Coding Instructions and Tables](#).

Grade Post Therapy Path (yp)

Item Length: 1

NAACCR Item #: 3845

NAACCR Name: Grade Post Therapy Path (yp)

XML NAACCR ID: gradePostTherapy

Grade Post Therapy Path (yp), effective 01/01/2018, records the grade of a solid primary tumor that has been resected following neoadjuvant therapy or primary systemic/radiation therapy. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. For some sites, grade is required to assign the post-neoadjuvant stage group. The name was updated from *Grade Post Therapy* to *Grade Post Therapy Path (yp)* in 2021.

Refer to the most recent version of the [Grade Coding Instructions and Tables](#).

Derived Summary Grade 2018

Item Length: 1

NAACCR Item #: 1975

NAACCR Name: Derived Summary Grade 2018

XML NAACCR ID: derivedSummaryGrade2018

Derived Summary Grade 2018, effective 01/01/2024, is the grade calculated by central cancer registries for all cases diagnosed in 2018 and later. This data item uses the highest grade from *Grade Clinical* (NAACCR Item #3843) and *Grade Pathological* (NAACCR Item #3844). Breast is an exception because behavior affects the priority. If grade is needed in the EOD 2018 Derived Stage Group Calculation, this value is also used there.

Refer to the most recent version of the [Grade Coding Instructions and Tables](#).

Tumor Size Summary

Item Length: 3

NAACCR Item #: 756

NAACCR Name: Tumor Size Summary

XML NAACCR ID: tumorSizeSummary

Tumor Size Summary is the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.

Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Code	Description
000	No mass/tumor found
001	1 mm or described as less than 1 mm (0.1 cm or less than 0.1 cm)
002-988	Exact size in millimeters (2 mm-988 mm) (0.2 cm to 98.8 cm)
989	989 millimeters or larger (98.9 cm or larger)
990	Microscopic focus or foci only and no size of focus is given
998	Alternate descriptions of tumor size for specific sites:
	Familial/multiple polyposis:
	-Rectosigmoid and rectum (C19.9, C20.9)
	-Colon (C18.0, C18.2-C18.9)
	If no size is documented:
	Circumferential:
	-Esophagus (C15.0-C15.5, C15.8, C15.9)
	Diffuse; widespread: 3/4s or more; linitis plastica:
	-Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8, C16.9)
	Diffuse, entire lung or NOS:
	-Lung and main stem bronchus (C34.0-C34.3, C34.8, C34.9)
	Diffuse:
	-Breast (C50.0-C50.6, C50.8, C50.9)
999	Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed; No excisional biopsy or tumor resection done; The only measurement(s) describes pieces or chips; Not applicable

Note: All measurements should be in millimeters (mm).

Coding Instructions

1. Record the size in the specified order.
 - a. Size measured on the surgical resection specimen, when surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered.
 - i. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (also known as CAP protocol or pathology report checklist).

- ii. If only a text report is available, use: final diagnosis, microscopic, or gross examination, in that order.

Example 1: Chest x-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. Record tumor size as 028 (28 mm).

Example 2: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. Record tumor size as 032 (32 mm).

- b. If neoadjuvant therapy is followed by surgery, do not record the size from the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size as 999.

Example: Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size after total resection is 2.8 cm. Record tumor size as 022 (22 mm).
 - c. If no surgical resection, then largest measurement of the tumor from the imaging, physical exam, or other diagnostic procedures in this order of priority prior to any other form of treatment.
 - d. If a, b, and c do not apply, the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.
2. Tumor size is the **diameter** of the tumor, **not the depth or thickness** of the tumor.
 3. Record tumor size stated less than or greater than as follows.
 - a. If tumor size is reported as less than x mm or less than x cm, the reported tumor size should be 1 mm less.

Examples: Tumor size is stated as: < 1 cm, code as 009; < 2 cm, code as 019; < 3 cm, code as 029; < 4 cm, code as 039; < 5 cm is coded as 049. If stated as less than 1 mm, use code 001.
 - b. If tumor size is reported as more than or greater than x mm or more than x cm, code size as 1 mm more.

Examples: Tumor size is stated as: >10 mm or >1 cm, code as 011; > 2 cm, code as 021; > 3 cm, code as 031; > 4 cm, code as 041; > 5 cm, code as 051. If described as anything greater than 989 mm (98.9 cm), code as 989.
 - c. If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two: i.e., add the two sizes together and then divide by two.

Examples: Tumor size is between 2 and 3 cm, code as 025. Code size as 025 since $2 + 3 = 5$ divided by 2 = 2.5 cm (or 025 mm).
 4. Record the higher tumor size when stated as a range.

Example: Tumor size is 8-10 mm or tumor size is 8 to 10 mm. Code size as 010 since 10 mm is the higher of the values in the range.
 5. Round the tumor size only if it is described in fractions of millimeters.
 - a. When tumor size is greater than 1 millimeter, round tenths of millimeters in the 1-4 range down to the nearest whole millimeter and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. See Exception for breast cancer.
 - b. Do not round tumor size expressed in centimeters to the nearest whole centimeter; rather, convert the measurement to millimeters by moving the decimal point one space to the right.

Note 1: Record tumor size as 001 (do not round down to 000) when the largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm).

Note 2: Code 001 when tumor size is 1 mm.

Exception to rounding rules for BREAST primaries: Round tumor sizes greater than 1.0 mm and up to 2.4 mm to 2 mm (002). The purpose of this exception is so that the size recorded in the *Tumor Size Summary* data item will derive the correct AJCC TNM Primary Tumor (T) category for breast primaries. Do not apply this instruction to any other site.

Examples:

Breast cancer described as 6.5 millimeters in size. Round up to 7 mm and code as 007.

Breast cancer described as 1.3 mm in size. Round up to 2 mm and code as 002.

2.3 millimeter cancer in a polyp. Round down to 2 mm and code 002.

Hypopharynx: Focus of cancer described as 1.4 mm in size. Round down to 1 mm and code as 001.

5.2 cm breast cancer. Convert to millimeters and code 052.

2.5 cm rectal cancer. Do **not** round, record as 025 millimeters.

6. Priority of imaging/radiographic technique
 - a. Use information on size from imaging/radiographic techniques to code the tumor size when there is no more specific size information from pathology or operative report. It should be taken as a lower priority, but over a physical exam.
 - b. Record the largest size in the record when there are tumor size discrepancies among imaging and radiographic reports, regardless of the imaging technique reports unless the physician specifies which imaging is most accurate.
7. Code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis. However, if the tumor is described as a “cystic mass” and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.
8. Record the size of the invasive component, if given.
 - a. If both an in situ and an invasive component are present and the invasive component is measured, record the size of the invasive component even if it is smaller.

Example: Tumor is mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive. Record tumor size as 014 (14 mm).
 - b. If the size of the invasive component is not given, record the size of the entire tumor from the surgical report, pathology report, radiology report, or clinical examination.

Example 1: A breast tumor with infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023 (23 mm).

Example 2: Duct carcinoma in situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (19 mm).
9. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

Example 1: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).

Example 2: Anal canal tumor is 2.5 cm from proximal to distal (3.5 cm in circumference). Record tumor size as 035. The circumferential measurement is the largest measurement in this

example. In this case, the pathologist usually cuts the anus and rectum open like a tube; the circumference is measured flat.

10. Record the size as stated for purely in situ lesions.
11. Multifocal/multicentric tumors: Code the size of the largest invasive tumor, or the largest in situ tumor if all tumors are in situ, when the tumor is multi-focal or when multiple tumors are reported as a single primary.
12. Assign code 000 when
 - a. No residual tumor is found.
 - b. Schema is Cervical Lymph Nodes and Unknown Primary 00060
 - c. *EOD Primary Tumor* is coded 800 (No evidence of primary tumor) for any schema except for those listed in Coding Instruction 14
13. Assign tumor size for benign and borderline tumors in the schemas Brain, CNS Other, Intracranial Gland, and Medulloblastoma when provided; do not default to 999
14. Assign code 999 when
 - a. Size is unknown and for the following sites and schemas/schema IDs.
 - i. Any case coded to primary site C420, C421, C423, C424, C770-C779, or C809
 - ii. HemeRetic 00830
 - iii. Kaposi Sarcoma 00458
 - iv. Lymphoma 00790
 - v. Lymphoma-CLL/SLL 00795
 - vi. Melanoma Choroid and Ciliary Body 00672
 - vii. Melanoma Iris 00671
 - viii. Plasma Cell Disorders 00822
 - ix. Plasma Cell Myeloma 00821
 - b. The only measurement describes pieces or chips in a pathology report. Do not add the size of pieces or chips together to create a whole; they may not be from the same location, or they may represent only a very small portion of a large tumor.
However, when the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size.
 - c. The only measurement is for calcifications that span given distance or a cluster of microcalcifications. Do not record the size of calcifications as tumor size. If there is no measurement of the mass or tumor, record 999.
 - d. Neoadjuvant therapy has been administered and resection was performed. Do not use a post-neoadjuvant size to code pathologic tumor size; however, you may use the clinical tumor size if available.
15. Document the information to support coded tumor size in the appropriate text data item of the abstract.

Tumor size is important for staging of tumors in the following table of schemas. For more information about schemas and schema IDs, go to the [SSDI Manual, Appendix A](#).

Table. Schemas for which Tumor Size Affects Staging

Schema	Schema ID
Adrenal Gland	00760
Anus	09210
Bile Duct Distal	00260
Bile Ducts Intrahepatic	00230
Bone Appendicular Skeleton	00381
Bone Pelvis	00383
Breast	00480
Buccal Mucosa	00076
Cervix V9	09520
Conjunctiva	00650
Corpus Sarcoma	00541
Cutaneous Carcinoma of Head and Neck	00150
Floor of Mouth	00074
GIST	00430
Gum	00073
Hypopharynx	00112
Kidney Parenchyma	00600
Lacrimal Gland	00690
Lip	00071
Liver	00220
Lung V9	09360
Major Salivary Glands V9	09081
Merkel Cell Skin	00460
Minor Salivary Gland V9	09082
Mouth Other	00077
NET Adrenal Gland	00770
NET Appendix V9	09320
NET Colon and Rectum V9	09330
NET Pancreas V9	09340
NET Stomach V9	09290
Orbital Sarcoma	00700
Oropharynx HPV-Associated V9	09100
Oropharynx HPV-Independent	00111
Palate Hard	00075
Pancreas	00280
Primary Cutaneous Lymphomas (excluding MF and SS)	00812
Retroperitoneum	00440
Skin Eyelid	00640
Soft Tissue Head and Neck	00400
Soft Tissue Trunk and Extremities	00410
Thyroid	00730
Thyroid Medullary	00740
Tongue Anterior	00072
Vagina	00510
Vulva V9	09500

ICD-O-3 Conversion Flag

Item Length: 1

NAACCR Item #: 2116

NAACCR Name: ICD-O-3 Conversion Flag

XML NAACCR ID: icdO3ConversionFlag

This is a computer generated code specifying how the conversion of site and morphology codes from ICD-O-2 to ICD-O-3 was accomplished.

Code	Description
0	Morphology (Morph--Type&Behav ICD-O-3) originally coded in ICD-O-3
1	Morphology (Morph--Type&Behav ICD-O-3) converted from (Morph--Type&Behav ICD-O-2) without review
3	Morphology (Morph--Type&Behav ICD-O-3) converted from (Morph--Type&Behav ICD-O-2) with review
Blank	Not converted

Coding Instructions

1. Code **0** is assigned for death certificate only (DCO) cases.
2. Leave blank for cases coded in prior ICD-O version and not converted to ICD-O-3.

Section V

Stage of Disease at Diagnosis

Stage of Disease at Diagnosis data items contained within this manual fall under two categories

Extent of Disease

Summary Stage

Note: There are no specific instructions for pathology-only cases. Assign 9s or the appropriate "unknown" code when abstracting stage and related data items from pathology reports or HL-7 reports only and information is not provided.

For additional stage-related data items, refer to Section VI, Stage-related Data Items.

Extent of Disease Data Items

Three Extent of Disease (EOD) Data Items are presented in this manual. For additional information about EOD, refer to the separate schema and codes in [SEER Registrar Staging Assistant \(SEER*RSA\)](#).

Extent of Disease Primary Tumor

Item Length: 3

NAACCR Item #: 772

NAACCR Name: EOD Primary Tumor

XML NAACCR ID: eodPrimaryTumor

Description

Extent of Disease Primary Tumor (EOD Primary Tumor) is part of the EOD data collection system and is used to classify contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs at the time of diagnosis. See also *EOD Regional Nodes* and *EOD Mets*. Effective for cases diagnosed 01/01/2018, and later.

See the most current version of [EOD](#) for rules and [SEER*RSA](#) for site-specific schemas and codes.

Codes

Code	Description
000	In situ, intraepithelial, noninvasive Schema-specific codes where needed
800	No evidence of primary tumor
999	Unknown; primary tumor not stated Primary tumor cannot be assessed Not documented in patient record Death certificate only (DCO)

Extent of Disease Regional Nodes

Item Length: 3**NAACCR Item #: 774****NAACCR Name: EOD Regional Nodes****XML NAACCR ID: eodRegionalNodes**

Extent of Disease Regional Nodes (EOD Regional Nodes) is part of the EOD data collection system and is used to classify the regional lymph nodes involved with cancer at the time of diagnosis. See also *EOD Primary Tumor* and *EOD Mets*. Effective for cases diagnosed 01/01/2018, and later.

See the most current version of [EOD](#) for rules and [SEER*RSA](#) for site-specific schemas and codes.

Codes

Code	Description
000	None
	Schema-specific codes where needed
800	Regional lymph node(s), NOS
	Lymph node(s), NOS
888	Not applicable—e.g., CNS, hematopoietic
999	Unknown

Extent of Disease Mets

Item Length: 2
 NAACCR Item #: 776
 NAACCR Name: EOD Mets
 XML NAACCR ID: eodMets

Extent of Disease Mets (EOD Mets) is part of the EOD data collection system and is used to classify the distant site(s) of metastatic involvement at time of diagnosis. See also *EOD Primary Tumor* and *EOD Regional Nodes*. Effective for cases diagnosed 01/01/2018, and later.

See the most current version of [EOD](#) for rules and [SEER*RSA](#) for site-specific schemas and codes.

Codes

Code	Description
00	None No distant metastasis Unknown if distant metastasis Schema-specific codes where needed
70	Distant metastasis, NOS
88	Not applicable: Information not collected for this schema Use for these sites only HemeRetic Ill-Defined Other (includes unknown primary site) Kaposi Sarcoma Lymphoma Lymphoma-CLL/SLL Plasma Cell Disorders Plasma Cell Myeloma
99	Death certificate only (DCO)

Summary Stage

Two Summary Stage data items are presented in this manual. For additional information on Summary Stage, see [SEER*RSA](#).

Summary Stage 2018

Item Length: 1

NAACCR Item #: 764

NAACCR Name: Summary Stage 2018

XML NAACCR ID: summaryStage2018

Summary Stage 2018 stores directly assigned Summary Stage 2018. This data item is effective for cases diagnosed 01/01/2018, and later. Refer to [SEER*RSA](#) for additional information.

Code	Description
0	In situ
1	Localized only
2	Regional by direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension AND lymph node involvement
7	Distant site(s)/node(s) involved
8	Benign, borderline*
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death certificate only (DCO) case

*Applicable for the following Summary Stage 2018 chapters: Brain, CNS Other, Intracranial Gland, Medulloblastoma.

Derived Summary Stage 2018

Item Length: 1**NAACCR Item #: 762****NAACCR Name: Derived Summary Stage 2018****XML NAACCR ID: derivedSummaryStage2018**

Derived Summary Stage 2018 is derived using the EOD data collection system (*EOD Primary Tumor*, *EOD Regional Nodes*, and *EOD Mets*) algorithm. Other data items may be included in the derivation process. Effective for cases diagnosed 01/01/2018 and later.

Code	Description
0	In situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
7	Distant
8	Benign, borderline
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified)
	Death certificate only case

Section VI

Stage-related Data Items

Stage-related Data Items

Nine data items are presented in this section. See the [Site-specific Data Item \(SSDI\) Manual](#) for data items not included in this section.

For more information about schemas and schema IDs, go to the [SSDI Manual, Appendix A](#).

Lymphovascular Invasion

Item Length: 1

NAACCR Item #: 1182

NAACCR Name: Lymphovascular Invasion

XML NAACCR ID: lymphVascularInvasion

Lymphovascular Invasion indicates whether lymphatic duct or blood vessel invasion is identified in the pathology report.

Note: SEER requires *Lymphovascular Invasion (LVI)* for penis and testis cases only. SEER registries may submit *LVI* for other sites when available. State/central cancer registries may require *LVI* for sites other than penis and testis. Record 8 for sites other than penis or testis when *LVI* is not required. *LVI* is always coded 8 for certain sites (see Coding Instruction #9).

Code	Description
0	Lymphovascular Invasion stated as Not Present
1	Lymphovascular Invasion Present/Identified (NOT used for thyroid and adrenal)
2	Lymphatic and small vessel invasion only (L) OR Lymphatic invasion only (thyroid and adrenal only)
3	Venous (large vessel) invasion only (V) OR Angioinvasion (thyroid and adrenal only)
4	BOTH lymphatic and small vessel AND venous (large vessel) invasion OR BOTH lymphatic AND angioinvasion (thyroid and adrenal only)
8	Not applicable
9	Unknown/Indeterminate/not mentioned in path report

Coding Instructions

- Code from pathology report(s).** If not available, code the absence or presence of lymphovascular invasion as described in the medical record.
 - The primary source of information about lymphovascular invasion is the pathology check list (synoptic report) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from other sections of the pathology report or a physician's statement, in that order.
- Code *Lymphovascular Invasion* to 0, 2, 3, 4, or 9 for the following Schema IDs.
 - Thyroid 00730
 - Thyroid Medullary 00740
 - Adrenal Gland 00760
- Do not code perineural invasion in this data item.
- Use the pathology report for any specimen from the primary site to code this data item (biopsy or resection).
- Code as present/identified when lymphovascular invasion is identified in any primary tumor specimen except as noted in Coding Instruction 2.

6. Use the table below for cases treated with neoadjuvant (preoperative) therapy. Code lymphovascular invasion based on the documentation in the medical record when documentation in the medical record conflicts with this table.

LVI on pathology report PRIOR to neoadjuvant (preoperative) therapy	LVI on pathology report AFTER neoadjuvant (preoperative) therapy	Code LVI to
0 – Not present/Not identified	0 – Not present/Not identified	0 – Not present/Not identified
0 – Not present/Not identified	1 – Present/Identified	1 – Present/Identified
0 – Not present/Not identified	9 – Unknown/Indeterminate	9 – Unknown/Indeterminate
1 – Present/Identified	0 – Not present/Not identified	1 – Present/Identified
1 – Present/Identified	1 – Present/Identified	1 – Present/Identified
1 – Present/Identified	9 – Unknown/Indeterminate	1 – Present/Identified
9 – Unknown/Indeterminate	0 – Not present/Not identified	9 – Unknown/Indeterminate
9 – Unknown/Indeterminate	1 – Present/Identified	1 – Present/Identified
9 – Unknown/Indeterminate	9 – Unknown/Indeterminate	9 – Unknown/Indeterminate

7. Use code **0**
- When the pathology report indicates that there is **no** lymphovascular invasion
 - For **in situ** cases
 - When there is no residual tumor found after neoadjuvant treatment and there is no LVI on biopsy
8. Use code **1** when the pathology report or a physician's statement indicates that lymphovascular invasion (or one of its synonyms) is present in the specimen.
- Synonyms** include, but are not limited to
 - Angiolymphatic invasion
 - Blood vessel invasion
 - Lymph vascular emboli
 - Lymphatic invasion
 - Lymphovascular invasion
 - Vascular invasion
 - Lymphovascular space invasion
9. Use code **8**
- For the following Schemas/Schema IDs
 - GIST 00430
 - HemeRetic 00830
 - Lymphoma 00790
 - Lymphoma-CLL/SLL 00795
 - Lymphoma Ocular Adnexa 00710
 - Mycosis Fungoides (MF) 00811
 - Plasma Cell Disorders 00822
 - Plasma Cell Myeloma 00821

Primary Cutaneous Lymphoma (excluding MF and SS) 00812

For more information about schemas and schema IDs, go to the [SSDI Manual, Appendix A](#).

- b. For non-malignant brain (intracranial) and CNS tumors including C751, C752, and C753
 - c. When standard-setter does not require this item and state/central registry is not collecting it
10. Use code 9 when
- a. There is no microscopic examination of a primary tissue specimen.
 - b. The primary site specimen is cytology only or a fine needle aspiration.
 - c. The biopsy is only a very small tissue sample.
 - d. It is not possible to determine whether lymphovascular invasion is present.
 - e. The pathologist indicates the specimen is insufficient to determine lymphovascular invasion.
 - f. **For thyroid, thyroid medullary, or adrenal gland:** The pathology report states LVI is present but does not provide the required further specification lymphatic invasion, angioinvasion, or both lymphatic and angioinvasion. It is recommended that this be clarified with the physician as this distinction is required for CAP protocol.
 - g. Lymphovascular invasion is not mentioned in the pathology report.
 - h. There is no information/documentation from the pathology report or other sources.
 - i. Primary site is unknown
 - j. Ambiguous terminology is used

Example: Assign code 9 for “suspicious LVI.”

Mets at Diagnosis--Bone

Item Length: 1
 NAACCR Item #: 1112
 NAACCR Name: Mets at DX--Bone
 XML NAACCR ID: metsAtDxBone

This data item identifies whether bone is an involved metastatic site. The six Mets at Diagnosis-metastatic sites data items provide information on specific metastatic sites for data analysis.

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

Coding Instructions

1. **Code information about bone metastases only** (discontinuous or distant metastases to bone) identified at the time of diagnosis. Do **not** code bone marrow involvement in this data item. Do **not** record contiguous bone invasion by primary tumor in this data item.
Note: See code 1 in “Mets at Diagnosis--Other” for bone marrow involvement.
 - a. Bone involvement may be single or multiple.
 - b. Information about bone involvement may be clinical or pathological.
 - c. Code this data item for bone metastases even if the patient had neoadjuvant (preoperative) systemic therapy unless determined to be disease progression.
 - d. Code this data item for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas except as noted in 2.c. and 2.d.
 - i. Lymphoma Ocular Adnexa 00710
 - ii. Lymphoma 00790
 - iii. Lymphoma-CLL/SLL 00795
 - iv. Mycosis Fungoides (MF) 00811
 - v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812
 - vi. HemeRetic 00830 (excluding primary sites C420, C421, C423, C424)
2. **Use of codes:** Assign the code that best describes whether the case has bone metastases at diagnosis.
 - a. Use code 0 when the medical record
 - i. Indicates that there are no distant (discontinuous) metastases at all
 - ii. Confirms the tumor is benign (/0), borderline (/1), or in situ (/2).
 - iii. Includes a clinical or pathologic statement that there are no bone metastases.
 - iv. Includes imaging reports that are negative for bone metastases.

- v. Indicates that the patient has distant (discontinuous) metastases but bone is not mentioned as an involved site.
Example: Use code 0 when the patient has metastasis to lung and liver but not bone.
- b. Use code **1** when the medical record
 - i. Indicates that the patient has distant (discontinuous) metastases and bone is mentioned as an involved site.
 - ii. Indicates that bone is the primary site and there are metastases in a different bone or bones.
 - 1. Do **not** assign code 1 for a bone primary with multifocal bone involvement of the same bone.
 - iii. Indicates that the patient is diagnosed with an unknown primary (C809) and bone is mentioned as a distant metastatic site.
- c. Use code **8** (Not applicable) for the following
 - i. Any case coded to primary site C420, C421, C423, or C424
 - ii. Plasma Cell Disorders 00822
- d. Use code **9** when it cannot be determined whether the patient specifically has bone metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include bone.

For more information about schemas and schema IDs, go to the [SSDI Manual, Appendix A](#).

Mets at Diagnosis--Brain

Item Length: 1

NAACCR Item #: 1113

NAACCR Name: Mets at DX-Brain

XML NAACCR ID: metsAtDxBrian

This data item identifies whether brain is an involved metastatic site. The six Mets at Diagnosis-metastatic sites data items provide information on specific metastatic sites for data analysis.

Code	Description
0	None; no brain metastases
1	Yes; distant brain metastases
8	Not applicable
9	Unknown whether brain is involved metastatic site Not documented in patient record

Coding Instructions

1. **Code information about brain metastases only** (discontinuous or distant metastases to brain) identified at the time of diagnosis. Do **not** code involvement of spinal cord or other parts of the central nervous system in this data item.

Note: See code 1 in “Mets at Diagnosis--Other” for mets to spinal cord or other parts of the central nervous system.

 - a. Brain involvement may be single or multiple.
 - b. Information about brain involvement may be clinical or pathological.
 - c. Code this data item whether or not the patient had neoadjuvant (preoperative) systemic therapy unless determined to be disease progression.
 - d. Code this data item for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas except as noted in 2.c. and 2.d.
 - i. Lymphoma Ocular Adnexa 00710
 - ii. Lymphoma 00790
 - iii. Lymphoma-CLL/SLL 00795
 - iv. Mycosis Fungoides (MF) 00811
 - v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812
 - vi. HemeRetic 00830 (excluding primary sites C420, C421, C423, C424)
2. **Use of codes.** Assign the code that best describes whether the case has brain metastases at diagnosis.
 - a. Use code 0 when the medical record
 - i. Indicates that there are no distant (discontinuous) metastases at all
 - ii. Confirms the tumor is benign (/0), borderline (/1), or in situ (/2).
 - iii. Includes a clinical or pathologic statement that there are no brain metastases.
 - iv. Includes imaging reports that are negative for brain metastases.

- v. Indicates that the patient has distant (discontinuous) metastases but brain is not mentioned as an involved site.
***Example:** Use code 0* when the patient has metastasis to lung and liver but not brain.
- b. Use code **1** when the medical record
 - i. Indicates that the patient has distant (discontinuous) metastases and brain is mentioned as an involved site.
 - ii. Indicates that the patient is diagnosed with an unknown primary (C809) and brain is mentioned as a distant metastatic site.
- c. Use code **8** (Not applicable) for the following
 - i. Any case coded to primary site C420, C421, C423, or C424
 - ii. Plasma Cell Disorders 00822
- d. Use code **9** when it cannot be determined whether the patient specifically has brain metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include brain.

For more information about schemas and schema IDs, go to the [SSDI Manual, Appendix A](#).

Mets at Diagnosis--Liver

Item Length: 1

NAACCR Item #: 1115

NAACCR Name: Mets at DX-Liver

XML NAACCR ID: metsAtDxLiver

This data item identifies whether liver is an involved metastatic site. The six Mets at Diagnosis-metastatic sites data items provide information on specific metastatic sites for data analysis.

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

Coding Instructions

1. **Code information about liver metastases only** (discontinuous or distant metastases to liver) identified at the time of diagnosis. Do **not** record **contiguous involvement of liver by primary tumor** in this data item.
 - a. Liver involvement may be single or multiple.
 - b. Information about liver involvement may be clinical or pathological.
 - c. Code this data item whether or not the patient had neoadjuvant (preoperative) systemic therapy unless determined to be disease progression.
 - d. Code this data item for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas except as noted in 2.c. and 2.d.
 - i. Lymphoma Ocular Adnexa 00710
 - ii. Lymphoma 00790
 - iii. Lymphoma-CLL/SLL 00795
 - iv. Mycosis Fungoides (MF) 00811
 - v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812
 - vi. HemeRetic 00830 (excluding primary sites C420, C421, C423, C424)
2. **Use of codes:** Assign the code that best describes whether the case has liver metastases at diagnosis.
 - a. Use code **0** when the medical record
 - i. Indicates that there are no distant (discontinuous) metastases at all
 - ii. Confirms the tumor is benign (0/), borderline (/1), or in situ (/2).
 - iii. Includes a clinical or pathologic statement that there are no liver metastases.
 - iv. Includes imaging reports that are negative for liver metastases.
 - v. Indicates that the patient has distant (discontinuous) metastases but liver is not mentioned as an involved site.

Example: Use code **0** when the patient has metastasis to lung and brain but not liver.

- b. Use code **1** when the medical record
 - i. Indicates that the patient has distant (discontinuous) metastases and liver is mentioned as an involved site.
 - ii. Indicates that the patient is diagnosed with an unknown primary (C809) and liver is mentioned as a distant metastatic site.
- c. Use code **8** (Not applicable) for the following
 - i. Any case coded to primary site C420, C421, C423, or C424
 - ii. Plasma Cell Disorders 00822
- d. Use code **9** when it cannot be determined whether the patient specifically has liver metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include liver.

For more information about schemas and schema IDs, go to the [SSDI Manual, Appendix A](#).

Mets at Diagnosis--Lung

Item Length: 1

NAACCR Item #: 1116

NAACCR Name: Mets at DX-Lung

XML NAACCR ID: metsAtDxLung

This data item identifies whether lung is an involved metastatic site. The six Mets at Diagnosis-metastatic sites data items provide information on specific metastatic sites for data analysis.

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

Coding Instructions

1. **Code information about lung metastases only** (discontinuous or distant metastases to lung) identified at the time of diagnosis. Do **not** code pleural or pleural fluid involvement in this data item.

Note: See code 1 in *Mets at Diagnosis--Other* for pleural nodules, malignant pleural or pericardial effusion.

 - a. Lung involvement may be single or multiple.
 - b. Information about lung involvement may be clinical or pathological.
 - c. Code this data item whether or not the patient had neoadjuvant (preoperative) systemic therapy unless determined to be disease progression.
 - d. Code this data item for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas except as noted in 2.c. and 2.d.
 - i. Lymphoma Ocular Adnexa 00710
 - ii. Lymphoma 00790
 - iii. Lymphoma-CLL/SLL 00795
 - iv. Mycosis Fungoides (MF) 00811
 - v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812
 - vi. HemeRetic 00830 (excluding primary sites C420, C421, C423, C424)
2. **Use of codes:** Assign the code that best describes whether the case has lung metastases at diagnosis.
 - a. Use code 0 when the medical record
 - i. Indicates that there are no distant (discontinuous) metastases at all
 - ii. Confirms the tumor is benign (/0), borderline (/1), or in situ (/2).
 - iii. Includes a clinical or pathologic statement that there are no lung metastases.
 - iv. Includes imaging reports that are negative for lung metastases.

- v. Indicates that the patient has distant (discontinuous) metastases but lung is not mentioned as an involved site.

Note: A single tumor in each lung is two primaries, unless proven to be metastatic (see [Solid Tumor Rules](#) for Lung).

Example: Use **code 0** when the patient has metastasis to liver and brain but not lung.

- b. Use **code 1** when the medical record
 - i. Indicates that the patient has distant (discontinuous) metastases and lung is mentioned as an involved site.
 - ii. Indicates that lung is the primary site and there are metastases in the contralateral lung.
 - iii. Indicates that the patient is diagnosed with an unknown primary (C809) and lung is mentioned as a distant metastatic site.

Note: Do **not** assign **code 1** for a lung primary with multifocal involvement of the same lung.
- c. Use **code 8** (Not applicable) for the following
 - i. Any case coded to primary site C420, C421, C423, or C424
 - ii. Plasma Cell Disorders 00822
- d. Use **code 9** when it cannot be determined whether the patient specifically has lung metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include lung.

For more information about schemas and schema IDs, go to the [SSDI Manual, Appendix A](#).

Mets at Diagnosis--Distant Lymph Node(s)

Item Length: 1

NAACCR Item #: 1114

NAACCR Name: Mets at DX-Distant LN

XML NAACCR ID: metsAtDxDistantLn

This data item identifies whether distant lymph node(s) are an involved metastatic site. The six Mets at Diagnosis-metastatic sites data items provide information on specific metastatic sites for data analysis.

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

Coding Instructions

Note 1: Use AJCC TNM to determine regional versus distant lymph nodes.

Note 2: Assign code **0** (None) for unknown primaries, unless involved lymph nodes are stated to be distant lymph nodes.

Note 3: Placental lymph node involvement for placental primaries is classified as distant lymph node involvement (M1) and recorded in this data item.

1. **Code information about distant lymph node(s) metastases only** (metastases to distant lymph nodes) identified at the time of diagnosis.
 - a. Distant lymph node involvement may be single or multiple.
 - b. Information about distant lymph node involvement may be clinical or pathological.
 - c. Code this data item whether or not the patient had neoadjuvant (preoperative) systemic therapy unless determined to be disease progression.
 - d. Do **not** code this data item for regional lymph node involvement.
 - e. Code this data item for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas except as noted in 2.c. and 2.d.
 - i. Lymphoma Ocular Adnexa 00710
 - ii. Lymphoma 00790 (excluding primary sites C770-C779; see 2.c.)
 - iii. Lymphoma-CLL/SLL 00795 (excluding primary sites C770-C779; see 2.c.)
 - iv. Mycosis Fungoides (MF) 00811
 - v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812
 - vi. HemeRetic 00830 (excluding primary sites C420, C421, C423, C424, see 2.c.)
2. **Use of codes:** Assign the code that best describes whether the case has distant lymph node metastases at diagnosis.
 - a. Use code **0** when the medical record
 - i. Indicates that there are no distant (discontinuous) metastases at all

- ii. Confirms the tumor is benign (/0), borderline (/1), or in situ (/2).
- iii. Includes a clinical or pathologic statement that there are no distant lymph node metastases.
- iv. Includes imaging reports that are negative for distant lymph node metastases.
- v. Indicates lymph nodes are involved, but there is no indication whether they are regional or distant.
- vi. Indicates that the patient has distant (discontinuous) metastases but distant lymph node(s) are not mentioned as an involved site.

Example: Use code **0** when the patient has metastasis to lung and liver but not distant lymph node(s).

- b. Use code **1** when the medical record
 - i. Indicates that the patient has distant (discontinuous) metastases and distant lymph node(s) are mentioned as an involved site.
- c. Use code **8** (Not applicable) for the following
 - i. Any case coded to primary site C420, C421, C423, C424, or C770-C779
 - ii. Plasma Cell Disorders 00822
- d. Use code **9** when it cannot be determined whether the patient specifically has distant lymph node metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include distant lymph node(s).

For more information about schemas and schema IDs, go to the [SSDI Manual, Appendix A](#).

Mets at Diagnosis--Other

Item Length: 1

NAACCR Item #: 1117

NAACCR Name: Mets at DX-Other

XML NAACCR ID: metsAtDxOther

The six Mets at Diagnosis-metastatic sites data items provide information on metastases for data analysis. This data item identifies any type of distant involvement not captured in the *Mets at Diagnosis--Bone*, *Mets at Diagnosis--Brain*, *Mets at Diagnosis--Liver*, *Mets at Diagnosis--Lung*, and *Mets at Diagnosis--Distant Lymph Nodes* data items. It includes involvement of other specific sites and more generalized metastases such as carcinomatosis. Some examples include but are not limited to the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum, and skin.

Code	Description
0	None; no other metastases
1	Yes; distant metastases in known site(s) other than bone, brain, liver, lung, or distant lymph nodes <i>Note:</i> includes bone marrow involvement for lymphomas
2	Generalized metastases such as carcinomatosis
8	Not applicable
9	Unknown whether any other metastatic site or generalized metastases Not documented in patient record

Coding Instructions

1. **Code information about other metastases only** (discontinuous or distant metastases) identified at the time of diagnosis. This data item should not be coded for bone, brain, liver, lung, or distant lymph node metastases.
 - a. Other involvement may be single or multiple.
 - b. Information about other involvement may be clinical or pathological.
 - c. Code this data item whether or not the patient had any preoperative (neoadjuvant) systemic therapy unless determined to be disease progression.
 - d. Code this data item for all solid tumor schemas (including Kaposi Sarcoma and Ill-Defined Other [includes unknown primary site]) and the following Hematopoietic schemas except as noted in 2.d. and 2.e.
 - i. Lymphoma Ocular Adnexa 00710
 - ii. Lymphoma 00790 (see 2.d.)
 - iii. Lymphoma-CLL/SLL 00795 (see 2.d.)
 - iv. Mycosis Fungoides (MF) 00811
 - v. Primary Cutaneous Lymphoma (excluding MF and SS) 00812
 - vi. HemeRetic 00830 (excluding primary sites C420, C421, C423, C424, see 2.d.)

Note: Do not code spleen involvement for Hodgkin lymphoma in *Mets at Diagnosis--Other*. Spleen involvement is not classified as distant mets for Hodgkin lymphoma in most staging systems.

2. **Use of codes:** Assign the code that best describes whether the case has other metastases at diagnosis.
- a. Use code **0** when the medical record
 - i. Indicates that there are no distant (discontinuous) metastases at all
 - ii. Confirms the tumor is benign (/0), borderline (/1), or in situ (/2).
 - iii. Includes a clinical or pathologic statement that there are no other metastases.
 - iv. Includes imaging reports that are negative for other metastases.
 - v. Indicates that the patient has distant (discontinuous) metastases but other sites are not mentioned as involved.

Example: Use code **0** when the patient has metastasis to lung and liver only.
 - b. Use code **1** when the medical record indicates
 - i. Distant (discontinuous) metastases in any site(s) other than bone, brain, liver, lung, or distant lymph node(s)
 1. Includes, but not limited to, the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum, and skin.
 - ii. Lymphomas with bone marrow involvement (Stage IV disease)

Note: Does **not** include lymphomas or lymphoma/leukemias where primary site is C421 (bone marrow).
 - c. Use code **2** when the medical record
 - i. Indicates that the patient has carcinomatosis.
 1. Carcinomatosis is a condition in which cancer is spread widely throughout the body, or, in some cases, to a relatively large region of the body.

Note: It is possible to have metastatic disease to a specific organ AND also have carcinomatosis. If a patient has metastatic disease to bone, brain, liver, lung, or distant nodes AND carcinomatosis, use code 1 for the appropriate data item (bone, brain, liver, lung, or distant nodes) and use code 2 for carcinomatosis. If a patient has metastatic disease to a site other than bone, brain, liver, lung, or distant nodes AND carcinomatosis, assign code 2 for carcinomatosis. Code 2 for carcinomatosis takes priority.

Example 1: Patient with breast cancer noted to have mets to the liver and carcinomatosis. Code *Mets at Diagnosis--Liver* as 1 and *Mets at Diagnosis--Other* as 2.

Example 2: Patient with colon cancer noted to have mets to the stomach and carcinomatosis. Code *Mets at Diagnosis--Other* as 2 for carcinomatosis.
 - d. Use code **8** (Not applicable) for the following
 - i. Any case coded to primary site C420, C421, C423, or C424
 - ii. Plasma Cell Disorders 00822
 - e. Use code **9** when it cannot be determined whether the patient has metastases other than bone, brain, liver, lung, or distant lymph node(s).

For more information about schemas and schema IDs, go to the [SSDI Manual, Appendix A](#).

Additional Stage-related Data Items

Site-specific Data Items (SSDIs)

Each Site-specific Data Item (SSDI) applies only to selected primary sites, histologies, and years of diagnosis. Depending on applicability and standard-setter requirements, SSDIs may be left blank.

[SEER*RSA](#) is a staging tool that provides information (primary site/histology/other factors defined) about each cancer schema.

For updates to schemas, schema IDs and SSDIs, refer to [SEER*RSA](#), SSDI Manual, and the 2027 [NAACCR Implementation Guidelines](#) for additional information. For additional required data items, see [NAACCR Version 27 Required Status Table](#) and the [SSDI Manual](#).

Section VII

First Course of Therapy

First Course of Therapy

This section applies to all neoplasms (including benign and borderline intracranial and CNS tumors) *except* hematopoietic and lymphoid neoplasms. For information regarding first course of therapy for hematopoietic and lymphoid neoplasms, refer to the NCI SEER [Hematopoietic and Lymphoid Neoplasm Coding Manual](#).

Definitions

Active surveillance: A treatment plan that involves closely watching a patient's condition but not giving any treatment unless there are changes in test results that show the condition is getting worse. Active surveillance may be used to avoid or delay the need for treatments such as radiation therapy or surgery, which can cause side effects or other problems. During active surveillance, certain exams and tests are done on a regular schedule. It may be used in the treatment of certain types of cancer, such as prostate cancer, urethral cancer, and intraocular (eye) melanoma. It is a type of expectant management. Also called active monitoring. (Source: [NCI Dictionary of Cancer Terms](#))

Cancer tissue: Proliferating malignant cells; an area of active production of malignant cells. Cancer tissue includes primary tumor and metastatic sites where cancer tissue grows. Cells in fluid such as pleural fluid or ascitic fluid are not "cancer tissue" because the cells do not grow and proliferate in the fluid.

Concurrent therapy: A treatment that is given at the same time as another.

Example: Chemotherapy and radiation therapy

Deferred therapy: Closely watching a patient's condition but not giving treatment unless symptoms appear or change, or there are changes in test results. Deferred therapy avoids problems that may be caused by treatments such as radiation or surgery. It is used to find early signs that the condition is getting worse. During deferred therapy, patients may be given certain exams and tests. It is sometimes used in prostate cancer. Also called expectant management. (Source: [NCI Dictionary of Cancer Terms](#))

Disease recurrence: For solid tumors, see the [Solid Tumor Rules](#) and for hematopoietic and lymphoid neoplasms see the [Hematopoietic and Lymphoid Neoplasm Coding Manual and Database](#) to determine disease recurrence.

Expectant management: Closely watching a patient's condition but not giving treatment unless symptoms appear or change, or there are changes in test results. Expectant management avoids problems that may be caused by treatments such as radiation or surgery. It is used to find early signs that the condition is getting worse. During expectant management, patients may be given certain exams and tests. It is sometimes used in prostate cancer. Also called deferred therapy. (Source: [NCI Dictionary of Cancer Terms](#))

First course of therapy: All treatments administered to the patient after the original diagnosis of cancer in an attempt to **destroy or modify the cancer tissue**. See [below](#) for detailed information on timing and treatment plan documentation requirements.

Hospice: A program that provides special care for people who are near the end of life and for their families, either at home, in freestanding facilities, or within hospitals. Hospice care **may** include treatment that destroys or modifies cancer tissue. If performed as part of the first course, treatment that destroys or modifies cancer tissue is collected when given in a hospice setting. "Hospice, NOS" is not specific enough to be included as first course treatment.

Neoadjuvant therapy: Systemic therapy or radiation therapy given prior to surgery to shrink the tumor.

Palliative treatment: The World Health Organization describes palliative care as treatment that improves the quality of life by preventing or relieving suffering.

Note: Palliative therapy is **part of the first course of therapy only** when it **destroys or modifies cancer tissue**.

Example: The patient was diagnosed with stage IV cancer of the prostate with painful bone metastases. The patient starts radiation treatment intended to shrink the tumor in the bone and relieve the intense pain. The radiation treatments are palliative because they relieve the bone pain; the radiation is also first course of therapy because it destroys proliferating cancer tissue.

Surgical procedure: Any surgical procedure coded in the data items *Surgery of Primary Site 2023*, *Scope of Regional Lymph Node Surgery* (excluding code 1), or *Surgical Procedure of Other Site*.

Treatment: Procedures that destroy or modify primary (primary site) or secondary (metastatic) cancer tissue.

Treatment failure: The treatment modalities did not destroy or modify the cancer cells. The tumor either became larger (disease progression) or stayed the same size after treatment.

Watchful waiting: Closely watching a patient's condition but not giving treatment unless symptoms appear or change. Watchful waiting is sometimes used in conditions that progress slowly. It is also used when the risks of treatment are greater than the possible benefits. During watchful waiting, patients may be given certain tests and exams. Watchful waiting is sometimes used in prostate cancer. It is a type of expectant management. (Source: [NCI Dictionary of Cancer Terms](#))

Treatment Timing

Use the following instructions **in hierarchical order**

1. Use the **documented** first course of therapy (treatment plan) from the medical record. First course of therapy ends when the treatment plan is **completed** no matter how long it takes to complete the plan, unless there is documentation of disease progression, recurrence, or treatment failure (see #2 below).

Example: Hormonal therapy (e.g., Tamoxifen) after surgery, radiation, and chemotherapy. First course ends when hormonal therapy is completed, even if this takes years, unless there is documentation of disease progression, recurrence, or treatment failure (see #2 below).

2. First course of therapy ends when there is documentation of **disease progression, recurrence, or treatment failure**.

Example 1: The documented treatment plan for sarcoma is pre-operative (neoadjuvant) chemotherapy, followed by surgery, then radiation or chemotherapy depending upon the pathology from surgery. Scans show the tumor is not regressing after pre-operative chemotherapy. Plans for surgery are cancelled, radiation was not administered, and a different type of chemotherapy is started. Code only the first chemotherapy as first course. Do **not** code the second chemotherapy as first course because it is administered after documented treatment failure.

Example 2: The documented treatment plan for a patient with locally advanced breast cancer includes mastectomy, chemotherapy, radiation to the chest wall and axilla, and hormone therapy. The patient has the mastectomy and completes chemotherapy. During the course of radiation therapy, the liver enzymes are rising. Workup proves liver metastases. The physician stops the radiation and does not continue with hormone therapy (the treatment plan is altered). The patient is placed on a clinical trial to receive Herceptin for metastatic breast cancer. Code

the mastectomy, chemotherapy, and radiation as first course of treatment. Do not code the Herceptin as first course of therapy because it is administered after documented disease progression.

3. When there is **no documentation** of a treatment plan or progression, recurrence, or a treatment failure, first course of therapy ends one year after the date of diagnosis. **Any treatment given after one year is second course of therapy in the absence of a documented treatment plan or a standard of treatment.**

Coding Instructions

1. Code all treatment data items to 0 or 00 (Not done) when the physician opts for **active surveillance, deferred therapy, expectant management, or watchful waiting**. When the disease progresses or the patient becomes symptomatic, any prescribed treatment is second course.
 - a. Code *Treatment Status (RX Summ--Treatment Status)* to 2
2. Code the treatment as first course of therapy if the patient refuses treatment but changes his/her mind and **the prescribed treatment is implemented less than one year** from the date of diagnosis, AND there is no evidence of disease progression.
3. The first course of therapy is **no treatment** when the patient **refuses** all treatment. Code all treatment data items to Refused.
 - a. Keep the refused codes even if the patient later changes his/her mind and decides to have the prescribed treatment.
 - i. More than one year after diagnosis, or
 - ii. When there is evidence of disease progression before treatment is implemented
4. Code all treatment that was started and administered, whether completed or not. Document treatment discontinuation in text fields.

Example: The patient completed only the first dose of a planned 30-day chemotherapy regimen. Code chemotherapy as administered.
5. Code the treatment on each abstract when a patient has multiple primaries and the treatment given for one primary also is clinically recognized to affect/treat the other primary.

Example 1: The patient had prostate and bladder cancer. The bladder cancer was treated with a TURB. The prostate cancer was treated with radiation to the prostate and pelvis. The pelvic radiation includes the regional lymph nodes for the bladder. Code the radiation as treatment for both the bladder and prostate cases.

Example 2: The patient had a hysterectomy for ovarian cancer. The pathology report reveals a previously unsuspected microinvasive cancer of the cervix. Code the hysterectomy as surgical treatment for both the ovarian and cervix primaries.
6. Code the treatments only for the site that is affected when a patient has multiple primaries and the treatment affects only one of the primaries.

Example: The patient has colon and tonsil primaries. The colon cancer is treated with a hemicolectomy and the tonsil primary is treated with radiation to the tonsil and regional nodes. Do not code the radiation for the colon. Do not code the hemicolectomy for the tonsil.

7. Code the treatment given as first course even if the correct primary is identified later when a patient is diagnosed with an unknown primary.

Example: The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Code the chemotherapy as first course of treatment.

8. Do not code treatment as first course when it is added to the plan after the primary site is discovered. This is a change in the treatment plan.

Example: The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Hormonal treatment is started. Code the chemotherapy as first course of treatment. The hormone therapy is second course because it was not part of the initial treatment plan.

9. For information regarding first course of therapy for hematopoietic and lymphoid neoplasms, refer to the NCI SEER [*Hematopoietic and Lymphoid Neoplasm Coding Manual*](#).

Date Therapy Initiated

Item Length: 8

NAACCR Item #: 1260

NAACCR Name: Date Initial RX SEER

XML NAACCR ID: dateInitialRxSeer

Record the start date of the first course of therapy. This is the start date of any type of treatment for this tumor: surgery, chemotherapy, radiation therapy, or other types of therapy. Treatment may be given in a hospital or non-hospital setting.

Date Therapy Initiated must be transmitted in the YYYYMMDD format. *Date Therapy Initiated* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

Transmitting Dates

Transmit date data items in the year, month, day format (YYYYMMDD). Leave the year, month, and/or day blank when they cannot be estimated or are unknown.

Common Formats

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

Transmit Instructions

1. Transmit date data items in the year, month, day format (YYYYMMDD).
2. Leave the year, month, and/or day blank when they cannot be estimated or are unknown.
 - a. Leave the year, month, and day blank for death certificate only (DCO) cases when the date of therapy is unknown and cannot be estimated.
3. Most SEER registries collect the month, day, and year for date therapy initiated. When the full date (YYYYMMDD) is transmitted, the seventh and eighth digits (day) will be deleted when the data are received by SEER.

Codes for Year

Code the four-digit year of date therapy initiated.

Codes for Month

Code	Description
01	January
02	February
03	March
04	April

Code	Description
05	May
06	June
07	July
08	August
09	September
10	October
11	November
12	December

Codes for Day

01
02
03
..
..
31

Coding Instructions

- Code the **start date** of the first therapy. The first therapy may be recorded in the following data items.
 - Surgery of Primary Site 2023*
 - Scope of Regional Lymph Node Surgery* (excluding code 1)
 - Surgical Procedure of Other Site*
 - Radiation Treatment Modality--Phase I, II, III*
 - Chemotherapy*
 - Hormone Therapy*
 - Immunotherapy*
 - Hematologic Transplant and Endocrine Procedures*
 - Other Therapy*
- Record the date the decision was made for active surveillance even if the patient later changes their mind and opts for additional treatment. Code *Treatment Status* as 2, Active surveillance/watchful waiting.
- Code the date of **excisional biopsy** as the **date therapy initiated** when it is the first treatment. Code the date of a biopsy documented as incisional when further surgery reveals no residual or only microscopic residual.

Example: Breast biopsy with diagnosis of infiltrating duct carcinoma; subsequent re-excision with no residual tumor noted. Code the date of the biopsy as the date therapy initiated.

Note: Code date therapy initiated as the date the stereotactic core biopsy was performed when the entire tumor was removed.
- Record the actual date of treatment when treatment is performed prior to birth. Record the type of treatment in the appropriate data item, for example, *Surgery of Primary Site 2023*.

Example: On 01/03/2027, fetus is diagnosed with malignant teratoma. The teratoma is resected in utero on 01/10/2027. Live birth on 04/18/2027. Code the date therapy initiated as January 10, 2027 (20270110).

5. Code the date unproven therapy (cancer treatments administered by nonmedical personnel) was initiated as the date therapy initiated.
6. Code the date of admission to the hospital for inpatient or outpatient treatment when the exact date of the first treatment is unknown.
7. Leave blank
 - a. When no treatment is given during the first course
Note: This includes when a patient dies before treatment is recommended or given.
 - b. When it is known the patient had first course therapy, but it is impossible to estimate the date
 - c. When it is unknown whether the patient had treatment
 - d. For death certificate only (DCO) cases when the date is unknown and cannot be estimated
 - e. Autopsy only cases

Estimating Dates

Estimating the **month**

1. Code “spring of” to April.
2. Code “summer” or “middle of the year” to July.
3. Code “fall” or “autumn” as October.
4. For “winter of,” try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month.
5. Code “early in year” to January.
6. Code “late in year” to December.
7. Use whatever information is available to calculate the month.
8. Code the month of admission when there is no basis for estimation.
9. Leave month blank if there is no basis for approximation.

Estimating the **year**

1. Code “a couple of years” to two years earlier.
2. Code “a few years” to three years earlier.
3. Use whatever information is available to calculate the year.
4. Code the year of admission when there is no basis for estimation.

Treatment Status

Item Length: 1

NAACCR Item #: 1285

NAACCR Name: RX Summ--Treatment Status

XML NAACCR ID: rxSummTreatmentStatus

Treatment Status documents active surveillance/watchful waiting. Before this data item was implemented, active surveillance or watchful waiting was deduced from the codes in each of the treatment data items.

This data item is effective for cases diagnosed January 1, 2010, and later.

Code	Label	Definition
0	No treatment given	The patient did not receive any treatment
1	Treatment given	The patient received treatment
2	Active surveillance (watchful waiting)	The patient was under active surveillance or watchful waiting during the first course of treatment
9	Unknown if treatment given	It is unknown whether or not the patient received treatment

Coding Instructions

- Assign code **0** when the patient does not receive any treatment.
 - Scope of Regional Lymph Node Surgery* may be coded 0, 1-7, or 9.
- Assign code **1** when the patient receives treatment collected in any of the following data items.
 - Surgery of Primary Site 2023*
 - Surgical Procedure of Other Site*
 - Radiation Treatment Modality, Phase I, II, III*
 - Chemotherapy*
 - Hormone Therapy*
 - Immunotherapy*
 - Hematologic Transplant and Endocrine Procedures*
 - Other Therapy*
- Assign code **2** when there is documentation that the patient is being monitored using **active surveillance/watchful waiting/deferred therapy or other similar options**.
- Assign code **9** for death certificate only (DCO) cases.
- Leave **blank** for cases diagnosed prior to January 1, 2010

Date of First Surgical Procedure

Item Length: 8

NAACCR Item #: 1200

NAACCR Name: RX Date Surgery

XML NAACCR ID: rxDateSurgery

Date of First Surgical Procedure is the date the first surgery was performed as part of first course of therapy. This is either the date of the *Surgery of Primary Site 2023*, *Sentinel Lymph Node Biopsy*, *Scope of Regional Lymph Node Surgery* (codes 2-7), or *Surgical Procedure of Other Site*, whichever is earliest.

Date of First Surgical Procedure must be transmitted in the YYYYMMDD format. *Date of First Surgical Procedure* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

SEER Central Registries: Collect when available from CoC reporting facilities.

Coding Instructions

1. Record the date of the first/earliest surgery if *Surgery of Primary Site 2023*, *Sentinel Lymph Node Biopsy*, *Scope of Regional Lymph Node Surgery* (excluding cases coded to 1), or *Surgical Procedure of Other Site* was recorded as part of the first course of therapy.
2. Surgery date should be the same as the *Date Therapy Initiated* when surgery is the only treatment administered.
3. Transmit date data items in the year, month, day format (YYYYMMDD).
4. Record the polypectomy date as the date of first surgical procedure when a surgical procedure to remove polyps is performed without removing the entire tumor, and a subsequent surgery is performed.
 - a. When reportable tumor is found in the specimen, polypectomies are surgery for the purposes of cancer registry data collection regardless of whether or not there is residual tumor after the polypectomy.
5. Leave date blank when there is no surgery performed

Date of Most Definitive Surgical Resection of the Primary Site

Item Length: 8

NAACCR Item #: 3170

NAACCR Name: RX Date Mst Defn Srg

XML NAACCR ID: rxDateMostDefinSurg

Date of Most Definitive Surgical Resection of the Primary Site, effective 01/01/2018, captures the date of the most definitive (most invasive) surgical procedure of the primary site performed as part of the first course of therapy.

Date of Most Definitive Surgical Resection of the Primary Site must be transmitted in the YYYYMMDD format. *Date of Most Definitive Surgical Resection of the Primary Site* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

SEER Central Registries: Collect when available from CoC reporting facilities.

Coding Instructions

1. Record the date of the most invasive, extensive, or definitive surgery when *Surgery of Primary Site 2023* was recorded as part of the first course of therapy.
 - a. This is the date of the procedure coded in *Surgery of Primary Site 2023*
2. Transmit date data items in the year, month, day format (YYYYMMDD).
3. Leave date blank when *Surgery of Primary Site 2023* is coded A000 or B000 (no surgery of primary site performed).

Surgery of Primary Site 2023

Item Length: 4

NAACCR Item #: 1291

NAACCR Name: RX Summ--Surg Prim Site 2023

XML NAACCR ID: rxSummSurgPrimSite2023

Surgery of Primary Site 2023, effective 01/01/2023, describes a surgical procedure that removes and/or destroys tissue of the primary site that is performed as part of the initial diagnostic and staging work-up or first course of therapy. Site-specific surgery codes are included under [Appendix C](#) of this manual.

General Coding Structure

(See [Appendix C](#) for site-specific codes.)

Code	Description
A000; B000	None; no surgical procedure of primary site; diagnosed at autopsy only
A100-A190; B100-B190	Site-specific codes. Tumor destruction; no pathologic specimen or unknown whether there is a pathologic specimen
A200-A800; B200-B800	Site-specific codes. Resection; pathologic specimen
A900; B900	Surgery, NOS. A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
A980	Special codes for hematopoietic neoplasms; ill-defined sites; and unknown primaries (See site-specific codes for the sites and histologies), except death certificate only
A990; B990	Unknown if surgery performed

Use the **entire operative report** as the primary source document to determine the best surgery of primary site code. The body of the operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the **operative report takes precedence**.

Information from imaging may be used to assign the most accurate surgery code possible when information from post-operative imaging adds to what is known about the surgery performed.

Example: Craniotomy for brain tumor resection. No additional information regarding surgical procedure is available. Post-operative MRI states "there is a cavity with blood product from the gross total resection." Use this information to assign a more specific surgery of primary site code.

Coding Instructions

1. Code **A000** or **B000** when
 - a. No surgery was performed on the primary site, **OR**
 - b. First course of treatment was active surveillance/watchful waiting, **OR**
 - c. Case was diagnosed at autopsy.

Note: Codes **A000** and **B000** exclude all sites and histologies that are coded **A980**. (See Coding Instruction 12 below.)

2. Use the site-specific coding scheme corresponding to the primary site or histology.

3. Code the most **invasive, extensive, or definitive** surgery if the patient has multiple surgical procedures of the primary site even if there is no residual tumor found in the pathologic specimen from the more extensive surgery.

Example: Patient has a needle biopsy of prostate that is positive for adenocarcinoma. The patient chooses to have a radical prostatectomy. The pathologic examination of the prostatectomy specimen shows no residual tumor. Code the radical prostatectomy.

4. Code an **excisional biopsy**, even when documented as **incisional**, when
 - a. All disease is removed (**margins free**), OR
 - b. All gross disease is removed and there is only microscopic residual at the margin.

Note: Do **not** code an incisional biopsy as an excisional biopsy when there is macroscopic residual disease.

5. Code total **removal of the primary site** when a previous procedure resected a portion of the site and the current surgery removed the rest of the organ. The previous procedure may have been cancer directed or non-cancer directed surgery.

Example: Left thyroidectomy for suspicious nodules. Path showed papillary carcinoma. Completion thyroidectomy was performed. Code surgery of primary site as total thyroidectomy (B500).

6. Assign the code that reflects the **cumulative effect** of all surgeries to the primary site.
 - a. When a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, code the total or final results. Do not rely on registry software to perform this task.

Example: The patient underwent a partial mastectomy and sentinel lymph node biopsy, followed by an axillary lymph node dissection for the first right breast primary in 2011. The separate 2020 right breast primary was treated with a total mastectomy and removal of one involved axillary lymph node. The operative report only refers to this as a non-sentinel lymph node, with no mention of other axillary findings. Cumulatively, this patient has undergone a modified radical mastectomy since there were likely no remaining axillary lymph nodes. For the 2020 primary, code the cumulative effect of the surgery done in 2011 plus the surgery performed in 2020. Use text fields on both abstracts to record the details.

7. Code the removal of regional or distant **tissue/organs** when they are resected in continuity with the primary site (**en bloc**) and that regional organ/tissue is listed in the *Surgery of Primary Site 2023* codes. Specimens from an en bloc resection may be submitted to pathology separately.

Example: Code an en bloc removal when the patient has a hysterectomy and an omentectomy.

8. Code surgery for extra-lymphatic lymphoma using the **site-specific** surgery coding scheme for the primary site. Do **not** use the lymph node scheme.
9. Assign the surgery code(s) that best represents the extent of the surgical procedure that was actually carried out when surgery is aborted. If the procedure was aborted before anything took place, assign code A000 or B000. See 1.a. above.
10. Assign the code that best represents the procedure that was actually performed based on the surgeon's description of the procedure. Avoid assigning a code based on the procedure that was intended to be performed when there is a difference between the planned procedure and the actual procedure performed.
11. Code **A800, B800, A900, or B900** only when there is no specific information.
12. Code **A980** for the following primary sites **unless** the case is death certificate only (see #13 and #14 below).
 - a. Any case coded to C420, C421, C423, C424, C760-C768, or C809

13. When *Surgery of Primary Site 2023* is coded **A980**
 - a. Code *Surgical Margins of the Primary Site* (#1320) to 9
 - b. Code *Reason for No Surgery of Primary Site* (#1340) to 1
14. Code **A990 or B990** for death certificate only (DCO) cases or if patient record does not state whether a surgical procedure of the primary site was performed (i.e., is unknown).
15. Leave blank for diagnosis years 2003-2022.

Breast Reconstruction

Item Length: 4

NAACCR Item #: 1335

NAACCR Name: RX Sum--Recon Breast

XML NAACCR ID: rxSummReconBreast

Breast Reconstruction, effective 01/01/2024, describes the reconstruction procedure immediately following resection of the breast.

Breast reconstruction was previously collected within the breast surgery codes. CoC will collect this data item to support the Synoptic Operative Reports and allow for more descriptive reconstruction codes.

Code	Description
A000	No reconstruction No immediate reconstruction was performed at any facility
A100	Tissue expanded placement Tissue expanders were placed without implant or tissue placement
A200	Direct to implant placement Permanent implant is placed immediately following resection Example: A mastectomy is performed by the breast surgeon and an implant is placed at the same time by a plastic surgeon (some general /breast surgeons may place implants, but most are placed by plastics)
A300	Oncoplastic tissue rearrangement (not a formal mastopexy/reduction) Reconstruction performed with parenchymal flap or adjacent tissue transfer
A400	Oncoplastic reduction and/or mastopexy Breast conserving resection and a breast reduction/lift is performed
A500	Oncoplastic reconstruction with regional tissue flaps Breast conserving resection and reconstruction is performed with skin flaps
A600	Mastectomy reconstruction with autologous tissue, source not specified Autologous tissue source is unknown or not specified
A610	Mastectomy reconstruction WITH abdominal tissue
A620	Mastectomy reconstruction WITH thigh tissue
A630	Mastectomy reconstruction WITH gluteal tissue
A640	Mastectomy reconstruction WITH back tissue
A900	Reconstruction performed; method unknown
A970	Implant based reconstruction, NOS
A980	Autologous tissue-based reconstruction, NOS
A990	Unknown if immediate reconstruction was performed

Coding Instructions

1. Immediate reconstruction is defined as reconstruction performed during the same operative session as the operative procedure coded in *Surgery of Primary Site 2023* (NAACCR Item #1291).
2. One surgeon can perform the surgical resection to primary site and another surgeon can perform the reconstruction during the same operative session. As long as reconstruction was done during the same operative session, an immediate reconstruction code should be assigned.
3. Assign the breast reconstruction code for breast primaries with a date of diagnosis 01/01/2024, and forward.

4. Code only the **ipsilateral** breast reconstruction.
5. Do not record reconstruction performed on a different day than the breast primary definitive (most invasive) resection.
6. Assign code A000 if the reconstruction was started but not completed.
7. Assign code A300 when patient has reconstruction performed with parenchymal flap or adjacent tissue transfer.
8. Information for codes A600-A900 may be found in the Breast Plastic Reconstructive operative report.
9. Oncoplastic surgery is typically performed by the surgeon but sometimes found in the Breast Plastic Reconstructive operative note.

Surgical Margins of the Primary Site

Item Length: 1

NAACCR Item #: 1320

NAACCR Name: RX Summ--Surgical Margins

XML NAACCR ID: rxSummSurgicalMargins

Surgical Margins of the Primary Site describes the final status of the surgical margins after resection of the primary tumor.

This item serves as a quality measure for pathology reports, is used for staging, and may be a prognostic factor in recurrence. It applies to all cases that have a surgical procedure of the primary site.

Code	Description
0	No residual tumor
1	Residual tumor, NOS
2	Microscopic residual tumor
3	Macroscopic residual tumor
7	Margins not evaluable
8	No primary site surgery
9	Unknown or not applicable

Note: Codes were site-specific from 1998 to 2002 and have been changed to be generic across all disease sites.

Coding Instructions

1. Assign code 0 when
 - a. There is documentation of no residual disease on the pathology report.
 - b. All margins are negative both microscopically and macroscopically (grossly).
 - c. The entire organ is removed for localized disease, such as a hysterectomy performed for a localized endometrial cancer case unless there is information to the contrary.
2. Codes 0-3 are hierarchical
 - a. Assign the numerically higher code if two codes describe the margin status.
3. Assign code 1 for involvement of margins but not otherwise specified.
4. Assign code 2 for involvement of margins microscopically but not grossly (cannot be seen by the naked eye). Use the Margins section of the CAP protocol or the Microscopic Description from the pathology report to identify microscopic findings.
5. Assign code 3 for involvement of margins grossly (seen by the naked eye). Use the Margins section of the CAP protocol or the Gross Description from the pathology report to identify macroscopic findings.
6. Assign code 7 if the pathology report indicates the margins could not be determined.
7. Assign code 9
 - a. When *Surgery of Primary Site 2023* (NAACCR Item #1291) is coded to A980 (not applicable)

- b. When it is unknown whether a surgical procedure of the primary site was performed or there is no mention in the pathology report or no tissue was sent to pathology
- c. When patient has a transurethral biopsy of bladder tumor (TURBT) and surgical margins are not mentioned in the TURBT pathology report. The operative report may mention no residual tumor.
- d. When the physician documents the absence of residual invasive carcinoma or confirms that no residual cancer/carcinoma is present
- e. When surgical margin status is not documented
- f. For any case coded to primary site C420, C421, C423, C424, C760-C768, C770-C779, or C809
- g. For death certificate only (DCO) cases

Scope of Regional Lymph Node Surgery

Item Length: 1

NAACCR Item #: 1292

NAACCR Name: RX Summ--Scope Reg LN Sur

XML NAACCR ID: rxSummScopeRegLnSur

Scope of Regional Lymph Node Surgery describes the procedure of removal, biopsy, or aspiration of **regional** lymph nodes performed during the initial work-up or first course of therapy.

Instructions for coding **sentinel lymph node biopsies** (SLNBx) have been clarified for 2012 and later, diagnoses.

Additional instructions for **breast** primaries (C500-C509) are described below, following the general coding instructions.

Code	Description
0	No regional lymph nodes removed or aspirated; diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph node, NOS
2	Sentinel lymph node biopsy [only]
3	Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS
4	1 to 3 regional lymph nodes removed
5	4 or more regional lymph nodes removed
6	Sentinel node biopsy and code 3, 4, or 5 at same time or timing not noted
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

Coding Instructions

1. Use the **entire operative report** as the primary source document to determine whether the operative procedure was a SLNBx, or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The body of the operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the **operative report takes precedence** when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.
2. Code **regional** lymph node procedures in this data item. Record distant lymph node removal in *Surgical Procedure of Other Site*.
 - a. Include lymph nodes that are regional in the current AJCC Staging Manual or EOD 2018
3. Record all surgical procedures that remove, biopsy, or aspirate regional lymph node(s) whether or not there were any surgical procedures of the primary site. The regional lymph node surgical procedure(s) may be done to **diagnose** cancer, **stage** the disease, or as a part of the initial **treatment**.

Example: Patient has a sentinel node biopsy of a single lymph node. Assign code 2 (Sentinel lymph node biopsy [only]).

4. Include lymph nodes obtained or biopsied during any procedure within the first course of treatment. A separate lymph node surgery is not required.
 - a. Code the removal of intra-organ lymph nodes in *Scope of Regional Lymph Node Surgery*.
Example: Local excision of breast cancer. Specimen includes an intra-mammary lymph node. Assign code 4 (1 to 3 regional lymph nodes removed).
5. Add the number of all of the lymph nodes removed during each surgical procedure performed as part of the first course of treatment. The *Scope of Regional Lymph Node Surgery* data item is **cumulative**.
Example: Patient has excision of a positive cervical node. The pathology report from a subsequent node dissection identifies three cervical nodes. Assign code 5 (4 or more regional lymph nodes removed).
 - a. Lymph node aspirations
 - i. Do **not** double-count when a regional lymph node is aspirated and that node is in the resection field. Do **not** add the aspirated node to the total number.
 - ii. Count as an additional node when a regional lymph node is aspirated and that node is **NOT** in the resection field. **Add** it to the total number.
 - iii. Assume the lymph node that is aspirated is part of the lymph node chain surgically removed and do **not** include it in the count when its location is **not known**.
6. Code the removal of regional nodes for both primaries when the patient has **two primaries with common regional lymph nodes**.
Example: Patient has a cystoprostatectomy and pelvic lymph node dissection for bladder cancer. Pathology identifies prostate cancer as well as the bladder cancer and 4/21 nodes positive for metastatic adenocarcinoma. Code *Scope of Regional Lymph Node Surgery* to 5 (4 or more regional lymph nodes removed) for both primaries.
7. Assign the appropriate code for **occult head and neck primaries with positive cervical lymph nodes** (schema 00060). Do not default to code 9 for this schema.
8. Assign code **0** when
 - a. Regional lymph node removal procedure was **not** performed.
Note: Excludes all sites and histologies that would be coded 9. (See Coding Instruction #13 below.)
OR
 - b. First course of treatment was active surveillance/watchful waiting.
OR
 - c. The operative **report lists a lymph node dissection, but no nodes were found by the pathologist**.
9. Assign code **2** when
 - a. The operative report states that a **SLNBx was performed**.
OR
 - b. The operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination.
Note: When a SLNBx is performed, additional **non-sentinel nodes can be taken** during the same operative procedure. These additional non-sentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the

surgeon. Code this as a SLNBx (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.

10. Codes 3, 4, and 5: The operative report states that a regional lymph node dissection was performed (a SLNBx was **not** done during this procedure or in a prior procedure).
 - a. Code 3: Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7).
 - b. Code 4 should be used infrequently. Review the operative report to ensure the procedure was **not** a SLNBx only.
 - c. Code 5: If a relatively small number of nodes was examined pathologically, review the operative report to confirm the procedure was **not** a SLNBx only (code 2). If a relatively large number of nodes was examined pathologically, review the operative report to confirm that there was **not** a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7).

Note: Infrequently, a SLNBx is attempted, and the patient **fails to map** (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. **Code these cases as 2** if no further dissection of regional lymph nodes was undertaken, **or 6** when regional lymph nodes were dissected during the same operative event.
11. Code 6: SLNBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known.
 - a. Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes.
 - b. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only
 - c. Infrequently, a SLNBx is attempted and the patient fails to map (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. **Code these cases as 6.**
12. Code 7: SLNBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events.
 - a. Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes.
 - b. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only
13. Code 9: The status of regional lymph node evaluation should be known for surgically treated cases (i.e., cases coded A190-A900 or B190-B900 in the data item *Surgery of Primary Site 2023* (NAACCR Item #1291). Review surgically treated cases coded as 9 in *Scope of Regional Lymph Node Surgery* to confirm the code.
 - a. Assign code 9 for
 - i. Any case coded to primary site: C420, C421, C423, C424, C589, C700-C709, C710-C729, C751-C753, C761-C768, C770-C779, or C809

Coding Instructions – Sentinel lymph node biopsy (SLNBx), breast primary C500-C509

1. Use the **entire operative report** as the primary source document to determine whether the operative procedure was a SLNBx, an axillary node dissection (ALND), or a combination of

both SLNBx and ALND. The body of the operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and ALND, or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and an ALND.

2. Code 1

- a. Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7.

3. Code 2

- a. If a relatively large number of lymph nodes, more than 5, are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an axillary lymph node dissection (ALND).
- b. Infrequently, a SLNBx is attempted, and the patient fails to map (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. Review the operative report to confirm that an axillary incision was made and a node exploration was conducted. Patients undergoing SLNBx who fail to map will often undergo ALND. Use code 2 if no ALND was performed, or 6 when ALND was performed during the same operative event. Enter the appropriate number of nodes examined and positive in the data items *Regional Nodes Examined* (NAACCR Item #830) and *Regional Nodes Positive* (NAACCR Item #820).

4. Codes 3, 4, and 5: Generally, ALND removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same procedure (code 6 or 7).

5. Code 6

- a. Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes.
- b. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed.

6. Code 7

- a. Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes.
- b. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only, or whether a SLNBx plus an ALND was performed.

Date of Sentinel Lymph Node Biopsy

Item Length: 8

NAACCR Item #: 832

NAACCR Name: Date of Sentinel Lymph Node Biopsy

XML NAACCR ID: dateSentinelLymphNodeBiopsy

Date of Sentinel Lymph Node Biopsy, effective 01/01/2018, records the date of the sentinel lymph node biopsy procedure. **SEER requires this data item for breast and cutaneous melanoma cases only.**

Date of Sentinel Lymph Node Biopsy must be transmitted in the YYYYMMDD format. *Date of Sentinel Lymph Node Biopsy* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

SEER Central Registries: Collect when available.

Coding Instructions

1. Record the date of the sentinel lymph node biopsy procedure documented in the *Sentinel Lymph Nodes Examined* data item [NAACCR Item #834].
2. This data item documents the date of sentinel node biopsy. Do not record the date of lymph node aspiration, fine needle aspiration, fine needle aspiration biopsy, core needle biopsy, or core biopsy.
3. Record the date documented in this data item in the *Date of First Surgical Procedure* data item [NAACCR Item #1200] when the sentinel lymph node biopsy is the first or only surgical procedure performed.
4. Record the date of the sentinel lymph node biopsy in this data item and record the date the subsequent regional node dissection was performed in the *Date of Regional Lymph Node Dissection* data item [NAACCR Item #682] when both a sentinel node biopsy procedure and a subsequent regional node dissection procedure are performed.
5. Record the date of the procedure in both this data item and in the *Date of Regional Lymph Node Dissection* data item [NAACCR Item #682] when a sentinel lymph node biopsy is performed in the same procedure as the regional node dissection. The **dates should be the same**.
6. Leave this date blank
 - a. When sentinel lymph node biopsy was attempted, but unsuccessful (e.g., failed to map).
 - b. For cases other than breast and cutaneous melanoma
 - c. When *Sentinel Lymph Nodes Examined* [NAACCR Item #834] is assigned code 00, 95, or 99

Sentinel Lymph Nodes Examined

Item Length: 2

NAACCR Item #: 834

NAACCR Name: Sentinel Lymph Nodes Examined

XML NAACCR ID: sentinelLymphNodesExamined

Sentinel Lymph Nodes Examined, effective 01/01/2018, records the total number of lymph nodes sampled during the sentinel node biopsy and examined by the pathologist. **SEER requires this data item for breast and cutaneous melanoma cases only.**

SEER Central Registries: Collect when available.

This data item may be left blank for cases other than breast and cutaneous melanoma. If collected for other sites, refer to the STORE Manual for coding instructions.

Code	Description
00	No sentinel nodes were examined
01-90	Sentinel nodes were examined (code the exact number of sentinel lymph nodes examined)
95	No sentinel nodes were removed, but aspiration of sentinel node(s) was performed
98	Sentinel lymph nodes were biopsied, but the number is unknown
99	It is unknown whether sentinel nodes were examined; not stated in patient record; not applicable

Coding Instructions

- Document the **total number of nodes sampled during the sentinel node procedure** in this data item when both sentinel and non-sentinel nodes are sampled during the sentinel node biopsy procedure; i.e., record the total number of nodes from the procedure regardless of sentinel node status.
- Record the total number of nodes biopsied during the sentinel node biopsy procedure in this data item and record the total number of regional lymph nodes biopsied/dissected (**which includes the number of nodes documented in this data item**) in *Regional Nodes Examined* [NAACCR Item #830] when
 - Both a sentinel node biopsy procedure and a subsequent dissection procedure are performed OR
 - A sentinel node biopsy procedure is performed during the same procedure as the regional node dissection.
- Record the results for the sentinel node biopsy in this data item when an aspiration of sentinel lymph nodes(s) AND a sentinel node biopsy procedure were performed for same patient.
- The number of sentinel lymph nodes biopsied will typically be found in the pathology report, radiology reports, or documented by the physician. Determination of the exact number of sentinel lymph nodes examined may require assistance from the managing physician for consistent coding.
- The number of sentinel nodes should be equal to or less than the number of regional nodes examined recorded in *Regional Nodes Examined* [NAACCR Item #830].

Sentinel Lymph Nodes Positive

Item Length: 2

NAACCR Item #: 835

NAACCR Name: Sentinel Lymph Nodes Positive

XML NAACCR ID: sentinelLymphNodesPositive

Sentinel Lymph Nodes Positive, effective 01/01/2018, records the exact number of sentinel lymph nodes found to contain metastases. **SEER requires this data item for breast and cutaneous melanoma cases only.**

SEER Central Registries: Collect when available.

This data item may be left blank for cases other than breast and cutaneous melanoma. If collected for other sites, refer to the STORE Manual for coding instructions.

Code	Description
00	All sentinel nodes examined are negative
01-90	Sentinel nodes are positive (code exact number of nodes positive)
95	Positive aspiration of sentinel lymph node(s) was performed
97	Positive sentinel nodes are documented, but the number is unspecified. For breast ONLY: SLN and RLND occurred during the same procedure
98	No sentinel nodes were biopsied
99	It is unknown whether sentinel nodes are positive; not applicable; not stated in patient record

Coding Instructions

- Document the **total number of positive nodes** identified during the sentinel node procedure in this data item when, during a sentinel node biopsy procedure a few non-sentinel nodes happen to be sampled and are positive, i.e., record the total number of positive nodes from the sentinel node biopsy procedure regardless of whether the nodes contain dye or colloidal material (tracer or radiotracer).
- Record the number of **positive sentinel nodes** biopsied in this data item and record the total number of positive regional (**which includes sentinel**) lymph nodes biopsied/dissected in *Regional Nodes Positive* [NAACCR Item #820] when both sentinel and additional regional nodes are examined via sentinel node biopsy and subsequent regional node dissection.
- Record the results from the positive sentinel node biopsy procedure when a positive aspiration of sentinel lymph node(s) AND a positive sentinel node biopsy procedure were performed for same patient.
- FOR BREAST ONLY
 - Record the number of positive SLNs if the number is provided on pathology report. If a sentinel lymph node biopsy is performed **during the same procedure** as the regional node dissection, record the total number of positive sentinel nodes identified in this data item, and record the total number of positive regional lymph nodes identified (**both sentinel and regional**) in *Regional Nodes Positive* [NAACCR Item #820].
 - Use code **97** when a sentinel lymph node biopsy is performed **during the same procedure** as the regional node dissection, but the number of sentinel nodes is unknown/not stated on the pathology report. Record the total number of positive regional lymph nodes biopsied/dissected (which includes the sentinel lymph nodes) in *Regional Nodes Positive* (NAACCR Item #820).

- c. Sentinel lymph nodes are **negative** when only positive Isolated Tumor Cells (ITCs) are identified.
5. FOR CUTANEOUS MELANOMA ONLY
- a. Record the total number of positive sentinel nodes identified in this data item and record the total number of positive regional lymph nodes identified (**which includes the number of positive sentinel nodes documented in this data item**) in *Regional Nodes Positive* (NAACCR Item #820) when a sentinel lymph node biopsy is performed **during the same procedure** as the regional node dissection.
 - b. The CAP Protocol for melanoma captures both the number of positive sentinel nodes as well as the number of positive regional nodes (i.e., the number of positive sentinel nodes is captured) when the sentinel lymph node biopsy is performed during the same procedure as the regional node dissection.
 - c. Sentinel lymph nodes are **positive** when **only positive Isolated Tumor Cells (ITCs)** are identified.
6. The number of sentinel lymph nodes biopsied and found positive will typically be found in the pathology report; radiology reports or documented by the physician. Determination of the exact number of sentinel lymph nodes positive may require assistance from the managing physician for consistent coding.
7. The number of sentinel nodes positive should be less than or equal to the total number of *Regional Nodes Positive* [NAACCR Item #820].
8. mi (microscopic or micro mets) sentinel lymph nodes are positive.

Date of Regional Lymph Node Dissection

Item Length: 8

NAACCR Item #: 682

NAACCR Name: Date Regional Lymph Node Dissection

XML NAACCR ID: dateRegionallNDissection

Date of Regional Lymph Node Dissection records the date non-sentinel regional node dissection was performed.

Date of Regional Lymph Node Dissection must be transmitted in the YYYYMMDD format. *Date of Regional Lymph Node Dissection* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

SEER Central Registries: Collect when available from CoC reporting facilities.

Coding Instructions

1. Record the date of regional lymph node dissection documented in the *Regional Nodes Examined* data item [NAACCR Item #830].
2. Record the date of the regional lymph node dissection in this data item and record the date of the sentinel lymph node biopsy procedure in the *Date of Sentinel Lymph Node Biopsy* data item [NAACCR Item #832] for **breast and cutaneous melanoma cases** when
 - a. Both a sentinel lymph node biopsy procedure and a separate regional lymph node dissection procedure are performed OR
 - b. A sentinel lymph node biopsy is performed in the same procedure as the regional lymph node dissection. In this case, the **dates should be the same**.
3. Record the date of the regional lymph node dissection in this data item for **all other cases** (in addition to breast and cutaneous melanoma cases).
 - a. If a sentinel lymph node biopsy procedure is also performed, record the procedure in the *Date of Sentinel Lymph Node Biopsy* data item [NAACCR Item #832].
 - i. If the sentinel lymph node biopsy is performed in the same procedure as the regional lymph node dissection, the **dates should be the same**.
4. Leave *Date of Regional Lymph Node Dissection* blank when only a sentinel lymph node biopsy is performed.

Regional Nodes Positive

Item Length: 2

NAACCR Item #: 820

NAACCR Name: Regional Nodes Positive

XML NAACCR ID: regionalNodesPositive

Description

Regional Nodes Positive records the exact number of regional nodes examined by the pathologist and found to contain metastasis. This data item must be collected on all cases.

Codes	Description
00	All nodes examined are negative
01-89	1-89 nodes are positive (code exact number of nodes positive)
90	90 or more nodes are positive
95	Positive aspiration OR core biopsy of lymph node(s) was performed
97	Positive nodes are documented, but the number is unspecified
98	No nodes were examined
99	It is unknown whether nodes are positive; not applicable; not stated in patient record

Coding Instructions

- Regional lymph nodes only.** Record information only about regional lymph nodes in this data item.
 - Include lymph nodes that are regional in the current AJCC Staging Manual or *EOD Regional Nodes*.
- This data item is based on pathological information only**, including autopsy. This data item is to be recorded regardless of whether the patient received neoadjuvant (preoperative) treatment. Information from the autopsy may be used to code *Regional Nodes Positive*. Use text fields to explain the situation.
- True **in situ** cases cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined). Codes 01-90, 95, 97, and 99 are **not** allowed.
- Nodes positive is cumulative.** Record the total number of regional lymph nodes removed and found to be positive by pathologic examination. Record lymph nodes removed and found to be positive during an autopsy for autopsy-only cases.
 - The number of regional nodes positive is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.
 - Do **not** count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in *Regional Nodes Positive* when there are positive nodes in the resection. In other words, when there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also Use of Code 95 below.

Example 1: Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. **Code *Regional Nodes Positive* as 05 and *Regional Nodes Examined* as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.**

Example 2: Positive right cervical lymph node aspiration followed by right cervical lymph node dissection showing 1 of 6 nodes positive. **Code *Regional Nodes Positive* as 01 and *Regional Nodes Examined* as 06.**

- c. Include the node in the count of *Regional Nodes Positive* when the positive aspiration or core biopsy is from a node in a **different** node region.

Example: Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. **Code *Regional Nodes Positive* as 04 and *Regional Nodes Examined* as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.**

- d. Assume the lymph node that is core-biopsied or aspirated is part of the lymph node chain surgically removed and do **not** include it in the count of *Regional Nodes Positive* when its location is **not known**.

Example: Patient record states that lymph node core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. **Code *Regional Nodes Positive* as 07 and *Regional Nodes Examined* as 14.**

- 5. **Priority of lymph node counts.** Use information in the following priority when there is a discrepancy regarding the number of positive lymph nodes.

- a. Final diagnosis
- b. Synoptic report (also known as CAP protocol or pathology report checklist; the consolidated findings on the CAP protocol).
- c. Microscopic description
- d. Gross description

- 6. **Positive nodes in multiple primaries in same organ**

- a. Determine the histology of the metastases in the nodes and code the nodes as positive for the primary with that histology when there are multiple primary cancers with different histologic types in the same organ and the pathology report just states the number of nodes positive.
- b. Code the nodes as positive for all primaries when no further information is available.

Example: A breast case is two separate primaries as determined by the SEER multiple primary rules. The pathology report states "3 of 11 lymph nodes positive for metastasis" with no further information available. **Code *Regional Nodes Positive* as 03 and *Regional Nodes Examined* as 11 for both primaries.**

- 7. **Isolated Tumor Cells (ITCs) in lymph nodes**

- a. For all cases **except cutaneous melanoma and Merkel cell carcinoma of skin**
 - i. Count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size).
 - ii. Assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive when the path report indicates that nodes are positive but the size of metastasis is not stated.
 - iii. Do **not** include in the count of lymph nodes positive any nodes that are identified as containing ITCs.
- b. For cutaneous melanoma and Merkel cell carcinoma of skin
 - i. Count nodes with ITCs as positive lymph nodes.

8. Use code **95** when
 - a. The only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).
 - b. A positive lymph node is aspirated and there are no surgically resected lymph nodes.
Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. **Code *Regional Nodes Positive* as 95 and *Regional Nodes Examined* as 95.**
 - c. A positive lymph node is aspirated and surgically resected lymph nodes are negative.
Example: Lung cancer patient has aspiration of suspicious hilar mass that shows metastatic squamous carcinoma in lymph node tissue. Patient undergoes neoadjuvant (preoperative) radiation therapy followed by lobectomy showing 6 negative hilar lymph nodes. **Code *Regional Nodes Positive* as 95 and *Regional Nodes Examined* as the 06 nodes surgically resected.**
9. Code **97**. Use code 97 for any combination of positive aspirated, biopsied, sampled, or dissected lymph nodes when the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.
Example: Patient with carcinoma of the pyriform sinus has a mass in the mid neck. Fine needle aspiration (FNA) of one node is positive. The patient has neoadjuvant (preoperative) chemotherapy, then resection of the primary tumor and a radical neck dissection. In the radical neck dissection, “several” of 10 nodes are positive; the remainder of the nodes show chemotherapy effect. **Code *Regional Nodes Positive* as 97 because the total number of positive nodes biopsied and removed is unknown, and code *Regional Nodes Examined* as 10.**
Note: If the aspirated node is the only one that is microscopically positive, use code 95.
10. Use code **98** when
 - a. The assessment of lymph nodes is clinical only
 - b. No lymph nodes are removed and examined.
 - c. A “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
 - d. *Regional Nodes Positive* is coded 98, *Regional Nodes Examined* is usually coded 00
11. Use code **99** for
 - a. Any case coded to primary site C420, C421, C423, C424, C589, C700-C709, C710-C729, C751-C753, C761-C768, C770-C779, or C809
 - b. Lymphoma 00790
 - c. Lymphoma-CLL/SLL 00795
 - d. Plasma Cell Disorders (excluding 9734/3) 00822
 - e. HemeRetic 00830
 - f. Ill-Defined/Other 99999
 - g. Cases with no information about positive regional lymph nodes

For more information about schemas and schema IDs, go to the [SSDI Manual, Appendix A](#).

Regional Nodes Examined

Item Length: 2

NAACCR Item #: 830

NAACCR Name: Regional Nodes Examined

XML NAACCR ID: regionalNodesExamined

Description

Regional Nodes Examined records the total number of regional lymph nodes that were removed and examined by the pathologist. This data item must be collected on all cases.

Code	Description
00	No nodes were examined
01-89	1-89 nodes are examined (code exact number of nodes examined)
90	90 or more nodes were examined
95	No regional nodes were removed, but aspiration OR core biopsy of regional nodes was performed
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown
99	It is unknown whether nodes were examined; not stated in patient record; not applicable or negative

Coding Instructions

- Regional lymph nodes only.** Record information only about regional lymph nodes in this data item.
 - Include lymph nodes that are regional in the current AJCC Staging Manual or EOD Regional Lymph Nodes 2018
- This data item is based on pathologic information only**, including autopsy. This data item is to be recorded regardless of whether the patient received neoadjuvant (preoperative) treatment. Information from the autopsy may be used to code *Regional Nodes Examined*. Use text fields to explain the situation.
- Use code **00** when
 - The assessment of lymph nodes is clinical.
 - No lymph nodes are removed and examined.
 - A “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.

Note: When *Regional Nodes Examined* is coded 00, *Regional Nodes Positive* is coded 98.
- Nodes removed and examined is cumulative. Record the total number of regional lymph nodes removed and examined by the pathologist. Record lymph nodes removed during an autopsy for autopsy-only cases.

- a. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
 - b. Do **not** count an aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in *Regional Nodes Examined*.

Example: Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. **Code *Regional Nodes Positive* as 05 and *Regional Nodes Examined* as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.**
 - c. Include the node in the count of *Regional Nodes Examined* when the aspiration or core biopsy is from a node in a different node region.

Example: Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. **Code *Regional Nodes Positive* as 04 and *Regional Nodes Examined* as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.**
 - d. Assume the lymph node that is aspirated or core-biopsied is part of the lymph node chain surgically removed and do **not** include it in the count of *Regional Nodes Examined* when its location is not known.

Example: Patient record states that lymph node core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. **Code *Regional Nodes Positive* as 07 and *Regional Nodes Examined* as 14.**
5. **Priority of lymph node counts.** Use information in the following priority when there is a discrepancy regarding the number of lymph nodes examined.
 - a. Final diagnosis
 - b. Synoptic report (also known as CAP protocol or pathology report checklist; the consolidated findings on the CAP protocol).
 - c. Microscopic description
 - d. Gross description
 6. **Code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. **Code *Regional Nodes Positive* as 95 and *Regional Nodes Examined* as 95.**
 7. **Lymph node excision biopsy.** If a lymph node excision biopsy was performed, code the number of nodes removed, if known.
 8. **Definition of “sampling” (code 96).** A lymph node “sampling” is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy and selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.
 9. **Definition of “dissection” (code 97).** A lymph node “dissection” is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, and lymph node stripping. Removal of lymph nodes during autopsy is a dissection. Use code 97 when more than a limited number of lymph nodes are removed and the number is unknown.
 10. **Multiple lymph node procedures.** Use code 97 when both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown.

11. Use code **98** when neither the type of lymph node removal procedure nor the number of lymph nodes examined is known.
12. Use code **99** for
 - a. Any case coded to primary site C420, C421, C423-C424, C589, C700-C709, C710-C729, C751-C753, C761-C768, C770-C779, or C809
 - b. Lymphoma 00790
 - c. Lymphoma-CLL/SLL 00795
 - d. Plasma Cell Disorders (excluding 9734/3) 00822
 - e. HemeRetic 00830
 - f. Ill-Defined/Other 99999
 - g. Cases with no information about the examination of regional lymph nodes

For more information about schemas and schema IDs, go to the [SSDI Manual, Appendix A](#).

Surgical Procedure of Other Site

Item Length: 1

NAACCR Item #: 1294

NAACCR Name: RX Summ--Surg Oth Reg/Dis

XML NAACCR ID: rxSummSurgOthRegDis

Surgical Procedure of Other Site describes the surgical removal of distant lymph node(s) or other tissue(s) or organ(s) beyond the primary site. This data item is useful in evaluating the extent of metastatic involvement and in documenting whether surgery was performed for tumors having unknown or ill-defined primary sites or hematolymphoid malignancies.

Code	Description
0	None; diagnosed at autopsy
1	Non-primary surgical procedure performed
2	Non-primary surgical procedure to other regional sites
3	Non-primary surgical procedure to distant lymph node(s)
4	Non-primary surgical procedure to distant site
5	Combination of codes 2, 3, or 4
9	Unknown

Coding Instructions

1. Do **not** code tissue or organs such as an appendix that were removed **incidentally**, and the organ was not involved with cancer.

Note: Incidental removal of organs means that tissue was removed for reasons other than removing cancer or preventing the spread of cancer. Examples of incidental removal of organ(s) would be removal of appendix, gallbladder, etc., during abdominal surgery.

2. Do **not** code removal of **uninvolved** contralateral breast in this data item. See [Surgery Codes](#) for Breast in Appendix C.
3. For this data item, do not include organs beyond the primary site that are included in the *Surgery of Primary Site 2023* codes.

Example: A hemicolectomy including removal of the small bowel. *Surgery of Primary Site 2023* code A410 for colon includes resection of contiguous organ such as small bowel or bladder. Do not code removal of small bowel or bladder performed with a subtotal colectomy/hemicolectomy in *Surgical Procedure of Other Site*.

4. Assign code **0** when
 - a. No surgical procedures were performed that removed distant lymph node(s) or other tissue(s) or organ(s) beyond the primary site, or
 - b. First course of treatment was active surveillance/watchful waiting.
5. The codes are **hierarchical**
 - a. Codes **1-5** have **priority** over codes 0 and 9.
6. Assign code **1** when
 - a. Any surgery is performed to remove tumors for any case coded to primary site C420, C421, C423, C424, C760-C768, C770-C779, or C809

- i. **Excluding** cases coded to the schema Cervical Lymph Nodes and Unknown Primary 00060

For more information about schemas and schema IDs, go to the [SSDI Manual, Appendix A](#).

7. Assign code **2** for sites that are regional. Include sites that are regional in the current AJCC Staging Manual or EOD.
8. Assign code **4** for sites that are distant. Include sites that are distant in the current AJCC Staging Manual or EOD.
9. Assign code **9** for death certificate only (DCO) cases.

Reason for No Surgery of Primary Site

Item Length: 1

NAACCR Item #: 1340

NAACCR Name: Reason for No Surgery

XML NAACCR ID: reasonForNoSurgery

This data item records the reason that surgery of the **primary site** was not part of the first course of treatment.

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

Coding Instructions

- Assign code **0** when *Surgery of Primary Site 2023* is coded in the range of A100-A900 or B100-B900 (surgery of the primary site was performed).
- Assign code **1** when *Surgery of Primary Site 2023* is coded A980 (not applicable). For Autopsy Only cases, see coding instruction #4.
- Assign a code in the **range of 1-8** when *Surgery of Primary Site 2023* is coded A000 or B000

Note: Referral to a surgeon is **equivalent** to a recommendation for surgery.

- Assign code **1** when

- Primary site is C420, C421, C423, C424, C760-C768, or C809

Note: Surgery is not standard treatment for these cases.

- There is no information in the patient's medical record about surgery, AND

- It is known that surgery is not usually performed for this type and/or stage of cancer.

OR

- There is no reason to suspect that the patient would have had surgery of primary site.

Example: The patient would not be a surgical candidate because of advanced stage.

- iii. The treatment plan offered multiple treatment options and the patient selected treatment that did not include surgery of the primary site.

Example: Prostate cancer patient is offered three treatment options: a. Radical prostatectomy, b. Radiation therapy, or c. Hormone therapy. The patient chose to have radiation therapy. Assign code 1. Surgery of the primary site was not performed because it was **not part of the planned** first course of treatment. The treatment plan was for the patient to receive **ONE** of three treatment modality options: surgery, OR radiation, OR hormone therapy. At no time did the physician recommend that the patient have surgery AND radiation therapy AND hormone therapy. The patient chose radiation. This does not mean he refused surgery because at no time did the treatment plan include both radiation AND surgery. Recording that a patient refused the treatment modality means that the patient refused recommended therapy. This is a quality control check explaining why the patient did not receive the expected treatment for their cancer (patient's choice versus physician's choice, or facility's lack of providing quality care).

- iv. Surgery was part of the first course of treatment but was cancelled due to complete response to radiation and/or systemic therapy.
- v. Patient elected to pursue no treatment following the discussion of surgery. Discussion does not equal a recommendation. Patient's decision not to pursue surgery is not a refusal of surgery in this situation.
- vi. Active surveillance/watchful waiting is the first course (e.g., prostate).

- b. Assign code **2** when surgery of the primary site is contraindicated due to factors including, but not limited to, comorbid conditions, advanced age, and progression of tumor prior to planned surgery.

Example: Patient with metastatic cancer from the right kidney to the lung has a history of prior left nephrectomy with a current history of congestive heart disease and smoking. Surgery is not performed for the right kidney malignancy because the patient is considered a surgical risk.

- c. Assign code **6** when
 - i. It is **KNOWN** that surgery was recommended.
 - ii. **AND**
 - iii. It is **KNOWN** that surgery was **not** performed.
 - iv. **AND**
 - v. There is no documentation explaining why surgery was not done.

Example: The medical record has a recommendation that the patient have surgery. No further admissions or documentation of surgery found; the primary care physician replies that the patient did **NOT have surgery. No further information is given; it is unknown if the patient refused surgery or if there were co-morbid conditions that prevented the surgical procedure.**

- d. Assign code **7** when the patient
 - i. Refuses recommended surgery**OR**

- ii. Makes a blanket statement that he/she refused all treatment when surgery is a customary option according to NCCN guidelines and/or the NCI PDQ for the primary site/histology.

- Assign code 1 when surgery is not normally performed for the site/histology.

Note: Coding *Reason for No Surgery of Primary Site* as “refused” does not affect the coding of the other treatment data items (e.g., *Radiation*, *Chemotherapy*, *Hormone Therapy*, etc.). Code 7 means surgery is exactly what was recommended by the physician and the patient refused. If two treatment alternatives were offered and surgery was not chosen, code *Reason for No Surgery of Primary Site* as 1 [surgery of the primary site was not performed because it was not part of the planned first-course treatment].

- e. Assign code **8** when surgery is recommended, but it is unknown if the patient actually had the surgery.

Example: There is documentation in the medical record that the primary care physician referred the patient to a surgical oncologist. Follow-back to the surgical oncologist and primary care physician yields no further information. Assign code 8, it is known that surgery was recommended but there is no information on whether or not the patient actually had the surgical procedure.

Note: Cases coded 8 should be followed and updated to a more specific code as appropriate.

4. Assign code **9**

- a. When there is no documentation that surgery was recommended or performed
- b. For death certificate only (DCO) cases
- c. Autopsy only cases

Date Radiation Started

Item Length: 8

NAACCR Item #: 1210

NAACCR Name: RX Date Radiation

XML NAACCR ID: rxDateRadiation

Date Radiation Started is the date when radiation therapy began as part of the first course of therapy.

The date radiation started will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the date radiation started may require assistance from the radiation oncologist for consistent coding.

Date Radiation Started must be transmitted in the YYYYMMDD format. *Date Radiation Started* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

SEER Central Registries: Collect when available from CoC reporting facilities.

Coding Instructions

1. Record the date of the first/earliest radiation **treatment** if radiation was given and recorded as part of the first course of therapy.
 - a. Do **not** record the date of the initial radiation planning session.
2. Radiation date should be the same as the Date Therapy Initiated when radiation is the only treatment administered.
3. There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
4. Transmit date data items in the year, month, day format (YYYYMMDD).

Radiation Treatment Modality--Phase I, II, III

Item Length: 2

NAACCR Item #: 1506, 1516, 1526

NAACCR Name: Phase I Radiation Treatment Modality

Phase II Radiation Treatment Modality

Phase III Radiation Treatment Modality

XML NAACCR ID: phase1RadiationTreatmentModality

phase2RadiationTreatmentModality

phase3RadiationTreatmentModality

Radiation Treatment Modality--Phase I, II, and III, effective 01/01/2018, identify the radiation modality administered during the first, second, and third phase, respectively, of radiation treatment delivered during the first course of treatment.

Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities.

Code	Description
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, interstitial, LDR
11	Brachytherapy, interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, radium-232
15	Radioisotopes, strontium-89
16	Radioisotopes, strontium-90
98	Radiation therapy administered, but treatment modality is not specified or unknown
99	Unknown if radiation treatment administered

- Refer to the current [STandards for Oncology Registry Entry \(STORE\) Manual](#) and the [CTR Guide to Coding Radiation Therapy Treatment in the STORE](#) (see 2027 STORE Manual, Appendix R).

Coding Instructions

- Assign code **13** Radioisotopes, NOS for Radioembolization procedures, e.g., intravascular yttrium-90 or lutetium-177.

Radiation External Beam Planning Technique--Phase I, II, III

Item Length: 2

NAACCR Item #: 1502, 1512, 1522

NAACCR Name: Phase I Radiation External Beam Planning Tech

Phase II Radiation External Beam Planning Tech

Phase III Radiation External Beam Planning Tech

XML NAACCR ID: phase1RadiationExternalBeamTech

phase2RadiationExternalBeamTech

phase3RadiationExternalBeamTech

Radiation External Beam Planning Technique--Phase I, II, and III, effective 01/01/2018, identify the external beam radiation planning technique used to administer the first, second, and third phase, respectively, of radiation treatment during the first course of treatment.

SEER Central Registries: Collect when available from CoC reporting facilities.

Code	Label	Description
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific planning technique
02	Low energy x-ray/photon therapy	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Energies are typically expressed in units of kilovolts (kV). These type of treatments are sometimes referred to as electronic brachytherapy or orthovoltage or superficial therapy. Clinical notes may refer to the brand names of low energy x-ray delivery devices, e.g., Axxent®, INTRABEAM®, or Esteya®.
03	2-D therapy	An external beam planning technique using 2-D imaging, such as plain film x-rays or fluoroscopic images, to define the location and size of the treatment beams. Should be clearly described as 2-D therapy. This planning modality is typically used only for palliative treatments.
04	Conformal or 3-D conformal therapy	An external beam planning technique using multiple, fixed beams shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
05	Intensity modulated therapy	An external beam planning technique where the shape or energy of beams is optimized using software algorithms. Any external beam modality can be modulated but these generally refer to photon or proton beams. Intensity modulated therapy can be described as intensity modulated radiation therapy (IMRT), intensity modulated x-ray or proton therapy (IMXT/IMPT), volumetric arc therapy (VMAT) and other ways. If a treatment is described as IMRT with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.

Code	Label	Description
06	Stereotactic radiotherapy or radiosurgery, NOS	Treatment planning using stereotactic radiotherapy/radiosurgery techniques, but the treatment is not described as CyberKnife® or Gamma Knife®. These approaches are sometimes described as SBRT (stereotactic body radiation), SABR (stereotactic ablative radiation), SRS (stereotactic radiosurgery), or SRT (stereotactic radiotherapy). If the treatment is described as robotic radiotherapy (e.g., CyberKnife®) or Gamma Knife®, use stereotactic radiotherapy subcodes below. If a treatment is described as stereotactic radiotherapy or radiosurgery with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.
07	Stereotactic radiotherapy or radiosurgery, robotic	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which is specifically described as robotic (e.g., CyberKnife®)
08	Stereotactic radiotherapy or radiosurgery, Gamma Knife®	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which uses a Cobalt-60 gamma ray source and is specifically described as Gamma Knife®. This is most commonly used for treatments in the brain.
09	CT-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using a CT scan obtained at the treatment machine (online). These approaches are sometimes described as CT-guided online re-optimization or online re-planning. If a treatment technique is described as both CT-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as CT-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online," this code should not be used.
10	MR-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using an MRI scan obtained at the treatment machine (online). These approaches are sometimes described as MR-guided online re-optimization or online re-planning. If a treatment technique is described as both MR-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as MR-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online," this code should not be used.
88	Not Applicable	Treatment not by external beam
98	Other, NOS	Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown
99	Unknown	It is unknown whether radiation therapy was administered

- Radiation external beam treatment planning technique will typically be found in the radiation oncologist's summary letter. Determination of the external beam planning technique may require assistance from the radiation oncologist to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- In keeping with contemporary practice, modern radiotherapy allows phases to be delivered simultaneously so new terminology is needed. Each phase is meant to reflect a "delivered radiation prescription." At the start of the radiation planning process, physicians write radiation

prescriptions to treatment volumes and specify the dose per fraction (session), the number of fractions, the modality, and the planning technique. A phase simply represents the radiation prescription that has actually been delivered (as sometimes the intended prescription differs from the delivered prescription).

- Phases can be delivered sequentially or simultaneously. In sequential phases, a new phase begins when there is a change in the anatomic target volume of a body site, treatment fraction size (i.e., dose given during a session), modality, or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.

Note: “Online adaptive therapy” refers to treatment where radiation treatment plans are adapted or updated while a patient is on the treatment table. When treatment plans are adapted, the shape of the target volume may change from day to day but, for registry purposes, the volume that is being targeted will not change. An adapted plan should not be coded as though a new phase of treatment has been initiated unless, as above, the radiation oncologist documents it as a new phase in the radiation treatment summary. Two new technique codes have been added to capture when online adaptive therapy is occurring: CT-guided and MR-guided adaptive therapy.

- Refer to the current STAndards for Oncology Registry Entry (STORE) Manual and the CTR Guide to Coding Radiation Therapy Treatment in the STORE (see 2027 STORE Manual, Appendix R).

Coding Instructions

1. Assign code **00** when
 - a. The patient did not have radiation.
 - b. Diagnosed at autopsy (for death certificate only (DCO) cases)
2. Assign code **04** for Conformal or 3-D Conformal Therapy whenever either is explicitly mentioned.
3. Assign code **05** for Intensity Modulated Therapy (IMT) or Intensity Modulated Radiation Therapy (IMRT)
4. Document the planning technique in the appropriate text field when assigning code **98**

Radiation Sequence with Surgery

Item Length: 1

NAACCR Item #: 1380

NAACCR Name: RX Summ--Surg/Rad Seq

XML NAACCR ID: rxSummSurgRadSeq

This data item records the order in which surgery and radiation therapies were administered for those patients who had **both surgery and radiation**. For the purpose of coding the data item *Radiation Sequence with Surgery*, 'Surgery' is defined as a *Surgery of Primary Site 2023* (codes A100-A900 or B100-B900) or *Scope of Regional Lymph Node Surgery* (codes 2-7) or *Surgical Procedure of Other Site* (codes 1-5).

Code	Description
0	No radiation and/or surgery as defined above; Unknown if surgery and/or radiation given
2	Radiation before surgery
3	Radiation after surgery
4	Radiation both before and after surgery
5	Intraoperative radiation therapy
6	Intraoperative radiation with other radiation given before and/or after surgery
7	Surgery both before and after radiation (for cases diagnosed 01/01/2012 and later)
9	Sequence unknown, but both surgery and radiation were given

Coding Instructions

1. Assign code **0** when
 - a. The patient did not have either surgery or radiation.
 - b. The patient had surgery but not radiation.
 - c. The patient had radiation but not surgery.
 - d. It is unknown whether or not the patient had surgery and/or radiation.
 - i. For death certificate only (DCO) cases
2. Assign codes **2-9** when first course of therapy includes both cancer-directed surgery and radiation therapy.
 - a. Assign code **4** when there is at least one phase of radiation therapy given before and at least one more phase after a surgical procedure (includes surgery of the primary site, scope of regional lymph node surgery (excluding code 1), surgery to other regional site(s), distant site(s), or distant lymph node(s)).

Example

1. Preoperative radiation therapy was administered to shrink a large, bulky lesion.
2. Resection was performed
3. Postoperative radiation therapy was administered after resection.
- b. Assign code **7** when there are at least two surgeries; radiation was administered between one surgical procedure and a subsequent surgical procedure.

Example 1

1. Sentinel lymph node biopsy
2. Radiation therapy

3. Surgery of primary site

Code *Radiation Sequence with Surgery* as 7 (surgery both before and after radiation).

Example 2

1. Two regional lymph nodes removed.
2. Radiation
3. Surgery of primary site

Code *Radiation Sequence with Surgery* as 7 (surgery both before and after radiation) because regional lymph node removal is coded in *Scope of Regional Lymph Node Surgery*.

Reason for No Radiation

Item Length: 1

NAACCR Item #: 1430

NAACCR Name: Reason for No Radiation

XML NAACCR ID: reasonForNoRadiation

Reason for No Radiation, effective 01/01/2018, captures the reason the patient did not receive radiation treatment as part of first course of therapy.

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

Coding Instructions

1. Assign code **0** if the patient received regional radiation as part of first course of therapy.
2. Assign code **1** if the treatment plan offered multiple alternative treatment options but the patient selected treatment that did not include radiation therapy.
3. Assign code **7** if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
4. Assign code **8**
 - a. If it is known that a physician recommended radiation treatment, but no further documentation is available to confirm it was given
 - b. To indicate referral to a radiation oncologist was made and the registry should follow to determine whether radiation was administered.
 - c. If follow-up to the specialist or facility determines the patient was never there and no other documentation can be found, assign Code **1**.

Note: Cases coded **8** should be followed and updated to a more specific code as appropriate.
5. Assign code **9**
 - a. If the treatment plan offered multiple alternative treatment options, but it is unknown which treatment, if any, was provided.
 - b. If a DCO case

Date Systemic Therapy Started

Item Length: 8

NAACCR Item #: 3230

NAACCR Name: RX Date Systemic

XML NAACCR ID: rxDateSystemic

The earliest date of administration of chemotherapy agents, hormonal agents, biological response modifiers (BRMs), bone marrow transplants, stem cell harvests, or surgical and/or radiation endocrine therapy is recorded in this data item.

Date Systemic Therapy Started must be transmitted in the YYYYMMDD format. *Date Systemic Therapy Started* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

SEER Central Registries: Collect when available from CoC reporting facilities.

Coding Instructions

1. Record the date of the first/earliest systemic therapy if *Chemotherapy*, *Hormone Therapy*, *Immunotherapy*, or *Hematologic Transplant and Endocrine Procedures* was recorded as part of the first course of therapy.
2. Transmit date data items in the year, month, day format (YYYYMMDD).

Date Chemotherapy Started

Item Length: 8
NAACCR Item #: 1220
NAACCR Name: RX Date Chemo
XML NAACCR ID: rxDateChemo

Date Chemotherapy Started is the date when chemotherapy began as part of the first course of therapy.

Date Chemotherapy Started must be transmitted in the YYYYMMDD format. *Date Chemotherapy Started* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

SEER Central Registries: Collect when available from CoC reporting facilities.

Coding Instructions

1. Record the date of the first/earliest chemotherapy if chemotherapy was given and recorded as part of the first course of therapy.
 - a. Code the date that the prescription or physician order was written if date administered unknown.
2. Chemotherapy date should be the same as the *Date Therapy Initiated* when chemotherapy is the only treatment administered.
3. Transmit date data items in the year, month, day format (YYYYMMDD).

Chemotherapy

Item Length: 2

NAACCR Item #: 1390

NAACCR Name: RX Summ--Chemo

XML NAACCR ID: rxSummChemo

The data item *Chemotherapy* records the chemotherapy given as a part of the first course of treatment or the reason that chemotherapy was not given.

See [SEER*Rx](#) for chemotherapy drug codes and for information on the drug's function.

Code	Description
00	None, chemotherapy was not part of the planned first course of therapy; diagnosed at autopsy
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented in the patient record
02	Single agent chemotherapy administered as first course therapy
03	Multi-agent chemotherapy administered as first course therapy
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.)
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy
86	Chemotherapy was not administered. It was recommended by the patient's physician but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but the treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in the patient record

Important update effective for diagnosis date January 1, 2013, and forward

A comprehensive review of chemotherapeutic drugs currently found in the SEER*Rx – Interactive Drug Database was performed and in keeping with the U.S. Food and Drug Administration (FDA), the six (6) drugs listed in the table below have changed categories from Chemotherapy to BRM/Immunotherapy.

This change is effective for cases diagnosed January 1, 2013, and forward. For cases diagnosed prior to January 1, 2013, code these six (6) drugs as chemotherapy. Coding instructions related to this change have been added to the Remarks section for the applicable drugs in SEER*Rx.

Drug Name/Brand Name	Previous Category	New Category	Effective Date See Note
Alemtuzumab/Campath	Chemotherapy	BRM/Immuno	01/01/2013
Bevacizumab/Avastin	Chemotherapy	BRM/Immuno	01/01/2013
Rituximab/Rituxan	Chemotherapy	BRM/Immuno	01/01/2013
Trastuzumab/Herceptin	Chemotherapy	BRM/Immuno	01/01/2013
Pertuzumab/Perjeta	Chemotherapy	BRM/Immuno	01/01/2013
Cetuximab/Erbitux	Chemotherapy	BRM/Immuno	01/01/2013

Note: Use the **date of diagnosis**, not the date of treatment, to determine whether to code these drugs as chemotherapy or BRM/Immunotherapy.

Example 1: Patient diagnosed with HER2 positive breast cancer December 15, 2026, and was placed on planned Herceptin February 2, 2027. Code Herceptin in the *BRM/Immunotherapy* data item (as the patient was **diagnosed** after January 1, 2013).

Example 2: Patient diagnosed with breast cancer November 1, 2012, and begins receiving Rituximab January 30, 2013, as part of first course therapy. Code the Rituximab in the *Chemotherapy* data item because the patient was **diagnosed** prior to January 1, 2013.

Definitions

Chemotherapy recommended: A consult recommended chemotherapy, or the attending physician documented that chemotherapy was recommended. A referral to a clinical oncologist is equivalent to a recommendation.

Multiple agent chemotherapy: Planned first course of therapy included two or more chemotherapeutic agents and those agents were administered. The planned first course of therapy may or may not have included other agents such as hormone therapy, immunotherapy, or other treatment in addition to the chemotherapeutic agents.

Single agent chemotherapy: Only one chemotherapeutic agent was administered to destroy cancer tissue during the first course of therapy. The chemotherapeutic agent may or may not have been administered with other drugs classified as immunotherapy, hormone therapy, ancillary, or other treatment.

Coding Instructions

1. Code the chemotherapeutic agents whose actions are chemotherapeutic only; **do not code** the method of **administration**.
2. The physician may change a chemotherapy agent or one of the agents in a combination regimen, to an agent belonging to a different subcategory (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) due to reasons other than disease progression (e.g., patient cannot tolerate the original agent).
 - a. This is a continuation of the first course of therapy and does not automatically represent subsequent therapy.
 - b. Use [SEER*Rx](#) to determine whether the drugs used are classified as chemotherapeutic agents.
 - c. Code a chemotherapeutic agent listed in [SEER*Rx](#) as Chemotherapy regardless of the primary site(s) listed in SEER*Rx for that agent. Use SEER*Rx to determine whether the drugs used are classified as chemotherapeutic agents.

Example: Patient is diagnosed with a sarcoma. Neoadjuvant chemotherapy is administered (Alectinib). Alectinib is listed in SEER*Rx as a chemotherapeutic agent for Lung and Lymphoma. Code the chemotherapeutic agent under *Chemotherapy* [NAACCR #1390] regardless of the primary site(s) listed for that agent in SEER*Rx.

3. Code as treatment for both primaries when the patient receives chemotherapy for invasive carcinoma in one breast and also has an invasive or in situ carcinoma in the other breast. Chemotherapy would likely affect both primaries.

Example: Patient is diagnosed with infiltrating duct carcinoma, stage III, in the right breast and infiltrating duct carcinoma, stage I, in the left breast. Neoadjuvant chemotherapy is administered for the stage III neoplasm in the right breast per the breast surgeon consult, but not for the left breast. Code the chemotherapy on both abstracts for both primaries in this case (simultaneous bilateral breast primaries).

4. Assign code **00** when
 - a. The medical record documents chemotherapy was not given, was not recommended, or was not indicated.
 - b. There is no information in the patient's medical record about chemotherapy, AND
 - i. It is known that chemotherapy is not usually performed for this type and/or stage of cancer.
 - ii. OR
 - iii. There is no reason to suspect that the patient would have had chemotherapy.
 - c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include chemotherapy.
 - d. Patient elects to pursue no treatment following the discussion of chemotherapy. Discussion does not equal a recommendation. Patient's decision not to pursue chemotherapy is not a refusal of chemotherapy in this situation.
 - e. Active surveillance/watchful waiting is the first course of treatment (e.g., CLL).
 - f. Patient diagnosed at autopsy

Example: Patient is diagnosed with plasma cell myeloma. There is no mention of treatment or treatment plans in the medical record. Follow-back finds that the patient died three months after diagnosis. There are no additional medical records or other pertinent information available. Assign code 00 since there is no reason to suspect that the patient had been treated.

5. Do not code combination of ancillary drugs administered with single agent chemotherapeutic agents as multiple chemotherapy. For example, the administration of 5-FU (antimetabolite) and Leucovorin (ancillary drug) is coded to single agent (Code 02).
6. Assign code **82** when chemotherapy is a customary option for the primary site/histology but it was not administered due to patient risk factors, such as
 - a. Advanced **age**
 - b. **Comorbid** condition(s) (heart disease, kidney failure, other cancer, etc.)
 - c. Progression of tumor prior to administration
7. Assign code **87** when
 - a. The patient refused recommended chemotherapy.
 - b. The patient made a blanket refusal of all recommended treatment and chemotherapy is a customary option for the primary site/histology.
 - c. The patient refused all treatment before any was recommended and chemotherapy is a customary option for the primary site/histology.
8. Assign code **88** when the only information available is
 - a. The patient was **referred** to an oncologist.
 - b. Insertion of **port-a-cath**

Note: Review cases coded 88 periodically for later confirmation of chemotherapy.

9. Assign code **99** when there is no documentation that chemotherapy was recommended or administered.
 - a. For death certificate only (DCO) cases

Chemotherapeutic Agents

Chemotherapeutic agents are chemicals that affect cancer tissue by means other than hormonal manipulation. Chemotherapeutic agents can be divided into seven groups.

- Alkylating agents
- Antimetabolites
- Inhibitors
- Natural products
- Targeted therapy
- Taxanes
- Miscellaneous

Alkylating Agents

Alkylating agents are **not cell-cycle-specific**. Although they are toxic to all cells, they are most active in the resting phase of the cell. Alkylating agents directly damage DNA to prevent the cancer cell from reproducing. Alkylating agents are used to treat many different cancers including acute and chronic leukemia, lymphoma, Hodgkin disease, multiple myeloma, sarcoma, and cancers of the lung, breast, and ovary. Because the drugs damage DNA they can cause long-term damage to the bone marrow and can, in rare cases, lead to acute leukemia. The risk of leukemia from alkylating agents is “dose-dependent.” Examples of alkylating agents include

- Mustard gas derivatives/nitrogen mustards: mechlorethamine, cyclophosphamide, chlorambucil, melphalan, and ifosfamide
- Ethylenimines: thiotepa and hexamethylmelamine
- Alkylsulfonates: busulfan
- Hydrazines and Triazines: altretamine, procarbazine, dacarbazine, and temozolomide
- Nitrosoureas: carmustine, lomustine, streptozocin, and nitrosourea are unique because they can cross the blood-brain barrier and can be used in treating brain tumors.
- Metal salts: carboplatin, cisplatin, and oxaliplatin

Antimetabolites

Antimetabolites are **cell-cycle specific**. Antimetabolites are very similar to normal substances within the cell. When the cells incorporate these substances into the cellular metabolism, they are unable to divide. Antimetabolites are classified according to the substances with which they interfere.

- Folic acid antagonist: methotrexate
- Pyrimidine antagonist: 5-fluorouracil, floxuridine, cytarabine, capecitabine, and gemcitabine
- Purine antagonist: 6-mercaptopurine and 6-thioguanine
- Adenosine deaminase inhibitor: cladribine, fludarabine, nelarabine, and pentostatin

Inhibitors

Inhibitors are chemical compounds or plant alkaloids that inhibit enzymes that block cancer cells from dividing and spreading. Inhibitors include histone deacetylase inhibitors, topoisomerase inhibitors, and mitotic inhibitors.

Natural Products

1. Plant Alkaloids **are cell-cycle specific** which means they attack the cells during various phases of division. They block cell division by preventing microtubule function. Microtubules are vital for cell division. Without them, division cannot occur. Plant alkaloids, as the name implies, are derived from certain types of plants.
 - Vinca alkaloids: vincristine, vinblastine, and vinorelbine
 - Podophyllotoxins: etoposide and teniposide
 - Camptothecin analogs: irinotecan and topotecan
2. Antitumor antibiotics are also **cell-cycle specific** and act during multiple phases of the cell cycle. They are made from natural products and were first produced by the soil fungus *Streptomyces*. Antitumor antibiotics form free radicals that break DNA strands, stopping the multiplication of cancer cells.
 - Anthracyclines: doxorubicin, daunorubicin, epirubicin, mitotane, and idarubicin
 - Chromomycins: dactinomycin and plicamycin
 - Miscellaneous: mitomycin and bleomycin
3. Topoisomerase inhibitors interfere with the action of topoisomerase enzymes (topoisomerase I and II). They control the manipulation of the structure of DNA necessary for replication.
 - Topoisomerase I inhibitors: irinotecan, topotecan
 - Topoisomerase II inhibitors: amsacrine, etoposide, etoposide phosphate, teniposide

Targeted Therapy

Targeted cancer therapies are drugs or other substances that block the growth and spread of cancer by interfering with specific molecules ("molecular targets") that are involved in the growth, progression, and spread of cancer. Targeted cancer therapies are sometimes called "molecularly targeted drugs," "molecularly targeted therapies," "precision medicines," or similar names. Examples of molecularly targeted therapy are imatinib (Gleevec), lapatinib (Tykerb), erlotinib (Tarceva), sunitinib (Sutent).

Taxanes

Taxanes are a class of chemotherapy drugs used to treat cancer types including ovarian cancer, breast cancer and prostate cancer, among others. They prevent cell division, or mitosis, the process cancer cells use to make more cancer cells. They kill cancer cells and slow tumor growth. Taxanes include paclitaxel, docetaxel and cabazitaxel.

Miscellaneous

Miscellaneous antineoplastics that are unique

- Ribonucleotide reductase inhibitor: hydroxyurea
- Adrenocortical steroid inhibitor: mitotane

- Enzymes: asparaginase and pegaspargase
- Antimicrotubule agent: estramustine
- Retinoids: bexarotene, isotretinoin, tretinoin (ATRA)

Coding for Tumor Embolization

The American College of Surgeons Commission on Cancer (CoC), the Centers for Disease Control and Prevention National Program of Cancer Registries (NPCR), and the SEER Program have collaborated to clarify and refine coding directives for tumor embolization and are jointly issuing the following instructions.

Definitions

Chemoembolization: A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.

Radioembolization: Tumor embolization combined with the injection of small radioactive beads or coils into an organ or tumor.

Tumor embolization: The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

Bland embolization: There is no embolizing agent and/or the agent is not chemotherapeutic or radiation

Coding Instructions

Code as *Chemotherapy* when the embolizing agent(s) is a chemotherapeutic drug(s). Use [SEER*Rx](#) to determine whether the drugs used are classified as chemotherapeutic agents. Use codes 01, 02, 03 as specific information regarding the agent(s) is documented.

Example: The patient has hepatocellular carcinoma (primary liver cancer). From a procedure report: Under x-ray guidance, a small catheter is inserted into an artery in the groin. The catheter's tip is threaded into the artery in the liver that supplies blood flow to the tumor. Chemotherapy is injected through the catheter into the tumor and mixed with particles that embolize or block the flow of blood to the tumor.

A drug administered to a patient for treatment, listed in [SEER*Rx](#) as a chemotherapeutic agent should be coded as chemotherapy regardless of primary sites listed in [SEER*Rx](#) for that agent. Do not code under *Other Therapy* [NAACCR Item #1420].

Do not code pre-surgical (pre-operative) embolization of hypervascular tumors with agents such as particles, coils, or alcohol as a treatment. Pre-surgical embolization is typically performed to prevent excess bleeding during the resection of the primary tumor. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

Date Hormone Therapy Started

Item Length: 8

NAACCR Item #: 1230

NAACCR Name: RX Date Hormone

XML NAACCR ID: rxDateHormone

Date Hormone Therapy Started must be transmitted in the YYYYMMDD format. *Date Hormone Therapy Started* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

SEER Central Registries: Collect when available from CoC reporting facilities.

Coding Instructions

1. Record the date of the first/earliest hormone therapy if hormone therapy was given as part of the first course of therapy.
 - a. Code the date that the prescription was written if date administered unknown.
2. Hormone therapy date should be the same as the *Date Therapy Initiated* when hormone therapy is the only treatment administered.
3. Transmit date data items in the year, month, day format (YYYYMMDD).

Hormone Therapy

Item Length: 2

NAACCR Item #: 1400

NAACCR Name: RX Summ--Hormone

XML NAACCR ID: rxSummHormone

The data item *Hormone Therapy* records therapy administered as first course treatment that affects cancer tissue by adding, blocking, or removing the action or production of hormones.

See [SEER*Rx](#) for hormone therapy drug codes.

Note: Surgical removal of organs for hormone manipulation is not coded in this data item. Code these procedures in the data item *Hematologic Transplant and Endocrine Procedures*.

Code	Description
00	None, hormone therapy was not part of the planned first course of therapy; not usually administered for this type and/or stage of cancer; diagnosed at autopsy only
01	Hormone therapy administered as first course therapy
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.)
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy
86	Hormone therapy was not administered. It was recommended by the patient's physician but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered
99	It is unknown whether a hormonal agent(s) was recommended or administered

Coding Instructions

1. Refer to [SEER*Rx](#) to determine whether the drugs used are classified as hormonal agents. A drug administered to a patient for treatment, listed in [SEER*Rx](#) as a hormonal agent should be coded as hormone therapy regardless of the primary site(s) listed in SEER*Rx for that agent. Do **not** code under the data item, *Other Therapy* [NAACCR #1420].
2. Code the hormonal agent given as part of combination chemotherapy (e.g., R-CHOP), whether it affects the cancer cells or not
3. Code as treatment for both primaries when the patient receives hormone therapy for one primary and the hormone therapy is clinically recognized to also affect the other primary.
Example: Patient is diagnosed with infiltrating duct carcinoma in the right breast and ductal carcinoma in situ in the left breast. Both primaries are hormone positive. Code the hormone therapy for both primaries in this case (simultaneous bilateral breast primaries).
4. Assign code **00** when
 - a. The medical record states that hormone therapy was not given, was not recommended, or was not indicated.

- b. There is no information in the patient's medical record about hormone therapy **AND**
 - i. It is known that hormone therapy is not usually performed for this type and/or stage of cancer.

OR

 - ii. There is no reason to suspect that the patient would have had hormone therapy.
- c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include hormone therapy.
- d. Patient elected to pursue no treatment following the discussion of hormone therapy treatment. Discussion does not equal a recommendation. Patient's decision not to pursue hormone therapy is not a refusal of hormone therapy in this situation.
- e. Active surveillance/watchful waiting (e.g., prostate)
- f. Patient diagnosed at autopsy
- g. Hormone treatment was given for a non-reportable condition or as chemoprevention prior to diagnosis of a reportable condition.

Example 1: Tamoxifen given for hyperplasia of breast four years prior to breast cancer diagnosis. Code 00 in Hormone Therapy. Do not code tamoxifen given for hyperplasia as treatment for breast cancer.

Example 2: Patient with a genetic predisposition to breast cancer is on preventative hormone therapy. Do not code hormone therapy given before cancer is diagnosed.

- 5. Assign code **87** when
 - a. The patient refused recommended hormone therapy.
 - b. The patient made a blanket refusal of all recommended treatment and hormone therapy is a customary option for the primary site/histology.
 - c. The patient refused all treatment before any was recommended and hormone therapy is a customary option for the primary site/histology.
- 6. Assign code **88** when the only information available is that the patient was **referred** to an oncologist.

Note: Review cases coded 88 periodically for later confirmation of hormone therapy.
- 7. Assign code **99** when there is no documentation that hormone therapy was recommended or performed.
 - a. For death certificate only (DCO) cases

Coding Examples

Example 1: Endometrial cancer may be treated with progesterone. Code all administration of progesterone to patients with endometrial cancer in this data item. **Even if the progesterone is given for menopausal symptoms**, it has an effect on the growth or recurrence of endometrial cancer.

Example 2: Follicular, papillary, and oncocytic cancers of the **thyroid** are often treated with thyroid hormone to suppress serum thyroid-stimulating hormone (TSH). If a patient with papillary and/or follicular cancer of the thyroid is given a thyroid hormone, code the treatment in this data item.

Example 3: Bromocriptine suppresses the production of prolactin, which causes growth in pituitary adenoma. Code bromocriptine as hormone treatment for pituitary adenoma.

Example 4: Lupron is a hormonal treatment for prostate cancer. Code as hormonal treatment when Lupron is given for prostate cancer.

Example 5: Lupron is hormone therapy that has been approved as an ovarian suppressor for pre-menopausal breast cancer.

Hormone Categories

Hormones may be divided into several categories

- Androgens: fluoxymesterone
- Anti-androgens: bicalutamide (Casodex), flutamide (Eulexin), and nilutamide (Nilandron)
- Corticosteroids: adrenocorticotrophic agents
- Estrogens
- Progestins
- Estrogen antagonists, anti-estrogens: fulvestrant (Faslodex), tamoxifen, and toremifene (Fareston)
- Aromatase inhibitors, anti-aromatase: anastrozole (Arimidex), exemestane (Aromasin), and letrozole (Femara)
- GnRH or LH-RH: Lupron, Zoladex
- Polypeptide hormone release suppression
- Somatostatin analog
- Thyroid hormones: levothyroxine, liothyronine, Synthroid

Date Immunotherapy Started

Item Length: 8
NAACCR Item #: 1240
NAACCR Name: RX Date BRM
XML NAACCR ID: rxDateBrm

Date Immunotherapy Started is the date when immunotherapy began as part of the first course of therapy.

Date Immunotherapy Started must be transmitted in the YYYYMMDD format. *Date Immunotherapy Started* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

SEER Central Registries: Collect when available from CoC reporting facilities.

Coding Instructions

1. Record the date of the first/earliest immunotherapy if immunotherapy was given and recorded as part of the first course of therapy.
 - a. Code the date that the prescription was written if date administered unknown.
2. Immunotherapy date should be the same as the *Date Therapy Initiated* when immunotherapy is the only treatment administered.
3. Transmit date data items in the year, month, day format (YYYYMMDD).

Immunotherapy

Item Length: 2
 NAACCR Item #: 1410
 NAACCR Name: RX Summ--BRM
 XML NAACCR ID: rxSummBrm

The data item *Immunotherapy* records immunotherapeutic (biological therapy, biotherapy, or biological response modifier (BRM)) agents administered as first course of therapy. See [SEER*Rx](#) for immunotherapy drug codes.

Immunotherapy **uses** the body's **immune system**, either directly or indirectly, to fight cancer or to reduce the side effects that may be caused by some cancer treatments. Record only those treatments that are administered to affect the cancer cells.

Code	Description
00	None, immunotherapy was not part of the planned first course of therapy
01	Immunotherapy was administered as first course therapy
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.)
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy
86	Immunotherapy was not administered; it was recommended by the patient's physician but was not administered as part of the first-course of therapy. No reason was noted in the patient's record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered
99	It is unknown if immunotherapy was recommended or administered because it is not stated in patient record.

Important update effective for diagnosis date January 1, 2013, and forward

A comprehensive review of chemotherapeutic drugs currently found in the SEER*Rx – Interactive Drug Database was performed and in keeping with the U.S. Food and Drug Administration (FDA), the six (6) drugs listed in the table below have changed categories from Chemotherapy to BRM/Immunotherapy.

This change is effective for cases diagnosed January 1, 2013, and forward. For cases diagnosed prior to January 1, 2013, code these six (6) drugs as chemotherapy. Coding instructions related to this change have been added to the Remarks section for the applicable drugs in SEER*Rx.

Drug Name/Brand Name	Previous Category	New Category	Effective Date See Note
Alemtuzumab/Campath	Chemotherapy	BRM/Immuno	01/01/2013
Bevacizumab/Avastin	Chemotherapy	BRM/Immuno	01/01/2013
Rituximab/Rituxan	Chemotherapy	BRM/Immuno	01/01/2013
Trastuzumab/Herceptin	Chemotherapy	BRM/Immuno	01/01/2013
Pertuzumab/Perjeta	Chemotherapy	BRM/Immuno	01/01/2013
Cetuximab/Erbitux	Chemotherapy	BRM/Immuno	01/01/2013

Note: Use the **date of diagnosis**, not the date of treatment, to determine whether to code these drugs as chemotherapy or BRM/Immunotherapy.

Example: Patient diagnosed with breast cancer January 5, 2027, and begins receiving Herceptin as part of first course therapy on January 30, 2027. Code the Herceptin in the BRM/Immunotherapy data item.

Definitions

Immunotherapy is designed to

1. Make cancer cells more recognizable and therefore more susceptible to destruction by the immune system.
2. Boost the killing power of immune system cells, such as T-cells, NK-cells, and macrophages
3. Alter the growth patterns of cancer cells to promote behavior like that of healthy cells
4. Block or reverse the process that changes a normal cell or a pre-cancerous cell into a cancerous cell.
5. Enhance the body's ability to repair or replace normal cells damaged or destroyed by other forms of cancer treatment, such as chemotherapy or radiation
6. Prevent cancer cells from spreading to other parts of the body

Types of Immunotherapy

Cancer Treatment Vaccines: Also called therapeutic vaccines, are a type of [immunotherapy](#). The vaccines work to boost the body's natural defenses to fight a cancer. Doctors give treatment vaccines to people already diagnosed with cancer. The vaccines may:

- Prevent cancer from returning
- Destroy any cancer cells still in the body after other treatment
- Stop a tumor from growing or spreading

Please refer to [SEER*Rx](#) to determine how to code non-FDA approved vaccines.

Interferons: Interferons belong to a group of proteins called cytokines. They are produced naturally by the white blood cells in the body. Interferon-alpha is able to slow tumor growth directly as well as activate the immune system. It is used for a number of cancers including multiple myeloma, chronic myelogenous leukemia (CML), hairy cell leukemia, and malignant melanoma.

Interleukins (IL-2) are often used to treat kidney cancer and melanoma.

Monoclonal Antibodies: Monoclonal antibodies (Mabs) are produced in a laboratory. The artificial antibodies are used in a variety of ways in systemic therapy and can be chemotherapy, immunotherapy, or ancillary drugs. Some are injected into the patient to seek out and disrupt cancer cell activities. When the monoclonal antibody disrupts tumor growth, it is coded as chemotherapy. Other Mabs are linked to radioisotopes (conjugated monoclonal antibodies). The Mab finds and attaches to the target tumor cells and brings with it the radioisotope that actually kills the tumor cells. The monoclonal antibody itself does nothing to enhance the immune system. Conjugated monoclonal antibodies such as ibritumomab (Zevalin) are coded to the part of the drug that actually kills the cells, usually radioisotopes. A third function of Mab is to

enhance the immune response against the cancer, either by identifying tumor cells that are mimicking normal cells, or by boosting the body's natural defenses that destroy foreign cells. **Consult [SEER*Rx](#) for the treatment category in which each monoclonal antibody should be coded.**

Coding Instructions

1. Refer to [SEER*Rx](#) to determine whether the drugs used are classified as immunotherapeutic agents. A drug administered to a patient for treatment, listed in [SEER*Rx](#) as an immunotherapeutic agent should be coded as immunotherapy regardless of the primary site(s) listed in SEER*Rx for that agent. Do **not** code under *Other Therapy* [NAACCR #1420].
2. Code as treatment for both primaries when the patient receives immunotherapy for one primary and it is clinically recognized to also affect the other primary.
3. Assign code **00** when
 - a. The medical record states that immunotherapy was not given, not recommended, or not indicated.
 - b. There is no information in the patient's medical record about immunotherapy **AND**
 - i. It is known that immunotherapy is **not** usually given for this type and/or stage of cancer.
OR
 - ii. There is **no reason to suspect** that the patient would have had immunotherapy.
 - c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include immunotherapy.
 - d. Patient elects to pursue no treatment following the discussion of immunotherapy. Discussion does not equal a recommendation. Patient's decision not to pursue immunotherapy is not a refusal of immunotherapy in this situation.
 - e. Active surveillance, watchful waiting is the first course of treatment (e.g., prostate).
 - f. Patient diagnosed at autopsy
 - g. Anti-thymocyte globulin treatment is given. Anti-thymocyte globulin is used to treat transplant rejection. Do not code as immunotherapy.
4. Assign code **87** when
 - a. The patient refused recommended immunotherapy.
 - b. The patient made a blanket refusal of all recommended treatment and immunotherapy is a customary option for the primary site/histology.
 - c. The patient refused all treatment before any was recommended, and immunotherapy is a customary option for the primary site/histology.
5. Assign code **88** when the only information available is that the patient was referred to an oncologist.
Note: Review cases coded 88 periodically for later confirmation of immunotherapy.
6. Assign code **99**
 - a. When there is no documentation that immunotherapy was recommended or performed **AND**
 - b. Immunotherapy is usually given for this type and/or stage of cancer **OR**
 - c. For death certificate only (DCO) cases

Hematologic Transplant and Endocrine Procedures

Item Length: 2

NAACCR Item #: 3250

NAACCR Name: RX Summ--Transplnt/Endocr

XML NAACCR ID: rxSummTransplntEndocr

This data item records systemic therapeutic procedures administered as part of the first course of treatment. These procedures include bone marrow transplants (BMT) and stem cell harvests with rescue (stem cell transplant), endocrine surgery and/or radiation performed for hormonal effect (when cancer originates at another site), and a combination of transplants and endocrine therapy.

Code	Description
00	None, transplant procedure or endocrine therapy was not a part of the first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only
10	Bone marrow transplant, NOS. A bone marrow transplant procedure was administered as first course of therapy, but the type was not specified.
11	Bone marrow transplant autologous
12	Bone marrow transplant allogeneic
20	Stem cell harvest and infusion (stem cell transplant)
30	Endocrine surgery and/or endocrine radiation therapy as first course therapy
40	Combination of transplant procedure with endocrine surgery and/or endocrine radiation (Code 30 in combination with 10, 11, 12, or 20) as first course of therapy
82	Transplant procedure and/or endocrine therapy was not recommended/administered because it was contradicted due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to planned administration, etc.)
85	Transplant procedure and/or endocrine therapy was not administered because the patient died prior to planned or recommended therapy
86	Transplant procedure and/or endocrine therapy was not administered; it was recommended by the patient's physician but was not administered as part of first course therapy. No reason was noted in the patient's record.
87	Transplant procedure and/or endocrine therapy was not administered; this treatment was recommended by the patient's physician but was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Transplant procedure and/or endocrine therapy was recommended, but it is unknown if it was administered
99	It is unknown if a transplant procedure or endocrine therapy was recommended or administered because it is not stated in patient record

Definitions

Bone marrow transplant (BMT): Procedure where bone marrow is used to restore stem cells that were destroyed by chemotherapy and/or radiation. Replacing the stem cells allows the patient to undergo higher doses of chemotherapy.

BMT Allogeneic: Receives bone marrow from a donor. This includes haploidentical (or half-matched) transplants.

BMT Autologous: Uses the patient's own bone marrow. The tumor cells are filtered out and the purified blood and stem cells are returned to the patient.

BMT Syngeneic: Bone marrow received from an identical twin.

Conditioning: High-dose chemotherapy with or without radiation administered prior to transplant such as BMT and stem cells to kill cancer cells. This conditioning also destroys normal bone marrow cells so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the *Chemotherapy* data item and the radiation is coded in the *Radiation Treatment Modality--Phase I, II, III* data items.

Hematopoietic growth factors: A group of substances that support hematopoietic (blood cell) colony formation. The group includes erythropoietin, interleukin-3, and colony-stimulating factors (CSFs). The growth-stimulating substances are ancillary drugs and not coded.

Non-myeloablative therapy: Uses immunosuppressive drugs pre- and post-transplant to ablate (destroy) the bone marrow. These are not recorded as therapeutic agents.

Peripheral Blood Stem Cell Transplantation (PBSCT): Rescue that uses peripheral blood stem cells to replace stem cells after conditioning.

Rescue: Rescue is the actual BMT or PBSCT done after conditioning.

Stem cells: Immature cells found in bone marrow, blood stream, placenta, and umbilical cords. The stem cells mature into blood cells.

Stem cell transplant: Procedure to replenish supply of healthy blood-forming cells. Also known as bone marrow transplant, PBSCT, or umbilical cord blood transplant, depending on the source of the stem cells. When stem cells are collected from bone marrow and transplanted into a patient, the procedure is known as a **bone marrow transplant**. If the transplanted stem cells came from the bloodstream, the procedure is called a **peripheral blood stem cell transplant**, sometimes shortened to stem cell transplant.

Umbilical cord stem cell transplant: Treatment with stem cells harvested from umbilical cord blood.

Coding Instructions

1. Assign code **00** when
 - a. The medical record states that there was no hematologic transplant or endocrine therapy, or these were not recommended, or not indicated.
 - b. There is no information in the patient's medical record about transplant procedure or endocrine therapy **AND**
 - i. It is known that transplant procedure or endocrine therapy is not usually performed for this type and/or stage of cancer.
OR
 - ii. There is no reason to suspect that the patient would have had transplant procedure or endocrine therapy.
 - c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include transplant procedure or endocrine therapy.
 - d. Patient elects to pursue no treatment following the discussion of transplant procedure or endocrine therapy. Discussion does not equal a recommendation. Patient's decision not to pursue transplant procedure or endocrine therapy is not a refusal of transplant procedure or endocrine therapy in this situation.
 - e. Active surveillance/watchful waiting is the first course of treatment (e.g., CLL).

- f. Patient diagnosed at autopsy
2. Assign code **10** if the patient has a bone marrow transplant and it is unknown if autologous or allogeneic (BMT, NOS) or “mixed chimera transplant (mini-transplant or non- myeloablative transplant). These transplants are a mixture of the patient’s cells and donor cells.
3. Codes **11** (Bone marrow transplant autologous) **and 12** (Bone marrow transplant allogeneic) have priority over code 10 (BMT, NOS).
4. Assign code **12** (allogeneic) for a syngeneic bone marrow transplant (from an identical twin) or for a transplant from any person other than the patient.
5. Assign code **20** for all stem cell transplants.
 - a. Allogeneic stem cell transplant
 - b. Autologous stem cell transplant
 - c. Peripheral blood stem cell transplant
 - d. Umbilical cord stem cell transplant (single or double)

Note: If the patient does not have a rescue, code the stem cell harvest as **88**, (recommended, unknown if administered) or if harvested but unknown if infused.
6. Assign code **30** for endocrine radiation and/or surgery. Endocrine organs are testes and ovaries. Endocrine radiation and/or surgical procedures must be bilateral or must remove the remaining paired organ for hormonal effect.

Note: Bilateral oophorectomy is coded 30 when it is performed for hormonal effect for breast, endometrial, vaginal, and other primary cancers.
7. Assign code **87** if the patient.
 - a. **Refused** recommended transplant or endocrine procedure.
 - b. Made a **blanket refusal** of all recommended treatment and the treatment coded in this data item is a customary option for the primary site/histology.
 - c. **Refused all treatment** before any was recommended.
8. Assign code **88** when
 - a. The only information available is that the patient was referred to an oncologist for consideration of hematologic transplant or endocrine procedure.
 - b. A bone marrow or stem cell harvest was undertaken, but it was not followed by a rescue or reinfusion as part of first course treatment.

Note: Review cases coded 88 periodically for later confirmation of transplant procedure or endocrine therapy.
9. Assign code **99** when there is no documentation that transplant procedure or endocrine therapy was recommended or performed.
 - a. For death certificate only (DCO) cases

Systemic Treatment/Surgery Sequence

Item Length: 1

NAACCR Item #: 1639

NAACCR Name: RX SUMM--Systemic/SurSeq

XML NAACCR ID: rxSummSystemicSurSeq

This data item records the sequence of any systemic therapy and surgery given as first course of therapy for those patients who had both systemic therapy and surgery. For the purpose of coding systemic treatment sequence with surgery, 'Surgery' is defined as a *Surgery of Primary Site 2023* (codes A100-A900 or B100-B900) or *Scope of Regional Lymph Node Surgery* (codes 2-7) or *Surgical Procedure of Other Site* (codes 1-5).

Systemic therapy is defined as

- Chemotherapy
- Hormone therapy
- Biological response therapy/immunotherapy
- Bone marrow transplant
- Stem cell harvests
- Surgical and/or radiation endocrine therapy

Code	Label	Definition	Example(s)/Notes
0	No systemic therapy and/or surgical treatment; Unknown if surgery and/or systemic therapy given	The patient did not have both systemic therapy and surgery. It is unknown whether or not the patient had surgery and/or systemic therapy.	Example: Death certificate only (DCO) case
2	Systemic therapy before surgery	The patient had systemic therapy prior to surgery	
3	Systemic therapy after surgery	The patient had systemic therapy after surgery	
4	Systemic therapy both before and after surgery	Systemic therapy was administered prior to surgery and also after surgery	Note: Code 4 is intended for situations with at least two episodes or courses of systemic therapy.
5	Intraoperative systemic therapy	The patient had intraoperative systemic therapy	
6	Intraoperative systemic therapy with other systemic therapy administered before and/or after surgery	The patient had intraoperative systemic therapy and also had systemic therapy before and/or after surgery	Note: The systemic therapy administered before and/or after surgery does not have to be the same type as the intraoperative systemic therapy.
7	Surgery both before and after systemic therapy (effective for cases diagnosed 01/01/2012 and later)	Systemic therapy was administered between two separate surgical procedures	Example: Patient has LN dissection, followed by chemo, followed by primary site surgery.

Code	Label	Definition	Example(s)/Notes
9	Sequence unknown	The patient had systemic therapy and also had surgery. It is unknown whether the systemic therapy was administered prior to surgery, after surgery, or intraoperatively	

Date Other Treatment Started

Item Length: 8

NAACCR Item #: 1250

NAACCR Name: RX Date Other

XML NAACCR ID: rxDateOther

Date Other Treatment Started is the date when an alternative treatment other than surgery, radiation, chemotherapy, immunotherapy, and hematologic transplant and endocrine procedure is initiated/started as part of the first course of therapy. Examples include phlebotomy or aspirin (for essential thrombocytopenia cases only) when administered as forms of treatment.

Date Other Treatment Started must be transmitted in the YYYYMMDD format. *Date Other Treatment Started* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

SEER Central Registries: Collect when available from CoC reporting facilities.

Coding Instructions

1. Record the date of the first/earliest other treatment if an alternative treatment was given and recorded as part of the first course of therapy.
2. Other treatment date should be the same as the *Date Therapy Initiated* when an alternative treatment is the only treatment administered.
3. Transmit date data items in the year, month, day format (YYYYMMDD).

Other Therapy

Item Length: 1
 NAACCR Item #: 1420
 NAACCR Name: RX Summ--Other
 XML NAACCR ID: rxSummOther

Other Therapy identifies treatment given that cannot be classified as surgery, radiation, systemic therapy, or ancillary treatment. This data item includes all complementary and alternative medicine (CAM) used by the patient in conjunction with conventional therapy or in place of conventional therapy.

Code	Description
0	None
1	Other
2	Other-Experimental
3	Other-Double Blind
6	Other-Unproven
7	Refusal
8	Recommended, unknown if administered
9	Unknown

Coding Instructions

1. Assign code **0** when
 - a. There is no information in the patient's medical record about other therapy **AND**
 - i. It is known that other therapy is not usually performed for this type and/or stage of cancer.
 - ii. OR
 - iii. There is no reason to suspect that the patient would have had other therapy.
 - b. The treatment plan offered multiple treatment options and the patient selected treatment that did not include other therapy.
 - c. Patient elects to pursue no treatment following the discussion of other therapy. Discussion does not equal a recommendation. Patient's decision not to pursue other therapy is not a refusal of other therapy in this situation.
 - d. First course of treatment was active surveillance/watchful waiting.
 - e. Patient diagnosed at autopsy
2. Assign code **1** for
 - a. Hematopoietic treatments such as phlebotomy or aspirin (when used for essential thrombocytopenia cases only). (See [SEER*Rx](#) and [Hematopoietic and Lymphoid Neoplasm Coding Manual and Database](#) for specific guidance on coding).

Note: Do **not** code blood transfusion as treatment.

Rationale: Blood transfusions may be used for any medical condition that causes anemia. It would be virtually impossible for the registrar to differentiate between blood transfusions used for a co-morbidity (i.e., anemia) from those given as prophylactic treatment of a hematopoietic neoplasm.

- b. PUVA (Psoralen (P) and long-wave ultraviolet radiation (UVA)) in the **RARE** event that it is used as treatment for extremely thin melanomas or cutaneous T-cell lymphomas (e.g., mycosis fungoides).

Note: Code UVB phototherapy for mycosis fungoides as photodynamic therapy under *Surgery of Primary Site 2023* for skin. Assign code B110 [Photodynamic therapy (PDT)] when there is no pathology specimen.

- c. Photophoresis. This treatment is used **ONLY** for thin melanoma or cutaneous T-cell lymphoma (mycosis fungoides).
- d. Cancer treatment that could not be assigned to the previous treatment data items (surgery, radiation, chemotherapy, immunotherapy, or systemic therapy).
- e. Bland embolization: No embolizing agent is provided and/or the agent is not chemotherapeutic or radiation, including terms such as “tumor embolization” or “embolization of the tumor” for sites other than the liver.

Note: Do not code *Other Therapy* when a chemotherapeutic agent listed in SEER*Rx was administered to a patient for treatment but the primary site(s) is(are) not listed for that agent in SEER*Rx. Code treatment as *Chemotherapy* [NAACCR #1390].

- 3. Assign code **2** for any experimental or newly developed treatment, such as a clinical trial, that differs greatly from proven types of cancer therapy.

Note 1: Hyperbaric oxygen has been used to treat cancer in clinical trials, but it is also used to promote tissue healing following head and neck surgeries. Do not code the administration of hyperbaric oxygen to promote healing as an experimental treatment.

Note 2: Assign code 2 for any non-FDA approved cancer treatment.

- 4. Assign code **3** when the patient is enrolled in a double blind clinical trial. When the trial is complete and the types of treatment are revealed, i.e., code is broken, review and code the FDA approved treatment actually administered.

Note: If the code is broken, and the investigational drug has not been FDA approved, assign code 2.

- 5. Assign code **6** for

- a. Cancer treatment administered by nonmedical personnel

Example: Cannabis oil or medical marijuana that is used for treatment.

- b. **Unconventional** methods whether they are the only therapy or are given **in combination** with conventional therapy.

Example: DC vax given for brain cancer. Assign code 6. DC vax is not an approved treatment for brain cancer and should not be coded in *Immunotherapy* or any of the other treatment data items.

- c. **Complementary and Alternative Medicine (CAM)** as any medical system, practice, or product that is not thought of as “western medicine” or standard medical care. CAM treatments may include dietary supplements, megadose vitamins, herbal preparations, acupuncture, massage therapy, magnet therapy, spiritual healing, and meditation.

- i. **Alternative medicine** is treatment that is used instead of standard medical treatments. Alternative therapy is when the patient receives **no** other type of standard treatment.

- ii. **Complementary medicine.** Treatments that are used along with standard medical treatments but are not standard treatments; also called conventional medicine. One example is using acupuncture to help lessen some side effects of cancer treatment in conjunction with standard treatment.

- d. **Integrative medicine.** A total approach to medical care that combines standard medicine with the CAM practices that have shown to be safe and effective. They treat the patient's mind, body, and spirit.

Note: See complete information on types of complementary and alternative medicine specific to cancer at [NCI Office of Cancer Complementary and Alternative Medicine](#). For additional information on cancer and other diseases, please visit [NIH National Center for Complementary and Integrative Health](#).

- 6. Assign code **8** when other therapy was recommended by the physician but there is **no** information that the treatment was given.
- 7. Assign code **9** when there is **no** documentation that other therapy was recommended or performed.
 - a. For death certificate only (DCO) cases

Coding for Tumor Embolization

The American College of Surgeons Commission on Cancer (CoC), the Centers for Disease Control and Prevention National Program of Cancer Registries (NPCR), and the SEER Program have collaborated to clarify and refine coding directives for tumor embolization and are jointly issuing the following instructions.

Definitions

Chemoembolization: A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.

Radioembolization: Tumor embolization combined with injecting small radioactive beads or coils into an organ or tumor.

Tumor embolization: The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

Bland embolization: There is no embolizing agent and/or the agent is not chemotherapeutic or radiation.

Coding Instructions

Code as “*Other Therapy*” when tumor embolization is performed using **alcohol** as the embolizing agent. Use code 1.

Example: For head and neck primaries: Ideally, an embolic agent is chosen that will block the very small vessels within the tumor but spare the adjacent normal tissue. Liquid embolic agents, such as ethanol or acrylic, and powdered particulate materials can penetrate into the smallest blood vessels of the tumor.

Use code 1 for embolization of a tumor in a site other than the liver when the embolizing agent is unknown.

Do not code pre-surgical (pre-operative) embolization of hypervascular tumors with agents such as particles, coils, or alcohol as a treatment. Pre-surgical embolization is typically performed to prevent excess bleeding during the resection of the primary tumor. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

Section VIII

Follow Up Information

Cancer Status

Item Length: 1

NAACCR Item #: 1770

NAACCR Name: Cancer Status

XML NAACCR ID: cancerStatus

Cancer Status records the presence or absence of clinical evidence of the patient's malignant or non-malignant tumor as of the *Date of Last Cancer (tumor) Status* [NAACCR Item #1772]. If the patient has multiple primaries, the status may be different for each primary. SEER requires the registries to update the follow up information on all cases on an annual basis.

This data item can be used in follow-up and outcomes studies such as computing disease-free survival.

Code	Description
1	No evidence of this tumor
2	Evidence of this tumor
9	Unknown, indeterminate whether this tumor is present, not stated in patient record

Coding Instructions

1. Assign code **1** when
 - a. There is no indication or evidence of this tumor, for example, the patient is in remission for a hematopoietic disease.
 - b. Patient is on maintenance therapy that continues for years and that is the only information that suggests cancer may be present.

Example: Patients receiving long-term hormone therapy for breast or thyroid cancer.

2. Assign code **2** when there is an indication of this tumor, for example, patient died or is continuing active treatment for this tumor.
3. Use information from an official source such as a health care provider, the patient's physician, or other information such as a death certificate.

Example 1: Margin status along with additional information that determine cancer status.

Example 2: Stage and outcome of neoadjuvant or other therapy.

4. Use all entries on the death certificate to code *Cancer Status* for deceased patients.

Date of Last Cancer (Tumor) Status

Item Length: 8**NAACCR Item #: 1772****NAACCR Name: Date of Last Cancer (Tumor) Status****XML NAACCR ID: dateOfLastCancerStatus**

Date of Last Cancer (tumor) Status records the date of last known cancer status for this tumor. NCI SEER requires the registries to update the follow up information on all cases on an annual basis.

Date of Last Cancer (tumor) Status must be transmitted in the YYYYMMDD format. *Date of Last Cancer (tumor) Status* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

Transmitting Dates

Transmit date data items in the year, month, day format (YYYYMMDD). Leave the year, month, and/or day blank when they cannot be estimated or are unknown.

Common Formats

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

Transmit Instructions

1. Transmit date data items in the year, month, day format (YYYYMMDD).
2. Leave the year, month, and/or day blank when they cannot be estimated or are unknown.
3. Most SEER registries collect the month, day, and year for date therapy initiated. When the full date (YYYYMMDD) is transmitted, the seventh and eighth digits (day) will be deleted when the data are received by NCI SEER.

Codes for Year

Code the four-digit year.

Codes for Month

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

Codes for Day

01
02
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31

Coding Instructions

1. Code the month, day, and the year of the last known cancer status (*Cancer Status* [NAACCR Item #1770]) for this tumor.
2. Use information from a health care provider, the patient's physician, or other official source such as a death certificate. Do not use information from an unofficial source such as a family member, friend, or other non-official source.
3. Use the date of death as the Date of Last Cancer (Tumor) Status for deceased patients and use all entries on the death certificate to code Cancer Status.

Estimating Dates**Estimating the month**

1. Code "spring of" to April.
2. Code "summer" or "middle of the year" to July.
3. Code "fall" or "autumn" to October.
4. For "winter of," try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month.
5. Code "early in year" to January.
6. Code "late in year" to December.

7. Use whatever information is available to calculate the month.
8. Code the month of admission when there is no basis for estimation.
9. Leave month blank if there is no basis for approximation.

Estimating the **year**

1. Code “a couple of years” to two years earlier.
2. Code “a few years” to three years earlier.
3. Use whatever information is available to calculate the year.
4. Code the year of admission when there is no basis for estimation.

Cancer Status Following First Course of Treatment

Item Length: 1

NAACCR Item #: 1769

NAACCR Name: Cancer Status Following First Course of TX

XML NAACCR ID: cancerStatusFollowing1stCrstx

Cancer Status Following First Course of Treatment, effective 01/01/2027, records the presence or absence of the patient's disease following first course treatment. It corresponds with the Date of Cancer Status Following First Course of Treatment [NAACCR Item #1968]. The information is used to identify the cancer status of the patient following completion of first course treatment (not including long term maintenance therapy).

Code	Description
1	No evidence of this tumor
2	Evidence of disease
8	First course treatment in progress
9	Unknown, indeterminate whether this tumor is present, not stated in patient record

Coding Instructions

1. Use documentation from the patient's PAPP or other sources of physician documentation which may include pathology, radiology, follow up visits, and/or death certificate following completion of first course treatment.
 - a. First course of treatment may include neoadjuvant therapy, resection of primary site, and adjuvant therapy. This does not include long term maintenance therapy (such as hormonal therapy for breast and thyroid cancer).
2. Consult with a PAPP if cancer status is unclear; do **not** use.
 - a. Interpretation of cancer status determined by the registrar.
 - b. Information obtained from the patient, a family member, or other non-physician.
3. Assign code **1** when
 - a. There is no indication or evidence of this tumor, for example, the patient is in remission for a hematopoietic disease.
 - b. When a PAPP documents the patient has no evidence of disease prior to completion of the first course of treatment

Note: Do not assign code 1 if patient is on maintenance therapy that continues for years and that is the only information that suggests cancer may be present.

Example: Patients receiving long-term hormone therapy for breast or thyroid cancer.
4. Assign code **2** when there is an indication of this tumor, for example, patient is continuing active treatment for this tumor or refused treatment.
5. Assign code **8** when
 - a. Patient is undergoing first course of treatment.
 - b. Treatment plan is being developed.
6. Assign code **9** when
 - a. *Class of Case* is 00

- b. Status following first course treatment is unknown, indeterminate whether the tumor is present, or is not stated in the patient record.
- 7. Update cancer status only when first course treatment is in progress (Code 8) or when status is unknown (Code 9).
- 8. Do not change cancer status following first course treatment if
 - a. Coded as 1 or 2
 - b. The patient has a recurrence or relapse.
- 9. Assign cancer status for each primary if a patient has multiple primaries.

Date of Cancer Status Following First Course of Treatment

Item Length: 8

NAACCR Item #: 1768

NAACCR Name: Date of Cancer Status Following First Course of TX

XML NAACCR ID: dateOfCaStatusFollowing1stCrstTx

Date of Cancer Status Following First Course of Treatment, effective 01/01/2027, records the date of last known cancer status following first course of treatment. This date corresponds to the status recorded in *Cancer Status Following First Course of Treatment* [NAACCR Item #1769] for cases diagnosed 2027 and forward. This information is used for patient follow-up and outcomes studies.

SEER requires the registries to update the follow up information on all cases on an annual basis.

Date of Cancer Status Following First Course of Treatment must be transmitted in the YYYYMMDD format. *Date of Cancer Status Following First Course of Treatment* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

Transmitting Dates

Transmit date data items in the year, month, day format (YYYYMMDD). Leave the year, month, and/or day blank when they cannot be estimated or are unknown.

Common Formats

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

Transmit Instructions

1. Transmit date data items in the year, month, day format (YYYYMMDD).
2. Leave the year, month, and/or day blank when they cannot be estimated or are unknown.
3. Most SEER registries collect the month, day, and year for date therapy initiated. When the full date (YYYYMMDD) is transmitted, the seventh and eighth digits (day) will be deleted when the data are received by NCI SEER.

Codes for Year

Code the four-digit year.

Codes for Month

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

Codes for Day

01
02
03
..
..
31

Coding Instructions

- Code the month, day, and the year of the last known cancer status following first course of treatment (*Cancer Status Following First Course of Treatment* [NAACCR Item #1769]) was determined for this tumor.
- Enter the date that is documented in the medical record that the patient has no evidence of disease following completion of first course of treatment to align with the period of time the patient has no evidence of disease following first course of treatment.
 - Cancer Status Following First Course of Treatment [NAACCR Item #1769] is coded to 1, no evidence of disease.
 - Do not change the date once assigned.
- Enter the date the patient is documented to be no evidence of disease even though all first course of treatment has not been completed when a PAPP documents the patient has no evidence of disease **prior to** the first course of treatment plan being complete.
- Enter the date that reflects when first course treatment ended and there is still documentation of evidence of disease when the patient has evidence of disease at the end of first course treatment.
 - Cancer Status Following First Course of Treatment* [NAACCR #1769] is coded to 2, evidence of disease.
- When *Cancer Status Following First Course of Treatment* [NAACCR Item #1769] is code 8 or code 9
 - Leave the date blank.

- b. Enter the date when the patient's cancer status following first course treatment is later updated, i.e., status is now known/identified or treatment ends. The update reflects the date associated with the status of the cancer identified following first course treatment.
6. Assign the date the decision was made for patients choosing active surveillance or refusing treatment.
 - a. *Cancer Status Following First Course of Treatment* [NAACCR Item #1769] is code 2.
7. Do not change the date if the patient has a recurrence or relapse.
 - a. *Cancer Status Following First Course of Treatment* [NAACCR Item #1769] remains unchanged as the two data items correspond with each other.
8. Assign the date for each tumor if a patient has multiple primaries.
 - a. Each primary could have a different status; this differs from the *Date of Last Contact or Death* [NAACCR Item #1750].
9. Use information from a health care provider, the patient's physician, or other official source such as a death certificate. Do not use information from an unofficial source such as a family member, friend, or other non-official source.
10. Use the date of death for deceased patients and use all entries on the death certificate for deceased patients.

Estimating Dates

Estimating the **month**

1. Code "spring of" to April.
2. Code "summer" or "middle of the year" to July.
3. Code "fall" or "autumn" to October.
4. For "winter of," try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month.
5. Code "early in year" to January.
6. Code "late in year" to December.
7. Use whatever information is available to calculate the month.
8. Code the month of admission when there is no basis for estimation.
9. Leave month blank if there is no basis for approximation.

Estimating the **year**

1. Code "a couple of years" to two years earlier.
2. Code "a few years" to three years earlier.
3. Use whatever information is available to calculate the year.
4. Code the year of admission when there is no basis for estimation.

Disease Follow-up or First Recurrence/Progression

Item Length: 2

NAACCR Item #: 1880

NAACCR Name: Disease Follow-up or 1st Recurrence/Progression

XML NAACCR ID: recurrenceType1st

Disease Follow-up or First Recurrence/Progression indicates the current disease status until first recurrence, progression, or death. Once recurrence or progression occurs then identify the type of recurrence after a disease-free period or progression if the patient was never disease free. Prior to 2027, the title was named *Recurrence Type--1st*.

This data item is used to track the current status of the patient's disease through progression or recurrence and helps evaluate treatment efficacy.

Code	Description
00	Patient became disease-free after treatment and has not had a recurrence; leukemia in remission
04	In situ recurrence of an invasive tumor
06	In situ recurrence of an in situ tumor
10	Local recurrence. Local recurrence includes recurrence confined to the remnant of the organ of origin, to the organ of origin, to the anastomosis, or to scar tissue where the organ previously existed. (This includes local recurrence of an in situ tumor and trocar recurrence.)
20	Regional recurrence
40	Distant recurrence. This includes relapse of lymphoma, leukemia or other hematopoietic neoplasms.
70	Since diagnosis, patient has never been disease-free. This includes cases with distant metastasis at diagnosis, systemic disease, unknown primary, or minimal disease that is not treated.
80	Patient has never been disease-free and has documentation of progression of disease
88	Disease has recurred, but the type of recurrence is unknown
98	Physician documented recurrence but collected as a new primary (using <i>Solid Tumor Rules</i>)
99	It is unknown whether the disease has recurred/progressed; or first course treatment is still in progress (Cancer Status Code 8)

Coding Instructions

1. Assign the patient's disease status with successful follow-up performed annually until first recurrence or progression occurs. This item is associated with *Disease Follow-up /First Recurrence or Progression Date* [NAACCR Item #1860].
2. Assign the type of first recurrence as local, regional, or distant. Only the first recurrence/progression should be recorded.
3. Check the current *Solid Tumor Rules* to determine which subsequent tumors should be coded as recurrences vs. a new primary tumor. If it is determined based on the *Solid Tumor Rules* to code the documented recurrence as a new primary tumor assign code 98 and tracking of this tumor would be considered complete and disease follow up would not continue to be tracked.
4. Continue to check for disease-free status, which may occur after subsequent treatment has been completed, when the patient has never been disease-free (code 70)
5. Continue to check until a recurrence occurs when the patient is disease-free (code 00). First recurrence may occur well after completion of the first course of treatment.

6. Do **not** assign code 99 solely because no new disease follow-up documentation is available.
7. Do **not** assign a subsequent recurrence or progression once a recurrence/progression has been recorded. Patient would no longer be followed for recurrence/progression after the first occurrence was established.
8. Assign the highest-numbered applicable response for hierarchical codes 00-80.
 - a. Change the code to 00 the first time a patient converts from code 80 (never disease free) to disease-free.
9. Assign the proper code for the recurrence the first time a patient converts from code 00 to a recurrence. No further changes (other than corrections) should be made.
10. Assign code 06 or 20 for recurrence when the tumor was originally diagnosed as in situ. Do not use those codes for any other tumors.
11. Assign code 00 for lymphomas or leukemias that are in remission. The patient is in remission when the lymphoma or leukemia is controlled by drugs (e.g., Gleevec for chronic myeloid leukemia).
 - a. Update to code 40 when recurrence/relapse of lymphoma or leukemia occurs.
12. Code the recurrent disease for each tumor when there is more than one primary tumor and the physician is unable to decide which has recurred. If the recurrent primary is identified later, revise the codes appropriately.
13. Assign code 10 for recurrence of a benign brain tumor.

Disease Follow-up or First Recurrence/Progression Date

Item Length: 8

NAACCR Item #: 1860

NAACCR Name: Date--1st Recurrence

XML NAACCR ID: recurrenceDate1st

Disease Follow-up or First Recurrence/Progression Date records the most current date on which the patient's disease status was followed up or date of documentation of the patient's first recurrence or progression of disease. It corresponds to the information identified in *Disease Follow-up or First Recurrence/Progression* data item [NAACCR Item #1880]. Prior to 2027, it was titled *Recurrence Date--1st*.

Disease Follow-up or First Recurrence/Progression Date must be transmitted in the YYYYMMDD format. *Disease Follow-up or First Recurrence/Progression Date* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

Transmitting Dates

Transmit date data items in the year, month, day format (YYYYMMDD). Leave the year, month, and/or day blank when they cannot be estimated or are unknown.

Common Formats

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

Transmit Instructions

1. Transmit date data items in the year, month, day format (YYYYMMDD).
2. Leave the year, month, and/or day blank when they cannot be estimated or are unknown.
3. Most SEER registries collect the month, day, and year. When the full date (YYYYMMDD) is transmitted, the seventh and eighth digits (day) will be held confidentially and only used for survival calculations when received by NCI SEER.

Codes for Year

Code the four-digit year.

Codes for Month

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

Codes for Day

01
02
03
..
..
31

Coding Instructions

1. Assign the most current date on which the patient's disease status was followed up corresponding to *Disease Follow-up or First Recurrence/Progression* data item [NAACCR Item #1880].
 - a. PAPP statement of no evidence of disease/still no evidence of disease, no evidence of recurrence, etc.
 - b. Follow-up from a patient letter indicating still no evidence of disease (previously documented no evidence of disease).
 - c. PAPP statement of progression or recurrence
2. Assign/update the date the PAPP diagnosed the first progression, metastasis, or recurrence of disease after a disease-free period.
 - a. Do not continue to update the date once progression or metastasis is recorded.
3. Assign/update the date the physician diagnosed the first recurrence of disease after a disease-free period.
 - a. Do not continue to update this data item once recurrence is recorded.
4. Continue to follow *Vital Status* [NAACCR Item #1760] annually until patient death occurs or 15 years past the initial diagnosis date/year.
5. Leave blank if *Disease Follow-up or First Recurrence/Progression* [NAACCR Item #1880] is assigned code 99

Estimating Dates

Estimating the **month**

1. Code “spring of” to April.
2. Code “summer” or “middle of the year” to July.
3. Code “fall” or “autumn” to October.
4. For “winter of,” try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month.
5. Code “early in year” to January.
6. Code “late in year” to December.
7. Use whatever information is available to calculate the month.
8. Code the month of admission when there is no basis for estimation.
9. Leave month blank if there is no basis for approximation.

Estimating the **year**

1. Code “a couple of years” to two years earlier.
2. Code “a few years” to three years earlier.
3. Use whatever information is available to calculate the year.
4. Code the year of admission when there is no basis for estimation.

Death Clearance Instructions

See the [NAACCR Death Clearance Manual](#).

There are two SEER requirements that differ from the current NAACCR manual. SEER requires

- Use of all entries on the death certificate to be matched at the patient level, not just the underlying cause of death.
- Tumor comparison– link all reportable death certificates at the tumor level, looking for possible second primaries

Date of Last Follow-Up or of Death

Item Length: 8**NAACCR Item #: 1750****NAACCR Name: Date of Last Contact****XML NAACCR ID: dateOfLastContact**

This data item records the date of last follow-up or the date of death. SEER requires the registries to update the follow up information on all cases on an annual basis.

Date of Last Follow-Up or of Death must be transmitted in the YYYYMMDD format. *Date of Last Follow-Up or of Death* may be recorded in the transmission format or recorded in the traditional format (MMDDYYYY) and converted electronically to the transmission format.

Transmitting Dates

Transmit date data items in the year, month, day format (YYYYMMDD). Transmit only known or estimated **year** of last follow-up or death; blanks will not be accepted for year. Leave the year¹, month and/or day blank when they cannot be estimated or are unknown.

Common Formats

YYYYMMDD	Complete date is known
YYYYMM	Year and month are known/estimated; day is unknown
YYYY	Year is known/estimated; month and day cannot be estimated or are unknown
Blank	Year, ¹ month, and day cannot be estimated or are unknown

Transmit Instructions

1. Transmit date data items in the year, month, day format (YYYYMMDD).
2. Leave the year, month, and/or day blank when they cannot be estimated or are unknown.
3. Most SEER registries collect the month, day, and year. When the full date (YYYYMMDD) is transmitted, the seventh and eighth digits (day) will be held confidentially and only used for survival calculations when received by NCI SEER.

Codes for Year

Code the four-digit year.

Cases NOT transmitted to SEER only

Codes for Month

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

Codes for Day

01
02
03
..
..
31

Coding Instructions

1. Code the date the patient was actually seen by the physician or contacted by the hospital registry as the follow-up date. Do not code the date the follow-up report was received.
2. Do not change the follow-up date unless new information is available.
3. The data item is associated with the patient, not the cancer, so all records (primary sites) for the same patient will have the same follow-up date.
4. Record the date of death for deceased patients.
 - a. Death certificate only (DCO) cases
5. Autopsy only cases

Estimating Dates**Estimating the month**

1. Code “spring of” to April.
2. Code “summer” or “middle of the year” to July.
3. Code “fall” or “autumn” to October.
4. For “winter of,” try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month.

5. Code “early in year” to January.
6. Code “late in year” to December.
7. Use whatever information is available to calculate the month.
8. Code the month of admission when there is no basis for estimation.
9. Leave month blank if there is no basis for approximation.

Estimating the **year**

1. Code “a couple of years” to two years earlier.
2. Code “a few years” to three years earlier.
3. Use whatever information is available to calculate the year.
4. Code the year of admission when there is no basis for estimation.

Vital Status

Item Length: 1
NAACCR Item #: 1760
NAACCR Name: Vital Status
XML NAACCR ID: vitalStatus

SEER requires the registries to update the follow up information on all cases on an annual basis. This data item records the vital status of the patient on the date of last follow up.

The code for Dead has been changed from 4 to 0 beginning with cases diagnosed in 2018. Earlier cases may be converted if desired.

Code	Description
0	Dead
1	Alive

The data item is associated with the patient, not the cancer, so if the patient has multiple primary tumors, vital status should be the same for all tumors.

Coding Instructions

1. Assign code **0** for
 - a. Deceased patients
 - b. Death certificate only (DCO) cases
 - c. Autopsy only cases

ICD Code Revision Used for Cause of Death

Item Length: 1**NAACCR Item #: 1920****NAACCR Name: ICD Revision Number****XML NAACCR ID: icdRevisionNumber**

SEER requires the registries to update the follow up information on all cases on an annual basis. This data item shows the revision of the International Classification of Diseases (ICD) used to code the underlying cause of death. This data item is populated by the central registry.

If the patient has multiple tumor records, the *ICD Code Revision Used for Cause of Death* must be identical on each record.

Code	Description
0	Patient alive at last follow up
1	ICD-10 (1999+ deaths)
7	ICD-7 (1958-1967)
8	ICDA-8 (1968-1978)
9	ICD-9 (1979-1998)

Coding instructions

1. Assign code **1** for death certificate only (DCO) cases.

Underlying Cause of Death

Item Length: 4
 NAACCR Item #: 1910
 NAACCR Name: Cause of Death
 XML NAACCR ID: causeOfDeath

This is the official underlying cause of death coded from the death certificate using ICD-7, ICDA-8, ICD-9, or ICD-10 codes. This data item is populated by the central registry.

Special Codes

Code	Description
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

Coding Instructions for ICD-10

1. Ignore (do not record) decimal points when copying codes.
2. The cause of death code is commonly four characters. Ignore (do not code) a fifth character if present.
3. Left justify the codes; if less than four characters, leave the fourth character blank.
Note: This is a change from previous instructions.
4. If the underlying cause of death code is not available, do not attempt to code the underlying cause of death unless you have a trained ICD-10 nosologist on staff or on consult.

Priority Order for use of source documents to assign codes, with 1 having the highest priority.

1. Use the underlying cause of death as coded by a state health department even if the code seems to be in error.
2. Report the coded underlying cause of death code from another source such as NDI Plus or state data exchange.
3. Code the underlying cause of death if a trained ICD-10 nosologist is on staff or under contract.
4. Code the underlying cause of death as **7797** when the death certificate is available, but the underlying cause of death code is not coded and cause of death is not available from another source such as NDI Plus or state data exchange.
5. Code **7777** when the death certificate is not available AND the coded underlying cause of death is not available from other sources such as NDI or state data exchange.

Example: Medical doctor states patient died, but death certificate not available (not on state death file, not available through federal or state agencies); code 7777.

Beginning with deaths in 1999, the United States agreed to code all deaths using the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* (ICD-10). The ICD-10 codes have up to four characters: a letter followed by 2 or 3 digits.

Examples:

Underlying Cause of Death	ICD-10	SEER Code
Malignant neoplasm of the thyroid	C73	C73
Acute appendicitis with peritonitis	K35.0	K350
Malignant neoplasm of stomach	C16.9	C169

If the patient has multiple records, the underlying cause of death must be identical on each record.

Survival Data Items

Effective January 1, 2015, there were seven new NAACCR data items to facilitate survival analysis by NAACCR registries. The data items are derived for SEER registries. For further information on each specific data item, see the [NAACCR Data Dictionary](#) and the [NAACCR 2015 Implementation Guidelines](#).

Survival Data Items

Item #	Data Item Name	XML NAACCR ID
1782	Surv-Date Active Followup	survDateActiveFollowup
1783	Surv-Flag Active Followup	survFlagActiveFollowup
1784	Surv-Mos Active Followup	survMosActiveFollowup
1785	Surv-Date Presumed Alive	survDatePresumedAlive
1786	Surv-Flag Presumed Alive	survFlagPresumedAlive
1787	Surv-Mos Presumed Alive	survMosPresumedAlive
1788	Surv-Date DX Recode	survDateDxRecode

No Patient Contact Flag

Item Length: 1**NAACCR Item #: 1854****NAACCR Name: No Patient Contact Flag****XML NAACCR ID: noPatientContactFlag**

No Patient Contact Flag, effective 01/01/2023, flags a record when a patient, family member, or provider informs the physician, hospital, or central registry that they do not want to be contacted for research purposes. This data item is populated by the central registry.

Restrictions on release do not apply to routine surveillance reporting to NCI, CDC, and NAACCR, for which all reportable tumor records are to be submitted. It also does not apply to release for studies where no patient contact is planned. This data item is applied at the patient level and used to exclude all tumor records of the patient. It is used in combination with the data item *Reporting Facility Restriction Flag* (NAACCR Item #1856) to identify data at the patient and tumor level that the registry may not be allowed to release.

Code	Description
0	Patient may be contacted for research purposes
1	Patient may NOT be contacted for research purposes, per notification from patient, family member, or provider

Coding Instructions

1. Code this data item as either 0 or 1. Blanks are not allowed regardless of diagnosis year.
 - a. This data item should always have a value for all diagnosis years. If there is not a known restriction, then code 0 (e.g., the person can be contacted unless known otherwise).
2. Assign the code that best describes whether the patient should or should not be contacted for research purposes.
3. Assign this flag at the patient-level so that it can be used to flag release of all associated tumors.
4. Code 1 takes precedence over code 0 when consolidating records.

Reporting Facility Restriction Flag

Item Length: 2

NAACCR Item #: 1856

NAACCR Name: Reporting Facility Restriction Flag

XML NAACCR ID: reportingFacilityRestrictionFlag

Reporting Facility Restriction Flag, effective 01/01/2023, flags cases that the central cancer registry may not be allowed to release for research and certain other types of uses due to the restrictions of the reporting facility. This data item is populated by the central registry.

Case data, regardless of the reporting facility, can be released for routine surveillance reporting to NCI, CDC, and NAACCR, for which all reportable tumor records are to be submitted. This item is used in combination with the data item *No Patient Contact Flag* (NAACCR Item #1854) to identify data that the registry may not be allowed to release.

Code	Description
00	No restrictions on release based on reporting facility. This code is assigned if the tumor record is only reported by a facility without potential restrictions on release of data (e.g., in-state hospital, physician offices, pathology lab). The code is also assigned if the tumor record is reported by both a facility without restrictions and a facility listed below that potentially has restrictions. For example, if an in-state hospital and a VHA facility report the same tumor, code 00 would be assigned upon consolidation.
01	OOS: Tumor records received only from Out of State (OOS) data exchange with another central registry
02	VHA: Tumor records received only from Veterans Health Administration (VHA)
03	DoD: Tumor records received only from Department of Defense (DOD)
04	VHA and OOS
05	DoD and OOS
06	DoD and VHA
07	DoD, VHA and OOS

Coding Instructions

- Code this data item using the most appropriate code. Blanks are not allowed regardless of diagnosis year.
 - This data item should always have a value for all diagnosis years. If there is no known restriction, assign code 00.
- Assign code 00 when codes 01-07 do not apply.
- Record the flag that best describes the reporting facility(ies) that have contributed to the case.
- Update the flag when additional reporting facilities contribute to the case.
- Work with software vendors to populate this data item for information previously captured in other fields and/or based on the reporting facilities contributing to the case.

Section IX

Administrative Codes

Each calendar year the SEER registries submit records to NCI for all persons/reportable neoplasms diagnosed since the registry started reporting to NCI. Many of these records have been updated with information received by the registry since the prior data submission. NCI edits the information to ensure correctness and comparability of reporting. Some of these edits identify 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 show that the information in a record has already been reviewed.

Site/Type Interfield Review

Item Length: 1

NAACCR Item #: 2030

NAACCR Name: Over-ride Site/Type

XML NAACCR ID: overrideSiteType

Site/Type Interfield Review (used by edits: IF25, IF25_3, IF510)

This data item is used to flag those cases where the primary site and histology are unusual.

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed as reported: The coding of an unusual combination of primary site and histologic type has been reviewed

Histology/Behavior Interfield Review**Item Length: 1****NAACCR Item #: 2040****NAACCR Name: Over-ride Histology****XML NAACCR ID: overrideHistology****Histology/Behavior Interfield Review (used by edits: IF31_3, Morph_P2, MorphICDO3_P1, MorphICDO3_P4)**

This data item is used to identify whether a case was reviewed and coding confirmed for those cases where the behavior code differs from the ICD-O-3 behavior code, i.e., ICD-O-3 only lists a behavior code of /3 and the case was coded /2, or the ICD-O-3 only lists behavior codes of /0 and /1 and the case is coded /3. It is also used to flag those cases that are in situ and not microscopically confirmed.

Code	Description
Blank	Not reviewed or reviewed and corrected
1	Reviewed and confirmed that the pathologist states the primary to be “in situ” or “malignant” although the behavior code of the histology is designated as “benign” or “uncertain” in ICD-O-2 or ICD-O-3 (flag for a “Morphology Type & Behavior” edit)
2	Reviewed and confirmed that the behavior code is “in situ,” but the case is not microscopically confirmed (flag for a “Diagnostic Confirmation, Behavior Code” edit)
3	Reviewed and confirmed that conditions 1 and 2 both apply

Age/Site/Histology Interfield Review

Item Length: 1

NAACCR Item #: 1990

NAACCR Name: Over-ride Age/Site/Morph

XML NAACCR ID: overRideAgeSiteMorph

Age/Site/Histology Interfield Review (used by edits: IF13, IF15, IF15_3, IF47, IF118, IF119, S011)

This data item is used to identify whether a case was reviewed and coding confirmed for those cases with an unusual site/histology combination for a given age-group.

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed that age/site/histology combination is correct as reported
2	Reviewed and confirmed that case was diagnosed in utero
3	Reviewed and confirmed that conditions 1 and 2 both apply

Sequence Number/Diagnostic Confirmation Interfield Review**Item Length: 1****NAACCR Item #: 2000****NAACCR Name: Over-ride SeqNo/DxConf****XML NAACCR ID: overRideSeqnoDxconf****Sequence Number/Diagnostic Confirmation Interfield Review (used by edit: IF23)**

This data item is used to identify whether a case was reviewed and coding confirmed for those cases where a patient has separate primary records and one of them has not been microscopically confirmed. The unconfirmed primary should be reviewed to determine whether it is a true primary or metastasis from a previous one.

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed as reported: Multiple primaries of special sites in which at least one diagnosis has not been microscopically confirmed have been reviewed

Site/Histology/Laterality/Sequence Interrecord Review**Item Length: 1****NAACCR Item #: 2010****NAACCR Name: Over-ride Site/Lat/SeqNo****XML NAACCR ID: overRideSiteLatSeqno****Site/Histology/Laterality/Sequence Number Interrecord Review (used by edits IR09, IR09_3)**

This data item is used to identify whether a case was reviewed and coding confirmed for cases having multiple primaries with the same histology and the same primary site. This review ensures that over-reporting does not happen.

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed as reported: Multiple primaries of the same histology (3 digit) in the same primary site group have been reviewed

Surgery/Diagnostic Confirmation Interfield Review**Item Length: 1****NAACCR Item #: 2020****NAACCR Name: Over-ride Surg/DxConf****XML NAACCR ID: overrideSurgDxconf****Surgery/Diagnostic Confirmation Interfield Review (used by edits: IF46 and IF76)**

This data item is used to identify whether a case was reviewed and coding confirmed for cases where the patient had surgery but the specimen was so small that it was not possible to confirm the diagnosis microscopically.

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed as reported: 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

Item Length: 1

NAACCR Item #: 2050

NAACCR Name: Over-ride Report Source

XML NAACCR ID: overRideReportSource

Type of Reporting Source/Sequence Number Interfield Review (used by edit: IF04_3)

This data item is used to identify whether a case was reviewed and coding confirmed for cases where the second or subsequent primary added to a patient's record was a Death Certificate Only (DCO) case. The DCO case should be reviewed to determine that it is not a metastasis from the prior primary.

Code	Description
Blank	Not reviewed, or reviewed, and corrected
1	Reviewed and confirmed as reported: A second or subsequent primary with a reporting source of death certificate only has been reviewed and is indeed an independent primary

Sequence Number/Ill-Defined Site Interfield Review

Item Length: 1

NAACCR Item #: 2060

NAACCR Name: Over-ride Ill-define Site

XML NAACCR ID: overRideIllDefineSite

Sequence Number/Ill-defined Site Interfield Review (used by edit: IF22_3)

This data item is used to identify whether a case was reviewed and coding confirmed when a subsequent primary has an ill-defined primary site code. The ill-defined site should be reviewed to determine that it is not the same as a previous tumor.

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed as reported: A second or subsequent primary reported with an ill-defined primary site (C760-C768, C80.9) has been reviewed and is an independent primary

Leukemia or Lymphoma/Diagnostic Confirmation Interfield Review**Item Length: 1****NAACCR Item #: 2070****NAACCR Name: Over-ride Leuk, Lymphoma****XML NAACCR ID: overRideLeukLymphoma****Leukemia or Lymphoma/Diagnostic Confirmation Interfield Review (used by edits: IF48 and IF48_3)**

This data item is used to identify whether a case was reviewed and coding confirmed for leukemia or lymphoma cases that have not been microscopically confirmed.

IF48 identifies lymphoma cases with a diagnostic confirmation code of 6 (direct visualization) or 8 (clinical), and leukemia cases with a diagnostic confirmation code of 6 (direct visualization).

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed as reported: A patient was diagnosed with leukemia or lymphoma and the diagnosis was not microscopically confirmed

Over-ride Flag for Name/Sex Assigned at Birth**Item Length: 1****NAACCR Item #: 2078****NAACCR Name: Over-ride Name/Sex****XML NAACCR ID: overRideNameSex****Over-ride Flag for Name/Sex Assigned at Birth**

Over-ride Flag for Name/Sex Assigned at Birth, effective 01/01/2018, does not allow extremely rare or nonexistent combinations of first name and sex, such as John/female. Edits do not apply to this data item as registries use this internally and it is not transmitted to SEER.

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed as reported

Over-ride Flag for Sex Assigned at Birth

Item Length: 1

NAACCR Item #: 2079

NAACCR Name: Over-ride Sex Assigned at Birth

XML NAACCR ID: overrideSexAssignedAtBirth

Over-ride Flag for Sex Assigned at Birth

Over-ride Flag for Sex Assigned at Birth, effective 01/01/2027, does not allow extremely rare or nonexistent combinations of primary site and sex, such as prostate/female.

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed as reported

Over-ride Flag for Site/Behavior (IF39)**Item Length: 1****NAACCR Item #: 2071****NAACCR Name: Over-ride Site/Behavior****XML NAACCR ID: overRideSiteBehavior****Over-ride Flag for Site/Behavior (Interfield Edit 39) (used by edit: IF39_3)**

This data item is used to identify whether a case was reviewed and coding confirmed for cases where the behavior is coded to a /2 and the primary site is nonspecific, such as female genital tract, NOS.

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed as reported: A patient has an in situ cancer of a nonspecific site and no further information about the primary site is available

The IF39 edit does not allow in situ cases of nonspecific sites, such as gastrointestinal tract, NOS; uterus, NOS; female genital tract, NOS; male genital organs, NOS; and others. This over-ride indicates that the conflict has been reviewed.

This was a new over-ride flag in the third edition of the code manual, but the flag may be applied to cases from any year.

Over-ride Flag for Site/EOD/Diagnosis Date (IF40)**Item Length: 1****NAACCR Item #: 2072****NAACCR Name: Over-ride Site/EOD/DX Dt****XML NAACCR ID: overRideSiteEodDxDt****Over-ride Flag for Site/EOD/Diagnosis Date (used by edits: IF40_3 and IF176)**

This data item is used to identify whether a case was reviewed and coding confirmed for cases where the patient has a localized disease with the primary site coded to a non-specific site, like colon, NOS.

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed as reported: A patient had “localized” disease with a non-specific site and no further information about the primary site is available

The IF40 and IF176 edits do not allow “localized” disease with non-specific sites, such as mouth, NOS; colon, NOS (except histology 8220); bone, NOS; female genital system, NOS; male genital organs, NOS; and others. This over-ride indicates that the conflict has been reviewed.

This was a new over-ride flag in the third edition of the code manual, but the flag may be applied to cases from any year.

Over-ride Flag for Site/Laterality/EOD (IF41)**Item Length: 1****NAACCR Item #: 2073****NAACCR Name: Over-ride Site/Lat/EOD****XML NAACCR ID: overRideSiteLatEod****Over-ride Flag for Site/Laterality/EOD (Interfield Edit 41) (used by edits: IF41_3 and IF177)**

This data item is used to identify whether a case was reviewed and coding confirmed for cases with a non-specific laterality code.

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed as reported: A patient had laterality coded non-specifically and extension coded specifically

The IF41 and IF177 edits for paired organs do not allow EOD/CS Extension to be specified as in situ, localized, or regional by direct extension if laterality is coded as “bilateral, side unknown,” or “laterality unknown.” This over-ride indicates that the conflict has been reviewed.

This was a new over-ride flag in the third edition of the code manual, but the flag may be applied to cases from any year.

Over-ride Flag for Site/Laterality/Morphology (IF42)**Item Length: 1****NAACCR Item #: 2074****NAACCR Name: Over-ride Site/Lat/Morph****XML NAACCR ID: overRideSiteLatMorph****Over-ride Flag for Site/Laterality/Morphology (Interfield Edit 42) (used by edit: IF42_3)**

This data item is used to identify whether a case was reviewed and coding confirmed for paired-organ primary site cases with an in situ behavior and the laterality is not coded right, left, or one side involved, right or left origin not specified.

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed as reported: A patient had behavior code of in situ and laterality is not stated as right: origin of primary; left: origin of primary; or only one side involved, right or left origin not specified

The IF42 edit does not allow behavior code of in situ with non-specific laterality codes. This over-ride indicates that the conflict has been reviewed.

This was a new over-ride flag in the third edition of the code manual, but the flag may be applied to cases from any year.

Over-ride Flag for TNM Tis

Item Length: 1**NAACCR Item #: 1993****NAACCR Name: Over-ride TNM Tis****XML NAACCR ID: overRideTnmTis**

Over-ride Flag for TNM Tis (used by edit IF623)

This data item, effective 01/01/2018, is used to identify whether a case was reviewed and coding confirmed for a T value of in situ/noninvasive, but N, M, and/or stage group indicates invasive disease. There are certain circumstances where AJCC does allow a T value indicating in situ/noninvasive and N, M, and/or stage group that indicates invasive disease. An over-ride is required to accommodate these situations. This over-ride will allow registrars to enter combination of T, N, and M with a stage group that differs from the combinations documented in the AJCC Staging Manual.

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed as reported

Over-ride Flag for Site/TNM-Stage Group

Item Length: 1**NAACCR Item #: 1989****NAACCR Name: Over-ride Site/TNM-StgGrp****XML NAACCR ID: overrideSiteTnmStggrp****Over-ride Flag for Site/TNM-Stage Group (used by edits: IF506, IF507, IF508, IF509, IF610, IF611, IF613)**

This data item, effective 01/01/2018, indicates whether a case was reviewed and coding confirmed for pediatric cases not coded according to the AJCC manual. Pediatric Stage groups should not be recorded in the TNM Clinical Stage Group or TNM Pathologic Stage Group items. When neither clinical nor pathologic AJCC staging is used for pediatric cases, code all AJCC items 88. When any components of either is used to stage a pediatric case, follow the instructions for coding AJCC items and leave Over-ride Site/TNM-Stage Group blank.

Code	Description
Blank	Not reviewed, or reviewed and corrected
1	Reviewed and confirmed as reported: case is confirmed to be a pediatric case that was coded using a pediatric coding system