WASHINGTON STATE DEPARTMENT OF HEALTH

2025 Washington State Cancer Registry Reporting Handbook

Washington State Department of HEALTH

WSCR Washington State CANCER REGISTRY

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**DO NOT use email to send documents containing confidential information. Use the WSCR secure fax or WebPlus. **

General Information

Background

In 1990, the Revised Code of Washington (RCW 70.54.230) made cancer a reportable condition and mandated the Department of Health to establish a statewide cancer registry program. Under this mandate, the Department of Health established the Washington State Cancer Registry (WSCR) in 1991 with the collection of cancer data beginning January 1, 1992. The registry is dedicated to the fulfillment of the legislative intent "...to establish a system to accurately monitor the incidence of cancer in the state of Washington for the purposes of understanding, controlling and reducing the occurrence of cancer in this state." In 1995, WSCR received funding through the Centers for Disease Control and Prevention's National Program of Cancer Registries.

Mission

The mission of the Washington State Cancer Registry (WSCR) is to collect and disseminate high-quality statewide cancer data for use by public health agencies, health care providers, voluntary organizations, researchers, and academic institutions in their efforts to prevent and control cancer in Washington State.

Administration

The Washington State Cancer Registry is part of the Washington State Department of Health, Prevention and Community Health Division, Office of Healthy & Safe Communities, Community Based Prevention Section.

Cancer data for the state of Washington is collected primarily from hospital registries, private physicians, treatment centers, ambulatory surgery centers, and pathology laboratories. In addition, the Washington State Cancer Registry contracts with the Cancer Surveillance System (CSS) at the Fred Hutchinson Cancer Center to collect population-based data on cancer incidence and survival from 13 counties in western Washington. CSS is part of the Surveillance, Epidemiology and End Results (SEER) program at the National Cancer Institute.

The US Census Bureau showed an estimated 2025 population of Washington State to be approximately 7.9 million. The American Cancer Society shows that an estimated average of 46,500 new cancer cases will be reported in Washington State in 2025.

Purpose

The purpose of WSCR is to identify and gather information from a variety of reporting sources throughout the state to monitor cancer trends over time, determine cancer patterns in various populations, plan and evaluate cancer prevention and control, help set priorities for allocating health resources, and assist with the advancement of clinical, epidemiologic, and health services research.

Every year the state submits its data to the National Program of Cancer Registries (NPCR) and the North American Association of Central Cancer Registries (NAACCR).

Goals

- To collect data in a timely, accurate and efficient manner.
- Ensure the validity and reliability of the data through ongoing quality assurance activities.
- Utilize data from public health surveillance to support decision-making processes in cancer prevention and control.
- Make WSCR data and reports readily available to all parties or agencies interested or involved in accomplishing the registry's mission.
- Identify additional opportunities to promote WSCR data usage both within the state and beyond its borders.
- Assist all entities reporting to WSCR with updated data collection and reporting requirements.

Partnerships

Washington State Cancer Registry works closely with two other CDC funded Cancer Programs, Comprehensive Cancer Control and the Breast Cervical and Colon Health Program. The Breast Cervical and Colon Health Program provides free breast and cervical cancer screening to eligible people in Washington State. Eligibility for BCCEDP is primarily based on health insurance status, income, and age. The Washington State Department of Health administers the program through grants from CDC and state funding. The department contracts with six regional organizations throughout the state, known as Prime Contractors, who operate the programs within their local regions. The Comprehensive Cancer Control Program is dedicated to organizing partnerships and implementing evidence-based interventions that reduce the cancer burden in Washington State. The programs' main priorities include strategies to address primary prevention, early detection, and screening, supporting survivors, and addressing health equity. Some areas of work include increasing HPV vaccination rates, decreasing commercial tobacco use, increasing CRC screening rates, and strengthening provider skills in caring for survivors. Comprehensive Cancer Control is also working closely with diverse partners to relaunch a state-wide Cancer Coalition guided by a new 5-Year Cancer Plan.

Cancer Action Plan of Washington

Statewide Coalition and 5-Year Strategic Plan

The Comprehensive Cancer Control Program at WA Department of Health, alongside Fred Hutch Cancer Center, American Cancer Society, Andy Hill CARE Fund, and other key stakeholders have re-launched a statewide cancer coalition called the Cancer Action Plan of Washington (CAPOW) that is guided by a strategic 5-Year Plan. This coalition brings together any partners working to prevent cancer, increase screening rates, support survivors, and those interested in engaging in activities or goals outlined in the plan to reduce the burden of cancer in Washington. Comprehensive Cancer Control worked closely with the Washington State Cancer Registry to utilize data throughout the plan that describes the current cancer burden in WA and provides numerous measurements for goals included in the 5-Year Plan. Each year the coalition will use data from the Washington State Cancer Registry to evaluate these objectives identified by the plan, report on progress, and make recommendations for future work. This plan will be implemented by all partners associated with the coalition and can act as a roadmap to help inform the work done by any health jurisdiction, community-based organization, provider, health care system, health insurer, policy maker, employer, or professional organization. To join the coalition, read the plan, or find out more information, click on the following link to see their website: Cancer Action Plan of Washington.

Cancer Action Plan of Washington

Statewide Coalition

Washington State Cancer Registry Advisory Committee

The Washington State Cancer Registry (WSCR) Advisory Committee is a multidisciplinary committee that advises and advocates for the state central cancer registry. The committee will guide the registry to strengthen its policies, procedures, systems, data quality, partnerships, public visibility, and awareness of cancer registry data. Accomplishing this will improve the effectiveness of registry activities, increase understanding about the role of the registry, and ensure the registry is supported as a valuable cancer prevention and control resource for the Washington State Department of Health (DOH).

HIPPA Laws & Patient Privacy

HIPPA 1996 and the Washington State Cancer Registry

There is a public health surveillance exemption clause[i] to the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA) that applies to state cancer registries. This exemption clause allows disclosure of certain protected health information. State cancer registries are a Public Health Authority under HIPPA and according to federal law and state statutes, Washington State Cancer Registry staff may collect or receive individually identifiable health information as a Public Health Authority to "monitor the incidence of cancer in the state and report applicable limited data according to federal requirements." For more information, please visit: HIPAA Resources for Cancer Registries

Case information received by the Washington State Cancer Registry is restricted and highly confidential. All research projects go through an extensive Washington State Institutional Review Board (WSIRB) process. The WSIRB protects the rights and welfare of individuals in accordance with state and federal law. Information on patient age, sex, county of residence, cancer type and treatment are generally accessible as aggregate statistical data to the public. Patient names, social security numbers, physicians, facility names and other personal identifiers are confidential.

For more information on the Washington State Institutional Review Board, please visit: *Human Research Review Section | DSHS (wa.gov)*.

ICD-10-CM Casefinding Lists

ICD-10-CM Casefinding List, 2023

https://seer.cancer.gov/tools/casefinding/icd-10-cm-casefinding-list.20230403.pdf

Effective dates: 10/1/2022 – 9/30/2023

ICD-10-CM Casefinding List, 2024

https://seer.cancer.gov/tools/casefinding/icd-10-cm-casefinding-list.20231005.pdf

Effective dates: 10/1/2023 – 9/30/2024

ICD-10-CM Casefinding List, 2025

https://seer.cancer.gov/tools/casefinding/icd-10-cm-casefinding-list.20240924.pdf

Effective dates: 10/1/2024 – 9/30/2025

General Case Ascertainment Information

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 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.

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

                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.

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 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 biopsy was performed to further evaluate the suspicious stereotactic biopsy finding. The suspicious diagnosis was proven false.

Example 4: Esophageal biopsy with diagnosis of "focal areas suspicious for adenocarcinoma in situ." Diagnosis on partial esophagectomy specimen "with foci of high-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 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 used 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.

Ambiguous Terms at Diagnosis

As part of the registry casefinding activities, all diagnostic reports should be reviewed to confirm whether a case is required. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included. Words or phrases that appear to be synonyms of these terms do not constitute a diagnosis. For example, "likely" alone does not constitute a diagnosis. Words in parenthesis are optional.

Ambiguous Terms that Constitute a Diagnosis	
Apparent(ly)	Presumed
Appears	Probable
Comparable with	Suspect(ed)
Compatible with	Suspicious (for)
Consistent with	Tumor* (beginning with 2004 diagnoses and only for C70.0 – C72.9, C75.1 – C75.3)
Favors	Typical of
Malignant appearing	
Most likely	
Neoplasm* (beginning with 2004 diagnoses and only for C70.0 – C72.9, C75.1 – C75.3_	

*Additional terms for nonmalignant primary intracranial and central nervous system tumors only

Exception: If cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer. The case would be abstracted only when a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Examples of Diagnostic Terms:

- The inpatient discharge summary documents a chest x-ray *consistent with carcinoma* of the right upper lobe. The patient refused further work-up or treatment. *Consistent with carcinoma* is indicative of cancer.
- The pathology report states *suspicious for malignancy*. *Suspicious for malignancy* is indicative of cancer.

Ambiguous Terms That *Do Not* Constitute a Diagnosis *without additional information*	
Cannot be ruled out	Questionable
Equivocal	Rule out
Possible	Suggests
Potentially malignant	Worrisome

Examples of Nondiagnostic Terms:

- The inpatient discharge summary documents a chest x-ray consistent with neoplasm of the right upper lobe. The patient refused further work-up or treatment. Consistent with neoplasm is not indicative of cancer. While "consistent with" can indicate involvement, "neoplasm" without specification of malignancy is not diagnostic except for non-

malignant primary intracranial and central nervous system tumors.

- Final diagnosis is reported as possible carcinoma of the breast. Possible is not a diagnostic term for cancer.

Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only and do not constitute a diagnosis.

Ambiguous Terminology Lists: References of Last Resort

The section clarifies the use of Ambiguous Terminology as listed in STORE 2018 for case reportability 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, the list 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 list 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, as a result, the Ambiguous Terminology list delineated above must be used in CoC-accredited programs as "references of last resort."

Class of Case

All accessioned cases are assigned a *Class of Case* [610] based on the nature of involvement of the facility in the care of the patient.

Analytic Cases

Cases diagnosed and/or administered any of the first course of treatment at the accessioning facility are analytic *(Class of Case 00-22)*. The CoC is aligned with the Federal Employer Tax ID (FEIN) for your hospital/facility. Any services of facility covered under your FEIN would then be covered under your CoC accreditation and you would be responsible for reporting the associated data that is reportable as defined in the STORE Manual. Generally, any facility/service included in your FEIN is included with your accreditation and therefore reportable to NCDB. You may also submit data from associated physician offices, outpatient or ambulatory centers/clinics, or other entities that share a FEIN, are owned and operated by your accredited facility, or are otherwise covered by your facility's American College of Surgeons Business Associate/Data Use Agreement.

Analytic cases *Class of Case* 10-22 are included in treatment and survival analysis.
Analytic cases *Class of Case* 00 are not required to be staged or followed, regardless of the year of diagnosis. *Class of Case* 00 is reserved for patients who are originally diagnosed by the reporting facility and receive all of their treatment elsewhere or a decision not to treat is made elsewhere. If the patient receives no treatment, either because the patient refuses recommended treatment or a decision is made not to treat, the *Class of Case* is 14. If there is no information about whether or where the patient was treated, the *Class of Case* is 10.

Nonanalytic Cases

Nonanalytic cases (*Class of Case* 30-99) are not usually included in routine treatment or survival statistics. The CoC does not require registries in accredited programs to accession, abstract, or follow these cases, but the program or central registry may require them.

Class of Case
(NAACCR Item #610)

Description

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 treatment. Nonanalytic 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. Nonanalytic 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.

Explanation

Class of Case reflects the facility's role in managing the cancer and whether the cancer is required to be reported by CoC.

Coding Instructions

- Code the Class of Case that most precisely describes the patient's relationship to the facility.
- Code 00 applies only when it is known the patient went elsewhere for treatment. If it is not known that the patient actually went somewhere else, code Class of Case 10.
- It is possible that information for coding Class of Case will change during the patient's first course of care. If that occurs, change the code accordingly.
- Document NPI-Institution Referred To [2425] or the applicable physician NPI (NAACCR #s 2485, 2495, 2505) for patients coded 00 to establish that the patient went elsewhere for treatment.
- Code 34 or 36 if the diagnosis benign or borderline (Behavior 0 or 1) for any site is diagnosed before 2004 or for any site other than meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of central nervous system (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3) that was diagnosed in 2004 or later.
- Code 34 or 36 for carcinoma in situ of the cervix (CIS) and intraepithelial neoplasia grade III (8077/2 or 8148/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III).
- Physicians who are not employed by the hospital but are under contract with it or have routine admitting privileges there are described in coded 10-12 and 41 as physicians with admitting privileges. Treatment provided in the office of a physician with admitting privileges is provided "elsewhere". That is because care given in the physician's office is

not within the hospital's realm of responsibility.

- If the hospital purchases a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved have routine admitting privileges or not, as with any other physician.
- "In-transit" care is care given to a patient who is temporarily away from the patient's usual practitioner for continuity of care. If these cases are abstracted, they are Class of Case 31. Monitoring of oral medication started elsewhere is coded Class of Case 31. If a patient begins first course radiation or chemotherapy infusion elsewhere and continues at the reporting facility, and the care is not in-transit, then the case is analytic (Class of Case 21).
- First course maintenance treatment provided at the reporting facility prior to disease progression or recurrence is reportable IF the maintenance treatment is part of first course treatment plan and is provided by reported facility with documentation or prescription/administration. For example, if a patient is diagnosed and treated at another facility per the treatment plan was started on hormone therapy at the other facility then presents to your facility for continuation of hormone therapy the continuation of hormone therapy by your facility must be documented in medical record to assign class of case 21 (part of first course treatment elsewhere, part of first course of treatment at the reporting facility). This applies even if there is no longer active disease.

Code	Label
Analytic Classes of Case (Required by CoC to be abstracted by accredited programs)	
Initial diagnosis at reporting facility or in a staff physician's office	
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
11	Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility
12	Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility
13	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility
Initial diagnosis elsewhere	
20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere

22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility
Code	**Label**
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	
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere)
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement)
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease)
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active)
34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility
35	Case diagnosed before 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	
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 difference 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 or diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43	Pathology or other lab specimens only
49	Death certificate only
99	Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).

Laterality

Laterality [410] must be recorded for the following paired organs as 1-5 or 9. Organs that are not paired, unless they are recorded "right" or "left" laterality, are coded 0. When the primary site is unknown (C80.9), code 0. Midline origins are coded 5. "Midline" in this context refers to the point where the "right" and "left" sides of paired organs come into direct contact and a tumor forms at that point. Most paired sites cannot develop midline tumors. For example, skin of the trunk can have a midline tumor, but the breasts cannot.

Paired Organ Sites	
ICD-O-3	**Site**
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.1 - C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bones of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face
C44.4	Skin of Scalp and Neck
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C50.0 - C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0 - C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0 - C69.9	Eye and lacrimal gland

C70.0	Cerebral meninges, NOS
C71.0	Cerebrum
C71.1	Frontal lobe
C71.2	Temporal lobe
C71.3	Parietal lobe
C71.4	Occipital lobe
C72.2	Olfactory nerve
C72.3	Optic nerve
C72.4	Acoustic nerve
C72.5	Cranial nerve, NOS
C74.0 - C74.9	Adrenal gland
C75.4	Carotid body

Laterality
(NAACCR Item #410)

Description

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

Explanation

Laterality supplements stating and extent of disease information and defines the number of primaries involved.

Coding Instructions

- Code laterality for all paired sites.
- Do not code metastatic sites as bilateral involvement.
- Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites 0.
- Code 9 for Death Certificate Only

Code	Label
0	Organ is not a paired site.
1	Origin of primary is right.
2	Origin of primary is left.
3	Only one side involved, right or left origin not specified.
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries are involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5	Paired site: midline tumor
9	Paired site, but no information concerning laterality.

Treatment

First Course of Treatment

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. "Active surveillance" is a form of planned treatment for some patients; its use is coded in the *RX Summ – Treatment Status* [1285]. "No therapy" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, the physician recommends no treatment be given, or the physician recommends palliative care for pain management only. If the patient refuses all treatment, code "patient refused" (code 7 or 87) for all treatment modalities. Maintenance treatment given as part of the first course of planned care (for example, for leukemia) is first course treatment, and cases receiving that treatment are analytic. If the first course of treatment plan changes due to an improvement in the tumor burden, the added treatment would still be considered first course.

Treatment Plan

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

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

Time Periods for First Course of Treatment

If first course treatment was provided, the *Date of First Course of Treatment* [1270] is the earliest of *Date of First Surgical Procedure* [1200], *Date Radiation Started* [1210], *Date Systemic Therapy Started* [3230], or *Date Other Treatment Started* [1250].

- If no treatment is given, record the date of the decision not to treat, the date of patient refusal, or the date the patient expired if the patient died before treatment could be given.
- If active surveillance ("watchful waiting") was selected, record the date of that decision.
- Data item, *RX Summ-Treatment Status* [1285], implemented in 2010, summarizes whether the patient received any first course treatment, no treatment, or is being managed by active surveillance.

All Malignancies except Leukemias

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

Leukemias

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

Surgery

First course surgery items describe the most definitive type of surgical treatment the patient received from any facility, when it was performed, and its efficacy. When no surgical treatment is given, the reason is recorded.

Rx Summ – Surg 2023 [1291], *Scope of Regional Lymph Node Surgery* [1292], *and Surgical Procedure/Other Site* [1294] record three distinct aspects of first course therapeutic surgical procedures that may be performed during one or multiple surgical events. If multiple primaries are treated by a single surgical event, code the appropriate surgical items separately for each primary.

Rx Summ – Surg 2023 [1291] is a site-specific item that describes the most invasive extent of local tumor destruction or surgical resection of the primary site and of surrounding tissues or organs that are removed in continuity with the primary site.

Scope of Regional Lymph Node Surgery [1292] (excluding code 1) describes the removal, biopsy, or aspiration of sentinel nodes and other regional lymph nodes that drain the primary site and may include surgical procedures to aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease as well as removal of nodes for treatment of the disease.

Surgical Procedure/Other Site [1294] describes first course resection of distant lymph node(s) and/or regional or distant tissue or organs beyond the Surgical Procedure of the Primary Site range.

If surgery of the respective type was performed, the code that best describes the surgical procedure is recorded whether or not any cancer was found in the resected portion.

Scope of Regional Lymph Node Surgery [1292] distinguishes between sentinel lymph node biopsy and removal of other regional lymph nodes and distinguishes removal of regional lymph nodes during the same surgical procedure as a sentinel node biopsy from subsequent removal.

Surgical Procedure/Other Site [1294] describes surgery performed on tissues or organs other than the primary site or regional lymph nodes. It is also used to describe whether surgery was performed for tumors having unknown or ill-defined primary sites or hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease morphologies. If any surgical treatment was

performed on these cancers, *Surgical Procedure/Other Site* is coded 1.

Radiation Therapy

The radiation items in STORE are clinically relevant and reflect contemporary practice. These items record new "phase" terminology, replacing the traditional terms of "regional" and "boost." The first phase (Phase I) of a radiation treatment may be commonly referred to as an initial plan and a subsequent phase (Phase II) may be referred to as a boost or cone down. 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 represents the radiation prescription that has actually been delivered (as sometimes the intended prescription differs from the delivered prescription).

The details of the radiation course can typically be found in the radiation oncologist's radiation treatment summary.

Phases can be delivered sequentially or simultaneously. In sequential phases, a new phase begins when there is a change in the anatomic target volume or a body site, treatment fraction size, modality, or technique.

When phases are delivered simultaneously, this is sometimes referred to as "dose painting" or "simultaneous integrated boost (SIB)". If multiple phases start on the same date, then summarize in order from highest 'Total Phase Dose' to lowest 'Total Phase Dose'. If multiple phases start on the same date and have the same Total Phase Dose, then any order is acceptable.

Systemic Therapy

Systemic therapy encompasses the treatment modalities captured by the item's chemotherapy, hormone therapy, and immunotherapy. The systemic therapy items in FORDS/STORE separate the administration of systemic agents or drugs from medical procedures which affect the hormonal or immunologic balance of the patient.

Clarification of Systemic Therapy Terms	
Term	**Definition**
Chemotherapy	Cancer therapy that achieves its antitumor effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis. (i.e. gemcitabine, etoposide, capecitabine)
Hormone Therapy	Cancer therapy that achieves its antitumor effect through changes in hormonal balance. This type of therapy includes the administration of hormones, agents acting via hormonal mechanisms, antihormones, and steroids. (i.e. leuprolide, acetate, levothyroxine sodium, anastrozole)
Immunotherapy	Cancer therapy that achieves its antitumor effect by altering the immune system or changing the host's response to the tumor cells. (i.e. panitumumab, rituximab, ramucirumab)

Endocrine Therapy	Cancer therapy that achieves its antitumor effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient (when the cancer occurs at another site) and therefore alter or affect the long-term control of the cancer's growth. (i.e. oophorectomy, orchiectomy performed for the purposes of hormonal suppression)
Hematologic Transplants	Bone marrow or stem cell transplants performed to protect patients from myelosuppression or bone marrow ablation associated with the administration of high-dose chemotherapy or radiation therapy. (i.e. stem cell harvest, bone marrow autologous transplant, umbilical cord stem transplant)

Chemotherapy or hormone therapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more drugs. If a patient has an adverse reaction, the managing physician may change one of the agents in a combination regimen. If the replacement agent belongs to the same subcategory as the original agent, there is no change in the regimen. However, if the replacement agent is of a different subcategory than the original agent, the new regimen represents the start of subsequent therapy, *only the original agent or regimen is recorded as first course therapy*. Refer to the SEER*Rx Interactive Drug Database for a list of systemic therapy agents. This rule does not apply for hormone therapy. If a change is made from Tamoxifen to Arimidex this is still all first course of treatment.

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

Other Treatment

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

This item is also used for supportive care treatment for reportable hematopoietic disease that do not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Treatments such as phlebotomy, transfusions, and aspirin are recorded in *Other Treatment* data item for certain hematopoietic disease and should be coded 1. Consult the most recent version of the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual for instructions for coding care of specific hematopoietic neoplasms in this item.

Palliative Care

Palliative care is provided to prolong the patient's life by controlling symptoms, to alleviate persistent pain, or to make the patient comfortable. Palliative care provided to relieve symptoms may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or other pain management therapy. Palliative care is not used to diagnose or stage the primary tumor.

Any surgical procedure, radiation therapy, and/or systemic therapy that is provided to modify, control,

remove, or destroy primary or metastatic cancer tissue, is coded in the respective first course of treatment fields and can also be identified in the *Palliative Care* items. Because these treatments are less aggressive when given for palliation than for treatment, the treatment plan or treatment notes will indicate when they are performed for palliative purposes.

- Record as palliative care any of the treatment recorded in the first course therapy items that was provided to prolong the patient's life by managing the patient's symptoms, alleviating pain, or making the patient more comfortable. This includes care received during hospice.
- Palliative care can involve pain management that may not include surgery, radiation, or systemic treatment.
- It is possible for a patient to receive one or a combination of treatment modalities in conjunction with palliative care intended to reduce the burden of pain. For example, a patient with metastatic prostate cancer may receive an orchiectomy and systemic hormone therapy in combination with palliative radiation for bone metastasis.

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. Frist 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 liver cancer. Code the mastectomy, chemotherapy, and radiation as first course 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 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 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 does 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 affects/treats another 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 lymph 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 Project - SEER Registrars

Death Clearance

Death Certificate Clearance Overview

The Washington State Cancer Registry conducts Death Clearance on an annual basis by following the North American Association of Central Cancer Registries guidelines for conducting death clearance. You can find a complete overview, explanation, and minimum guidelines for conducting death clearance in the Death Clearance Manual on the NAACCR website: https://www.naaccr.org/wp-content/uploads/2023/05/NAACCR_Death-Clearance_Manual-4-23-FINAL.pdf

Explained in this section are specific practices and procedures that may be unique to our registry.

We perform a manual review of all vital statistics records and use the information to update matching cases in our database. To ensure accurate incidence reporting, we perform follow back on death file records that indicate cancer as a cause of death for the individuals listed in the master death file who are not in our database. We also perform follow-back on record matches that list a type of cancer not previously captured in our database to ensure the individual did not develop additional reportable cancers. Our registry only performs follow-back on cases that are not part of the 13-county western Washington NCI-SEER region.

Follow-Back Procedures

The registry will send a letter to the certifying physician indicated in the death file requesting information on patients that died of cancer but were not captured in our database.

We use the information received from the certifying physician to determine whether the case is reportable and requires additional follow-up with other physicians and treatment centers. Based on the information received from the facilities, cases are either abstracted as Death Certificate Only (DCO) cases, (if no further information can be provided) physician cases, or full incidence cases. If we do not receive follow-back information before the completion of death clearance, we update and enter the case information into our database as soon as the data becomes available.

Demographics

Patient Address and Residency Rules

The patient's address at diagnosis is the patient's place of residence at the time of original diagnosis. It does not change if the patient moves. If the patient has more than one primary tumor, the address at diagnosis may be different for each primary tumor.

The current address initially is the patient's residence at the time the patient was first seen at the accessioning facility for this primary. The current address is updated if the patient moves. If the patient has more than one primary tumor, the current address should be the same for each primary. Normally a residence is the home named by the patient. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with the rules of the Census Bureau's definition, "the place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home." State Vital Statistics rules may differ from Census rules. Do not record residence from the death certificate. Review each case carefully.

Rules for Persons with Ambiguous Residences

Persons with More than One Residence (summer and winter homes): Use the address the patient specifies if a usual residence is not apparent.

Persons with No Usual Residence (transients, homeless): Use the address of the place the patient was staying when the cancer was diagnosed. This location may be a shelter or the diagnosing facility.

Persons Away at School: College students are residents of the school area. Boarding school students below the college level are residents of their parents' homes.

Persons in Institutions: The Census Bureau states, "Persons under formally authorized, supervised care or custody" are residents of the institution. This classification includes the following:

- Incarcerated persons
- Persons in nursing, convalescent, and rest homes
- Persons in home, schools, hospitals, or wards for the physically disabled, mentally retarded, or mentally ill.
- Long-term residents of other hospitals, such as Veterans Affairs (VA) hospitals.

Person in the Armed Forces and on Maritime Ships: Members of the armed forces are residents of the installation area. Use the stated address for military personnel and their families. Military personnel may use installation address or the surrounding community's address. The Census Bureau has detailed residency rules for Navy personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for the detailed rules.

City/Town at Diagnosis (City or Town)
(NAACCR Item #70)

Description

Identifies the name of the city or town in which the patient resides at the time the tumor is diagnosed and treated.

Explanation

The city or town is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Coding Instructions

- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.
- If the patient has multiple malignances, the city or town may be different for subsequent primaries.
- Do not update this data item if the patient's city or town of residence changes.
- See Residency Rules for further instructions.

Examples

Code	Reason
CITY NAME	Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting. Abbreviate where necessary.
UNKNOWN	If the patient's city or town is unknown.

State at Diagnosis-- (State)

(NAACCR Item #80)

Description

Identifies the patient's state of residence at the time of diagnosis.

Explanation

The state of residence is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Coding Instructions

- Use U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province or territory in which the patient resides at the time the tumor is diagnosed and treated.
- If the patient has multiple tumors, the state of residence may be different for subsequent primaries.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
- Do not update this data item if the patient's state of residence changes.

Code	Label	Code	Label	Code	Label
AL	Alabama	MB	Manitoba	PW	Palau
AK	Alaska	MH	Marshall Islands	PA	Pennsylvania
AB	Alberta	MD	Maryland	PE	Prince Edward Island
AS	American Samoa	MA	Massachusetts	PR	Puerto Rico
AA	APO/FPO Armed Services America	MI	Michigan	QC	Quebec
AE	APO/FPO Armed Serviced Europe	FM	Micronesia	ZZ	Residence Unknown
AP	APO/FPO Armed Services Pacific	MN	Minnesota	XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is *known*.

AZ	Arizona	MS	Mississippi	YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is un*known*.
AR	Arkansas	MO	Missouri	CD	Resident of Canada and the province is *unknown*.
BC	British Columbia	MT	Montana	US	Resident of the U.S. (including its territories, commonwealths, or possessions) and the state is *unknown*.
CA	California	NE	Nebraska	RI	Rhode Island
CD	Canada, province unknown	NV	Nevada	SK	Saskatchewan
CO	Colorado	NB	New Brunswick	SC	South Carolina
CT	Connecticut	NH	New Hampshire	SD	South Dakota
DE	Delaware	NJ	New Jersey	US	United States, state unknown
DC	District of Columbia	NM	New Mexico	TN	Tennessee
FL	Florida	NY	New York	TX	Texas
GA	Georgia	NL	Newfoundland and Labrador	UT	Utah
GU	Guam	NC	North Carolina	VT	Vermont
HI	Hawaii	ND	North Dakota	VI	Virgin Islands
ID	Idaho	NT	Northwest Territories	VA	Virginia
IL	Illinois	NS	Nova Scotia	WA	Washington
IN	Indiana	NU	Nunavut	WV	West Virginia
IA	Iowa	OH	Ohio	WI	Wisconsin
KS	Kansas	OK	Oklahoma	WY	Wyoming
KY	Kentucky	ON	Ontario	YT	Yukon
LA	Louisiana	OR	Oregon		
ME	Maine	UM	Outlying Islands		

Postal Code at Diagnosis (ZIP Code)
(NAACCR Item #100)

Description

Identifies the postal code of the patient's address at diagnosis.

Explanation

The postal code is part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies.

Coding Instructions

- For U.S. residents, record the patient's nine-digit extended postal code at the time of diagnosis and treatment.
- For Canadian residents, record the six-character postal code.
- When available, record the postal code for other countries.
- If the patient has multiple malignancies, the postal code may be different for subsequent primaries.
- Do not update this data item if the patient's postal code changes.
- See Residency Rules for further instructions.

CODE	DESCRIPTION
(fill spaces)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
60611_ _ _ _	When the nine-digit extended US Zip Code is not available, record the five-digit zip code 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 zip code is unknown.
99999 _ _ _ _ or 999999999	Permanent address in Canada, United States, or U.S. possession and postal code is unknown.

Address at Dx - Country
(NAACCR Item #102)

Description

Identifies the country of the patient's residence at the time of diagnosis. The codes are based on International Organization for Standardization (ISO) 3166-1 alpha-3 country codes, with some custom codes.

Explanation

The country code is part of the patient's demographic data and has multiple uses. If may be useful for understanding risk factors, assessment of patient prognosis, and chances for survival.

Coding Instructions

- This item corresponds to the other Addr at DX items (state, postal code).
- Do not change if the patient moves to another country. Patients with more than one tumor may have different countries at diagnosis, however.
- See Appendix C in the STORE Manual for a list of country codes and their respective state codes.
- This item was first defined for use in 2013; cases diagnosed before that date should be converted automatically by the registry's software.

Examples

CODE	Label
USA	United States
CAN	Canada

County at Diagnosis
(NAACCR Item #90)

Description

Identifies the county of the patient's residence at the time the reportable tumor is diagnosed.

Explanation

This data item may be used for epidemiological purposes. For example: to measure the cancer burden in a particular geographical area.

Coding Instructions

- For U.S. residents, use codes issued by the Federal Information Processing Standards (FIPS) publication Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas. This publication is available in a reference library or can be accessed on the internet through the U.S. EPA's Envirofacts Data Warehouse and Applications Web site at https://www.epa.gov/.
- If the patient has multiple tumors, the county codes may be different for each tumor.
- If the patient is a non-US resident, use code 999.
- Do not update this data item if the patient's county of residence changes.

CODE	DESCRIPTION	DEFINITION
001–997	County at diagnosis	Valid FIPS code
998	Outside state/county code is unknown	Known town, city, state, or country of residence, but county code not known and a resident outside the state of the reporting institution (must meet all criteria).
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.

Primary Payer at Diagnosis
(NAACCR Item #630)

Description
Identifies the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

Explanation
This item is used in financial analysis and as an identifier for quality and outcome analyses. It is required the patient admission page documents the type of insurance or payment structure that will cover the patient while being cared for at the hospital.

Coding Instructions
- If the patient is diagnosed at the reporting facility, record the payer at the time of diagnosis.
- If the patient is diagnosed elsewhere or the payer at the time of diagnosis is not known record the payer when the patient is initially admitted for treatment.
- Record the type of insurance reported on the patient's admission page.
- Codes 21 and 65-68 are to be used for patients diagnosed on or after January 1, 2006.
- If more than one payer or insurance carrier is listed on the patient's admission page record the first.
- If the patient's payer or insurance carrier changes, do not change the initially recorded code.

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 the 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 on 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 described in code 35.
35	Medicaid administered through a Managed Care plan	Patient is enrolled in Medicaid through a Managed Care program (for example, HMO or PPO). The Managed Care plan pays for all incurred costs.
60	Medicare without supplement, Medicare, NOS	Federal government funded insurance for persons who are 65 years of age or older or are chronically disabled (Social Security insurance eligible). 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.

62	Medicare administer through a Managed Care plan	Patient is enrolled in Medicare through a Managed Care plan (for example, HMO or PPO). The Managed Care plan pays for all incurred costs.
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare.
64	Medicare with Medicaid eligibility	Federal government Medicate insurance with State Medicaid administered supplement.
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. Formally CHAMPUS (Civilian Health and Medicap Program of the Uniformed Services).
66	Military	Military personnel or their dependents who are treated at a military facility.
67	Veterans Affairs	Veterans who are treated in Veteran Affairs facilities.
68	Indian/Public Health Service	Patient who receives care at an Indian Health Service facility or at another facility, and the 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	It is unknown from the patient's medical record whether or not the patient is insured.

Industry and Occupation

Industry: Business activity of a person's employer. This should be 1-3 words and abbreviations should be avoided.

Occupation: What a person does for work or their job. This should be 1-3 words and may be a person's job title.

Text Usual Industry
(NAACCR Item #320)

Description

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

Explanation

Used to identify work-related health hazards; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

Definition

Type of business or industry where the patient worked in his or her usual occupation. Examples include manufacturing of tires, dry cleaning services, training of dogs, hospital.

Coding Instructions

1. Document the patient's usual (longest held) industry to the extent that the information is available in the medical record.
2. Be descriptive and specific.

   Examples:

   Inadequate: "Automobile industry"

   Adequate: "Automobile manufacturing"

   Inadequate: "Mine"

   Adequate: "Copper mine"

   Inadequate: "Retail"

   Adequate: "Retail bookstore"

3. When recording government agencies record the level (federal, state, county, municipal) and the division.

   Example:

   Inadequate: "Census"

   Adequate: "U.S. Census Bureau"

4. Be complete. If the primary activity of the industry is unknown, record the name of the company (with city or town) in which the patient worked the greatest number of years before diagnosis.

   Example:

   Inadequate: "ABC, Inc."

   Adequate: "ABC, Inc., Tumwater, WA"

5. If the patient's usual industry is not available or is unknown, but the patient's current or most recent occupation is recorded, the information for industry should be based upon the information in occupation. Therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient's current or most recent business/industry. If no information is available regarding patient's industry, document "Unknown" in the text field. This should be used only as a last resort.

Text Usual Occupation
(NAACCR Item #310)

Description

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

Explanation

Used to identify work-related health hazards; identifies occupational groups in which cancer screening or prevention activities may be beneficial.

Definition

The type of job the patient was engaged in for the longest time. It is not necessarily the highest paid job, or the job considered the most prestigious, but the one that accounted for the greatest number of working years.

Exception

If a patient has been a homemaker for most of her adult life, but has ever worked outside the home, report the occupation held outside the home.

Coding Instructions

1. Document the patient's usual occupation, the kind of work performed during most of the patient's working life before diagnosis of this tumor, to the extent that the information is available in the medical record. Make sure the recorded usual occupation matches the recorded industry. Do not record "retired."
2. Be descriptive, specific, and complete: Record the word or words which most clearly describe the kind of work or type of duties performed by the patient.

   Examples:

   Inadequate: "Teacher"

   Adequate: "Preschool teacher," "high school teacher"

   Inadequate: "Laborer"

   Adequate: "Residential bricklayer"

   Inadequate: "worked in a warehouse," "worked in a shipping department"

   Adequate: "Warehouse forklift operator"

Inadequate: "Engineer"

Adequate: "Chemical engineer," "Railroad engineer"

Inadequate: "Self-employed"

Adequate: "Self-employed auto mechanic"

3. If the patient's usual occupation is not known, record the patient's current or most recent occupation, or any available occupation. If no information is available regarding patient's occupation document "Unknown" in the text field. This should be used only as a last resort.

Commonly confused occupations

Contractor vs. skilled worker—

a. A contractor mainly obtains contracts and supervises work.
b. A "skilled worker" works with his or her own tools as a carpenter, plasterer, plumber, or electrician.

Machine operator vs. machinist vs. mechanic—

a. A "machine operator" operates machines.
b. A "machinist" sets up and operates machines.
c. A "mechanic" repairs, installs, and adjusts machines.

2023 CHANGES

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.

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 below.
        i. High-grade astrocytoma with piloid features (HGAP) (9421/3) as of 01/01/2023
        ii. Lymphangioleiomyomatosis (9174/3) is reportable as of 01/01/2023; behavior changed from /1 to /3.
        iii. Mesothelioma in situ (9050/2) is reportable as of 01/01/2023.
        iv. Diffuse leptomeningeal glioneuronal tumor (9509/3) is reportable as of 01/01/2023.
        v. Low-grade appendiceal mucinous neoplasm (LAMN) is reportable.
        vi. Early or evolving melanoma, in situ and invasive: As of 01/01/2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable.
        vii. **All** GIST tumors, ***except*** for those stated to be benign, are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2.
        viii. Nearly all thymomas are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2. The exceptions are
            1. Microscopic thymoma or thymoma benign (8580/0)
            2. Micronodular thymoma with lymphoid stroma (8580/1)
            3. Ectopic hamartomatous thymoma (8587/0)
        ix. Carcinoid, NOS of the appendix is reportable. As of 01/01/2015, the ICD-O-3 behavior code changed from /1 to /3.
        x. The following diagnoses **are reportable** (not a complete list)
            1. Lobular carcinoma in situ (LCIS) of breast
            2. Intraepithelial neoplasia, high grade, grade II, grade III
                a. ***Examples*** (Not a complete list)
                    i. Anal intraepithelial neoplasia II (AIN II) of the anus or anal canal (C210-C211)

ii. Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211)

iii. Biliary intraepithelial neoplasia, high grade

iv. Differentiated vulvar intraepithelial neoplasia (VIN)

v. Endometrioid intraepithelial neoplasia

vi. Esophageal intraepithelial neoplasia (dysplasia), high grade

vii. Intraductal papillary neoplasm with high grade intraepithelial neoplasia

viii. Intraepithelial neoplasia, grade III

ix. Laryngeal intraepithelial neoplasia II (LIN II) (C320-C329)

x. Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)

xi. Lobular neoplasia grade II (LN II)/lobular intraepithelial neoplasia grade II (LIN II) breast (C500-C509)

xii. Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509)

xiii. Pancreatic intraepithelial neoplasia (PanIN II) (C250-C259)

xiv. Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259)

xv. Penile intraepithelial neoplasia, grade II (PeIN II) (C600-C609)

xvi. Penile intraepithelial neoplasia, grade III (PeIN III) (C600-C609)

xvii. Squamous intraepithelial neoplasia, grade II excluding cervix (C53_) and skin sites coded to C44_

xviii. Squamous intraepithelial neoplasia III (SIN III) excluding cervix (C53_) and skin sites coded to C44_

xix. Vaginal intraepithelial neoplasia II (VAIN II) (C529)

xx. Vaginal intraepithelial neoplasia III (VAIN III) (C529)

xxi. Vulvar intraepithelial neoplasia II (VIN II) (C510-C519)

xxii. Vulvar intraepithelial neoplasia III (VIN III) (C510-C519)

xi. 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.

xii. Mature teratoma of the testes in adults is malignant and reportable as 9080/3

xiii. **Urine** cytology positive for malignancy is reportable for diagnoses in 2013, and forward.

1. ***Exception:*** When subsequent biopsy of a urinary site is negative, do not report.
2. Code the primary site to C689 in the absence of any other information
3. 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

1. Malignant neoplasm (8000-8005)
2. Epithelial carcinoma (8010-8046)
3. Papillary and squamous cell carcinoma (8050-8084)
4. Squamous intraepithelial neoplasia III (SIN III) (8077) of skin sites coded to C44_
5. Basal cell carcinoma (8090-8110)

a. ***Note:*** 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.

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

1***. 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. Prostatic intraepithelial neoplasia (PIN III) (C619)

1***. Note:*** Collection stopped effective with cases diagnosed 01/01/2001 and later.

iv. Colon atypical hyperplasia

v. High-grade dysplasia in colorectal and esophageal primary sites

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

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).

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

ii. ***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 MYBK1-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.

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 has developed a staging tool referred to as SEER*RSA that provides information (primary site/histology/other factors defined) about each cancer schema. The following table lists the site-specific data items (SSDIs) that are new and required for collection in 2023. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.

Site-specific Data Items Implemented in 2023

Schema	NAACCR Item #	SSDI
Appendix	3960	Histologic Subtype (Appendix 8480)
Melanoma Skin	3961	Clinical Margin Width
Anus V9 (existing SSDI added to schema)	3957	p16

STORE 2023 Summary of Changes

New Data Items

STORE 2023 Page Number	NAACCR Number	Data Item Name
94	344	Tobacco Use Smoking Status
216	671	Rx Hosp – Surg 2023 Replacing Surgical Procedure of Primary Site at this Facility [670] for cases with diagnosis year 2023 For diagnosis years 2003 – 2022, leave this data item blank and complete date items Surgical Procedure of Primary Site at this Facility [NAACCR data item #670] utilizing the STORE manual based on the year of diagnosis. All 2023 site specific surgery codes begin with a letter A except for skin which start with a letter B to indicate a significant change in coding. For melanoma skin surgical codes ONLY: ○ The priority order for sources used to assign surgery codes: ▪ Operative report, statement from a physician, description of the surgical procedure on a pathology report, results of the pathology report. Code based on the description of the procedure. ▪ Do not code based on margin status documented in the pathology report.
218	1291	Rx Summ – Surg 2023 Replacing Surgical Procedure of Primary Site [1290] for cases with diagnosis year 2023 For diagnosis years 2003 – 2022, leave this data item blank and complete data item Surgical Procedure of Primary Site [NAACCR data item #1290] utilizing the STORE manual based on the year of diagnosis. All 2023 site specific surgery codes begin with a letter A except for skin which start with a letter B to indicate significant change in coding. For melanoma skin surgical codes ONLY: ○ The priority order for sources used to assign surgery codes: ▪ Operative report, statement from a physician, description of the surgical procedure on a pathology report, results of the pathology report. Code based on the description of the procedure. ▪ Do not code based on margin status documented in the pathology report.

Data Items with Name Changes

NAACCR Number	Previous Name	Current Name
670	Surgical Procedure of Primary Site at this Facility	Rx Hosp Surg Prim Site 03-2022
1290	Surgical Procedure of Primary Site	Rx Summ – Surg Prim Site 03-2022

Data Items removed from STORE 2023

STORE 2022 Page Number	NAACCR Number	Data Item Name
82	241	Date of Birth Flag
125	581	Date of First Contact Flag
141	1281	Rx Date – Dx/Stg Proc Flag
217	1201	Rx Date – Surgery Flag
219	1290	Surgical Procedure of Primary Site All instructions for #1290 have been changed to reflect the new surgical codes for diagnosis year 2023 Rx Summ – Surg [1291]
221	670	Surgical Procedure of Primary Site at this Facility All instructions for #670 have been changed to reflect the new surgical codes for diagnosis year 2023 Rx Hosp – Surg 2023 [671]
297	1221	Rx Date – Chemo Flag
306	1231	Rx Date – Hormone Flag
313	1241	Rx Date – BRM Flag

Surgery of Primary Site 2023
(NAACCR Item #1291)

Description

Surgery of Primary Site 2023, effective 01/01/2023, describes a surgical procedure that removed 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 can be found Appendix C: Site Specific Coding Modules - 2023 SEER Coding and Staging Manual (cancer.gov).

General Coding Structure

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 where 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 would be coded as

A980. (See Coding Instruction 11 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.
    a. ***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 and **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 1: 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 and en bloc removal when the patient has a hysterectomy and an omentectomy.

8. Code surgery for extra-lymphatic lymphoma using **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 where 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 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

2024 CHANGES

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.

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. High-grade astrocytoma with piloid features (HGAP) (9421/3) as of 01/01/2023
        ii. Lymphangioleiomyomatosis (9174/3) is reportable as of 01/01/2023; behavior changed from /1 to /3
        iii. Mesothelioma in situ (9050/2) is reportable as of 01/01/2023
        iv. Diffuse leptomeningeal glioneuronal tumor (9509/3) is reportable as of 01/01/2023
        v. Low-grade appendiceal mucinous neoplasm (LAMN) is reportable
        vi. Early or evolving melanoma, in situ and invasive: As of 01/01/2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable
        vii. **All** GIST tumors, ***except*** for those stated to be benign, are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2.
        viii. Nearly all thymomas are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2. The exceptions are
            1. Microscopic thymoma or thymoma, benign (8580/0)
            2. Micronodular thymoma with lymphoid stroma (8580/1)
            3. Ectopic hamartomatous thymoma (8587/0)
        ix. Carcinoid, NOS of the appendix is reportable. As of 01/01/2015, the ICD-O-3 behavior code changed from /1 to /3.
        x. The following diagnoses **are reportable** (not a complete list)
            1. Lobular carcinoma in situ (LCIS) of breast
            2. Intraepithelial neoplasia, high grade, grade II, grade III
            3. **Examples:** (not a complete list. See ICD-O-3.2. See 1b.iii for PIN III.)
                a. Anal intraepithelial neoplasia II (AIN II) of the anus or anal canal (C210-C211)

b. Anal intraepithelial neoplasia III (AIN III) of the anus or annual canal (C210-C211)
c. Biliary intraepithelial neoplasia, high grade
d. Differentiated vulvar intraepithelial neoplasia (VIN)
e. Endometrioid intraepithelial neoplasia
f. Esophageal intraepithelial neoplasia (dysplasia), high grade
g. Glandular intraepithelial neoplasia, high grade
h. Intraductal papillary neoplasm with high grade intraepithelial neoplasia
i. Intraepithelial neoplasia, grade III
j. Laryngeal intraepithelial neoplasia II (LIN II) (C320-C329)
k. Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)
l. Lobular neoplasia grade II (LN II)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509)
m. Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509)
n. Pancreatic intraepithelial neoplasia (PanIN II) (C250-C259)
o. Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259)
p. Penile intraepithelial neoplasia, grade II (PeIN II) (C600-C609)
q. Penile intraepithelial neoplasia, grade III (PeIN III) (C600-C609)
r. Squamous intraepithelial neoplasia, grade II excluding cervix (C53_) and skin sites coded to C44_
s. Squamous intraepithelial neoplasia III (SIN III) excluding cervix (C53_) and skin sites coded to C44_
t. Vaginal intraepithelial neoplasia II (VAIN II) (C529)
u. Vaginal intraepithelial neoplasia III (VAIN III) (C529)
v. Vulvar intraepithelial neoplasia II (VIN II) (C510-C519)
w. Vulvar intraepithelial neoplasia III (VIN III) (C510-C519)

xi. 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.

xii. Mature teratoma of the testes in adults is malignant and reportable as 9080/3

xiii. **Urine** cytology positive for malignancy is reportable for diagnoses in 2013, and forward

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

1. Code the primary cite to C689 in the absence of any other information
2. Do not implement new/additional casefinding methodes to capture these cases

b. Do not report (Exceptions to reporting requirements)
   i. **Skin** primary (C440-C449 with any of the following histologies
      1. Malignant neoplasm (8000-8005)
      2. Epithelial carcinoma (8010-8046)
      3. Papillary and squamous cell carcinoma (8050-8084)
      4. Squamous intraepithelial neoplasia III (SIN III) (8077) of skin sites coded to C44_
      5. Basal cell carcinoma (8090-8110)
         a. ***Note:*** 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
   ii. **In situ** carcinoma of **cervix** (/2), any histology, cervical intraepithelial neoplasia (**CIN III**), or SIN III of the cervix (C530-C539)
      1. ***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. Prostatic intraepithelial neoplasia (PIN III) (C619)
      1. ***Note:*** Collection **stopped** effective with cases diagnosed 01/01/2001 and later.
   iv. Colon atypical hyperplasia
   v. High grade dysplasia on colorectal sites.
   vi. Adenocarcinoma in situ, HPV associated (8483/2) (C53)

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-0-3 (effective with cases diagnosed 01/001/2004 to 12/31/2020) of ICD-0-3.2 (effective with cases diagnosed 01/01/2021 and later). See the table below for the specific sites.
      i. ***Note 1***: Benign and borderline tumors of the cranial bones (C410) are **not reportable**
      ii. ***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 vacuolation 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.

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 has developed a staging tool referred to as SEER*RSA that provides information (primary site/histology/other factors defined) about each cancer schema. The following table lists the site-specific data items (SSDIs) that are new and required for collection in 2024. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.

Site-specific Data Items Implemented in 2024

Schema	NAACCR Item #	SSDI
Brain V9; CNS Other V9 (significant update)	3816	Brain Molecular Markers
Vulva V9 (existing SSDI added to schema)	3956	p16
Brain V9 (new)	3964	Brain Primary Tumor Location

STORE 2024 Summary of Changes

New Data Items

STORE 2024 Page Number	NAACCR Number	Data Item Name
195	3956	SSDI: Vulva primary site added to p16 SSDI
207	751	Rx Hosp – Recon Breast
209	1335	Rx Summ – Recon Breast

Data Items removed from STORE 2024

STORE 2023 Page Number	NAACCR Number	Data Item Name
207	3884	SSDI: LN Status Femoral-Inguinal, Para Aortic, Pelvic Site-Specific Data Item
219	10104	Rx Hosp – Surg Breast
222	10105	Rx Summ – Surg Breast
225	10106	Rx Hosp – Recon Breast
227	10107	Rx Summ – Recon Breast

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 for 2024: Tumor site-morphology combinations are designated as valid, unlikely, or impossible. Valid tumor entities can be abstracted without any issues. For cases diagnosed as of January 1, 2024, Impossible tumor entities will trigger an error on the Primary Site, Morphology-Type, Beh ICD03 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 by thoroughly reviewing the medical record. If the information is determined to be correct as coded, the Site/Type Interfield Review override flag will need to be set for the abstract.

The 2024 Cancer PathCHART ICD-O-3 Site Morphology Validation List: The 2024 Cancer PathCHART ICD-O-3 Site Morphology Validation List (CPC SMVL), output directly from the Cancer PathCHART database, is a comprehensive table that replaces both the ICD-O-3 SEER Site/Histology Validation List and the list of impossible site and histology combinations included in the Primary Site, Morphology-Imposs ICD03 (SEER IF38) edit. The 2024 CPC SMVL is 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 list can be found at** https://seer.cancer.gov/cancerpathchart/products.html.

Cancer PathCHART SVML Search Tool: For January 2024 implementation, a webtool will be available on the Cancer PathCHART website that will allow searches for tumor topography, histology, and behavior codes and terms and whether the site-morphology combinations are biologically valid, impossible, or unlikely.

Tumor Size Summary
(NAACCR Item #756)

Description: *Tumor Size Summary* is the most accurate measurement of a solid primary tumor, usually 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 (2mm – 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) In 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 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 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 of thickness** of the tumor.

3. Record tumor size states 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, code as 049. If state 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; > 5cm, code as 051. If described as anything great then 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 -59 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 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 millimeters 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 o14 (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 and area of invasive ductal carcinoma. Record tumor size as 019 (19 mm).

9. Record the largest dimension of diameter of tumor, whether it is from an excisional biopsy specimen of 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

       i. Neoadjuvant therapy has been administered, ***and*** **the resection shows no residual tumor.**

    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 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

           1. Excluding Spleen (C422)

       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 of 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 resections 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 items 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	00210
Bile Duct Distal	00260
Bile Ducts Intrahepatic	00230
Bone Appendicular Skeleton	00381
Bone Pelvis	00383
Breast	00480
Buccal Mucosa	00076
Cervix	00520
Conjunctiva	00650
Corpus Sarcoma	00541
Cutaneous Carcinoma of Head and Neck	00150
Floor of Mouth	00074
GIST	00430
Hypopharynx	00073
Kidney Parenchyma	00600
Lacrimal Gland	00690
Lip	00071
Liver	00220
Lung	00360

Major Salivary Glands	00080
Merkel Cell Skin	00460
Mouth Other	00077
NET Adrenal Gland	00770
NET Appendix	00320
NET Colon and Rectum	00330
NET Pancreas	00340
NET Stomach	00290
Orbital Sarcoma	00700
Oropharynx (p16-)	00111
Oropharynx HPV-Mediated (p16+)	00100
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	00500

Breast Reconstruction
(NAACCR Item #1335)

Description: *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 the 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 replacement 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 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.

2025 CHANGES

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.

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. Post Transplant Lymphoproliferative Disorder (PTLD) 9971/1 is reportable as 9971/3 as of 01/01/2025
        ii. High-grade astrocytoma with piloid features (HGAP) (9421/3) as of 01/01/2023
        iii. Lymphangioleiomyomatosis (9174/3) is reportable as of 01/01/2023; behavior changed from /1 to /3
        iv. Mesothelioma in situ (9050/2) is reportable as of 01/01/2023
        v. Diffuse leptomeningeal glioneuronal tumor (9509/3) is reportable as of 01/01/2023
        vi. The following diagnoses **are reportable** (not a complete list)
            1. Lobular carcinoma in situ (LCIS) of breast
            2. Intraepithelial neoplasia, high grade, grade II, grade III

            Examples: (Not a complete list. See ICD-O-3.2)

                a. Anal intraepithelial neoplasia II (AIN II) of the anus or anal canal (C210-C211)
                b. Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211)
                c. Biliary intraepithelial neoplasia, high grade
                d. Conjunctival intraepithelial neoplasia with severe dysplasia, or Grade III; squamous intraepithelial neoplasia Grade II of conjunctiva
                e. Differentiated vulvar intraepithelial neoplasia (VIN) of differentiated exophytic vulvar intraepithelial lesion (DEVIL)
                f. Endometrioid intraepithelial neoplasia (atypical hyperplasia, EIN)
                g. Esophageal intraepithelial neoplasia (dysplasia), high grade or Grade III
                h. Glandular intraepithelial neoplasia, high grade
                i. High grade dysplasia of esophagus, stomach, small intestine

j. High grade squamous dysplasia of larynx

k. High grade squamous intraepithelial lesion (HGSIL) of the anus

l. High grade vulvar intraepithelial neoplasia

m. Intraductal papillary neoplasm with high grade intraepithelial neoplasia

n. Intraepithelial neoplasia, grade III

o. Laryngeal intraepithelial neoplasia II (LIN II) (C320-C329)

p. Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)

q. Lobular neoplasia grade II (LN II)/lobular intraepithelial neoplasia grade II (LIN II) breast (C500-C509)

r. Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509)

s. Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259)

t. Penile intraepithelial neoplasia, grade II (PeIN II) (C600-C609)

u. Penile intraepithelial neoplasia, grade III or high-grade dysplasia (PeIN III) (C600-C609)

v. Squamous intraepithelial neoplasia, grade II excluding cervix (C53_) and skin sites coded to C44_

w. Squamous intraepithelial neoplasia III (SIN III) excluding cervix (C53_) and skin sited coded to C44_

x. Vaginal intraepithelial neoplasia II (VAIN II) (C529)

y. Vaginal intraepithelial neoplasia III (VAIN III) (C529)

z. Vulvar intraepithelial neoplasia II (VIN II) (C510-C519)

aa. Vulvar intraepithelial neoplasia III (VIN III) (C510-C519)

vii. 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.

viii. Mature teratoma of the testes in adults is malignant and reportable as 9080/3

ix. **Urine** cytology positive for malignancy is reportable for diagnoses in 2013, and forward

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

1. Code the primary site to C689 in the absence of any other information
2. 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

1. Malignant neoplasm (8000-8005)
2. Epithelial carcinoma (8010-8046)
3. Papillary and squamous cell carcinoma (SCC) (8050-8086)
4. 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. Prostatic intraepithelial neoplasia (PIN II and PIN III (C619)

Note: Collection **stopped** effective with cases diagnosed 01/01/2001 and later.

iv. Colon atypical hyperplasia

v. High grade dysplasia in colorectal sites (C180-C189, and C209)

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

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 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 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

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 has developed a staging tool referred to as SEER*RSA that provides information (primary site/histology/other factors defined) about each cancer schema. The following tables list the site-specific data items (SSDIs) that are new and required for collection in 2025 and the Schemas added for 2025. For more information about schemas and schema IDs, go to the SSDI Manual, Appendix A.

Site-specific Data Items Implemented in 2025

Schema	NAACCR Item #	SSDI
Lymphoma, Lymphoma (CLL/SLL), Plasma Cell Disorders, Plasma Cell Myeloma, Primary Cutaneous Lymphoma (excluding MF/SS)	1172	Post Transplant Lymphoproliferative Disorder (PTLD)
Lung (V9)	1174	PD-L1
Colon and Rectum (Code added to an existing SSDI)	3940	BRAF Mutational Analysis

Schemas Added for 2025

Schema	Schema ID
Nasopharynx [V9: 2025+]	09090
Thymus [V9: 2025+]	09350
Lung [V9: 2025+]	09360
Pleural Mesothelioma [V9: 2025+]	09370

STORE 2025 Summary of Changes

New Data Items

STORE 2025 Page Number	NAACCR Number	Data Item Name
157	1172 1174	Two new SSDI • PLTD • PD-L1

Coding Changes

STORE 2025 Page Number	NAACCR Number		Data Item Name
137 149	1004 1014	AJCC TNM Clin Stage Group AJCC TNM Path Stage Group	Removed: Blank from Allowable Values
166 168	671 1291	Rx Hosp – Surg 2023 Rx Summ – Surg 2023	Removed: Blank from Allowable Values
202 208 210 212 216 218 220	1504 1505 1506 1502 1501 1503 1507	Phase I-II-III Radiation Primary Treatment Volume Phase I-II-III Radiation to Draining Lymph Nodes Phase I-II-III Radiation Treatment Modality Phase I-II-III External Beam Radiation Planning Technique Phase I-II-III Dose per Fraction Phase I-II-III Number of Fractions Phase I-II-III Total Dose	Removed: Blank from Allowable Values for Phase I Radiation Data items.

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 for 2024: Tumor site-morphology combinations are designated as valid, unlikely, or impossible. Valid tumor entities can be abstracted without any issues. For cases diagnosed as of January 1, 2024, Impossible tumor entities will trigger an error on the Primary Site, Morphology-Type, Beh ICD03 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 by thoroughly reviewing the medical record. If the information is determined to be correct as coded, the Site/Type Interfield Review override flag will need to be set for the abstract.

The 2024 Cancer PathCHART ICD-O-3 Site Morphology Validation List: Two Cancer PathCHART ICD-O-3 Site Morphology Validation Lists (CPC SMVL) have been output directly from the Cancer PathCHART database. The 2024 CPC SMVL applies to cases diagnosed January 1, 2024, and forward, and the 2025 CPC SMVL applies to cases diagnosed January 1, 2025, and forward. These CPC SMVLs are each a comprehensive table that replace 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 ICD03 (SEER IF38) edit. Both the 2024 CPC SMVL and the 2025 CPC SMVL 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 list can be found at** https://seer.cancer.gov/cancerpathchart/products.html.

Cancer PathCHART SVML Search Tool: Launched April 2024, the CPC*Search webtool is available on the Cancer PathCHART website at https://seer.cancer.gov/cancerpathchart/search/. It allows searches for tumor topography, histology, and behavior codes and terms and shows whether the site-morphology combination is biologically valid, impossible, or unlikely.

Sites Reviewed for Cancer PathCHART: For lists of organ systems and sites reviewed for the 2024 CPC SMVL or for the 2025 CPC SMVL, refer to table provided: https://seer.cancer.gov/cancerpathcart/products.html. For sites that have not been reviewed for an update in validity standards for 2024 or 2025, 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 ICD03 (SEER IF38) edit were impossible. All other site-morphology code combinations were unlikely.

Documenting Text

TEXT DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT

Text information to support cancer diagnosis, stage, and coded treatment **MUST BE PROVIDED BY ALL FACILITIES**.

Text documentation is an important element of a complete abstract. It is critical for quality assurance and special studies and is used to support coded values and to provide supplemental information not transmitted within coded values. Complete text documentation facilitates consolidation of information from multiple reporting sources.

The text field must contain a description that has been entered by the abstractor. Cancer registry software generating text automatically from coded data cannot be utilized to support coded values. Information documenting the disease and treatment must be entered manually from the medical record. **TNM staging is not an acceptable substitute for stage documentation**. Document all the **first course** of definitive treatment administered, regardless of where the treatment was received, in chronological order. Text documentation should explain where the cancer started, where it went (lymph nodes, other organs) and how it got there (direct extension, metastasis, implants). Clinical and pathological findings should be documented.

Always use text to document certain basic information:

1. The date of the examination or procedure; **keep dates in chronological order.**
2. The name of the examination or procedure.
3. The results of the examination or procedure and any pertinent **positive or negative** information.
4. The diagnostic impression, final diagnosis, or conclusion if one is given.
5. The planned treatment, whether or not it is known if the treatment was given.
6. The date and type of treatment given, even if it was done at another institution.
7. Specific subsite of primary site.
8. Specific number, chain of lymph nodes examined, and results.
9. Specific information about metastatic spread of disease to lymph nodes and/or other organs and tissues.
10. Demographic information such as age at diagnosis, race, gender, marital status, insurance, and smoking status of the patient should also be recorded in text fields.

Unknown should only be used when there is insufficient information to determine the stage or extent of disease. If the primary site is unknown (C809) then the Summary Stage must be unknown. Document where the cancer was found if the primary site is unidentified.

Documentation is necessary to verify types and timing of treatment. If a port is placed for chemotherapy, record this information but do not code that chemotherapy was given unless it is known that it was.

Call WSCR for technical assistance if additional direction is needed to determine the appropriate information to document. WSCR staff may request copies of the necessary reports with your data submission to assist you.

Types of Reports to Review

Medical imaging: Medical imaging can provide key information for evaluating the clinical extent of disease. For example, a CT of the lung can show the size and location of the tumor within the lung. It can demonstrate the presence of pleural effusion, or extension of the tumor to other tissues such as ribs, chest wall, or pleura. Bone scans and MRI or CT of the brain are often used to evaluate metastatic sites. History and Physical reports sometimes give the results from imaging studies done outside of the reporting facility. Documentation of all positive and negative findings from imaging exams should be recorded.

Physical exam (PE) or History and Physical (H&P): The PE or H&P can provide the size for palpable masses and information regarding palpable lymph nodes. For example, during a digital rectal exam (DRE) the prostate is palpated. The physician will note findings such as nodularity, induration, fixation of seminal vesicles, enlargement, firmness, etc. All positive and negative findings pertinent to the patient's cancer are an important aspect and must be noted to support coding. Patient demographics can also be found in the H&P. Record age, race, and sex when available. This information is useful in record consolidation.

Pathology reports: Pathology reports provide key information including **cell type, grade, size** and **location** of tumor, **number of lesions or foci, depth of invasion, spread of tumor to other organs,** and **lymph node involvement**. Record each of these items. Be sure to record the furthest extension that the pathologist mentions, for example: confined to mucosa; into subserosa; through full thickness of abdomen wall, etc.

Operative reports: Operative reports will often contain the surgeon's observations regarding involvement or lack of involvement of lymph nodes or other organs. The operative report will also contain detailed information of the exact type of surgery performed, tissue or organ(s) excised, and tissue or organ(s) left intact. Record these findings.

Discharge summaries, treatment summaries, clinical notes, or progress reports: These are good sources for treatment information. Review all available reports and document all planned treatment, as well as the date and modalities of known treatment in the specific treatment text fields. Give specific information when available such as the type and number of courses of chemotherapy. If no treatment is planned or the patient refuses recommended treatment, include this information in the text field.

Lab results: These can be and are used to code many of the Site-Specific Data Items (SSDI)

Specific Instruction on Involvement

Venous Invasion: An assessment of blood vessels within the primary organ. This does not constitute regional or distant spread of malignancy.

Lymphatic Invasion: A microscopic assessment of involvement of the lymphatic channels within the primary organ and at the margins of resection. This is an assessment of the potential, from the primary tumor, to metastasize to lymph nodes, even though the tumor has extended no further than the lymph channels and is still confined to the primary site.

Residual Tumor: Refers to the status of the margins after a surgical procedure of the primary site. It is important to document this information if it is available in the pathology and/or operative report.

> ***Microscopic residual tumor*** is identified by the pathologist through the microscope but is not grossly visualized. An example would be a positive margin of resection when the surgeon stated that the tumor was completely removed.
>
> ***Macroscopic residual tumor*** is identified during the procedure by the surgeon and is a tumor that is grossly visualized. An example of this would be a tumor adhering to another structure that the surgeon could not remove.

Determination of the cancer stage is both a subjective and objective assessment of how far the cancer has spread. The following list of terms may be used to determine involvement for **SEER Summary Staging only**.

Note: Do not use these lists for case finding or to determine multiple primaries or histology.

Consider as Involvement

adherent	Incipient invasion
apparent(ly)	induration
appears to	infringe/infringing
comparable with	into*
compatible with	intrude
consistent with	most likely
contiguous/continuous with	onto*
encroaching upon*	overstep
extension to, into, onto, out onto	presumed
features of	probable
fixation to a structure other than primary**	protruding into (unless encapsulated)
fixed to another structure**	suspected
impending perforation of	suspicious
impinging upon	to*
impose/imposing on	up to

*Interpreted as involvement whether the description is clinical or operative/pathological

**Interpreted as involvement of other organ or tissue

Do Not Consider as Involvement

abuts	extension to without invasion/involvement of
approaching	kiss/kissing
approximates	matted (except for lymph nodes)
attached	possible
cannot be excluded/ruled out	questionable
efface/effacing/effacement	reaching
encased/encasing	rule out
encompass(ed)	suggests
entrapped	very close to
equivocal	worrisome

Text Field Examples

The following table lists suggestions for the type of text to include for each text field.

NAACCR TEXT FIELD AND DATA ITEM#	TEXT SUGGESTIONS	DATA ITEM(S) VERIFIED WITH TEXT
Other Pertinent Information #2680	Age, sex, and race of patient Spanish/Hispanic Origin Place of birth Country of Birth Insurance/primary payer information Name of Follow Up Physician Unknown demographic information (unknown SS#, unknown address at diagnosis) Overflow or problematic coding issues	Date of Birth #240 Age at Diagnosis #230 Sex #220 Race 1-5 #160-164 Spanish/Hispanic Origin #190 Birthplace - State #252 Birthplace – Country #254 Primary Payer at Dx #630
Other Primary Tumors #2220	Site of Other Primary Morphology of Other Primary DX Date of Other Primary	Sequence Number #560
Summary Stage Documentation #2600	Date(s) of procedure(s) including biopsies and clinical procedures that provide staging information such as x-rays. Organs involved by direct extension. Size of tumor Status of margins Number and sites of positive lymph nodes Metastatic sites Physician's specialty (Surgeon, Oncologist, etc.) Physician's comments	Date of Initial Diagnosis #390 Diagnostic Confirmation #490 Primary site #400 Histology # 522 Regional Nodes Positive #820 Regional Nodes Examined #830 Laterality #410
Summary Stage Documentation –PE #2520	Date of diagnosis History relating to cancer diagnosis. Impression pertaining to cancer diagnosis. Positive and negative clinical findings Palpable lymph nodes Treatment plan	Date of First Contact #580 Date of Diagnosis #390 Race 1-5 #160-164 Span/Hispanic Origin #190 Sex #220 Primary Site #400 Laterality #410 Histology ICD-0-3 #522 Sequence # Hospital #560 Collaborative Stage variables #2800-2930 SEER Summary Stage 2000 #759

Summary Stage Documentation-Xray/Scan #2530	Date and type of X-ray or Scan Primary site Histology (if given) Tumor location Tumor size Lymph nodes Record positive and negative findings. Distant disease or mets	Date of Diagnosis #390 Primary Site #400 Laterality #410 Histology ICD-0-2 #420 Histology ICD-0-3 #522 Collaborative Stage variables #2800-2930 SEER Summary Stage 2000 #759
Summary Stage Documentation-Scopes #2540	Dates of endoscopic exams Primary site Histology Tumor location Tumor size Site and type of endoscopic biopsy Positive and negative clinical findings	Date of Diagnosis #390 Diagnostic Confirmation #490 Primary Site #400 Laterality #410 Histology ICD-0-2 #420 Histology ICD-0-3 #522 Collaborative Stage variables #2800-2930 SEER Summary Stage 2000 #759 RX Date-Surgery #1300
Summary Stage Documentation-Lab Tests #2550	Type of lab test/tissue specimen Both positive and negative findings Tumor markers, special studies etc. Including: Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu, Human Chorionic Gonadotropin (hCG) Date of lab tests	Primary Site #400 Grade #440 Diagnostic Confirmation #490 Collaborative Stage variables #2800-2930 Date of Diagnosis #390
Summary Stage Documentation-Op #2560	Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived. Number of lymph nodes removed. Size of tumor removed. Documentation of residual tumor Evidence of invasion of surrounding areas Reason primary site surgery could not be completed	Date of Diagnosis #390 Diagnostic Confirmation #490 Primary Site #400 Collaborative Stage variables #2800-2930 SEER Summary Stage 2000 #759 Reason for No Surgery #1340
Summary Stage Documentation Path #2570	Dates of procedures Anatomic source of specimen Type of tissue specimen Tumor type and grade (include all modifying adjectives: predominantly, with features of etc.) Gross tumor size Extent of tumor spread. Involvement of resection margin Number of lymph nodes involved and examined.	Date of Diagnosis #390 Primary Site #400 Laterality #410 Histologic Type ICD-0-3 #522 Grade #440 Collaborative Stage variables #2800-2930 Diagnostic Confirmation #490 RX Summ-Surg Prim Site #670 RX Sum-Scope Reg LN Sur #1392 RX Summ-Surg Oth Reg/Dis # 1394

	Both positive and negative findings Record any additional comments from the pathologist, including differential diagnosis considered and any ruled out or favored	SEER Summary Stage 2000 #759 Regional Nodes Positive #820 Regional Nodes Examined #830 RX Date-Surgery #1300 Reason for No Surgery #1340 RX Summ-Surg/Rad Seq #1380 RX Summ-Systemic/Sur Seq #1639
Final Diagnosis (Primary, Laterality) #2580	Location of primary site of tumor Information on laterality of tumor	Primary site #400 Laterality #410
Final Diagnosis (Morphology, Behavior, Grade) #2590	Morphology/Behavior Grade of tumor	Morphology/Behavior #522, #523 Grade #440
Rx Text Surgery #2610	Date of each surgical procedure Type(s) of surgical procedure(s), including surgery to other and distant sites. Lymph nodes removed. Regional tissues removed. Metastatic Sites Facility and date for each procedure Record positive and negative findings. Record Positive findings first. Reason for no surgery Other treatment information, e.g., planned procedure aborted.	DX confirmation #490 RX Date Surgery #1300 Surgery Rx Code #1390 RX Summ Scope of Reg LN Surgery #1392 RX Summ-Surg Other/Dist RX Code #1394 Reason for No Surgery #1340 RX-Summ-Radiation # 1360
Rx Text-Radiation #2620	Date radiation treatment began and ended. Where treatment given Type(s) of radiation Planned doses. Other treatment information (discontinued after 2 treatments.)	Date Radiation Started #1310 Rad-Regional RX Modality Code #1570 RX Summ-Surg/Rad Sequence #1380
Rx Text-Chemo #2640	Date when chemotherapy began and ended. Where chemotherapy was given Type of chemotherapy (name of agent(s) and doses planned/received. Other treatment information (treatment cycle incomplete.)	Chemotherapy Code #1390 RX Date-Systemic #3230 Systemic/Surgery Sequence #1639 RX Date Chemo #1220

Rx Text-Hormone #2650	Planned hormone treatment. Date treatment was started. Where treatment was given Type of hormone or antihormone Type of endocrine surgery or radiation Other treatment Information, e.g., Treatment cycle incomplete.	Hormone Code #1400 RX Date-Systemic #3230 Systemic/Surgery Sequence #1639
Rx Text-BRM Immunotherapy #2660	Date treatment began. Where treatment was given e.g., at this facility, at another facility. Planned immunotherapy treatment. BRM procedures, e.g., bone marrow transplant, stem cell transplant Type of immunotherapy given Type of BRM agent, e.g., Interferon, BCG Other treatment information e.g., treatment cycle incomplete.	Immunotherapy Code #1340
Rx Text-Other #2670	Date treatment was started. Where treatment was given Type of other treatment Other treatment information (incomplete)	Date of Initial Treatment #1360 RX Summ-Other #1420 RX Date-Other #1350

Text Documentation Examples

The pertinent information in the following examples has been documented in bold lettering for easier identification of required text.

CASE #1 LUNG

Imaging Reports

2/18/18 VA Clinic: CT Chest: Supraclavicular, axillary, and mediastinal structures unremarkable. No mediastinal or hilar adenopathy. 2.8 x 2.4 x 4.8cm mass in the right lower lobe, margins are well defined with minimal peripheral ground-glass opacity, and probably some degree of obstructive pneumonitis. Remainder of the lungs is clear. Impression: Lobulated soft tissue mass in the right lower lobe consistent with neoplasm. No evidence of adenopathy, mediastinal, or hilar spread.

2/28/18 CT Brain Your Hospital: No evident disease process.

Pathology Reports

2/28/18 Your Hospital: Fine Needle Aspirate, right lower lobe lung: positive for malignant cells

3/1/18 Your Hospital: Superior segment right lower lobe, resection: moderately differentiated squamous cell carcinoma, maximum tumor diameter 5.0cm, 2nd nodule in right lower lobe measures 0.5cm, resection margin free of tumor, peribronchial lymph node negative for tumor, right lower paratracheal lymph node negative for tumor, right pretracheal lymph node negative for tumor.

Clinical Reports

3/15/18: Oncologist recommended 4 cycles of adjuvant Taxol and carboplatin. The patient would rather receive treatment closer to home and has been referred to an oncologist in that area.

Treatment Documentation

3/1/17 RLL lobectomy with mediastinal ln dissection

3/15/18 Oncologist recommends 4 cycles adjuvant Taxol and carboplatin. PT wants treatment closer to home, referred to oncologist in his area, unknown if chemo done.

CASE #2 BREAST

Imaging Reports

6/1/18 Mammogram: In the right breast there is a 1.2 x 1.5cm mass in the upper-outer quadrant. There is no evidence of axillary lymphadenopathy. The left breast appears normal.

6/14/18 Chest Xray: Within normal limits

6/14/18 Bone Scan: **Impression**: No evidence of skeletal disease. Thoracic and lumbar spine negative for metastases.

Pathology Reports

6/8/18 Right breast fine needle aspiration cytology: Adenocarcinoma

6/15/18 Right breast modified radical mastectomy: **Final Diagnosis:** Infiltrating ductal carcinoma, tubular type, 1.4cm, margins clear, Bloom Richardson score 3, no dermal or lymphatic invasion, no evidence of tumor in 32 regional lymph nodes, Estrogen and Progesterone Receptors negative, HER2 IHC 3+, positive.

Clinical Reports

6/1/18 History and Physical: Family physician noted 2cm mass in right breast on physical exam. No pain or tenderness; no nipple discharge; no skin changes. Slight nipple retraction. Freely movable mass. Left breast: no masses palpated. No enlarged lymph nodes.

10/13/18 Oncology Clinic Follow-up Note: Patient started 3 cycles of adjuvant Adriamycin and Cytoxan on

7/20/18, recently completed and now has begun Tamoxifen.

Treatment Documentation

6/15/18 Rt breast modified radical mastectomy.

10/13/18 Oncology note: Pt had 3 cycles Adriamycin and Cytoxan begun on 7/20/18, recently completed and has begun Tamoxifen.

CASE #3 COLON/RECTUM

Imaging Reports

4/20/2017 CT Abdomen and Pelvis: **Conclusion**: Two areas of circumferential colonic wall thickening affecting the distal sigmoid colon and a loop of colon in the right lower quadrant/right pelvic region with multiple low-density lesions being noted in the liver. Although these could represent incidental benign hepatic cysts, metastatic liver disease cannot be excluded at this time as colonic carcinoma is one of the causes of cystic liver metastasis. It should be noted that although there are shotty lymph nodes present, there is no definite lymphadenopathy demonstrated. History of uterine cancer in 2003 with evidence of prior hysterectomy. This is not usually a cause of cystic liver metastasis. Otherwise, unremarkable CT scan of the abdomen and pelvis with other incidental findings as noted above.

4/25/17 Whole Body PET Scan: **Conclusion**: Radionuclide uptake in the left abdomen, representing a nonspecific finding. No focal areas of increased uptake are seen in the liver to suggest hepatic metastasis.

Pathology Reports

4/15/2017 Final Diagnosis: Colon biopsy at 135cm: moderately differentiated adenocarcinoma, mucin producing signet ring cell, high-grade.

5/1/2017 Final Diagnosis: Right hemicolectomy: High-grade mucin-producing signet ring cell carcinoma, 4 cm in size and located in colon near ileocolic junction, tumor invades pericolonic adipose tissue, (PT3). No evidence of lymph node metastasis among seven lymph nodes. (PNO). Excision margin is negative. Microsatellite Instability-Stable. KRAS mutated. Normal heterozygous state (Normal LOH)

Operative Report

Date of Procedure: 5/1/17

PREOPERATIVE DIAGNOSIS: Right colon cancer

POSTOPERATIVE DIAGNOSIS: Right colon cancer, with adhesive bowel disease.

PROCEDURES PERFORMED: Exploratory laparotomy, lysis of adhesions, right hemicolectomy.

Findings: On exploration of the abdomen, the liver was palpated and found to be unremarkable. There were no lesions in the colon other than in the right colon. In the small bowel, there were adhesions, especially in the terminal ileum, adherent to the cecum.

ONCOLOGY CONSULT: 5/15/17

The patient has a new diagnosis of high-grade mucin producing signet ring cell adenocarcinoma of the colon. This is about 4 cm in size with pericolonic tissue invasion. Based on these reports and findings, the patient may benefit from adjuvant chemotherapy.

Treatment Documentation

5/1/17 Right Hemicolectomy

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 at unknown at the time of diagnosis. At a later date, the physician determines that the cancer is primary to a specific site. Change the primary site from unknown to the now known specific site.

   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 is 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 information 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 benign argentaffin carcinoid (8240/1) of the sigmoid colon in May 2023. In January 2024, the patient is admitted with widespread metastasis consistent with malignant argentaffin carcinoid. The registrar accessions the malignant argentaffin carcinoid as a 2024 diagnosis. Two months later, the pathologist reviews the slides from the May 2023 surgery and concludes that the carcinoid diagnosed in 2023 was malignant. Change the date of diagnosis to May 2023 and histology to 8241 and the behavior code to malignant (/3).

Additional Resources

Lymph Node/Lymph Node Chain Reference Table

Use this table with the Primary Site and Histology Rules to determine whether involved lymph nodes are in a single ICD-O-3 lymph node region or in multiple ICD-O-3 lymph node regions.

This table contains the names of lymph nodes that have the capsule and sinus structure of true lymph nodes. Lymphoid tissue such as that in the GI tract, tonsils, etc., is not represented in this table.

Note: Pathology reports may identify lymph nodes within most organs, the most common being breast, parotid gland, lung, and pancreas. The lymph nodes in these organs are called intra-(organ name) lymph nodes such as intramammary lymph nodes. We have included the most common intra-organ lymph nodes on this table. For an intra-organ lymph node not listed on the table, code to the ICD-O-3 topography code for that organ's regional lymph node chain(s).

Lymph Node/Lymph Node Chain	ICD-O-3 Code	ICD-O-3 Lymph Node Region(S)	TNM Staging
Abdominal	C772	Intra-abdominal	Mesenteric
Anorectal (pararectal)	C775	Pelvic	Pelvic, right and left*
Anterior axillary (pectoral)	C773	Axilla or arm	Axillary, right and left*
Anterior cecal (prececal)	C772	Intra-abdominal	Mesenteric
Anterior deep cervical (laterotracheal, recurrent laryngeal, recurrent pharyngeal)	C770	Head, face, and neck	Cervical, right and left*
Anterior jugular	C770	Head, face, and neck	Cervical, right and left*
Anterior mediastinal	C771	Intrathoracic	Mediastinal
Aortic (ascending, lateral, lumbar, subaortic, NOS)	C772	Intra-abdominal	Para-aortic
Aortico-pulmonary window (subaortic)	C772	Intra-abdominal	Para-aortic
Apical (subclavian)	C770	Head, face, and neck	Cervical, right and left*
Appendiceal	C772	Intra-abdominal	Mesenteric
Apical axillary (deep axillary, Level III axillary)	C773	Axilla or arm	Axillary, right and left*
Aselli's glands (nodes near pancreas)	C772	Intra-abdominal	Para-aortic
Auricular (infraauricular, postauricular, preauricular, retroauricular, NOS)	C770	Head, face, and neck	Cervical, right and left*
Axillary (anterior, brachial, deep, lateral, superficial, NOS)	C773	Axilla or arm	Axillary, right and left*
Axillary (Level 1 [low axillary, superficial axillary], Level II, Level III [apical, deep])	C773	Axillar or arm	Infraclavicular, right and left*
Azygos (lower paratracheal)	C771	Intrathoracic	Mediastinal
Brachial (lateral axillary)	C773	Axilla or arm	Axillary, right and left*
Brachiocephalic	C773	Axilla or arm	Axillary, right and left*
Bronchial	C771	Intrathoracic	Hilar

Bronchopulmonary (hilar) (proximal lobar) (pulmonary root)	C771	Intrathoracic	Hilar
Buccal (buccinator)	C770	Head, face, and neck	Cervical, right and left*
Calot's node (cystic, cysto-hepatic triangle or hepato-biliary triangle)	C772	Intra-abdominal	Para-aortic
Cardiac (cardial)	C771	Intrathoracic	Mediastinal
Cardioesophageal (tracheobronchial, tracheal bifurcation)	C771	Intrathoracic	Mediastinal
Carinal (tracheal bifurcation, tracheobronchial)	C771	Intrathoracic	Mediastinal
Caval (para-)	C772	Intra-abdominal	Para-aortic
Cecal (anterior, posterior, prececal, retrocecal, NOS)	C772	Intra-abdominal	Mesenteric
Celiac	C772	Intra-abdominal	Para-aortic
Central compartment (paralaryngeal, prelaryngeal, [Delphian]) adjacent to thyroid gland	C770	Head, face, and neck	Cervical, right and left*
Cervical, NOS	C770	Head, face, and neck	Cervical, right and left*
Cervical paratracheal	C770	Head, face, and neck	Cervical, right and left*
Cervical periesophageal	C770	Head, face, and neck	Cervical, right and left*
Cloquet's node (inguinal)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Colic (ileocolic, left, mesocolic, middle, right, NOS)	C772	Intra-abdominal	Mesenteric
Common bile duct (pericholedochal)	C772	Intra-abdominal	Para-aortic
Common hepatic	C771	Intrathoracic	Mediastinal
Common iliac	C775	Pelvic	Pelvic, right and left*
Cubital	C773	Axilla or arm	Axillary, right and left*
Cystic (Calot's node, cysto-hepatic triangle, or hepato-biliary triangle)	C772	Intra-abdominal	Para-aortic
Cystic duct	C772	Intra-abdominal	Para-aortic
Deep axillary	C773	Axilla or arm	Axillary, right and left*
Deep cervical (lower, middle, upper, NOS)	C771	Intrathoracic	Cervical, right and left*
Delphian node (precricoid)	C770	Head, face, and neck	Cervical, right and left*
Deltopectoral	C773	Axilla or arm	Axillary, right and left*
Diaphragmatic, sub	C771	Intrathoracic	Mediastinal
Duodenal	C772	Intra-abdominal	Para-aortic
Epicolic (Foramen or Winslow, omental)	C772	Intra-abdominal	Mesenteric
Epitrochlear	C773	Axilla or arm	Axillary, right and left*
Esophageal (para-, peri-)	C771	Intrathoracic	Mediastinal
Esophageal groove	C770	Head, face, and neck	Cervical, right and left*
External iliac	C775	Pelvic	Pelvic, right and left*
Facial (buccal, buccinator, nasolabial)	C770	Head, face, and neck	Cervical, right and left*
Femoral (superficial inguinal)	C774	Inguinal region or leg	Inguino-femoral, right and left*

Foramen of Winslow (epicolic, omental)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Gastric (inferior, left, right, superior, NOS)	C772	Intra-abdominal	Mesenteric
Gastrocolic	C772	Intra-abdominal	Mesenteric
Gastroduodenal	C772	Intra-abdominal	Mesenteric
Gastroepiploic (gastro-omental)	C772	Intra-abdominal	Mesenteric
Gastrohepatic	C772	Intra-abdominal	Mesenteric
Gastropancreatic	C772	Intra-abdominal	Mesenteric
Gerota'a node (promontorial, middle sacral)	C775	Pelvic	Para-aortic
Greater curvature	C772	Intra-abdominal	Mesenteric
Greater omentum (greater omental)	C772	Intra-abdominal	Mesenteric
Hemorrhoidal (inferior, middle, superior, NOS)	C775	Pelvic	Pelvic, right and left*
Hepatic artery	C772	Intra-abdominal	Para-aortic
Hepatic pedicle	C772	Intra-abdominal	Para-aortic
Hepatoduodenal ligament (hilar)	C772	Intra-abdominal	Para-aortic
Highest deep inguinal (Rosenmuller or Node of Cloquet)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Hilar ([in hilus of liver], hepatoduodenal ligament, porta hepatis, portal, splenic, NOS)	C772	Intra-abdominal	Mesenteric
Hilar (bronchial, bronchopulmonary, proximal lobar, pulmonary root)	C771	Intrathoracic	Hilar, right and left*
Hypogastric (internal iliac)	C775	Pelvic	Pelvic, right and left*
Ileocolic	C772	Intra-abdominal	Mesenteric
Iliac (common, external, internal [hypogastric, obturator])	C775	Pelvic	Pelvic, right and left*
Inferior deep cervical (scalene)	C770	Head, face, and neck	Cervical, right and left*
Inferior gastric (right, NOS)	C772	Intra-abdominal	Mesenteric
Inferior hemorrhoidal	C775	Pelvic	Pelvic, right and left*
Inferior (deep) jugular	C770	Head, face, and neck	Cervical, right and left*
Inferior mesenteric	C772	Intra-abdominal	Mesenteric
Inferior rectal (hemorrhoidal)	C775	Pelvic	Pelvic, right and left*
Inferior phrenic vein	C771	Intra-thoracic	Mediastinal
Inferior vena cava	C772	Intra-abdominal	Para-aortic
Infraauricular	C770	Head, face, and neck	Cervical, right and left*
Infraclavicular (subclavicular)	C773	Axilla or arm	Infraclavicular, right and left*
Infrapyloric	C772	Intra-abdominal	Para-aortic
Infundibulopelvic (utero-ovarian)	C775	Pelvic	Pelvic, right and left*
Inguinal (deep, sublingual, superficial, NOS)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Interaortocaval	C772	Intra-abdominal	Para-aortic
Intercostal	C771	Intrathoracic	Mediastinal

Interlobar (within the lung) (intrapulmonary)	C771	Intrathoracic	Mediastinal
Internal iliac (hypogastric, obturator)	C775	Pelvic	Pelvic, right and left*
Internal jugular (upper deep cervical)	C770	Head, face, and neck	Cervical, right and left*
Internal mammary (parasternal)	C771	Intrathoracic	Mediastinal
Interpectoral (Rotter's node)	C773	Axilla or arm	Axillary, right and left*
Intestinal	C772	Intra-abdominal	Mesenteric
Intra-abdominal	C772	Intra-abdominal	Mesenteric
Intrabronchial, NOS	C771	Intrathoracic	Hilar
Intramammary	C773	Axilla or arm	Axillary, right and left*
Intrapancreatic	C772	Intra-abdominal	Para-aortic
Intraparotid	C770	Head, face, and neck	Cervical, right and left*
Intrapelvic	C775	Pelvic	Pelvic, right and left*
Intrapulmonary (segmental, subsegmental)	C771	Intrathoracic	Mediastinal
Jugular (anterior, inferior [deep], internal, lateral, lower, mid, superior, NOS)	C770	Head, face, and neck	Cervical, right and left*
Jugulodigastric (subdigastric)	C770	Head, face, and neck	Cervical, right and left*
Jugulo-omohyoid (supraomohyoid)	C770	Head, face, and neck	Cervical, right and left*
Lateral aortic (ascending, lumbar, subaortic)	C772	Intra-abdominal	Para-aortic
Lateral axillary (brachial)	C773	Axilla or arm	Axillary, right and left*
Lateral compartment (jugular, mid and lower; supraclavicular; upper deep jugular; spinal accessory; retropharyngeal; submandibular; submental)	C770	Head, face, and neck	Cervical, right and left*
Lateral jugular	C770	Head, face, and neck	Cervical, right and left*
Laterosacral (lateral sacral)	C775	Pelvic	Pelvic, right and left*
Laterotracheal (anterior deep cervical)	C771	Intrathoracic	Cervical, right and left*
Left colic	C772	Intra-abdominal	Mesenteric
Left gastric (superior gastric)	C772	Intra-abdominal	Mesenteric
Left gastrocolic (superior gastrocolic)	C772	Intra-abdominal	Mesenteric
Left supraclavicular (Virchow's node, Trosier's node)	C770	Head, face, and neck	Cervical, right and left*
Leg/Lower limb	C774	Inguinal region or leg	Inguino-femoral, right and left*
Lesser curvature	C772	Intra-abdominal	Mesenteric
Lesser omentum (lesser omental)	C772	Intra-abdominal	Mesenteric
Level I axillary (low axillary) (superficial axillary)	C773	Axilla or arm	Infraclavicular, right and left*
Level II axillary	C773	Axillar or arm	Infraclavicular, right and left*
Level III axillary (deep axillary, high axillary)	C773	Axillar or arm	Infraclavicular, right and left*

Lineal (splenic)	C772	Intra-abdominal	Mesenteric
Lobar (intrapulmonary)	C771	Intrathoracic	Hilar
Lobar (proximal, pulmonary)	C771	Intrathoracic	Hilar
Low axillary (Level I axillary)	C773	Axilla or arm	Infraclavicular, right and left*
Lower deep cervical	C771	Intrathoracic	Cervical, right and left*
Lower jugular	C770	Head, face, and neck	Cervical, right and left*
Lower paratracheal (azygos)	C771	Intrathoracic	Mediastinal
Lower periesophageal (intrathoracic esophagus)	C771	Intrathoracic	Mediastinal
Lower peritracheal	C771	Intrathoracic	Mediastinal
Lower thoracic paraesophageal	C771	Intrathoracic	Mediastinal
Lumbar aortic (ascending, lateral, subaortic)	C772	Intra-abdominal	Para-aortic
Mandibular	C770	Head, face, and neck	Cervical, right and left*
Mastoid (postauricular, retroauricular, NOS)	C770	Head, face, and neck	Cervical, right and left*
Mediastinal (anterior, posterior, superior, NOS)	C771	Intrathoracic	Mediastinal
Mesenteric (inferior, sigmoid [sigmoidal], superior, NOS)	C772	Intra-abdominal	Mesenteric
Mesocolic	C772	Intra-abdominal	Mesenteric
Mid jugular	C770	Head, face, and neck	Cervical, right and left*
Midcolic	C772	Intra-abdominal	Pelvic, right and let*
Middle deep cervical	C771	Intrathoracic	Cervical, right and left*
Middle (right) colic	C772	Intra-abdominal	Mesenteric
Middle hemorrhoidal	C775	Pelvic	Pelvic, right and left*
Middle sacral (Gerota's node, promontorial)	C775	Pelvic	Pelvic, right and left*
Middle thoracic paraesophageal	C771	Intrathoracic	Mediastinal
Nasolabial (facial)	C770	Head, face, and neck	Cervical, right and left*
Node of Cloquet's or Rosenmuller (highest deep inguinal)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Obturator (internal iliac)	C775	Pelvic	Pelvic, right and left*
Pancreatic (Aselli's glands [nodes near pancreas], parapancreatic; peripancreatic, NOS)	C772	Intra-abdominal	Para-aortic
Pancreaticoduodenal (anterior, posterior, NOS)	C772	Intra-abdominal	Para-aortic
Pancreaticosplenic (pancreaticolineal)	C772	Intra-abdominal	Mesenteric
Para-aortic	C772	Intra-abdominal	Para-aortic
Parabronchial (peribronchial)	C771	Intrathoracic	Mediastinal
Paracardial	C772	Intra-abdominal	Mesenteric
Paracaval	C772	Intra-abdominal	Para-aortic
Paracervical	C775	Pelvic	Pelvic, right and left*
Paracolic (pericolic)	C772	Intra-abdominal	Para-aortic

Paraesophageal	C771	Intrathoracic	Mediastinal
Paralaryngeal	C770	Head, face, and neck	Cervical, right and left*
Parametrial	C775	Pelvic	Pelvic, right and left*
Parapancreatic	C772	Intra-abdominal	Para-aortic
Parapharyngeal	C770	Head, face, and neck	Cervical, right and left*
Pararectal (anorectal)	C775	Pelvic	Pelvic, right and left*
Parasternal (internal mammary)	C771	Intrathoracic	Mediastinal
Paratracheal (lower, NOS)	C771	Intrathoracic	Mediastinal
Parotid (peri-, NOS)	C770	Head, face, and neck	Cervical, right and left*
Pectoral (anterior axillary)	C773	Axilla or arm	Axillary, right and left*
Pelvic, NOS	C775	Pelvic	Pelvic, right and left*
Peri-aortic	C772	Intra-abdominal	Para-aortic
Peri-parotid	C770	Head, face, and neck	Cervical, right and left*
Peri-thymic	C770	Head, face, and neck	Cervical, right and left*
Peribronchial (parabronchial)	C771	Intrathoracic	Mediastinal
Pericardial (pericardiac)	C771	Intrathoracic	Mediastinal
Pericaval	C772	Intra-abdominal	Para-aortic
Pericholedochal (common bile duct)	C772	Intra-abdominal	Para-aortic
Pericolic (paracolic)	C772	Intra-abdominal	Mesenteric
Periduodenal	C772	Intra-abdominal	Para-aortic
Periesophageal	C771	Intrathoracic	Mediastinal
Perigastric (except cardiac)	C772	Intra-abdominal	Mesenteric
Peripancreatic	C772	Intra-abdominal	Para-aortic
Periportal	C772	Intra-abdominal	Pelvic, right and left*
Periprostatic	C775	Pelvic	Pelvic, right and left*
Perirectal	C775	Pelvic	Pelvic, right and left*
Periparotid	C770	Head, face, and neck	Cervical, right and left*
Perithyroidal	C771	Intrathoracic	Mediastinal
Peritracheal (lower)	C771	Intrathoracic	Mediastinal
Periureteral	C772	Intra-abdominal	Para-aortic
Perivesical	C775	Pelvic	Pelvic, right and left*
Pharyngeal (Delphian node, prepharyngeal, retropharyngeal, NOS)	C770	Head, face, and neck	Cervical right and left*
Phrenic vein (inferior, superior, NOS)	C771	Intra-thoracic	Mediastinal
Popliteal	C774	Inguinal region or leg	Inguino-femoral, right and left*
Porta hepatis (in hilus of liver)	C772	Intra-abdominal	Para-aortic
Portal (portal vein)	C772	Intra-abdominal	Para-aortic
Postauricular (mastoid, retroauricular)	C770	Head, face, and neck	Cervical, right and left*
Posterior axillary (subscapular)	C773	Axilla or arm	Axillary, right and left*
Posterior cecal (retrocecal)	C772	Intra-abdominal	Para-aortic
Posterior cervical (spinal accessory)	C770	Head, face, and neck	Cervical, right and left*
Posterior mediastinal (tracheoesophageal)	C771	Intrathoracic	Mediastinal
Postglandular	C770	Head, face, and neck	Cervical, right and left*
Posterior triangle	C770	Head, face, and neck	Cervical, right and left*

Postvascular	C770	Head, face, and neck	Cervical, right and left*
Preaortic	C772	Intra-abdominal	Para-aortic
Preauricular	C770	Head, face, and neck	Cervical, right and left*
Precarinal	C771	Intrathoracic	Mediastinal
Prececal (anterior cecal)	C772	Intra-abdominal	Mesenteric
Precricoid (Delphian node)	C770	Head, face, and neck	Cervical, right and left*
Preglandular	C770	Head, face, and neck	Cervical, right and left*
Prepharyngeal (Delphian node), adjacent to thyroid gland; anterior to thyroid isthmus	C770	Head, face, and neck	Cervical, right and left*
Presacral	C775	Pelvic	Pelvic, right and left*
Presymphseal	C775	Pelvic	Pelvic, right and left*
Pretracheal	C770	Head, face, and neck	Cervical, right and left*
Prevascular	C770	Head, face, and neck	Cervical, right and left*
Promontorial (Gerota's node, middle sacral)	C775	Pelvic	Para-aortic
Proximal lobar (bronchopulmonary, hilar, pulmonary root)	C771	Intrathoracic	Hilar
Proximal mesentery	C772	Intra-abdominal	Mesenteric
Pulmonary ligament	C771	Intrathoracic	Mediastinal
Pulmonary (pulmonary root, NOS)	C771	Intrathoracic	Hilar
Pyloric (infrapyloric, subpyloric, suprapyloric)	C772	Intra-abdominal	Para-aortic
Rectal (superior, NOS)	C775	Pelvic	Pelvic, right and left*
Recurrent laryngeal (anterior deep cervical, laterotracheal)	C770	Head, face, and neck	Cervical, right and left*
Recurrent pharyngeal (anterior deep cervical)	C770	Head, face, and neck	Cervical, right and left*
Renal artery	C772	Intra-abdominal	Para-aortic
Renal hilar	C772	Intra-abdominal	Para-aortic
Retroaortic	C772	Intra-abdominal	Para-aortic
Retro-auricular (mastoid, postauricular)	C770	Head, face, and neck	Cervical, right and left*
Retrocaval	C772	Intra-abdominal	Para-aortic
Retrocecal (posterior cecal)	C772	Intra-abdominal	Para-aortic
Retrocrural	C771	Intra-thoracic	Mediastinal
Retropancreatic	C772	Intra-abdominal	Para-aortic
Retroperitoneal	C772	Intra-abdominal	Para-aortic
Retropharyngeal	C770	Head, face, and neck	Cervical, right and left*
Retrotracheal (tracheal)	C771	Intrathoracic	Mediastinal
Right colic	C772	Intra-abdominal	Mesenteric
Right gastric	C772	Intra-abdominal	Mesenteric
Rosenmuller or Node of Cloquet (highest deep inguinal)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Rotter's nodes (interpectoral between major and minor pectoralis)	C773	Axilla or arm	Axillary, right and left*
Rouviere's node (retropharyngeal)	C770	Head, face, and neck	Cervical, right and left*

Sacral (lateral sacral, laterosacral, middle sacral, presacral, NOS)	C775	Pelvic	Pelvic, right and left*
Sacral (uterosacral)	C774	Pelvic	Pelvic, right and left*
Scalene (inferior deep cervical)	C770	Head, face, and neck	Cervical, right and left*
Segmental (intrapulmonary, subsegmental)	C771	Intrathoracic	Mediastinal
Sigmoid (sigmoidal mesenteric, NOS)	C772	Intra-abdominal	Mesenteric
Sister Mary Joseph	C772	Intra-abdominal	Mesenteric
Spermatic vein	C774	Inguinal region or leg	Inguino-femoral, right and left*
Spinal accessory (posterior cervical)	C770	Head, face, and neck	Cervical, right and left*
Splenic (hilar, lineal)	C772	Intra-abdominal	Mesenteric
Subaortic (ascending, lateral, lumbar)	C772	Intra-abdominal	Para-aortic
Subcapsular (posterior axillary)	C773	Axilla or arm	Infraclavicular, right and left*
Subcarinal	C771	Intrathoracic	Mediastinal
Subclavian (apical)	C770	Head, face, and neck	Cervical, right and left*
Subclavicular (infraclavicular)	C773	Axilla or arm	Axillary, right and left*
Subdigastric (jugulodigastric)	C770	Head, face, and neck	Cervical, right and left*
Subinguinal (superficial inguinal)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Sublingual	C770	Head, face, and neck	Cervical, right and left*
Submandibular (submaxillary)	C770	Head, face, and neck	Cervical, right and left*
Submaxillary (submandibular)	C770	Head, face, and neck	Cervical, right and left*
Submental	C770	Head, face, and neck	Cervical, right and left*
Suboccipital (occipital)	C770	Head, face, and neck	Cervical, right and left*
Subpleural (in the periphery of the lung)	C771	Intrathoracic	Mediastinal
Subpyloric	C772	Intra-abdominal	Para-aortic
Subsegmental (intrapulmonary, segmental)	C771	Intrathoracic	Mediastinal
Substernal	C771	Intrathoracic	Mediastinal
Superficial axillary (Level I axillary)	C773	Axilla or arm	Infraclavicular, right and left*
Superficial inguinal (femoral, subinguinal)	C774	Inguinal region or leg	Inguino-femoral, right and left*
Superior gastric (left gastric)	C772	Intra-abdominal	Mesenteric
Superior gastrocolic (left gastrocolic)	C772	Intra-abdominal	Mesenteric
Superior hemorrhoidal	C775	Pelvic	Pelvic, right and left*
Superior hilum	C772	Intra-abdominal	Pelvic, right and left*
Superior jugular	C770	Head, face, and neck	Cervical, right and left*
Superior mediastinal	C771	Intrathoracic	Mediastinal
Superior mesenteric	C772	Intra-abdominal	Pelvic, right and left*
Superior phrenic vein	C771	Intra-thoracic	Mediastinal
Superior rectal (hemorrhoidal)	C775	Pelvic	Pelvic, right and left*
Supraclavicular (transverse cervical)	C770	Head, face, and neck	Cervical, right and left*
Supraomohyoid (jugulo-omohyoid)	C770	Head, face, and neck	Cervical, right and left*

Suprapancreatic	C772	Intra-abdominal	Para-aortic
Suprapyloric	C772	Intra-abdominal	Para-aortic
Thoracic	C771	Intrathoracic	Mediastinal
Thyroid	C770	Head, face, and neck	Cervical, right and left*
Tibial	C774	Inguinal region or leg	Inguino-femoral, right and left*
Tracheal (retrotracheal, NOS)	C771	Intrathoracic	Mediastinal
Tracheal bifurcation (carinal, tracheobronchial)	C771	Intrathoracic	Mediastinal
Tracheobronchial (carinal, tracheal bifurcation)	C771	Intrathoracic	Mediastinal
Tracheoesophageal (posterior mediastinal)	C771	Intrathoracic	Mediastinal
Transverse cervical (supraclavicular)	C770	Head, face, and neck	Cervical, right and left*
Trosier's node (left supraclavicular)	C770	Head, face, and neck	Cervical, right and left*
Upper deep cervical (internal jugular)	C770	Head, face, and neck	Cervical, right and left*
Upper thoracic paraesophageal	C771	Intrathoracic	Mediastinal
Utero-ovarian (infundibulopelvic)	C775	Pelvic	Pelvic, right and left*
Uterosacral	C774	Pelvic	Pelvic, right and left*
Virchow's node (left supraclavicular)	C770	Head, face, and neck	Cervical, right and left*

*The right and left are separate regions per AJCC.

UNIT ABBREVIATIONS

NUMBER	PREFIX	WRITTEN
1,000,000	Mega-	M
1,000	Kilo-	K
1 (baseline)	Deka-	Da
1/10	Deci-	d
1/100	Centi-	c
1/1000	Milli-	m
One millionth	Micro-	µ
One billionth	Nano-	n
One trillionth	Pico-	p
One quadrillionth	Femto	f

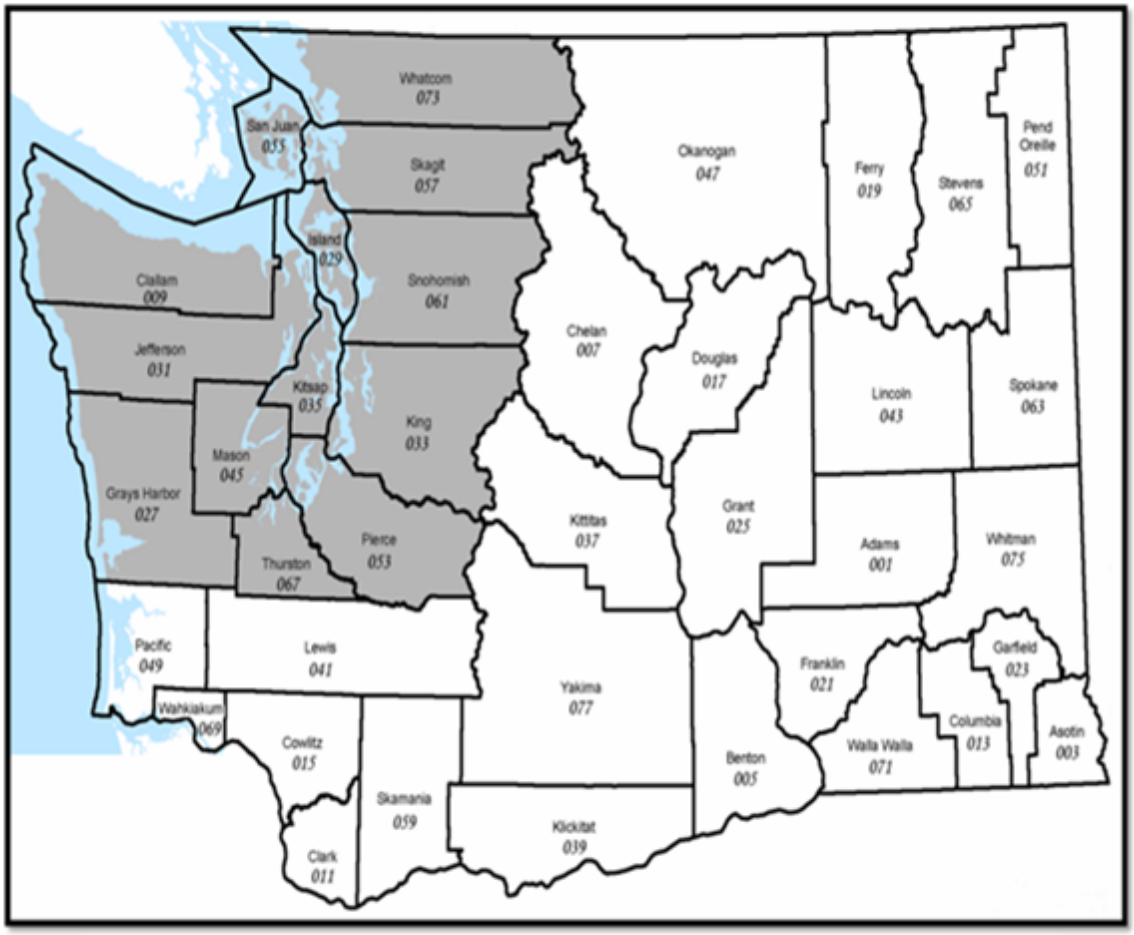
MEASUREMENT PREFIXES

UNIT	ABBREVIATION
Liter	l
Unit	U
Meter	m
Unit of substance	mole, mol
Gram	g, gr
milli Equivalent	mEq, meq

COMMON CODES IN SITE-SPECIFIC FACTORS

CODE	DESCRIPTION
000	0 ng/ml
001	0.1 or less ng/ml
002-979	0.2-97.9 ng/ml
980	98.0 or greater ng/ml
988	Not applicable. Information not collected for this case. May include cases converted from code 888 used in CSv1 for “Not Applicable” or when the item was not collected. If this item is required to derive T, N, M, or any stage, use of code 988 may result in an error.
997	Test ordered, results not in chart
998	Test not done (test was not ordered and was not performed)
999	Unknown or no information; Not documented in patient record

WASHINGTON STATE CANCER REGISTRY



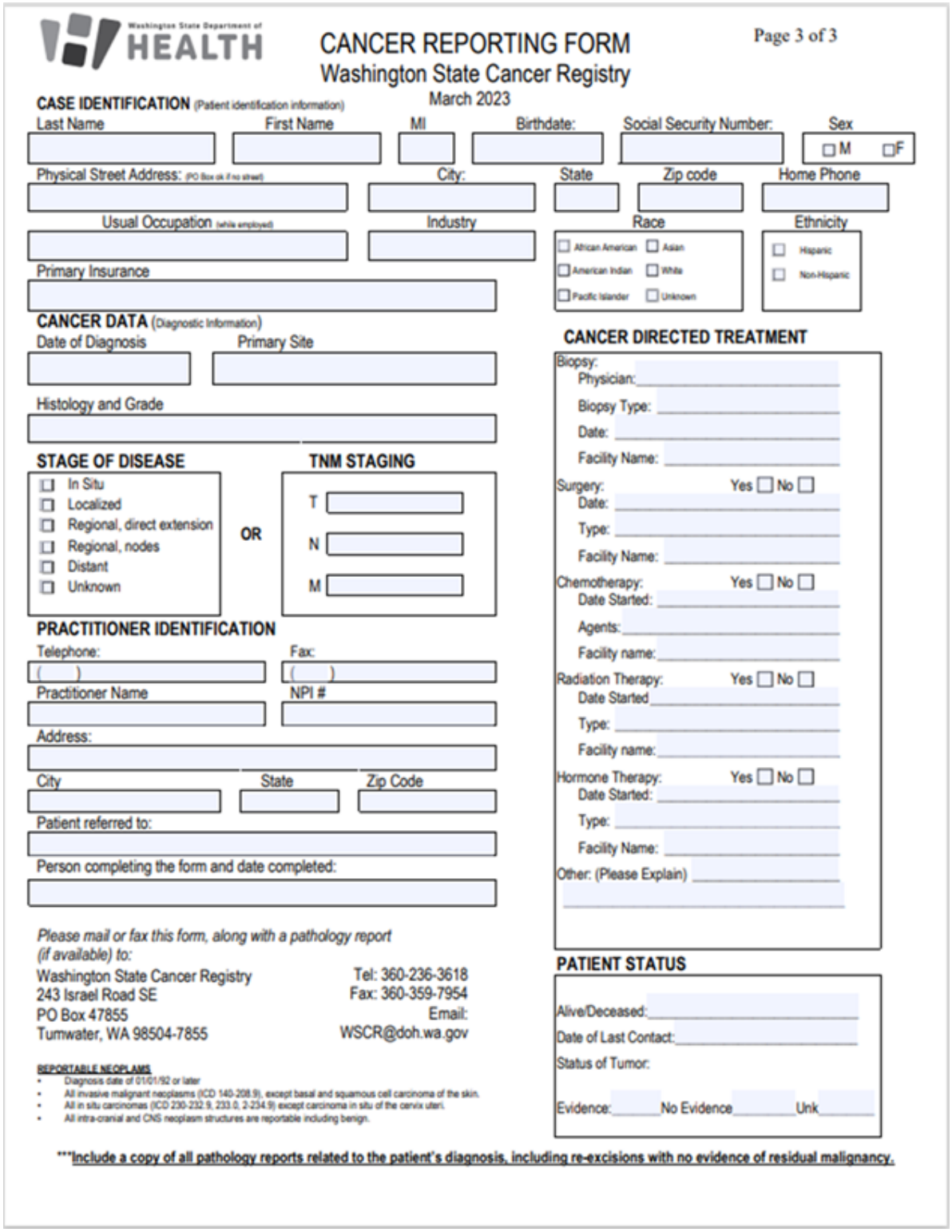
Washington State County FIPS Codes and Western Washington SEER Reporting Area.

= SEER Reporting Area

FIPS COUNTY CODES

County Code	County
001	Adams County
003	Asotin County
005	Benton County
007	Chelan County
009	Clallam County
011	Clark County
013	Columbia County
015	Cowlitz County
017	Douglas County
019	Ferry County
021	Franklin County
023	Garfield County
025	Grant County
027	Grays Harbor County
029	Island County
031	Jefferson County
033	King County
035	Kitsap County
037	Kittitas County
039	Klickitat County
041	Lewis County
043	Lincoln County
045	Mason County
047	Okanogan County
049	Pacific County
051	Pend Oreille County
053	Pierce County
055	San Juan County
057	Skagit County
059	Skamania County
061	Snohomish County
063	Spokane County
065	Steven County
067	Thurston County
071	Walla Walla County
073	Whatcom County
075	Whitman County
077	Yakima County

WSCR CANCER REPORTING FORM



Washington State Department of HEALTH

CANCER REPORTING FORM
Washington State Cancer Registry
March 2023

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CASE IDENTIFICATION (Patient identification information)

Last Name | First Name | MI | Birthdate: | Social Security Number: | Sex ☐M ☐F

Physical Street Address: (PO Box ok if no street) | City: | State | Zip code | Home Phone

Usual Occupation (while employed) | Industry

Race: ☐ African American ☐ Asian ☐ American Indian ☐ White ☐ Pacific Islander ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Primary Insurance

CANCER DATA (Diagnostic Information)

Date of Diagnosis | Primary Site

Histology and Grade

STAGE OF DISEASE

☐ In Situ
☐ Localized
☐ Regional, direct extension
☐ Regional, nodes
☐ Distant
☐ Unknown

OR

TNM STAGING

T
N
M

PRACTITIONER IDENTIFICATION

Telephone: ( ) | Fax: ( )

Practitioner Name | NPI #

Address:

City | State | Zip Code

Patient referred to:

Person completing the form and date completed:

Please mail or fax this form, along with a pathology report (if available) to:

Washington State Cancer Registry
243 Israel Road SE
PO Box 47855
Tumwater, WA 98504-7855

Tel: 360-236-3618
Fax: 360-359-7954
Email:
WSCR@doh.wa.gov

REPORTABLE NEOPLASMS

- Diagnosis date of 01/01/92 or later
- All invasive malignant neoplasms (ICD 140-208.9), except basal and squamous cell carcinoma of the skin.
- All in situ carcinomas (ICD 230-232.9, 233.0, 2-234.9) except carcinoma in situ of the cervix uteri.
- All intra-cranial and CNS neoplasm structures are reportable including benign.

CANCER DIRECTED TREATMENT

Biopsy:
Physician:
Biopsy Type:
Date:
Facility Name:

Surgery: Yes ☐ No ☐
Date:
Type:
Facility Name:

Chemotherapy: Yes ☐ No ☐
Date Started:
Agents:
Facility name:

Radiation Therapy: Yes ☐ No ☐
Date Started
Type:
Facility name:

Hormone Therapy: Yes ☐ No ☐
Date Started:
Type:
Facility Name:

Other: (Please Explain)

PATIENT STATUS

Alive/Deceased:
Date of Last Contact:
Status of Tumor:

Evidence: No Evidence Unk

***Include a copy of all pathology reports related to the patient's diagnosis, including re-excisions with no evidence of residual malignancy.

References & Resources

National Cancer Institute – Surveillance, Epidemiology, and End Results Program (SEER)
Surveillance, Epidemiology, and End Results Program (cancer.gov)

North American Association of Central Cancer Registries (NAACCR)
Home (naaccr.org)

National Cancer Registrars Association (NCRA)
National Cancer Registrars Association > Home (ncra-usa.org)

American College of Surgeons (ACOS)
American Joint Committee on Cancer
American Joint Committee on Cancer | ACS (facs.org)

Cancer Program
Cancer Programs | ACS (facs.org)

Commission on Cancer
Commission on Cancer | ACS (facs.org)

National Accreditation for Breast Cancer Programs
National Accreditation Program for Breast Centers (NAPBC) | ACS (facs.org)

National Accreditation Program for Rectal Cancer
National Accreditation Program for Rectal Cancer | ACS (facs.org)

National Cancer Database
National Cancer Database (NCDB) | ACS (facs.org)

Cancer Surgery Standards Program
Cancer Surgery Standards Program | ACS (facs.org)

College of American Pathologists
Cancer Protocol Templates | College of American Pathologists (cap.org)

Washington State Cancer Registry
Cancer Data | Washington State Department of Health

Washington State Comprehensive Cancer Control Program
About Comprehensive Cancer Control | Washington State Department of Health

Washington State Breast, Cervical, and Colon Health Program
Breast, Cervical and Colon Health Program | Washington State Department of Health

Revised Code of Washington
Revised Code of Washington (RCW)

Cancer Surveillance System (Fred Hutch Cancer Center)
Cancer Surveillance System (CSS) (fredhutch.org)

Resources for Registrars and Vendors | Washington State Department of Health
Resources for Registrars and Vendors | Washington State Department of Health

***Note: All information found in this handbook can be found by using the above-mentioned resources. While our office will always try to give you the most up to date information available, it is possible that updates will occur in between the dates we have updated this document, and you have received it. We encourage everyone to be diligent and always double check with standard setters and your own facility for additional information and updates. ***