



GEORGIA DEPARTMENT OF HUMAN
RESOURCES

Division of Public Health

Georgia Comprehensive Cancer Registry

*Policy and Procedure Manual for
Reporting Facilities*

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To download an electronic copy of this manual please visit our website at:
<http://health.state.ga.us/programs/gccr/reporting.asp>

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**Georgia Comprehensive Cancer Registry
Reporting Manual**

Section 1: Introduction

1. INTRODUCTION

The Georgia Comprehensive Cancer Registry (GCCR) is a population-based cancer registry that includes all cancer cases diagnosed in Georgia residents since January 1, 1995. The GCCR serves the entire state of Georgia, which includes a population of approximately 8.9 million people.

The purpose of the GCCR is to collect, analyze, utilize and disseminate cancer incidence information. Such information helps state agencies, health care providers and Georgia citizens to monitor cancer incidence trends; plan and implement cancer control and prevention activities; develop public and professional education programs; and stimulate scientific cancer research.

Legal authority of the Georgia Department of Human Resources (DHR) to collect health information established the GCCR. The Official Code of Georgia (O.G.C.A.) Chapter 12 § 31-12-1 empowers the DHR to "... conduct studies, research and training appropriate to the prevention of diseases...". O.C.G.A. § 31-12-2 allows the DHR to require certain diseases and injuries to be reported in a manner and at such times as may be prescribed. (A copy of the official codes can be referenced in Section 7 of this manual).

All health care providers in the state of Georgia are required to report specific information on cancer in their patient population to the Georgia Comprehensive Cancer Registry. This includes all facilities providing diagnostic evaluations and/or treatment for cancer patients, such as: hospitals, outpatient surgical facilities, laboratories, radiation therapy and medical oncology facilities, and physician's offices. In addition, reporting agreements are maintained with neighboring states so that Georgia residents who are diagnosed or treated in facilities out of state can be identified.

The code also addresses the confidentiality of information requested by DHR, and releases from civil liability providers reporting this information (§ 31-12-2 (a)). This section states, "...all such reports shall be deemed confidential and shall not be open to inspection by the public."

The GCCR participates in the National Program for Cancer Registries (NPCR). NPCR was established by the Centers for Disease Control and Prevention (CDC) in 1992 through the Federal Cancer Registry Amendment Act (Public Law 102-515). NPCR provides funding and guidance for the development of cancer registries throughout the United States.

The GCCR is a member of the North American Association of Central Cancer Registries (NAACCR), which is a professional society that was established in 1987. NAACCR provides ongoing development of cancer registries and the establishment of registry standards.

The Department of Human Resources, Division of Public Health has designated the Georgia Center for Cancer Statistics (GCCS) at the Rollins School of Public Health of Emory University as its agent for the purpose of collecting and editing cancer data. The GCCS is one of the fourteen population-based cancer registries supported by the Surveillance,

Epidemiology, and End Results (SEER) Program of the National Cancer Institute. The SEER Program is the most authoritative source of information on cancer incidence and survival in the United States. Since 1975, the GCCS has collected detailed information on incident cases of cancer in a five county area of metropolitan Atlanta. In 1978, ten rural Georgia counties were added to the SEER program creating the Metropolitan Atlanta and Rural Georgia SEER Registry. Given its extensive background in cancer registration, the GCCS was selected to be the designated agent of DHR to conduct the day-to-day data collection and management activities for the entire state of Georgia.

**Georgia Comprehensive Cancer Registry
Reporting Manual**

Section 2: Reporting Guidelines

2. GCCR REPORTING GUIDELINES

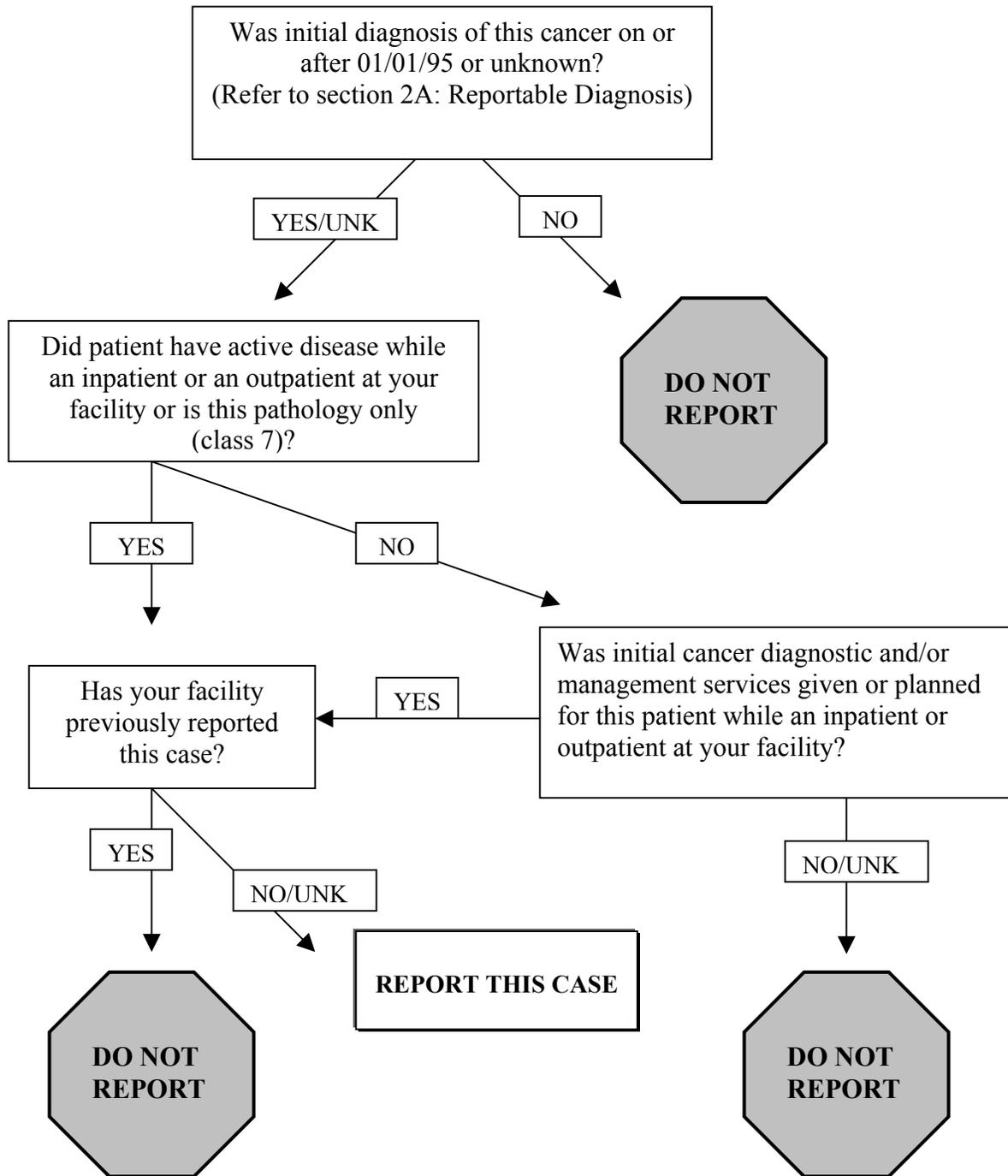
A. REPORTABLE DIAGNOSES

The Notifiable Disease Law, Official Code of Georgia Annotated (O.C.G.A.) § 31-12-2, mandates the reporting of certain diseases including cancer. All cancers diagnosed since January 1, 1995, in persons receiving cancer diagnostic and/or management services or who have active disease must be reported to the Georgia Comprehensive Cancer Registry (GCCR) unless previously reported by that facility. This includes all cancers indicated in the appropriate version of the International Classification of Diseases for Oncology (ICD-O), with a behavior code of 2 or 3. As of January 1, 2004, any case diagnosed with benign brain or central nervous system tumors are also now reportable. See the table below for the list of exceptions.

The reportable list below is based on the NPCR required data set.

	Cases diagnosed 1/1/1995 and later	Cases diagnosed 1/1/2004 and later
Reportable Diagnoses	Behavior code of '2' or '3' as defined in ICD-O-2 and ICD-O-3 <ul style="list-style-type: none"> • VIN III (Vulvar intraepithelial neoplasia, grade III) • VAIN III (Vaginal intraepithelial neoplasia, grade III) • Skin cancer of the genital sites (C51-, C52.9, C60-, C63.2) with histology (8000-8110) • Borderline cystadenomas of the ovaries (M8442, 8451, 8462, 8472, 8473) Cases diagnosed 2001 and later <ul style="list-style-type: none"> • AIN III (Anal intraepithelial neoplasia, grade III) • Pilocytic/juvenile astrocytoma (M9421) will be collected as a/3 	Behavior code of '0' or '1' as defined in ICD-O-3 <ul style="list-style-type: none"> • Meninges (C70.0 – C70.9) • Brain (C71.0 – C71.9) • Spinal Cord, cranial nerves, and other parts of the Central nervous System (C72.0 – C72.9) • Pituitary gland (C75.1) • Craniopharyngeal duct (C75.2) • Pineal gland (C75.3)
Exceptions (not reportable)	<ul style="list-style-type: none"> • Carcinoma in situ of the cervix and CIN III (Cervical intraepithelial neoplasia) • Skin cancer (C44-) with histology (M8000-8110) of the non-genital sites Cases diagnosed 2001 and later <ul style="list-style-type: none"> • Borderline cystadenomas of the ovaries (M8442, 8451, 8462, 8472, & 8473) • PIN III (Prostatic intraepithelial neoplasia) 	

B. REPORTING CHART



C. WHO IS REQUIRED TO REPORT

All providers of health care including, but not limited to, hospitals, outpatient surgical facilities, laboratories, radiation therapy facilities, medical oncology facilities and physician offices are required to report.

NOTE: The hospital that receives a pathology specimen diagnostic of cancer from another hospital is not required to report the case. It is the responsibility of the hospital or outpatient facility that first collected or received the specimen to report the case. However, if a hospital receives a pathology specimen diagnostic of cancer from a physician's office, the hospital is required to report the case. Laboratory only cases are not required to be reported.

D. HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not impact the status of cancer reporting procedures. HIPAA allows for the reporting of identifiable cancer data and other reportable conditions to public health entities. The Georgia Comprehensive Cancer Registry falls under the definition of a public health entity. HIPAA allows all facilities to continue reporting data to the GCCR in compliance with state law.

For up to date interpretations of HIPAA rules, refer to NAACCR website at www.naaccr.org additional information can be found in Section 7 (Reporting Law and Mandate) of this manual.

E. WHAT TO REPORT

Report all required data elements as described in Section 4 (GCCR Required Data Set and Instructions for Abstracting and Coding.)

F. HOW TO REPORT

All hospitals with a total licensed bed size greater than 100 beds or with an average case load of 100 cases or more must submit the required data electronically using Abstract Plus software provided free of charge by GCCR, or using other available registry software. Electronic files must be submitted via e-mail attachment utilizing the GCCR provided encryption software and file naming conventions outlined in the GCCR Policy and Procedure Manual section 2G.2.

All hospitals with a total licensed bed size less than or equal to 100 beds may also submit the required data electronically. Alternatively, photocopies of medical records may be submitted as outlined in the *GCCR Casefinding Manual* (The following reports from the medical record should be submitted: Face sheet, H&P, pathology report, operative report, discharge summary, X-Rays, scans, scopes, and other diagnostic reports). Once submitted, send notification on hospital letterhead to GCCS via fax, U.S mail or e-mail that your disease index has been submitted to your regional coordinator.

Guidelines for ALL facilities regardless of size:

A facility will be considered delinquent for the monthly submission if data has not been received at GCCR by the last day of the month.

If a facility had no reportable cases for a month, a written notice on hospital letterhead should be submitted stating so. Also, if it is not possible for a facility to submit during a given month, a notice must be submitted in writing stating the reason and when the facility plans to report cases. The facility will not be considered delinquent if notice is received by the last day of the month. Acceptable reasons for not reporting are 1) recent personnel losses, 2) recent computer problems (software/hardware), 3) natural disasters, and 4) no cases to report.

The facility will receive a postcard or e-mail from GCCS notifying the facility that the data submission has been received. **If you do not receive the postcard/e-mail within a week after sending your submission, you should call GCCS for confirmation.**

G. ELECTRONIC REPORTING FACILITIES

G.1 DATA EDITING

GCCR requires all submitted data to be edited by the GA edit software. An edit report should be attached to or included with each submitted data file. To obtain the GA edit software please contact your regional coordinator. The GA edit software is free of charge and available to all hospitals.

G.2 File naming conventions for data sent to the Georgia Center for Cancer Statistics

GCCR requires all confidential data be encrypted before the electronic transmission of data. Hospitals should use the encryption software provided by GCCR “Advanced Encryption Package developed by Secure Action (www.secureaction.com).

Submitted files should follow the format: **XXXXXXMMYY_#EXT.txt** where,
 XXXXXX = the 6 digit facility number of the facility submitting the data
 MMM = the first 3 characters of the month in which the file is submitted
 YY = the last 2 digits of the year in which the file is submitted
 _ = an ‘underscore’ character (hold shift key and press minus sign)
 # = the submission number for that month of the same file type (see EXT below)
 EXT = a file extension indicating the type of the data submission (see below)
 .txt = a text file extension

Re-submitted files due to records rejected during a prior submission should follow the format: XXXXXXMMYY_#EXTR.txt., where the R represents the file is a resubmission.

Valid file extensions (EXT) include:

HOS: Monthly hospital submission

HOSR: Monthly hospital resubmission

(resubmitted data from corresponding rejected abstract reports)

PHD: Photocopy Disk submission

PHDR: Photocopy Disk resubmission*(resubmitted data from corresponding rejected abstract reports)***CFA: Case-finding audit submission***(data identified as missing from the registry based on the Casefinding audit match)***DCO: Death clearance submission***(data identified as missing from the Registry based on the state death certificates)***DIS: Hospital discharge submission***(data identified as missing from the Registry based on Hospital discharge match)***CSA: Cancer state aid submission***(data identified as missing from the Registry based on the Cancer State Aid match)***RCA: Rapid Case Ascertainment***(data identified as part of rapid case ascertainment process)***MSC: Any other miscellaneous data submission***(all other submissions not falling into any of the above categories should include detailed text describing exactly what the miscellaneous submission includes)*

Examples:

Facility Number	Type of Data Submission	Data Submitted in Month Year	Submission number that month for the same file type	Appropriate File Name
380000	Monthly Hospital	January 2006	1	380000JAN06_1HOS.txt
380000	Monthly Hospital (2 nd submission, same month and year)	January 2006	2	380000JAN06_2HOS.txt
380000	Resubmission of January 2003 rejected data	February 2006	1	380000JAN06_1HOSR.txt
380000	Case-Finding Audit	March 2006	1	380000MAR06_1CFA.txt
380000	Death Clearance	January 2006	1	380000JAN06_1DCO.txt

G.3 ADVANCED ENCRYPTION PACKAGE

The GCCR has purchased encryption software for all of our electronic reporting facilities. This software will allow you to encrypt files so that you can safely and quickly submit your data to the Georgia Center for Cancer Statistics by email. The encryption software was purchased from SecureAction (www.secureaction.com). The encryption algorithm uses "very strong military grade encryption to make sure that your private data remains confidential."

Your facility has been provided with one licensed copy of this software to be installed on a single computer. Refer to the instructions below for properly using the encryption software before you submit your data via email.

1. Name your data file as described in "2G.2 File naming conventions for data sent to the Georgia Center for Cancer Statistics" above.
2. Start the application.
3. Click the "**Encryption**" button in the upper right corner of the screen.

4. Using the file manager on the left side of the screen, locate and select the file you would like to encrypt.
5. Under “**Encryption settings,**” enter the password provided to you in both the “**Password:**” and “**Confirmation:**” text boxes.
6. Select “**DESX**” as the encryption algorithm.
7. Select “**Leave it alone**” for the original file option.
8. Make sure the “**Compress**” option is checked.
9. Press “**GO!**” The encrypted file will be created in the same directory as the original file and will have a “.aep” extension.
10. Open your email application and attach the encrypted file in an email to gccs@sph.emory.edu

For additional information on Advanced Encryption Package refer to your regional coordinator (Section 8:Resources and References.)

H. WHEN TO REPORT

GCCR should comply with the established goals and standards set by the National Program for Cancer Registries (NPCR) of the Centers for Disease Control and Prevention (CDC) for timeliness of data collection. The established standard for timeliness is to have each cancer reported to the central registry within six months from the date of diagnosis of the cancer.

1. Facilities should report monthly either by electronic or photocopy submission. The facility will be notified by GCCS when the data submission has been received.
2. A facility will be considered delinquent for the monthly submission if data has not been received at GCCS by the last day of the month. For example, January submissions should be received on or before January 31st to be considered timely. If it is not possible for a facility to submit data during a given month, a notice should be submitted in writing on the facility’s letterhead to GCCS prior to the end of the month stating both the reason for not submitting data and when the hospital plans to report. If an acceptable reason is provided the facility will not be considered delinquent. Acceptable reasons for not reporting include but are not limited to 1) recent personnel losses, 2) recent computer problems (software/hardware), 3) natural disasters, and 4) no data to report.
3. Timeliness will be monitored by GCCS staff. The facility will receive a phone call and/or letter from the GCCR Regional Coordinator if a data submission is overdue.

I. WHERE TO SEND REPORTS

GCCR requires all confidential data be encrypted before the electronic transmission of data. Hospitals should have the encryption software “Advanced Encryption Package.” Contact your Regional Coordinator to obtain a copy of the encryption software. Refer to Section 9: Resources and References in this manual.

Email: GCCS@sph.emory.edu

UPS/Other Special Delivery:
ATTN: DATA SUBMISSION
Georgia Center for Cancer Statistics
1462 Clifton Road, NE, Fifth Floor
Atlanta, GA 30322
404-727-8700
404-727-7261 (fax)

Mail Delivery:
ATTN: DATA SUBMISSION
Georgia Center for Cancer Statistics
1462 Clifton Road, NE, Fifth Floor
Atlanta, GA 30322

J. REPORTING EDITS, REJECTION, UPDATES, AND DELETIONS TO THE GCCR

Corrected edit error reports and rejected data must be resubmitted to the GCCR within 30 days of the date stated on the letter or email your facility receives. Re-submitted files due to records rejected during a prior submission should follow the format stated in Section 2G.2 (see Section 8: Resources and References of this manual for more information on GCCR submission web site. (File naming conventions for data sent to the Georgia Center for Cancer Statistics.) Edited error reports should be emailed (encrypted) or mailed to GCCS to the address listed above in Section 2I.

Changes, deletions or updates to cases should be submitted using the incidental form “GCCR Incidental Updates” (see Section 8: Resources and References of this manual). A printed copy of the hospital abstract may be sent; highlighting the fields that have been changed, deleted and/or updated. Submit this information via mail or electronically (encrypted) to the above address. It is important to notify the GCCR of any changes in your database so that GCCR can maintain an up-to-date registry <http://www.sph.emory.edu/GCCS>.

K. CONFIDENTIALITY

The Georgia Comprehensive Cancer Registry maintains the confidentiality of the information in submitted reports. For specific policies and procedures, see Section 3: Confidentiality.

L. REQUIRED CODING AND INSTRUCTION DOCUMENTS

1. International Classification of Diseases for Oncology — edition based on year of diagnosis.
 - ICD-O-2 for cases diagnosed 1/1/95 –12/31/2000
 - ICD-O-3 for cases diagnosed 1/1/2001 and after <http://seer.cancer.gov/icd-o-3/>
2. SEER Extent of Disease 1998 Codes and Coding Instructions (case diagnosed 1995-2003)
3. Summary Staging Guide - edition based on year of diagnosis
 - Summary Staging Guide, SEER Program, April 1977 for cases diagnosed 1/1/1995-12/31/2000
 - SEER Summary Staging Manual 2000 for cases diagnosed 1/1/2001-12/31/2003. <http://seer.cancer.gov/tools/ssm/index.html>
4. Collaborative Staging and Coding Manual for cases diagnosed 1/1/2004 and after. <http://www.cancerstaging.org/cstage/manuals.html>

L.1 ICD-O-3 MANUAL CHANGES/UPDATE

For updates and errata to the ICD-O-3 manual see the SEER website at <http://seer.cancer.gov/icd-o-3/>

M. CASEFINDING

Casefinding is the system used to identify patients with reportable cancer. Casefinding involves thorough, systematic monitoring of records maintained by various departments throughout the hospital. Multiple sources should be used to ensure complete reporting of all cases.

Casefinding Sources:

Admission and discharge documents	Autopsy reports
Disease indexes	Outpatients medical records/logs
Surgery schedules/logs	Nuclear medicine documents
Pathology and Cytology reports	Radiation oncology logs
Hematology reports	Medical oncology logs
Diagnostic imaging	Neurology clinics

Refer to the GCCR Casefinding Manual for a complete guide on how to conduct systematic casefinding at your hospital.

ICD-9-CM CODES FOR CASEFINDING BY DISEASE INDEX SCREENING

Casefinding in medical records/health information should be done using both inpatient and outpatient disease/diagnostic indexes. Review all records with the following ICD-9 codes.

An asterisk (*) indicates conditions that are reportable as of January 1, 2001. A number sign (#) indicate conditions that are reportable as of January 1, 2004

- 140.0 -195.8 Primary malignant neoplasms, of specified sites, except of lymphatic & hematopoietic tissue
- 196.0 - 198.8 Secondary malignant neoplasms, of specified sites
- 199.0 - 199.1 Malignant neoplasms, without specification of site
- 200.0 - 208.9 Malignant neoplasms of lymphatic and hematopoietic tissue
- 205.1* Chronic neutrophilic leukemia
- 225.0 – 225.9# Benign neoplasm of brain and other parts of nervous system
- 227.3# Benign neoplasm of pituitary, craniopharyngeal duct, craniobuccal pouch, hypophysis, Rathke's pouch, sella turcica
- 227.4# Benign neoplasm of pineal gland, pineal body
- 230.0 - 234.9 Carcinoma in situ (exclude 233.1, cervix)
- 235.0 - 238.9 Neoplasms of uncertain behavior
 - 237.0# Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct
 - 237.1# Neoplasm of uncertain behavior of pineal gland
 - 237.5# Neoplasm of uncertain behavior of brain and spinal cord
 - 237.6# Neoplasm of uncertain behavior of meninges: NOS, cerebral, spinal
 - 237.70# Neurofibromatosis, Unspecified von Recklinghausen's Disease
 - 237.71# Neurofibromatosis, Type One von Recklinghausen's Disease
 - 237.72# Neurofibromatosis, Type Two von Recklinghausen's Disease
 - 237.9# Neoplasm of uncertain behavior of other and unspecified parts of nervous system; cranial nerves
 - 238.4* Polycythemia vera
 - 238.7* Chronic myeloproliferative disease
 - Myelosclerosis with myeloid metaplasia
 - Idiopathic thrombocythemia
 - Essential (Idiopathic) thrombocythemia
 - Refractory cytopenia with multilineage dysplasia
 - Myelodysplastic syndrome with 5q- syndrome
 - Therapy related myelodysplastic syndrome
- 239.0 - 239.9 Neoplasms of unspecified nature
- 273.2 Gamma heavy chain disease; Franklin's disease
- 273.3 Waldenstrom's macroglobulinemia
- 284.9* Refractory anemia
- 285.0* Refractory anemia with ringed sideroblasts
 - Refractory anemia with excess blasts
 - Refractory anemia with excess blasts in transformation
- 288.3* Hypereosinophilic syndrome
- 289.8 Acute myelofibrosis

N. CASEFINDING AUDITS

Annually, the GCCR director selects hospitals that will undergo casefinding audits. The purpose of the casefinding audit is to provide reporting facilities with an external assessment of the completeness of their reporting. A hospital also can request an audit be conducted on their facility. To do so, please contact your regional coordinator. Refer to Section 8 (Resources and References) of this manual to find the regional coordinator in your region. The following steps are taken when a hospital participates in a casefinding audit:

1. Regional coordinator contacts the facility to schedule an audit.
2. GCCR provides the regional coordinator with a list of reported patients for the facility.
3. Regional coordinator identifies all casefinding sources at the hospital.
4. Regional coordinator requests and reviews a disease index for the audit period.
5. Regional coordinator uses Abstract Plus casefinding program to input data from the sources screened.
6. Once the screening of hospital records is done, the regional coordinator compares the list of cases reported by the hospital before the audit with the cancer identified during the audit.
7. Regional coordinator provides a list of all patients missed by the hospital to the appropriate hospital personnel.
8. Hospital submits missed cases within 60 days after the end of the case finding audit.
9. GCCR director sends letter to the hospital administrator summarizing the results of the audit.

O. DEATH CLEARANCE

Death clearance is conducted every year by GCCR to improve completeness of reporting. Death clearance in a population-based registry includes two steps. The first step is to link death records from Georgia's vital statistics to the cancer registry records. This linkage produces three outcomes: positive matches, possible matches and non-matches. The second step is to seek information about the diagnosis of cancer from the institution mentioned on the death certificate for deaths that were non-matches. On a yearly basis, GCCR conducts death clearance and a follow-back list is created and disseminated to the appropriate hospitals. Hospitals are expected to send the follow-back data to GCCR within 60 days from the date they receive the list.

See Section 2I (Where to Send Reports) and Section 2G (Electronic Reporting Facilities) for the appropriate naming and submission of the death follow-back records.

P. HOSPITAL DISCHARGE LINKAGE

The hospital discharge linkage is another method used by GCCR to improve completeness. Each year, GCCR links the hospital discharge database to the central cancer registry database. This linkage included two steps. The first step is to link the hospital discharge database records to the cancer registry database records with three possible outcomes: positive matches, possible matches and non-matches. The second step is to seek information about the

cases with an ICD-9-CM diagnosis code of cancer as the principal cause of hospital admission in the hospital discharge database but were not reported to GCCR (non-matches).

Every year the GCCR will send non-match lists to the appropriate hospitals. Hospitals should evaluate these cases for reportability. Once the hospital determines that the case is a reportable case based on Section 2A in this manual, the hospital should submit these cases to GCCR. Hospitals are expected to send information about previously unreported cases within 90 days to the GCCR.

See Section 2I (Where to Send Reports) and Section 2G (Electronic Reporting Facilities) for the appropriate naming and submission of the hospital discharge follow-back records.

Q. RAPID CASE ASCERTAINMENT

Rapid Case Ascertainment (RCA) is a casefinding procedure to identify cancer cases very soon after diagnosis. Information obtained through RCA will serve as a basis for quality control of GCCR case completeness, and will permit cancer incidence in Georgia to be reported earlier than would otherwise be possible. GCCR is testing the implementation of a RCA system in several hospitals throughout Georgia (3/2003). Once this testing has been completed and feed-back has been addressed, GCCR will notify all facilities of the start date for implementation of RCA in Georgia. At that point, GCCR staff will visit pathology laboratories on a regular basis to rapidly identify cancer cases and abstract preliminary demographic, cancer identification, stage and treatment information into the computerized Abstract Plus RCA system.

The RCA system will be used to improve GCCR completeness and timeliness. It also can assist researchers in identifying cases who may be eligible to participate in research studies that have been approved by the Department of Human Resources, Institutional Review Board (DHR/IRB) (see Section 3: Confidentiality). In addition, the RCA system could be used to identify patients who may be eligible for and may benefit from clinical therapeutic trials.

**Georgia Comprehensive Cancer Registry
Reporting Manual**

Section 3: Confidentiality

3. CONFIDENTIALITY

INTRODUCTION

Confidentiality of data is of great concern to the Georgia Comprehensive Cancer Registry (there in after referred to as Registry) and is extremely important to the operation and maintenance of the Registry. The following are critical elements of the Registry's comprehensive confidentiality policies and procedures that relate to research use, reporting, and release of cancer data.

Confidentiality policies, pledges, and procedures are required in all phases of registry operation in order to:

- Protect the privacy of the individual cancer patient.
- Protect the privacy of the facilities reporting the case.
- Protect the privacy of the physicians and other providers responsible for the care of the cancer patient.
- Provide public assurance that the data will not be abused.

OFFICIAL CODE OF GEORGIA ANNOTATED (O.C.G.A.)

Since 1989 cancer has been a reportable disease in Georgia and the Registry has been delegated the responsibility for collecting data on cancer from health care facilities or providers, including but not limited to hospitals, radiation treatment centers, outpatient surgical facilities, oncology clinics, pathology laboratories, and physicians' offices.

Furthermore, since the Registry database is used for research, O.C.G.A § 31-12-2(b) protects persons submitting reports or data to the Registry, in good faith, from liability for any civil damages. (Refer to Section 7: Reporting Laws and Mandate)

DEFINITION OF CONFIDENTIAL DATA

The Registry defines confidential as all data that identifies patient-specific information. The Registry also treats information that specifically identifies a health care provider or an institution as confidential. Information that characterizes the caseload of a specific institution or health care professional is considered proprietary and confidential.

THE RESPONSIBILITIES OF REGISTRY PERSONNEL

It is the responsibility of the Registry to protect the data from unauthorized access and release. The Registry maintains the same standards of confidentiality as customarily apply to the physician-patient relationship as well as the confidentiality of medical records. This obligation extends indefinitely, even after the patient is deceased.

The costs of inappropriate release of confidential data are many. Inappropriate release of data could damage an individual whose diagnosis of cancer is made public. In addition, support and cooperation of facilities providing data to the Registry could also be severely compromised. Registry personnel responsible for violating confidentiality policies and

procedures will be administratively disciplined up to and including dismissal from employment.

Security of data maintained both on paper and in electronic form are addressed below in DATA SECURITY.

Each staff member, as part of his/her employment agreement, reads the confidentiality policy and signs a pledge that confidential information will not be released to unauthorized persons (Exhibit A). The pledge remains in effect after cessation of employment. The Registry secretary maintains a file of staff members who have signed pledges.

The orientation and training of each new staff member includes instructions concerning the confidentiality of data.

Failure to observe the confidentiality policies will result in firm disciplinary action up to and including dismissal from employment. In extreme circumstances legal action may be warranted against a staff member who fails to comply with the Registry's confidentiality policies.

Non-registry personnel or organizations, including medical investigators, may request access to confidential registry data. Requests should be in writing with an agreement to adhere to the same confidentiality standards practiced by registry staff members.

DATA SECURITY

The Registry Director is responsible for data security.

Registry staff are responsible for the confidentiality of all data they encounter during their collection of cancer data.

The following components are required to assure data security in all areas of registry operation:

- Suitable locks are installed to control access to the Registry and custodial staff are notified of the importance of maintaining a secure environment.
- Confidential data will not be transmitted from the Registry by any means (mail, telephone, electronic, or facsimile) without explicit authority from the Registry Director or a staff member to whom such authority has been delegated. All mail with confidential data should be marked "confidential".
- Precautions must be taken, for both physical and electronic security of confidential data sent on magnetic or electronic media, include secure packaging, tracking (i.e. using federal express for deliveries to be delivered only to the appropriate person) and marking data not to be X-rayed (to ensure data integrity). Submission of all electronic data must be encrypted and password protected. The GCCR uses the "Advanced Encryption Package" for encrypting electronic data.

The use of personal and notebook computers for the ascertainment and management of confidential data should be controlled by electronic and physical measures to protect the security of the data. This includes passwords, screen savers, and data encryption.

Training and demonstration of computer systems should be performed with separate fictitious and/or anonymous data sets, or when this is not possible (i.e. training registry staff on new procedures, or during data audit for quality assurance), observers are required to sign confidentiality agreements.

The physical security of confidential data stored on paper documents, computer printouts, microfiche/microfilm, and other media present in the Registry should be ensured. For instance when reports, computer printouts, and microfiche/microfilm printouts are no longer necessary, they are disposed of by shredding. Data abstracts are kept secure in a locked room which has limited access by the Registry staff. Microfiche/microfilm are stored in designated cabinets with secure locks.

Confidential documents to be destroyed are kept in a secure environment (i.e. kept in a box labeled "confidential documents to be shredded" and kept in a locked room with limited Registry staff access) until they are shredded.

Computer security safeguards should be followed, including, but not limited to:

- a dial up security system and internal file protection. (e.g. database content are password protected, password is changed every 90 days.)
- an in-house printer for all print jobs. (Printer for copying confidential data is located in a locked room)
- copies of data file at the Rollins School of Public Health Information Services Computing Center on registry-dedicated tapes or disks.
(Cancer data is only backed-up to registry-dedicated tapes on a daily basis and stored off site and securely locked in a cabinet with limited access)

RELEASE OF REGISTRY DATA

Release of registry data for clinical purposes, research, and health care planning is central to the purpose of the Registry. The Registry has developed procedures for data release that ensure the maintenance of confidentiality.

For the purpose of complete case ascertainment, the Registry exchanges confidential data with the other state registries with whom Georgia has reciprocal case-sharing agreements.

The Registry may release limited patient data to providers of health services to that patient. Such data will not include the names of the other health care providers used by the patient.

Individual patient information may also be released in response to a request to computer link or provide confidential data for approved research projects where a written agreement specifies and ensures the protection of information identifying any individual patient. Such

studies should be approved by the Registry management team and the appropriate Institutional Review Board (IRB).

No information identifying an individual health care provider or facility will be made available except as required by Georgia Law or with written consent of that health care provider or facility.

Copies of specific patient information will not be provided to individuals (patients), except when required by Georgia Law.

Confidential information will not, under any circumstances, be published or made available to the general public.

Inquiries from the press should be referred to the cancer registry director, state epidemiologist, state chronic disease epidemiologist or other persons designated by the Georgia Division of Public Health. Inquiries could be referred to the Georgia Center for Cancer Statistics (GCCS) co-directors or another member of the staff who has been delegated the authority to respond. Measures will be taken to eliminate the possible identification of individual patients from data table cells containing very small numbers (i.e. less than five).

Researchers are reminded that all publications resulting from research performed under the National Cancer Institute (NCI), Department of Human Resources (DHR), and Centers for Disease Control and Prevention (CDC), or other funded contract shall acknowledge support of the supporting organization.

Any data released or published where it is known that fewer than 90% of the expected cancer cases have been registered should include a qualifier indicating this fact (e.g. Data in this geographic area is less than 90% complete).

INAPPROPRIATE USES OF CONFIDENTIAL INFORMATION

Confidential data will never be made available for commercial purposes including but not limited to:

- Businesses that are trying to market a product to cancer patients.
- Health care institutions that are trying to recruit new patients.
- Insurance companies that are trying to determine the status of an individual patient.

The Registry has a data request form (Exhibit B) for use by researchers, registry staff, and others. The form serves as internal documentation of data requests, documents all requests for information, assists in the monitoring of staff efforts, and is used to prepare periodic data request summary reports.

Statistical data requests received via the telephone and in writing (such as cancer inquiries from citizens) are processed by the Registry's Program Director. Written documentation of the requested data is prepared for the programming staff. Copies of all correspondence along

with a computer output of the data are filed in locked cabinets at the Georgia Division of Public Health to be used for summary tabulations to prepare routine reports.

DATA FOR SUMMARY STATISTICS

Reports of summary statistics do not generally raise concerns about confidentiality. However, confidential information may be inadvertently conveyed through summary statistics. The Registry has instituted a policy to suppress the publication of summary statistics in some instances, especially where data are being presented for geographic areas with small populations. For example, the Registry will suppress the reporting of statistical data when there are fewer than five cases reported in a single cell of a table, if a cell of the table represents a combination of variables, such as small geographic area, race, age, and sex, that can inadvertently identify individuals. However, breakdowns by age, sex, and large geographic areas such as the state of Georgia and having cells with less than five cases will not be suppressed.

DATA FOR RESEARCH

The Registry uses the following guidelines for controlling access to registry data for research purposes:

Requests for research data should be in writing and include a detailed outline of the proposed research and justification for the need of any confidential data.

The Registry management team (i.e. director of the registry, co-directors of the Georgia Center for Cancer Statistics, director of the registry operations, the cancer control director, and the chronic disease chief epidemiologist) and others, who serve in an advisory capacity, review and approve research requests.

The written proposed research plan will be reviewed by the appropriate registry management team or committee to assess the following:

- Scientific and technical merit of the study
- Type of confidential and/or non-confidential data required
- Adherence to Registry's guidelines on confidentiality
- Approval of the appropriate Institutional Review Board (IRB)
- Credentials of the researcher
- Costs incurred and budget requirements

The investigator should assure that he/she requests consent to conduct this research from each health care facility. In addition physician consent should be obtained for each case to be contacted and consent should be obtained from each patient (a copy of the consents should be attached to the research proposal).

IRB approval is required before releasing registry data on individual patients. If the researcher is affiliated with another institution, then IRB approval is also required from that institution (e.g. academic institution, health care facility, government agency, etc.).

The scientific objectives of the study should be peer reviewed to ensure scientific validity.

After the review of the research proposal, the registry management team may request the researcher to revise the data request, work plan, and/or the cost estimate. Work will not begin on the data request until there is a mutually agreed upon plan and cost estimate.

The researcher must sign a written agreement to adhere to all confidentiality policies. Written agreements will include provisions for use of this information and for its return or destruction at the end of the study (see Exhibit C: Georgia Comprehensive Cancer Registry Research Agreement).

The researcher should demonstrate adequate resources to conduct the research, including funding, staff, and technical expertise.

The Registry will ensure that confidential information is not under any circumstances published or displayed in reports that summarize the research results. The Registry will retain the right to review any reports prior to their dissemination to ensure that confidentiality has been respected.

A researcher who receives computerized data sets from the Registry should provide assurances that any confidential data will be destroyed or returned to the Registry after the project ends. Confidential data should be protected after the research investigator leaves the employment of the institution. The researcher is liable for civil damages for improper use of data.

DATA FOR QUALITY ASSURANCE STUDIES

Quality control studies of the cancer registry data, including re-abstracting and completeness studies will be conducted periodically by Registry staff and funding agency contractors. Registry staff and agency contractor persons are subject to the same confidentiality standards as indicated in this document. The results of the quality control audits for each individual institution will be kept confidential and only shared with that institution.

PATIENT CONTACT FOR PARTICIPATION IN EPIDEMIOLOGIC STUDIES

The Registry assists in the identification of cancer patients as potential subjects for epidemiologic studies. In these instances, the investigator should meet all the criteria outlined above. Nationally, philosophies differ as to whether physician permission is needed prior to patient contact. Several patient advocacy groups maintain that only a patient has the right to decide study participation, and his/her physician does not have the right to make the choice on the patient's behalf.

The policy at the Registry is, except under unusual circumstances (i.e. physician could not be identified or available or selects not to be contacted), a patient's physician will be asked for permission to contact the patient and asked whether there are any contra-indications to contacting the patient (patient too ill, patient unaware of the diagnosis, etc.). This procedure involves the physicians in the research activity and provides an opportunity for him/her to refuse patient contact.

EXHIBIT A

GEORGIA COMPREHENSIVE CANCER REGISTRY CONFIDENTIALITY STATEMENT

I understand that the records and information I will have access to as an employee of (including contractors and temporary employees) the Georgia Division of Public Health (GDPH) are confidential and protected by the state and federal law and by DHR Rules and Regulations. Confidential information includes, but is not limited to, medical, financial and demographic information about clients and employees. Confidential information can be verbal or it can be contained in an electronic or a hard copy format.

I agree to share pertinent and confidential information only in the context of my job responsibilities and only with appropriate department personnel. I agree not to discuss confidential information, including but not limited to the names of clients, outside the appropriate work situation.

I understand that if I have any questions about the confidentiality of information or the appropriateness of its disclosure, it is my responsibility to notify my immediate supervisor.

I understand that a breach of this confidentiality will result in disciplinary action, up to and including termination of employment, as well as possible civil and/or criminal liability for me and/or the GDPH.

I understand that even when I am no longer an employee (contractor, temporary employee) at GDPH, the information I had access to must continue to be kept confidential.

My signature certifies the following:

1. The DPH Confidentiality Policies and Procedures have been explained to me and I have had the opportunity to ask questions about the policies.
2. I have received a copy of the DPH Confidentiality Policies and Procedures.
3. I understand the DPH Confidentiality Policies and Procedures and agree to comply with them.

Employee's (contractor) Signature

Date

Supervisor's Signature

Date

EXHIBIT B



**Georgia Comprehensive Cancer Registry
Cancer Data Request Form**

Return To: Georgia Comprehensive Cancer Registry
2 Peachtree St NW, 14th Floor, Ste 14-283 Atlanta GA 30303

Date: _____ **Time:** _____ **Consultant Name:** _____

Name of Requester: _____ **Organization:** _____

Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Telephone: _____ **Fax:** _____ **E-mail:** _____

If Date Requested, Please Check

Incidence **Years:** _____ **Site/s:** _____

<p>Metro Atlanta Start Year: 1975 OR -- Clayton -- Cobb -- Dekalb -- Fulton -- Gwinnett</p>	<p>East Central Georgia Start Year: 1978 OR -- Glasscock -- Greene -- Hancock -- Jasper -- Jefferson</p>	<p>Southeast Georgia Start Year: 1991 OR -- Morgan -- Putnam -- Taliaferro -- Warren -- Washington</p>	<p>State of Georgia Start Year: 1995 OR Specify County or District -- Bryan -- Bulloch -- Burke -- Chatham -- Columbia -- Effingham</p>	<p>-- Evans -- Jefferson -- Jenkins -- McDuffie -- Richmond -- Screven</p>
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Note: Georgia data outside East Central Georgia or Southeast Georgia counties are likely to be incomplete for certain years. Therefore, only counts not rates can be supplied.

Mortality **Years:** _____ **Site/s:** _____

County/ies: _____ **District/s:** _____

Comments (Please Specify): _____

Follow-Up:	----- Not Needed	----- Urgent	-----Next Day	-----When Convenient
Notification:	-----County	-----District		

EXHIBIT C

GEORGIA COMPREHENSIVE CANCER REGISTRY RESEARCH AGREEMENT

This Agreement is entered into as of (date), by (investigator's institution) and between _____, a _____, and ("Recipient").

RECITALS

- A. Recipient is involved in study entitled ("Study"). A description of the Study is incorporated as part of this document (Exhibit A).
- B. For purposes of the study, Recipient would like to access to the information described on Exhibit B to this Agreement ("Information").
- C. The Department of Human Resources is willing to provide the information subject to the terms of this Agreement.

1. Confidentiality of Information: Recipient agrees that all information is confidential and proprietary to the Department of Human Resources and its contractor (hereafter referred to as DHR). Recipient agrees that the information is being provided by DHR solely in furtherance of the Study and for no other purpose. Recipient further acknowledges that a confidential relationship exists between it and DHR and that the Information is being disclosed to it in reliance on that confidential relationship as well as the terms of this Agreement.

2. Reimbursement of Expenses: Recipient agrees to pay DHR and contractor a fixed fee for providing the Information to Recipient. Payment will be made on the following terms:

80% of fixed fee upon execution of this agreement

20% of fixed fee upon receipt by Recipient of a tape containing the data outlined in Exhibit A.

Payment will be made by Recipient no more than 30 calendar days after receipt of an invoice from DHR. DHR will submit one copy of the invoice for payment to: (person responsible for payment).

3. Use of Information:

- a. Recipient agrees that it will maintain the confidentiality of and will not make use of, copy, or disclose any and all Information either orally or in writing except as expressly permitted by this Agreement. Recipient may use the information in connection with the Study and may furnish the information to its employees, consultants, or advisors working on the Study provided that Recipient has first obtained their written agreement to comply with the terms of this Agreement and has on file a signed 'Confidentiality Pledge' (sample is attached).

EXHIBIT C

b. Information may be published as part of the Study provided that neither the identity of any patient nor the primary source of the information is determinable from the publication. Publications and other forms of presentation to any third party which disseminate, or contain information provided by the DHR must be reviewed and approved by the Department of Human Resources/Division of Public Health prior to publication or dissemination. Recipient agrees to provide DHR with a copy of any proposed publication, presentation or other disclosure in any form disseminating, using, or containing Information at least 60 days prior to its publication, presentation, or dissemination to any third party. Recipient agrees to acknowledge the contribution of DHR investigator(s) and the Georgia Center for Cancer Statistics (GCCS) investigator(s), and if applicable, include them as co-authors. Any publication, presentation, or other disclosure in any form disseminating, using or containing information will carry a footnote acknowledging assistance from DHR and/or contractor.

c. This agreement will not prohibit Recipient from using, copying, or disclosing information which (1) at the time of its receipt is or later becomes available to the public through no fault of Recipient; (2) is independently known by Recipient prior to its receipt from GCCR as shown by Recipient's written records; or 3) is obtained without an obligation of confidentiality from a third party who had a legal right to disclose the information to Recipient.

d. Recipient agrees that it will comply with all laws regarding the use or disclosure of health care or other personal information.

4. Standard of Care: Recipient agrees that it will exercise reasonable and appropriate care to protect the confidentiality of all information and will use its best efforts to prevent any disclosure of the information except in accordance with this Agreement.

5. Return of Information: Upon completion of the Study or expiration of the term of the agreement whichever comes first, Recipient agrees to return all Information and all copies thereof in its possession or the possession of anyone receiving the Information from Recipient to DHR. Information may not be used for any other purpose without the written, prior approval of DHR.

6. Disclosure Required by Law: If Recipient is required by law to disclose Information including without limitation by discovery, subpoena, or other legal or administrative process, Recipient agrees to provide DHR prompt notice of the required disclosure to permit DHR, at its option and expense, to seek an appropriate protective order or waive the requirements of this Agreement. If no protective order or waiver is obtained and disclosure is legally required, such disclosure may be made but only to the extent required. Recipient agrees that it will cooperate with DHR and will not oppose any action by DHR to obtain a protective order or other assurance that information which must be disclosed will be accorded confidential treatment.

7. Remedies: Recipient acknowledges that the unauthorized disclosure or use of the information could cause irreparable harm and significant injury, which may be difficult to ascertain. Accordingly, Recipient agrees that DHR shall have the right to seek an immediate injunction enjoining any breach of this Agreement and shall be entitled to equitable relief in addition to other remedies and recovery of costs and attorney's fees.

8. Indemnity: Recipient agrees to indemnify, defend and hold harmless DHR and its trustees, officers, professional staff, employees, contractors, and agents and the respective successors, heirs and assigns for and against any one or more of the following:

EXHIBIT C

a. All claims, liabilities, damages or losses which arise from or relate to or are alleged to arise from or relate to (i) the disclosure of the information by DHR to Recipient, (ii) the disclosure by Recipient to any other person of the information; or (iii) any breach of this Agreement by Recipient.

b. All action, suits, proceedings, demands, assessments, adjustments, costs and expenses arising from or incident to the foregoing, including without limitation, reasonable attorney's fees, litigation costs and other out-of-pocket expenses.

This indemnification shall apply whether or not the matter for which indemnification is sought is attributable to the negligent acts or omissions of any one or more of the Indemnities.

9. Institutional Review: No work shall commence under this Agreement until the Department of Human Resources Institutional Review Board has reviewed and approved the Study. Recipient agrees to submit the Study for ongoing Department of Human Resources Institutional Review Board on at least an annual basis in accordance with all DHR procedures and policies as long as activities using Information provided by DHR are active.

Signature _____ Date _____

Print Name _____ Phone Number _____

**Georgia Comprehensive Cancer Registry
Reporting Manual**

**Section 4: GCCR Required Data Set and Instructions for
Abstracting and Coding**

4. GCCR REQUIRED DATA SET

Data Item	Usual Data Source	Comments
<i>Patient Confidential Section</i>		
Patient System ID Hosp	Hospital Tumor Registry Software	Pg. 4 – 6
Patient Last Name	Medical/Accounting Records	Pg. 4 – 6
Patient First Name	Medical/Accounting Records	Pg. 4 – 6
Patient Middle Initial	Medical/Accounting Records	Pg. 4 – 6
Alias	Medical/Accounting Records	Pg. 4 – 6
Maiden Name	Medical/Accounting Records	Pg. 4 – 6
Spouse/Parent Name	Medical/Accounting Records	Pg. 4 – 6
Social Security Number	Medical/Accounting Records	Pg. 4 – 7
Medical Records Number	Medical/Accounting Records	Pg. 4 – 7
Primary Payer at DX	Medical/Accounting Records	Pg. 4 - 7 Cases diagnosed 1/1/2006 and later.
Physician-Managing	Medical/Accounting Records	Pg. 4 – 7
Physician-Follow-up	Medical/Accounting Records	Pg. 4 – 7
<i>Demographic Section</i>		
Address at Diagnosis - No & Street	Medical/Accounting Records	Pg. 4 – 8
Address at Diagnosis - City	Medical/Accounting Records	Pg. 4 – 8
Address at Diagnosis - State	Medical/Accounting Records	Pg. 4 – 9
Patient Telephone	Medical/Accounting Records	Pg. 4 – 9
County of Residence at Diagnosis	Medical/Accounting Records	Pg. 4 – 9
Postal Code at Diagnosis	Medical/Accounting Records	Pg. 4 – 10
Marital Status	Medical/Accounting Records	Pg. 4 – 10
Race 1	Medical/Accounting Records	Pg. 4 – 11 Primary race code for all diagnosis years. Code only this field if the date of diagnosis is before 2000 .
Race 2-5 (4 Fields)	Medical/Accounting Records	Pg. 4 – 12 Cases diagnosed 1/1/2000 and later .
Spanish/Hispanic Origin	Medical/Accounting Records	Pg. 4 – 13
Sex	Medical/Accounting Records	Pg. 4 – 13
Age at Diagnosis		Pg. 4 – 14 Calculated from birth date and date of diagnosis.

Data Item	Usual Data Source	Comments
Birth Date	Medical/Accounting Records	Pg. 4 – 14
Birthplace	Medical/Accounting Records	Pg. 4 – 15
<i>Cancer Identification Section</i>		
Date of Diagnosis	Diagnostic/Op/Path Reports	Pg. 4 – 16
Primary Site (ICD-O code)	Diagnostic/Op/Path Reports	Pg. 4 - 18
Laterality code	Diagnostic/Op/Path Reports	Pg. 4 – 18
Histology code ICD-O-2	Path/Cytology/Lab Reports	Pg. 4 – 20 Cases diagnosed 1/1/1995 through 12/31/2000
Behavior code ICD-O-2	Path Reports	Pg. 4 – 22 Cases diagnosed 1/1/1995 through 12/31/2000
Histology code ICD-O-3	Path/Cytology/Lab Reports	Pg. 4 – 20 Cases diagnosed 1/1/2001 and later.
Behavior code ICD-O-3	Path Reports	Pg. 4 – 22 Cases diagnosed 1/1/2001 and later.
Grade	Path Reports	Pg. 4 – 23
Diagnostic Confirmation	Diagnostic/Op/Path/Lab	Pg. 4 – 23
Type of Reporting Source	Medical/Accounting/Records	Pg. 4 – 24
<i>Hospital Specific Section</i>		
Reporting Hospital		Pg. 4 – 25
Sequence Number - Hospital		Pg. 4 – 25
Abstracted By		Pg. 4 – 26
Date of First Contact	Medical/Accounting Records	Pg. 4 – 26, Related to first diagnosis and/or treatment date for cancer.
Class of Case	Medical/Accounting Records	Pg. 4 – 27 Abstracting decision
Case Finding Source	Medical Records	Pg. 4-28 Cases diagnosed 1/1/2006 and later.
<i>Stage/Other Prognostic Factors Section</i>		
SEER Summary Stage 2000	Path/Op/Diagnostic Reports	Pg. 4 – 29 Cases diagnosed 1/1/2001 through 12/31/2003
SEER Summary Stage 1977	Path/Op/Diagnostic Reports	Pg. 4 – 29 Cases Diagnosed 1/1/1995 through 12/31/2000
EOD-Tumor Size	Path/OP/Diagnostic Reports	Pg. 4 – 30 Cases diagnosed 1/1/1999 through 12/31/2003
EOD-Extension	Path/OP/Diagnostic Reports	Pg. 4 – 30 Cases diagnosed 1/1/1999 through 12/31/2003
EOD-Extension Prostate Path	Pathology report	Pg. 4 – 30 Cases diagnosed 1/1/1999 through 12/31/2003

Data Item	Usual Data Source	Comments
EOD-Lymph Node Involvement	Path/OP/Diagnostic Reports	Pg. 4 – 30 Cases diagnosed 1/1/1999 through 12/31/2003
Tumor Marker 1 Tumor Marker 2	Lab/Pathology Reports	Pg. 4 – 31 Breast cases diagnosed 1/1/1995–12/31/2003 ; prostate and testis cases diagnosed 1/1/1998-12/31/2003 .
Tumor Marker 3	Lab/Pathology Reports	Pg. 4 – 32 Testis cases diagnosed 1/1/1998-12/31/2003 .
<i>Collaborative Stage (CS) Section</i>		
CS Tumor Size	Path/Op/Diagnostic Reports	Pg. 4-33 Cases diagnosed 1/1/2004 and later
CS Extension	Path/Op/Diagnostic Reports	Pg. 4 – 33 Cases Diagnosed 1/1/2004 and later
CS TS/Ext-Eval	Path/Op/Diagnostic Reports	Pg. 4 – 33 Cases Diagnosed 1/1/2004 and later
CS Lymph Nodes	Path/OP/Diagnostic Reports	Pg. 4 – 33 Cases Diagnosed 1/1/2004 and later
Regional Nodes Positive	Pathology report	Pg. 4 – 33 Cases diagnosed 1/1/1999 and later
Regional Nodes Examined	Pathology Report	Pg. 4 – 34 Cases diagnosed 1/1/1999 and later
CS Reg. Nodes Eval	Pathology Report	Pg. 4 – 34 Cases diagnosed 1/1/2004 and later
CS Mets at DX	Path/OP/Diagnostic Reports	Pg. 4 – 34 Cases Diagnosed 1/1/2004 and later
CS Mets Eval	Path/OP/Diagnostic Reports	Pg. 4 – 34 Cases Diagnosed 1/1/2004 and later
CS Site Specific Factor 1	Pathology report	Pg. 4 – 34 Cases Diagnosed 1/1/2004 and later
CS Site Specific Factor 2	Pathology report	Pg. 4 – 35 Cases Diagnosed 1/1/2004 and later
CS Site Specific Factor 3	Pathology report	Pg. 4 – 35 Cases Diagnosed 1/1/2004 and later
CS Site Specific Factor 4	Pathology report	Pg. 4 – 35 Cases Diagnosed 1/1/2004 and later
CS Site Specific Factor 5	Pathology report	Pg. 4 – 36 Cases Diagnosed 1/1/2004 and later
CS Site Specific Factor 6	Pathology report	Pg. 4 – 36 Cases Diagnosed 1/1/2004 and later

Data Item	Usual Data Source	Comments
<i>First Course of Treatment Section</i>		
Rx Date- Surgery	Medical/Accounting Records	Pg. 4 – 37
RX Date- Radiation		Pg. 4 – 38
Rx Date- Systemic	Medical/Accounting Records	Pg. 4 – 39 For Chemo, BRM, Hormone, Transplant and Endocrine Therapy.
Rx Date- Other	Medical/Accounting Records	Pg. 4 – 40
Date of Initial Treatment – SEER	Medical/Accounting Records	Pg. 4 – 40
Date of 1 st CRS RX-COC ACOS Facility		
Rx Summ - Surg Prim Site	Operative Report	Pg. 4 – 42 Cases diagnosed 1/1/2003 and Later.
Rx Summ – Surg Site 98-02	Operative Report	Pg. 4 – 43 Cases diagnosed 1/1/1998 through 12/31/2002.
Rx Summ- Surgery Type	Operative Report	Pg. 4 – 43 Cases diagnosed 1/1/1995 through 12/31/1997
Rx Summ - Scope Reg LN Surg	Operative Report/Path Report	Pg. 4 – 43 Cases diagnosed 1/1/2003 and Later.
Rx Summ - Scope Reg Surg 98-02	Operative Report/Path Report	Pg. 4 – 45 Cases diagnosed 1/1/1998 through 12/31/2002.
Rx Summ - Reg LN Examined	Pathology Report	Pg. 4 – 45 Cases diagnosed 1/1/1998 through 12/31/2002
Rx Summ - Surg Other Reg/Dis	Operative Report	Pg. 4 – 46 Cases diagnosed 1/1/2003 and Later.
Rx Summ - Surg Oth 98-02	Operative Report	Pg. 4 – 47 Cases diagnosed 1/1/1998 through 12/31/2002
Rx Summ - Reconstruction 1st Course	Operative Report	Pg. 4 – 47 Code for breast cases 1/1/1998 through 12/31/2002
Reason for No Surgery	Medical Records	Pg. 4 – 48
Rx Summ - Radiation	Medical Records	Pg. 4 – 49
Rx Summ - Surg/Rad Seq	Medical Records	Pg. 4 – 49
Rx Summ – Systemic Sur Seq	Medical Records	Pg. 4 – 51 Cases diagnosed 1/1/2006 and later
Rx Summ – Chemotherapy	Medical Records	Pg. 4 – 52
RX Summ - Hormone	Medical Records	Pg. 4 – 53
RX Summ – BRM(Immunotherapy)	Medical Records	Pg. 4 – 54
Rx Summ - Other	Medical Records	Pg. 4 – 55
RX Summ – Transplant/Endocr	Medical Records	Pg. 4 – 56

Data Item	Usual Data Source	Comments
RAD- Regional RX Modality	Medical Records	Pg. 4 – 58
RAD- Boost RX Modality	Medical Records	Pg. 4 – 59
<i>Follow-up Section</i>		
Date of Last Contract	Medical/Accounting Records	Pg. 4 – 61
Vital Status	Medical/Accounting Records	Pg. 4 – 61
Autopsy	Medical/Accounting Records	Pg. 4 – 62
<i>Text - Diagnosis Section</i>		Pg. 63-66
Text-Dx Physical Exam Text-Dx Procedure - Radiology Text-Dx Procedure - Scopes Text-Dx Procedure Lab Tests Text-Dx Procedure - Op Report(s) Text-Dx Procedure - Pathology Report(s) Text-Primary Site Title Text-Histology Title Text-Staging	Medical Records	There MUST be text to support coding of data fields in the cancer identification, stage and treatment sections of the abstract.
<i>Text - Treatment Section</i>		
Text-Rx Surgery Text-Rx Radiation (Beam) Text-Rx Radiation (Other) Text-Rx Chemotherapy Text-Rx Hormone Text-Rx BRM Text-Rx Other	Medical Records	There MUST be text to support coding of data fields in the cancer identification, stage and treatment sections of the abstract.
<i>Text - Miscellaneous</i>		
Text-Remarks		Additional text field; overflow from other text fields.
Text-Occupation/Industry	Medical/Accounting Records	Usual lifetime occupation and primary type of business or industry (do not use retired).
Place of Diagnosis		Narrative text about facility, city, state and/or country where diagnosis was made if other than your facility.

4. INSTRUCTIONS FOR ABSTRACTING AND CODING

PATIENT CONFIDENTIAL SECTION

PATIENT SYSTEM ID HOSP

NAACCR Item #21

Description

A unique non-repeating number automatically assigned to patients by hospital tumor registry software system. The same number is used for all the patient's subsequent tumors. This number is different from Accession Number-Hosp, the Patient System ID number is created and maintained by the hospital tumor registry's software system, and requires no key entry.

LAST NAME

NAACCR Item #2230

Instructions for Coding

- Blanks, spaces, apostrophes, and punctuation marks are not allowed.
- Hyphens are allowed.
- Code as UNKNOWN if the patient's last name is unknown.
- This field may be updated, if the last name changes.

Code	Reason
Mc Donald	Recorded without space as MCDONALD.
O'Hara	Recorded without apostrophe as OHARA.
Smith-Jones	Janet Smith marries Fred Jones and changes her name to Smith-Jones.

Note: The COC FORDS Manual: This field is required. Last name of the patient must be entered left justified with trailing blanks. Mixed case is allowed. Blanks, spaces, hyphens, apostrophes, and punctuation marks are allowed. The field may not be blank. If last name is unknown, code UNKNOWN.

FIRST NAME

NAACCR Item #2240

Instructions for Coding

- Spaces or special characters are not allowed.
- If first name unknown, code UNKNOWN.

Note: The COC FORDS Manual allows this field to be left blank.

MIDDLE INITIAL

NAACCR Item # 2250

ALIAS

NAACCR Item # 2280

MAIDEN

NAACCR Item # 2390

SPOUSE/PARENT

NAACCR Item # 2290

Instructions for Coding

- Enter only middle initial for patient.
- Enter an alternate name used by patient, if known. Leave blank if Alias name is unknown.
- Enter Maiden name of female patient who are or have been married.
- Leave blank if Maiden name is unknown.
- Leave blank Spouse/Parent if Unknown.

**SOCIAL SECURITY
MEDICAL RECORD NUMBER**

 NAACCR Item # 2320
 NAACCR Item # 2300

Instructions for Coding

- Social security number is entered without dashes
- Social security numbers is entered without any letter suffix.
- Code as 999999999 if Social Security number is unknown.
- Record medical record number used by the facility to identify patient
- Code as 9999999999 if Medical Record Number is unknown.

Note: The COC FORDS Manual instructs registrars to record number assigned by the facility's Health Information Management (HIM) Department only, and not department-specific numbers.

PRIMARY PAYER AT DX

NAACCR Item # 630

Description

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

Codes

Code	Definition	Code	Definition
01	Not insured	62	Medicare-Administered through a Managed Care Plan
02	Not insured, self-pay	63	Medicare with private supplement
10	Insurance, NOS	64	Medicare with Medicaid eligibility
20	Private Insurance: Managed Care, HMO or PPO	65	TRICARE
21	Private Insurance: Fee-for-Service	66	Military
31	Medicaid	67	Veteran Affairs
35	Medicaid-Administered through a Managed Care Plan	68	Indian/Public Health Service
60	Medicare/Medicare, NOS	99	Insurance status unknown
61	Medicare with supplement, NOS		

**PHYSICIAN -MANAGING
PHYSICIAN -FOLLOW-UP**

 NAACCR Item #2460
 NAACCR Item #2470

Description

Code for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer. Registry may use physicians' medical license numbers or may create individual numbering systems.

Codes (in addition to medical license numbers or facility-generated codes)

99999999 Managing physician unknown or ID number not assigned
 99999999 Follow-up physician unknown or ID number not assigned

DEMOGRAPHIC SECTION

ADDRESS AT DIAGNOSIS- NO & STREET

NAACCR Item #2330

Instructions for Coding

- Record the number and street address or the rural mailing address of the patient's usual residence when the tumor was diagnosed.
- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at <http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf>
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to: AVE (avenue), BLVD (boulevard), CIR (circle), CT (court), DR (drive), PLZ (plaza), PARK (park), PKWY (parkway), RD (road), SQ (square), ST (street), APT (apartment), BLDG (building), FL (floor), STE (suite), UNIT (unit), RM (room), DEPT (department), N (north), NE (northeast), NW (northwest), S (south), SE (southeast), SW (southwest), E (east), W (west).
- A complete list of recognized street abbreviations is in Appendix C of USPS Pub 28.
- Punctuation is normally limited to periods (i.e., 39.2 RD), slashes for fractional addresses (i.e., 101 ½ MAIN ST), and hyphens when a hyphen carries meaning (i.e., 289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (i.e., 425 FLOWER BLVD # 72).
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not update this data item if the patient's address changes.

Code	Definition
103 FIRST AVE SW APT 102	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
UNKNOWN	If the patient's address is unknown, OR patient has a history of cancer and the address at the time of diagnosis is unknown.

ADDRESS AT DIAGNOSIS- CITY

NAACCR Item #70

Instructions for Coding

- 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 malignancies, the city or town may be different for subsequent primaries.
- Do not update this data item if the patient's city/town of residence changes.

Code	Definition
CITY NAME	Do not use punctuation, special characters, or numbers. The USPS prefers the use of capital letters; it also guarantees consistent results in queries and reporting. Abbreviate where necessary.
UNKNOWN	If the patient's city or town is unknown OR patient has a history of cancer and the city at the time of diagnosis is unknown.

ADDRESS AT DIAGNOSIS- STATE

NAACCR Item #80

Instructions for Coding

- U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/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	Definition
GA	If the state in which the patient resides at the time of diagnosis and treatment is Georgia, then use the USPS code for the state of Georgia.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is known.
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is unknown.
ZZ	Resident of U.S., NOS (including its territories, commonwealths, or possessions); Canada, NOS; residence unknown.

PATIENT TELEPHONE

NAACCR Item #2360

Description

Current telephone number with area code for the patient. Number is entered without dashes.

Codes (in addition to valid telephone number)

0000000000 Patient does not have a telephone

9999999999 Telephone number unavailable or unknown

Note: The Patient-Confidential Section contains fields that can be used to identify the individual. This includes the patient's name and identifying numbers, and also the most specific parts of the address at diagnosis and the follow-up contact address. The other fields needed to complete the addresses are in the Demographic Section and the Follow-Up/Recurrence Section.

COUNTY OF RESIDENCE AT DIAGNOSIS

NAACCR Item #90

Instructions for Coding

- 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 <http://www.itl.nist.gov/fipspubs/index.htm>. For Georgia County FIPS Codes, go to the Resource Section of this manual.
- If the patient has multiple tumors, the county codes may be different for each tumor.
- If the patient is a non-U.S. resident and is coded XX in Address At Diagnosis- State (NAACCR Item #80), then code the patient's country of residence in this space.
- Do not update this data item if the patient's county of residence changes.

Code	Label	Definition
001-997	County at diagnosis	Valid FIPS code.

998	Outside state/county code unknown	Known town, city, state, or country of residence, but county code not known AND a resident outside of the state of the reporting institution (Must meet all criteria).
999	County unknown	The county of the patient is unknown. It is not documented in the patient's medical record OR patient has a history of cancer and the county at the time of diagnosis is unknown.

POSTAL CODE AT DIAGNOSIS

NAACCR Item #100

Instructions for Coding

- 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.
- Postal codes are available at: <http://www.usps.com/zip4>.
- 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 in Section One for further instructions.

Code	Definition
(Fill spaces)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
60611_ _ _ _	When the nine-digit extended U.S. ZIP Code is not available record the five-digit postal code left justified followed by four blanks.
M6G2S8_ _ _	The patient's six-character Canadian postal code left justified, followed by three blanks.
888888888	Permanent address in a country other than Canada, United States, or U.S. possessions and postal code is unknown.
999999999	Permanent address in Canada, United States, or U.S. possession and postal code is unknown. Use if patient has a history of cancer and the postal code at the time of diagnosis is unknown.

MARITAL STATUS

NAACCR Item #150

Rationale

Marital status is linked to sexual activity and to hormonal status as a surrogate for parity. Incidence and survival with certain cancers vary by marital status. The item also helps in patient identification.

Code	Definition
1	Single (Never Married)
2	Married (including common law)
3	Separated
4	Divorced
5	Widowed
9	Unknown

RACE 1

NAACCR Item #160

Instructions for Coding

- Additional races reported by the person should be coded in Race 2, 3, 4, and 5 for cases diagnosed 2000 and later.
- Race 1 is the field used to compare with race data on cases diagnosed prior to January 1, 2000. Race is analyzed with *Spanish/Hispanic Origin*. Both items must be recorded.
- All tumors for the same patient should have the same race code.
- If the patient is multiracial, then code all races using *Race 2* through *Race 5*.
- For cases diagnosed prior to January 1, 2000, Race 2 through Race 5 must be blank unless the patient has more than one primary with at least one primary diagnosed after January 1, 2000.
- If Race 1 is unknown (Code 99) then Race 2 through 5 must be coded 99.

Code	Definition	Code	Definition
01	White	20	Micronesia NOS
02	Black	21	Chamorrans
03	American Indian Aleutian or Eskimo	22	Guamanian
04	Chinese	25	Polynesian
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian
09	Asian Indian Pakistani	31	Fiji Islander
10	Vietnamese	32	New Guinean
11	Laotian	96	Other Asian including Asian NOS and Oriental NOS
12	Hmong	97	Pacific Islander NOS
13	Kampuchean (Including Khmer and Cambodian)	98	Other
14	Thai	99	Unknown

Examples:

Code	Reason
01	A patient was born in Mexico of Mexican parentage. Code also <i>Spanish/Hispanic Origin</i> (NAACCR Item#190).
02	A black female patient. A specific race code (other than blank or 99) must not occur more than once. For example, do not code. Black in <i>Race 1</i> for one parent and Black in <i>Race 2</i> for the other parent.

05	A patient has a Japanese father and a Caucasian mother. (Caucasian will be coded to <i>Race 2</i>). If a person's race is recorded as a combination of white and any other race, code to the appropriate <i>other</i> race in this field and then code Caucasian as White in the next race field.
06	A patient's race is listed as Asian and the birthplace is Japan. Code to birthplace. When the race is recorded as Oriental, Mongolian, or Asian, and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on birthplace information.
07	A patient has a Hawaiian father, black mother, Japanese grandfather, and Korean grandmother. If a person's race is recorded as a combination of Hawaiian and any other race(s), code the person's primary race as Hawaiian and code the other races in <i>Race 2</i> , <i>Race 3</i> , <i>Race 4</i> , and <i>Race 5</i> as appropriate. In this case, black to <i>Race 2</i> ; Japanese to <i>Race 3</i> ; and Korean to <i>Race 4</i> .
08	A patient is of Korean and Asian ancestry. Do not code Asian in a subsequent race field if a specific Asian race(s) has already been coded.
25	A patient with a Polynesian mother, Tahitian father, and Samoan grandparents.
99	A patient's race is unknown. <i>Race 2</i> through <i>Race 5</i> must also be 99.

RACE 2,3,4 & 5

NAACCR Item #161, 162, 163 &164

Instructions for Coding

- Race is analyzed with Spanish/Hispanic Origin (NAACCR Item #190). Both items must be recorded.
- All tumors for the same patient should have the same race code.
- For cases diagnosed prior to January 1, 2000, Race 2 through Race 5 must be blank unless the patient has more than one primary with at least one primary diagnosed after January 1, 2000.

Code	Reason
01	A patient was born in Mexico of Mexican parentage. Code also <i>Spanish/Hispanic Origin</i> (NAACCR Item#190).
02	A black female patient. A specific race code (other than blank or 99) must not occur more than once. For example, do not code. Black in <i>Race 1</i> for one parent and Black in <i>Race 2</i> for the other parent.
05	A patient has a Japanese father and a Caucasian mother. (Caucasian will be coded to <i>Race 2</i>). If a person's race is recorded as a combination of white and any other race, code to the appropriate <i>other</i> race in this field and then code Caucasian as White in the next race field.
06	A patient's race is listed as Asian and the birthplace is Japan. Code to birthplace. When the race is recorded as Oriental, Mongolian, or Asian, and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation, code the race based on birthplace information.
07	A patient has a Hawaiian father, black mother, Japanese grandfather, and Korean grandmother. If a person's race is recorded as a combination of Hawaiian and any other race(s), code the person's primary race as Hawaiian and code the other races in <i>Race 2</i> , <i>Race 3</i> , <i>Race 4</i> , and <i>Race 5</i> as appropriate. In this case, black to <i>Race 2</i> ; Japanese to <i>Race 3</i> ; and Korean to <i>Race 4</i> .

08	A patient is of Korean and Asian ancestry. Do not code Asian in a subsequent race field if a specific Asian race(s) has already been coded.
25	A patient with a Polynesian mother, Tahitian father, and Samoan grandparents.
99	A patient's race is unknown. <i>Race 2</i> through <i>Race 5</i> must also be 99.
88	No further race documented.

SPANISH/HISPANIC ORIGIN

NAACCR Item #190

Instructions for Coding

- Persons of Spanish or Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.
- Code Portuguese and Brazilian persons 0 (Non-Spanish; non-Hispanic).
- If the patient has multiple tumors, all records should have the same code.

Code	Definition
0	Non-Spanish; non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central America (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1-5).
8	Spanish surname only (The only evidence of the person's Hispanic origin is surname or maiden name, and there is no contrary evidence that the person is not Hispanic).
9	Unknown whether Spanish or not; not stated in patient record.

SEX

NAACCR Item #220

Instructions for Coding

Code	Definition
1	Male
2	Female
3	Other (hermaphrodite)
4	Transsexual
9	Not stated in patient record

AGE AT DIAGNOSIS

NAACCR Item #230

Instructions for Coding

- Patients with multiple primaries, age at diagnosis may be different for subsequent primaries.
- Age at diagnosis is calculated from birth date and date of diagnosis.

Code	Definition
000	Less than one year old
001	One year old, but less than two years old
002	Two years old
---	Show actual age in years
120	One hundred twenty years old
999	Unknown age

BIRTH DATE

NAACCR Item #240

Instructions for Coding

Code	Definition
MMDDCCYY	The date of birth is the month, day, and year that the patient was born. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

Examples:

Code	Reason
06301906	The patient's date of birth is June 30, 1906.
99991940	The patient is 60 years old on June 15, 2000. The medical record does not have a date of birth. Record unknown month (99) and day (99). Calculate the year as 1940.
99991927	The medical record contains only the year of birth (1927).
99999999	Date of Birth unknown. Use 99 for unknown day, 99 for unknown month and 9999 for unknown year.

BIRTH PLACENAACCR Item #250

Instructions for Coding

Use the most specific code. Refer to SEER Program Code Manual, Appendix B for SEER Geocodes <http://seer.cancer.gov/tools/codingmanuals/> or NAACCR Volume II: Data Standards and Data Dictionary, Volume II, Tenth Edition, Record layout Version 11 <http://www.naacr.org>

Code	Definition
000-750	SEER Geocode
998	Place of birth outside of the United States, no other detail known.
999	Place of birth unknown.

CANCER IDENTIFICATION SECTION

DATE OF DIAGNOSIS

NAACCR Item # 390

Description

Records the date of initial diagnosis by a Health Care Professional for the tumor being reported.

Instructions for Coding

- Use the first date of diagnosis whether clinically or histologically confirmed.
- If the physician states that in retrospect the patient had cancer at an earlier date, then use the earlier date as the date of diagnosis.
- Use the date therapy was started as the date of diagnosis if the patient receives a first course of treatment before a definitive diagnosis.
- The date of death is the date of diagnosis for a Class of Case 5.
- **Avoid using code 9's** unknown for month, day or year. Use all information in the medical records to estimate the date of diagnosis if possible.
- Example: The history and physical indicates that the patient was diagnosed in May of 1996. Enter 05/01/1996 as date of diagnosis instead of 05/99/1996. Document in the text that the diagnosis date is approximate.

Code	Definition
MMDDCCYY	The date of initial diagnosis is the month, day, and year that this primary cancer was first diagnosed by a recognized medical practitioner. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year. (Note: If the exact date on which the diagnosis was made is not available, then record an approximate date.)
99999999	When the date of initial diagnosis is unknown. Approximation is preferable to recording the date as unknown.
01/01/1999	When the date of initial diagnosis is stated 3 years ago, Approximate date to 3 years ago from date of admission. Admission date is 04/10/2002, DX date is 01/10/1999. This alerts Quality Control Editors that the date is approximate. Document in Text Diagnosis that the date is approximate.

Examples:

Code	Reason
06302005	June 30, 2005
03122005	A March 12, 2005 mammogram reveals a mass in the upper-outer quadrant of a patient's right breast compatible with carcinoma. On March 20, 2005, the patient has an excision breast biopsy that confirms infiltrating ductal carcinoma.
05122003	A physician notes a prostate nodule that is suspicious for cancer during a May 12, 2003 physical examination. On June 15, 2003, an ultrasound guided needle biopsy of the prostate provides histologic confirmation of adenocarcinoma.
01992004	A patient has a total abdominal hysterectomy for endometriosis in January 2004. The patient is admitted to the hospital with abdominal pain and distention in November 2005. A laparoscopy with omental biopsy shows metastatic cystadenocarcinoma. Pathologists review the 2004 hysterectomy specimen. They identify an area of cystadenocarcinoma in the left ovary.
09012005	If the exact date of the beginning of treatment is not available, then record an

	approximate date. For example, September 2005.
04012003	If information is limited to the description Spring, 2003, document in the text that date is estimate along with description “Spring 2003”.
07012003	If information is limited to the description the middle of the year, 2003.
10012003	If information is limited to the description Fall, 2003.
12012003 or 01012004	If information is limited to the description Winter, try to determine if this means the beginning or the end of the year. Code January or December as indicated.

List of Ambiguous Diagnostic Terms for Cancer Diagnosis

Terms That Constitute a Diagnosis	Terms That <i>Do Not</i> Constitute a Diagnosis
Apparent(ly)	Cannot be ruled out
Appears to	Equivocal
Comparable with	Possible
Compatible with	Potentially malignant
Consistent with	Questionable
Favor(s)	Rule out
Malignant appearing	Suggests
Most likely	Worrisome
Presumed	
Probable	
Suspect	
Suspicious	
Typical of	

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

If a phrase such as “strongly suggestive” or “highly worrisome” is used, disregard the modifier (“-ly”) and refer to the guidelines above regarding the primary term.

For SEER list please go to: <http://seer.cancer.gov/manuals/codeman.pdf>

FOR FORDS list please go to: <http://www.facs.org/cancer/coc/fordsmanual.html>

For non-malignant primary intracranial and central nervous system tumors (C70.0 – 72.9, C75.1 – C75.3), the terms “tumor and ‘neoplasm’ are considered diagnostic for the purpose of case reporting, in addition to the terms generally applicable to malignant tumors.

PRIMARY SITE

NAACCR Item # 400

Instructions for Coding

- Record the ICD-O-3 topography code for the site of origin.
 - Consult the physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.
 - Primary site codes may be found in the ICD-O-3 Topography, Numerical List section (ICD-O-3, p.43) and in the Alphabetic Index (ICD-O-3, p.105).
 - Topography codes are indicated by a “C” preceding the three-digit code number (do not record the decimal point). Follow the coding rules outlined in ICD-O-3, pp. 20-40.
 - Use subcategory 8 for single tumors that overlap the boundaries of two or more sub-sites and the point of origin is not known.
 - Use subcategory 9 for multiple tumors that originate in one organ. Code adenocarcinoma in multiple polyps as a single primary even if they involve more than one segment of the colon.
 - Code leukemia to bone marrow (C42.1).
- EXCEPTIONS:** Myeloid sarcoma and leukemic reticuloendotheliosis (see ICD-O-3 for coding rules). See <http://seer.cancer.gov/icd-o-3/> for updates, errata and clarifications.

LATERALITY CODE

NAACCR Item # 410

Description

Identifies the side of a paired organ or the side of the body on which the reportable tumor originated.

Instructions for Coding

- Record laterality for unknown primary site (C80.9) as 0 (not a paired site).
- Do not code metastatic sites as bilateral involvement.

Code	Definition
0	Organ is not considered to be 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. If it is not documented anywhere and it is believed to involve only one side of a paired site, code to 3.
4	Bilateral involvement, side of origin unknown, stated to be a single primary. This includes: <ul style="list-style-type: none"> • Both ovaries simultaneously involved with a single histology • Bilateral retinoblastomas • Bilateral Wilms tumors
9	Paired site, but lateral origin unknown; midline tumor.

List of Paired Organ Sites

ICD-O-3	Site	ICD-O-3	Site
C07.9	Parotid gland	C44.7	Skin of lower limb and hip
C08.0	Submandibular gland	C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C08.1	Sublingual gland	C49.1	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C09.0	Tonsillar fossa	C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C09.1	Tonsillar pillar	C50.0-C50.9	Breast
C09.8	Overlapping lesion of tonsil	C56.9	Ovary
C09.9	Tonsil, NOS	C57.0	Fallopian tube
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)	C62.0-C62.9	Testis
C30.1	Middle ear	C63.0	Epididymis
C31.0	Maxillary sinus	C63.1	Spermatic cord
C31.2	Frontal sinus	C64.9	Kidney, NOS
C34.0	Main bronchus (excluding carina)	C65.9	Renal pelvis
C34.1-34.9	Lung	C66.9	Ureter
C38.4	Pleura	C69.0-C69.9	Eye and lacrimal gland
C40.0	Long bones of upper limb and scapula	C70.0	Cerebral meninges, NOS
C40.1	Short bones of upper limb	C71.0	Cerebrum
C40.2	Long bones of lower limb	C71.1	Frontal lobe
C40.3	Short bones of lower limb	C71.2	Temporal lobe
C41.3	Rib and clavicle (excluding sternum)	C71.3	Parietal lobe
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis)	C71.4	Occipital lobe
C44.1	Skin of eyelid	C72.2	Olfactory nerve
		C72.3	Optic nerve
C44.2	Skin of external ear	C72.4	Acoustic nerve
C44.3	Skin of other and unspecified parts of face	C72.5	Cranial nerve, NOS
C44.5	Skin of trunk	C74.0-C74.9	Adrenal gland
C44.6	Skin of upper limb and shoulder	C75.4	Carotid body

HISTOLOGY 02 and 03

NAACCR Item # 420 & 522

Description

Identifies the microscopic anatomy of cells.

Instructions for Coding

- Use ICD-O-3 manual in the Numeric Lists/Morphology section (ICD-O-3, pp. 69-104) and in the Alphabetic Index (ICD-O-3, pp. 105.218) for cases diagnosed 1/1/2001 and later.
- ICD-O-3 identifies the morphology codes with M preceding the code number.
- Follow the coding rules outlined on pages 20 - 40 of ICD-O-3.
- Use ICD-O-2 manual for cases diagnosed 01/01/1995 to 12/31/2000. **This is a separate field.**
- To code morphology (histology, behavior and grade), use the best information from the entire pathology report (microscopic description, final diagnosis, comments).
- For coding complex morphological diagnoses, refer to “Coding Complex Morphological Diagnoses” in the Resource Section of this manual or visit the SEER website at <http://seer.cancer.gov/manuals/codeman.pdf>
- Refer below to the SEER rules for coding histology.

Single lesion – same behavior

1. Code the histologic type using the following rules in sequence.

A. a combination code if one exists

Examples of when to use the combination code

“...predominantly lobular with a ductal component.” *Use the combination code for lobular and ductal carcinoma (8522/3).*

“Invasive breast carcinoma – predominantly lobular with foci of ductal carcinoma.” *Use the combination code for lobular and ductal carcinoma (8522/3).*

B. the more specific term if one is an ‘NOS’ term (carcinoma) and the other term is more specific

Examples of when to use the more specific codes

“Adenocarcinoma (8140/3) of the sigmoid colon, predominantly mucin-producing.” *Code to mucin-producing adenocarcinoma (8481/3).*

“Invasive carcinoma, probably squamous cell type.” *Code squamous cell (8070/3) since it is more specific than carcinoma (8010/3).*

“Adenocarcinoma of prostate, with cribriform differentiation.” *Code cribriform carcinoma (8201/3) since it is more specific than adenocarcinoma.*

C. the majority of the tumor if Rule 1A or Rule 1B above cannot be used

Terms that indicate a majority of tumor Terms that do not indicate a majority of tumor

“predominantly...”

“...with foci of...”

“...with features of...”

“...focus of/focal...”

“...major”

“...areas of...”

“type”‡

“...elements of...”

“with ... differentiation”‡

“...component”‡

‡ *Terms approved for use effective with 1/1/1999 diagnoses and after.*

Single lesion – same behavior Rule 1C (continued)

Ignore terms that do not indicate a majority of tumor. When both terms are specific (in other words, not NOS) and no combination code exists, code the majority of the tumor.

Example of majority tumors:

“Predominantly leiomyosarcoma associated with foci of well-developed chondrosarcoma.” Code the majority tumor – leiomyosarcoma (8890/3).

2. Histologies with the same behavior code are coded to the higher histology code in ICD-O unless a combination histology code is available. Rule 1 takes precedence over rule 2.

Example Ductal carcinoma (8500/3) and medullary carcinoma (8510/3) would be coded to the higher number (8510/3).

Single lesion – different behaviors

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

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

Exception: If the histology of the invasive component is an ‘NOS’ term (e.g., carcinoma, adenocarcinoma, melanoma, sarcoma), then use the specific term associated with the in situ component and an invasive behavior code.

Example of exception: Squamous cell carcinoma in situ (8070/2) with areas of invasive carcinoma (8010/3) would be coded squamous cell carcinoma (8070/3).

Multiple lesions – considered a single primary

1. If one lesion is stated to be an ‘NOS’ term (e.g., carcinoma, adenocarcinoma, melanoma, sarcoma) and the second lesion is an associated but more specific term (e.g., large cell carcinoma, mucinous adenocarcinoma, spindle cell sarcoma, respectively) code to the more specific term.

2. For colon and rectum primaries:

When an adenocarcinoma (8140/_; in situ or invasive) arises in the same segment of the colon or rectum as an adenocarcinoma in a polyp (8210/_ , 8261/_ , 8263/_), code as adenocarcinoma (8140/_).

When a carcinoma (8010/_; in situ or invasive) arises in the same segment of the colon or rectum as a carcinoma in a polyp (8210), code as carcinoma (8010/_).

3. If the histologies of multiple lesions can be represented by a combination code, use that code.

BEHAVIOR CODE 02 and 03

NAACCR Item # 430 and 523

Description

Record the behavior of the tumor being reported using the appropriate edition of ICD-O. The fifth digit of the morphology code is the behavior code. The GCCR requires facilities to abstract and report all cancer with behavior codes 2 and 3.

Instructions for Coding

- Use ICD-O-2 manual for cases diagnosed 1/1/1995-12/31/2000.
- Use ICD-O-3 manual for cases diagnosed 1/1/2001 and later

Code the fact of invasion, no matter how limited. Even a pathological diagnosis qualified as “micro-invasive” must be coded malignant, ‘3.’ Note that in situ is a concept based on histologic evidence.

Therefore, clinical evidence alone cannot justify the use of this term.

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

Bowen's disease (not reportable for C44.0-C44.9)	Clark's level 1 for melanoma (limited to epithelium)
Confined to epithelium	Hutchinson's melanotic freckle, NOS (C44. _)
Intracystic non-infiltrating	Intraductal
Intraepidermal, NOS	Intraepithelial, NOS
Involvement up to but not including the basement membrane	Lentigo maligna (C44. _)
Lobular neoplasia (C50. _)	Lobular, noninfiltrating (C50. _)
Noninfiltrating	Noninvasive
No stromal invasion	Papillary, noninfiltrating or intraductal
Precancerous melanosis (C44. _)	Queyrat's erythroplasia (C60. _)
VAIN III (C52.9)	VIN III (C51. _)

The following in situ diagnoses are not reportable to GCCR:

CIN III (C53. _)
 Carcinoma in situ of the cervix (C53. _)
 PIN III (C61.9)

The following benign diagnosis are reportable to GCCR as of January 1, 2004:

Beginning with tumors diagnosed 1/1/2004, reportable tumors required to be abstracted include non-malignant primary intracranial and central nervous system tumors in ICD-O-3 with behavior code of ‘0’ or ‘1’ regardless of histologic type for the following:

C70.0	Cerebral meninges	C75.1	Pituitary gland
C70.1	Spinal meninges	C75.2	Craniopharyngeal duct
C70.9	Meninges, NOS	C75.3	Pineal gland
C71.0 – C71.9	Brain		
C72.0 – C72..9	Spinal Cord, Cranial Nerves and Other Parts of the Central Nervous System		

GRADE

NAACCR Item #440

Description

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

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

Instructions for Coding

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

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

DIAGNOSTIC CONFIRMATION CODE

NAACCR Item #490

Description

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

Instructions for Coding

- This is a hierarchical scheme to identify how the malignancy was determined from histologic confirmation (1) being most precise to unknown (9) being the least. Code 1 is the highest determination and takes precedence.
- This data item must be changed to the lower code if a more definitive method confirms the diagnosis at any time during the course of the disease.

Code	Label	Definition
1	Positive histology.	Histologic confirmation (tissue microscopically examined).
2	Positive cytology.	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
4	Positive microscopic confirmation, method not specified.	Microscopic confirmation only. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study.	A clinical diagnosis of cancer is based on laboratory tests/marker studies, which are clinically diagnostic for cancer. This includes alpha-fetoprotein for liver cancer and abnormal electrophoretic spike for multiple myeloma. Elevated PSA is nondiagnostic of cancer. If the physician uses the PSA as a basis for diagnosing

		prostate cancer with no other workup, record as code 5. (Adapted from SEER.)
6	Direct visualization without Microscopic confirmation.	The tumor was visualized during a surgical/endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation.	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only (other than 5, 6, or 7).	The malignancy was reported by the physician in the medical record. Refer to Resources Section for Ambiguous Terminology.
9	Unknown whether or not microscopically confirmed.	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually Class of Case 3).

TYPE OF REPORTING SOURCE

NAACCR Item #500

Description

Code for the source of documents used to abstract the cancer being reported. This item is used by the central registries.

Code	Source
1	Hospital inpatient, hospital outpatient and clinic
2	Radiation treatment centers, medical oncology (hospital-affiliated or independent)
3	Laboratory only (hospital-affiliated or independent)
4	Physician's office/private medical practitioner
5	Nursing home, convalescent home, convalescent hospital, hospice
6	Autopsy only
7	Death Certificate only
8	Other hospital outpatient units/surgery centers

Hospital Specific Section

REPORTING HOSPITAL

NAACCR Item # 540

Description

Code for facility reporting the case.

Rationale

This number is unique and identifies a reporting facility in the central registry database. This is useful in monitoring data submission, ensuring the accuracy of data and identifying areas for special studies.

SEQUENCE NUMBER - HOSPITAL

NAACCR Item # 560

Description

Code indicates the sequence of all reportable neoplasms over the lifetime of the patient. This item differs from the Sequence Number--Central [380] because the definitions of reportable neoplasms often vary between a hospital and a central registry. Each neoplasm is assigned a different number. Sequence Number 00 indicates that the person has only one reportable malignant neoplasm in his lifetime (regardless of hospital registry reference date). Sequence Number 01 indicates the first of two or more reportable malignant neoplasms, while 02 indicate the second of two or more reportable malignant neoplasm, and so on. In addition, GCCR requires that if an in situ tumor is followed by an invasive tumor in the same site more than two months apart, two primary cancers are reported. For more information please go to the Section 6: Determining Multiple Primaries.

Sequencing Non-malignant tumors:

- Primary non-malignant tumors diagnosed 1/1/2004 and later should be sequenced in the range of 60-87.
- Non-malignant tumors diagnosed before 1/1/2004 should be included in the lifetime sequence of non-malignant and borderline tumors in the range 60-87.
- A primary non-malignant tumor of any of the sites specified diagnosed before 1/1/2004, is not reportable.
- The sequencing of non-malignant tumors does not affect the sequencing of malignant tumors, and vice versa. For example, a first malignancy (sequence 00) will remain sequence 00 if followed by a non-malignant tumor (sequence 60-87).
- The sequence number for malignant tumors is in the range 00-35.

Codes COC Required:

Codes	Definition
00	One primary only in the patient's lifetime
01	First of two or more primaries
02	Second of two or more primaries
..	(Actual number of this primary)
..	
..	
35	Thirty-fifth of thirty-five primaries
99	Unspecified COC-required sequence number or unknown

ABSTRACTED BY

NAACCR Item # 570

Description

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

DATE OF FIRST CONTACT

NAACCR Item # 580

Description

Date of first admission to the facility for diagnosis and/or treatment of reportable tumor.

Instructions for Coding

- Date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or treatment of a reportable tumor.
- This may be the date of an outpatient visit for a biopsy, x-ray, or laboratory test, or the date a pathology specimen was collected at the hospital.
- If this is an autopsy-only or death certificate-only case, then use the date of death.

Code	Definition
MMDDCCYY	The date the patient first had contact with the reporting facility for a diagnostic procedure; review or administration of treatment; palliative care; or, for pathology-only Class of Case 7 cases, the date on which the specimen was taken. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
99999999	When it is unknown when the first patient contact occurred.

Examples:

Code	Reason
02122004	If a patient has an outpatient mammography that is suspicious for malignancy on February 12, 2004, and subsequently undergoes an excisional biopsy or radical surgical procedure on February 14, 2004, then record the date of the mammography (February 12, 2004) as the date of first contact/first admission to this facility.
09082003	Patient undergoes a biopsy in a physician's office on September 8, 2003. The pathology specimen was sent to the reporting facility and was read as malignant melanoma. The patient enters that same reporting facility on September 14, 2003 for wide reexcision. The date of first contact is September 8, 2003.
12072004	Patient has an MRI of the brain on December 7, 2004 for symptoms including severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery on December 19 removes all gross tumor. The date of first contact is December 7, 2004.
09992005	If the exact date of admission to the reporting facility is not known, then record an approximate date. For example, September 2005.
04012003	If information is limited to the description "Spring" 2003.
07012003	If information is limited to the description "The middle of the year" 2003.
10012003	If information is limited to the description. "Fall"2003.

12012003 or 01012004	If information is limited to the description “Winter” Try to determine if this means the beginning or the end of the year. Code January or December as indicated.
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CLASS OF CASE

NAACCR Item #610

Description

Hospital based registry classifies cases into two groups analytic and non-analytic.

Instructions for Coding

- Class of Case has ten categories 0-9. Analytic cases are coded 0-2. Non-analytic cases are coded 3-9.
- Class of Case 0-7 are reportable to GCCR.
- Abstracting for Class of Case 0 and 1 is to be completed within six months of diagnosis.
- Abstracting for Class of Case 2 is to be completed within six months of first contact with the facility.

Code	Definition
0	Diagnosis at the reporting facility and all of the first course of treatment was performed elsewhere or the decision not to treat was made at another facility.
1	Diagnosis at the reporting facility, and all or part of the first course of treatment was performed at the reporting facility.
2	Diagnosis elsewhere, and all or part of the first course of treatment was performed at the reporting facility.
3	Diagnosis and all of the first course of treatment was performed elsewhere. Presents at your facility with persistent disease.
4	Diagnosis and/or first course of treatment were performed at the reporting facility prior to the reference date of the registry.
5	Diagnosed at autopsy.
6	Diagnosis and all of the first course of treatment was completed by the same staff physician in an office setting. Staff physician is any medical staff with admitting privileges at the reporting facility.
7	Pathology report only. Patient does not enter the reporting facility at any time for diagnosis or treatment. This category includes cases known as (Tissue no Body). This category excludes cases diagnosed at autopsy. Do not report pathology only cases from another hospital.
8	Diagnosis was established by death certificate only. <i>Used by central registries only.</i>
9	Unknown. Sufficient detail for determining Class of Case is not stated in patient record. <i>Used by central registries only.</i>

Examples:

Code	Reason
0	Patient enters the reporting facility with dizziness and falling, and receives a clinical workup including CT and MRI of the brain. Results are positive for multiple metastatic deposits in both lobes of the brain. CT of the lung shows 4 cm mass in the right upper lung with mediastinal and hilar adenopathy. The patient is discharged to hospital B for treatment with a diagnosis of lung cancer with

	metastasis to the brain.
1	Patient is admitted with hemoptysis. Workup reveals right upper lobe mass. A biopsy is positive for adenocarcinoma. The patient undergoes surgery followed by radiation therapy at same facility.
2	Patient was diagnosed and had surgery at another facility for primary breast cancer. The patient then comes to your facility for XRT.
3	Patient was diagnosed and treated for primary bladder cancer four years prior to admission. Patient is then admitted to your facility for cystectomy for recurrent bladder cancer.
5	Patient dies at home, but autopsy performed at reporting facility. No previous knowledge or suspicion of cancer.
7	Hospital pathology department received a tissue sample for evaluation which was positive for malignant melanoma. The patient never visited the hospital.

CASEFINDING SOURCE

NAACCR Item #501

Rationale

This data item will help reporting facilities as well as GCCR in prioritizing casefinding activities.

Instructions for Coding

- Determine where the case was first identified and enter the appropriate code.
- Code the earliest source (based on patient or specimen contact at the facility).
- If death certificate, consultation-only report from a hospital or other report was used to identify the case, enter the code for the source that first identified the case, not the source from which it was subsequently abstracted.

Code	Definition
10	Reporting Hospital, NOS
20	Pathology Department Review(surgical pathology reports, autopsies, or cytology reports)
21	Daily Discharge Review (daily screening of charts of discharged patients in the medical records department)
22	Disease Index Review (review of disease index in the medical records department)
23	Radiation Therapy Department/Center
24	Laboratory Reports (other than pathology reports, code 20)
25	Outpatient Chemotherapy
26	Diagnostic Imaging/Radiology (other than radiation therapy, codes 23; includes nuclear medicine)
27	Tumor Board
28	Hospital Rehabilitation Service or Clinic
29	Other Hospital Source (including clinic, NOS or outpatient department, NOS)
Case first identified by source other than a reporting facility covered in the codes above	
30	Physician-Initiated Case

40	Consultation-only or Pathology-only report (not abstracted by reporting hospital)
50	Independent (non-hospital) Pathology-Laboratory Report
60	Nursing Home-Initiated Case
70	Coroner's Office Records Review
75	Managed Care Organization (MCO) or Insurance Records
80	Death Certificate (case identified through death clearance)
90	Other-Non-Reporting Hospital Source
95	Quality Control Review (case initially identified through quality control activities such as casefinding audits by GCCR)
99	Unknown

STAGE/OTHER PROGNOSTIC FACTORS SECTION

SEER SUMMARY STAGE 2000 **1/1/2001 through 12/31/2003** NAACCR Item # 759

Description

SEER Summary Stage 2000 is used to describe disease spread at diagnosis for cancer cases diagnosed 01/01/2001 and later. It is a prognostic factor used in the analysis of patient care and outcomes. For hospital registries, COC requires its use in the absence of a defined AJCC classification.

Instructions for Coding

Refer to the *SEER Summary Staging Manual 2000* for site-specific coding instructions. This information can be found online at <http://seer.cancer.gov/tools/ssm/>.

Code	Definition
0	In situ
1	Localized
2	Regional by direct extension
3	Regional to lymph nodes
4	Regional (both codes 2 and 3)
5	Regional, NOS
7	Distant metastasis/systemic disease
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified); death certificate only.

SEER SUMMARY STAGE 1977 **1/1/1995 through 12/31/2000** NAACCR Item # 760

Description:

SEER Summary stage 1977 is used to describe the disease spread at diagnosis for cancers diagnosed 01/01/2000 and earlier. It is a prognostic factor used in the analysis of patient care and outcomes. For hospital registries, COC requires its use in the absence of a defined AJCC classification. .

Instructions for Coding

Refer to SEER Summary Staging Guide 1977 for site-specific coding instructions.

Code	Definition
0	In situ.
1	Localized.
2	Regional by direct extension.
3	Regional to lymph nodes.
4	Regional (both codes 2 and 3).
5	Regional, NOS.
7	Distant metastasis/systemic disease.
9	Unknown if extension or metastasis (un-staged, unknown, or unspecified); death certificate only.

EOD TUMOR SIZE **1/1/1999 through 12/31/2003** NAACCR Item #780
Description

Describes the largest dimension of the diameter of the primary tumor in millimeters (mm).

Instructions for Coding

See SEER Extent of Diseases, 1998: Codes and Coding Instructions, Third Edition for Site Specific codes and coding rules for all EOD fields. This information can be found online at <http://seer.cancer.gov/tools/codingmanuals/> or <http://seer.cancer.gov/manuals/EOD10Dig.3rd.pdf>

EOD - EXTENSION **1/1/1999 through 12/31/2003** NAACCR Item #790
Description:

Part of the 10- digit EOD (item 779). Detailed site-specific codes for EOD for cases diagnosed from 1998 forward. Codes were revised effective January 1998, to reflect changes in the AJCC Cancer Staging Manual, Fifth Edition.

Instructions for Coding:

See SEER Extent of Diseases, 1998: Codes and Coding Instructions, Third Edition for Site Specific codes and coding rules for all EOD fields. <http://seer.cancer.gov/tools/codingmanuals/> or <http://seer.cancer.gov/manuals/EOD10Dig.3rd.pdf>

EOD - EXTENSION PROSTATE PATH **1/1/1998 through 12/31/2003** NAACCR Item # 800
Description:

Part of the 10 digit EOD (item 779). Detailed site specific codes for anatomic EOD for cases diagnosed from 1998 forward. Codes were revised effective January 1998, to reflect changes in the AJCC Cancer Staging Manual, Fifth Edition.

Instructions for Coding:

See SEER Extent of Diseases, 1998: Codes and Coding Instructions, Third Edition for Site Specific codes and coding rules for all EOD fields. This information can be found online at <http://seer.cancer.gov/tools/codingmanuals/> or <http://seer.cancer.gov/manuals/EOD10Dig.3rd.pdf>

EOD – LYMPH NODE INVOLVEMENT 1/1/1998 through 12/31/2003 NAACCR Item # 810**Description:**

Part of the 10 digit EOD (item 779). Detailed site-specific codes for anatomic EOD for cases diagnosed from 1998 forward. Codes were revised effective January 1998, to reflect changes in the AJCC Cancer Staging Manual, Fifth Edition.

Instructions for Coding:

See SEER Extent of Disease, 1998: Codes and Coding Instruction, Third Edition for site-specific codes and coding rules for all EOD fields. <http://seer.cancer.gov/tools/codingmanuals/> or <http://seer.cancer.gov/manuals/EOD10Dig.3rd.pdf>

**TUMOR MARKER 1 Breast 1/1/1995 through 12/31/2003 NAACCR Item # 1150
Prostate, and Testicular 1/1/1995 through 12/31/2003****Description**

Records prognostic indicators for specific sites or histologies, for specific site requirements refer to the 1998 SEER program Code Manual. This information can be found online

<http://seer.cancer.gov/tools/codingmanuals/> or <http://seer.cancer.gov/manuals/codeman.pdf>.

See Section 4 page 3 of this manual for specific diagnosis dates.

Codes	Definition
0	None Done
1	Positive/ elevated
2	Negative/ normal; within limits
3	Borderline, undetermined whether positive/elevated or negative/normal
Three Tiered System	
4	Range 1 (S1)
5	Range 2 (S2)
6	Range 3 (S3)
8	Ordered but results not in chart
9	Unknown or no information
For sites for which Tumor Marker 1 is not collected	
9	Not Applicable

**TUMOR MARKER 2 Breast 1/1/1995 through 12/31/2003 NAACCR Item # 1160
Prostate and Testicular 1/1/1998 through 12/31/2003****Description**

Records prognostic indicators for specific sites or histologies. For the specific sites, histologies, and diagnosis years for which this item coded, see the 1998 SEER program Code Manual. This information can be found online <http://seer.cancer.gov/tools/codingmanuals/> or <http://seer.cancer.gov/manuals/codeman.pdf>.

See Section 4 page 3 of this manual for specific diagnosis dates.

Codes	Definition
0	None Done
1	Positive/ elevated
2	Negative/ normal; within limits
3	Borderline, undetermined whether positive/elevated or negative/normal
Three Tiered System	
4	Range 1 (S1)
5	Range 2 (S2)
6	Range 3 (S3)
8	Ordered but results not in chart
9	Unknown or no information
For sites for which Tumor Marker 1 is not collected	
9	Not Applicable

TUMOR MARKER 3
Testicular cancer cases

1/1/1998 through 12/31/2003

NAACCR Item # 1170

Description

Records prognostic indicators for specific sites or histologies. For specific sites, histologies, and diagnosis years for which this item is coded, see the 1998 SEER Program Code Manual.

This information can be found online <http://seer.cancer.gov/tools/codingmanuals/> or <http://seer.cancer.gov/manuals/codeman.pdf>. Code 9 for sites for which tumor marker is not collected. See Section 4 page 3 of this manual for specific diagnosis dates.

Code	Definition
0	None done (SX)
1	Positive/elevated
2	Negative/normal; within normal limits (S0)
3	Borderline; undetermined whether positive/elevated or negative/normal
Three-Tiered System:	
4	Range 1 (S1)
5	Range 2 (S2)
6	Range 3 (S3)
8	Ordered, but results not in chart
9	Unknown or no information

CS Tumor Size	1/1/2004 and later	NAACCR Item # 2800
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Description

Describes the largest dimension of the diameter of the primary tumor in millimeters (mm).

Instructions for Coding

See Collaborative Staging Manual and Coding Instructions, Version 1.0 for Site Specific codes and coding rules. This information can be found online at

<http://www.cancerstaging.org/cstage/manuals.html>

CS Extension	1/1/2004 and later	NAACCR Item # 2810
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Description:

This field replaces EOD-Extension NAACCR Item 790 and EOD-Extension Prostate Path 800 and is collapsible into AJCC sixth editions T code. Reporting is effective as of January 1, 2004.

Instructions for Coding

See Collaborative Staging Manual and Coding Instructions, Version 1.0 for Site Specific codes and coding rules. This information can be found online at

<http://www.cancerstaging.org/cstage/manuals.html>

CS TS/Ext-Eval	1/1/2004 and later	NAACCR Item # 2820
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Description:

This field records how the codes for “CS Tumor Size” and “CS Extension” were determined based on the diagnostic methods employed. This field is used in CS to identify whether the T (of AJCC TNM) was clinically or pathologically diagnosed.

Instructions for Coding

See Collaborative Staging Manual and Coding Instructions, Version 1.0 for Site Specific codes and coding rules. This information can be found online at

<http://www.cancerstaging.org/cstage/manuals.html>

CS Lymph Nodes	1/1/2004 and later	NAACCR Item # 2830
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Description:

This field replaces EOD-Lymph Nodes Involvement NAACCR Item 810 and is collapsible into AJCC N code according to the AJCC sixth edition. Reporting is effective as of January 1, 2004.

Instructions for Coding

See Collaborative Staging Manual and Coding Instructions, Version 1.0 for Site Specific codes and coding rules. This information can be found online at

<http://www.cancerstaging.org/cstage/manuals.html>

REGIONAL NODES POSITIVE	1/1/1999 and later	NAACCR Item # 820
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Description

Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases.

Instructions for Coding

See SEER Extent of Diseases, 1998: Codes and Coding Instructions, Third Edition for Site Specific codes and coding rules for all EOD fields. This information can be found online at

<http://seer.cancer.gov/tools/codingmanuals/> or <http://seer.cancer.gov/manuals/EOD10Dig.3rd.pdf>

REGIONAL NODES EXAMINED	1/1/1999 and later	NAACCR Item # 830
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Description:

Records the total number of regional lymph nodes that were examined by the pathologist.

Instructions for Coding

See SEER Extent of Diseases, 1998: Codes and Coding Instructions, Third Edition for Site Specific codes and coding rules for all EOD fields. This information can be found online at <http://seer.cancer.gov/tools/codingmanuals/> or <http://seer.cancer.gov/manuals/EOD10Dig.3rd.pdf>

CS Reg Nodes Eval	1/1/2004 and later	NAACCR Item # 2840
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Description:

This field records how the codes for “CS Lymph Nodes” were determined based on the diagnostic methods employed. This field is used in CS to identify whether the N (of AJCC TNM) was clinically or pathologically diagnosed.

Instructions for Coding

See Collaborative Staging Manual and Coding Instructions, Version 1.0 for Site Specific codes and coding rules. This information can be found online at <http://www.cancerstaging.org/cstage/manuals.html>

CS Mets at DX	1/1/2004 and later	NAACCR Item # 2850
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Description:

This field is collapsible into AJCC M code according to the AJCC sixth edition. Reporting is effective as of January 1, 2004.

Instructions for Coding

See Collaborative Staging Manual and Coding Instructions, Version 1.0 for Site Specific codes and coding rules. This information can be found online at <http://www.cancerstaging.org/cstage/manuals.html>

CS Mets Eval	1/1/2004 and later	NAACCR Item # 2860
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Description:

This field records how the codes for “CS Mets at DX” were determined based on the diagnostic methods employed. This field is used in CS to identify whether the M (of AJCC TNM) was clinically or pathologically diagnosed.

Instructions for Coding

See Collaborative Staging Manual and Coding Instructions, Version 1.0 for Site Specific codes and coding rules. This information can be found online at <http://www.cancerstaging.org/cstage/manuals.html>

CS Site Specific Factor 1	1/1/2004 and later	NAACCR Item # 2880
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Description:

Site Specific Factors 1-6 are used to code additional site-specific information needed to derive AJCC stage six edition or to code prognostic factors that have an effect on stage or survival. Reporting is effective as of January 1, 2004.

Instructions for Coding

See Collaborative Staging Manual and Coding Instructions, Version 1.0 for Site Specific codes and coding rules. This information can be found online at

<http://www.cancerstaging.org/cstage/manuals.html>

Code WHO Grade for Brain and other Central Nervous System sites

Code	Definition
010	WHO Grade I non-malignant or benign tumors
020	WHO Grade II malignant tumor as well as non-malignant
030	WHO Grade III malignant
040	WHO Grade IV malignant
999	WHO Grade unknown

CS Site Specific Factor 2

1/1/2004 and later

NAACCR Item # 2890

Description:

Site Specific Factors 1-6 are used to code additional site-specific information needed to derive AJCC stage six edition or to code prognostic factors that have an effect on stage or survival. Reporting is effective as of January 1, 2004.

Instructions for Coding

See Collaborative Staging Manual and Coding Instructions, Version 1.0 for Site Specific codes and coding rules. This information can be found online at

<http://www.cancerstaging.org/cstage/manuals.html>

CS Site Specific Factor 3

1/1/2004 and later

NAACCR Item # 2900

Description:

Site Specific Factors 1-6 are used to code additional site-specific information needed to derive AJCC stage six edition or to code prognostic factors that have an effect on stage or survival. Reporting is effective as of January 1, 2004.

Instructions for Coding

See Collaborative Staging Manual and Coding Instructions, Version 1.0 for Site Specific codes and coding rules. This information can be found online at

<http://www.cancerstaging.org/cstage/manuals.html>

CS Site Specific Factor 4

1/1/2004 and later

NAACCR Item # 2910

Description:

Site Specific Factors 1-6 are used to code additional site-specific information needed to derive AJCC stage six edition or to code prognostic factors that have an effect on stage or survival. Reporting is effective as of January 1, 2004.

Instructions for Coding

See Collaborative Staging Manual and Coding Instructions, Version 1.0 for Site Specific codes and coding rules. This information can be found online at

<http://www.cancerstaging.org/cstage/manuals.html>

CS Site Specific Factor 5	1/1/2004 and later	NAACCR Item # 2920
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Description:

Site Specific Factors 1-6 are used to code additional site-specific information needed to derive AJCC stage six edition or to code prognostic factors that have an effect on stage or survival. Reporting is effective as of January 1, 2004.

Instructions for Coding

See Collaborative Staging Manual and Coding Instructions, Version 1.0 for Site Specific codes and coding rules. This information can be found online at

<http://www.cancerstaging.org/cstage/manuals.html>

CS Site Specific Factor 6	1/1/2004 and later	NAACCR Item # 2930
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Description:

Site Specific Factors 1-6 are used to code additional site-specific information needed to derive AJCC stage six edition or to code prognostic factors that have an effect on stage or survival. Reporting is effective as of January 1, 2004.

Instructions for Coding

See Collaborative Staging Manual and Coding Instructions, Version 1.0 for Site Specific codes and coding rules. This information can be found online at

<http://www.cancerstaging.org/cstage/manuals.html>

FIRST COURSE OF TREATMENT SECTION

RX DATE SURGERY (Date First Surgical Procedure)

NAACCR Item # 1200

Description

Records the earliest date on which any first course surgical procedure was performed. Formerly called. Date of Cancer-Directed Surgery.

Instructions for Coding

- Record the date of the first surgical procedure of the types coded as Surgery of Primary Site (NAACCR Item #1290 or 1646), Scope of Regional Lymph Node Surgery (NAACCR Item #1292 or 1647) or Surgical Procedure/Other Site (NAACCR Item # 1292 or 1648) performed at this or any facility.
- The date in this item may be the same as that in Date of Most Definitive Surgical Resection of the Primary Site (NAACCR Item #3170), if the patient received only one surgical procedure and it was a resection of the primary site.
- If surgery is the first or only treatment administered to the patient, then the date of surgery should be the same as the date entered into the item Date of First Course Treatment (NAACCR Item #1260 or 1270).
- **Avoid using 9's** for unknown month, day or year. Use all information in the medical records to estimate the date if possible. Document in the text that the date is approximate.

Code	Definition
MMDDCCYY	The date of first surgical procedure is the month, day, and year (MMDDCCYY) of the procedure at this or any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	When no surgical procedure was performed. Diagnosed at autopsy.
99999999	When it is unknown whether a surgical procedure was performed, the date is unknown, or the case was identified by death certificate only.

Examples:

Code	Definition
09992005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04012003	If information is limited to the description Spring, 2003.
07012003	If information is limited to the description the middle of the year, 2003.
10012003	If information is limited to the description Fall, 2003.
12012003 or 01012004	If information is limited to the description Winter, try to determine if this means the beginning or the end of the year. Code January or December as indicated.

RX DATE RADIATION

NAACCR Item # 1210

Description

Records the date on which radiation therapy began at any facility that is part of the first course of treatment.

Instruction for coding

- If radiation therapy is the first only treatment administered to the patient, then the date radiation started should be the same as the date entered into the item. *Date of first course of treatment (NAACCR Item # 1270 + 1260)*
- **Avoid using 9's** for unknown month, day or year. Use all information in the medical records to estimate the date if possible. Document in the text that the date is approximate.

Code	Description
MMDDCCYY	The month, day, and year (MMDDCCYY) that the first course of radiation therapy began at any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	No radiation therapy administered. Diagnosed at autopsy.
88888888	When radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up. The date should be revised at the next follow-up.
99999999	When it is unknown whether any radiation therapy was administered, the date is unknown, or the case was identified by death certificate only.

Code	Reason
12152003	A patient has external beam radiation on December 15, 2003.
10122003	A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on October 12, 2003.
06022003	A patient enters the facility for interstitial radiation boost for prostate cancer that is performed on August 6, 2003. Just prior to this, the patient had external beam therapy to the lower pelvis that was started on June 2, 2003 at another facility. Record the first date of radiation, regardless of the location of treatment.
09012005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04012003	If information is limited to the description Spring, 2003.
07012003	If information is limited to the description the middle of the year, 2003.
10012003	If information is limited to the description Fall, 2003.
12012003 or 01012004	If information is limited to the description Winter, try to determine if this means the beginning or the end of the year. Code January or December as indicated.

RX DATE –SYSTEMIC

NAACCR Item # 3230

Description

Enter the date of initiation of systemic therapy that is part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormone agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy.

Instructions for Coding

- Record the first or earliest date in which systemic therapy was administered. *Systemic therapy includes Chemotherapy (NAACCR Item # 1390), Hormone Therapy (NAACCR Item # 1400), Immunotherapy (NAACCR Item # 1410), and Hematologic Transplant and Endocrine Procedures (NAACCR Item # 3250).*
- Code 88888888 if systemic therapy was planned but not started at the time of most recent follow-up. The date should be revised at the next follow up.
- **Avoid using 9's** for unknown month, day or year. Use all information in the medical records to estimate the date if possible. Document in the text that the date is approximate.

Codes	Definition
MMDDCCYY	The date systemic therapy started is the month, day, and year that systemic therapy was first administered. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year. If the exact date on which systemic therapy was started is not available, then record an approximate date.
00000000	When no systemic therapy was administered, or the case was diagnosed at autopsy.
88888888	When systemic therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up. The date should be revised at the next follow-up.
99999999	When it is unknown if any systemic therapy was administered, the date is unknown, or the case was identified by death certificate-only.

Examples:

Code	Reason
12152003	A patient with breast cancer begins her regimen of chemotherapy on December 15, 2003, and is subsequently given tamoxifen on January 20, 2004.
06022003	A patient with Stage IV prostate cancer has an orchiectomy on June 2, 2003. The patient is then started on a regime of hormonal agents on June 9, 2003.
09992005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description Spring, 2003.
07992003	If information is limited to the description the middle of the year, 2003.
10992003	If information is limited to the description Fall, 2003.
12992003 or 01992004	If information is limited to the description Winter, try to determine if this means the beginning or the end of the year. Code January or December as indicated.

RX DATE-OTHER

NAACCR Item # 1250

Description

Records the date on which other treatment began at any facility.

Instructions for Coding

- Other treatment is that which cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.
- If other treatment is the first or only treatment administered to the patient, then the date other treatment started should be the same as the *Date of First Course of Treatment* (NAACCR Item #1270).
- **Avoid using 9's** for unknown month, day or year. Use all information in the medical records to estimate the date if possible. Document in the text that the date is approximate.

Code	Definition
MMDDCCYY	The month, day, and year other treatment began at any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	When no other treatment was administered. Diagnosed at autopsy.
99999999	When it is unknown if other treatment was administered, the date is unknown, or the case was identified by death certificate only.

Examples:

Code	Reason
03162003	A patient with metastatic disease was started on an experimental therapy on March 16, 2003.
06022005	On June 2, 2005, a patient started treatment which cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.
09012005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04012003	If information is limited to the description Spring, 2003.
07012003	If information is limited to the description the middle of the year, 2003.
10012003	If information is limited to the description Fall, 2003.
12012003 or01012004	If information is limited to the description Winter, try to determine if this means the beginning or the end of the year. Code January or December as indicated.

DATE OF INITIAL RX—SEER

NAACCR Item # 1260

DATE OF 1ST CRS RX—COC

NAACCR Item # 1270

Description

Records the date on which treatment (surgery, radiation, systemic, or other therapy) of the patient began at any facility. Date fields for both COC and SEER are required.

Instructions for Coding

- Record the earliest of the following dates: *Date of First Surgical Procedure* (NAACCR Item #1200), *Date Radiation Started* (NAACCR Item #1210), *Date Systemic Therapy Started* (NAACCR Item #3230), or *Date Other Treatment Started* (NAACCR Item #1250).

- In the absence of exact date of treatment, use the date of admission for that hospitalization during which the first treatment was begun.
- In case of no treatment, in which a physician decides not to treat a patient or all treatment is declined, the date of first course of treatment is the date this decision was made.
- **Avoid using 9's** for unknown month, day or year. Use all information in the medical records to estimate the date if possible. Document in the text that the date is approximate.

Code	Definition
MMDDCCYY	The date of first course of treatment is the month, day, and year (MMDDCCYY) of the beginning of treatment (surgery, radiation, systemic, or other therapy) at any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	Diagnosed at autopsy.
99999999	When it is unknown whether any treatment was administered to the patient, the date is unknown, or the case was identified by death certificate only.

Examples:

Code	Reason
02142004	If a patient has an incisional, core, or fine needle biopsy on February 12, 2004 and subsequently undergoes an excisional biopsy or radical surgical procedure on February 14, 2004, then record the date of the excisional biopsy or radical surgery (February 14, 2004) as the date of first course of treatment. <i>Note:</i> If a biopsy is not stated to be excisional, but no residual cancer was found at a later resection, assume the biopsy was excisional. Do not record the date of incisional, core, or fine needle biopsies as the date of first course of treatment.
08112003	If a patient has an excisional biopsy on August 11, 2003 followed by a radical surgical procedure on September 18, 2003, then record the date of the excisional biopsy (August 11, 2003) as the date of first course of treatment.
12072010	If a patient has a surgical excision on December 7, 2010 and subsequently undergoes a radical surgical procedure on December 19, 2010, then record the date of the first surgical excision (December 7, 2010) as the date of first course of treatment.
04212005	If a patient begins receiving preoperative radiation therapy on April 21, 2005 and subsequent surgical therapy on June 2, 2005, then record the date of the preoperative radiation therapy (April 21, 2005) as the date of first course of treatment.
01012003	If a patient is diagnosed with cancer at your facility and receives radiation therapy in January 2003 at another facility before returning for surgery on February 2, 2003 at your facility, then record the date of the radiation therapy (January 2003) as the date of first course of treatment. Since the exact day of treatment is unknown or unavailable, estimate day as 01.
09012005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04012003	If information is limited to the description Spring, 2003.
07012003	If information is limited to the description the middle of the year, 2003.
10012003	If information is limited to the description Fall, 2003.

12012003 or 01012004	If information is limited to the description Winter, try to determine if this means the beginning or the end of the year. Code January or December as indicated.
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RX SUMM-SURG PRIM SITE

1/1/2003 and later

NAACCR Item # 1290

Description

Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment **for cases diagnosed January 1, 2003 and later**. This includes treatment given at all facilities as part of first course of treatment.

Instructions for Coding

- Site-specific codes for this data item are found in the SEER Program Coding and Staging Manual 2004 see *Appendix C: SEER Site-Specific Surgery of Primary Site Codes* and the COC FORDS Manual. <http://seer.cancer.gov/tools/codingmanuals/>
- If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site.
- If registry software allows multiple procedures to be recorded, this item refers to the most invasive surgical procedure of the primary site.
- For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00.
- Biopsies that remove all of the tumor and/or leave only microscopic margins are to be coded in this item.
- Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted in SEER Code Program Manual and FORDS Manual.
- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results.

Code	Label	Definition
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10-19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to SEER Program Coding and Staging Manual 2004 see <i>Appendix C: SEER Site-Specific Surgery of Primary Site Codes</i> . COC FORDS Manual for the correct site-specific code for the procedure.
20-80	Site-specific codes; Resection	Refer to SEER Program Coding and Staging Manual 2004 see <i>Appendix C: SEER Site-Specific Surgery of Primary Site Codes</i> . COC FORDS Manual for the correct site-specific code for the procedure.
90	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Site-specific codes; Special code.	Refer to SEER Program Coding and Staging Manual 2004 see <i>Appendix C: SEER Site-Specific Surgery of Primary Site Codes</i> . COC FORDS Manual for the correct site-specific code for the procedure.
99	Unknown	Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

RX SUMM – SURG SITE 98-02 **1/1/1998 through 12/31/2002** NAACCR Item # 1646

Description

Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment for cases diagnosed between January 1, 1998 and December 31, 2002. This includes treatment given at all facilities as part of the first course of treatment.

Instructions for Coding

For site specific codes for cases diagnosed 1998-2002 refer to:

SEER Program Code Manual 1998, Appendix C or

ROADS Manual Appendix D

RX SUMM- SURGERY TYPE **1/1/1995 through 12/31/1997** NAACCR Item # 1640

Description

Site-specific surgery codes for cases diagnosed prior to January 1998. For GCCR, use these codes for cases diagnosed 1995-1997. This 2 digits code includes removal of lymph nodes and reconstruction.

Instruction for Coding

For site-specific codes, see SEER Program Code Manual, 1998, Appendix D.

RX SUMM-SCOPE REG LN SURG **1/1/2003 and later** NAACCR Item # 1292

Description

Identifies the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event. **For cases diagnosed January 1, 2003 and later.**

Instructions for Coding

- The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.
- Record surgical procedures, which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item. Record the date of this surgical procedure in data item *Date of First Course of Treatment* (NAACCR Items #1260 and 1270).
- Codes 07 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- For primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (C70.0.C70.9, C71.0.C71.9, C72.0.C72.9), code 9.
- For lymphomas (M-9590.9596, 9650.9719, 9727.9729) with a lymph node primary site (C77.0.C77.9), code 9.
- For an unknown or ill-defined primary (C76.0.C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9750, 9760.9764, 9800.9820, 9826, 9831.9920, 9931.9964, 9980.9989), code 9.
- Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field *Surgical Procedure/Other Site* (NAACCR Item #1294).
- Refer to the current *SEER-EOD* manual for site-specific identification of regional lymph nodes.

Code	Label	Definition
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph node, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease. For a procedure stated

		to be a biopsy of a lymph node, use code 1. For a procedure stated to be removal of one lymph node, use code 4.
2	Sentinel lymph node biopsy	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	Number of regional nodes removed unknown or not stated; regional lymph nodes removed, NOS	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel node biopsy.
4	1-3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated.	Code 2 was performed in a single surgical event with code 3, 4, or 5. Or, code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.
9	Unknown /not applicable/not stated.	It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

Examples:

Code	Reason
0	There was an attempt at regional lymph node dissection or sentinel lymph node dissection, but no lymph nodes were found in the pathological specimen.
1	(C14.0-Pharynx) Aspiration of regional lymph node to confirm histology of widely metastatic disease.
2	(C44.5-Skin of Back) Patient has melanoma of the back. A sentinel lymph node dissection was done with the removal of one lymph node. This node was negative for disease.
3	(C61.9-Prostate) Bilateral pelvic lymph node dissection for prostate cancer.
6	(C50.3-Breast) Sentinel lymph node biopsy of right axilla, followed by right axillary lymph node dissection during the same surgical event.
9	(C34.9-Lung) Patient was admitted for radiation therapy following surgery for lung cancer. There is no documentation on the extent of surgery in patient record.

RX SUMM – SCOPE REG 98-02 **1/1/1998 through 12/31/2002** NAACCR Item # 1647
Description

Describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at all facilities **between January 1, 1998 and December 31, 2002 only.**

Instructions for Coding

For site-specific codes for cases diagnosed 1998- 2002 refer to:
SEER Program Code Manual 1998, Appendix C or ROADS Manual Appendix D.

RX SUMM- REG LN EXAMINED **1/1/1998 through 12/31/2002** NAACCR Item # 1296
Description

Codes for the number of regional lymph nodes examined in conjunction with surgery performed as a part of the first course treatment **for cases diagnosed between January 1, 1998 and December 31, 2002 only.** This field is uniform across all primary sites.

Instructions for Coding

- Record the number of regional lymph nodes examined by the pathologist for this surgical procedure only. **DO NOT** add numbers of nodes removed at different surgical events.
- If no regional lymph nodes are identified in the pathology report, code 00 even if the surgical procedure includes a lymph node dissection (i.e., modified radical mastectomy) or if the operative report documents removal of lymph nodes.
- Because this field is not cumulative and not affected by timing issues, it does not replace or duplicate the field “Regional Lymph Nodes Examined” in the EOD coding section. Do not copy the values from one field to the other.

Priority of Codes

In the Number of Regional Lymph Nodes Examined codes, the following priorities hold:

- If lymph node surgery is done at the same time as definitive surgery, priority is given to the information connected with the most definitive surgery. Use the priority order listed under “Surgery of Primary Site” to determine the most definitive surgery of primary site.
- If lymph node surgery is done at a different time than the definitive surgery, priority is given to the code connected with the most definitive lymph node surgery. Use the priority order listed under “Scope of Regional Lymph Node Surgery” to determine the most definitive lymph node surgery.

Codes	Definition
00	No lymph nodes examined.
01	One regional lymph node examined.
02	Two regional lymph nodes examined.
....	
90	90 or more regional lymph nodes examined.
...	
95	No regional lymph nodes removed but aspiration of regional lymph nodes was performed.
96	Regional lymph node removal documented as sampling and number of lymph nodes unknown/not stated.
97	Regional lymph node removal documented as a dissection and number of lymph nodes

	unknown/not stated.
98	Regional lymph nodes surgically removed, but number of lymph nodes unknown/not stated and not documented as sampling or dissection.
99	Unknown; not stated; death certificate-only.

RX SUMM-SURG OTHER REG/DIS

1/1/2003 and later

NAACCR Item # 1294

Description

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

Instructions for Coding

- Assign the highest numbered code that describes the surgical resection of *distant lymph node(s)* and/or regional/distant tissue or organs.
- Incidental removal of tissue or organs is not a “Surgical Procedure/Other Site”.

Code	Label	Definition
0	None	No surgical procedure of nonprimary site was performed. Diagnosed at autopsy.
1	Nonprimary surgical procedure performed	Nonprimary surgical resection to other site(s), unknown if the site(s) is regional or distant.
2	Nonprimary surgical procedure of other regional sites	Resection of regional site. Note: For en bloc resection with primary site, see surgery of Primary Site field. Do not code en bloc resection here.
3	Nonprimary surgical procedure of <i>distant lymph node(s)</i>	Resection of <i>distant lymph node(s)</i> .
4	Nonprimary surgical procedure of distant site	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only.

Examples:

Code	Reason
0	(C18.1.Colon) The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon.
1	Surgical biopsy of metastatic lesion from liver; unknown primary.
2	(C18.3.Colon) Surgical ablation of solitary liver metastasis, hepatic flexure primary.
4	(C19.9.Rectosigmoid) Excision of multiple liver metastasis.
4	(C34.9.Lung) Removal of solitary brain metastasis.
5	(C21.0.Anus) Excision of solitary liver metastasis and one large hilar lymph node.

RX SUMM – SURG OTH 98-02 1/1/1998 through 12/31/2002 NAACCR Item # 1648

Description

Records the surgical removal of *distant* lymph nodes or other tissue(s)/organ(s) beyond the primary site given at all facilities as part of the first course of treatment for all cases diagnosed **between January 1, 1998 and December 31, 2002 only.**

Instructions for Coding

For site- specific codes for cases diagnosed 1998-2002 refer to:
SEER Program Code Manual 1998, Appendix C or ROADS Manual Appendix D

RX SUMM – RECONSTRUCTION 1ST COURSE NAACCR Item # 1330
For Breast Cases Only 1/1/1998 through 12/31/2002

Description

Codes for surgical procedures done to reconstruct, restore, or improve the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or cancer-directed therapies. Reconstructive/restorative procedures are coded here when started during the first course of cancer-directed therapy. GCCR collects this field only for breast cancer and only for cases diagnosed between January 1, 1998 and December 31, 2002.

COC introduced site-specific codes for this item in the COC *ROADS Manual* 1998 Supplement. Item 1460 (RX Coding System--Current) identifies which coding system applies. SEER collects reconstructive procedures for breast cancer cases only.

Priority of Codes

If the Reconstruction—First Course codes, the following priorities hold

- Code ‘1’ – ‘8’ have priority over code ‘0’ and ‘9’.
- In the range of codes ‘1’ – ‘8’ the numerically higher code has priority.

Instructions for Coding

- Breast only cases.
- All other primary sites enter a blank in this field.

Code	Definition
0	No reconstruction/restoration
1	Reconstruction, NOS (unknown if flap)
2	Implant; reconstruction Without flap
3	Reconstruction With flap, NOS
4	Latissimus dorsi flap
5	Abdominus recti flap
6	Flap, NOS plus implant
7	Latissimus dorsi plus implant
8	Abdominus recti plus implant
9	Unknown, not stated, death certificate only

REASON FOR NO SURGERY

NAACCR Item # 1340

Description

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

Instructions for Coding

- If *Surgical Procedure of Primary Site* (NAACCR Item #1290 or 1646) is coded 00 or 98, then record the reason based on documentation in the patient record.
- Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include surgery of the primary site, or if the option of .no treatment. was accepted by the patient.
- Code 7 if the patient refused recommended surgical treatment, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Cases coded 8 should be followed and updated to a more definitive code as appropriate.
- Code 9 if the treatment plan offered multiple choices, but it is unknown which treatment, if any was provided.

Code	Definition
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in patient record.
7	Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only.

Examples:

Code	Reason
2	A patient with a primary tumor of the liver is not recommended for surgery due to advanced cirrhosis.
8	A patient is referred to another facility for recommended surgical resection of a gastric carcinoma, but further information from the facility to which the patient was referred is not available.

RX SUMM- RADIATION

NAACCR Item # 1360

Description

Codes for the type of radiation therapy performed as part of the first course of treatment. Includes treatment given at all facilities as part of first course.

This code will be derived from Rad-Regional Rx Modality (NAACCR Item # 1570) and Rad-Boost Rx Modality (NAACCR Item # 3200).

Note: Radiation to brain and central nervous system for leukemia and lung cases is coded as radiation in this field.

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

RX SUMM- SURG/RAD SEQ

NAACCR Item # 1380

Description

Records the sequencing of radiation and surgical procedures given as part of the first course of treatment.

Instructions for Coding

Surgical procedures include *Surgical Procedure of Primary Site* (NAACCR Items #1290 and 1646); *Scope of Regional Lymph Node Surgery* (NAACCR Items #1292 and 1647); *Surgical Procedure/Other Site* (NAACCR Items #1294 and 1648). If all of these procedures are coded 0, then this item should be coded 0.

Code	Label	Definition
0	No radiation therapy and/or surgical procedures	No radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery.
2	Radiation therapy	Radiation therapy given before surgery to primary site; scope

	before surgery	of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
4	Radiation therapy both before and after surgery	Radiation therapy given before and after any surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown	Administration of radiation therapy and surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is unknown if radiation therapy was administered and/or it is unknown if surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed.

Examples:

Code	Reason
0	Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.
2	A large lung lesion received radiation therapy prior to resection.
3	A patient received a wedge resection of a right breast mass with axillary lymph node dissection followed by radiation to right breast.
4	Preoperative radiation therapy was given to a large, bulky vulvar lesion and was followed by a lymph node dissection. This was then followed by radiation therapy to treat positive lymph nodes.
5	A cone biopsy of the cervix was followed by intracavitary implant for IIB cervical carcinoma.
6	Stage IV vaginal carcinoma was treated with 5,000 cGy to the pelvis followed by a lymph node dissection and 2,500 cGy of intracavitary brachytherapy.
9	An unknown primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. The patient enters for chemotherapy.

RX SUMM- SYSTEMIC SUR SEQ

NAACCR Item # 1639

Description

Records the sequencing systemic therapy (Rx Summ-Chemo, RX Summ-Hormone, and RX Summ-Transplnt/Endocr) and surgical procedure given as part of the first course of treatment.

Instructions for Coding

Surgical procedures include *Surgical Procedure of Primary Site* (NAACCR Items #1290 and 1646); *Scope of Regional Lymph Node Surgery* (NAACCR Items #1292 and 1647); *Surgical Procedure/Other Site* (NAACCR Items #1294 and 1648). If all of these procedures are coded 0, then this item should be coded 0.

Code	Label	Definition
0	No systemic therapy	No systemic therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery.
2	Systemic therapy before surgery	Chemotherapy, hormonal, or bone marrow transplant and or endocrine therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
3	Systemic therapy after surgery	Chemotherapy, hormonal, or bone marrow transplant and or endocrine therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
4	Systemic therapy both before and after surgery	Chemotherapy, hormonal, or bone marrow transplant and or endocrine therapy given before and after any surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
5	Intraoperative systemic therapy	Intraoperative systemic therapy (Chemotherapy, hormonal, or bone marrow transplant and or endocrine) given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with other therapy administered before or after surgery	Intraoperative systemic therapy (Chemotherapy, hormonal, or bone marrow transplant and or endocrine) given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) and with other therapy administered before or after surgery to primary site scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence Unknown	Unknown if systemic therapy (Chemotherapy, hormonal, or bone marrow transplant and or endocrine) were given before, during or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).

RX SUMM- CHEMO

NAACCR Item # 1390

Description

Records the type of chemotherapy administered as first course treatment at this and all other facilities. If chemotherapy was not administered, then this item records the reason it was not administered to the patient.

Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Instructions for Coding

- Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy.
- If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered. Note: codes 82-86 are invalid for Abstract Plus users.
- Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.
- If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy, and only the original agent or regimen is recorded as first course therapy.
- Refer to the Self-Instructional Manual for Tumor Registrars: Book 8. Antineoplastic Drugs, Third Edition, for a list of chemotherapeutic agents.

Code	Definition
00	None, chemotherapy was not part of the planned first course of therapy.
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as first course therapy.
03	Multi agent chemotherapy administered as first course therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age). Invalid for Abstract Plus users.
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy. Invalid for Abstract Plus users.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record. Invalid for Abstract Plus users.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.

88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples:

Code	Reason
01	A patient with primary liver cancer is known to have received chemotherapy, however, the name(s) of agent(s) administered is not stated in patient record.
02	A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the administration of fluorouracil as single agent chemotherapy, and levamisole as an immunotherapeutic agent.
02	A patient with non-Hodgkin lymphoma is treated with fludarabine.
03	A patient with early stage breast cancer receives chemotherapy. The patient chart indicates that a regimen containing doxorubicin is to be administered.

RX SUMM- HORMONE

NAACCR Item # 1400

Description

Records the type of hormone therapy administered as first course treatment at this and all other facilities. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Instructions for Coding

- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.
- Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include hormone therapy.
- Code 01 for thyroid replacement therapy, which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
- If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered. Note: Codes 82-86 are invalid for Abstract Plus Users.
- Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.

- Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8. Antineoplastic Drugs*, Third Edition, for a list of hormonal agents.

Code	Definition
00	None, hormone therapy was not part of the planned first course of therapy.
01	Hormone therapy administered as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age). Invalid for Abstract Plus users.
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy. Invalid for Abstract Plus users.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record. Invalid for Abstract Plus users.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples:

Code	Reason
00	A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormonal therapy.
00	A patient with breast cancer may be treated with aminoglutethimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. This patient must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (Florinef) as a replacement therapy.
00	A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy.
01	A patient with metastatic prostate cancer is administered flutamide (an antiestrogen).
87	A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) and the refusal is noted in the patient record.

RX SUMM- BIOLOGICAL RESPONSE MODIFIER THERAPY (Immunotherapy)

NAACCR Item # 1410

Description

Records the type of immunotherapy administered as first course treatment at this and all other facilities. If immunotherapy was not administered, then this item records the reason it was not administered to the patient. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Instructions for Coding

- Code 00 if immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include immunotherapy.
- If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered. Note: Codes 82-86 are invalid for Abstract Plus Users
- Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8. Antineoplastic Drugs*, Third Edition, for a list of immunotherapeutic agents.

Code	Definition
00	None, immunotherapy was not part of the planned first course of therapy.
01	Immunotherapy administered as first course therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age). Invalid for Abstract Plus users.
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy. Invalid for Abstract Plus users.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record. Invalid for Abstract Plus users.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples:

Code	Reason
01	A patient with malignant melanoma is treated with interferon.
87	Before recommended immunotherapy could be administered, the patient refused treatment.

RX SUMM- OTHER

NAACCR Item # 1420

Description

Identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.

Instructions for Coding

- A complete description of the treatment plan should be recorded in the text field for Other Treatment on the abstract.
- Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment modifies, controls, removes, or destroys proliferating cancer tissue. Such treatments include phlebotomy, transfusions, and aspirin (see Notes below), and should be coded 1.

Code	Label	Definition
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment.
1	Other	Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases (see Notes below).
2	Other-Experimental	This code is not defined. It may be used to record participation in institution- based clinical trials.
3	Other-Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven	Cancer treatments administered by nonmedical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment.

- Phlebotomy may be called blood removal, blood letting, or venisection.
- Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.
- Aspirin (also known as ASA, acetylsalicylic acid, or by a brand name) is used as a treatment for essential thrombocythemia. Record **ONLY** aspirin therapy to thin the blood for symptomatic control of thrombocythemia. To determine whether aspirin is administered for pain, cardiovascular protection, or thinning of platelets in the blood, use the following general guideline:
 - Pain control is approximately 325.1000 mg every 3.4 hours.
 - Cardiovascular protection starts at about 160 mg/day.
 - Aspirin treatment for essential thrombocythemia is low dose, approximately 70.100 mg/day.

RX SUMM--TRANSPLNT/ENDOCR 1/1/2003 and later
NAACCR Item # 3250

Description

Identifies systemic therapeutic procedures administered as part of the first course of treatment at this facility and all other facilities **for cases diagnosed January 1, 2003 and later.**

Instructions for Coding

- Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.
- Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.
- Endocrine irradiation and/or endocrine surgery are procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or effect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.
- Code 00 if a transplant or endocrine procedure was not administered to the patient, and it is known that these procedures are not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include a transplant or endocrine procedure.
- If it is known that a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered. Note: Codes 82-86 are invalid for Abstract Plus users.
- Code 87 if the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 99 if it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.

Codes	Definition
00	No transplant procedure or endocrine therapy was not part of the first course of therapy.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant—autologous.
12	Bone marrow transplant—allogeneic.
20	Stem cell harvest.
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12 or 20).
82	Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.). Invalid for Abstract Plus users.
85	Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy. Invalid for Abstract Plus users.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered; it was recommended by the patient's physician, but was not administered as part of first-course therapy. No reason was noted in the patient record. Invalid for Abstract Plus users.
87	Hematologic transplant and/or endocrine surgery/radiation was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.

88	Hematologic Transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99	It is unknown if a hematologic transplant or endocrine surgery/radiation were recommended or administered because it is not stated in patient record. Death certificate-only cases and autopsy-only cases.

RAD-REGIONAL RX MODALITY

NAACCR Item # 1570

Description:

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

Code	Definition
00	No radiation treatment
20	External beam, NOS
21	Orthovoltage
22	Colbalt-60, Cesium-137
23	Photons (2-5 MV)
24	Photons (6-10 MV)
25	Photons (11-19 MV)
26	Photons (> 19 MV)
27	Photons (mixed energies)
28	Electrons
29	Photons and electrons mixed
30	Neutrons, with or without photons/electrons
31	IMRT
32	Conformal or 3-D therapy
40	Protons
41	Stereotactic radiosurgery, NOS
42	Linac radiosurgery
43	Gamma Knife
50	Brachytherapy, NOS
51	Brachytherapy, Intracavitary, Low Dose Rate (LDR)
52	Brachytherapy, Intracavitary, High Dose Rate (HDR)
53	Brachytherapy, Interstitial, Low Dose Rate (LDR)
54	Brachytherapy, Interstitial, High Dose Rate (HDR)
55	Radium
60	Radio-isotopes, NOS
61	Strontium-89

62	Strontium-90
80	Combination of beam with radioactive implants or radioisotopes, NOS
85	Other combinations of treatment modalities, NOS
98	Others, NOS
99	Unknown

RAD—BOOST RX MODALITY

NAACCR Item # 3200

Description

Records the radiation treatment—boost modality used to deliver the most clinically significant dose to the primary volume of interest during the first course of treatment. This is accomplished with external beam fields of reduced size (relative to the regional treatment fields), implants, stereotactic radiosurgery, conformal therapy, or intensity-modulated radiation therapy. External beam boosts may consist of two or more successive phases with progressively smaller fields, and they are generally coded as a single entity. This field is used with Rad--Regional RX Modality Item #1570.

Code	Definition
00	No radiation treatment
20	External beam, NOS
21	Orthovoltage
22	Colbalt-60, Cesium-137
23	Photons (2-5 MV)
24	Photons (6-10 MV)
25	Photons (11-19 MV)
26	Photons (> 19 MV)
27	Photons (mixed energies)
28	Electrons
29	Photons and electrons mixed
30	Neutrons, with or without photons/electrons
31	IMRT
32	Conformal or 3-D therapy
40	Protons
41	Stereotactic radiosurgery, NOS
42	Linac radiosurgery
43	Gamma Knife
50	Brachytherapy, NOS
51	Brachytherapy, Intracavitary, Low Dose Rate (LDR)
52	Brachytherapy, Intracavitary, High Dose Rate (HDR)
53	Brachytherapy, Interstitial, Low Dose Rate (LDR)
54	Brachytherapy, Interstitial, High Dose Rate (HDR)

55	Radium
60	Radio-isotopes, NOS
61	Strontium-89
62	Strontium-90
80	Combination of beam with radioactive implants or radioisotopes, NOS
85	Other combinations of treatment modalities, NOS
98	Others, NOS
99	Unknown

FOLLOW-UP SECTION

DATE OF LAST CONTACT

NAACCR Item # 1750

Description

Records the date of last contact with the patient or the date of death.

Instructions for Coding

- Record the last date on which the patient was known to be alive or the date of death.
- If a patient has multiple primaries, all records should have the same date of last contact.
- **Avoid using 9's** for unknown for month, day or year. Use all information in the medical records to estimate the date if possible. Document in the text that the date is approximate.

Code	Definition
MMDDCCYY	The date of last contact is the month, day, and year that last contact was made. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year. If the exact date on which last contact was made is not available, then record an approximate date.

Examples:

Code	Reason
06302004	The patient's date of death was June 30, 2004.
01012003	The medical record contains only the year of death (2003).
01142005	A patient returns his follow-up inquiry with no date information; the envelope is postmarked January 14, 2005.

VITAL STATUS

NAACCR Item # 1760

Description

Records the vital status of the patient as of the date entered in *Date of Last Contact or Death* (NAACCR Item #1750).

Instructions for Coding

- This item is collected during the follow-up process with *Date of Last Contact or Death* (NAACCR Item#1750).
- If a patient has multiple primaries, all records should have the same vital status.

Code	Label
0	Dead
1	Alive

Examples:

Code	Reason
0	Death clearance information obtained from a state central registry confirms the death of the patient within the past year.
1	In response to a follow-up letter to a patient's following physician, it is learned the patient is alive.

AUTOPSYNAACCR Item # 1930

Description

Code indicating whether or not an autopsy was performed.

Codes

Codes	Description
0	Not applicable; patient alive
1	Autopsy performed
2	No autopsy performed
9	Patient expired, unknown if autopsy performed

Note: Codes 1–9 used only if the patient has expired.

Note: Beginning January 1, 2003, COC will no longer support this data item.

TEXT DIAGNOSIS AND TREATMENT SECTION

Description:

Text description of the corresponding data field.

Rationale For Using Text In Addition To Codes:

Text is needed to justify the codes selected for the data items and to allow recording information that is not coded at all. It is a component of a complete electronic abstract to be printed or reviewed on the screen as needed. The text is used for quality control and special studies. As the purpose of text information is to provide an opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should not be generated electronically from coded values.

Examples of Use of Text for Quality Control Purposes:

- Supports Coding Choices
 - Laterality on lung cases coded right
 - Text for X-ray and op states left
- Typos and Transposed Characters
 - Histology coded 8410/39
 - Path text states adenocarcinoma
- Confirmation of Age, Sex, and Race
- Multiple abstracts of one patient
 - Hospital A- Primary Site Colon, NOS
 - Hospital B- Primary Site Sigmoid Colon

Instruction for Coding:

- Record only pertinent information
- Document complete date MM/DD/YYYY
- Use abbreviations and shortened words

Text Field	Description	Instructions
Text DX Physical Exam NAACCR # 2520	Text area for information from history and physical exam	<ul style="list-style-type: none"> • Include complete date of PE (MM/DD/YYYY) • Age, sex and race of patient at the time of PE. • This information helps establish age and verify DOB, sex and race.
Text DX Procedure Radiology NAACCR # 2530	Text area for information from diagnostic imaging reports	<ul style="list-style-type: none"> • Include complete date (MM/DD/YYYY) • Type of exam/procedure • Pertinent findings
Text DX Procedure- Scope NAACCR #2540	Text area for information from endoscopic examinations	<ul style="list-style-type: none"> • Include complete date (MM/DD/YYYY) • Type of exam/procedure • Pertinent findings

Text DX- Procedure - Lab Tests NAACCR #2550	Text area for information from laboratory tests other than cytology or histopathology	<ul style="list-style-type: none"> • Include complete date (MM/DD/YYYY) • Type of exam/procedure • Pertinent findings
Text DX- Procedure Op Reports NAACCR # 2560	Text area for information from operative reports	<ul style="list-style-type: none"> • Include complete date (MM/DD/YYYY) • Type of exam/procedure • Pertinent findings
Text DX Procedure – Pathology NAACCR #2570	Text area for information from cytology and histopathology	<ul style="list-style-type: none"> • Complete date (MM/DD/YYYY) • Specimen number • Histology/Behavior/Grade • Tumor Size • Extent of Disease • Lymph Node Involvement
Text - Primary Site Title NAACCR # 2580	Text area for information of primary site in natural language.	
Text – Histology Title NAACCR # 2590	Text area for description of histology type, behavior and grade in natural language.	
Text – Staging NAACCR # 2600	Additional text area for staging information not already entered in Text-DX Proc areas. Can also be used for Summary Stage or TNM description.	
Text – RX Surgery NAACCR # 2610	Text area for information about surgical procedures performed as part of treatment.	<ul style="list-style-type: none"> • Complete date (MM/DD/YYYY) • Procedure name • Findings
Text – RX Radiation (Beam) NAACCR # 2620	Text area for information about beam radiation given for cancer treatment.	<ul style="list-style-type: none"> • Complete date (MM/DD/YYYY) • Specify type
Text – RX Radiation Other NAACCR # 2630	Text area for information about nonbeam radiation given for cancer treatment.	<ul style="list-style-type: none"> • Complete date (MM/DD/YYYY) • Specify type
Text – RX Chemo NAACCR # 2640	Text area for information about chemotherapy treatment.	<ul style="list-style-type: none"> • Complete date (MM/DD/YYYY) • Specify type
Text – RX Hormone NAACCR # 2650	Text area for information about hormonal cancer-directed therapy.	<ul style="list-style-type: none"> • Complete date (MM/DD/YYYY) • Specify type
Text – RX BRM NAACCR # 2660	Text area for information about biologic response modifiers.	<ul style="list-style-type: none"> • Complete date (MM/DD/YYYY) • Specify type
Text – RX Other NAACCR # 2670	Text area for information about other cancer directed therapy.	<ul style="list-style-type: none"> • Complete date (MM/DD/YYYY) • Specify type

Examples of Right amount of Text to be used

Text Field	Comments/Example
Text DX Physical Exam	4/3/99 45 yrs WF Pt. Dx'd w/duct breast ca last mth
Text DX Procedure-X-Ray/Scan	4/23/99 CT Chest- 2.0 cm mass RML w/mediastinal adenopathy, enlarged para and pre-trach LNs
Text DX Procedure- Scope	3/10/02 Colonoscopy-3cm mass asc colon c/w ca
Text DX- Procedure - Lab Tests	
Text DX- Procedure Op Reports	2/5/03 R MRM
Text DX Procedure -Pathology	1/6/99 3 cm cecal mass, md adenoca ext thru bowel wall, 2/13 reg Lns mets ca.
Text – Primary Site Title	R UOQ breast
Text – Histology Title	Infil adenoca, md
Text – Staging	Reg to LNs

TEXT-REMARKS

NAACCR Item # 2680

Description:

Record history of previous cancer(s) including primary site, laterality and date of diagnosis if available.

TEXT-USUAL INDUSTRY

NAACCR Item # 320

Description:

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

Rationale

Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial. The data item usual industry is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death.

Abstracting Instructions

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

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

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

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

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

TEXT-USUAL OCCUPATION

NAACCR Item # 310

Description:

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

Rationale

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

The data item usual occupation is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death.

Abstracting Instructions

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

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

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

If no information is available, record unknown.

This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

PLACE OF DIAGNOSIS

NAACCR Item # 2690

Description:

Text area for information about the facility, city, state, or county where the diagnosis was made.

**Georgia Comprehensive Cancer Registry
Reporting Manual**

**Section 5: SEER Site Specific Surgery of Primary Site
Surgery Codes**

5. SEER SITE SPECIFIC SURGEY OF PRIMARY SITE CODES

This section in GCCR Policy and Procedure Manual for Reporting Facilities can be downloaded from

<http://seer.cancer.gov/tools/codingmanuals>

Click on the link for [SEER Site-Specific Surgery of Primary Site Codes Appendix C](#)

**Georgia Comprehensive Cancer Registry
Reporting Manual**

**Section 6: Determining Multiple Primaries
*1/1/1995 through 12/31/2006***

6. DETERMINING MULTIPLE PRIMARIES (1/1/1995 through 12/31/2006)

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

In general, if there is a difference in the site where the cancer originates, it is fairly easy to determine whether it is a separate primary, regardless of dates of detection and differences in histology. Likewise, if there is a clear-cut difference in histology, other data such as site and time of detection are not essential. In some neoplasms, however, one must be careful since different histologic terms are used, for example, "leukemic phase of" or "converting to," to describe progressive stages or phases of the same disease process. Additional guidelines on determining single or multiple primaries are described below.

How Are Multiple Primary Cancers Determined?

Definitions

1. *Site differences:*

Main Rule: Each category (first three characters) as delineated in ICD-0-2 or ICD-0-3 is considered to be a separate site. There are two sets of exceptions to this rule:

Exception A: Certain specific sites. For the following three-character categories, each subcategory (4 characters) as delineated in ICD-0-2 or ICD-0-3 is considered to be a separate site.

Colon (C18)

Anus and anal canal (C21)

Bones, joints, and articular cartilage (C40 - C41)

Melanoma of skin (C44)

Peripheral nerves and autonomic nervous system (C47)

Connective, subcutaneous and other soft tissues (C49)

Examples: Transverse colon (C 18.4) and descending colon (C 18.6) are considered separate sites. Trigone of bladder (C67.0) and lateral wall of bladder (C67.2) are considered subsites of the bladder and would be treated as one site -either overlapping lesion of subsites of the bladder (C67.8) or bladder, NOS, if multi focal (C67.9).

Exception B: Certain sites that were combined in the first edition of ICD-0.

Between the first edition and second and third editions of ICD-0, some subcategories having code numbers with the same first three characters in the first edition of ICD-0 were split into separate three-character categories in ICD-0-2, and some subcategories having code numbers with different first three characters were grouped under the same first three characters. To avoid artificial change in numbers of cancers by site over time, refer to the tables on page 25.

To use the table, locate the horizontal row containing the ICD-0 topography codes for each pair of subsites/subcategories that are being checked. If they are in the SAME horizontal row, consider them to be the SAME site, whether the first three characters are the same or different. If they are in DIFFERENT horizontal rows, consider them to be DIFFERENT sites, whether the first three characters are the same or different. If both are not on the table, refer to the Main Rule and Exception A above. Note that when determining multiple primaries using the table on page 26, both invasive and in situ cancers are to be considered.

Examples: Base of tongue (C01.9) and border of tongue (C02.1) are considered subsites of the tongue and would be treated as one site and coded as C02.8, overlapping lesion of tongue or C02.9, tongue, NOS.

An invasive transitional cell carcinoma of the renal pelvis (C65.9) and an in situ transitional cell carcinoma of the mid-ureter (C66.9) would be considered one site in the urinary system.

2. Histologic type differences:

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

3. Simultaneous/Synchronous:

Diagnosed within two months of each other.

**CODES TO BE CONSIDERED THE SAME THREE-DIGIT SITE GROUPING WHEN
DETERMINING MULTIPLE PRIMARIES**
(Table of Sites for Exception B)

Site Codes	Site Groupings
C01 C02	Base of tongue Other and unspecified parts of tongue
C05 C06	Palate Other and unspecified parts of mouth
C07 C0--	Parotid gland Other and unspecified major salivary glands
C09 C10	Tonsil Oropharynx
C12 C13	Pyrifony sinus Hypopharynx
C23 C24	Gallbladder Other and unspecified parts of biliary tract
C30 C31	Nasal cavity and Middle ear Accessory sinuses
C33 C34	Trachea Bronchus and Lung
C37 C38.0 C38.1- C38.3 C38.8	Thymus Heart Mediastinum Overlapping lesion of heart, mediastinum, and pleura
C38.4	Pleura (visceral, parietal, NOS)
C51 C52 C57.7 C57.8 -C57.9	Vulva Vagina Other specified female genital organs Unspecified female genital organs
C56 C57.0 C57.1 C57.2 C57.3 C57.4	Ovary Fallopian tube Broad ligament Round ligament Parametrium Uterine adnexa
C60 C63	Penis Other and unspecified male genital organs
C64 C65 C66 C68	Kidney Renal pelvis Ureter Other and unspecified urinary organs
C74 C75	Adrenal gland Other endocrine glands and related structures

Rules for Determining Multiple Primary Cancers *Except* Lymphatic and Hematopoietic Diseases:

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

Examples: A single lesion involving the tongue and floor of mouth would be one primary. A single, large mucinous adenocarcinoma involving the sigmoid and descending colon segments is considered one primary.

2. A single lesion composed of multiple histologic types is to be considered as a single primary. The most frequent combinations of histologic types are listed in ICD-0-2 and ICD-0-3. For example, combination terms such as "adenosquamous carcinoma (8560/3)" or "small cell-large cell carcinoma (8045/3)" are included. Any single lesion containing mixed histologies is to be considered one primary.

Examples: A single lesion containing both embryonal cell carcinoma and teratoma is one primary and would be coded to 9081/3, mixed embryonal carcinoma and teratoma. A single lesion of the liver composed of neuroendocrine carcinoma (8246/3) and hepatocellular carcinoma (8170/3) is one primary and would be coded to the higher ICD-0 code.

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

Examples: Infiltrating duct carcinoma of the UOQ right breast diagnosed March 2001 and treated with lumpectomy. Previously unidentified mass in LIQ right breast noted in July 2001 mammogram. This was removed and found to be infiltrating duct carcinoma. *Count and abstract as two primaries.*

Adenocarcinoma in adenomatous polyp in sigmoid colon removed by polypectomy in December, 2001. At segmental resection in January 2001, an adenocarcinoma in a tubular adenoma adjacent to the previous polypectomy site was removed. *Count as one primary.*

Exception 1: Invasive adenocarcinomas of the prostate, site code C61.9, and invasive bladder cancers, site codes C67.0 - C67.9, with histology codes 8120-8130, are the exceptions to the above rule. For these cancers, a single abstract is required for the first invasive lesion only. If there is an in situ cancer followed by an invasive cancer, refer to Exception 2.

Exception 2: Effective with cases diagnosed January 1995 and after, if an in situ tumor is followed by an invasive cancer in the same site more than two months apart, report as two primaries even if stated to be a recurrence. The invasive primary should be reported with the date of the *invasive* diagnosis. (Note: The purpose of this guideline is to ensure that the case is counted as an incident case (i.e., invasive) when incidence data are analyzed.)

Exception 3: Kaposi's sarcoma (9140/3) is reported only once and is coded to the site in which it arises. If Kaposi's sarcoma arises in skin and another site simultaneously, code to skin (C44._). If no primary site is stated, code to skin (C44.9).

4. Multiple lesions of the same histologic type

- **Simultaneous multiple lesions of the same histologic type within the same site (i.e., multi focal tumors) will be considered a single primary.**

Further, if one lesion has a behavior code of in situ and another behavior code of malignant, still consider this to be a single primary whose behavior is malignant.

Examples: At nephrectomy, two separate, distinct foci of renal cell carcinoma are found in the specimen in addition to the 3.5 cm primary renal cell carcinoma. *Count as one primary.*

At mastectomy for removal of a 2 cm invasive ductal carcinoma, an additional 5 cm area of intraductal carcinoma was noted. *Count as one invasive primary.*

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

Examples: During the workup for a squamous cell carcinoma of the vocal cord, a second squamous cell carcinoma is discovered in the tonsillar fossa. *Count as two primaries.*

A patient with adenocarcinoma of the prostate undergoes a fine needle aspiration biopsy of a lung mass which is also adenocarcinoma. Special pathology stains indicate that the mass in the lung is a metastasis from the prostate. *Code as one primary of the prostate.*

5. Multiple lesions of different histologic types

- **Multiple lesions of different histologic types within a single site are to be considered separate primaries whether occurring simultaneously or at different times.**

Examples: A patient undergoes a right pneumonectomy for squamous cell carcinoma of the upper lobe. In the pathology specimen, an adenocarcinoma of the middle lobe is identified. *Count as two primaries.*

A patient undergoes a partial gastrectomy for adenocarcinoma of the body of the stomach. In the resected specimen, the pathologist finds both adenocarcinoma and nodular non-Hodgkin's lymphoma. *Count as two primaries.*

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

Exceptions for colon and rectum tumors:

When an adenocarcinoma (8140/_; in situ or invasive) arises in the same segment of the colon or rectum as an adenocarcinoma in a polyp (8210/_ , 8261/_ , 8263/J, code as adenocarcinoma (8140/J. When a carcinoma (8010/_; in situ or invasive) arises in the same segment of the colon or rectum as a carcinoma in a polyp (8210), code as carcinoma (8010/_).

Exception 2: Within each breast, combinations of ductal and lobular carcinoma occurring within two months of each other are to be considered a single primary and the histology coded according to ICD-0-2 and ICD-0-3. These histologic combinations are morphology codes 8522/2 and 8522/3.

Example: A left mastectomy specimen yields lobular carcinoma in the upper inner quadrant and intraductal carcinoma in the lower inner quadrant. *Code as one primary, C5 0.9 with morphology 8522/3.*

Exception 3: Certain neoplasms may demonstrate both multiple foci of tumor and multiple histologic types that are commonly found together. In such cases, consult ICD-0-2 or ICD-0-3 for a list of the most frequent histologic combinations. These multi focal, multi-histologic tumors occur most frequently in the thyroid, bladder, and breast. They are to be considered a single primary with a mixed histology.

Example: A thyroid specimen contains two separate carcinomas - one papillary and the other follicular. *Code as one primary with morphology 8340/3, papillary and follicular.* Multiple lesions of different histologic types occurring in different sites are considered separate primaries whether occurring simultaneously or at different times.

Examples: In 1999, the patient had a mucin-producing carcinoma of the transverse colon. In 2000, the patient was diagnosed with an astrocytoma of the frontal lobe of the brain. Count as separate primaries. During the workup for a transitional cell carcinoma of the bladder, the patient has a TURP which shows adenocarcinoma of the prostate. *Count as separate primaries.*

6. Paired sites

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

Exception 1: Simultaneous bilateral involvement of the ovaries in which there is only a single histology is to be considered one primary and laterality is to be coded '4'.

Exception 2: Bilateral retinoblastoma and bilateral Wilms' tumor are always considered single primaries (whether simultaneous or not), and laterality is coded '4'.

- **If one histologic type is reported in one side of a paired organ and a different histologic type is reported in the other paired organ**, consider these two primaries unless there is a statement to the contrary.

Example: If a ductal lesion occurs in one breast and a lobular lesion occurs in the opposite breast, these are considered to be two primaries.

Rules for Determining Multiple Primaries for Lymphatic and Hematopoietic Diseases for Cases Diagnosed Prior to January 1, 2001

The table “**Determination of Subsequent Primaries of Lymphatic (Nodal and Extra Nodal) and Hematopoietic Diseases for Cases Diagnosed January 2001 and Before**” is to be used to help determine multiple primaries of the lymphatic and hematopoietic diseases. This table can be found in the **SEER Program Code Manual** 3rd Edition, 1998 (page 15-37) or it can be downloaded from <http://seer.cancer.gov/tools/codingmanuals/>. Because of the rarity of subacute leukemias and aleukemias, they have been excluded from this table.

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

Example 1: first diagnosis: small cleaved cell, diffuse lymphoma (9672) b. second diagnosis: Hodgkin's disease, mixed cellularity (9652) *This case would be considered two primaries.*

Example 2: first diagnosis: small cleaved cell, diffuse lymphoma (9672) b. second diagnosis: acute lymphocytic leukemia (9821 or 9828) *This case would be considered one primary.*

Rules:

1. The topography (site) is to be disregarded in determining multiple primaries of lymphatic and hematopoietic diseases.
2. The interval between diagnoses is NOT to enter into the decision.

Example: A lymphocytic lymphoma (M-9670/3) diagnosed in March 1987 and an unspecified non-Hodgkin's lymphoma (M-9591/3) diagnosed in April 1988 would be considered one primary, a lymphocytic lymphoma diagnosed in March 1987 (the earlier diagnosis).

Rules for Determining Multiple Primaries Based on ICD-0-3 Reportable Neoplasms for Cases Diagnosed January 1, 2001 and After

A table based on ICD-0-3 reportable malignancies can be found in this section as well as in FORDS manual Appendix A. This table is effective with diagnosis January 1, 2001 and after. To use the table, assign the ICD-0-3 code to the first diagnosis and find the row containing that code. Assign the ICD-0-3 code for the second diagnosis and find the row containing that code. In the cell at the intersection of the first diagnosis row and the second diagnosis column, an "S" symbol indicates that the two diagnosis are most likely the same disease process (prepare a single abstract) and a "D" indicates they are different disease process (prepare more than one abstract).

GENERAL GUIDELINES FOR DETERMINING MULTIPLE PRIMARIES

Lesions	Site (s)	Histology	Variables	Primary
Single	Single	Single		Single
	Single	Mixed/multiple		Single
	Single	Single	Simultaneous	Single
Single or Multiple	Single	Single	Different behavior codes, in situ (2) and invasive (3)	Single (invasive) if <u>simultaneous</u> Multiple if invasive occurs 2 mos. or more after in situ
	Same as previous site	Same as previous histology	Within two months of diagnosis	Recurrence of the original primary
	Same as previous site	Same as previous histology	More than two months after diagnosis	New primary unless physician states it is metastatic Exceptions: Bladder, Kaposi's sarcoma, adenocarcinoma of prostate
Multiple	Multiple	Single	Simultaneous	Multiple UNLESS Physician states it is metastatic Exceptions: Ovaries (simultaneous bilateral), Bilateral retinoblastoma, and Wilms' tumor are single primaries
	Single	Mixed/multiple (single lesion)	Simultaneous	Single
	Single	Multiple (Each tumor has a different histology)	Simultaneous	Multiple Exceptions: Breast (lobular and ductal); bladder (transitional and papillary);thyroid (follicular and papillary)
	Multiple			

See the preceding site and histology **rules for definition of "multiple"**. To Determine Multiple Primaries in case of lymphoma and other hemopoetic conditions, refer to the table, "Single Versus Subsequent Primaries of Lymphatic and Hemopoetic Diseases". This can be downloaded from <http://seer.cancer.gov/icd-o-3/>. Click on [ICD-O-3 Hematopoietic Primaries Table \(PDF\)](#) - 3/15/2001

Rules for Determining Multiple Primaries for non-malignant primary intracranial and central nervous system tumors (C70.0 – C72.9, C75.1 – C75.3) cases diagnosed 1/1/2004 and later

Rationales for multiple primaries rules:

1. The natural biology of non-malignant tumors is that of expansive, localized growth, with local recurrences common, and metastasis uncommon or unusual.
2. Non-malignant tumors of the same histology, same site, and same side will recur in the same location. If they recur, even after 20 years, they are still the same tumor.
3. The corollary to statement 2 is that multiple non-malignant tumors of the same histology identified in different locations or sides of the CNS should be considered separate primaries.

A. Multiple lesions in which all are non-malignant tumors

1. If different sites, then separate primaries
 2. If different histologies, then separate primaries
 3. If same site and same histology*:
 - a. and laterality is same side, one side unknown or not applicable, then single primary
 - b. and laterality is both sides, then separate primaries
- * Note: if two histologies are in the same group in Table 2, code the more specific histology

B. Multiple tumors in which one was non-malignant and the other was a malignant lesion

1. Non-malignant tumor followed by malignant tumor: separate primaries regardless of timing
2. Malignant tumor followed by a non-malignant tumor: separate primaries regardless of timing

C. Multiple malignant tumors

1. If same histology:
 - a. < 2 months:
 - i. 1 if same site
 - ii. 2 if different site and not stated to be a recurrence or metastases
 - b. 2+ months (site does not matter):
 - i. 2 unless stated to be a recurrence or metastases
2. If different histologies:
 - a. <2 months:
 - i. 2 if same site unless one is more specific histology
 - ii. 2 if different site
 - b. 2+ months:
 - i. always 2 primaries

Histologic groupings to determine same histology for non-malignant brain tumors.
(See COC FORDS and SEER Program Manual for histology coding instructions.)

Choroid plexus neoplasms	9390/0, 9390/1
Ependymomas	9383, 9394, 9444
Neuronal and neuronal-glial neoplasms	9384, 9412, 9413, 9442, 9505/1, 9506
Neurofibromas	9540/0, 9540/1, 9541, 9550, 9560/0
Neurinomatosis	9560/1
Neurothekeoma	9562
Neuroma	9570
Perineurioma, NOS	9571/0

Rationale: Brain tumor histologies grouped in Table 2 do not follow the standard 3-digit histology difference rule because they represent a progression, differentiation or subtype of a single histologic category.

In a review of the ICD-O histology codes, applying the current 3-digit histology rule to non-malignant tumors would combine tumors that are no longer considered to be biologically related.

**Georgia Comprehensive Cancer Registry
Reporting Manual**

Section 7: Reporting Laws and Mandate

Georgia Department of Human Resources • Division of Public Health • Kathleen E. Toomey, M.D., M.P.H., Director
2 Peachtree Street NW • Suite 15.470 • Atlanta, Georgia 30303-3142 , 404-657-2700 • FAX: 404-657-2715

March 22, 2004

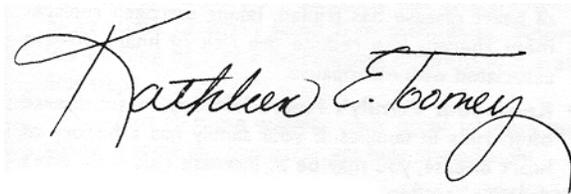
Dear Colleague:

The President signed the Benign Brain Tumor Cancer Registries Amendment Act in October 2002. This Act became Public Law 107-260. Effective with 2004 diagnosis, this Act requires the collection of benign brain and borderline intracranial and central nervous system tumors by all registries participating in the federal National Program of Cancer Registries (NPCR) of the Centers for disease Control and Prevention. The Georgia Comprehensive Cancer Registry (GCCR) of the Department of Human Resources is a participating registry.

On January 21, 2004, the Georgia Board of Human Resources added the benign brain and central nervous system tumors to the Department's official list of notifiable diseases. All Georgia cases diagnosed as of January 1, 2004, are to be reported to the Georgia Comprehensive Cancer Registry.

Thank you for your cooperation in implementing this new reporting requirement. If you have any questions, please contact Rana Bayakly at (404) 657-1943.

Sincerely,



Kathleen E. Toomey, M.D., M.P.H.
Director
Georgia Division of Public Health

Georgia Department of Human Resources • Division of Public Health • Stuart T. Brown, M.D., Director
2 Peachtree Street NW • Suite 15.470 • Atlanta, Georgia 30303-3142
404-657-2700 • FAX: 404-657-2715

April 26, 2006

Dear Colleague:

Legal authority for the Georgia Department of Human Resources to collect health information is provided in Chapter 12 of the Official Code of Georgia.

Official Code 31-12-1 empowers the Department to "...conduct studies, research, and training appropriate to the prevention of diseases...."

Official Code 31-12-2 allows the Department to declare certain diseases and injuries to be reported in a manner and at such times as may be prescribed. Under this authority, information on persons with cancer is required to be reported to the Department or its designated agent.

As the Director of the Division of Public Health, I am empowered to issue directives to health care providers regarding reporting requirements. This letter is to serve as a written directive requiring the reporting of selected information on patients diagnosed with or treated for cancer in Georgia. Such information must be reported to the Department or our appointed agent. Individuals and agencies required to report include, but are not limited to, all health care providers and facilities located in Georgia, such as the following:

1. Physicians;
2. Hospitals;
3. Laboratories; and
4. Free-standing diagnostic and treatment facilities

Under the provisions of this law, it is not necessary to obtain individual patient consent to allow the Department or its designated agent to collect information on patients with cancer from medical records or related documents for surveillance purposes.

Official Code 31-12-2a addresses the confidentiality of information requested by the Department, and releases from civil liability providers reporting information. Official Code 31-12-2b states that "... all such reports shall be deemed confidential and shall not be open to inspection by the public." Only aggregate reports without name identifiers can be released.

The Department has designated the Georgia Center for Cancer Statistics (GCCS) at the Rollins School of Public Health of Emory University as its designated agent for the purpose of collecting and editing cancer data to help monitor the incidence of cancer throughout Georgia. Strict measures to protect the confidentiality of these documents are in place at both the Department of Human Resources and the Rollins School of Public Health. As documented in the surveillance protocol, patient names and other identifiers will not be released by the Department or the Rollins School of Public Health.

Please contact A. Rana Bayakly at (404) 657-1943 if you have any questions.

Sincerely,



Stuart T. Brown, M.D.
Director

cc: John Horan, M.D., M.P.H.
John Young, Dr.P.H., CTR



Jim Martin, Commissioner
Kathleen E. Toomey, M.D., M.P.H., Division Director

Georgia Department of Human Resources • Division of Public Health • Epidemiology Branch • Chronic Disease, Injury and Environmental Epidemiology Section • Two Peachtree Street, NW • 14th Floor • Atlanta, Georgia 30303-3186

December 3, 2001

F & Lname
CEO/CFO/Administrator
Hospital Name
Address
City, GA zip

Dear Mr/s Lname:

I am writing to provide you with information about the new cancer reporting requirements in the Hospital Participation Agreement you have recently signed with the Georgia Department of Community Health (DCH). The pertinent component of the Agreement is as follows:

“3.11 Statewide Cancer Registry. Hospital agrees to timely and accurately report to the Georgia Comprehensive Cancer Registry certain information on cancer for patients who receive Hospital Services at the Hospital as required by the Georgia Department of Human Resources, Division of Public Health ("DHR/DPH") pursuant to O.C.G.A. § 31-12-2(a) and as more specifically set forth in the Georgia Comprehensive Cancer Registry Policy and Procedures Manual ("Cancer Registry Manual") issued by DHR/DPH. A copy of the Cancer Registry Manual has been provided to the Hospital by DHR/DPH and is hereby incorporated herein by reference. In the event Hospital fails to meet its obligation to timely and accurately report cases of cancer as required by the Cancer Registry Manual, DCH may, in its sole discretion and in addition to any other remedies under this Agreement, require Hospital to submit a corrective plan of action to DCH which, if approved by DCH, will permit Hospital to become compliant with this provision within a prescribed time period.”

In order to comply with the provision of the agreement, the Division of Public Health has arranged with the Department of Community Health for the following reporting procedures:

1. Frequency of reporting: As stated in the Georgia Comprehensive Cancer Registry (GCCR) Policy and Procedures Manual (Section 3, GCCR Cancer Reporting) hospitals are to report monthly to the GCCR. Reports are to be received by the 5th of every month, and a report is required even if there are no cases to report. Beginning January 2002, the names of hospitals which have not reported in at least 2 of the last 3 months will be provided to the DCH.

December 3, 2001

Page 2

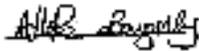
2. Completeness of reporting: As stated in the Manual (Section 3, GCCR Cancer Reporting) hospitals are expected to report cases within 6 months from the date of diagnosis. Beginning July 2002 the names of hospitals which have not reported at least 90% of the expected number of cases for 2000 and 95% of the expected number for 1999 will be provided to the DCH. Please note that in July 2002 hospitals will be provided with six extra months to achieve the goals for completeness of reporting.

Beginning July 2003 the names of hospitals which have not reported at least 90% of the expected number of cases for their hospital for 2001 and 95% of the expected number for 2000 will be provided to DCH.

3. Accuracy of reporting: Beginning January 2003, the names of hospitals from which more than 1% of submitted records were rejected because of multiple errors or errors of vital information will be reported to DCH.

Please contact me at 404-657-1943 if you have any questions about our procedures.

Sincerely,



Rana Bayakly, MPH
Director/Epidemiologist
Georgia Comprehensive Cancer Registry

cc: Kathleen Toomey, Director, Division of Public Health
Carol Steiner, Director, Cancer Control Section
Kathy Driggers, Director of Managed Care, DCH
Clyde Reese, General Counsel, DCH
Gary Redding, Commissioner, DCH
Vi Naylor, Vice President, Georgia Hospital Association



Tommy C. Olmstead, Commissioner
Kathleen E. Toomey, M.D., M.P.H., Division Director

Georgia Department of Human Resources • 2 Peachtree Street, NW • Atlanta, Georgia 30303-3142
Division of Public Health • 2 Peachtree Street, NW • Atlanta, Georgia 30303-3142 • (404) 657-2700

July 10, 1999

Dear Colleague:

The Centers for Disease Control and Prevention (CDC) is encouraging states participating in the National Program of Cancer Registries (NPCR) to change their method of staging cancers from summary staging to Surveillance, Epidemiology and End Results (SEER) Extent of Disease (EOD). The Georgia Cancer Control Advisory Committee, Cancer Registry Subcommittee, has approved the change. Reporting entities such as physicians, hospitals, laboratories and free-standing diagnostic or treatment facilities shall immediately begin reporting SEER EOD for cases diagnosed as of January 1, 1999.

To differentiate between summary staging and SEER EOD, reporting entities are currently using summary staging, which is also called general staging, to report the staging information to the Georgia Comprehensive Cancer Registry (GCCR). This staging classifies cancer into five categories: In Situ, Localized, Regional, Distant, and Unknown. These categories are so broad that a wide variety of cases are included. Detailed analysis and matching of cancers between cancer programs is limited and sometimes not possible. SEER EOD is for all cancer sites and is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are particularly important when all malignant tissue is not removed. In the event of a discrepancy between pathology and operative reports concerning excised tissue, priority is given to the pathology report.

Thank you for your cooperation in implementing this new reporting requirement. If you have any questions, please contact Rana Bayakly at (404) 657-1943.

Sincerely,

A handwritten signature in black ink that reads "Kathleen E. Toomey". The signature is fluid and cursive, with a large, sweeping flourish at the end.

Kathleen E. Toomey, M.D., M.P.H.

CC: James H. Brannon
Carol B. Steiner
John L. Young Jr.



Jim Martin, Commissioner
Kathleen E. Toomey, M.D., M.P.H., Division Director

Georgia Department of Human Resources • Division of Public Health
Two Peachtree Street NW • Suite 15-470 • Atlanta, Georgia 30303-3142 • Tel: (404) 657-2700 • Fax: (404) 657-2715

October 17, 2002

F & Lname
CEO/CFO/Administrator
Hospital Name
Address
City, GA zip

Dear Mr/s Lname:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) became law April 14, 2001. Although most organizations have until April 14, 2003 to comply, we have already received questions regarding how this new law will affect cancer reporting.

HIPAA regulations will not impact current state cancer reporting procedures. HIPAA allows for the reporting of identifiable cancer data and other reportable conditions to public health entities. Because the Georgia Comprehensive Cancer Registry (GCCR) falls under the definition of a public health entity, HIPAA allows your facility to continue to report data to the GCCR in compliance with state law. Written informed consent from each cancer patient reported to public health entities is not required; rather hospitals must simply document that reporting has occurred. Documentation could be done by keeping a log of the data submitted monthly and keeping a copy of the email/post card sent from the Georgia Center for Cancer Statistics (GCCS) acknowledging receipt of the submission.

Enclosed is a list of frequently asked questions and answers as well as copies of a letter from the legal counsel of the North American Association of Central Cancer Registries (NAACCR) and an academic interpretation of HIPAA from Professor James G. Hodge, Jr., J.D., LL.M., of the Georgetown University Law Center. Please let us know if you have any further questions or concerns. Thank you for your support for our cancer registry program.

Sincerely,

A handwritten signature in black ink that reads "Kathleen E. Toomey". The signature is fluid and cursive, written over a light-colored rectangular background.

Kathleen E. Toomey, M.D., M.P.H.
Director
Division of Public Health

Enclosures
cc: Name, Medical Record Director

For Georgia Reporting Law and Mandate, please go to:

http://www.legis.state.ga.us/legis/2003_04/gacode/31-15-5.html

http://www.legis.state.ga.us/legis/2003_04/gacode/31-12-2.html

For Public Laws, Cancer Registry Amendment Act please go to:

CDC Cancer Control and Prevention, Cancer Registries Amendment Act

<http://www.cdc.gov/cancer/npcr/npcrpdfs/publaw.pdf>

<http://www.cdc.gov/cancer/npcr/npcrpdfs/publawnpcr98.pdf>

CDC Cancer Prevention and Control , Cancer Legislative Information

<http://www.cdc.gov/cancer/legislation>

Public Law 107-260, Benign Brain Tumor Cancer Registries Amendment Act

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107_cong_public_laws&docid=f:publ260.107

**Georgia Comprehensive Cancer Registry
Reporting Manual**

Section 8: Resources and References

List of Various Reference Manuals and Effective Dates*

Dates indicated are official dates of implementation of various reference manuals. GCCR recommendations do not vary from these dates.

STAGING AND CODING	CANCER PROGRAM STANDARDS
<ul style="list-style-type: none"> ▪ <i>International Classification of Diseases for Oncology</i> <i>First Edition (Red Book)</i>.....1976-1988 <i>Field Trial (Red Spiral Book.)</i>.....1989-1990 Second Edition¹1992-2000 Third Edition¹2001 ▪ <i>American Joint Commission on Cancer (AJCC), TNM Staging System</i> Second Edition..... 1983(breast only**) – 1988 Third Edition..... 1989-1992 (All Sites***) Fourth Edition..... 1993-1997 Fifth Edition¹.....1998-2002 Sixth Edition.....2003 > ▪ <i>SEER Extent of Disease Manual</i> First Edition1988-1991 Second Edition1992-1997 Third Edition¹1998-2003 ▪ <i>SEER Summary Staging Manual</i> Summary Staging Guide.....1977-2000 SEER Summary Staging Manual 2000¹.....2001-2003 ▪ <i>Collaborative Staging System</i>..... Effective 2004‡ 	<ul style="list-style-type: none"> ▪ <i>Cancer Program Manual</i>.....1986-1990 ▪ <i>Cancer Program Manual 1991</i>..... 1991-1995 ▪ <i>Cancer Program Standards (Volume I)</i>.....1996-2003 (June)‡ ▪ <i>Revised Cancer Program Standards (Volume II)</i>July (2003)>‡ <p>DATA COLLECTION</p> <ul style="list-style-type: none"> ▪ <i>Data Acquisition Manual 1988-1994</i>1988-1994 1st revision 10/89 2nd revision 10/90 ▪ <i>Data Acquisition Manual, Revised</i>..... 1994-1995 ▪ <i>Registry Operations and Data Standards (ROADS Manual)</i>1996-2002 2-digit surgery codes.....1988-1997 “New Surgery Codes”¹.....1998-2002 ▪ <i>Facility Oncology Registry Data Standards (FORDS)</i>.2003> ▪ <i>SEER Program Code Manual</i> First Edition.....1988-1991 Second Edition.....1992-1997 Third Edition¹.....1998-2003‡ Third Edition Revision (Treatment Codes Only)¹..... 2003 ▪ <i>SEER Self-instructional Manuals for Cancer Registrars, Book 8: Antineoplastic Agents</i> Third Edition¹..... 1993 Fourth Edition2004

* Effective with cases diagnosed on or after January 1 of initial stated year and ending with cases diagnosed on December 31 of the closing year.

** TNM Staging of breast cancer was required as of 1982, proper to the second edition.

*** The Commission on cancer urged implementation of TNM staging of all sites as of 1989 but did not require it until 1991.

¹ Updated pages/errata were released after publication. Contact the publishing organization’s website for a copy.

USEFUL REFERENCES FOR CANCER REGISTRARS: RESOURCE LIST

1. Anatomy book
2. Medical dictionary
3. AJCC Manual for Staging of Cancer - current edition
4. SEER Self Instructional Manuals (1-5,7 and 8)
5. American Cancer Society Textbook of Clinical Oncology
6. Physician's Desk Reference or other drug reference book, current edition
7. Cancer Registry Management Principles and Practice, *Carol L. Hutchison, Steven D. Roffers, April G. Fritz.*

8. SEER Self Instructional Manuals (Book 1 – Book 8) for Tumor Registrars:

Book 1 - Objectives and Functions of a Tumor Registry (1999) Self-instructional Manual, describes the functions, objectives, activities required to run a tumor registry, and the various portions of a registry. (e.g. describes the various record systems required to run a registry accession file, case file, follow-up cards).

Book 2 - Cancer Characteristics and Selection of Cases (1991) Self-instructional Manual, provides instruction in the terminology associated with cancer. Brief description of the natural history of the major cancer types. Introduces the use of ICD-O.

Book 3 - Tumor Registrar Vocabulary: The Composition of Medical Terms (1992) Self-instructional Manual, medical terminology.

Book 4 - Human Anatomy as Related to Tumor Formation (1995) Self-instructional Manual, introduction to human anatomy and neoplasm(s) associated with each body system.

Book 5 - Abstracting Medical Record: Patient Identification, History, and Examinations (1993) Self-instructional Manual, describes the medical record, how to locate and record the information related to a cancer registry (abstract case information).

Book 6 - Out of print, substitute: Summary Staging Guide (1977) Provides anatomical diagrams and rules for determining localized, regional and distant stage for major cancer sites.

Book 7 - Statistics and Epidemiology for Cancer Registries (1994) Self-instructional Manual, introduces tumor registrar to the statistics required to run a registry: includes discussion of incidence, mortality, and survival.

Book 8 - Antineoplastic Drugs (Third Edition, 1993) Provides list of drugs that should be included under cancer-directed therapy (chemotherapy, biological response modifiers, and hormones). Get list (PDF) of FDA approved oncology agents not listed in SEER Book 8.

STUDY GUIDES FOR THE CERTIFIED TUMOR REGISTRAR'S EXAMINATION:

Certified Tumor Registrar Examination Preparation Manual

Published by the Northern California Cancer Registrar's Association

Northern California Cancer Center
322960 Alvarado Niles Road, Suite 600
P.O. Box 5033
Union City, CA 94587
510/429-5858 (phone)
510/991-4404 (fax)
E-mail: eprestos@nccc.org

Send orders for this manual to:

Saint Joseph Hospital – Cancer Registry
2700 Dolbeer Street
Eureka, CA 95501
Fax: 707-445-8121
Fax: 707-269-3863
E-mail jviegas@sje.stjoe.org.

Cost \$57 - Make check payable to NCCRA.

Professional Review for Tumor Registrars: A study Guide

Published by the Florida Tumor Registrars Association

For Information pertaining to the certification examination contact:

National board of certification of Registrars, Inc. (NCRB)

P.O. Box 15945-302
Lenexa, KS 66285
Email: nbc-info@applmeapro.com

North American Association of Central Cancer Registries (NAACCR)

2121 West White Oaks Drive
Springfield, IL 62704
Phone : 217-698-0800
Fax: 271-698-0188
www.naacr.org

INTERNET SITES OF INTEREST FOR INFORMATION

Brain and Neurosurgery Information Center: www.brain-surgery.com/index.html

Brain and Spinal Cord Tumors – Hope through Research:
www.ninds.nih.gov/health_and_medical/pubs/brain_tumor_hope_through_research.htm

Brain Tumor Guide: <http://virtualtrials.com/faq/toc.cfm>

Central Brain Tumor Registry of the US: www.cbtrus.org

Georgia Comprehensive Cancer Registry (GCCR): <http://health.state.ga.us/programs/gcct/index.asp>

Georgia Tumor Registrar's Association: www.gatrweb.org

SEER Training Website, coding materials, latest SEER manual updates:
<http://training.seer.cancer.gov/>

The American Cancer Society: **Cancer statistics, information, research and community activities**
<http://www.cancer.org/docroot/home/index.asp>

The American College of Surgeons (ACOS): www.facs.org

The Brain Tumor Foundation: www.brainumorfoundation.org/neurosurgery/ss3_3.htm

The Cancer Quest: Information on biology of cancer, cancer treatment and a lot more
www.cancerquest.org

The Centers for Disease Control and Prevention/National Program for Central Cancer Registries
<http://www.cdc.gov/cancer/npcr/>

The Georgia Center for Cancer Statistics (GCCS): <http://www.sph.emory.edu/GCCS>

The Georgia Center for Cancer Statistics (GCCS): **Training Program in Cancer Registration, Surveillance and Control** <http://www.sph.emory.edu/GCCS/training/>

The National Cancer Institute: **Cancer information, latest on cancer research, cancer statistics.**
<http://www.cancer.gov>

The National Cancer Registrar's Association (NCRA): www.ncra-usa.org

The National Library of Medicine: www.nlm.nih.gov

The North American Association of Central Cancer Registries: www.naacrr.org

North Cancer Registry Coordinator

Margaret Padgett, CTR
North west Health District
100 W. Walnut Street
Dalton, GA 30720

Phone: 706-272-2125 ext 354
Cellular: 706-217-7941
Fax: 706-272-2159
Email: mapadgett@dhr.state.ga.us

County	Facility Name	County	Facility Name
Northwest (Rome) Health District (1-1)		North (Gainesville) Health District (2-0)	
Bartow	Cartersville Medical Center	Forsyth	Northside Hospital - Forsyth
Catoosa	Hutcheson Medical Center	Franklin	Cobb Memorial Hospital
Dade	Wildwood Lifestyle Center and Hospital	Habersham	Habersham County Medical Center
Floyd	Floyd Medical Center Redmond Regional Medical Center	Hall	Northeast Georgia Medical Center, Inc.
Gordon	Gordon Hospital	Hart	Hart County Hospital
Haralson	Tanner Health System - Higgins General Hospital	Lumpkin	Chestatee Regional Hospital
Paulding	Wellstar Health System - Paulding	Rabun	Mountain Lakes Medical Center
Polk	Polk Medical Center	Stephens	Stephens County Hospital
<i>Chattooga, Walker</i>		<i>No Hospitals</i>	
		Union	Union General Hospital
		<i>Banks, Dawson, White</i>	
		<i>No Hospitals</i>	
North Georgia (Dalton Health District (1-2)		Northeast (Athens) Health District (10-0)	
Cherokee	Northside Hospital-Cherokee	Barrow	Barrow Medical Center
Fannin	Fannin Regional Hospital	Clarke	Athens Regional Medical Center St. Mary's Health Care System Inc.
Gilmer	North Georgia Medical Center	Elbert	Elbert Memorial Hospital
Murray	Murray Medical Center	Greene	Minnie G. Boswell Memorial Hospital
Pickens	Mountainside Medical Center	Jackson	BJC Medical Center
Whitfield	Hamilton Medical Center	Walton	Walton Medical Center

Metro Cancer Registry Coordinator

Judy Andrews, CTR
 Georgia Center for Cancer Statistics
 1518 Clifton Road NE
 Atlanta, GA 30322

Phone: 404-727-9787
 Cell: 678-524-6194
 Fax: 404-727-7261
 Email: jandr04@sph.emory.edu

County	Facility Name	County	Facility Name
Cobb/Douglas Health District (3-1)		Clayton (Morrow) Health District (3-3)	
Douglas	Wellstar Health System - Douglas Emory Parkway Medical Center	Clayton	Southern Regional Medical Center
Cobb	Wellstar Health System - Cobb Wellstar Health System - Kennestone Emory Adventist Hospital Wellstar Health System - Windy Hill		
Fulton Health District (3-2)		East Metro (lawrenceville) Health District (3-4)	
Fulton	Grady Health System - Hughes Spalding Children's Hospital Metropolitan Hospital Children's Healthcare of Atlanta-Scottish Rite Emory Crawford W. Long Hospital Atlanta Medical Center Grady Health System Kindred Hospital North Fulton Regional Hospital Northside Hospital Piedmont Hospital Saint Josephs Hospital Atlanta South Fulton Medical Center Select Specialty Hospitals	Gwinnett	Emory Eastside Medical Center Gwinnett Health System
		Newton	Newton General Hospital
		Rockdale	Rockdale Hospital
		DeKalb Health District (3-5)	
		DeKalb	Decatur Hospital DeKalb Medical Center Emory Dunwoody Medical Center Children's Healthcare of Atlanta -Egleston Emory University Northlake Regional Medical Center Wesley Woods Geriatric Hospital VA Medical Center-Atlanta

Central Cancer Registry Coordinator

Betty Gentry, RHIT, CTR
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 Macon, GA 31201

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County	Facility Name	County	Facility Name
LaGrange Health District (4-0)		North Central (Macon) Health District (5-2)	
Butts	Sylvan Grove Hospital	Baldwin	Central State Hospital Oconee Regional Medical Center
Carroll	Tanner Medical Center/Carrollton Tanner Medical Center/Villa Rica	Bibb	Coliseum Health System Coliseum Northside Hospital Medical Center of Central Georgia
Coweta	Newnan Hospital	Houston	Houston Medical Center Perry Hospital USAF Hospital Robins
Fayette	Fayette Community Hospital	Jasper	Jasper Memorial Hospital
Henry	Henry Medical Center	Monroe	Monroe County Hospital
Meriwether	Warm Springs Medical Center	Peach	Peach Regional Medical Center
Spalding	Spalding Regional Hospital	Putnam	Putnam General Hospital
Troup	West Georgia Health System	Washington	Washington County Regional Medical Center
Upson	Upson Regional Medical Center		
<i>Heard, Lamar, Pike</i>		<i>No Hospitals</i>	
		<i>Crawford, Hancock, Jones, Twiggs, Wilkinson</i>	
East Central (Augusta) Health District (6-0)		Northeast (Athens) Health District (10)	
McDuffie	McDuffie Regional Medical Center	Morgan	Morgan Memorial Hospital
Richmond	Augusta State Medical Prison Doctor's Hospital - Augusta Dwight D. Eisenhower Army Medical Center Medical College of Georgia Saint Joseph's Hospital Augusta University Hospital VA Medical Center Augusta	<i>Oconee Oglethorpe</i>	<i>No Hospitals</i>
Wilkes	Wills Memorial Hospital		
<i>Columbia, Glascock, Lincoln Tallaferro, Warren</i>		<i>No Hospitals</i>	

Southeast Cancer Registry Coordinator

Sheree Holloway, RN, CTR
Southeast Georgia Health District
120 Druid Circle
Savannah, GA 31410

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County	Facility Name	County	Facility Name
South Central (Dublin) Health District (5-1)		East Central (Augusta) Health District (6-0)	
Bleckley	Bleckley Memorial Hospital	Burke	Burke County Hospital
Dodge	Dodge County Hospital	Emanuel	Emanuel Medical Center
Laurens	VA Medical Center Dublin Fairview Park Hospital	Jefferson	Jefferson County Hospital
Pulaski	Taylor Regional Hospital	Jenkins	Jenkins County Hospital
Telfair	Telfair Regional Medical Center	Screven	Screven County Hospital
Wheeler	Wheeler County Hospital	East (Savannah) Health District (9-1)	
<i>Johnson, Montgomery, Treutlen, Wilcox</i>	<i>No Hospitals</i>	Chatham	Memorial Health University Medical Center Saint Joseph's/Candler Health System
Southeast (Waycross) Health District (9-2)		Effingham	Effingham County Hospital
Appling	Appling Health Care System	Camden	Southeast Georgia Regional Hospital – Camden Campus
Bacon	Bacon County Health Services	Glynn	Southeast Georgia Regional Medical Center
Bulloch	East Georgia Regional Medical Center		
Candler	Candler County Hospital	Liberty	Liberty Regional Medical Center Winn Army Community Hospital
Charlton	Charlton Memorial Hospital	<i>Bryan, Long, McIntosh</i>	<i>No Hospitals</i>
Clinch	Clinch Memorial Hospital	Southeast (Waycross) Health District (9-2)....contd	
Coffee	Coffee Regional Medical Center	Toombs	Meadows Regional Medical Center
Evans	Evans Memorial Hospital	Ware	Satilla Regional Medical Center
Jeff Davis	Jeff Davis Hospital	Wayne	Wayne Memorial Hospital
Tattnall	Tattnall Memorial Hospital	<i>Atkinson, Brantley, Pierce</i>	<i>No Hospitals</i>

Southwest Cancer Registry Coordinator

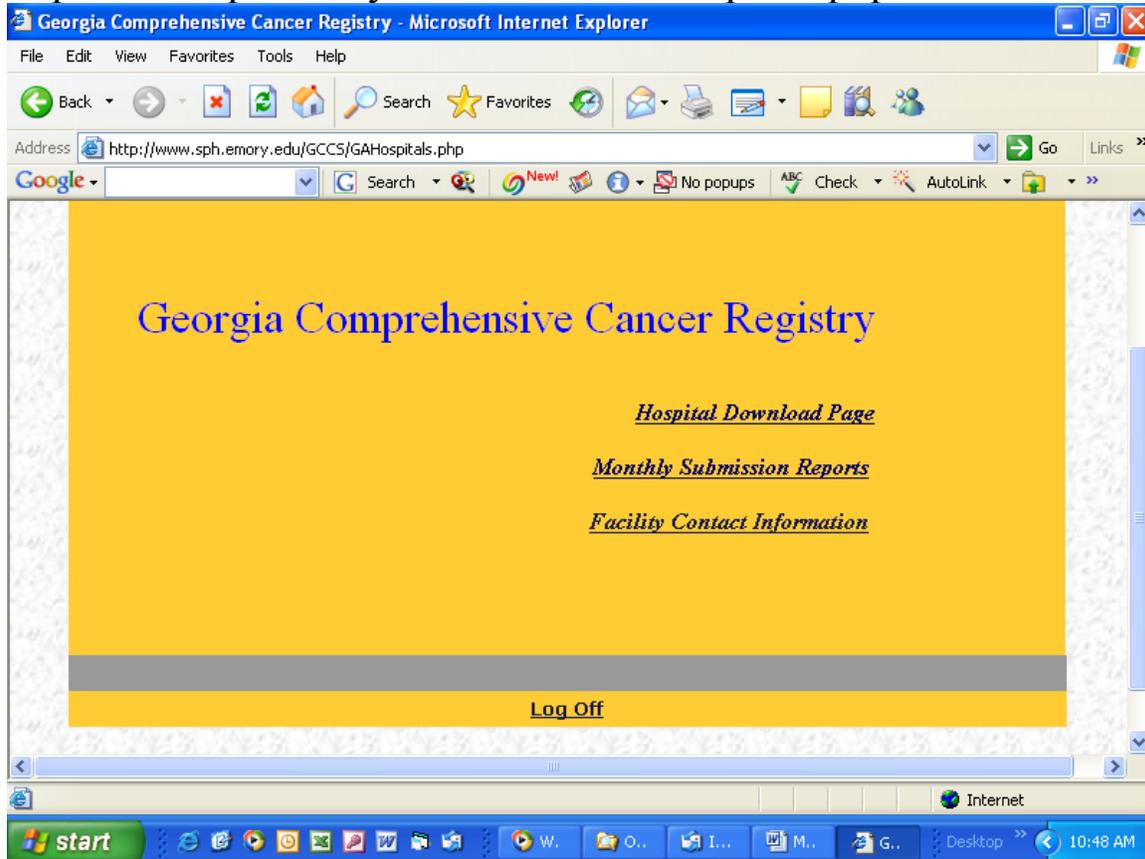
Carol Crosby, CTR
Southwest Georgia Health District
1306 S. Slappey Blvd, Suite A
Albany, GA 31701

Phone: 229- 430-6388
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E- mail: CTCROSBY@dhr.state.ga.us

<i>County</i>	<i>Facility Name</i>	<i>County</i>	<i>Facility Name</i>
West Central (Columbus) Health District (7-0)		South (Valdosta) Health District (8-1)	
Chattahoochee	Martin Army Community Hospital	Ben Hill	Dorminy Medical Center
Crisp	Crisp Regional Hospital	Berrien	Berrien County Hospital
		Brooks	Brooks County Hospital
Macon	Flint River Community Hospital	Cook	Memorial Hospital of Adel
Muscogee	Doctors Hospital - Columbus Saint Francis Hospital, Inc. The Medical Center	Irwin	Irwin County Hospital
Stewart	Stewart Webster Hospital	Lanier	Louis Smith Memorial Hospital
Sumter	Sumter Regional Hospital	Lowndes	Moody USAF Hospital Smith Northview Hospital South Georgia Medical Center
Randolph	Southwest Georgia Regional Medical Center	Tift	Tift Regional Medical Center
<i>Clay, Dooly, Harris, Marion, Schley, Quitman, Talbot, Taylor, Webster</i>	<i>No Hospitals</i>	<i>Echol, Turner</i>	<i>No Hospitals</i>
Southwest (Albany) Health District (8-2)			
Calhoun	Calhoun Memorial Hospital	Miller	Miller County Hospital
Colquitt	Colquitt Regional Medical Center	Mitchell	Mitchell County Hospital
Decatur	Memorial Hospital and Manor	Seminole	Donalsonville Hospital
Dougherty	Palmyra Medical Center Phoebe Putney Memorial Hospital	Thomas	John D. Archbold Memorial Hospital
Early	Early Memorial Hospital	Worth	Phoebe Worth Medical Center
Grady	Grady General Hospital	<i>Baker, Lee, Terrell</i>	<i>No Hospitals</i>

GEORGIA COMPREHENSIVE CANCER REGISTRY DATA SUBMISSION WEB PAGE

<http://www.sph.emory.edu/GCCS/GAHospitals.php>



A. FEATURES OF EACH LINK

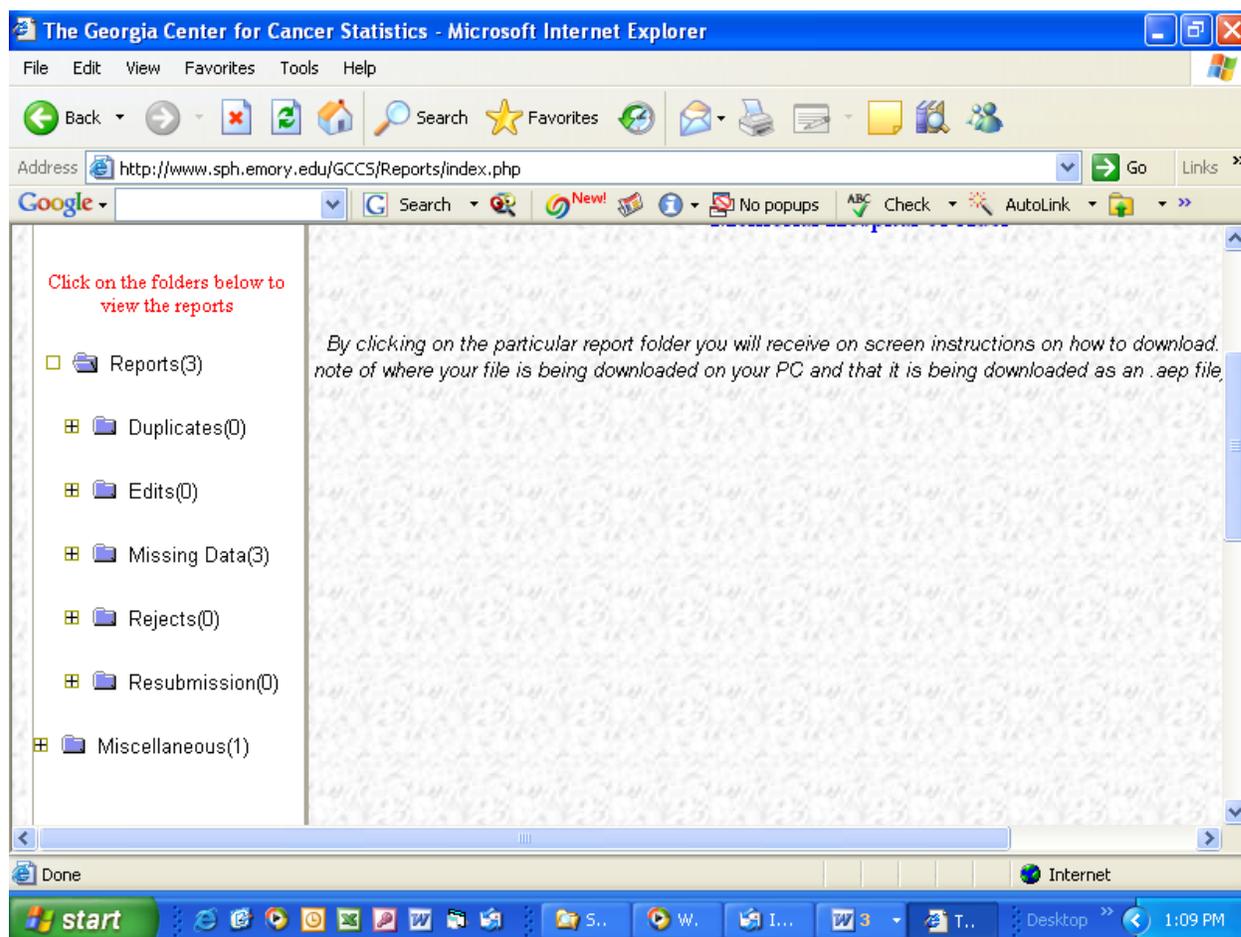
1. **Hospital Download Page** – facility number and password needed for access
 - Abstract Plus System free software for cancer abstracting
 - Incidental Update Form form to provide updated data on previously submitted abstracts
 - Mortality Query System allows user to view Mortality Data for the State of Georgia.
 - Microsoft Snapshot Viewer allows the user to view any Microsoft Access report with a .snp extension. GCCS transmits encrypted Microsoft Access reports to Georgia hospitals that can only be viewed with the Snapshot Viewer.
 - Georgia Hospital Edits Software application for running Georgia's State specific edits
2. **Monthly Submission Reports** – facility number and password needed for access You can download copies of submission receipts for each monthly submission up to a year's worth of data.
3. **Facility Contact Information** - facility number and password needed for access
 - a) Update Facility Information
 - b) View Facility Information
 - c) Update Facility Password
 - d) Facility Name Change

B. ACCESSING MONTHLY SUBMISSION REPORTS ON GCCR WEB PAGE

You can now access via our secured web site your monthly submission reports. All reports are encrypted. You will need your facility number and password in order to access your reports as well as the encryption software and the snapshot viewer program.

<http://www.sph.emory.edu/GCCS/index.html>

Click on the 'Hospital' link at the bottom of the right hand column. Click on monthly submission reports. Enter facility number and password.



The folders to the left of your screen show the five types of reports that are generated with each submission. You must click on the folder icon to open a particular folder. Below is a description of each folder and the reports that are found within. You can refer to each folder for more information regarding each report.

Duplicates - Report is generated if there are any duplicate abstracts within a particular monthly submission. Reports are named with the addition of **Dup** after the file type extension - ie 380000MAY04_1HOS**Dup**.SNP.AEP

Edits - Report is generated if there are edit errors within a particular monthly submission.

Missing Data - Report is generated on accepted abstracts submitted showing missing, unknown and unspecified data values for selected list of fields.

Rejects - Report shows a summary of the submitted, accepted, rejected, and duplicate abstracts.

Resubmissions - Report showing your resubmission progress for rejected/edit error reports

Some reports are named using the naming conventions that have been established ie
380000May06_1HOS***.SNP.AEP where

*** = See specific report folders for explanation.

SNP = Microsoft Snapshot viewer format (snapshot viewer program needed to view file)

AEP = Advanced Encryption Program format (File is encrypted and must be decrypted in order to be viewed).

Refer to section 2 page 4 of this document for more details on the naming conventions.

Once you open a particular folder you can download any or all reports found within the folder. By clicking on the particular report you will receive on screen instructions on how to download. (Be sure you make note of where your file is being downloaded on your computer and that it is being downloaded as an .aep file).

**Georgia Comprehensive Cancer Registry
Reporting Manual**

Section 9: GA County Codes

Georgia (FIPS) County Codes

County	FIPS Code	County	FIPS Code	County	FIPS Code
Appling	001	Evans	109	Newton	217
Atkinson	003	Fannin	111	Oconee	219
Bacon	005	Fayette	113	Oglethorpe	221
Baker	007	Floyd	115	Paulding	223
Baldwin	009	Forsyth	117	Peach	225
Banks	011	Franklin	119	Pickens	227
Barrow	013	Fulton	121	Pierce	229
Bartow	015	Gilmer	123	Pike	231
Ben Hill	017	Glascok	125	Polk	233
Berrien	019	Glynn	127	Pulaski	235
Bibb	021	Gordon	129	Putnam	237
Bleckley	023	Grady	131	Quitman	239
Brantley	025	Greene	133	Rabun	241
Brooks	027	Gwinnett	135	Randolph	243
Bryan	029	Habersham	137	Richmond	245
Bulloch	031	Hall	139	Rockdale	247
Burke	033	Hancock	141	Schley	249
Butts	035	Haralson	143	Screven	251
Calhoun	037	Harris	145	Seminole	253
Camden	039	Hart	147	Spalding	255
Candler	043	Heard	149	Stephens	257
Carroll	045	Henry	151	Stewart	259
Catoosa	047	Houston	153	Sumter	261
Charlton	049	Irwin	155	Talbot	263
Chatham	051	Jackson	157	Taliaferro	265
Chattahoochee	053	Jasper	159	Tattnall	267
Chattooga	055	Jeff Davis	161	Taylor	269
Cherokee	057	Jefferson	163	Telfair	271
Clarke	059	Jenkins	165	Terrell	273
Clay	061	Johnson	167	Thomas	275
Clayton	063	Jones	169	Tift	277
Clinch	065	Lamar	171	Toombs	279
Cobb	067	Lanier	173	Towns	281
Coffee	069	Laurens	175	Treutlen	283
Colquitt	071	Lee	177	Troup	285
Columbia	073	Liberty	179	Turner	287
Cook	075	Lincoln	181	Twiggs	289
Coweta	077	Long	183	Union	291
Crawford	079	Lowndes	185	Upson	293
Crisp	081	Lumpkin	187	Walker	295
Dade	083	McDuffie	189	Walton	297
Dawson	085	McIntosh	191	Ware	299
Decatur	087	Macon	193	Warren	301
DeKalb	089	Madison	195	Washington	303
Dodge	091	Marion	197	Wayne	305
Dooly	093	Meriwether	199	Webster	307
Dougherty	095	Miller	201	Wheeler	309
Douglas	097	Mitchell	205	White	311
Early	099	Monroe	207	Whitfield	313
Echols	101	Montgomery	209	Wilcox	315
Effingham	103	Morgan	211	Wilkes	317
Elbert	105	Murray	213	Wilkinson	319
Emanuel	107	Muscogee	215	Worth	321

For US Zip Codes go to: <http://www.usps.com/zip4>



Georgia Department of Human Resources
Georgia Division of Public Health
Georgia Comprehensive Cancer Registry
2 Peachtree Street NW
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GCCR Policy and Procedure Manual
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