SECTION ONE – INTRODUCTION

Preface

The Maine Cancer Registry (MCR) is a statewide population-based cancer surveillance system. Our specific objectives are to collect information on all cancers diagnosed or treated in Maine, accurately determine patterns of cancer incidence in the state, contribute to epidemiological research and provide data for the planning and evaluation of cancer interventions. The general goal of the MCR is to help reduce the incidence of, and mortality from, cancer.

To accomplish these ends, the MCR was created by legislative mandate MRSA 22 § 1401-1407 (Appendix A) and began collecting data January 1, 1983. Since then, the MCR has undergone a number of changes to improve the utility of the database:

- In 1986, patient's usual occupation and industry became reportable data items.
- In 1989, AJCC stage, social security number, and patient's mailing address were made reportable.
- Cooperative case exchange agreements exist with Massachusetts, New Hampshire, New York, Vermont, Connecticut, Rhode Island, Florida, Arizona, Colorado, Nevada, Utah, and Wyoming in order to improve case ascertainment among Maine residents diagnosed out of state.
- In 1994, the MCR was awarded a grant from the Centers for Disease Control and Prevention through the National Program of Cancer Registries (NPCR), enabling the MCR to expand both the data set of collected items and the existing reporting requirements to include physicians.

The MCR strives to maintain compliance with the standards for abstracting and coding practices promoted by the national groups, including NPCR, the National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) Program, the North American Association of Central Cancer Registries (NAACCR), the American Joint Committee on Cancer (AJCC), and the American College of Surgeons (ACoS), including the Commission on Cancer (COC). These standards facilitate data exchange and allow for a "big picture" analysis of cancer in the United States.

Data are submitted annually to NAACCR for Registry Certification and publication in *Cancer in North America (CINA)*, to NPCR for assessment of standards and publication in *United States Cancer Statistics*, and to the Central Brain Tumor Registry for the United States (CBTRUS). Registries whose data meet NAACCR's established criteria for timeliness, quality, and completeness are recognized annually as Silver Certified or Gold Certified registries. MCR was recognized as a Gold Certified registry in 2004 and has since maintained that status.

The purpose of this manual is to provide data standards for abstracting, coding and reporting cancer data to the MCR. Standard reporting is necessary for producing reliable and high quality information on cancer in Maine. Due to the ever-changing nature of the cancer registry world, this manual is designed to be a working document that can be modified to reflect changes in abstracting, coding, and reporting standards. As changes are made, replacement pages will be sent to all hospitals to be incorporated into the manual.

MCR staff is available to answer registry-related questions and to provide educational workshops. We thank you for your continued cooperation, and we look forward to working with you to attain our common goal of reducing the burden of cancer in the state of Maine. For more information, refer to the MCR website www.mainepublichealth.gov click on Cancer Registry located in the PH Program Index.

Confidentiality

The MCR follows strict requirements of federal and state law to keep all personal information confidential. Any information that could identify a person is kept in locked files or secured computer accounts. Strict policies are in place regarding the release of data. In addition, MCR employees are required to sign confidentiality agreements and follow confidentiality procedures set forth in the Maine Cancer Registry Rules and Regulations (Appendix B).

HIPAA allows for the reporting of identifiable cancer data to public health authorities. The MCR falls under the definition of a public health authority. HIPAA allows facilities to report cancer incidence data to MCR in compliance with state statutes (MRSA 22 § 1401-1407). Written informed consent from each cancer patient reported to the MCR is not required by HIPAA nor is a Business Associated Agreement required. Facilities must simply document that reporting has occurred and will not be held liable for reporting.

Audits

The MCR will periodically conduct case-finding and re-abstracting audits as required by NPCR. The purpose of these audits is to assess the quality and completeness of reporting to the MCR. Audit results will be summarized and shared with hospital registrars and reporters.

Summary of Maine Cancer Registry Reporting Requirements

By law all hospitals that diagnosis and/or treat cancer patients must report to the Maine Cancer Registry. Below is a general summary of the MCR reporting requirements. For detailed instructions on determining case reportability, see Section Two of this manual.

Which cases are reportable to the Maine Cancer Registry?

1. Patients seen at your hospital for the diagnosis, evaluation, treatment and/or treatment planning of a reportable neoplasm. This includes:
    a. A new diagnosis or a recurrence
    b. Inpatient and/or outpatient encounters
2. Patients who died at your hospital with a reportable neoplasm even if no evaluation or treatment was performed at your hospital.

What is a reportable neoplasm?

1. All primary malignant neoplasms diagnosed on or after January 1, 1995. These include both in situ and invasive tumors.

    Exception 1*:* Beginning with cases diagnosed January 1, 2004, the MCR no longer requires facilities to report carcinoma in situ of the cervix.
    Exception 2*:* Pilocytic (Juvenile) astrocytoma, listed as 9421/1 in ICD-O-3, is required and should be recorded as 9421/3 in the registry.

2. Basal and squamous cell skin cancers of the genital area.
3. Malignant melanoma.

4. Non-malignant tumors of the brain, central nervous system and other intracranial sites.
5. **Intraepithelial neoplasia, grade III (VIN III, VAIN III and AIN III).**
6. All analytic and non-analytic cases are reportable (See pages 10-11 for Class of Case definitions). Non-analytic cases include patients seen for second opinion or treatment planning only; patients diagnosed with or treated for recurrence or progression of disease; patients diagnosed at autopsy; patients diagnosed and treated in a staff physician office; and pathology report only cases.
7. Both Maine residents and non-residents diagnosed or treated in Maine facilities. Reporting of out-of-state residents allows MCR to honor data exchange agreements with other states.

What cases are not reportable?

1. Cases diagnosed prior to January 1, 1995
2. Non-genital basal and squamous carcinomas of skin including tumors invading underlying tissue.
3. Benign tumors or tumors of uncertain behavior unless of the brain, central nervous system, or other intracranial sites.
4. Recurrences or secondary (metastatic) tumors from previously reported primary tumors.
5. Carcinoma in situ of the cervix, effective for cases diagnosed on or after January 1, 2004.

What is the deadline for reporting cases to the MCR?

Cases are to be reported within six months of diagnosis, discharge or date of first contact at the reporting hospital. Please use the following deadlines for reporting.

Dates of Diagnosis, Discharge, or First Contact	Due Date at MCR
January 1st through March 31st	Last day in September of the same year
April 1st through June 30th	Last day in December of the same year
July 1st through September 30th	Last day in March of the following year
October 1st through December 31st	Last day in June of the following year

What data items are required to be reported to the MCR?

The MCR must collect all data items required by the NPCR. In addition, the MCR may collect data items not required by NPCR, but necessary for complete reporting and analysis. Please see Section Three of this manual for the list of required data items.

What is the recommended method for submitting new cases to the MCR?

Facilities that do not have cancer registry software can report using the most recent paper abstract located on MCR's website. All other facilities must report electronically using the most current version of the NAACCR Record Layout. Data may be submitted on a floppy disk, a CD, by encrypted e-mail or by a secure ftp site. In order to protect patient confidentiality, MCR recommends applying a password to all electronic submissions that are sent through the mail.

What is the recommended method for resubmitting cases to the MCR?

Hospitals resubmitting cases with changes should print out the electronic abstract, highlight the changes, and mail it to the MCR.

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SECTION TWO –DATA COLLECTION

I. DETERMINING REPORTABILITY

Casefinding

Casefinding is the process used by hospitals to identify patients with reportable neoplasms. Casefinding involves careful, systematic monitoring of records maintained by those departments and services that usually deal with cancer patients. Never rely strictly on the pathology department as a casefinding source, as that would exclude cases that were diagnosed elsewhere but received all or part of first course therapy at your facility or cases diagnosed clinically.

The primary sources for case identification include the following records:

- Pathology reports (including histology, cytology, hematology, bone marrow, immunoelectrophoresis, and autopsy findings)
- Daily discharges
- Disease indices
- Outpatient records
- Radiation therapy records
- Oncology clinic records

The following should also be considered as additional sources for casefinding:

- Surgery reports
- Nuclear medicine logs
- Radiology logs (including logs of scans)
- Newspaper obituary listings

The casefinding lists on the next two pages are intended for use when reviewing the above casefinding sources that use ICD-9-CM diagnosis codes. The lists in this manual are adapted from the revised casefinding lists (effective date: October 1, 2006) on SEER training website. The SEER casefinding lists can be downloaded from the following SEER training website: (**http://www.training.seer.cancer.gov/module_icdo3/icd_o_3_lists.html**).

Nonreportable List

A nonreportable list or file is a valuable casefinding tool. Maintaining a list that documents patient information, ICD-9-CM code, date seen, and reason a case is not reportable can help avoid duplication of effort when, upon review, a case is determined not to meet MCR reportability criteria. In the event that MCR completes a casefinding audit, this list will facilitate the resolution of casefinding discrepancies.

COMPREHENSIVE ICD-9-CM CASEFINDING LIST FOR REPORTABLE TUMORS (Effective Date: 10/1/2006)

140.0 – 208.9	Malignant neoplasms
225.0 – 225.9	Benign neoplasm of brain and spinal cord neoplasm
227.3 – 227.4	Benign neoplasm of pituitary gland, pineal body, and other intracranial endocrine-related structures
230.0 – 234.9	Carcinoma in situ
237.0 – 237.9	Neoplasm of uncertain behavior [borderline] of endocrine glands and nervous system
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)
238.6	Extramedullary plasmacytoma (9734/3)
238.71*	Essential thrombocythemia (9962/3)
238.72*	Low grade myelodysplastic syndrome lesions (includes 9980/3, 9982/3, 9985/3)
238.73*	High grade myelodysplastic syndrome lesions (includes 9983/3)
238.74*	Myelodysplastic syndrome with 5q deletion (9986/3)
238.75*	Myelodysplastic syndrome, unspecified (9985/3)
238.76*	Myelofibrosis with myeloid metaplasia (9961/3)
238.79*	Other lymphatic and hematopoietic tissues (includes 9960/3, 9961/3, 9970/1, 9931/3)
273.2	Gamma heavy chain disease (9762/3); Franklin's disease (9762/3)
273.3	Waldenstrom's macroglobulinemia (9761/3)
288.3	Hypereosinophilic syndrome (9964/3)
289.83*	Myelofibrosis (NOS) (9961/3)
795.06*	Papanicolaou smear of cervix with cytologic evidence of malignancy (without histologic confirmation) (positive Pap smear)
V10.0 – V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries, and/or subsequent treatment)

* New code effective 10/1/2006

Effective with 10/1/2006, screening for malignancies is no longer required for the following codes:

238.7	This code is no longer in effect.
284.9	Aplastic anemia, unspecified
285.0	Sideroblastic anemia
289.89	Other specified diseases of blood and blood-forming organs

Please note:

- Prostatic Intraepithelial Neoplasia (PIN III) M-8148/2 is NOT reportable to MCR.
- Pilocytic/juvenile astrocytoma M-9421 which moved from /3 in ICD-O-2 to /1 in ICD-O-3 should be reported a /3.
- Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries which moved from /3 in ICD-O-2 to /1 in ICD-O-3 are not reportable if diagnosed on or after 1/1/2001.
- The World Health Organization (WHO) diagnosis "B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma" is coded as 9823/3, and cross-referenced to 9670/3, malignant lymphoma, small B lymphocytic. If this WHO term is diagnosed in blood or bone marrow, code 9823/3; if diagnosed in tissue, lymph nodes or any organ in combination with blood or bone marrow, code 9670/3.

SUPPLEMENTARY ICD-9-CM CODES TO SCREEN FOR CANCER CASES NOT IDENTIFIED BY OTHER CODES (Effective Date: 10/1/2006)

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

042	AIDS (This is not a malignancy code; this is for AIDS itself. Coders are instructed to add codes for AIDS-associated malignancies. Screen 042 for 'history of' cancers that might not be coded as active cancers.)
210.0 – 229.9	Benign neoplasms (screen for incorrectly coded malignancies or reportable-by-agreement tumors)
235.0 – 236.9	Neoplasms of uncertain behavior (screen for reportable-by-agreement tumors)
238.0 – 238.9	Neoplasms of uncertain behavior (screen for reportable-by-agreement tumors)
239.0 – 239.9	Neoplasms of unspecified behavior (screen for incorrectly coded malignancies or reportable-by-agreement tumors)
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)
338.3	Neoplasm related pain (acute) (chronic) (new code) Cancer associated pain; Pain due to malignancy (primary) (secondary) Tumor associated pain
528.01	Mucositis due to antineoplastic therapy (new code)
790.93	Elevated prostate specific antigen [PSA]
795.8	Abnormal tumor markers (new sub-category) Elevated tumor associated antigens [TAA] Elevated tumor specific antigens [TSA] Excludes: elevated prostate specific antigen [PSA] (790.93)
795.81	Elevated carcinoembryonic antigen [CEA] (new code)
795.82	Elevated cancer antigen 125 [CA 125] (new code)
795.89	Other abnormal tumor markers (new code)
E879.2	Adverse effect of radiation therapy
E930.7	Adverse effect of antineoplastic therapy
E933.1	Adverse effect of immunosuppressive drugs
V07.3	Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
V07.8	Other specified prophylactic measure
V58.0	Encounter or admission for radiotherapy
V58.11	Encounter for antineoplastic chemotherapy
V58.12	Encounter for antineoplastic immunotherapy
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow-up
V67.2	Chemotherapy follow-up
V76.0 - V76.9	Special screening for malignant neoplasm
V86.0	Estrogen receptor positive status [ER+] (new code)
V86.1	Estrogen receptor negative status [ER-] (new code)

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Reportable Diagnoses

Maine law requires that hospitals submit to the Maine Cancer Registry all cases diagnosed on or after January 1, 1995 that are seen at their facility and meet the MCR reportability criteria. For reportability, MCR generally follows the *Surveillance Epidemiology and End Results (SEER) Program* rules.

Cases are reportable to the MCR if they are included on the ICD-9-CM casefinding list on pages 6-7 and meet the reportable criteria listed below:

- Neoplasms classified as in-situ or malignant (behavior codes 2 or 3) in the "Morphology of Neoplasms" section of ICD-0-3. The ICD-O-2 coding rules must be used for cases diagnosed prior to 2001.

  Exceptions are the following morphology-site combinations:

  - Malignant primary skin lesions (C44._) with morphology codes 8000-8110 (basal cell and squamous cell carcinomas) are <u>not</u> reportable. Basal cell and squamous cell carcinomas <u>are reportable for skin</u> of the genital sites – vagina (C52.9), vulva & clitoris (C51._), prepuce (C60.0), penis (C60.9) and scrotum (C63.2).

  - Effective for cases diagnosed on or after January 1, 2004, carcinoma in situ of the cervix (behavior code 2) is <u>not</u> reportable.

- **The following intraepithelial neoplasia grade III's (8077/2) are reportable (per NPCR requirement): AIN III (C21._); VIN III (C51._) and VAIN III (C52.9).**

- Non-malignant primary tumors of the brain, central nervous system and other intracranial sites (behavior code of 0 or 1) are reportable. These sites include meninges (C70._), brain (C71._), spinal cord (C72.0), cranial nerves (C72.5) and other parts of the central nervous system (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3).

  - Pilocytic (Juvenile) astrocytoma, listed as 9421/1 in ICD-O-3, is required and should be recorded as 9421/3 in the registry.

Clinical and Pathologic Cases

A patient is considered to have a reportable neoplasm if a recognized medical practitioner determines the diagnosis, even if the diagnosis is never pathologically confirmed. In most instances, the patient's medical record clearly presents the diagnosis of cancer by use of specific terms that are synonymous with cancer. Cases diagnosed clinically, as well as those pathologically confirmed, are reportable. In the absence of a histologic or cytologic confirmation, report a case based on the clinical diagnosis when a recognized medical practitioner says the patient has a cancer or carcinoma. A clinical diagnosis may be recorded in the final diagnosis on the face sheet or in other parts of the medical record.

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

Exception 1: If the physician treats a patient for a reportable diagnosis in spite of the negative biopsy, report the case.

Exception 2: If enough time has passed that it is reasonable to assume that the physician has seen the negative pathology, but the clinician continues to call this a reportable diagnosis, report the case. A reasonable amount of time would be equal to or greater than 6 months.

The physician, however, may not always be certain, nor the recorded language definitive. The terminology used to describe a reportable diagnosis may be vague or ambiguous. The following lists should be used as a guide in determining reportability.

Ambiguous Terminology

Ambiguous terminology may originate from any source document, such as pathology report, radiology report, or from a clinical report. If any of the reportable **ambiguous terms precede** a word that is **synonymous** with an in situ or invasive tumor (e.g.: cancer, carcinoma, malignant neoplasm, etc.) or a benign or borderline tumor of the brain, CNS or other intracranial site, the case is reportable. Abstract the case.

Ambiguous terms that are reportable	
Apparent(ly)	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect(ed)
Consistent with	Suspicious (for)
Favor(s)	Typical (of)
Malignant appearing	
For site codes C70.0-C72.9; C75.1-C75.3 only	
Neoplasm	Tumor

Ambiguous terms that are not reportable (Do not report cases with a diagnosis based on only these terms)	
Cannot be ruled out	Questionable
Equivocal	Rule(d) out
Possible	Suggests
Potentially malignant	Worrisome
Early	Approaching

Note: Do not accession a case based only on suspicious cytology. The case is accessioned if proven by positive cytology or other diagnostic methods including a physician's clinical diagnosis. See the data item Diagnostic Confirmation for methods of diagnosis.

In Situ Lesion Followed By Invasive Malignancy in the Same Primary Site

One major difference between CoC and SEER reporting rules is the SEER requirement to report invasive malignancies that occur in the same primary site more than two months after an in situ lesion of the same histologic type, even if the invasive malignancy is stated to be a recurrence. These cases must be reported to the MCR per NPCR requirements. Hospitals with CoC-approved Cancer Programs may not wish to include them as analytic cases in their databases. The MCR suggests that CoC-approved hospitals abstract these cases and submit a copy of the paper abstract to the MCR. Case status can be flagged as something other than "Complete", such as "Reviewed/ reportable to central registry", in the hospital's database.

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Analytic and Nonanalytic Cases

Class of case is a Commission on Cancer (CoC) concept that does not directly apply to central registries; however, it is a convenient way to define the types of cases that must be reported. Although the CoC does not require nonanalytic cases, population-based cancer registries, such as the MCR, must collect all cases regardless of place of diagnosis or CoC class of case. The MCR, therefore, requires that recurrent cases (COC class of case 3), which have not been previously reported by your hospital, be submitted to MCR. An abstract is required even if the patient was diagnosed and/or treated elsewhere previously. Because much of the information regarding initial diagnosis, stage and treatment on such patients is often not available to the reporting hospital, the MCR reporting requirements for nonanalytic cases are less stringent than for analytic cases. Information contained in the medical record should be reported, but it is not necessary to acquire missing information.

Commission on Cancer (CoC) Class of Case Definitions	
Case	**Includes**
Analytic Cases	
Class 0	Diagnosis at the accessioning facility and all of the first course of treatment was performed elsewhere or the decision not to treat was made at another facility. • Patients diagnosed at the accessioning facility who choose to be treated elsewhere. • Patients diagnosed at the accessioning facility who are referred elsewhere for treatment.
Class 1	Diagnosis at the accessioning facility, and all or part of the first course of treatment was performed at the accessioning facility. • Patients diagnosed at the accessioning facility whose treatment plan is either not to treat or watchful waiting. • Patients diagnosed at the accessioning facility who refuse treatment. • Patients diagnosed at the accessioning facility who are not treatable or who were given palliative care only due to age, advanced disease, or other medical conditions. • Patients diagnosed at the accessioning facility for whom it is unknown whether treatment was recommended or administered. • Patients diagnosed at the accessioning facility for whom treatment was recommended, but it is unknown whether it was administered. • Patients diagnosed at a staff physician's office who receive their first course of treatment at the accessioning facility. "Staff physician" refers to any medical staff with admitting privileges at the accessioning facility. • Patients diagnosed at the accessioning facility who received all or part of their first course of treatment in a staff physician's office.
Class 2	• Diagnosis elsewhere, and all or part of the first course of treatment was performed at the accessioning facility. • Diagnosed elsewhere and provided palliative care in lieu of first course treatment, or as part of the first course of treatment, at the accessioning facility.
Nonanalytic Cases	
Class 3	Diagnosis and all of the first course of treatment was performed elsewhere. • Patients treated at the accessioning facility for whom no information on first course of treatment is available. • Patients for whom the accessioning facility developed a treatment plan or provided "second opinion" services, but the diagnosis and treatment was provided elsewhere. • Patients treated for recurrence or progression for a previously diagnosed malignancy.

Determining Multiple Primaries: Hematopoietic Primaries
[*SEER Program Coding and Staging Manual 2004* p. 18]

For lymphomas and leukemias, use the SEER table "Definitions of Single and Subsequent Primaries for Hematologic Malignancies" (Appendix I in this manual) to decide whether differing histologies represent one or more primaries. Primary site and timing are not applicable for determining whether these malignancies represent one or more primaries.

Determining Multiple Primaries: Non-malignant Primary Intracranial and CNS Tumors [*SEER Program Coding and Staging Manual 2004* pp 18-19]

Definitions

Same site: The first two numeric digits of the ICD-O-3 topography code are identical.

Different site: The first two numeric digits of the ICD-O-3 topography code are different.

Timing: The amount of time between the original and subsequent tumors is not used to determine multiple primaries because the natural biology of non-malignant tumors is that of expansive, localized growth.

Same Vs. Different Histologies Based On Histologic Groupings

When there are **multiple tumors**, use the following table to determine if the non-malignant brain tumors are the same histology or different histologies.

Histologic Group	ICD-O-3 Code
Choroid plexus neoplasm	9390/0, 9390/1
Ependymoma	9383, 9394, 9444
Neuronal and neuronal-glial neoplasm	9384, 9412, 9413, 9442, 9505/1, 9506
Neurofibroma	9540/0, 9540/1, 9541, 9550, 9560/0
Neurinomatosis	9560/1
Neurothekeoma	9562
Neuroma	9570
Perineurioma, NOS	9571/0

Instructions for Using Histologic Group Table

1. **Both histologies are listed in the table**

   a. Histologies that are in the **same grouping** or row in the table are the **same histology**.

   b. ***Note:*** Histologies that are in the same grouping are a progression, differentiation or subtype of a single histologic category.

a. Histologies listed in **different groupings** in the table are **different histologies**.

2. One or both of the histologies is not listed in the table

a. If the **ICD-O-3 codes** for both histologies have the **identical** first three digits, the histologies are the **same**.

b. If the first three digits of the **ICD-O-3** histology code are **different**, the histology types are **different**.

Multiple Primary Rules For Non-malignant Primary Intracranial And CNS Tumors

Use the following rules to determine whether to report a single primary or multiple primaries.
Coding rules for the data items mentioned such as primary site, histology, laterality, etc. are not described in detail here; refer to the instructions for coding in Section Three of this manual for each date item.

Note: If there is a single tumor, it is always a single primary.

Rule 1: Multiple non-malignant tumors of the **same histology** that recur in the **same site** and s**ame side** (laterality) as the original tumor are recurrences (single primary) even after 20 years.

Rule 2: Multiple non-malignant tumors of the **same histology** that recur in the **same site** and it is unknown if it is the **same side** (laterality) as the original tumor are recurrences (single primary) even after 20 years.

Rule 3: Multiple non-malignant tumors of the same histology in **different sites** of the CNS are separate (multiple) primaries.

Rule 4: Multiple non-malignant tumors of the same histology in **different sides** (laterality) of the CNS are separate (multiple) primaries.

Rule 5: Multiple non-malignant tumors of different histologies are separate (multiple) primaries.

CANCER IDENTIFICATION			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
400	Primary Site	All	57
560	Sequence Number – Hospital	All	58
410	Laterality	All	59
522	Histologic Type ICD-O-3	2001 +	60
523	Behavior Code ICD-O-3	2001 +	65
420	Histology ICD-O-2	1992-2000	67
430	Behavior ICD-O-2	1992-2000	68
440	Grade	All	69
490	Diagnostic Confirmation	All	72
500	Type of Reporting Source	2004 +	73
610	Class of Case	2004 +	74
580	Date of 1st Contact (previously Date of Adm)	All	75
390	Date of Diagnosis	All	76
1080	Date of 1st Positive BX	2005 +	77
630	Primary Payer at DX	2004 +	78
STAGING AND EXTENT OF DISEASE INFORMATION			
NAACCR Item #	**NAACCR Item Name**	**Diagnosis Year Required**	**Page Number**
2800	CS Tumor Size	2004 +	80
2810	CS Extension	2004 +	83
2820	CS Tumor Size/Ext Eval	2004 +	85
830	Regional Nodes Examined	2001 +	87
820	Regional Nodes Positive	2001 +	88
2830	CS Lymph Nodes	2004 +	89
2840	CS Reg Nodes Eval	2004 +	92
2850	CS Mets at DX	2004 +	94
2860	CS Mets Eval	2004 +	96
2880	CS Site-Specific Factor 1	2004 +	98
2890	CS Site-Specific Factor 2	2004 +	99
2900	CS Site-Specific Factor 3	2004 +	100
2910	CS Site-Specific Factor 4	2004 +	101
2920	CS Site-Specific Factor 5	2004 +	102
2930	CS Site-Specific Factor 6	2004 +	103
760	SEER Summary Stage 1977	Prior to 2001	105
759	SEER Summary Stage 2000	2001-2003	106
1060	TNM Edition Number	Prior to 2004	108
880	TNM Path T	Prior to 2004	109
890	TNM Path N	Prior to 2004	110
900	TNM Path M	Prior to 2004	111
910	TNM Path Stage Group	Prior to 2004	112

ADDRESS (NUMBER AND STREET) CURRENT	Item Length: 40 NAACCR Item #2350 Source of Standard: CoC (Revised 01/08) Dx Yr Req by MCR: All

Description: *Identifies the patient's current address (number and street).*

Instructions for Coding (See *FORDS Revised for 2007* p. 49)

- Record the number and street address or the rural mailing address of the patient's current usual residence.

  Do not record a Post Office Box in this field. See *Current Address – Supplemental*.

- 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. A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub 28.

- If the street or physical address is not available, record unknown.

- Update this data item if the patient's address changes.

- Do not change this item when the patient dies.

- See "**Patient Address and Residency Rules**" page 38A for further instructions.

Patient Address and Residency Rules

The current address initially is the patient's residence at the time the patient was first seen at the reporting facility for this primary. The current address is updated if the patient moves. If the patient has more than one primary tumor, the current address should be the same for each primary.

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

Normally a residence is the home named by the patient. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with the rules of the Census Bureau whenever possible. The registry can resolve residency questions by using the Census Bureau's definition, "the place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home."

Rules for Persons with Ambiguous Residences

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

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

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

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

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

Persons in the Armed Forces and on Maritime Ships: Members of the armed forces are residents of the installation area. Use the stated address for military personnel and their families. Military personnel may use the installation address or the surrounding community's address.

The Census Bureau has detailed residency rules for Navy personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for the detailed rules.

ADDRESS – SUPPLEMENTAL CURRENT	Item Length: 40 NAACCR Item #2355 Source of Standard: CoC (Revised 01/08) Dx Yr Req by MCR: 2005+

Description: *Provides the ability to store additional address information such as the name of a place or facility (i.e., a nursing home or name of an apartment complex).*

Instructions for Coding (See *FORDS Revised for 2007* p. 50)

- Record information about the patient's current usual address that is either additional to street address, such as the name of a place or facility (i.e., a nursing home or an apartment complex).

  Record information other than a physical address (i.e., post office box).

- If this field is not needed, leave blank.
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Update this data item if a patient's address changes.
- Do not change this item when the patient dies.
- See "**Patient Address and Residency Rules**" page 38A for further instructions.

ADDRESS – CITY (OR TOWN) CURRENT	Item Length: 20 NAACCR Item #1810 Source of Standard: CoC (Revised 01/08) Dx Yr Req by MCR: All

Description: *Identifies the name of the city or town of the patient's current usual residence.*

Instructions for Coding (See *FORDS Revised for 2007* p. 51)

- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.

> The name of the city or town must be spelled out completely. Do not use abbreviations, punctuation, special characters or numbers.
>
> ***Examples:*** Record Fort Kent not Ft. Kent; Mount Vernon not Mt. Vernon; Old Orchard Beach not OOB.

- If the patient has multiple malignancies, the current city or town should be the same for all tumors.
- Record unknown, if the city or town is not known. Do not leave blank.
- Update this data item if the patient's city/town of residence changes.
- Do not change this item when the patient dies.
- See "**Patient Address and Residency Rules**" page 38A for further instructions.

ADDRESS – STATE CURRENT	Item Length: 2 NAACCR Item #1820 Source of Standard: CoC (Revised 01/08) Dx Yr Req by MCR: All

Description: *Identifies the patient's current state of residence.*

Instructions for Coding (See *FORDS Revised for 2007* p. 52)

- Record the U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory of the patient's current usual residence. See the following page for common abbreviations.
- Codes in addition to the U.S. and Canadian Postal Services abbreviations
  - CD Resident of Canada, NOS (province/territory unknown)
  - US Resident of United States, NOS (state/commonwealth/territory/possession unknown)
  - XX Resident of country other than the United States (including its territories, commonwealths or possessions) or Canada, and country is known
  - YY Resident of a country other than the United States (including its territories, commonwealths or possessions) or Canada, and country is unknown
  - ZZ Residence unknown
- If the patient has multiple tumors, the current state of residence should be the same for all tumors.
- Update this data item if the patient's state of residence changes.
- Do not change this item when the patient dies.
- See "**Patient Address and Residency Rules**" page 38A for further instructions.

ADDRESS – POSTAL CODE CURRENT [ZIP CODE]	Item Length: 9 NAACCR Item #1830 Source of Standard: CoC (Revised 01/08) Dx Yr Req by MCR: All

Description: *Identifies the postal code of the patient's current address.*

Instructions for Coding (See *FORDS Revised for 2007* p. 54)

- For U.S. residents, record either the five-digit or the nine-digit extended ZIP code for the patient's current usual residence.

  See Appendix C for a listing of Maine cities and towns with corresponding county and ZIP codes.

- For Canadian residents, record the six-character alphanumeric postal code.
- When available, record the postal code for other countries.
- If the patient has multiple tumors, the postal code should be the same.
- Update this data item if the patient's postal code changes.
- Do not change this item when the patient dies.
- See "**Patient Address and Residency Rules**" page 38A for further instructions.

Codes in addition to U.S. or Canadian postal codes:

Code	Definition
888888888	Resident of country other than United States (including positions, etc.) or Canada and postal code unknown
999999999	Resident of United States (including positions, etc.) or Canada and postal code unknown
999999	Resident of Canada and postal code unknown

Code	Label	Definition
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare.
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with State Medicaid administered supplement.
65	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents. Formally CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).
66	Military	Military personnel or their dependents who are treated at a military facility.
67	Veterans Affairs	Veterans who are treated in Veterans Affairs facilities.
68	Indian/Public Health Service	Patient who receives care at an Indian Health Service facility or at another facility, and the medical costs are reimbursed by the Indian Health Service. Patient receives care at a Public Health Service facility or a another facility, and medical costs are reimbursed by the Public Health Service.
99	Insurance status unknown	It is unknown from the patient's medical record whether or not the patient is insured.

Use code 68 for patients who receive services through the **Maine Breast and Cervical Health Program (MBCHP**).

RX SUMM – SURG PRIMARY SITE **[SURGICAL PROCEDURE OF PRIMARY SITE]**	Item Length: 2 NAACCR Item #1290 Source of Standard: SEER/CoC (Revised 01/08) Dx Yr Req by MCR: All

Description: *Records the surgical procedure(s) performed to the primary site.*

Instructions for Coding (See *FORDS Revised for 2007* p. 135)

- Site-specific codes for this data item are found in *FORDS Revised for 2007* Appendix B.
- If registry software allows multiple surgical procedures to be recorded, document each surgical procedure separately.
- If registry software allows only one surgical procedure to be collected, document the most invasive surgical procedure for the primary site, but code the date of surgical procedure to *Rx Date – Surgery [Date of First Surgical Procedure] (*NAACCR Item #1200).
- 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. Use codes 80 and 90 only if more precise information about the surgery is unavailable.
- 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 Appendix B.
- 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.
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care** (NAACCR Item #3270)

MCR suggests the hospitals that report only to MCR insert the site-specific surgery codes (Appendix B in the ***FORDS*** manual) into this manual for easy of reference. The most recent version of the ***FORDS*** Manual can be downloaded at http://www.facs.org/cancer/coc/standards.html.

***Note:** Information about palliative procedures is not required by the MCR.

RX SUMM – CHEMOTHERAPY	Item Length: 2 NAACCR Item # 1390 Source of Standard: SEER/CoC (Revised 01/08) Dx Yr Req by MCR: All

Description: *Records the type of chemotherapy administered as first course treatment at this and all other facilities. 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 (See *FORDS Revised for 2007* pp. 171-172)

- For cases diagnosed prior to 2005, refer to the SEER *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of chemotherapeutic agents. Effective for cases diagnosed January 1 2005 refer to **SEER*Rx.**

- 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*.

- If chemotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy administered in the item *Palliative Care****** (NAACCR Item #3270).

Code	Definition
00**	None, chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as first course therapy.
03	Multiagent 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).
85**	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86**	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course therapy. No reason was stated in patient record.
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 was not stated in patient record. Death certificate-only cases.

***** Information about palliative procedures is not required by the MCR.

****** YOUR CANCER REGISTRY SOFTWARE MAY HAVE A SEPARATE DATA FIELD ENTITLED ***REASON FOR NO CHEMO***. IF THAT IS THE CASE, THEN THE CODES 00, 82, 85, 86, 87, 88 AND 99 MUST BE RECORDED IN THE ***REASON FOR NO CHEMO*** FIELD.

Note: **SEER*Rx**, an interactive antineoplastic drug database, replaces the printed SEER Book 8 (published in 1993) and the update to Book 8 issued in May 2002. The categories for a few drugs have changed, notably some monoclonal antibodies such as Avastin, Velcade, Rituxan, Herceptin, and a few others that have been determined to be cytostatic chemotherapy agents rather than traditional immunotherapy. Recoding of these agents for cases diagnosed prior to 2005 is not required or recommended.

SEER*Rx can be downloaded from http://www.seer.cancer.gov/seerrx at no charge.

RX SUMM – HORMONE THERAPY (HORMONE/STEROID THERAPY)	Item Length: 2 NAACCR Item # 1400 Source of Standard: SEER/CoC (Revised 01/08) Dx Yr Req by MCR: All

Description: *Records the type of hormone therapy administered as first course treatment at this and all other facilities. 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 (See *FORDS Revised for 2007* pp. 175-176)

- For cases diagnosed prior to 2005, refer to the SEER *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of hormonal agents. Effective for cases diagnosed January 1 2005 refer to **SEER*Rx.**

- 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 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 hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy administered in the item *Palliative Care** (NAACCR Item #3270).

Code	Definition
00**	None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Hormone therapy administered as first course therapy.
82**	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age).
85**	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86**	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course therapy. No reason was stated in patient record.
87**	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in 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 was not stated in patient record. Death certificate-only cases.

***** Information about palliative procedures is not required by the MCR.

****** YOUR CANCER REGISTRY SOFTWARE MAY HAVE A SEPARATE DATA FIELD ENTITLED ***REASON FOR NO HORMONE***. IF THAT IS THE CASE, THEN THE CODES 00, 82, 85, 86, 87, 88 AND 99 MUST BE RECORDED IN THE ***REASON FOR NO HORMONE*** FIELD.

Note: **SEER*Rx**, an interactive antineoplastic drug database, replaces the printed SEER Book 8 (published in 1993) and the update to Book 8 issued in May 2002. The categories for a few drugs have changed, notably some monoclonal antibodies such as Avastin, Velcade, Rituxan, Herceptin, and a few others that have been determined to be cytostatic chemotherapy agents rather than traditional immunotherapy. Recoding of these agents for cases diagnosed prior to 2005 is not required or recommended.

SEER*Rx can be downloaded from http://www.seer.cancer.gov/seerrx at no charge.

RX SUMM – BRM [IMMUNOTHERAPY]	Item Length: 2 NAACCR Item # 1410 Source of Standard: SEER/CoC (Revised 01/08) Dx Yr Req by MCR: All

Description: *Records the type of immunotherapy administered as first course treatment at this and all other facilities. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.*

Instructions for Coding (See *FORDS Revised for 2007* pp. 179-180)

- For cases diagnosed prior to 2005, refer to the SEER *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of chemotherapeutic agents. Effective for cases diagnosed January 1 2005 refer to **SEER*Rx**.

- If immunotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy administered in the item *Palliative Care** (NAACCR Item #3270).

Code	Definition
00**	None, immunotheray was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Immunotherapy administered as first course therapy.
82**	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age).
85**	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86**	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course therapy. No reason was stated in patient record.
87**	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in 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 was not stated in patient record. Death certificate-only cases.

***** Information about palliative procedures is not required by the MCR.

****** YOUR CANCER REGISTRY SOFTWARE MAY HAVE A SEPARATE DATA FIELD ENTITLED ***REASON FOR NO IMMUNO***. IF THAT IS THE CASE, THEN THE CODES 00, 82, 85, 86, 87, 88 AND 99 MUST BE RECORDED IN THE ***REASON FOR NO IMMUNO*** FIELD.

Note: **SEER*Rx**, an interactive antineoplastic drug database, replaces the printed SEER Book 8 (published in 1993) and the update to Book 8 issued in May 2002. The categories for a few drugs have changed, notably some monoclonal antibodies such as Avastin, Velcade, Rituxan, Herceptin, and a few others that have been determined to be cytostatic chemotherapy agents rather than traditional immunotherapy. Recoding of these agents for cases diagnosed prior to 2005 is not required or recommended.

SEER*Rx can be downloaded from http://www.seer.cancer.gov/seerrx at no charge.

RX SUMM – TRANSPLNT/ENDOCR [HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURES]	Item Length: 2 NAACCR Item # 3250 Source of Standard: CoC (Revised 01/08) Dx Yr Req by MCR: 2005+

Description: *Identifies systemic therapeutic procedures administered as part of the first course of treatment at this and all other facilities. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.*

Instructions for Coding (See *FORDS Revised for 2007* p. 182-183*)*

- 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.

- If the hematologic transplant or endocrine procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hematologic transplant or endocrine procedure provided in the items *Palliative Care** (NAACCR Item #3270).

Code	Definition
00**	No transplant procedure or endocrine therapy was administered as part of first course therapy. Diagnosed at autopsy.
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 and infusion.
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 (ie, comorbid conditions, advanced age).
85**	Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.

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 the first course therapy. No reason was stated in patient record.
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 patient record.
88**	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99**	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it was not stated in patient record. Death certificate-only cases.

Note: *For Cases diagnosed prior to 2003, the information in this data item was coded as immuntherapy.)*

***** Information about palliative procedures is not required by the MCR.

****** YOUR CANCER REGISTRY SOFTWARE MAY HAVE A SEPARATE DATA FIELD ENTITLED ***REASON FOR NO HTE***. IF THAT IS THE CASE, THEN THE CODES 00, 82, 85, 86, 87, 88 AND 99 MUST BE RECORDED IN THE ***REASON FOR NO HTE*** FIELD.

RX SUMM – OTHER **[OTHER TREATMENT]**	Item Length: 1 NAACCR Item # 1420 Source of Standard: SEER/CoC (Revised 01/08) Dx Yr Req by MCR: All

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 (See *FORDS Revised for 2007* p. 186)

- Treatment for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the ususal definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Such treatments include phlebotomy, transfusions, and aspirin (see *FORDS Revised for 2004* Section One), and should be coded 1.

- A complete description of the treatment plan should be recorded in the text field for "Other Treatment" on the abstract.

- If other treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item *Palliative Care** (NAACCR Item #3270).

Code	Label	Definition
0**	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.
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. Death certificate-only cases.

***** Information about palliative procedures is not required by the MCR.

****** YOUR CANCER REGISTRY SOFTWARE MAY HAVE A SEPARATE DATA FIELD ENTITLED ***REASON FOR NO OTHER***. IF THAT IS THE CASE, THEN THE CODES 0, 7, 8 AND 9 MUST BE RECORDED IN THE ***REASON FOR NO OTHER*** FIELD.

CAUSE OF DEATH (If Available)	Item Length: 4 NAACCR Item #1910 Source of Standard: SEER (Revised 01/08) Dx Yr Req by MCR: 2001+

Description: *Official cause of death as coded from the death certificate in valid ICD-O-9 or ICD-O-10 codes.*

Instructions for Coding (See *ROADS p. 271 and *SEER Program Coding and Staging Manual* pp. 208-209)**

- Record the cause of death listed on the death certificate. Use the underlying cause of death (ICD code) identified by the state health department.
- If the patient has multiple primaries, the underlying cause of death must be identical on each record.
- Special codes in addition to ICD-O-9 and ICD-O-10 codes:

Code	Definition
0000	Patient alive at last contact
7777	State death certificate not available
7797	State death certificate/listing available but underlying cause of death is not coded.

A specific **Cause of Death** should be entered only if you have access to the coded underlying cause of death from the death certificate, do not code cause of death from any other source, such as a discharge summary or an oncology chart. If you do not have access to the coded underlying case of death as listed on the death certificate, enter the code 7797.

*Note: As of January 1, 2003, this data item is no longer supported by CoC.

ICD REVISION NUMBER	Item Length: 1 NAACCR Item #1920 Source of Standard: SEER (Revised 01/08) Dx Yr Req by MCR: 2005+

Description: *Indicator for the coding scheme used to code the cause of death.*

Instructions for Coding (See *SEER Program Coding and Staging Manual 2004* p. 207*)*

- If Cause of Death (NAACCR Item #1910) is recorded, indicate the ICD revision used to code the underlying cause of death.
- If the patient has multiple primaries, the ICD Code Revision used for cause of death must be identical on each record.

Code	Definition
0	Patient alive at last follow-up
1	ICD-10
9	ICD-9

Note: ICD-10 was implemented for coding causes of death on death certificates in the United States effective January 1, 1999. For deaths occurring on or after that date the **ICD Revision Number** should be coded as 1 (ICD-10) even when one of the special codes for cancer registries (7777 or 7797) is entered in the **Cause of Death** field.

ADDRESS (NUMBER AND STREET) AT DIAGNOSIS	Item Length: 40 NAACCR Item #2330 Source of Standard: CoC (Revised 01/08) Dx Yr Req by MCR: All

Description: *Identifies the patient's address (number and street) at the time of diagnosis*.

Instructions for Coding (See *FORDS Revised for 2007* p. 42)

- Record the number and street address or the rural mailing address of the patient's usual residence when the tumor was diagnosed.

  Do not record Post Office Box in this field. See *Address-Supplemental.*

- 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. A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub 28.

- If the street or physical address is not available, record unknown.

- 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.

- See "**Patient Address and Residency Rules**" page 38A for further instructions.

ADDRESS- SUPPLEMENTAL AT DIAGNOSIS	Item Length: 40 NAACCR Item #2335 Source of Standard: CoC (Revised 01/08) Dx Yr Req by MCR: 2005+

Description: *Provides the ability to store additional address information such as the name of a place or facility (ie, a nursing home or name of an apartment complex) at the time of diagnosis.*

Instructions for Coding (See *FORDS Revised for 2007* p. 43)

- Record information about the patient's usual residence when the tumor was diagnosed that is either additional to street address, such as name of a place or facility (i.e., a nursing home or an apartment complex).

  Record information other than a physical address (i.e., post office box).

- If this field is not needed, leave blank.
- 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.
- See "**Patient Address and Residency Rules**" page 38A for further instructions.

ADDRESS – CITY (OR TOWN) AT DIAGNOSIS	Item Length: 20 NAACCR Item #70 Source of Standard: CoC (Revised 01/08) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2007* p. 44)

- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.

> The name of the city or town must be spelled out completely. Do not use abbreviations, punctuation, special characters or numbers.
>
> ***Examples:*** Record Fort Kent not Ft. Kent; Mount Vernon not Mt. Vernon; Old Orchard Beach not OOB.

- 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.
- See "**Patient Address and Residency Rules**" page 38A for further instructions.

ADDRESS – STATE AT DIAGNOSIS	Item Length: 2 NAACCR Item #80 Source of Standard: CoC (Revised 01/08) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2007* p. 45)

- Record the 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. See following page for common abbreviations.
- Codes in addition to the U.S. and Canadian Postal Services abbreviations
  - CD Resident of Canada, NOS (province/territory unknown)
  - US Resident of United States, NOS (state/commonwealth/territory/possession unknown)
  - XX Resident of country other than the Unites States (including its territories, commonwealths or possessions) or Canada and the country is known
  - YY Resident of a country other than the United States (including its territories, commonwealths or possessions) or Canada and the country is unknown
  - ZZ Residence unknown
- If the patient has multiple tumors, the state of residence may be different for subsequent primaries
- Do not update this data item if the patient's state of residence changes.
- See "**Patient Address and Residency Rules**" page 38A for further instructions.

ADDRESS POSTAL CODE AT DIAGNOSIS [ZIP CODE]	Item Length: 9 NAACCR Item #100 Source of Standard: CoC (Revised 01/08) Dx Yr Req by MCR: All

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

Instructions for Coding (See *FORDS Revised for 2007* p. 47)

- For U.S. residents, record either the five-digit or the nine-digit extended ZIP code at the time of diagnosis and treatment.

> See Appendix C for a listing of Maine cities and towns with corresponding county and ZIP codes.

- For Canadian residents, record the six-character alphanumeric postal code.
- When available, record the postal code for other countries.
- If the patient has multiple malignancies, the postal code may be different for subsequent primaries.
- Do not update this data item if the patient's postal code changes.
- See "**Patient Address and Residency Rules**" page 38A for further instructions.

Codes in addition to U.S. or Canadian postal codes:

Code	Definition
888888888	Resident of country other than United States (including positions, etc.) or Canada and postal code unknown
999999999	Resident of United States (including positions, etc.) or Canada and postal code unknown
999999	Resident of Canada and postal code unknown

NPI – REPORTING FACILITY	Item Length: 10 NAACCR Item #545 Source of Standard: NAACCR (Revised 01/08) Dx Yr Req by MCR: 2007+

Description: *The NPI (National Provider Identifier) identifies the facility submitting the data in the record.*

NPI, a unique identification number for health care providers, is scheduled for 2007-2008 implementation by the Centers for Medicare & Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Instructions for Coding (See *FORDS Revised for 2007 p 208A)*

- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definitions
(fill spaces)	10-digit NPI number for the facility
(leave blank)	NPI for facility is unknown or not available.

TEXT – REMARKS	Item Length: 350 NAACCR Item #2680 Source of Standard: NPCR (Revised 01/08) Dx Yr Req by MCR: 2005+

Description: *Text area for manual documentation of information that is given only in coded form elsewhere or for which the abstract provides no other place. Overflow data from other text fields can also be placed here. Problematic coding issues can also be discussed in this section.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. The text should justify the code(s) and not vice versa.
- NAACCR-approved abbreviations should be utilized. See Appendix E in this manual.
- Additional comments can be continued in empty fields including "Remarks".
- Do not include irrelevant information.

Suggestions for text: Include information on cancer history if a person was previously diagnosed with another reportable tumor, including laterality for a paired-organ site; information regarding synchronous tumors; justification of over-ride flags; any relevant information not documented in another text field.

Use this field to document as much as possible when reporting a recurrent (nonanalytic) case. Give a summary of what you know about the initial diagnosis as well as the reason the patient was seen at your facility for this cancer.

Remember the information in the coded fields must reflect the initial diagnosis, stage and treatment. DO NOT CODE SUBSEQUENT TREATMENT OR STAGE AT PROGRESSION OR RECURRENCE/METASTASIS. That kind of information should be reported only in a text field.

- **Do not include information that MCR is not authorized to collect. (i.e., AIDS or HIV status)**

PLACE OF DEATH	Item Length: 3 NAACCR Item #1940 Source of Standard: NPCR Dx Yr Req by MCR: 2005+

Description: *Records the state or country where the patient died and where certificate of death is filed.*

Instructions for Coding (See current version of *NAACCR Volume II, Data Standards and Data Dictionary)*

- Use the SEER Geocodes for "Place of Death." These codes include states of the United States as well as foreign countries.
- Use the most specific code.
- For SEER Geocodes, see Appendix D in this manual.

Codes in addition to geocodes

Code	Definition
997	Not applicable, patient alive
999	Place of death unknown