THE OKLAHOMA CENTRAL CANCER REGISTRY CODING MANUAL

A TOOL TO ENHANCE KNOWLEDGE OF CANCER DATA COLLECTION AND REPORTING

1000 N.E. 10th STREET
ROOM 1205
OKLAHOMA CITY, OKLAHOMA 73117-1299
405-271-4072

http://www.health.ok.gov/program/cdc/cancerreg.html

ACKNOWLEDGEMENTS

We want to acknowledge the support and technical references availed in writing this manual. The Texas Central Registry Manual was exceptional and was used as the primary guideline for this manual.

REFERENCE RESOURCES

State Manual References:

- Missouri Cancer Registry Manual
- Oregon Cancer Registry Manual
- Texas Central Registry Manual

These sources were used in the preparation of this manual.

- AJCC Cancer Staging Manual 6th Edition – American Joint Committee on Cancer
- Collaborative Staging Manual and Coding Instructions – Version 01.03.00
- FORDS Manual – Revised for 2004
- International Classification of Diseases for Oncology – ICD-O – Third Edition
- NAACCR Data Standards and Data Dictionary, Volume II - Eleventh Edition, Version 11.1, Aril 2006
- RMCDS Manual and Software
- SEER Extent of Disease 1998, Codes and Coding Instructions – Third Edition, 1998
- SEER Program Coding and Staging Manual 2004
- SEER Summary Staging Guide – Revision 2000

WRITER

Pat Downing, B.S., C.T.R.

EDITORS

Elaine Pierce – Editorial Consultant
Delores Greene, C.T.R. – Technical Consultant
Robb Sandefur– Computer Consultant
Charlotte Murphy, RHIA, CTR, - Administrative Consultant

Replacement of 1995 OCCR POLICY & PROCEDURE MANUAL

OKLAHOMA STATE DEPARTMENT OF HEALTH

Web Site: http://www.health.ok.gov/

Dr. Michael Crutcher, M.D., M.P.H., FACPM.
Commissioner of Health

Joe Mallonee, M.P.H.
Deputy Commissioner, Disease and Prevention Services

Adeline Yerkes, R.N., M.P.H.
Chief, Chronic Disease Service

OKLAHOMA CENTRAL CANCER REGISTRY

Web Site: http://www.health.ok.gov/program/cds/cancereg.html
Oklahoma State Department of Health
Chronic Disease Service
1000 N.E. 10th St
Oklahoma City, OK 73117
(405) 271-4072 or Toll Free: 1-888-669-5934

Adeline Yerkes, RN, M.P.H.
Chief, Chronic Disease Service
Program Director, Oklahoma Central Cancer Registry
(405) 271-4072

Charlotte Murphy, RHIA, CTR
Program Coordinator, Oklahoma Central Cancer Registry
(405) 271-4072 ext. 57119

OKLAHOMA CENTRAL CANCER REGISTRY STAFF

(405)-271-4072
Fax: (405) 271-6315
Toll Free: 1-888-669-5934

Janis Campbell, PhD
Principal Investigator: ext. 57129
janisc@health.ok.gov

Charlotte Murphy, RHIA, CTR
Program Coordinator: ext. 57119
charlotr@health.ok.gov

Paula Marshall, BBA, CTR
Data Manager: ext. 57121
paulam@health.ok.gov

Cheryl Lucas, BA, CTR
Quality Assurance/Compliance Manager: ext. 57122
cheryl@health.ok.gov

Bonnie Connelly, CTR
Western Regional Consultant: ext. 57124
bonniemc@health.ok.gov

Darla Dennis, CTR
Follow-up Consultant: ext. 57125
darlad@health.ok.gov

Judy Hanna, HT (ASCP)
Pathology Laboratories Consultant: ext. 57118
judy@health.ok.gov

Gwen Filler, RMA
Ambulatory Surgery Center Consultant: ext. 57120
gwendolynf@health.ok.gov

Dana Lloyd, RHIA, CTR
Treatment Consultant: ext. 57151
danal@health.ok.gov

Delores Greene, CTR
Eastern Regional Consultant: ext. 57103
deloresg@health.ok.gov

Leslie Dill
Medical Record Consultant: ext. 57106
leslied@health.ok.gov

THE OKLAHOMA CENTRAL CANCER REGISTRY CODING MANUAL

OKLAHOMA STATE DEPARTMENT OF HEALTH

This manual provides instructional information to help your facility meet the requirements to comply with the Oklahoma State law to report all cancer diagnosed or treated in your facility.

Volume I is a step-by-step process for establishing and administering a reporting cancer registry in your organization.

Volume II is a step-by-step process for completing a cancer case **Abstract** using the Rocky Mountain Cancer Data Systems software or the Oklahoma Cancer Reporting on the Web (OCROW) application for reporting. It addresses both NAACCR and COC data requirements.

The Oklahoma Central Cancer Registry provides Rocky Mountain Cancer Data Systems (RMCDS) for data reporters to use. Chapters 12 – 19 describe the reporting format. The FORDS requirements are coded in **blue** if they differ from the NAACCR requirements.

A **Data Reporting Appendage** to the FORDS manual is included. It compares all the data elements to meet NPCR, COC and Oklahoma requirements.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS 2
OKLAHOMA STATE DEPARTMENT OF HEALTH 3
OKLAHOMA CENTRAL CANCER REGISTRY STAFF 4
TABLE OF CONTENTS 6
DATA ITEM LISTING & FORDS APPENDAGE 12
ACRONYMS USED 20
ACRONYMS NO LONGER IN USE 21
WORDS COMMON TO DATA REPORTING 22
INTRODUCTION 24
Compliance 25
STANDARDS FOR CONFIDENTALITY, DISCLOSURE OF DATA AND DATA QUALITY 26
Confidentiality & HIPAA 26
Disclosure Of Data 26

Quality Assurance 26
VOLUME I - ADMINISTRATION OF A CANCER REGISTRY 28
CHAPTER 1 - SETTING UP A REGISTRY 29
Getting Started 29
The Function of A Cancer Registry 29
Training 30
CHAPTER 2 - REFERENCE MATERIAL REQUIRED FOR DATA REPORTING 31
Additional Helpful References 33
CHAPTER 3 - CASES AND CASEFINDING 35
Reportable Malignant Case Requirements 35
Non-Malignant Central Nervous System (Benign Brain Tumors) Case Reporting Requirements .36
Reportable-By-Agreement 38
Comprehensive Reportable List 38
Cases Not Required To Be Accessioned 42
Multiple Primaries 46
Primary Site Differences 47
Morphology/Histology Differences 49
Single Primaries 50
Timing 51
Casefinding Methods 51
Casefinding Resources 52
Casefinding Process 54
Casefinding Quality Assurance 55
CHAPTER 4 - RECORDKEEPING 56
Suspense List 56
Accession List 56
Patient Index File 56
Non-Reportable Cases Log 57
Filing 57
CHAPTER 5 - CONFIDENTIALITY IN REPORTING 58
Submitting Patient Data To OCCR 58
Facility Electronic and OCROW Web-Based Cancer Reporting 58
State Personnel Confidentiality Policies 59
State Computer Security 59
Handling of Data In The Field 60
State Information Requests 60
State Release of Information 61
CHAPTER 6 - REPORTING PREPARATION 62
To Whom And When To Report 62
Data Reporting Requirements 62
Cancer Data Reporting Schedule 63
OCROW Reporting 63
OCCR Data Submission Instructions 64
Quality Control 64
Software Updates ....6**Error! Bookmark not defined.**

CHAPTER 7 - ACCURACY OF TRANSMISSION 77
State Confirmation/Error Identification 77
CHAPTER 8 - DATA CORRECTION FOR REPORTED ABSTRACTS 78
Changing Data You Have Reported 78
When And How The Data Can Be Changed 78
Submitting Data Corrections To The State 78
CHAPTER 9 - OCCR DATA QUALITY CONTROL 79
Internal Review 79
Monthly Letter Of Acknowledgement 79
Quarterly Compliance Letter 79
Annual Report 80
Cancer Death Clearance Report 80
Internal Data Review 80
External Review 81
State Data Exchange 86
OCCR “Case Completeness And Data Quality Audit” 81
CHAPTER 10 - FOLLOW-UP 83
When To Follow 83
Whom To Follow 83
How To Do Follow-Up 83
Follow-Up Resources 84
Division of Vital Records 84
State Registry 84
RMCDS Follow-up Letter Instructions 85
Follow-up Letters and Worksheets 85
Re-Exam Worksheets 86
VOLUME II CANCER CASE ABSTRACTING 88
CHAPTER 11 - CODING INSTRUCTIONS FOR A HOSPITAL ABSTRACT 89
Completion Date For Cancer Case Abstract 89
Overview 90
Data Reporting Requirements 90
Abstracting in OCROW 95
Coding Clues - (Learning From Others) 107
Setting Up Your System 109
Adding Physicians To Your Program 118
Open An Abstract 121
Open Cases From A Subset 123
Other Functions 123
The Abstract Program 125
Abstract Screen Navigation And Control 133
Running Error Checks For An Abstract 136
Print An Abstract 137
Case Search 138
Deleting/Undeleting A Case In RMCDS 142
Compare Two Abstracts 144
CHAPTER 12 - ABSTRACTING 146

Using the Abstract Program 148
RMCDS Screens For Abstracting Data 151
Abstracted By (S-OK) 163
Date of First Admit/ First Contact (R) 163
Type of Reporting Source (R) 164
Accession Number Or Registry Number (S) 165
Sequence Number (S) 166
Tumor Record Number (R) 168
Medical Record Number (S) 168
Social Security Number (R) 169
CHAPTER 13 - ENTERING PATIENT INFORMATION 170
Name-Last (R) 170
Name-First (R) 170
Name-Middle Or Initial (R) 171
Address At Diagnosis-No. & Street (R-OK) 171
Address At Diagnosis-City/Town (R) 173
Address At Diagnosis -State And Territory Code (R) 173
Address At Diagnosis - Zip Code (R) 174
Telephone Number (S-Ok) 175
Address Current - No. & Street (S-OK) 176
Address Current - City/Town (S-OK) 176
Address Current - State And Territory Code (S-OK) 177
Address Current - Zip Code (S-OK) 177
Place of Birth (R) 178
Date of Birth (R) 178
Age At Diagnosis (R) 179
Race 1 Through Race 5 (R) 179
Spanish/Hispanic (R) 180
Sex (R) 183
Marital Status (S) 183
Primary Payer (S-OK) 184
Text - Usual Occupation (R-When Available) 185
Text - Usual Industry (R-When Available) 185
Family History of Cancer (R-OK) 18186
Tobacco Use (R-OK) 185
Alcohol History (R-OK) 185
CHAPTER 14 - ABSTRACTING CANCER INFORMATION 187
Cancer Identification 187
Class of Case (S) 187
Facility Referred From (S-OK) 188
Facility Referred To (S-OK) 189
Date of Initial Diagnosis (R) 189
Primary Site (R) 191
Guidelines For Four-Character Site Codes 191
Additional Guidelines For Coding Primary Sites 192
Laterality (R) 193

Histology Code & Behavior Code (R) 196
Handling Single Lesion Mixed/Multiple Morphology Same Behavior Code 198
Grade/Differentiation of Tumor (R) 199
Other Primary Tumor-Text (R-OK) 201
Other Pertinent Information -Text (R-OK) 201
Diagnostic Confirmation (R) 202
Tumor Size (S-OK) 203
Description of Tumor Size 205
Physician - Primary/Surgeon (R-OK) 205
Physician - Follow-Up (R-OK) 206
Physician - Managing (R-OK) 207
Physician 3 (R-OK) 207
Physician 4 (R-OK) 208
CHAPTER 15 - SEER SUMMARY STAGING 210
SEER Summary Stage 2000 (RH) 210
CHAPTER 16 - ABSTRACTING COLLABORATIVE STAGING 212
Changes In Abstracting Rules 212
How The Collaborative Staging System Works 213
Codes And Guidelines For Using The Collaborative Staging System 213
General Guidelines 214
Timing The Data Collection 214
CS Extension (R) 216
CS Lymph Nodes (R) 216
Regional Nodes Positive (S) 217
Regional Nodes Examined (S) 218
CS Metastasis At Diagnosis (R) 220
CS Site-Specific Factor 1 (RS) 220
CS Site-Specific Factor 3 (RS) 221
CS Version 1st 222
CS Version Latest (R) 222
CHAPTER 17 - ABSTRACTING TREATMENT DATA 224
First Course of Treatment 224
Date of Initial Treatment (R) 224
RX Summary-Surgery Primary Site (R) 225
RX Summary-Scope of Regional Lymph Node Surgery (R) 226
RX Summary-Surgery Other Regional /Dist RX Code (R) 227
Reason For No Cancer-Directed Surgery (R) 228
Radiation-Regional Treatment Modality (R) 229
Rx Summary - Radiation/Surgery Sequence (R) 230
Rx Summary - Chemotherapy (R) 231
Rx Summary - Hormone Therapy (R) 230
Rx Summary - BRM/Immunotherapy (R) 234
Rx Summary - Transplant And Endocrine Procedures (R) 235
Rx Summary - Other (R) 237
Rx Summary – Systemic/Surgery Sequence (R) 236
CHAPTER 18 - ABSTRACTING FOLLOW-UP DATA 240

Date of First Recurrence - (R-OK).....240
Date of Last Contact Or Date of Death (R).....241
Vital Status (R).....242
Cause of Death (R).....243
Place of Death (S-OK).....243
Type of First Recurrence Type-(R).....244
Cancer Status.....244
Following Registry - (R).....244
Follow-up Source (R).....245
Next Follow-up Source (R).....245
CHAPTER 19 - ABSTRACTING COMPLETION DATA.....246
Date Abstracted.....246
Data Review Guidelines.....246
APPENDIX A - REPORTING LAWS.....250
Federal Legislation.....250
Oklahoma Cancer Registry Reporting.....250
APPENDIX B - MULTIPLE PRIMARIES OF LYMPHATIC & HEMATOPOIETIC DISEASE.....258
APPENDIX C - SEER GEOCODES ALPHABETICAL LIST.....267
APPENDIX D - WEBSITES FOR THE CANCER REGISTRAR.....281
APPENDIX E - RMCDS COMPUTER SYSTEM REQUIREMENTS.....282

DATA ITEM LISTING

(Required Reportable Data Items)

DATA ITEMS REQUIRED BY OKLAHOMA, FORDS AND NAACCR (NPCR)

January 1, 2007

Not all the data items you may be able to report in your software will be found on this list. This is only a comparison of the three reporting specification systems for Oklahoma. The full listing (with the exception of the Oklahoma specific required data items) is in NAACCR beginning on page 55 in version 11.1. The location will change in more current versions.

These are the abbreviations **used** in this reportable list:

Blank **Not reportable**
S **Recommend to report**
***** **When available**
RS **Required site specific**
R **Required**
RH **Historically collected and currently transmitted**

These NAACCR codes **are not** used on this list:

. **No recommendation**
S+ **Supplementary/recommend**
T **Always transmitted**
**Central Registry Use**
RC **Collected by SEER from COC approved hospitals**
D **Derived by the computer**

DATA ITEMS REQUIRED BY OKLAHOMA, FORDS AND NAACCR (NPCR)

January 1, 2007

DATA ITEM IDENTIFICATION	OKLA	FORDS	NAACCR	NAACCR NUMBER
Accession Number	S	R	S	550
Sequence Number	S	R	S	560
Medical Record Number	R	R	R	2300
Military Medical Number		R		2310
Social Security Number	R	R	R	2320
Name - Last	R	R	R	2230
Name – Middle	R	R	R	2250
Name – First	R	R	R	2240
Name - Maiden	R		R	2390
Name – Alias	R		R	2280
Patient Address at Diagnosis – No. and Street	R	R	R	2330
Patient Address at Diagnosis-Supplemental…	R	R	R	2335

DATA ITEM IDENTIFICATION	OKLA	FORDS	NAACCR	NAACCR NUMBER
City/Town at Diagnosis	R	R	R	70
State at Diagnosis	R	R	R	80
Postal Code at Diagnosis	R	R	R	100
County at Diagnosis	R	R	R	90
Patient Address Current-Supplemental		R		2355
Patient Address Current - Number	S	R		2350
City/Town – Current	S	R		1810
State – Current	S	R		1820
Postal Code – Current	S	R		1830
Telephone	S	R		2360
Date of Birth	R	R	R	240
Birthplace	R*	R*	R*	250
Age at Diagnosis (derived by some software)	R	R	R	230
Race 1	R	R	R	160
Race 2	R	R	R	161
Race 3	R	R	R	162
Race 4	R	R	R	163
Race 5	R	R	R	164
Spanish Origin	R	R	R	190
Sex	R	R	R	220
Marital Status (Oklahoma follow up purposes)	S			150
Text - Usual Occupation	R*		R*	310
Text - Usual Industry	R*		R*	320
Family History of Cancer	R-OK			360
Tobacco History	R-OK			340
Alcohol History	R-OK			350
Primary Payer at Diagnosis	S-OK	R		630
Comorbidities and Complications #1		R		3110
Comorbidities and Complications #2		R		3120
Comorbidities and Complications #3		R		3130
Comorbidities and Complications #4		R		3140
Comorbidities and Complications #5		R		3150
Comorbidities and Complications #6		R		3160
Following Physician	S-OK	R		2470
Primary Surgeon	S-OK	R		2480
Physician #3 (Oncologist suggested)	S-OK	R		2490
Physician #4 (Radiologist suggested)	S-OK	R		2500
CANCER IDENTIFICATION				
Class of Case	R	R	R	610
Facility Referred From	S-OK	R		2410
Facility Referred To	S-OK	R		2420
Date of First Contact	R	R	R	580

DATA ITEM IDENTIFICATION	OKLA	FORDS	NAACCR	NAACCR NUMBER
Date of Initial Diagnosis	R	R	R	390
Tumor Size	S-OK	RH		780
Primary Site	R	R	R	400
Laterality	R	R	R	410
Histology	R	R	R	522
Behavior Code	R	R	R	523
Grade/Differentiation	R	R	R	440
Diagnostic Confirmation	R	R	R	490
STAGING				
Date of Surgical Diagnostic & Staging Procedure		R		1350
Surgical Diagnostic & Staging Procedure at This Facility		R		740
Clinical T		R		940
Clinical N		R		950
Clinical M		R		960
Clinical Stage Group		R		970
Clinical Stage (prefix/suffix Descriptor		R		980
TNM Clinical Staged By		R		990
Pathologic T		R		880
Pathologic N		R		890
Pathologic M		R		900
Pathologic Staging Group		R		910
Pathologic Stage (prefix/suffix) Descriptor		R		920
Staged By (pathologic stage)		R		930
SEER Summary Stage 2000	RH	R	RH	759
CS Tumor Size		R	S	2800
CS Extension	R	R	R	2810
CS Tumor Size Ext Eval		R	S	2820
CS Lymph Nodes	R	R	R	2830
CS Reg Node Eval		R	S	2840
CS Mets at DX	R	R	R	2850
CS Mets Eval		R	S	2860
CS Site-Specific Factor 1	RS	R	RS	2880
CS Site-Specific Factor 2		R	S	2890
CS Site-Specific Factor 3	RS	R	RS	2900
CS Site-Specific Factor 4		R	S	2910
CS Site-Specific Factor 5		R	S	2920
CS Site-Specific Factor 6		R	S	2930
CS Version 1st (2006 requirement)	R	R	R	2935
CS Version Latest (2006 requirement)	R	R	R	2936
TREATMENT				
Date of First Course of Treatment	R	R		1270

DATA ITEM IDENTIFICATION	OKLA	FORDS	NAACCR	NAACCR NUMBER
Date of First Surgical Procedure		R	S	1200
Date of Most Definitive Surgical Resection of Primary Site		R	S	3170
Surgical Procedure of Primary Site	R	R	R	1290
Surgical Procedure of Primary Site at This Facility		R		670
Surgical Margins of the Primary Site		R		1320
Scope of Regional Lymph Node Surgery	R	R	R	1292
Scope of Regional Lymph Node Surgery at This Facility		R		672
Surgical Procedure/Other Site	R	R	R	1294
Surgical Procedure/Other Site at This Facility		R		674
Date of Surgical Discharge		R		3180
Readmission to the Same Hospital Within 30 Days of Surgical Discharge		R		3190
Reason for No Surgery of Primary Site		R	S	1340
Date of Radiation Started		R	S	1210
Location of Radiation Treatment		R		1550
Radiation Treatment Volume		R		1540
Regional Radiation Treatment Modality	R	R	R	1570
Regional Radiation Dose: cGy		R		1510
Boost Radiation Treatment Modality		R		3200
Boost Radiation Dose: cGy		R		3210
Number of Treatments of This Volume		R		1520
Radiation/Surgery Sequence	R	R	R	1380
Date Radiation Ended		R		3220
Reason for No Regional Radiation Therapy		R	S	1430
Date Systemic Therapy Started		R	S	3230
Chemotherapy	R	R	R	1390
Chemotherapy at This Facility		R		700
Hormone Therapy	R	R	R	1400
Hormone Therapy at This Facility		R		710
Immunotherapy	R	R	R	1410
Immunotherapy at This Facility		R		720
Hematologic Transplant and Endocrine Procedures	R	R	R	3250
Date Other Treatment Started		R	S	1250
Other Treatment	R	R	R	1420
Other Treatment at This Facility		R		730
Pain Assessment		R		3260
Palliative Procedure		R		3270
OUTCOMES				
Date of First Recurrence	R	R	S	1860
Type of First Recurrence		R	S	1880

DATA ITEM IDENTIFICATION	OKLA	FORDS	NAACCR	NAACCR NUMBER
Date of Last Contact or Death	R	R	R	1750
Vital Status	R	R	R	1760
Cancer Status	S	R		1770
Place of Death	R		R	1940
Following Registry		R		2440
Follow-up Source		R		1790
Next Follow-up Source		R		1800
ADMINISTRATION				
Abstracted By	R-OK	R		570
Facility Identification Number	R-OK	R [ ]	S	538
Reporting Hospital ID	R	R	R	540
Archive FIN		R		3100
Over-ride Acsn/Class/Seq		R		1985
Over-ride Age/Site/Morhp		R	R	1990
Over-ride CoC-Site/Type		R		1987
Over-ride Site/Type		R	R	2030
Over-ride Histology		R	R	2040
Over-ride Leuk/Lymphoma		R	R	2070
Over-ride Site/Behavior		R	R	2071
Over-ride Site/Lat/Morph		R	R	2074
Over-ride HospSeq/DxConf		R		1986
Over-ride HospSeq/Site		R		1988
Over-ride Surg/DxConf		R	R	2020
Commission on Cancer Coding System-Current		R		2140
Commission on Cancer Coding System- Original		R		2150
Race Coding System-Current		R		170
Race Coding System-Original		R		180
Site Coding System – Current	R	R	R	450
Site Coding System – Original		R		460
Morphology Coding System-Current	R	R	R	470
Morphology Coding System-Original		R		480
ICD-0-2 Conversion Flag		R		1980
ICD-0-3 Conversion Flag		R	R	2116
TNM Edition Number		R		1060
RX Coding System Current	R	R	R	1460

DATA ITEMS NOT SUPPORTED BY FORDS

DATA ITEM IDENTIFICATION	OKLA	FORDS	NAACCR	NAACCR NUMBER
Name – Prefix		**X**		**2260**
Name – Suffix		**X**		**2270**
Name – Maiden	**R**	**X**	**R**	**2390**
Name – Alias		**X**		**2280**
Martial Status		**X**		**150**
County-Current		**X**		**1840**
Census Tract		**X**		**110**
Census Tract Coding System		**X**		**120**
Text – Usual Occupation	**R**	**X**		**310**
Text – Usual Industry	**R**	**X**		**320**
Family History of Cancer	**R**	**X**		**360**
Tobacco History	**R**	**X**		**340**
Date of Inpatient Admission		**X**		**590**
Date of Inpatient Discharge		**X**		**600**
Inpatient/Outpatient Status		**X**		**640**
Screening Date		**X**		**510**
Screening Result		**X**		**520**
Presentation of CA Conf		**X**		**650**
Date of CA Conference		**X**		**660**
Referral to Support Service		**X**		**1490**
Site of Distant Mets 1-3		**X**		**1090 1100 1110**
EOD – Extension		**X**		**790**
EOD – Lymph Node Inv		**X**		**810**
TNM Other T		**X**		**1000**
TNM Other N		**X**		**1010**
TNM Other M		**X**		**1020**
TNM Other Stage Group		**X**		**1030**
TNM Other Descriptor		**X**		**1050**
TNM Other Staged By		**X**		**1040**
Other Staging System		**X**		**1070**
Pediatric Staging System		**X**		**1130**
Pediatric Stage		**X**		**1120**
Pediatric Staged By		**X**		**1140**
Date of 1st Positive Bx		**X**		**1080**
Rx Summ/Hosp – Screen/Bx Proc 1-4		**X**		**742 743 744 745 1642 1643 1644 1645**
Rx Summ – Surgical Approach		**X**		**1310**
				NAACCR

CASE IDENTIFICATION	OKLA	FORDS	NAACCR	NUMBER
Rx Summ/Hosp-Number of Regional Lymph Nodes Removed		X		**676 1296**
Rx Summ – Reconstruct 1st		X		**1330**
Rx Summ/Hosp Radiation		X		**690 1360**
Rad – Elapsed Rx Days		X		**1530**
Rad – Intent of Treatment		X		**1560**
Rx Summ – Rad to CNS		X		**1370**
Rad – Rx Completion Status		X		**1580**
Rad – Local Control Status		X		**1590**
Rx Date – Chemo		X		**1220**
Chemotherapy 1, 2,3, 4		X		**1600 1610 1620 1630**
Reason For No Chemo		X		**1440**
Rx Date – Hormone		X		**1230**
Reason For No Hormone		X		**1450**
Rx – Date BRM		X		**1240**
Protocl Eligibility Stat		X		**1470**
Protocol Participation		X		**1480**
Recurrence Type – 1st – Other		X		**1890**
Sebsq Rx 2rd 3rd 4th Course Date		X		**1660 1680 1700**
Subq Rx 2nd 3rd 4th Course (Surg, Reg Ln Rem, Scope N Su, Surg Oth, Rad, Chemo, Hormone, BRM, Other)		X		**1671 1672 1673 1674 1675 1676 1677 1679 1691 1692 1693 1694 1695 1696 1697 1698 1699 1711 1712 1713 1714 1715 1716 1717 1718 1719**
Recurrence Distant Site 1-3		X		**1871 1872 1873**
Subsq Rx – Reconstruction Del		X		**1741**
Quality of Survival		X		**1780**
Unusual Follow-up Method		X		**1850**
Cause of death		X		**1910**
ICD Revision Number		X		**1920**
Autopsy		X		**1930**
Type of Reporting Source		X		**500**
				NAACCR

CASE IDENTIFICATION	OKLA	FORDS	NAACCR	NUMBER
Tumor Marker 1- 3		**X**		**1150 1160 1170**
Year First Seen This CA		**X**		**620**
SEER Summary Staging 1977		**X**		**760**
Reporting Hospital FAN		**X**		**538**
Physician Managing	**R**	**X**	**R**	**2460**

The International Classification of Diseases for Oncology, Third Edition (ICD-0-3) must be used for coding primary cancer site (topography), cell type (morphology) and grade of tumor information for all cases **diagnosed/admitted** on **January 1, 2001 and forward.** These cases must be reported in the NAACCR version 11 format and **must** include the newly required reportable data items.

The **SEER** Summary Staging Manual 2000 is used for cases diagnosed/admitted January 2001 and forward. This manual has detailed information regarding sites and site specific notes, coding guidelines, and anatomic drawings. **Summary Stage must include all the clinical and pathological assessments available through completion of surgery (ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.**

NOTE: Non-analytical cases with an unknown diagnosis date should be coded based upon the admission date.

ACRONYMS USED

The following acronyms are used in this manual or are commonly used terms in the cancer registry field.

ACoS	American College of Surgeons
ACS	American Cancer Society
AJCC	American Joint Committee on Cancer
DRG	Diagnostic Related Group
DVR	Division of Vital Records
CA	Cancer
CDC	Centers for Disease Control and Prevention
COC	Commission on Cancer (of the American College of Surgeons)
CCR	Central Cancer Registry
CTR	Certified Tumor Registrar
DOH	Department of Health
EDITS	Exchangeable-edits, Data-dictionary and Information Translation Standard
EOD	Extent of Disease
FIPS	Federal Information Processing System
FORDS	Facility Oncology Registry Data Standards, Revised for 2004 (Manual from ACoS)
HIPAA	Health Insurance Probability and Accountability Act
ICDO, ICD-0-1 ICD-0-2, ICD-0-3	International Classification of Diseases for Oncology, Third edition, 2000 (Replacement for 1st and 2nd editions, respectively)
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
NAACCR	North American Association of Central Cancer Registries

ACRONYMS USED

NCDB	National Cancer Data Base
NCI	National Cancer Institute
NCRA	National Cancer Registrars Association
NIH	National Institutes of Health
NPCR	National Program of Cancer Registries (of the CDC)
OCCR	Oklahoma Central Cancer Registry
OCRA	Oklahoma Cancer Registrars Association
OCROW	Oklahoma Cancer Reporting on the Web
RMCDS	Rocky Mountain Cancer Data System (data management software available for reporting to OCCR)
SEER	Surveillance, Epidemiology and End Results (National Cancer Institute Program)
TNM	Tumor, Nodes, Metastasis (staging)

ACRONYMS NO LONGER IN USE

DAM	Data Acquisition Manual (manual of ACoS used prior to 1998)
ROADS	Registry Operations and Data Standards (manual of ACoS used 1998 thru 2002)

WORDS COMMON TO DATA REPORTING

Abstract - The format in which data is reported for each patient

Cancer Disease – a general term frequently used to indicate any of various types of malignant neoplasms, most of which invade surrounding tissues, may metastasize to several sites, and are likely to recur after attempted removal and to cause death of the patient unless adequately treated; especially, any such carcinoma or sarcoma, but in ordinary usage, especially the former.

Clinic – Any licensed facility serving persons on an outpatient basis, which provides diagnostic services and/or treatment of cancerous diseases and precancerous conditions.

Diagnostic Services – Any service that entails the diagnosis of a cancerous disease or precancerous condition, including such services as those provide by Oncologists, Pathologists, Radiologists and Surgeons.

Facility & Hospital – Any licensed or certified medical facility or establishment that provides medical care on an inpatient or out-patient basis, diagnostic services and/or treatment of cancerous and precancerous conditions. (It is sometimes used interchangeably in this manual).

Histology – The microscopic description of the type of cells in the specimen examined pathologically. The components of the histology shall include but are not limited to: Morphology, Behavior, and Grade.

Hospital identifier – A unique code assigned to each hospital in the state, which serves to uniquely identify that hospital in the State Central Cancer Registry, to assure the proper assignment of cancer data to the correct hospital.

In Situ – Local, within the original place, or, a growth of abnormal cells which is detected in its anatomic site of origin.

Laboratory – Any accredited or certified laboratory that provides cytopathology services for defining the degree of abnormality of cells related to both cancerous and precancerous conditions.

Pathologist - A person licensed by the State who has board certification to carry out pathologic examination and performs scientific study of the nature of disease, its causes, processes, development, and consequences. This includes the study of the anatomic or functional manifestations of cancerous disease and precancerous conditions.

Physician – Any person who has completed a course of medical training, has received a degree and is licensed by the Oklahoma State Board of Medical Licensure or the Oklahoma Osteopathic Board of Examiners to practice medicine.

Precancerous Condition – Exhibiting a likelihood of becoming cancerous.

Registry – A computerized system for collecting and compiling cancer data in a standard format, with the functional ability to merge data from various sources and perform correlations between a variety of data

elements within the system. The registry is also designed to produce summary reports and statistical analysis reports from the data contained in the Registry.

Stage of Disease – Terms frequently used to describe stage of disease: localized (if limited to the primary site), regional (if the disease has spread to adjacent organs or tissues and/or regional lymph nodes), and distant (if the cancer has spread to distant organs or nodes.)

TNM – The summary stage of a tumor, "T" means tumor, "N" means nodes and "M" means metastasis.

Treatment Services – Any type of treatment delivery for cancerous disease or precancerous conditions, performed in a medical facility on an out-patient or in-patient basis.

Tumorous – A circumscribed, non-inflammatory growth arising from existing tissue but growing independently of the normal rate or structural development of such tissue and serving no physiological function.

INTRODUCTION

The vehicle for capturing cancer data for the state of Oklahoma is the Oklahoma Central Cancer Registry (OCCR). In 2004, 2005 and again in 2006, OCCR received the highest level of certification available (Gold) from the North American Association of Central Cancer Registries. The certification is based on quality completeness and timeliness of data collected for 2001, 2002, and 2003. The data reporting entities within our state share in this accomplishment because of the quality and timeliness of their case reporting.

In 1992, the federal government found that approximately 38 of 50 states had established registries; many did not gather statewide data, and ten states had no cancer registry at all. Public Law 102-515 (Appendix A) was passed on October 24, 1992. The Centers for Disease Control (CDC) was authorized to disburse funding, by way of grants through the National Program of Cancer Registries (NPCR), to aid in the establishment and operation of State Cancer Registries, providing that prevention and early detection of cancer are best addressed by state health departments. NPCR is responsible for the accurate reporting of all cases of cancer. They monitor the timely reporting of the data and the quality of the information submitted. CDC conducts audits of the State Registries each five-year grant cycle to evaluate the accuracy of the number of cases reported, meeting the completeness requirements, and the quality of the data submitted by each state.

In 1987, the legislative body of Oklahoma recognized the need to address the issue of the burden of cancer in Oklahoma. They passed legislation under Oklahoma Statue Title 63 Public Health and Safety, Title 310, Chapter 567 establishing the Oklahoma Central Cancer Registry (OCCR) under the control of the State Commissioner of Health, Oklahoma State Department of Health - Chronic Disease Division. It mandates the inclusion of data in the registry that is necessary for epidemiologic surveys and scientific research, and other data necessary and proper to further the recognition, prevention, control, treatment and cure of cancer, precancerous and tumorous disease [OAC310:567 63O.S. 1991 S1-1551.1 and 1-552] (Appendix A). The statute did not provide funding for the registry. However, on 6-21-1994 under an emergency amendment, funding was added to implement the state cancer registry [(Source: Added at 11 Ok Reg. 3959 (emergency); Added at 12 Ok Reg 1691, eff 6-12-95; Amended at 14 Ok Reg. 250, eff. 11-5-96 thru 7-14-97 (emergency); Amended at 14 Ok Reg 3138, eff 07-25-97] (Appendix A).

It is mandatory to report all cancer cases diagnosed in Oklahoma. The Oklahoma Central Cancer Registry (OCCR) is a population-based cancer incidence reporting system that collects, analyzes and disseminates information on all new cases of cancer. This information is a valuable and essential tool in the identification of populations at high risk for cancer. The monitoring of cancer incidence trends will facilitate the development and evaluation of cancer control initiatives. The registry was originally started in 1995, with an official reference date for data submission established as January 1, 1997.

The data collected by the statewide cancer registry in Oklahoma enables researchers, policymakers and consumers to access incidence, prevalence and survival information. This in turn permits both private and public health agencies to study trends and develop cancer prevention and/or control programs that are based on reliable data.

The State registry can be reached by contacting 405-271-4072 or via internet at www.health.state.ok.us/program/cds/cancereg.html for help in reporting cancer cases to the state.

The content of this manual is based on guidelines and standards for cancer reporting established by the Center for Disease Control (CDC), North American Association of Central Cancer Registries (NAACCR), Surveillance, Epidemiology and End Results (SEER) program, and American College of Surgeons (ACoS).

COMPLIANCE

The Commissioner, under the rules of the State Board of Health, requires that hospitals, ambulatory surgery centers, free standing medical oncology clinics, free standing radiation oncology clinics, pathology laboratories, physician's or dentist's offices, or any facility providing diagnostic or treatment services, report to OCCR to be in compliance.

All facilities providing diagnostic and/or treatment services in relation to cancer disease or pre-cancerous conditions shall report all cancer cases (with the exception of basal cell and squamous cell carcinoma of the skin) within 180 days of diagnosis. Monthly reporting is a state requirement and is monitored by OCCR. Those complying with the Oklahoma reporting Act are protected from liability for furnishing the required information.

Questions regarding your facility's compliance should be directed (405) 271-4072 ext. 57122 at OCCR.

STANDARDS FOR CONFIDENTALITY, DISCLOSURE OF DATA AND DATA QUALITY

CONFIDENTIALITY & HIPAA

Article 5 of the Public Health Code under Oklahoma Statue Title 63 protects the identity of the patient and any physician identified in the data reported to the Oklahoma Central Cancer Registry. Written consent is required for release of confidential information. The Commissioner of Health may authorize release of information for research activity in the interest of public health and welfare. Those doing the research must protect the confidentiality of the patient. A researcher can request additional information or patient participation in research only by getting the physician's signature, and obtaining from the patient a completed "release of confidential medical information" form.

The Federal government addressed disclosure of confidential data within the Health Insurance Portability and Accountability Act of 1996 (HIPAA) enacted by Federal Public Law 104-191, and implemented beginning April 24, 2003. It provides access to protected health information without an individual authorization if required for the provision, coordination or management of health care, including consultation between providers regarding a patient, and referral of a patient by one provider to another. It also covers Health Care Operations that involve quality assessment and improvement activities, and authorizes the release of data sets for the purpose of research and public health. The exact law can be accessed on the Internet.

DISCLOSURE OF DATA

Since 2003 when HIPAA was implemented, public health reporting of cancer patient information to the Oklahoma State Health Department has been exempt from the HIPAA disclosure requirement. This law permits disclosures, without individual authorization, to public health authorities authorized by law to collect or receive information for the purpose of preventing or controlling disease including but not limited to public health surveillance, investigation and intervention [Federal Public Law 164.512 (b)].

State law stipulates that patient data may be shared with other registries, private or governmental, within or without the state, provided that a reciprocal data sharing agreement, approved by the Commissioner of Health, is implemented with that Registry.

QUALITY ASSURANCE

The OCCR closely follows the quality assurance procedures that have been established by the SEER Program, CDC recommendations, and NAACCR standards. These procedures consist of both internal and external processes to ensure the reliability, completeness, consistency and comparability of Oklahoma reported data.

When data is submitted to OCCR, it is processed through a set of edits to ensure that it meets accuracy standards. OCCR uses other resources, such as facility training, to continually improve the quality of Oklahoma data. These additional reviews are performed:

STATE DATA REVIEW:

- Audits: Casefinding
  - Re-abstracting Review
  - Death Clearance
- Race Verification – American Indian and Alaskan Native

CDC DATA REVIEW:

- Audit Review
- NPCR-CSS

VOLUME I – ADMINISTRATION OF A CANCER REGISTRY

CHAPTER 1 – SETTING UP A REGISTRY

This manual is written to give you a step-by-step process for implementing state reporting within your organization. The Oklahoma Central Cancer Registry (OCCR) is available to answer your questions and guide you in setting up your state reporting by calling (405)-271-4072.

GETTING STARTED

You have taken the first step toward reporting by reading this policy and procedure manual. The Central Registry will send a Facility Authorization Form to your facility to complete. Once it has been returned, OCCR will assign you a Facility Identification Number

THE FUNCTION OF A CANCER REGISTRY

A Cancer Registry is the organization resource that assures complete and accurate data is collected and maintained for all patients diagnosed and/or treated within a reporting entity. It is the registry's responsibility to identify new cancer cases, and collect diagnosis, treatment and follow-up information. The registry reports its information under approved guidelines so that the patient cancer data can be universally used for education, lifetime follow-up and research. Patient confidentiality is always protected.

The Central Cancer Registry uses the Rocky Mountain Cancer Data System (RMCDS) for the collection, management and analysis of data on patients with the diagnosis of a malignant or benign tumor that is required by law to be reported to the state. Other available data systems are compatible for downloading data to RMCDS. From the data input to these systems, an individual Patient Abstract is generated. This document will include all the required data elements that must be reported. Ultimately, this information is made available for local and national study in the hopes of reducing the effects of cancer and improving the early detection and treatment of cancer, while preserving the quality of life for those patients.

For many years, the basic document resource has been the patient's hospital medical record. Changes in patient health care options have made it important to require additional health care organizations to provide patient information on the diagnosis and treatment of their patients with cancer or reportable benign tumors. Physician offices, pathology laboratories, ambulatory surgery centers and free-standing clinics have been added to the hospital facility requirement for reporting cancer. These organizations may not have a separate department to handle reporting. Reporting offices may have only one person responsible for complying with the state law. Each reporting facility should provide the name, telephone number and email address of its contact person to OCCR. By Federal Law every facility should have an emergency email address in case of a national disaster. If there is no other email contact location, this would be the appropriate location to set up a response email address for OCCR to send information to your facility.

The Oklahoma Central Cancer Registry (OCCR) has been established to monitor the reporting of all Oklahoma cases diagnosed with cancer. OCCR monitors timely reporting, information consistency, and data quality before transmitting to the Center of Disease Control for use in evaluating and increasing knowledge about cancer. OCCR is your resource for establishing your registry, receiving training to help

with your data submission, monitoring the quality of the data, updating you on new data requirements, and a continued available resource. They can be reached at 405-271-4072.

Volume I covers the specific administration requirements for a cancer registry and for submitting date to OCCR... Volume II covers the specific steps to complete the patient **Abstract.**

TRAINING

Free training is available by contacting OCCR. The one-day training is designed to enhance knowledge in data collection, skills in the use of the manuals, and an understanding of correctly reporting patient information to OCCR. The current training schedule is available on the OCCR website http://www.health.ok.us/program/cds/cancereg.html or by calling OCCR at (405)-271-4072.

Additional web based training is available by downloading training modules accessible at these sites:
http://www.naaccr.org
http://www.SEER.cancer.gov

The Oklahoma Cancer Registrars Association (OCRA) is a non-profit state organization whose main goal is education of its members and promotion of awareness and professional growth in the cancer registry profession. OCRA sponsors a one-day educational conference in the spring and a two-day workshop in the fall. These conferences are held to increase the knowledge of oncology data management with lectures and scenario exercises. The conference speakers are registrars, physicians and national speakers in the field of oncology. The organization distributes a quarterly newsletter and updates the membership on changes occurring in the registry field as well as sponsoring CTR workshops for members preparing for certification. OCRA serves as an excellent networking tool for the members. Visit the website http://ww.ocra-ok.org/.

Appendix D lists an assortment of web sites that have been handed out over the year as an additional resource. The availability of these sites has not been validated.

CHAPTER 2 –REFERENCE MATERIAL REQUIRED FOR DATA REPORTING

Below is a listing of the reference material to obtain in preparation for reporting. Most of them can be ordered on the Internet. Some are free and some are not. Each reference here lists the document sections you will be using to abstract your cases. If there is not a specific section, the whole reference will be needed. Refer to the web site listed to see what is available. Many web sites provide training, additional resources to reference while abstracting, and links to other resources.

1. **Oklahoma Central Cancer Registry Coding Manual** (free)
   (Updated 11/2/2006)

   Contact: OCCR http://www.health.ok.gov/ Telephone (405) 271-4072

2. **Facility Oncology Registry Data Standards** (FORDS)
   (Revision for 2004 data collection)

   Sections to Reference:
   Section One – Case Eligibility, Cancer Identification and Overview of Coding Principles

   Section Two – Coding Instructions
   Appendix A – Definition of single and subsequent primaries

   Appendix B – Site-specific surgery codes

   Contact: Commission on Cancer (COC) Publications
   http://www.facs.org/cancer/index.html Telephone (312) 202-5401
   Free to download or can be purchased. (Notices of current errata will be published in the OCCR quarterly newsletter.)

3. **AJCC Cancer Staging Manual, 6th Edition** – American Joint Committee on Cancer
   Published in 2002 [ISBN: 0-387-95271-3] (a charge)
   (Used by accredited COC cancer programs)

   Contact: Springer-Verlag
   http://www.cancerstaging.net Telephone: 1-800-SPRINGER

   Updates to these manual and other pertinent resources are available on the website http://www.cancerstaging.org under products/ajccproducts.html.

4. **NAACCR Data Standards and Data Dictionary**
   Standards for Cancer Registries, Volume II,
   Eleventh Edition, Record Layout version 11.1 (2007 data collection)

Contact: North American Association of Central Cancer Registries (NAACCR) Manuals
http://www.naaccr.org Telephone (217) 698-0188
It can be downloaded from the web site.

5. **International Classification of Diseases for Oncology, Third Edition**
(ICD-03) published in 2000

Sections to Reference:

First Section
The introduction and the guidelines are helpful when you're coding the cancer diagnosis.

Second Section
Topography (site) codes listed numerically (Pages 45 – 68)

Morphology (histology) codes listed numerically (pages 69-104)

Third section
Topography Codes and Morphology codes indexed alphabetically (pages 105-218)

Contact: World Health Organization
www.who.int./classifications/icd/adaptactions/oncology/en/ (for a printable version)
or purchase at bookorders@who.int.

SEER Program Manuals (free)
The references Number 6 thru 9 can be downloaded or ordered from the SEER (Surveillance Epidemiology and End Results) website. SEER has an excellent on-line training program. The contact information for SEER is listed below.

6. **SEER Program Coding and Staging Manual 2004** [No. T-691] Pub. No. 04-5581
For abstracting cases after January 1, 2004. – (compact disk)
(Replaces the SEER Program Code Manual, Third Edition)

This book provides the codes and coding instructions for the data items required by SEER for cases diagnosed January 1, 2004 and forward.

7. **SEER Summary Staging Manual - 2000** [No. T-880] Pub. No. 01-4969

It is arranged by anatomical site, corresponding with the ICDO-3 coding scheme, and comprised of specific staging schemes, starting with the oral cavity. (also included on the SEER Manuals CD)

8. **SEER Self-Instructional Manuals for Tumor Registrars** (free compact disk)

Book One thru Book Eight are designed to provide the new registrar the information needed to understand what is required for cancer reporting. All volumes are on one CD.
These manuals cover:

Book One: Objectives and Functions of Cancer Registries
Book Two: Cancer Characteristics and Selection of Cases
Book Three: The Composition of Medical Terms
Book Four: Human Anatomy as Related to Tumor Formation
Book Five: Abstracting a Medical Record: Patient Identification, History and Examinations
Summary Staging Guide: Cancer Surveillance Epidemiology and End Results Reporting
Book Seven: Statistics and Epidemiology for Cancer Registries
Book Eight: Anti-neoplastic Drugs
Summary Staging Manual 2000: Codes and Coding Instructions

9. **Collaborative Staging Manual and Coding Instructions**
(Version 1.03.000) Version date: September 8, 2006 [No. T-999] Pub. No. 04-5496

The consolidation of multiple staging plans into one process. This started January 2004.

10. **Rocky Mountain Cancer Data Systems (RMCDS) Software**
Free – Make request from OCCR – (405) 271-4072

Software is available to be used to abstract and submit data.

11. **A good Medical Dictionary**

ADDITIONAL HELPFUL REFERENCES

International Classification of Diseases (ICD-9, the 9th Revision)
International Classification of Diseases (ICD-10, the 10th Revision)
From the World Health Organization – your Health Information (Medical Records) Dept will have this information. A conversion manual is also available

COLLABORATIVE STAGE INDEX DIVIDERS – Generic index dividers are available from OCCR for Oklahoma data reporters. A color-coded version with very helpful additional material included may be available from www.lcrs.usa.org

A Good Anatomy Book

Workbook for Staging Cancer –
NCRA publication www.ncra-usa.org

Cancer Registry Management: Principles & Practice
Second edition: 2004
It provides valuable information to hospitals and outpatient treatment centers on how to set up and maintain a Cancer Registry.

Contact: download order form (PDF 2.2MB) or calling (800) 228-0810 or visit http://www.kendallhunt.com.

Professional Review for Cancer Registrars – a Study Guide
Published by the Florida Cancer Registrars Association, Fourth Edition – order on-line at www.fcra.org.

CTR Examination Preparation Manual
Cancer Registry of Northern California
Contact:
Judy Viegas, CTR
Cancer Registry
St. Joseph Hospital
Eureka, CA 95501 (707) 269-4242
Northern - California Cancer Registrars Association
Email:Judy.viegas@stjoe.org
Update to cover 2003 changes Cost in 2005 $57.00 Includes shipping

Education Seminars
Oklahoma Central Cancer Registry
Oklahoma Cancer Registrars Association – Spring/Fall
American College of Surgeons
National Cancer Institute - Basic Registry Training

CHAPTER 3 – CASES AND CASEFINDING

This chapter is an in-depth reference for determining case eligibility for reporting all your cases. Linked to case eligibility is casefinding which is a systematic method used to identify all the cases that **must** be reported if they fall within the eligible cancer reporting category.

When using this manual, if there is any doubt on how to code your information, the reference for case eligibility can be found in NAACCR Chapter III (Standards for Tumor Inclusion and Reportability), FORDS (Case Eligibility in Section One) and SEER. The different written approaches can help lessen reporting bewilderment. Your software should be able to guide you or you can contact OCCR.

Oklahoma statute requires that all hospitals, clinics, laboratories, pathologists, physicians, dentists, or facilities providing diagnostic or treatment services in relation to cancer must submit an Abstract for each reportable diagnosis or initial treatment of cancer to OCCR. This includes Ambulatory Surgery Centers, Free Standing Clinics, Oncology Clinics, and Free Standing Radiation Oncology Clinics. The requirement includes the first course of treatment and subsequent courses of treatment, recurrences, continuous follow-up and death. [OAC 310:567-3-2]

REPORTABLE MALIGNANT CASE REQUIREMENTS

These are the reportable malignant cases:

- Malignancies with an ICD-0-3* behavior code of 2 or 3 (in situ and malignant) must be reported for all sites. (See exceptions)
- Benign and borderline neoplasms of central nervous system
- Carcinoma in-situ (see exceptions)
- Carcinoid, NOS (excluding Appendix, unless stated to be malignant)
- Pilocytic/juvenile astrocytoma listed as 9421/1 (see coding under exceptions)

**Fritz, A. Perry C. Jack A, et al (eds): ICD-0: International Classification of Disease for Oncology, Third Edition. Geneva, World Health Organization, 2000*

The reporting rule exceptions are:

EXCEPTION: 1: Juvenile astrocytoma, pilocytic astrocytoma, or piloid astrocytoma listed with a behavior code of 1 (border line) coded as 9421/1 in ICD-0-3, is **required** and should be recorded as 9421/3 when abstracted into the registry.

EXCEPTION: 2: Malignant skin primaries (C44) are reportable with the exception of squamous cell and basal cell carcinoma of the skin *8000-8110 which are not required.

NOTE: The ACoS requirement to report (8000-8110) AJCC stage II, III or IV was dropped.

EXCEPTION: 3: Squamous intraepithelial neoplasia grade III of vulva, Carcinoma in situ of the

cervix (CIS) and cervical intraepithelial neoplasia grade III (8077/2, CIN III), and prostatic intraepithelial neoplasia (PIN III), vulvar intraepithelial neoplasia (VIN III), vaginal intraepithelial neoplasia (VAIN III), and anal intraepithelial neoplasia (AIN III) have not been required since 2001**.**

Reportable skin tumors such as adnexal carcinoma (e.g., carcinomas of the sweat gland, ceruminous gland and hair follicle), adenocarcinomas, lymphomas, melanomas, sarcomas and Merkel cell tumor **must be reported regardless of site.**

Any carcinoma arising in a hemorrhoid is reportable since hemorrhoids arise in mucosa, not in skin.

All neoplasms of genital sites **are reportable.** These sites include: Vagina, clitoris, vulva, prepuce, penis and scrotum.

Evolution of reporting over time can change a neoplasm from reportable to borderline and from borderline to reportable. It is important to reference the ICD-O-3 to be sure you are reporting correctly.

You should evaluate all pathology reports for inpatient or outpatient cases that have either a clinical or pathologic diagnosis of cancer. As you get further into evaluating a case, you may find a patient has had surgery after a biopsy, and there is no cancer reported on your pathology report. This is still a reportable case because the surgery is part of "first course of treatment". This is explained later in this chapter.

OCCR is required to collect data on persons who are diagnosed with cancer who, at the time of diagnosis, are **residents** of the geographic area covered by the Statute OS 63-1-551.1. Cases diagnosed on or after January 1, **1997** are reportable to OCCR. Facilities that opened after 1997 have different reporting start dates.

There is no provision in the law to exclude any cases designated by class, nor does state statute reference, (and certainly does not exclude), anything called a "nonanalytic case".

NON-MALIGNANT CENTRAL NERVOUS SYSTEM (BENIGN BRAIN TUMORS) CASE REPORTING REQUIREMENTS

The Benign Brain Tumor Cancer Registries Amendment Act, public Law 107-260, requires programs participating in the National Program for Cancer Registries (NPCR) to collect data on benign and borderline tumors of the central nervous system in addition to the previously required data on malignant tumors. On January 1, 2004 this became a reporting requirement. NCI, SEER, and ACoS supported this change.

Report non-malignant primary intracranial and central nervous system tumors with a behavior code of /0 or /1 (benign, borderline or "non-malignant") in ICD-0-3* regardless of their histologic type or topography.

These are the primary tumor sites required:

- meninges (C70.0-C70.9)
- brain (C71.0-C71.9)

- spinal cord (72.0)
- cauda equine (72.1)
- cranial nerve or nerves (C72.2-C72.5)
- pituitary gland (C75.1)
- craniopharyngeal duct (75.2)
- pineal gland (75.3)

AMBIGUOUS TERMS

Ambiguous words make it difficult to determine reportability of cases. These terms are used only as a last resort in determining reportability. The entire medical record and any treatment resources should be reviewed before determining reportability by an ambiguous term. Ultimately, you may need to contact the physician to make the final decision as to a case being reportable.

The listing of ambiguous terminology (vague or inconclusive diagnostic language) can be an easy reference for evaluating cases.

LIST OF AMBIGUOUS DIAGNOSTIC TERMS

Terms Confirming of a Cancer Diagnosis

Adherent	Induration
Apparent (ly)	Infringe/infringing
Appears to	Into*
Comparable with	Malignant appearing
Compatible with (for)	Most likely
Consistent with (beginning with Diagnoses only for: C70.0-C72.9, C75.1-C75.3)	Neoplasm (beginning 2004) (only for C70.0-C72.9, C75.1-C75.3)
Contiguous/continuous with	Onto*
Encroaching upon*	Overstep
Extension to, into, onto, out onto	Presumed
Favors	Probable
Features of	Protruding into (less encapsulated
Fixation to another structure**	Suspicious
Fixed**	To*
Impending perforation of	Tumor**(beginning 2004) (only for C70.0-C72.9, C75.1-C75.3)
Impending upon	Typical of
Impose/imposing on	Up to
Incipient invasion	

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

**** Interpreted as involvement of other organ or tissue**

**Fritz, A. Perry C. Jack A, et al (eds): ICD-0: International Classification of Disease for Oncology, Third Edition. Geneva, World Health Organization, 2000*

** Additional terms only for non-malignant primary intracranial and central nervous system tumors

***American Joint Committee on Cancer (Chicago, IL) and U.S. Department of Health and Human Services (Bethesda, MD) Collaborative Staging Manual and Coding Instructions

Some terms have been determined to **not** constitute a diagnosis of cancer.

LIST OF AMBIGUOUS DIAGNOSTIC TERMS

Terms That *Do Not* Constitute a Diagnosis Without Additional Information

Abuts	Equivocal
Approaching	kiss/kissing
Approximates	matted (except for lymph nodes)
Attached	Possible
cannot be excluded/ ruled out	potentially malignant
efface/effacing/'effacement	Questionable
encased/encasing	Reaching
encompass (ed)	rule out
Entrapped	Suggests
Equivocal	very close to
extension to without invasion/involvement of	Worrisome

EXCEPTION: If cytology is reported as *suspicious*, do ***not*** interpret it as a diagnosis of cancer. These cases should not be abstracted unless a positive biopsy is done or the physician's clinical impression supports the cytology findings to represent cancer.

NOTE: When modifying terms are used with ambiguous words to determine or not determine a diagnosis of cancer, drop the modifying term and refer to the guidelines above.

REPORTABLE-BY-AGREEMENT

A Hospital Cancer Committee may request the collection of information about tumors that are not required by approved programs or state reporting. The facility will set its own requirements, and the cases do not have to be reported to the state.

Example: Your facility may want to assess all cases to determine revenue generated by your facility for the treatment of cancer.

COMPREHENSIVE REPORTABLE LIST

This ICDO-9-CM cancer-screening code list is included to help you or the person you have designated to develop your reportable list. By using this list, you can start your initial casefinding process.

Updates for reporting will be sent out by OCCR when the manual is updated, and can also be found on the OCCR website www.health.state.ok.us/program/cds/cancereg.html or the SEER website training.seer.cancer.gov/module_casefinding/casefinding_home.html.

OKLAHOMA REPORTABLE LIST

CANCER SCREENING LIST OF ICD-9-CM CODES FOR CASEFINDING	
CODE	**DESCRIPTION**
O42	AIDS (review cases for Aids-related malignancies)
140.0 – 208.9	Malignant neoplasms
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
210.0 – 229.9	Benign neoplasms
230.0 – 234.9	Carcinoma in situ
235.0 – 238.9	Neoplasms of uncertain behavior
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9734/3)
238.7	Chronic myeloproliferative disease (9961/3)
238.7	Myelosclerosis with myeloid metaplasia (9961/3)
238.7	Essential thrombocythemia (992/3)
238.7	Refractory cytopenia with multilineage dysplasia (9985/3)
238.7	Myelodysplastic syndrome with 5q-syndrome (9986/3)
238.7	Therapy-related myelodysplastic syndrome (9987/3)
239.0 – 239.9	Neoplasms of unspecified behavior
273.2	Gamma heavy chain disease; Franklin's disease
273.3	Waldenstrom's macroglobulinemia
273.9	Unspecified disorder of plasma protein metabolism (screen For potential 273.3 miscodes)
284.9	Refractory anemia (9980/3)
285.0	Refractory anemia with ringed sideroblasts (9982/3)
285.0	Refractory anemia with excess blasts (9983/3)
285.0	Refractory anemia with excess blasts in transformation (9984/3)
288.3	Hypereosinophilic syndrome (9964/3)
289.8	Acute myelofibrosis (9932/3)
V07.3	Other prophylactic chemotherapy (screen carefully for miscoded Malignancies)
V07.8	Other specified prophylactic measure
V10.0-V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries and/or subsequent treatment
V58.0	Admission for radiotherapy
V58.1	Admission for chemotherapy
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow-up
V67.2	Chemotherapy follow-up
V71.1	Observation for suspected malignant neoplasm
V76.0 –V76.9	Special screening for malignant neoplasia

The World Health Organization (WHO) diagnosis "B-cell chronic lymphocytic leukemia/small lymphocytic lymphomas" 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.
*International Classification of Diseases, Ninth Revision, Clinical Modification, U.S. Dept. of Health and Human Services, Public Health Service – Health Care Finance Administration; DHHS Publication No. (PHS) 80-1260

ICD-9-CM CASEFINDING CODES FOR BENIGN AND BORDERLINE INTRACRANIAL AND CNS TUMORS

ICD-9-CM CODE	DESCRIPTION OF NEOPLASM
225.0	Benign neoplasm of brain
225.1	Benign neoplasm of cranial nerves
225.2	Benign neoplasm of cerebral meninges; cerebral meningioma
225.3	Benign neoplasm of spinal cord, cauda equina
225.4	Benign neoplasm of spinal meninges, spinal meningioma
225.8	Benign neoplasm of other specified sites of nervous system
225.9	Benign neoplasm of nervous system, part unspecified
227.3	Benign neoplasm of pituitary, craniopharyngeal duct, craniobuccal pouch, hypophysis, Rathke pouch, sella turcica
227.4	Benign neoplasm of pineal gland, pineal body
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 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 disease
237.71	Neurofibromatosis, Type One Von Recklinghausen disease
237.72	Neurofibromatosis, Type Two Von Recklinghausen disease
237.9	Neoplasm of uncertain behavior of other and unspecified part of nervous system; cranial nerves

PRIMARY SITE CODES FOR NON-MALIGNANT PRIMARY INTRACRANIAL AND CENTRAL NERVOUS SYSTEM TUMORS

	TOPOGRAPHY
Codes	**Description**
	Meninges
C70.0	Cerebral Meninges
C70.1	Spinal meninges
C70.9	Meninges, NOS
	Brain
C71.0	Cerebrum
C71.1	Frontal lobe
C71.2	Temporal lobe
C71.3	Parietal lobe
C71.4	Occipital lobe
C71.5	Ventricle, NOS
C71.6	Cerebellum, NOS
C71.7	Brain stem
C71.8	Overlapping lesion of brain
C71.9	Brain, NOS
	Spinal Cord, Cranial Nerves, and Other Parts of the Central Nervous System
C72.0	Spinal cord
C72.1	Cauda equine
C72.2	Olfactory nerve
C72.3	Optic nerve
C72.4	Acoustic nerve
C72.5	Cranial nerve, NOS
C72.8	Overlapping lesion of brain and central nervous system
C72.9	Nervous system, NOS
	Other Endocrine Glands and Related Structures
C75.1	Pituitary gland
C75.2	Craniopharyngeal duct
C75.3	Pineal gland

CASES NOT REQUIRED TO BE ACCESSIONED

- Patients who are seen in consultation to confirm a diagnosis or treatment plan.
- Patients who receive transient care to avoid interrupting a course treatment started elsewhere.

Admissions that are specifically related to cancer treatment **must** be screened for a reportable neoplasm. They may provide updated treatment information, corrections to information already reported and new reportable primaries.

ANALYTIC REPORTABLE CASES

Class of Case

Class 0	**Diagnosed at the reporting facility and all of first course of treatment was performed elsewhere.** ***Cases include:*** • Patients who choose to be treated elsewhere. • Patients referred elsewhere for treatment due to lack of special equipment; proximity of a patient's residence to the treatment center; financial, social or rehabilitative considerations, etc.
Class 1	**Diagnosed at the reporting facility and had all or part of the first course of treatment at the reporting facility or was never treated at all.** ***Cases include:*** • Patients whose treatment plan is watchful waiting. • Patients refused any treatment • Patients who were untreatable due to age, advanced disease, or other medical conditions. • Specific therapy was recommended but not received at the reporting facility and it is unknown if therapy was ever administered. • It is unknown if therapy was recommended or administered. • Patients diagnosed but not treated at the reporting facility and all or parts of the first course of treatment was received at a staff physician's office. **"Staff physician"** refers to any physician with admitting privileges at the reporting facility. • Patients diagnosed and treatment plan developed and documented at the reporting facility. Therapy was delivered elsewhere in accordance with the treatment plan. **Note: ACoS** facilities should include cases in which patients are diagnosed at the reporting facility prior to the registry's reference date and all or part of the first course of treatment was received at the reporting facility after the registry's reference date.
Class 2	**First diagnosed elsewhere and treatment plan developed and/or the first course of treatment given at the reporting facility.** ***Cases included:*** • The reporting facility administered all or part of the first course of treatment. • The reporting facility developed and documented a treatment plan or made the management decisions.

NON-ANALYTIC CASES

Class of Case

Class 3	**First diagnosed and all of the first course of treatment administered elsewhere. Patients are seen at the reporting facility for additional therapy or management, and have active disease and/or are on cancer treatment** ***Cases include:*** • No information on first course of treatment. The patient is treated or managed at the reporting facility for an unrelated condition and has active disease and/or on cancer treatment. • The reporting facility is treating or managing the recurrence, progression, or

	subsequent treatment of a previously diagnosed malignancy. **NOTE:** If a facility does not deliver **any** of the first course of treatment, Class of Case is coded to 3. **Do not** code to 9
Class 4	**Patients who were first diagnosed and received their first course of therapy at the reporting facility BEFORE the registry's reference date. The reporting facility manages or treats a recurrence or progression of that cancer AFTER the registry's reference date.** ***Cases include:*** • Patients for whom the reporting facility manages or treats a recurrence or progression of disease after the reference date. • Patients for whom it is unknown whether the reporting facility delivered the first course of treatment prior to the reference date. **NOTE**: This class applies to ACoS facilities and/or facilities with a cancer program and reference date **only**.
Class 5	**First diagnosed at autopsy.** Prior to autopsy, there was no suspicion or diagnosis of cancer.
Class 6	**Diagnosed and the entire first course of treatment completed in a staff physician's office. Staff physician** refers to any physician with admitting privileges at the reporting facility.
Class 7	**Pathology report only.** Patient does not enter the reporting facility at any time for diagnosis or treatment **NOTE:** This category excludes cases diagnosed at autopsy.
Class 8	**Diagnosis established only by death certificate.** **Note:** Used by central registries **only.**
Class 9	**Unknown.** Sufficient detail for determining Class of Case is not stated in medical records. Unknown if previously diagnosed. Unknown if previously treated. Previously diagnosed, date unknown. **NOTE:** Used by central registries **only.**

If the patient is already in your database, an admission or re-admission may mean a second primary, a cancer treatment for an existing cancer or recurrence of the original primary. It is also a good resource for finding information that was not in the chart originally. See Chapter 8 –Data Correction for Reported Abstracts to correct information that has changed or been added since reported to the state.

The newly identified cancer cases should be checked against a list of patients already reported to OCCR. An Abstract should be completed for patients that have not been previously reported to OCCR. Sometimes, a case identified as new will be eliminated during the abstracting process when the chart information is reviewed and it does not meet the reportability guidelines.

Once it is determined that a case should be reported, the earlier you add the patient to your database the sooner your data becomes a useable tool, because you can create your own lists to support your work. When you do death review, you have an up-to-date list available identifying all the patients in your registry. The software can create your Accession List. It also gives you the ability to pull a Suspense List to monitor your workload, calculate your expected cases for the year and generate a report to monitor abstract completion within the 6-month reporting guideline for timely state reporting. These Lists are discussed under Chapter 4 – Recordkeeping of Reportable/Non-reportable Cases.

Many registry software providers have designed their programs to create a work list that can be set up in the same format used by your Medical Records Department to pull your charts. If you have already seen the chart, you can just cross it off your list to Medical Records. Some registries make arrangements to have the appropriate charts routed to the person reporting the cases to the state. Some find it helpful to stamp and place them on a shelf designated for the tumor registry. You must determine the best alternative for identifying your cases and how you want the charts pulled. Some software will automatically download information into your department for your review. You can review the chart on-line and quickly determine if it is reportable or goes on your Non-Reportable Case log.

If a case is added to your registry, and then it is determined that the case is not reportable, it can be deleted from your database. The number assigned should not be reused. It should be added to your non-reportable log.

As mentioned before, the most thorough Casefinding in the pathology department is having a copy of ALL pathology reports (both positive and negative) routed to the registry. This should also include all cytology, hematology, bone marrow biopsies and autopsies done in your facility or referred to another location for evaluation. Be sure that any outside consults or assessments are sent to you (i.e. ER/PR Her2Neu, verification of diagnosis). You can do a more thorough evaluation of the report, and fewer reportable cases will be missed. Build into your process a way to track reports to ensure that each report has been included in your review. Sometimes developing a monitoring system takes time.

If your facility has a radiation oncology department, a procedure must be developed to identify patients receiving radiation that includes ALL patients. Registries have devised many different solutions to do this. Some receive the initial visit evaluation, the beginning of treatment summary, the final treatment summary, or an office list of patients being treated. Sometimes their patients appear on the hospital disease index, and sometimes their records are generated from their separate files as part of the hospital record. Some registrars have access to the radiation oncology department daily appointment book or direct access to the office charts. Being creative and resourceful will help in finding new cases.

If you have a designated oncology/hematology unit, ambulatory unit or freestanding clinic where patients receive treatment for your facility, you should have the same type of tracking method as for other departments and should be able to pull reports for these patients. If not, you will need to create a process for finding these patients. Your oncology physicians may be located in your hospital or next to your hospital. Even if you do not use them for case identification, you may be able to get approval to access their records for treatment information. If you are an accredited cancer program, they are also a good resource for referral to protocols that are not usually reported in the medical chart.

It has been mentioned that daily scheduling lists in your facility are very beneficial for finding outpatient department, hematology clinic, laboratory, emergency room, nuclear medicine and diagnostic radiology and oncology departments. A method to identify reportable cases from these departments **must** also be established. Even their daily appointment books are a resource. If you are a one-person reporting office consideration of time allotment and department cooperation will make a difference in how you approach your solutions.

When reviewing additional admits to the hospital for tests or surgeries for previously reported cancer patients, consider that the visit may really be for a new primary or completion of planned first course of treatment. It could also be additional or corrective information on a previously reported case.

Understanding of what is reportable and what is non-reportable is very important. The use of a non-reportable log will save you many hours of research when people call and you do not have the patient in the registry. It will save you time when the central registry asks for clarification on a non-reportable case or does audit review. It will save you time when you do a final disease index at the end of the year to determine if all cases have been reported. This report is discussed under Chapter 4 - Record keeping of Reportable/Non-Reportable Cases.

Cases diagnosed and/or treated for cancer prior to admission **should be reported** if there is evidence of **active disease,** whether or not diagnostic or therapeutic procedures were performed.

> **NOTE**: stable disease indicates active disease
>
> Cases diagnosed at autopsy with no suspicion of cancer prior to death are reportable cases.
>
> Patients with a history of cancer, **with no evidence of active disease,** should **not** be reported.
>
> NOTE: Be careful about **history of cancer**: this is a very ambiguous statement. The physician, admissions, lab and radiology departments and any other healthcare provider may all say a history of cancer when in fact this is the patient's initial diagnosis of cancer. The patient may have had an evaluation for cancer the day before in the physician office. Call the physician if there is any doubt about the date the patient was first seen for cancer or diagnosed with cancer. It could easily be a reportable case.

A patient may come to your facility for chemotherapy or radiation prior to having definitive surgery. In this situation it is still a reportable case. If the patient has surgery and all tissue is benign, it may still be a reportable case. (i.e. Modified Mastectomy). Close evaluation of the patient record should make this clear, or a call to the physician may be required. (See example below under Casefinding Resources, Pathology Department)

MULTIPLE PRIMARIES

Numerous factors affect the decision in determining multiple primaries. It is discussed in this section.

If there are two primaries, complete two abstracts. Code each primary to the appropriate laterality and stage. Code the more extensive tumor as the first primary.

If there is one primary, prepare one abstract and code laterality to the side of the origin.

If there is a single primary and the side of the origin cannot be identified, prepare a single abstract and code laterality as 3 – only one side involved, right or left origin unspecified.

Additionally, check your Patient Accession List to determine if this cancer is a second primary or more. The rules are very specific in reaching this conclusion.

The case can be coded into the database based upon the physician statement that it is a single or multiple primaries. If he does not specify this information, or you disagree with his statement based upon standard guidelines, a call to the physician could help in determining the answer. If a physician determination is absent or cannot be obtained, then use the following guidelines in the order they are listed. The primary site, laterality, morphology and timing are each considered.

PRIMARY SITE DIFFERENCES

Determining single and multiple primary is evaluated by using the instructions relating to site differences to help in determining if one site or multiple sites.

Primary Site (NAACCR Item #400) and *Laterality* (NAACCR Item #410) are used together to determine whether two lesions are considered one or two tumors based upon their anatomic location. The ICD-0-3 topography code has four characters, the letter C followed by three digits (e.g. C61.9). The fourth character is always a subcategory of the first three. Usually, the first three characters represent an individual organ and the fourth character is a sub-site or a separate portion of that organ for clarification.) There are situations where two or more three-character ICD-0-3 topography codes apply to a single organ.

To make the decision of a single vs. multiple primary site rules, ask these questions:

Is a unique tumor represented by one three-character ICD-0-3 topography code?
A difference in the **third** character of the ICD-O-3 topography code is for a separate site for all primaries except those listed under the next question about unique tumors.

Do organs or sub-sites of organs represent a unique tumor?
A difference in the fourth or final character of the ICD-0-3 topography code designates a separate site for the listed site groups listed here, except for NOS (C--.9) with a specific four-digit site code in the same rubric.

- Colon (C18.0-C18.9) except colon and rectum polyps involving multiple segments
  (1) Simultaneous lesions and polyps in the same segment of the colon are a single primary.

  (2) Polyps may be present in more than one segment of the colon. If the pathology reads "adenocarcinoma in multiple polyps" it is one primary, colon NOS (C18.9)

(3) Familial polyposis is a genetic disease where polyps increase in numbers and may cover the mucosal surface of the colon. This benign disease usually develops into adenocarcinoma in adenomatous polyposis coli or adenocarcinoma in multiple adenomatous polys.

(4) Patients with the histologies "adenocarcinoma in adenomatous polyposis coli (8220/3) and adenocarcinoma in multiple adenomatous polyps (8221/3) have a different disease process than frank adenocarcinomas of the colon or typical colon polyps. If multiple segments of the colon or the colon and rectrosigmoid, or the colon, rectosigmoid and rectum are involved with adenocarcinoma in adenomatous polyposis coli or adenocarcinoma in multiple adenomatous polyps, it is a single primary. Code the primary site to colon, NOS (C18.9).

- Anus/anal canal (C21.0-C21.8)
- Pleura (visceral, parietal, NOS) (C38.4)
- Bone (C40.0-C41.9)
- Melanoma of the skin (C44.0-C44.9)
- Peripheral nerves/autonomic nervous system (C47.0-C47.9)
- Connective tissue (C49.0-C49.9)
- Non-malignant meninges (C70.0-C70.9) with Behavior Code /0 or /1)
- Non-malignant brain (C71.0-C71.8 with Behavior Code /0 or/1)
- Non-malignant spinal cord, cranial nerves, and other parts of central nervous system (C72.0-C72.8 with Behavior Code /0 or /1)

Is the unique tumor represented by more than one three-character ICD-0-3 topography code?
The following groups of three-character ICD-O-3 topography codes refer to single organs. Lesions within any combination of each group are considered to be the same primary site.

C01 Base of tongue; C02 Other and unspecified parts of the tongue
C05 Palate; C06 Other and unspecified parts of mouth
C07 Parotid gland; C08 Other and unspecified major salivary glands

C09 Tonsil; C10 Oropharynx
C12 Pyriform sinus; C13 Hypopharynx

C23 Gallbladder; C24 Other and unspecified major salivary glands
C30 Nasal cavity and middle ear; C31 Accessory sinuses
C33 Trachea; C34 Bronchus and lung
C37 Thymus; C38.0 Heart; C38.1-3 Mediastinum; C38.8 Overlapping lesion of heart, mediastinum, and plura
C51 Vulva; C52 Vagina; C57.7 Other specified female genital organs; C57.8-9 Unspecified female genital organs
C56 Ovary; C57.0 Fallopian tube; C57.1 Broad ligament; C57.2 Round ligament; C57.3 Parametrium; C57.4 Uterine adenxa
C60 Penis; C63 Other and unspecified male genital organs
C64 Kidney; C65 Renal pelvis; C66 Ureter; C68 Other and unspecified urinary organs
C74 Adrenal gland; C75 Other endocrine glands and related structures

Is a paired site involved?
The list of paired organs can be found in the section on coding *Laterality* (NAACCR Item #410).

Each side of a paired organ is a **separate** site **unless** a physician determines one side is metastatic from the other side.

EXCEPTION 1: These are always single primaries:
Simultaneous bilateral involvement of the ovaries with a single histology

Simultaneous bilateral retinoblastomas

Simultaneous bilateral Wilms tumors

EXCEPTION 2: Do not consider laterality for determining single or multiple primaries of behavior codes of /2 or /3 for:

meninges (C70._)

spinal cord, cranial nerves, and other parts of central nervous system (C72._).

Both sides of a paired organ may be involved with tumors at the same time. If the tumors are of the same histology, the patient may have one or two primaries. Consult the managing physician or the registry advisor.

MORPHOLOGY/HISTOLOGY DIFFERENCES
The ICD-O-3 Morphology code has five digits (i.e. 8500/3). The **fifth digit** is the behavior code. The behavior code is not used in determining multiple primaries.

EXCEPTION: Two primary intracranial and central nervous system tumors (C70.0-C72.9, C75.1-C75.3) in which one is malignant (behavior of /2 or /3) and one is non-malignant (behavior

of /0 or /1) are always separate primaries regardless of timing.

The first **four digits** are sometimes referred as the "histology code." Multiple terms may describe a single histology. Refer to the ICD-0-3 histology code to determine whether two or more lesions represent the same tumor histologically.

SINGLE PRIMARIES

If the first three digits of the ICD-O-3 histology codes are identical, then the histologies are the same.

Lesion(s) may have a single histology (the first three digits of the morphology code are the same) with invasive and in situ components. This is a single histology. Code the behavior of the invasive component.

A single lesion is one primary even if it crosses site boundaries.

A single lesion with mixed histologic types is one primary.

A difference in the first three digits of the ICD-O-3 histology code indicates a **different** histologic type.

EXCEPTION 1: If one malignancy is stated to be carcinoma, NOS adenocarcinoma, NOS, sarcoma, NOS or melanoma, NOS and the second lesion is a more specific term, such aslarge cell carcinoma, mucinous adenocarcinoma, spindle cell sarcoma or superficial spreading melanoma, consider this to be a **single** histology.

EXCEPTION 2: For lymphatic and hematopoietic disease use Appendix A of FORDS to determine which histologies represent single or multiple primaries. The primary site and timing do not apply in determining lymphomas and leukemias as if they are two malignancy types or one.

EXCEPTION 3: Considering the following as a **single** histology, even though the first three digits of the ICD-O-3 morphology codes differ. Code its histology according to the rules for mixed histologies.

- Transitional cell carcinoma (8120-8131) of the bladder (C67.-)
- Ductal (8500) and lobular (8520) adenocarcinoma of the breast (C50.-)

EXCEPTION 4: Use the following for the determination of single or multiple primaries of non-malignant (behavior /0 or /1) primary intracranial and central nervous system tumors (C70.0-C72.9, C75.1-C75.3).

- Two histologies appearing in the same group in the following table are the **same;** code the more specific histology.

- A histology in the table and a histology not in the table that have the same first three digits are the **same**; code its histology according to the rules of mixed histologies.

Gliomas*	9380, 9381, 9382, 9400, 9401, 9410, 9411, 9420 9421, 9423, 9424, 9430, 9440, 9441, 9442
Subependymomas	9383, 9384
Chroid plexus neoplasms	9390
Ependymomas	9391, 9392, 9393, 9394, 9444
Neuronal and neuronal-glial	9421, 9413, 9505, 9506
Neoplasms	
Oligodendrogliomas	9450, 9451, 9460

*Includes gliomas, astrocytomas, astroblastomas, and glioblastomas

- Multiple lesions with the **same** histology occurring in different sites are **separate** primaries **unless** a physician says they are metastatic.

- Multiple lesions with **different** histologies occurring in different sites are **separate** primaries **unless** a physician states otherwise.

TIMING

- For most cancers, timing can be used to decide if one or more primaries are involved.

- Lesions occurring within two months of each other are "simultaneous."

- If two malignancies of the same histology (see rules for histology difference) occur in the same site as stated under site difference (including those for laterality for paired organs), there is only **one** primary.

  EXCEPTON: Each occurrence of melanoma of the skin is a new or **separate** primary **unless** a physician states otherwise.

- Multiple lesions with different histologies in a single site are **separate** primaries, whether they occur simultaneously or at different times.

CASEFINDING METHODS

It is important to be resourceful in finding cases in your facility. There are two ways to report cancer data: Either by reporting it yourself or by notification from another person. A combination of these two practices will increase the number of cases you need to report and increase the quality of your reporting. Because patients pursue different healthcare providers for their care, the patient may go to several institutions before their treatment is complete.

Some registries make arrangements with other departments in their facility to provide them with immediate information to review for new cancer patients (all pathology reports, radiation oncology initial treatment evaluations and end of treatment reports). The sooner you have a patient in the registry, the

sooner you can obtain additional information from outside resources. Be sure to review your facility confidentiality and HIPAA policies before sharing information with an outside resource.

Initial Casefinding starts with preparation of an index report by sorting the hospital diagnosis indices by ICD-9-CM diagnosis codes. This can be done through the Health Information Management (HIM) department, your Information Services Department, or some registrars have departmental access to do this themselves. These codes are intended to identify potential cancer cases that **must** be reported to OCCR. This list is found at the beginning of this chapter.

CASEFINDING RESOURCES

Review of only one type of source document cannot identify all cases diagnosed or treated in the hospital. Multiple resources are necessary to obtain a complete description of the patient's cancer experience in your facility. Once your process for Casefinding is established, it should be evaluated from time to time and amended as your facility procedures or services are changed. When long-range plans are announced in your facility or at meetings, determine what effect they will have on your process. A passive approach to casefinding will result in missed reportable cases.

The reports generated for each resource listed may require that Information Services generate the report rather than the department using the report. Some reports must be set up to run monthly as a backup to daily reports you may already be reviewing. Some examples of these that will be referenced under the department suggestions are: the daily surgery or lab schedules, daily admissions and discharges. Monthly reports will catch cases that might be missed due to delays incurred for various reasons. Year-end reports can be designed based only on admissions and will ensure quality reporting and reduce unreported cases. Be sure to run them in alphabetical order by patient name.

These are suggestions of departments where you might find your cases:

Medical Records Department

The records you will review are found by requesting a disease index, also known as the diagnosis index. A customized disease index can be designed for the cancer registry by using those ICD-9 diagnosis codes specifically required for cancer identification. Some facilities use their Information Services department to develop and run this report on a monthly basis. Some registries have the software capability to prepare their own report.

Disease Index

The disease index should include both **inpatient** and **outpatient** cases. Medical Records should be given enough time to have completed the monthly chart coding before the Disease Index should be run. Thirty days (30) after the admission month ends is a good objective in most facilities. Run in alphabetical order.

Hospital Admission & Discharge Reports
Outpatient Admission & Discharge Reports
Emergency Room Admission & Discharge
History of Cancer Admission & Discharge reports

These reports are usually generated by information Services

Outpatient Department

If outpatient records are separate from the inpatient records, an additional disease index will be needed to identify your cases, or it can be incorporated into one report. It is usually called the Outpatient Admission and Discharge Report. It is usually generated by your Information Services Department.

Pathology Department

All the reports from the Pathology Department should be reviewed to find reportable neoplasms. Be sure to include bone marrow reports and cytology reports such as pleural and peritoneal fluids and bronchial washings (even if these are clear, it can be an evaluation for suspected lung cancer). There may be a separate file for each report category stored in the pathology department:

Histology reports
Cytology reports
Hematology reports
Autopsy reports
Case consultations

Sometimes, arrangements can be made to receive a copy of all the pathology reports generated for your facility. A patient may come into your facility for first course of treatment but the tissue sample is disease free (i.e. Modified Mastectomy). **It is still a reportable case.**

EXAMPLE: A patient with a breast tumor has a biopsy showing malignant cancer. A modified mastectomy is done, and the tissue has no disease. The case is reportable. The surgery was still part of first course of treatment.

Some cytology evaluations, biopsies or surgeries signal the need to review the medical chart. The tissue does not have to be positive for cancer to be a reportable cancer case or to help in determining further treatment options. The biopsy of lymph nodes can be for evaluation of the spread of disease, lymphoma, or to determine more radical surgery for the prostate. An Orchiectomy can be a hormone treatment option. Evaluation of pleural fluid can be for lung cancer.

Autopsy Reports

Check for these in the pathology department if your facility does autopsy reports. Sometimes the patient is sent somewhere other than your facility for the autopsy, and the report is either in the medical chart or a separate file in the pathology department.

Emergency Room Reports

Patients admitted to ER may be clinically diagnosed with cancer from diagnostic radiology evaluation. Because of other extenuating circumstances, a biopsy or treatment may not be appropriate. The patient or family may decide that no further diagnostic evaluation or treatment is wanted. The physician may state “referral to hospice” or “no treatment would be beneficial”. In these three situations, it is still a treatment decision and reportable if the physician has stated that it is cancer. Each case in question should be evaluated to determine if it is a reportable case. The report is usually called the “Emergency Room Admission and Discharge Report and generated by Information Services.

Department Treatment Logs

Other department logs (surgery, radiation therapy, radiation oncology, oncology unit, senior diagnostic center etc) should be reviewed in the same manner to identify cases that need to be reported. Sometimes, admissions from these departments are tied into your data system and information can be pulled from these departments. If this is not the case or it is a freestanding clinic, arrangements should be made to obtain a record of the patient so the department charts can be reviewed for reportable cases.

Cancer Conference/Tumor Board

The Cancer Committee of the hospital is responsible for conducting cancer conference (tumor board) to provide consultative services to patients and to educate the medical staff. In many locations, the cancer registry staff is in charge of arrangements for this activity. If this is not is case, attendance at the conference or review of the minutes may identify additional cancer patients, or clarify information recorded in the chart, or provide information not recorded.

Free-Standing Clinics

If your facility owns/operates separate freestanding facilities, their cases must also be reported as part of your facility.

The SEER Program Self-Instructional Manual for Cancer Registrars, Book 1, may have some additional suggestions for Casefinding.

CASEFINDING PROCESS

Casefinding requires obtaining information from many resources. Cooperation and good working relationships between reporting personnel and other departments are essential for accurate case ascertainment. It is the Registrar's responsibility to identify the process that will work best for Casefinding. These suggestions may speed up the process for you. The work lists discussed here are described in Chapter 4.

The newly identified cancer cases should be checked against a list of patients already accessioned into your registry. This list is called the Registry Accession List and is described in Chapter 4.

Not all cases are reportable so making this determination as you review the patient records can save time. If the case is **reportable**, an Abstract should be completed for a patient who has not been previously added to the registry or reported to OCCR. If a case is late in being reported and found as part of a quality review, note this in the remark section of the abstract so OCCR will know how the patient was found. The record is a good document for quality review. Sometimes, a case identified as new will be eliminated during the abstracting process when the chart information is reviewed and it does not meet the reportable guidelines. The Accession Number should **not** be reused.

Some registries keep a paper Accession List, as well as a computer-generated report. If you do this, a note should be added to that list to indicate the reason the case was dropped. This is a good audit tool for future reference. If you work with only a computerized Accession List, any cases **not** reported should be kept on a Non-Reportable List for future reference.

If you are getting daily admission or discharge reports, testing or surgery schedules, pathology reports or oncology reports, you may find some of your patients before you ever pull up the disease index. When reviewing the reports, observe why the patient was admitted and what physician is attending the patient. All this information can be clues to suspicion of a cancer diagnosis or treatment. Pay particular attention to expired patients. They may be cases that were previously diagnosed or newly diagnosed with cancer without any treatment.

Calls may come in from other registrars requesting information about a patient. A physician could request a patient be placed on the agenda for Cancer Conference who has not been identified by other resources.

When information is received from a resource outside your department, review your Accession List to see if the patient has already been added to your registry and the information already reported. See if the patient has been evaluated as a non-reportable case for the same tumor site.

Quick Process Check List of casefinding:

1. Run an alphabetic list of your disease index for reportable cases. Review the Accession List and the Non-reportable List for cases already evaluated.

   Remember: Some skins cancers are reportable. Watch for Melanoma cases; they are reportable. Watch for Central Nervous System (CNS) cases.

2. Pull the charts for review or access the electronic record for the patient.

3. Review the case for reportable/non-reportable situations.

4. Accession the patient into the registry.

5. Prepare an abstract for each reportable case

NOTE: If a previously reported patient is found to have a multiple primary, assign the new primary to the patient's original registry number. Change the sequence number to reflect the new primary and abstract the pertinent cancer information.

CASEFINDING QUALITY ASSURANCE

To ensure that all cases have been reported, another Disease Index List should be run quarterly or after the end of the year to verify that all cases have been picked up. Keeping a Non-Reportable Cases Log will eliminate duplication of work and make the reconciliation easier. It is also useful when calls come in about patients not listed in your registry. If you have questions about your Casefinding, OCCR will be glad to assess the Casefinding procedures you follow.

CHAPTER 4 – RECORDKEEPING

Standard lists are used to identify potential cancer cases, to prepare the abstract, to meet reporting guidelines and to help ensure the quality of the cases reported. Each report will clarify how it will benefit registry work functions and reporting timeliness.

SUSPENSE LIST

A suspense system is a temporary file or list of cases that have been identified as potential cancer cases, and cases that have not been completely abstracted. With so many resources for case finding, the final chart evaluation may not be sufficient to make the final reporting determination. The earlier a patient is identified as a potential case, the more information may be available for the abstract from outside medical sources calling about the same patient. It is also helpful in identifying expired patients outside your facility before they have been abstracted.

Most of the vendors have designed a Suspense List in their software. It is a good tool to identify cases per month, reduce duplicate cases, determine workload, reportable cases for any time period, or to accumulate site-specific case information. Some software is designed to make a custom list to pull medical charts by using the suspense list information.

A suspense list typically includes:

Patient name
Patient identifier
Date of diagnosis or date of first contact
Primary site

ACCESSION LIST

The Accession List is an annual, sequential listing of all reportable cases included in a cancer registry. It can be used to identify, count, and evaluate the annual caseload. It can be used to audit other registry files, monitor Casefinding, assess the workload and verify patient identification. It can be used to compare one year with another. It can pull patient listings for studies.

The data items required for this report are:

- Date of initial diagnosis
- Patient name
- Primary site

PATIENT INDEX FILE

The Patient Index File is an alphabetical list of all patients, living or dead identified and reported by the provider since the reference date of your facility case reporting. It should **always** be checked to see if the patient has ever been accessioned in your registry.

NOTE: Be careful in screening patient information. Many patients have names that are similar or appear to be the same. Their age may be the same. Sometimes information is recorded for the wrong patient or patient address. Close review reduces duplication of patients and non-reporting or reportable cases.

This list should include:

- Date of birth
- Date of diagnosis
- Date of last contact or death
- Histology
- Laterality
- Medical record number
- Patient name
- Primary site(s)
- Sequence number
- Sex

NON-REPORTABLE CASES LOG

Offices handle this in different ways. Many set up a spreadsheet to record their information. Other facilities record their review in their electronic or paper medical chart. It is very important to keep this log, since it will reduce repetitive review of medical charts and reduce your workload. The list is usually kept by the year the case was not accessioned and in alphabetical order.

It is beneficial to keep this information:

Patient Name, Social Security Number, Date of Birth and Vital Status
Date of Diagnosis and Primary Site
Location and modality of Diagnosis
Physician treating the patient
Reason for not reporting

FILING

Some reporting entities keep an original patient abstract in file along with the path report and any information they deem pertinent. With computer systems, many facilities use that as their only record. It might be beneficial to keep an annual backup. Failures do occur, and data can be lost.

CHAPTER 5 - CONFIDENTIALITY IN REPORTING

SUBMITTING PATIENT DATA TO OCCR

The protection of confidentiality begins with the facility originating the data abiding by the confidentiality guidelines set forth by the facility and HIPAA guidelines. The facility is responsible for instructing its staff on the confidential nature of the patient information, for developing a procedure for handling the information and following hospital and HIPAA guidelines in determining who should have access to the information.

The central registry is committed to preserve the confidentiality of information obtained for medical education, research and statistical purposes. Safeguarding the confidential data within the registry involves not only securing against unauthorized access but also ensuring data is used only for the intended purpose. OCCR has signed confidentiality agreements to act in accordance with the legal responsibility to comply with HIPAA guidelines. You are covered under the confidentiality guidelines set forth by the state for reporting all patients diagnosed with cancer. The HIPAA guidelines protect you and your facility for sharing information with another caregiver who is involved in the direct treatment of the patient for the diagnosis or treatment for his cancer.

Accredited cancer programs sign a HIPAA Confidentiality Agreement with ACoS for protection of information for NCDB submission and data usage.

All facilities will upload the monthly data submission file and case listing file through the OCROW secure web site. The case listing document should note the date of submission, the number of cases being submitted, the name of the patients and the Accession Number.

Any confidential information sent to OCCR should be carefully sealed, inserted into a protective mailer marked ‘CONFIDENTIAL’, and addressed as follows:

Oklahoma Central Cancer Registry
Oklahoma State Department of Health/Chronic Disease
1000 N.E. 10th St., Room 1205
Oklahoma City, OK 73117-1299

There are different ways to protect the confidentiality of patient information, as discussed in this chapter.

FACILITY ELECTRONIC AND OCROW WEB-BASED CANCER REPORTING

The guidelines as set forth by your facility should be followed to ensure the protection of confidential information being gathered or submitted to OCCR. Care should be given to computer access, screen display of patient information or information records being used to compile patient information for abstracting into the computer. Regular backup of your information should be done to protect your database. To protect confidentiality, destruction of information used in compiling or recording a patient abstract should also be considered.

In April 2005, OCCR began the new web-based cancer reporting application called OCROW (Oklahoma Cancer Reporting on the Web). Those eligible to use this application report fewer than 25 cases per year. Training to use OCROW will be included in "Basic Cancer Registry Data Collection" offered by OCCR free of charge.

STATE PERSONNEL CONFIDENTIALTY POLICIES

The OCCR Program Director has ultimate responsibility for maintaining confidentiality and compliance with Oklahoma state law and federal HIPAA guidelines. All the OCCR staff are bound by the rules of confidentiality as set forth by state laws, administrative rules and this manual. Each staff member signs a Confidentiality Agreement. Other departments, sections or programs within the Oklahoma State Department of Health that are outside OCCR and have a need for Registry data must also sign a Confidentiality Agreement. The agreement covers their obligation regarding confidential data and documents that they have read this section of our confidential policy and understand that the penalty for not complying constitutes commission of a class A misdemeanor with discipline in accordance with State policies. A copy of the Confidentiality Agreement is available upon request.

The registry staff that collects the data information is responsible for the maintanence of confidentiality not only in respect to information on cancer, but to anything of a confidential nature they might see or hear.

To enter our work environment you must have a key or be escorted into the office. A badge must be obtained when entering the building. All employees have locking cabinets and desks to secure and protect records.

STATE COMPUTER SECURITY

The Program Director is responsible for assuring the overall security of the computer system. This includes verifying that only authorized individuals have access. Employees are strictly forbidden from releasing any information regarding codes, numbers or names used to access the computer except to authorized individuals. **Failure to comply with the provision is grounds for immediate dismissal.**

To access the computer, staff have a three-tiered level of access security that ensures that each member of the staff has his own separate security password. The first security level is the user Login Name and password. The user establishes this password, which is changed on a regular basis or if there is a concern that security may be in jeopardy. The next is the network file server access. The third level is password access to the Rocky Mountain Cancer Data System (RMCDS) software. Only those individuals for whom access to the database is essential will have this information. The RMCDS program can be set up as a "Read Only" resource. When other department network users need registry data to do studies, limited access to only the non-confidential portions of the registry database is approved for a set period of time.

Computer printouts can contain identifying information. These printouts are treated as a medical record, and all the procedures documented in this manual apply.

Backup disks for the statewide database are stored in a locked, fireproof safe.

The computers are positioned in each workstation so that easy viewing of the data screen is restricted.

HANDLING OF DATA IN THE FIELD

The field staff is discouraged from transporting any confidential information such as abstract forms or data disks. If confidential information must be transported, precautions are used to protect the information. It will be carried in a locked briefcase, which will never be left unattended unless it is within a secure locked enclosure.

When a site visit is made, the abstract forms being discussed will be shown or discussed only with the individual responsible for initially submitting the abstract form or their supervisor and our OCCR staff member.

STATE INFORMATION REQUESTS

If an individual were to call to ask if there is data in the state registry about them, they would be given no information. They would be referred to their treating physician for this information.

Data on deceased persons held in the cancer registry are subject to the same data release restrictions as those for the living.

Requests from reporting Oklahoma hospitals for data from their own hospital's registry may be made by phone or in writing. Confidential information may be released to health care providers and institutions directly involved in the care of the patient.

The State Registry may also release confidential data to treating hospitals for the purpose of patient follow-up. All requests for follow-up must be in compliance with 63 O.S., 1-551.1 and 1-552. Confidential data is information that is patient-specific or that identifies an individual patient.

Research activities are monitored by the Program Director who ensures that only relevant activities are undertaken. State affiliated researchers are expected to abide by the same restrictions as outside researchers.

Data from the State Registry may be used in research projects upon approval. Such uses include survival statistics, epidemiological studies, planning of services or controlling the disease and assessing the effects of intervention. Because any information that specifically identifies a health care professional is confidential, researchers must sign a confidentially statement. This statement confirms their agreement to maintain patient confidentiality, cite the source of the data in any presentation or publication, and provide the OCCR with copies of any publication or presentation prior to its being released. Violation of any part of the agreement shall prevent further access to the data and result in a letter of reprimand to the chief executive officer of the researcher's institution, and other researchers at the institution may be denied access to data for an indeterminate time.

Research data will be provided only upon a written request that **must** include:

- The exact purpose for the data requested.
- Agreement that the data will not be used for purposes other than agreed upon at the time of release.

- Data will not be released to unauthorized individuals or parties.
- Data that is no longer needed for the designated purpose will be returned or destroyed.

Confidential cancer registry data cannot be made available for the following purposes:

- Businesses that are trying to recruit new patients.
- Health care institutions that are trying to recruit new patients.
- Insurance companies that are trying to determine the medical status of a patient.

STATE RELEASE OF INFORMATION

OCCR keeps a list of persons who have had a legitimate request for access to their confidential cancer data and have been given information. This list gives the nature and extent of their access to the registry data.

Pursuant to 63 O.S. 1991, 1-551.1 and 1-552, OCCR may release confidential information concerning individual cancer patients to the cancer registry of another state or physician. This is allowed only if the other state has a reciprocal agreement with OCCR, and that the state or physician meets all HIPAA requirements.

CHAPTER 6 – REPORTING PREPARATION

TO WHOM AND WHEN TO REPORT

To meet the 90% Reporting compliance requirement, cases **must** be submitted **within 180 days of diagnosis,** which is the sixth (6) month after the date the patient was first diagnosed or treated in your facility for cancer (Class of Case 0, 1 and 2). Non-compliance is a violation the Oklahoma Statute Title 63 Public Health Code Article 17.1 & 17.2 listed in Appendix A. If a case is found after this time frame, a notation should be made in your abstract to explain the reason, i.e., late determination by physician of cancer diagnosis.

Although treatment is generally started within the first four (4) months, the initial course of treatment can cover a long period of time (i.e. prostate patient treated with hormone therapy before brachytherapy or surgery). That is why planned course of treatment can be used to complete treatment information. Once the treatment is completed, the additional treatment information should be submitted to the state for accurate and complete information reporting.

BE AWARE OF THIS STATEMENT WHEN YOU ARE REPORTING:

> **For COC accredited programs, the FORDS Manual reporting requirement is "within 6 months from the "Date of First Contact." The Oklahoma law states "within 180 days of Date of Diagnosis". This can make a big difference in your monthly reporting percentages results and your state reporting compliance.**

If you have reported that a patient is to have a specific treatment and the documented information is received later, it should be reported to complete the abstract with the most accurate information available.

At the time a medical record is reviewed for abstracting, the information may be inconclusive or not recorded, but then may be recorded on a subsequent visit. At any time new information is found, it can be entered in the abstract.

For both these situations, reporting instructions can be found in Chapter 8.

If you are using RMCDS, completion of their abstract will meet all the suggested and required data items requested by the state. Other vendor software should also meet NAACCR requirements.

DATA REPORTING REQUIREMENTS

The central registry reportable list includes 22 required data items and 19 recommended data items for a total of 43 items. They are listed in Section II, Chapter 11 of the abstracting process. Some data items are required for COC reporting and not for NAACCR reporting. This has been noted on every data item. If both OCCR and FORDS require the data item, no notation has made other than the black coding and the

"R" requirement. As changes are made to this requirement list, the updated requirements will be found on the OCCR website.

CANCER DATA REPORTING SCHEDULE

Completed Abstracts are due **NO LATER THAN SIX MONTHS** following the date of a confirmed case. The monthly report schedule is

MONTH OF DIAGNOSIS CONFIRMED DATE	OCCR REPORT DATE	
JANUARY	JULY	current year
FEBRUARY	AUGUST	current year
MARCH	SEPTEMBER	current year
APRIL	OCTOBER	current year
MAY	NOVEMBER	current year
JUNE	DECEMBER	current year
JULY	JANUARY	future year
AUGUST	FEBRUARY	future year
SEPTEMBER	MARCH	future year
OCTOBER	APRIL	future year
NOVEMBER	MAY	future year
DECEMBER	JUNE	future year

OCCR will distribute a current schedule the beginning of each year. When major data collection standards changes occur accompanied by delay in software distribution, the reporting time is usually adjusted to permit reasonable compliance.

OCCR has two mandated Data Submissions:

- NAACCR call for data due early December each year
- NPCR call for data due January 31 each year

RMCDS REPORT PREPARATION

Rocky Mountain users can find the data submission file and case listing report instructions at the end of this chapter. For accredited cancer programs that utilize a different software vendor, you will need to contact them for instructions to complete these activities.

OCROW REPORTING

Realizing that more and more patients are diagnosed exclusively in practitioner offices and outpatient clinics, OCCR developed and released OCROW in 2005 to provide physicians and smaller facilities with a less complicated means for reporting cancer cases. A Facility Authorization Request (FAR) form must be submitted to OCCR and be approved by the Data Manager in order to utilize OCROW for cancer reporting.

The Oklahoma State Department of Health (OSDH) and the Oklahoma Central Cancer Registry (OCCR) manage the OCROW system. OCROW is an ASP.NET Web application running on Microsoft Internet Information Services 5.1. OCROW uses Secure Sockets Layer (SSL) to encrypt all data communication (128 bit) between the end-user and the server. The application uses forms based authentication and role based security to control access to the application. The data that is collected and managed within the application is stored in Microsoft SQL Server 2000. The application has the ability to export data in formats required by the Rocky Mountain Software package used by the Oklahoma Central Cancer Registry. Criteria for selection are based on the number of reported cases per year being 25 or less. OCROW contains sections for Facility Information, Patient Information, Cancer Diagnosis, Collaborative Staging, Biopsy Information, Patient Treatment, and Referral Information. Each section contains required data fields and will not allow submission without all required data completed.

The OCCR training class, "Basic Cancer Registry Data Collection", offered free of charge will help you understand this new application and all the requirements for reporting. A training schedule can be found on the OCCR website.

OCCR DATA SUBMISSION INSTRUCTIONS

RMCDS software converts data to NAACCR format. Reporting instructions can be found in Chapter 12. If you are using another software vendor, they will have instructions for submitting your data to meet the Oklahoma data-reporting requirement. Questions about reporting compliance should be directed to OCCR.

All uploaded data submissions should be accompanied by a case listing report. If your vendor submits your data, they should also include the case listing report. If they do not submit a report, you should mail a report to OCCR each month. Even if your vendor prepares your report, it is a good idea to create your own monthly report. If the file of cases fails to transmit, then you will have a record of what should have been sent. This also alerts OCCR that there is a problem, and they can contact you or your vendor for resolution.

You can create your own report by running a completion list from the last report date to the current report date. It should be done before you complete any more abstracts or it will vary from the data sent by your vendor. OCCR will use the submitted report to verify that all cases were received.

Mail your report to the Regional Consultant for your facility, at:

Oklahoma Central Cancer Registry
Oklahoma State Department of Health
Chronic Disease Services
1000 N. E. 10th Street, Room 1205
Oklahoma City, Oklahoma 73117

QUALITY CONTROL

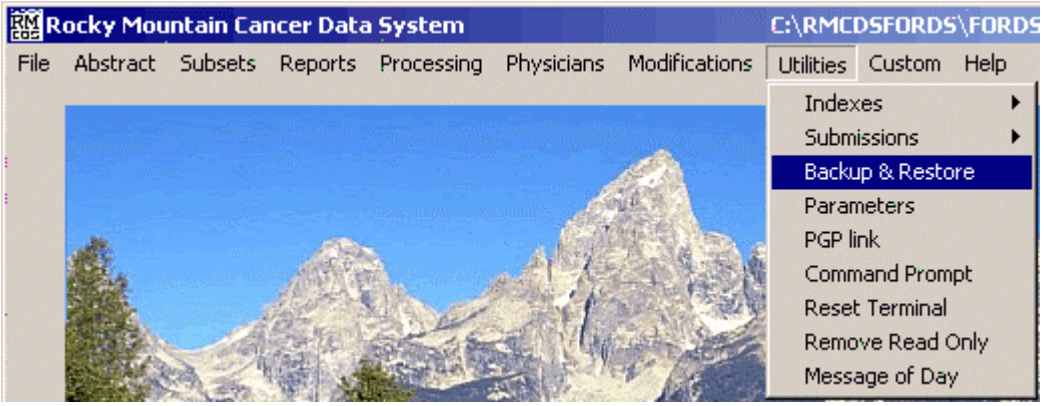
Retain a copy of your monthly case listing report to use in reconciling with OCCR after they have verified your data submission. It has been mentioned in other sections of this manual, to run another Disease Index List at the end of the year to verify that all cases have been picked up. This also ensures that all

cases have been reported to the state if your facility is ever involved in a CDC audit of the central registry. You will also need to refer to your Non-Reportable log to eliminate any cases found that were not reported. There is no retention time requirement, but if a case is ever referenced in the future, you will have the records to verify your review and resolution.

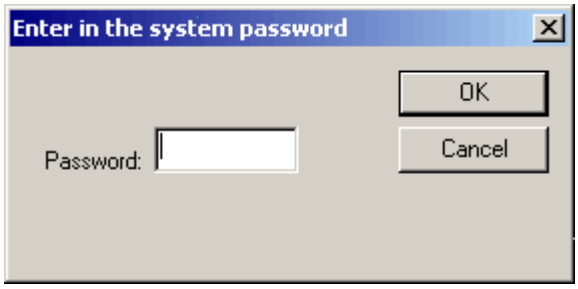
There will be times that corrections must be made to your data. Chapter 8 and Chapter 9 will help in the process for making corrections.

SENDING NEW CASES TO THE STATE CENTRAL REGISTRY

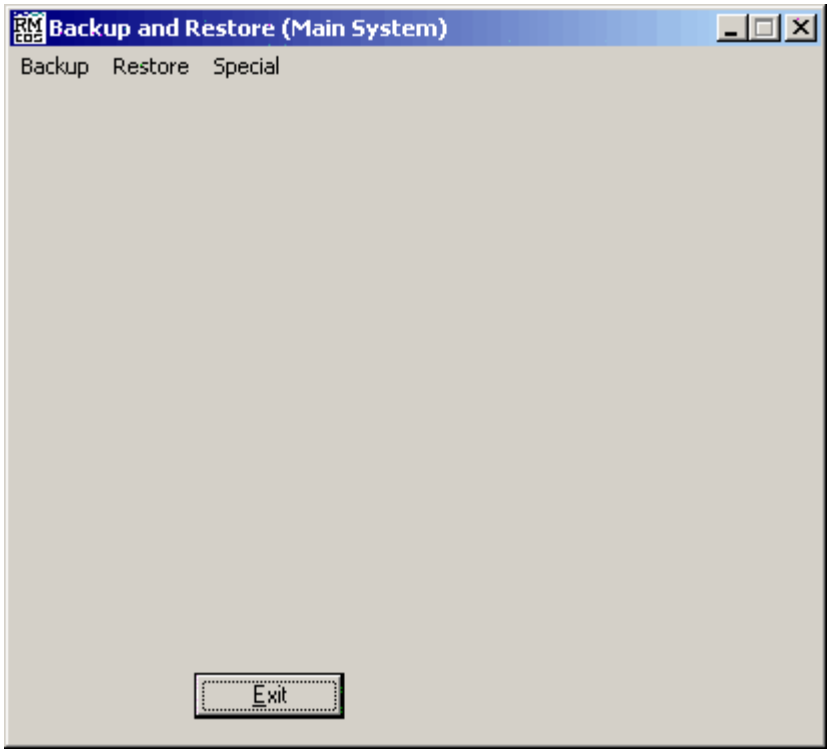
From the RMCDS Main Menu click on **Utilities > Backup & Restore**



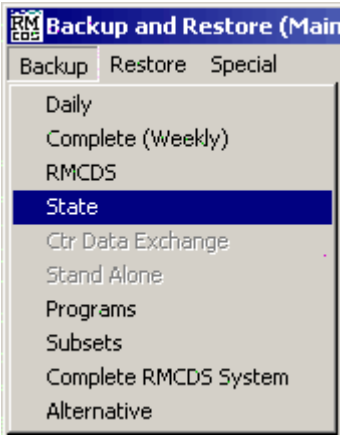
Type the password into the message box that appears.



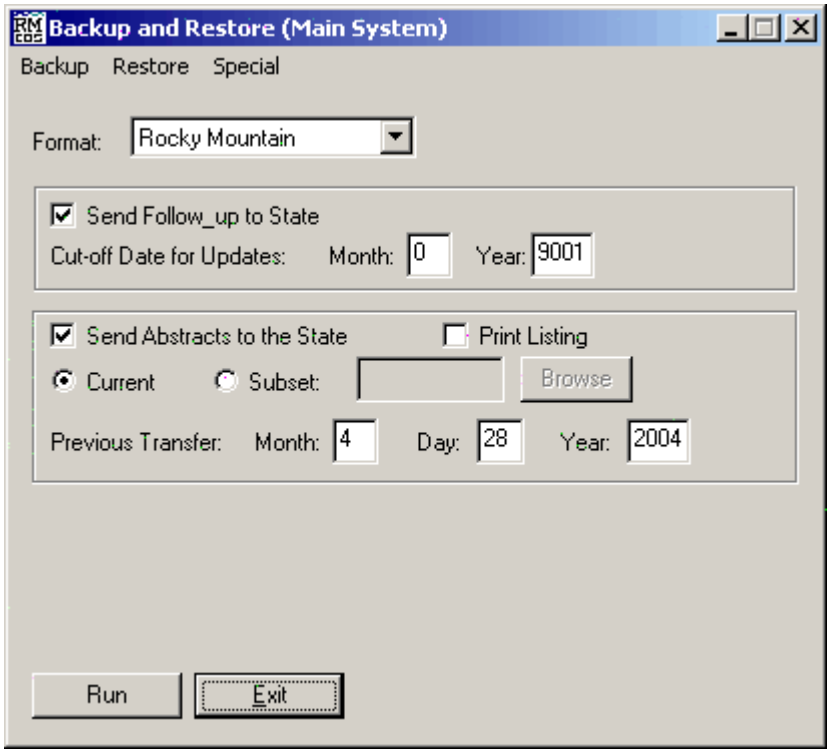
The **Backup and Restore** window will open.



The **Backup and Restore** window has three menus: **Backup**, **Restore**, and **Special**. Click on **Backup** > **State** to load the state backup options.



The State Backup Screen will load into the **Backup and Restore** Window.



The first time this utility is run the values for **Cut off Date for Updates** and **Previous Transfer** date will be 0. On subsequent submissions the dates will retain the previous value entered.

In the pull down box labeled **Format** you can choose between **Rocky Mountain** format and **NAACCR Versions**. Select **NAACCR version**.

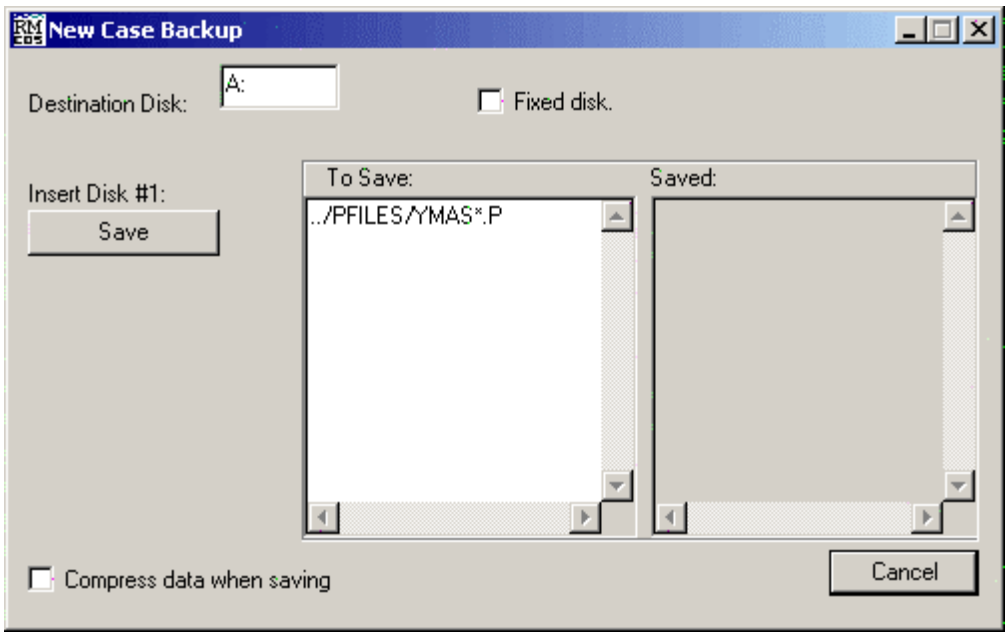
To send follow up information to the state, make sure there is a check in the **Send Follow-up to State** box and enter a **Cut-off Date for Updates** in the boxes provided. All follow up information entered since the cut off date will be sent to the state.

To send new abstracts to the state put a check in the box labeled **Send Abstracts to the State**. If you want a listing report of the patients included in this submission be sure to put a check in the **Print Listing** box. If you want to send cases from a subset that you have created click on the radio button labeled **Subset** and enter the name of the subset**.** Usually you will want to select the **Current** radio button. In the area labeled **Previous transfer** enter the date of the previous submission to the state. RMCDS will keep track of the previous transfer date and allows you the option to change it if you need to.

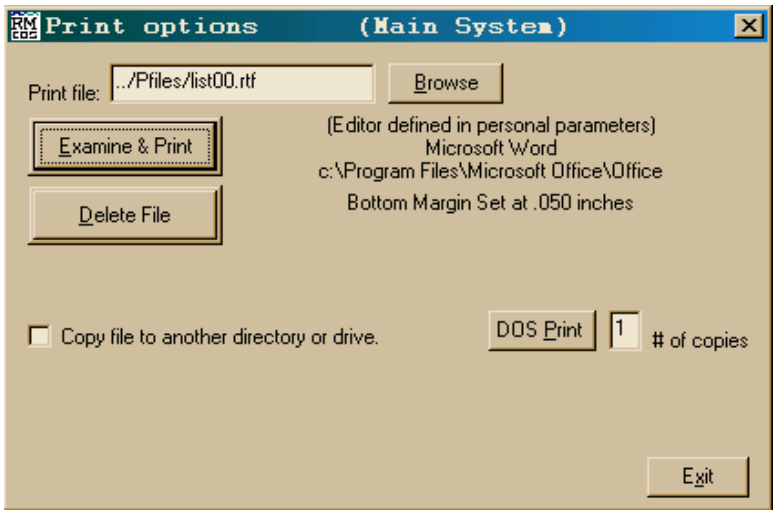
After selecting the options you want for the State submission click on **Run**. The program will begin and you will see a progress window that is updated with numbers. After the program is complete you will see a message that indicates the number of records that have been written out. Click on **OK**.

The **New Case Backup** window will open. You will see a message window letting you know how many new records are being written out for the state. Click on **OK**. The **New Case Backup** window will open.

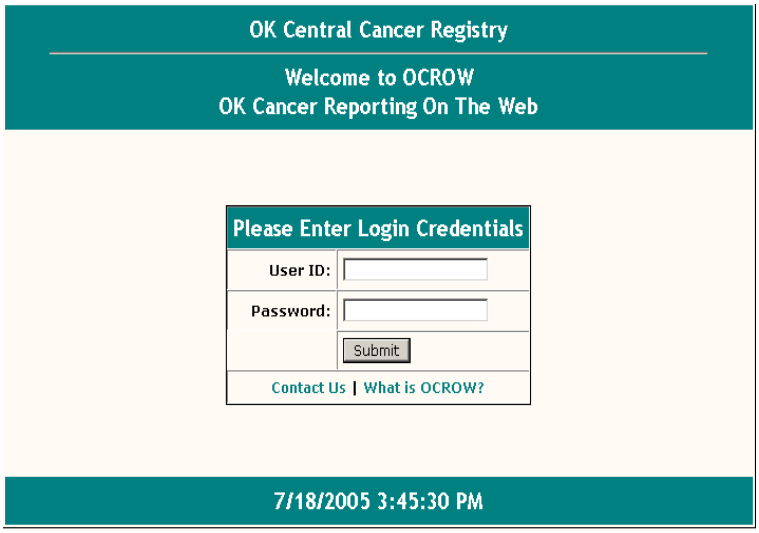
The name of the file that contains the state back-up cases (../PFILES/NAACCR.P) is listed in the **To Save** area of the window. Close the New Case Back-up window by selecting **Cancel**.



The Print options window will now appear. Click **Examine and Print**. The case listing report will be shown in your default word processing program. The print file name will be displayed next to the Browse button, i.e. ../Pfiles/list00.rtf. Print a hard copy for your reference. Click **Exit**.

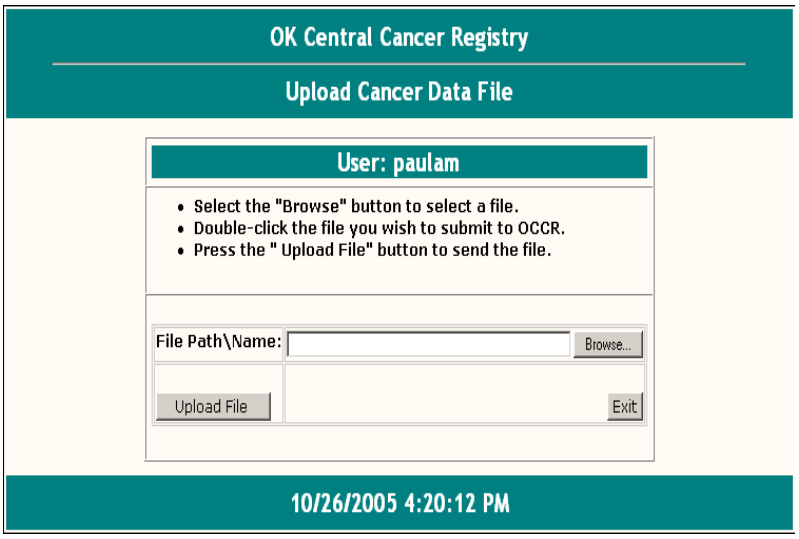


Go to Internet Explorer and type the following secured web site address: https://www.phin.state.ok.us/cancer Enter the assigned UserID and temporary password. You will be prompted to enter a new password.



Click Browse to select the state back-up file. Go to **My Computer** and select the drive RMCDS is stored on. The path to the RMCDS programs can be found on the third line below the mountain picture on the **RMCDS Main Menu**. Open the **RMCDS** folder, open the **FORDS** folder, open the **Pfiles** folder and select the **NAACCR.p** file that displays current date and size i.e. 67KB. Double-click the file you wish to submit. The file will display in the **File Path\Name**: box. Press the **Upload File** button to send the file. A message **File Upload Successful** will appear once the file has uploaded.

Follow the same procedure for uploading the case listing report. Open the **RMCDS** folder, open the **FORDS** folder, open the **Pfiles** folder and select the **list00.rtf** file that displays current date and size i.e. 67KB. Double-click the file you wish to submit. The file will display in the **File Path\Name**: box. Press the **Upload File** button to send the file. A message **File Upload Successful** will appear once the file has uploaded. Select **Exit**. Send an email to Paula Marshall at paulam@health.ok.gov that the data submission file has been uploaded.

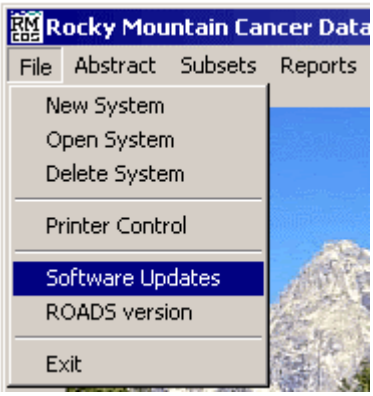


Software Updates

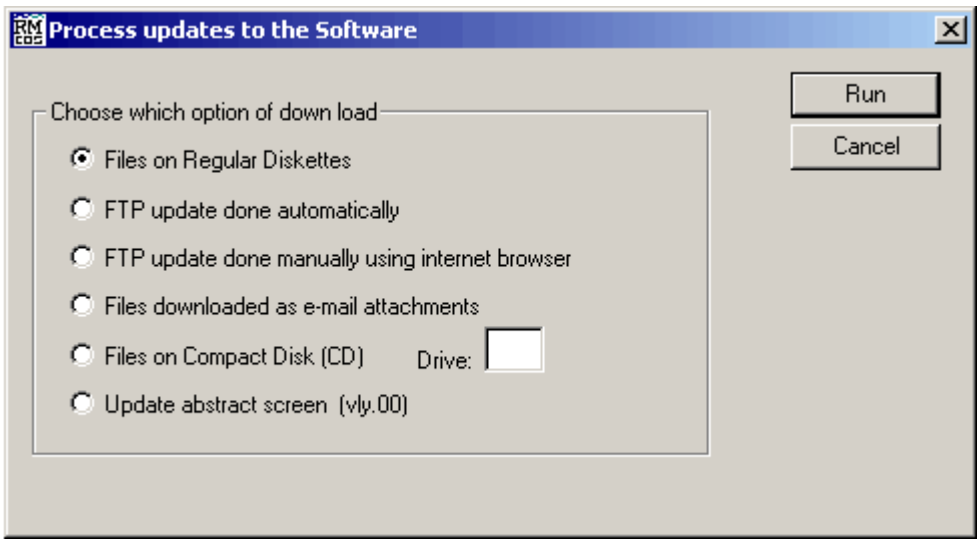
FTP Automatic Update

These instructions describe how to run the automatic FTP update. To use the Automatic Update you must have an active connection to the internet. Many facilities have firewalls set up to prevent access to certain sites on the internet. If your facility has a firewall it may prevent you from successfully updating utilizing this method. If you are unsuccessful in using the automatic update, contact your IS department to determine if your facility has a firewall. If you are behind a firewall, the IS department may be able to punch a hole through for you to access our site. The address they will need for this is ftp://rmcdsxxx@rmcds1.med.utah.edu (xxx is your RMCDS three digit hospital number.) You can cancel the automatic update anytime the **Cancel** button is available. If you cancel, you will have to re-enter your login to open RMCDS back up.

To run the automatic update, from the Main Menu click on **File > Software Updates**.



This will open a new window called **Process updates to the software.** The Main Menu will close.

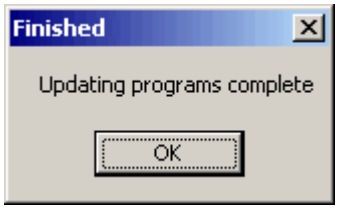


There are various options available for system updates and revision processing. Follow the instructions specific to the type of update you are doing. The instructions follow in the order they appear on the Process Updates window. You may need to scroll down to find the instructions specific to the type of update you are doing.

Files on Regular Diskettes

If you receive a revision on a 3 1/2 inch floppy disk select the first radio button labeled **Files on Regular Diskettes** and click on **Run**. You will see a message telling you to insert the revision disk.

Make sure the floppy is in the disk drive and click **OK**. The revision will run and when it is finished you will see the following message window letting you know that the revision has been processed.



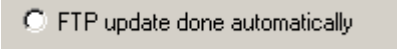
Click on **OK**. You will then be prompted to log back in to RMCDS.

FTP update done automatically

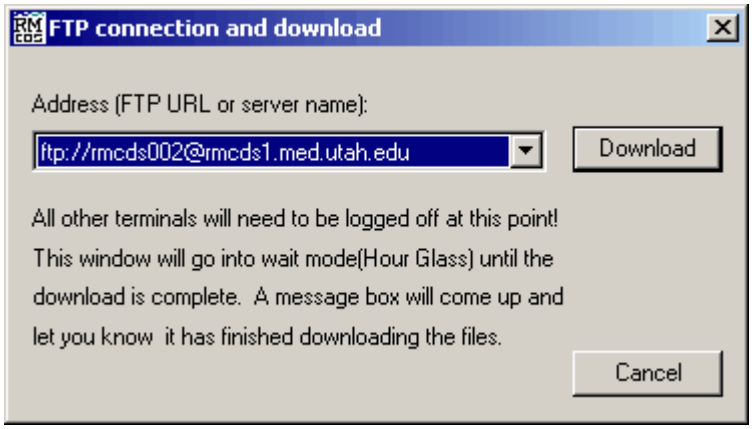
Before you are able to run this update option you must be connected to the Internet. Also, if your facility has a firewall it may block access to the RMCDS ftp site. Please contact your IT department if you are uncertain about the Internet and firewall settings at your facility.

Running automatic FTP updates is the easiest way to keep your RMCDS programs current. RMCDS recommends that you update your programs at least once a month to stay current.

To run the automatic FTP Update, click on the **FTP update done automatically** radio button and click **Run**.

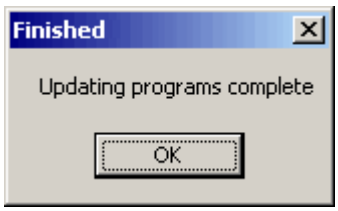


A window titled **FTP connection and download** will open.



The address to the RMCDS FTP site will appear in the Address box. Click on the black arrow at the right of the input line and choose the FTP address that is listed. If your RMCDS software is installed on a network, make sure that all other terminals are logged off of RMCDS before you continue. Click on **Download**. At this point the program will connect to the RMCDS ftp site and download the current files. Your cursor will turn into an hourglass during this process. PLEASE BE PATIENT, this process can take several minutes depending on the speed of your computer and network traffic. Once the required files are downloaded you will get the following message.

Click **OK**. A command window will open and you will see the program files being updated. Upon completion you will see another message letting you know that the update is complete:



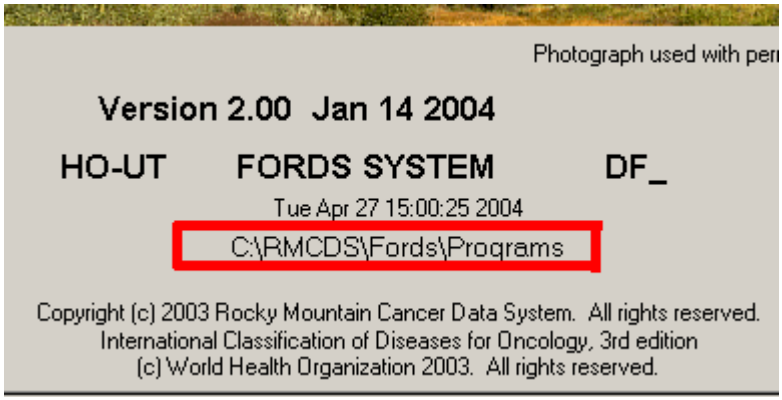
Click on **OK**. You will then be prompted to log back in to RMCDS. After you log back in to RMCDS, check the Version number and date to make sure the update worked properly. The date should have updated and should be no more than a few days prior to the current date. If this date was not updated then the revision was not successful and must be run again. If the date is current then all of your RMCDS programs will have been updated. We recommend that you update your programs about once a month to stay current. Updates are free and available 24 hours a day.

Click on **OK**. You will then be prompted to log back in to RMCDS.

FTP Update Done Manually Using Internet Browser

To run the manual FTP update you will need access to the Internet and an FTP capable web browser. Generally the FTP Update Done Automatically is easier and quicker but there may be situations that require you to use the manual FTP update.

Before you can run the Manual FTP Update, you must connect to the RMCDS FTP site manually and download the required files. These instructions describe how to do this using either Internet. Explorer or Netscape. Before you can complete this procedure, you will need to know the path to your RMCDS Programs. The path is the directory on your local computer or network where RMCDS is loaded. If you do not know the path to RMCDS on your computer look on the fourth line below the picture on your main menu.



Make sure you take note of the path before you begin the Manual Download.

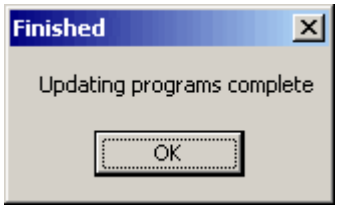
If you are using **Netscape,** use the following directions:
1) Open your Netscape browser.
2) In the address line type FTP://RMCDS###@rmcds1.med.utah.edu (### being your three digit hospital number.) When you press enter you will be asked for a password. Use the system password.
3) When the page comes up, open the "ho" folder. ("HO" is the abbreviation for Hospital, if the revision is for a Central Registry go to your state folder.)
4) In the "ho" folder, find the folder called "fords" and open it.
5) Two files will need to be saved in your RMCDS programs directory. The files are: COMPFORD.BAT and FORDSFTP.EXE.
6) To save the files, right click on them and choose the option **Save link target as**. Both files will need to be saved individually. Make sure to save both files into the Programs directory of RMCDS. (If you do not know where the programs directory is on your computer please return to the top of this section and read the information about finding the path to the RMCDS Programs.)
6) Once you have saved both files you can close Netscape.
7) You are now ready to process the update as described below under **Process**.

If you are using **Internet. Explorer**, use the following directions.

1a) Open Internet. Explorer.
2a) In the Address line type FTP://RMCDS###:passwd@rmcds1.med.utah.edu (### being your three digit hospital number, and **passwd** being the system password. If your hospital number is longer than three digits, enter the last three of your number)
3) When the page comes up, open the "ho" folder. ("HO" is the abbreviation for Hospital, if the revision is for a Central Registry go to your state folder.)
4) In the "ho" folder, find the folder called "fords" and open it.
5) Two files will need to be saved in your RMCDS programs directory. The files are: COMPFORD.BAT and FORDSFTP.EXE.
6) To save the files, right click on them and choose the option **Copy to Folder**. Both files will need to be saved individually. Make sure to save both files into the Programs directory of RMCDS. (If you do not know where the programs directory is on your computer please return to the top of this section and read the information about finding the path to the RMCDS Programs.)
6) Once you have saved both files you can close Internet. Explorer.
7) You are now ready to process the update as described below under **Process**.

Process
Once the required files are manually saved the update can be processed. From the Main Menu in RMCDS click on **File > Software Updates**. Select the radio button called **FTP update done manually using Internet browser.**

A command window will open and you will see the program files being updated. Upon completion you will see another message letting you know that the update is complete:

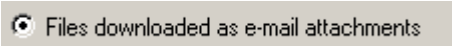


Click on **OK**. You will then be prompted to log back in to RMCDS. After you log back in to RMCDS, check the Version number and date to make sure the update worked properly.

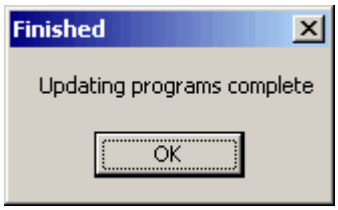
Files Downloaded as Email Attachments

Running this option requires that you first receive an e-mail revision from RMCDS. E-mail revisions are rare and RMCDS does not generally send them out. If you have received an E-MAIL REVISION from RMCDS then follow these instructions to process it. (Note: not all files sent from RMCDS via e-mail are e-mail revisions. Most files sent from RMCDS via e-mail do not require processing.)

From the **Process Updates to the Software Menu** choose the **Files downloaded as e-mail attachments** radio button and click on **Run**.



A command window will open and you will see the program files being updated. Upon completion you will see another message letting you know that the update is complete:



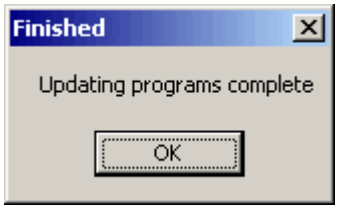
Click on **OK**. You will then be prompted to log back in to RMCDS.

Files on Compact Disk (CD)

Follow these instructions if you receive a CD from Rocky Mountain Cancer Data Systems. You will need to know the drive letter to your CD ROM before using this option. If you are unable to determine what your CD drive letter is, contact your IT or IS department.

Insert the RMCDS Revision CD into your CD ROM Click on the Radio button labeled **Files on Compact Disk (CD)**. In the box labeled **Drive,** type in the drive letter to your CD ROM.

A command window will open and you will see the program files being updated. Upon completion you will see another message letting you know that the update is complete:

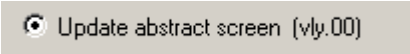


Click on **OK**. You will then be prompted to log back in to RMCDS.

Update Abstract Screen (vly.00)

Follow these instructions to update your abstract screens. Abstract screen do not need to be updated regularly because they don't change very often. Examples of times when you would need to update the abstract screen are after a coding standard change or after you request custom screen modifications.

To update the default abstract screens on your computer select the radio button labeled **Update abstract screen (vly.00)** and click **Run**.



A command window will open and you will see the program files being updated. Upon completion you will see another message letting you know that the update is complete:

Click on **OK**. You will then be prompted to log back in to RMCDS.

CHAPTER 7 – ACCURACY OF TRANSMISSION

STATE CONFIRMATION/ERROR IDENTIFICATION

Once the uploaded file is received from a reporting facility, the abstracts are automatically reviewed for accuracy as data is processed into the OCCR RMCDS data system. The review is based on the Oklahoma and NAACCR reporting guidelines.

Standardized Data Edit Sets:

- Standard 2006 Edits Report
- RMCDS DATA EDITS:
  - Duplicate submission of existing records
  - Multiple primaries
  - Unacceptable codes for any field or inter-fielded consistencies
  - Invalid or unusual site/sex, age/site, age/morphology combinations
  - Native American reporting inconsistencies

From the edited data, a report is generated listing the cases received and any edit errors found in the submitted data. Any data submitted with greater than 10% error rate is returned for correction. The data must be corrected and re-submitted to OCCR within two weeks to be considered compliant.

Reporting compliance is based on the estimated number of cases expected to be reported by your facility for the year. The calculation method for each facility is discussed in Chapter 9 under the Quarterly Report section.

The quality of the data submitted is also measured in the quarterly compliance report. Cases returned for correction will not be counted in the compliance percentage until resubmitted. If response is not received during the reporting quarter, compliance will not be picked up until the next quarterly report.

CHAPTER 8 - DATA CORRECTION FOR REPORTED ABSTRACTS

It is very important to correct any data information that is found to be inaccurate or unavailable at the time the patient case was abstracted or reported to the state. Correction improves the quality of Oklahoma statistics.

CHANGING DATA YOU HAVE REPORTED

Data is recorded in your abstract and reported to OCCR as it is documented in the medical record at initial diagnosis or treatment. Information that was missing in the original record, like physician notes, tests, radiographs and consultations may be added to the patient's medical record when it is determined to be accurate information. A patient's most recent facility visit may contain new information about the initial diagnosis or treatment. Another facility may call with information it has. In any of these situations, the new information can be added to your abstract and reported to OCCR if the information covers the time of initial diagnosis or start of initial or planned treatment.

The policy is to use the latest and most complete information available. It is acceptable to change the primary site, histology and extent of disease (staging data) if it falls into the reporting guideline for initial diagnosis or treatment. (NAACCR #390; FORDS pg 89)

WHEN AND HOW THE DATA CAN BE CHANGED

The abstract should be corrected as soon as new information is received. Document in your abstract what changes have been made in the original information and where the information was found.

SUBMITTING DATA CORRECTIONS TO THE STATE

The correction information or abstract should be sent to OCCR to correct the patient information. It can be submitted, in a separate file, at the same time as the next monthly report.

CHAPTER 9 – OCCR DATA QUALITY CONTROL

All state cancer registries are evaluated and awarded certification for outstanding data quality. Oklahoma has as their objective to maintain a "Gold" classification, which was obtained in 2004, 2005 and again in 2006. These are the requirements:

CENTRAL REGISTRY CERTIFICATION CRITERIA		
Registry Element	**Gold**	**Silver**
Completeness of Case Ascertainment	95%	90%
Completeness of Information Recorded:		
Missing/unknown "age at diagnosis"	<2%	<3%
Missing/unknown "sex"	<2%	<3%
Missing/unknown "race"	<3%	<5%
Missing/unknown "state & county"	<2%	<3%
Death Certificate Only cases	<3%	<5%
Duplicate Primary Cases	<=1 per 1000	<=2 per 1000
Passing EDITS	100%	97%
Timeliness	Data submitted within 24 months	

To meet these goals, OCCR monitors the quality of information received from all the offices. Internal and external reviews have been developed and implemented to monitor and improve our Oklahoma quality.

INTERNAL REVIEW

MONTHLY LETTER OF ACKNOWLEDGEMENT

After the monthly data disk has been received and reviewed, OCCR will generate an acknowledgement listing the name and accession number of each patient submitted and received by their office. It is "**VERY IMPORTANT"** that you compare the case listing with the submission on your file to assure data accuracy for your facility report. By reviewing your copy, discrepancies can be found and resolved.

QUARTERLY COMPLIANCE LETTER

In 2002, OCCR implemented distribution of a quarterly letter measuring compliance with 180 day reporting (within 6 months). The expected annual caseload estimate for each facility is based on the **average** of the previous three years of data.

Example: If you had 200 cases in 2003, 180 cases in 2002 ,and 160 cases for 2001, the "expected" number of cases for 2004 will be 180.

NOTE: Calculation of the report is based on the **"DATE OF DIAGNOSIS:** not the **"Date of First Contact."**

You have 30 days from receipt of the monthly report to submit all cases that exceed the 6-month time period or to have communicated with the Central Registry about the reason for non-compliance. If the expected cases are not submitted within 30 days of the first letter, a second letter will be sent to the corporate compliance officer and/or administrator of the organization being contacted. The third step (OS Title 63, Article 17.1 and 17.2) is a written 15-day notice of violation of the standard. It can require compliance immediately or within a specified time period or both. It can also assess an administrative fine for each day or part of a day that compliance to the order does not occur, not to exceed $10,000.00 per day. An Administrative warrant can be obtained to enforce access to the facility premises for investigation, inquiry and inspection by the State Board of Health.

ANNUAL REPORT

The Central Registry completes their annual report in June of each year. It is available on their web site, distributed at OCRA meetings or other meetings held by OCCR during the year.

CANCER DEATH CLEARANCE REPORT

Oklahoma cancer death clearance is checked annually to improve data completion and accuracy. OCCR matches their existing yearly cancer incidences against cancer deaths reported to the Oklahoma Division of Vital Records. Disparities between the two reports must be reconciled. A cancer patient death at your facility not reported to OCCR as a cancer case, will appear on your annual Death Clearance Report to reconcile. You will be required to report as quickly as possible any new cases you identify as reportable from this list. If you have maintained a Non-Reportable Patient List, you will be able to clear a majority of the cases from the information you have already reviewed.

You will be expected to submit an abstract for cases that should have been reported and substantiate enough information from your medical record to help OCCR refer the open cases to someone else for reporting.

A second mailing will go out based on the results from the first mailing. Usually, the majority of the cases not cleared by the first mailing are sent to a physician on the second mailing. There will always be a few stragglers for your facility if another facility reported the original diagnosis or treatment at your facility. It is vital that all these cases be reconciled for accurate Oklahoma reporting.

INTERNAL DATA REVIEW

OCCR is always looking for internal ways to review the reported data. For the past three years, OCCR linked with the Indian Health Services (IHS) to help in identifying American Indian and Alaskan Native cancer patients. The initial phase of the project was completed in 2004. This program found 3,725 cases submitted to OCCR that fall into the race category of "AI/AN. This was a significant improvement in the accuracy of cancer surveillance data for the American Indian populations within our respective Oklahoma area of coverage.

EXTERNAL REVIEW

STATE DATA EXCHANGE

Semi-annually, information is shared with bordering states and federal institutions to identify patients with out-of-state addresses that have been diagnosed and/or treated in facilities located in Oklahoma, as well as cases of State residents diagnosed and/or treated in facilities not located in Oklahoma

OCCR "CASE COMPLETENESS AND DATA QUALITY AUDIT"

During every five-year NPCR funding cycle, CDC conducts an audit of OCCR. The audit consists of an evaluation of central cancer registry cases for completeness and data quality. Because the information is generated from the local reporting entities throughout the state, these entities are involved in the site audits required by CDC. From the state-provided case information (6-8 weeks before the audit), CDC uses the Technical Assistance & Audit Program (TAA) auditors to conduct the on-site audit. Reviewers will perform casefinding and re-abstracting activities to assess data quality and verify the completeness of reporting for the months selected for review in each hospital.

The CDC contractor randomly selects, by a statistical program based on volume, the entities that will participate in the on-site record review. In Oklahoma, it has involved 9 hospitals. Hospital selection is based on the number of cases reported (small, medium, and large caseload) reported in Oklahoma for the four (4) primary sites. The reportable sites reviewed have been female breast, prostate, colon and rectum, lung and bronchus.

The reporting entities will be involved in supplying specific information to OCCR for the site visit by the CDC contract auditors. A letter will be sent to the hospital's Chief Executive Officer or Chairman of the Board, Medical Records Department Supervisor and the Cancer Registrar, along with a hospital profile sheet. The profile sheet returned to OCCR supplies information related to the specific functions of your cancer departments, the cases reported, how they are found and chart accessibility for the audit. Notification of the site visit is usually 6 weeks before the audit. OCCR reviews the profiles and forwards them to the CDC contractor.

The audit consists of two parts: 1) data quality and 2) casefinding. The CDC contractor usually selects 40 records for the specific reporting months being sampled in the audit. Only 33 cases are reviewed at each reporting entity. There are 13 data items involved in the audit. Any data item that is not found and verified will generate a documented query for follow up.

For the casefinding portion of the audit, the CDC contractor will review the medical record disease index, all benign and malignant pathology, cytology, and autopsy reports generated in the months of the audit. If available, radiation oncology and surgery logs are useful for the review. For every case that is not found to already be in the OCCR database, a query will be written. It is beneficial to have a "non-reportable" log in the registry. It will provide documented justification for a case being omitted from the reportable list. Later in the audit process an explanation for non-reported cases will be required. OCCR will bring a computer with the state registry data so reference can be made of case reporting by another reporting site. This reduces the number of cases found not to have been reported by Oklahoma and reduces the reconciliation process later in the audit.

The CDC audit usually takes two weeks. The CDC contractor will designate the date of the on-site visit. Representatives from OCCR and the contract auditors will visit your site. Requirements for the visit will have been covered in the initial information completed earlier.

The CDC contract team analyzes the results of the re-abstracting and casefinding audit and collaborates with the OCCR staff in the reconciliation of the discrepancies on the list of unmatched cases provided to the OCCR staff. OCCR is responsible for the reconciliation of these unresolved queries from the audit and providing the required documentation to the CDC contractor within seven (7) weeks.

Those queries that OCCR cannot resolve first, will be forwarded to the reporting facility for review. If your facility has a documented resource in your chart, it will help OCCR in eliminating this query from their list. After these responses have been returned, any reasons for differences in re-abstracting data will be investigated with the assistance of the OCCR staff. Upon the completion of investigating these unmatched cases, OCCR will provide the results of their investigation to the CDC contractor for final reconciliation. Any unresolved queries impact the data quality for Oklahoma.

The final report will be sent to OCCR 15 weeks after the audit is completed. It will not identify results from any specific hospital. If you receive an abstract to reconcile, it might be useful to copy it once it is reconciled. You can then use it to calculate the data quality and casefinding rate for your facility. It is also a good tool for better abstracting and case reporting for your facility. It is a training tool for changing incorrect abstracting practices in your facility. If you see a change should be made, consistent abstracting makes it easy to pull up a specific cancer site report from your database and correct any previously reported abstracting errors. It will make your data more accurate when you are doing cancer studies.

CHAPTER 10 – FOLLOW-UP

The importance of collecting the current health status for each patient is undeniable. Without this information much valuable information would be lost in determining outcomes and relating outcome to a patient's stage of cancer and the treatment the patient was given. The statistical outcomes derived from this information affect allocation of the available resources or treatment for cancer.

Oklahoma law 310:567-3.1 covers reporting requirements. In addition to reporting first course, there is also the requirement to report subsequent courses of treatment, recurrence, continuous follow-up and death.

WHEN TO FOLLOW

Cancer registries have many resources available to obtain the most current information on the patient's health. This is started 12 months after the patient was last treated in your facility and is considered delinquent if contact has not been made within 15 months. Follow-up is continued as long as the patient is alive, or until the patient is "lost to follow-up" because no information can be found relating to the patient.

WHOM TO FOLLOW

FOLLOW-UP LETTERS DO NOT HAVE TO BE SENT TO ALL YOUR PATIENTS. THESE ARE THE **EXCLUSIONS:**

1. Carcinoma in-situ of the cervix
2. Patients residing in foreign countries
3. Cases that were not required to be reported to the OCCR.

HOW TO DO FOLLOW-UP

The resources used should be consistent with the HIPAA guidelines that have been adopted by your facility. The majority of information will come from readmission or contact with the patient's physician. With the implementation of HIPAA, contact with the patient may be restricted unless the patient has signed a confidentiality form upon admission to the hospital. A Hospital might require retention a list of patients have contacted. Your letter mail-out list should meet this requirement.

Many hospitals send a letter to a patient who has signed a Confidentiality Statement without listing any restrictions. The facility has determined that this meets the HIPAA requirement for allowing patient contact. If you have a registry brochure, it is good to include it with your correspondence.

If patient contact is by telephone or letter, the conversation should be conducted in a sensitive and delicate manner. Some patients are very sensitive to the mention of their cancer or to having anyone know of

their diagnosis. Many registries use a generic envelope, basic hospital letterhead and designate the letter signature as being sent from the follow-up coordinator. All software vendors have provided a way to create and generate monthly letters to send out to physicians, patients and other resources.

FOLLOW-UP RESOURCES

There are many resources available for follow-up listed below:

Readmission (Inpatient, outpatient, lab work)

When you are doing casefinding, current cancer follow up information is often found in the medical record. The new admission date constitutes the follow-up requirement and extends the length of time before a letter needs to be generated.

Hospital Cancer Support Group

If your office is involved with this, it is another follow-up source.

Hospital Cancer Health Fairs/Education Seminars

Physician Letter

The physician will have more accurate clinical data. Design your letter with the original diagnosis included. If the patient has a second cancer, you will be able to add this to the patient's record. You may send the letter to physicians that did not see the patient directly for cancer. Just knowing they are alive will constitute a new follow-up date.

Patient Letter

Keep the letter generic. Do not use the word "cancer" in the letter or on the envelope. If the patient mentions cancer, you know they are "ok" with it.

Other Facilities

If another hospital treated the patient, they may have current follow-up.

Patient Telephone calls

Newspaper Obituaries & Articles

Daily obituary review will pick up your expired patients and keep you from sending a letter to a patient who has died.

Division of Vital Records

You can contact the Division of Vital Records to be put on their distribution of cancer-coded deaths. The telephone number is 405 721-4040.

State Registry

If all other resources have been exhausted, OCCR will be glad to help with lost patients. They will be researched as the OCCR work schedule will allow.

Internet

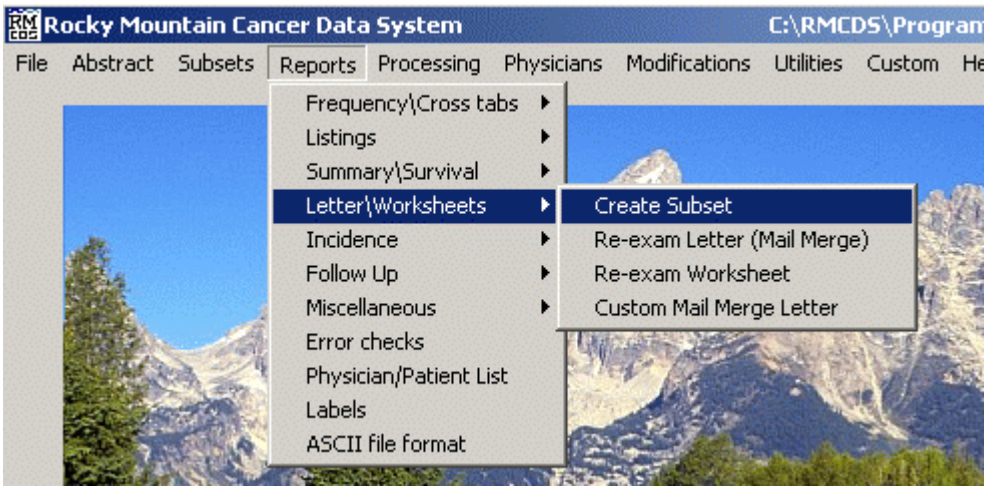
A list of websites is available in Appendix D.

RMCDS FOLLOW-UP LETTER INSTRUCTIONS

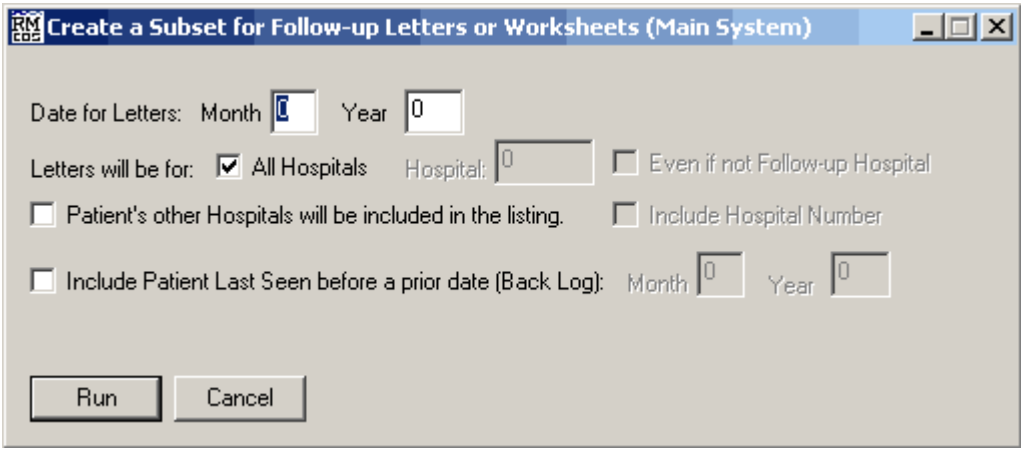
FOLLOW-UP LETTERS AND WORKSHEETS

The following instructions describe how to create follow-up letters and worksheets. The first step is to create a subset of cases to use in generating the reports.

Click on **Reports > Letter/Worksheets > Create Subset**.



This will bring up the **Create a Subset for Follow-up Letters or Worksheets** window.



In this window enter the month and year for the letters you want created on the first line. The second line gives the option for **All Hospitals**. If you have more than one hospital on the RMCDS system and wish to create letters or worksheets for only one hospital, take the check mark out of the **All Hospitals** box and then enter the hospital number you want the reports for in the box labeled **Hospital:**. Choose the other options that are wanted for these letters and

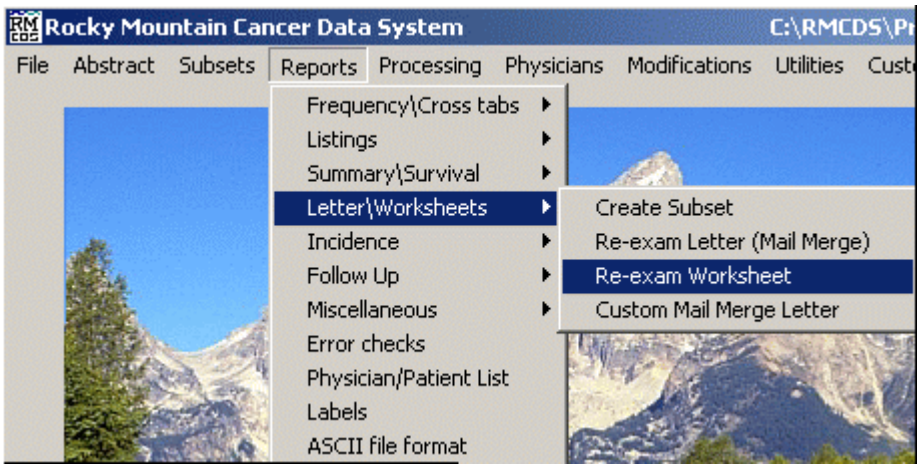
worksheets and click on **Run** when you are finished. The report will run and you will see the standard **Print Options** window. From here you can examine, print or delete the letter generation report. If you do not wish to examine or print at this time, simply click on **Exit** to close the **Print Options** window.

After you create the subset (which is called **letter**,) you will need to run the re-exam letter program to generate the follow-up letters. Please see the instructions labeled **Re-exam letters (Mail Merge).**

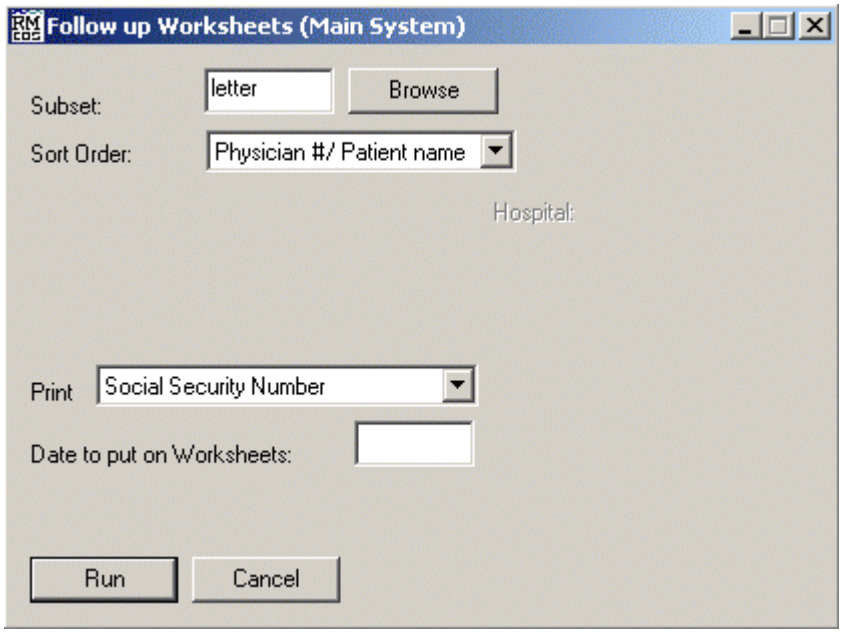
RE-EXAM WORKSHEETS

These instructions describe how to create the worksheets to go along with the follow-up letters. Before you can create the worksheets you must create a subset of cases. Please see the instructions for Creating Re-Exam Subset if you need help with this.

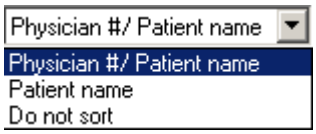
From the RMCDS Main Menu, click on **Reports > Letter/Worksheets >Re-exam Worksheets**



This will open up the **Follow up Worksheets** window.



The default for the subset name is **letter**. If letter is not the name of the desired subset, click on the **Browse** button and choose the subset you want to use. Choose the sort order from the pull down menu.



Select if you want to print the Social Security Number or the Medical Record Number. The last box asks for the date to put on the Worksheets. Type in the date and click on **Run**. The worksheet is generated and the **Print Options** window appears. From here you can view or print the worksheets. Please see the related instructions for assistance in using the Print Options.

VOLUME II

CANCER CASE ABSTRACTING

CHAPTER 11 - CODING INSTRUCTIONS FOR A HOSPITAL ABSTRACT

Both CoC accredited hospital based-cancer program registries and all other facilities that do state reporting must meet the state reporting requirements. Reference is made to accredited cancer program requirements, and if they differ from the state requirements, they are coded in blue to alert you to the differences in data requirements. You should go to the FORDS manual for guidance.

Chapter 11 – 19 is written in the format that data is input into the Rocky Mountain Cancer Data Systems abstract software. Most accredited programs do not use the Rocky Mountain software, and their vendors design their software to meet both state and CoC date reporting requirements. You will find that all the references recommended will help you prepare your abstract.

The FORDS manual references the NAACCR item number, and we have added the FORDS page number and SEER page number for items that must be reported. Sometimes it is helpful to read another resource because different writing styles make the information clearer.

The NAACCR Manual is designed with an alphabetical listing of data items. Sometimes their data name is not quite the same as the FORDS name and it is difficult to find the subject you are researching. The Index can help in identifying where your topic is located. It is a bit confusing at first. The page numbers were not added because they change when updates are sent out.

COMPLETION DATE FOR CANCER CASE ABSTRACT

Your Abstract can be completed between the fourth (4) month and sixth (6) month after the date of diagnosis. As stated before, documented first course of planned-treatment can be used as a positive response of treatment, whether the treatment has been started, completed or administered. The first course of cancer treatment is considered to be within the first four months after the patient has been initially diagnosed or treated for cancer. The initial planned course of treatment can cover a long period of time.

The cancer case **Abstract** is used to collect and report the state required information for each patient reported to the Oklahoma Central Cancer Registry. The **Abstract** is used to collect four information categories for each patient abstracted:

- Patient Data
- Hospital Data
- Tumor Status
- Treatment and Follow-Up Data

This chapter will cover each item within the abstract and make reference to the resources where additional information can be found.

OVERVIEW

To abstract your cases in the appropriate version format use these references:

Diagnosis/Admission Year	NAACCR Version
1997 to 2003	10.0 Required
2004	10.2 Preferred (10.1 Accepted)
2005	11.0 Required
2006	11.0 Required
2007	11.1 Preferred
2008	To be determined

DATA REPORTING REQUIREMENTS

OCCR monitors the reporting of 43 data items, though only 22 data items are specifically listed in the statute. By including the additional data items, more specific information is available to be used in cancer research.

1. Reporting hospital identification number.	Three-digit code provided by OCCR.
2. Abstracted By	Initials or code of abstractor. Can be used for quality control.
3. Date 1st Admit/Contact	Is the date of the facility's first inpatient or outpatient contact with the patient for diagnosis or treatment of cancer. This date may represent the date of a biopsy, x-ray, scan or laboratory test. (Measurement for length of time between first contact and treatment.)
4. Type of Reporting Source	This data item is intended to indicate the completeness of information available to the abstractor. It is the source that provides the best information. (1=Hospital, 2=Radiation Treatment Centers or Medical Oncology Centers *new item for 2006*, 3=Lab, 4=Physician, 5=Nursing Home, 6=Autopsy, 7=Death Certificate and 8= surgery centers)
5. Accession Number	Provides a unique identifier for the patient consisting of the year in which the patient was first seen at the reporting facility and the consecutive order in which the patient was abstracted. The first four numbers specify the year and the last five numbers are the numeric order in which the patient entered the data base. 2005*00015* FORDS Manual page 33. Year *Number in Registry*

6. Sequence Number	Indicates the sequence of malignant and non-malignant neoplasms over the lifetime of the patient. The sequence number distinguishes among cases having the same accession number. FORDS Manual page 34. 00 = One malignant or in situ primary 01= First of two or more primary tumors 02= Second of two or more primary tumors 60=Only one non-malignant primary 61=First of two or more non-malignant primary tumors 62=Second of two or more non-malignant primary tumors
7. Medical Record Number	This number identifies the patient within a reporting facility.
8. Social Security Number	Enter social security number with no dashes. This data item can be used to distinguish between patients with similar names.
9. Patient's Name	Enter patients last name, first name and middle name.
10. Address at Diagnosis	Identifies the patient's address (number and street) at the time of diagnosis. *Do not update this data item if the patient's address changes.*
11. County at Diagnosis	Please refer to the Oklahoma State FIPS codes by City then County.
12. Telephone Number	For follow-up purposes.
13. Address Current	Identifies the patient's current address. This can be different from *Patient Address at Diagnosis* as the patient may move. FORDS Manual page 42.
14. Place of Birth	This data item is used for evaluation of medical care to special populations.
15. Date of Birth	Record as follows 06071951
16. Race	Racial origin captures information used in research and cancer control activities. FORDS pages 59-64. Race 1; Identifies the primary race of the person. Race 2-5: Additional races reported by the person. If no other race is reported use code 88 in Race 2-5. See FORDS for coding of Spanish origin, page 65.
17. Primary Payer at Diagnosis	Identifies the patient's primary payer/insurance carrier at thime of initial diagnosis and/or treatment. Used in financial analysis and as an indicatior for quality and outcome analyses. FORDS Manual page 67.
18. Sex	Identifies the sex of the patient. FORDS Manual page 66.

19. Marital Status	Used for follow-up purposes.
20. Text Usual Occupation/Usual Industry (environmental exposures)	If occupation is not known/retired leave these items blank.
21. Class of Case	Classifies cases recorded in the database. Divides case records into analytic and nonanalytic cases. FORDS Manual page 83.
22. Date of initial diagnosis.	The date of diagnosis is the month, day and year the tumor was first diagnosed by a recognized medical practitioner, whether clinically or microscopically confirmed. *Note:* If the exact date on which the diagnosis was made is not available, then record an approximate date. Approximation is preferable to recording the date as unknown. *Example: 03/99/2005*
23. Primary Site Code/ Topography Code (ICD-O-3)	Topography terms are four character codes that run from C00.0 (external lip) to C80.9 (unknown primary). A decimal point (.) separates the primary subsites. The decimal point is not entered as part of the code. *Example:* The pathology report says the primary site is the cardia of the stomach. The code (C16.0) is found in the Alphabetic Index under either “stomach” or “cardia”.
24. Laterality	Identifies the side of a paired organ or side of the body on which the reportable tumor originated. *See* Page FORDS Manual page’s 11-12 for list of paired sites.
25. Morphology/Histology and Behavior (ICD-O-3)	Morphology is a 5 digit code consisting of two parts: 1. Histologic type (first 4-digits) 2. Behavior code (fifth digit). Use the best information from the entire pathology report (microscopic description, final diagnosis, comments.) Collect all malignancies with in-situ /2 and malignant /3 behavior codes. Also required are benign /0 and borderline /1 intracranial and CNS tumors diagnosed on or after January 1, 2004. *Example: Adenocarcinoma* M-8140/3 Tumor/cell type Behavior
26. Grade/Differentiation (ICD-O-3)	Describes how much or how little a tumor’s cell resembles the normal tissue from which it arose. Grade I/Well differentiated, Grade II/Moderately well differentiated or intermediate differentiation, Grade III/Poorly differentiated, Grade IV/Undifferentiated or Anaplastic. When the diagnosis indicates two different degrees of grading or differentiation, the higher

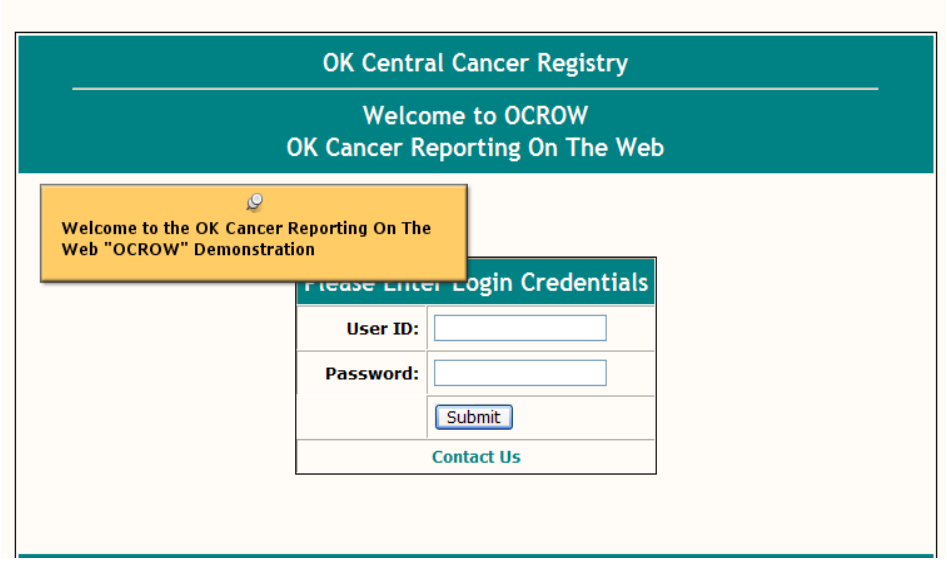
	number should be used. *See* FORDS Manual pages 12-14. *Example:* Moderately differentiated squamous cell carcinoma with poorly differentiated areas should be coded to Grade III.
27. Other Primary Tumors	Text field allows identification of mulitple primaries.
28. Text Diagnosis Procedure/Pathology	Text field used for quality control measure.
29. Diagnostic Confirmation	Records the best method used to confirm the diagnosis of the cancer at any time in the patient's history. Positive histology (tissue microscopically examined). Positive cytology (no tissue fluid cell microscopically examined). Positive laboratory test/markers study (alpha-fetoprotein for liver cancer). Radiographic (by imaging technique report only) and Clinical diagnosis only (reported by physician only in medical record). See FORDS Manual page 99.
30. Tumor Size	Describes the largest dimension of the diameter of the primary tumor in millimeters (mm). Tumor size is an important prognostic factor for cancer. FORDS Manual page 100.
31. Description of Tumor Size	Text field is used for quality control measures by recording three dimensional measurements. FORDS Manual page 101.
32. Regional Nodes Examined	Record the exact number of regional nodes examined by the pathologist. (FORDS Manual page 102.) Serves as a quality measure of the pathologic and surgical evaluation and treatment of patient.
33. Regional Nodes Positive	Record exact number of regional lymph nodes examined by the pathologist that contained metastases. (FORDS Manual page 103. This is a quality control measure of the pathology and extent of the surgical evaluation.
34. Collaborative Stage (CS)	Is a carefully selected set of data items that describe how far a cancer has spread at the time of diagnosis. *Collaborative Staging is collected on all cases regardless of whether they are microscopically confirmed*. The following items are required to derive SEER Summary Stage 2000: *CS Extension, CS Lymph Nodes, CS Mets at Diagnosis*. *Pleura Cancers require CS Site-Specific Factor 1 and Prostate Cancer requires CS Site-Specific Factor 3.* *See* Collaborative Staging Manual.
35. First Course Treatment (plus	All treatments administered to the patient after the

separate screens)	original diagnosis of cancer in an attempt to destroy or modify the cancer tissue. Palliative therapy is also part of the first course of therapy when the treatment destroys or modifies cancer tissue. *Note:* First course of therapy ends when there is documentation of disease progression, recurrence or treatment failure.
36. Date of 1st Course of Treatment	Records the date on which treatment (surgery, radiation, systemic, other, or palliative therapy) of the patient began. Treatment might be given in a hospital or non-hospital setting. See FORDS Manual pages 129-191.
37. Family History of Cancer	Record appropriate code located in Rocky Mountain top of page.
38. Tobacco History	Record appropriate code located in Rocky Mountain top of page.
39. Alcohol History	Record appropriate code located in Rocky mountain top of page.
40. Date of last contact or date of death	Code the date the patient was actually seen by the physician or contacted by the hospital registry as the follow up date. Do not count the date the follow up report was received.
41. Vital Status	Records whether the patient is alive or deceased at date of last contact. If the patient is deceased record the cause of death (7777) and the type of follow up source of the death information. See FORDS Manual page 201.
42. Place of Death	The state in which the patient died (a 3 digit number; Oklahoma 075) Verification of residency at time of death. Use drop down box next to field to find code if patient died in another state. If the patient is still alive, code 997.
43. Text	Quality control measure.

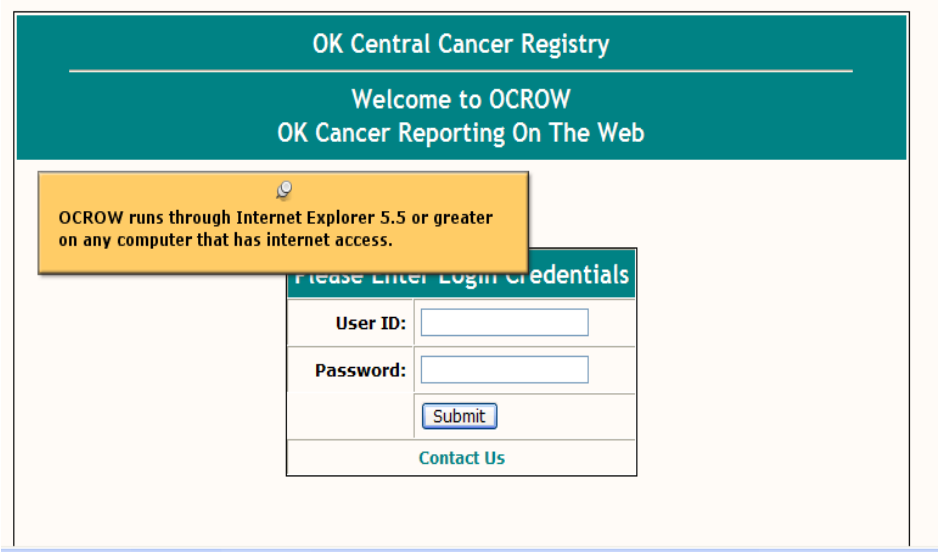
Abstracting in OCROW
(Oklahoma Cancer Reporting on the Web)

https://www.phin.state.ok.us/cancer

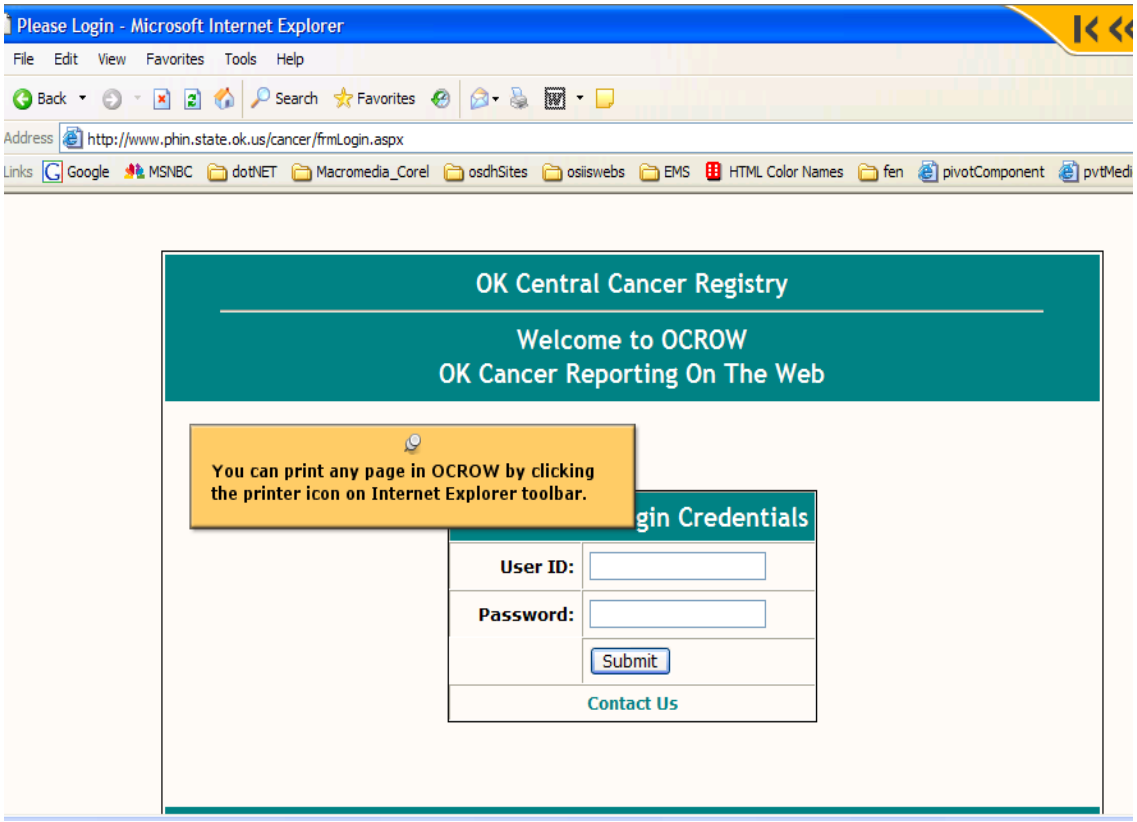
These instructions illustrate how to navigate through a case in the OCROW application.



OCROW is an ASP.NET Web application running on Microsoft Internet Information Services 5.1 and uses Secure Sockets Layer (SSL) to encrypt all data communication (128 bit) between the end-user and the server.

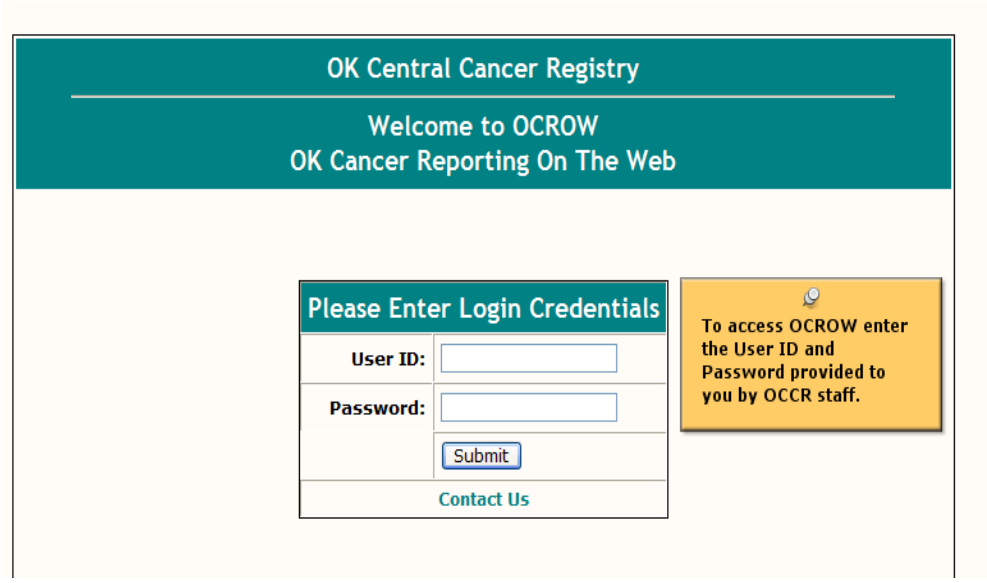


The OCROW application allows printing from any section in the cancer reporting form by clicking on the printer icon on the Internet Explorer toolbar. The completed abstract can be printed from the View Submitted Forms option.

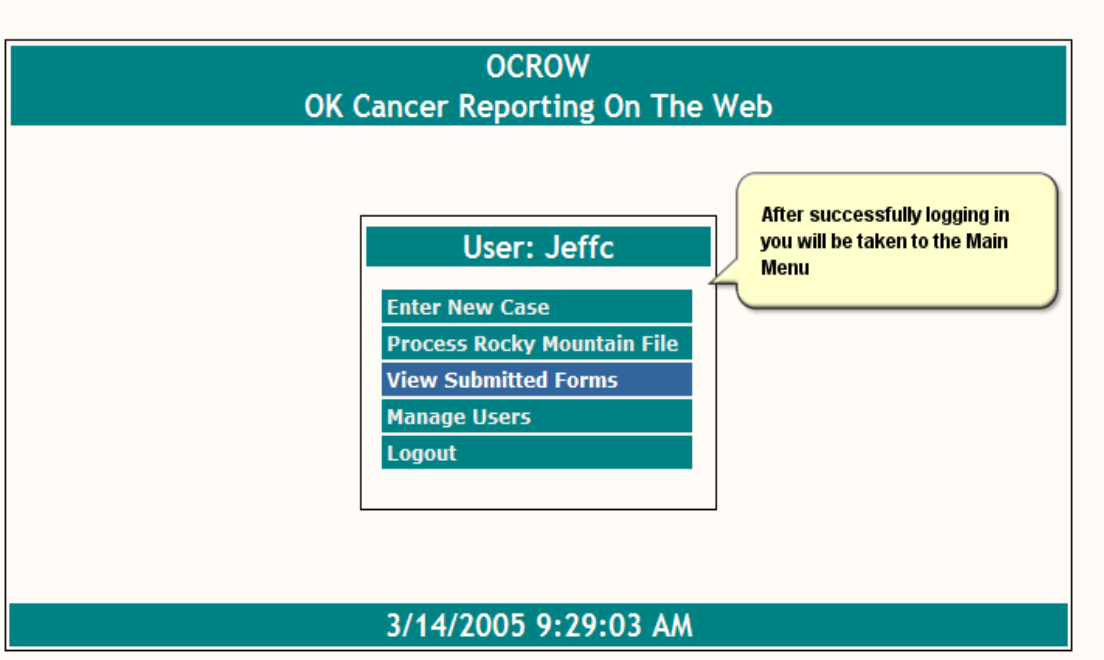


A Facility Authorization Request form must be submitted to OCCR in order to gain access to OCROW. This form can be found on our web site at http://www.health.state.ok.us/program/cds/cancereg.html

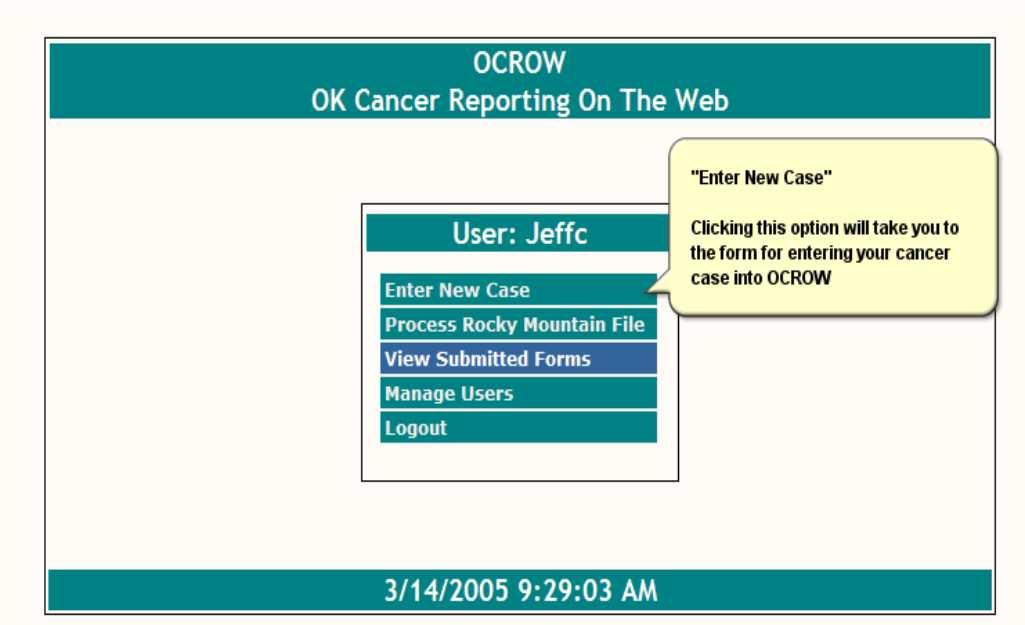
Upon receipt of the FAR form, the reporter will be notified via email of the new UserID and temporary password. After you enter this information, you will be prompted to change the password to a personal password that you will be responsible for remembering. The password is case sensitive.



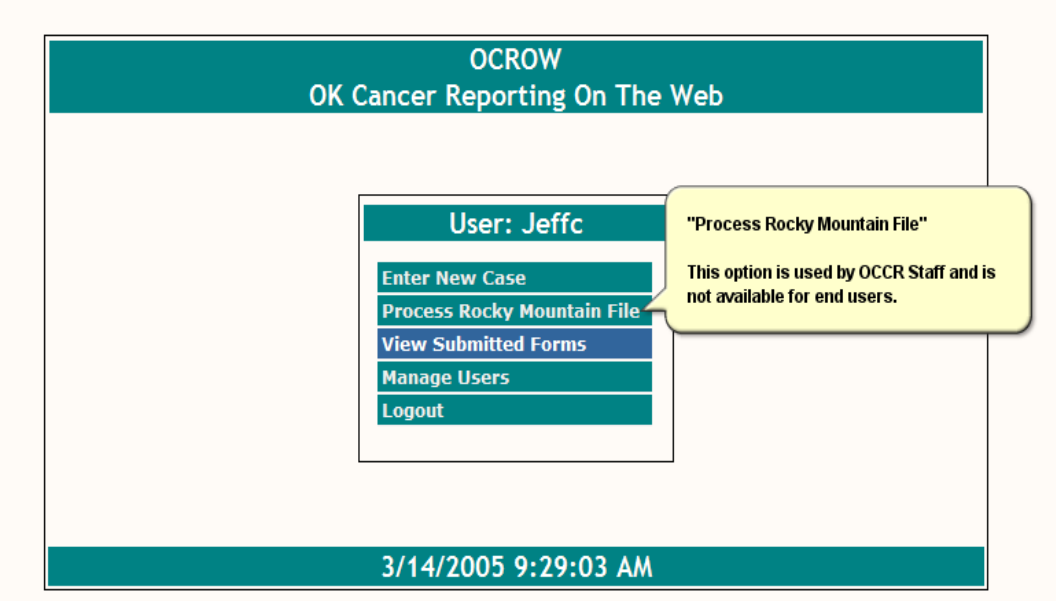
The next screen will reflect your **User ID** and the main menu items.



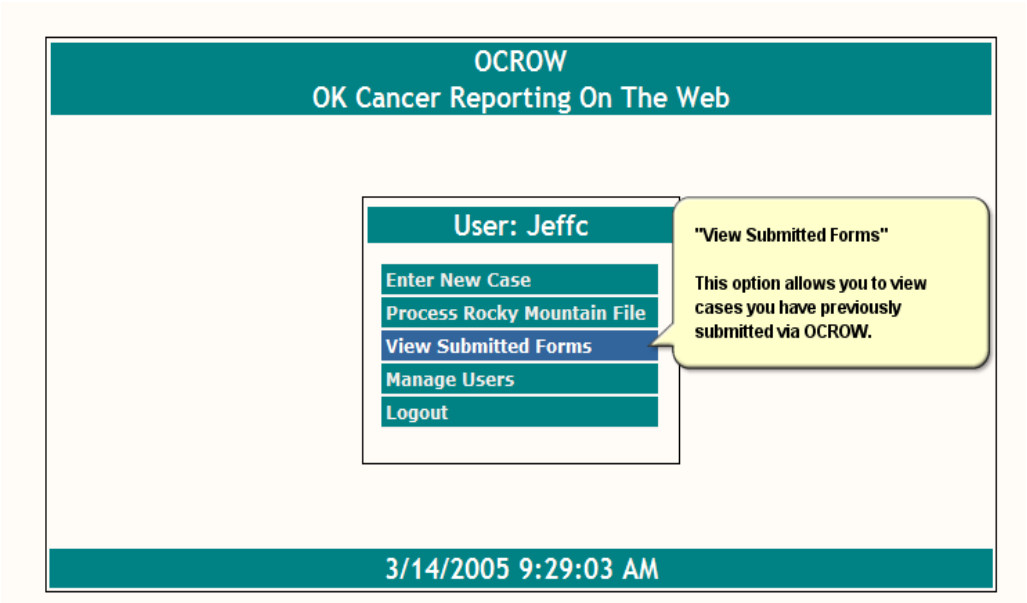
The first option is **Enter New Case**. The form contains sections for Facility Information, Patient Demographics, Cancer Diagnosis, Collaborative Staging, Biopsy Information, Patient Treatment, and Referral Information. Each section includes required data fields and will not allow submission without completed required data fields.



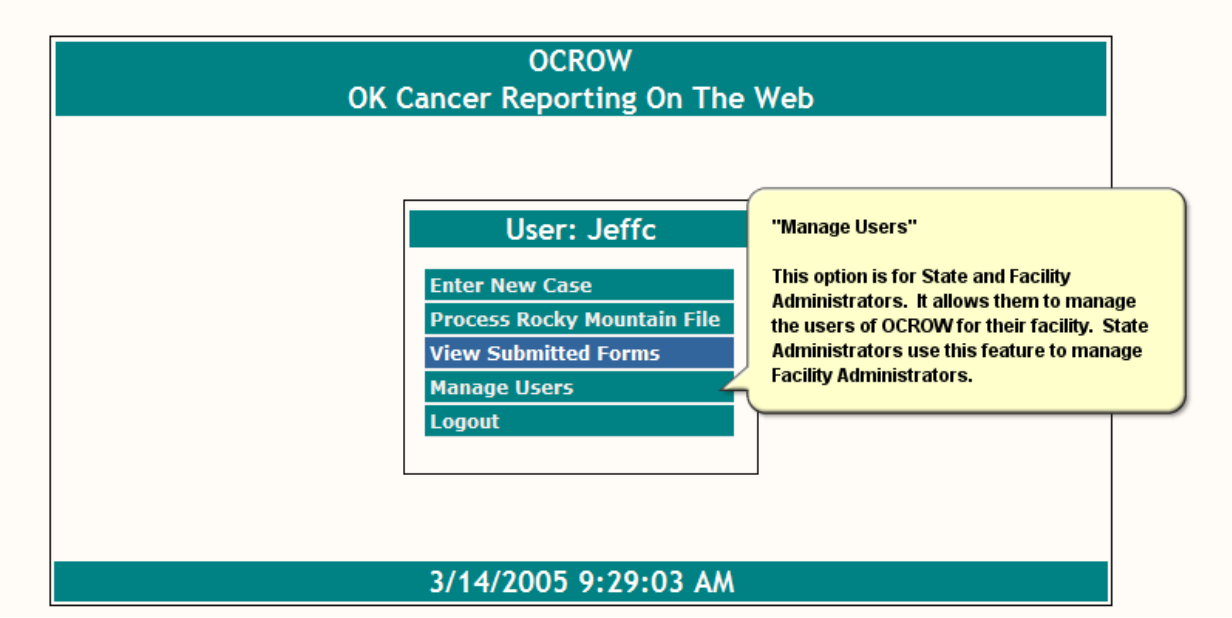
OCCR staff uses the next option **Process Rocky Mountain File**, to process the cases submitted via OCROW.



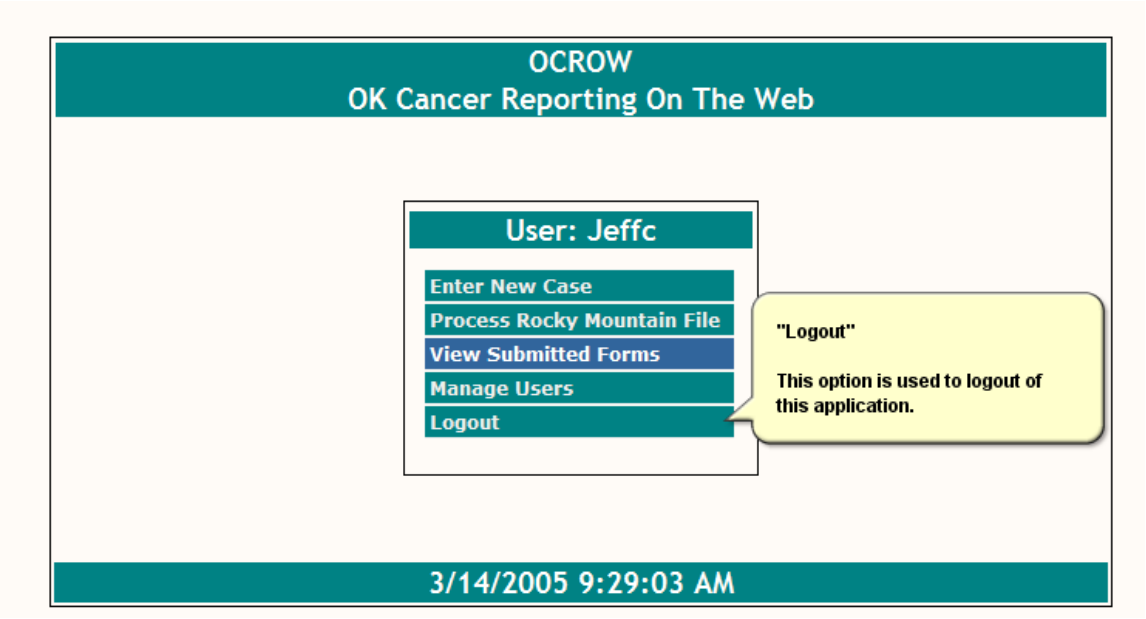
The next option is **View Submitted Forms**. OCROW allows the reporter to view all cases submitted by logged in facility only. Search options include Last Name Search or Social Security Number Search.



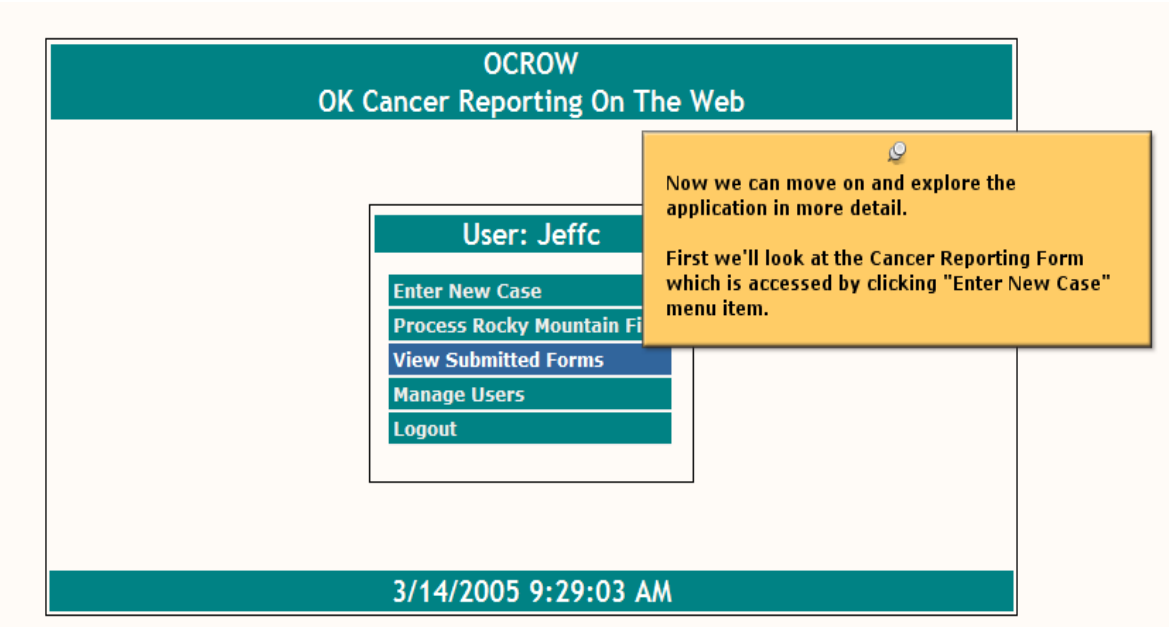
The next option is **Manage Users.** This option allows State and Facility Administrators to manage users of OCROW. Each Facility Administrator has the capability to add users for access to OCROW.



The next option is **Logout**. This selection will take you back to the Login screen and you will be required to re-enter your login credentials to log back into the application.



Clicking **Enter New Case** on the main menu displays the **Cancer Reporting Form.**



The first section of the Cancer Reporting Form is **Facility Information**. This section will automatically populate the facility information based on the login credentials.

OCROW
OK Cancer Reporting on the W

When you click "Enter New Case" on the main menu, you will bring up the Cancer Reporting Form.

Cancer Reporting Form

Please complete all sections (* = Required)

☐ Is this a a Response to a Death Clearance Inquiry

Facility Information

*Facility Name:	Facility Phone:
OSDH Vital Stats	(405)271-4072
*Facility Street Address:	
1000 NE 10th	
*Facility City:	*Facility State:
Oklahoma City	Oklahoma
*Facility Zip:	

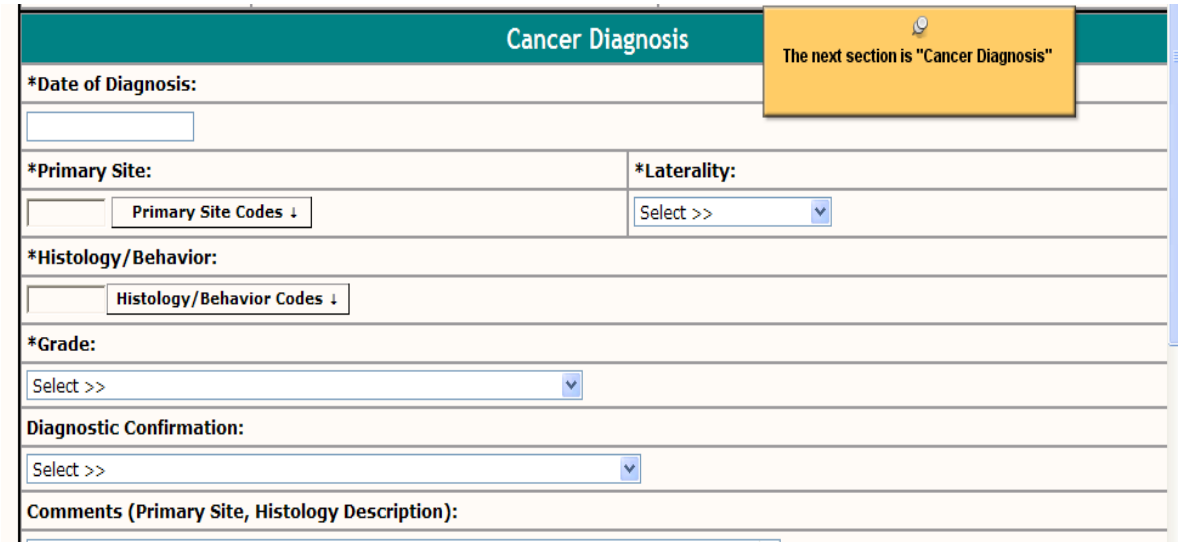
The next section of the Cancer Reporting Form is **Patient Information**. The options in this section should be filled in according to the specific case you are working. Make note of the **Asterisks**. All required items will have an asterisk next to the form label and the cancer reporting form will not submit until all discrepancies are resolved.

Patient Information

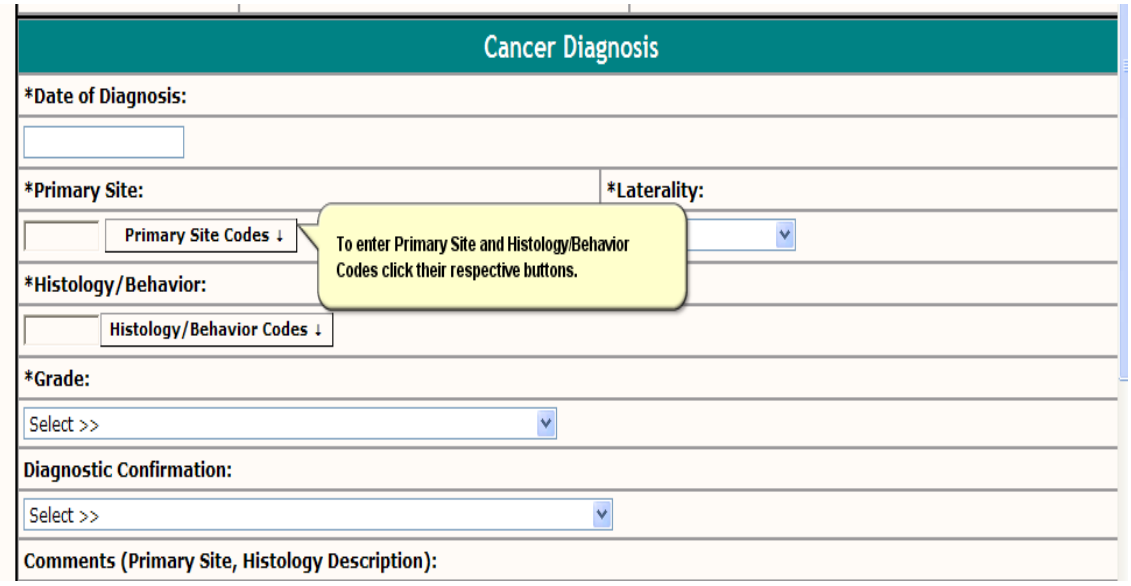
The Next section is "Patient Information"

*Patient Last Name:	*Patient First Na	
*Patient SSN:	*Patient Sex:	
	Select >>	
*Patient Address:		
*Patient City:	*Patient State:	*Patient Zip:
	Select >>	
*Patient Date of Birth:	Marital Status:	
	Select >>	
*Patient Race: (select all that apply)		
☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander		
*Hispanic Origin:		

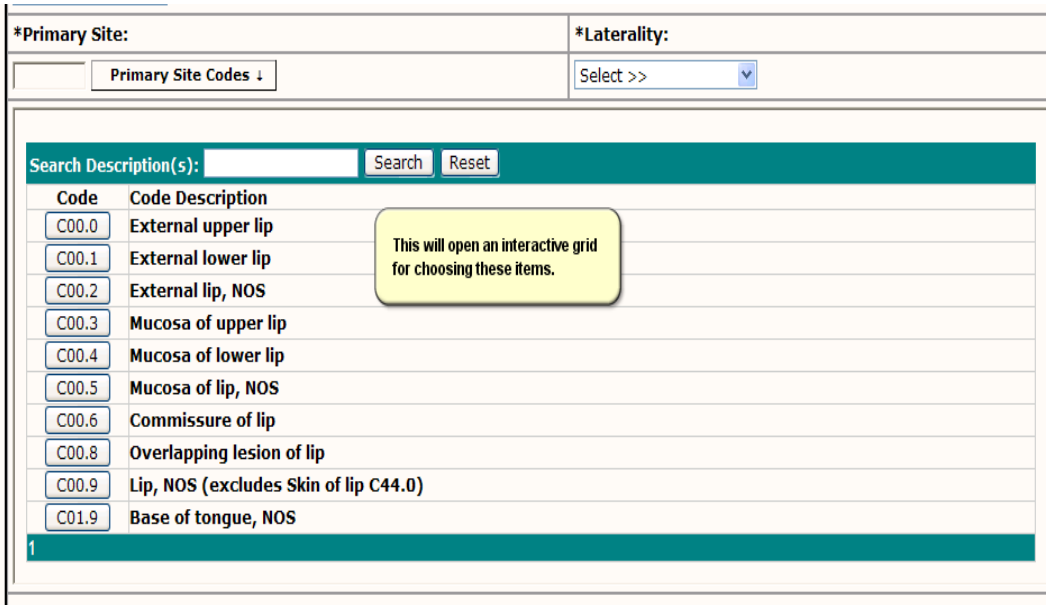
The next section of the Cancer Reporting Form is **Cancer Diagnosis**. This section is for entering diagnostic information pertaining to the cancer.



To enter Primary Site and Histology/Behavior codes simply click the tab with the black down arrow. Make note that the **Comments** box should include as much text information possible about the primary site, histology and any pertinent information from the pathology report if available. This information is used in quality control measures.

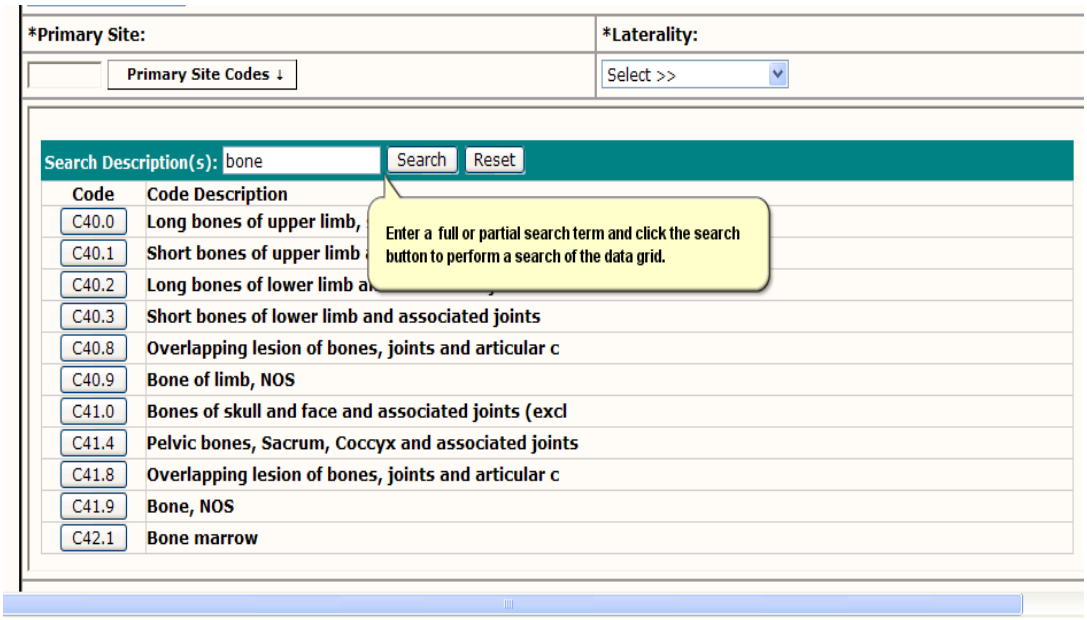


An interactive grid will open for selecting the appropriate code.



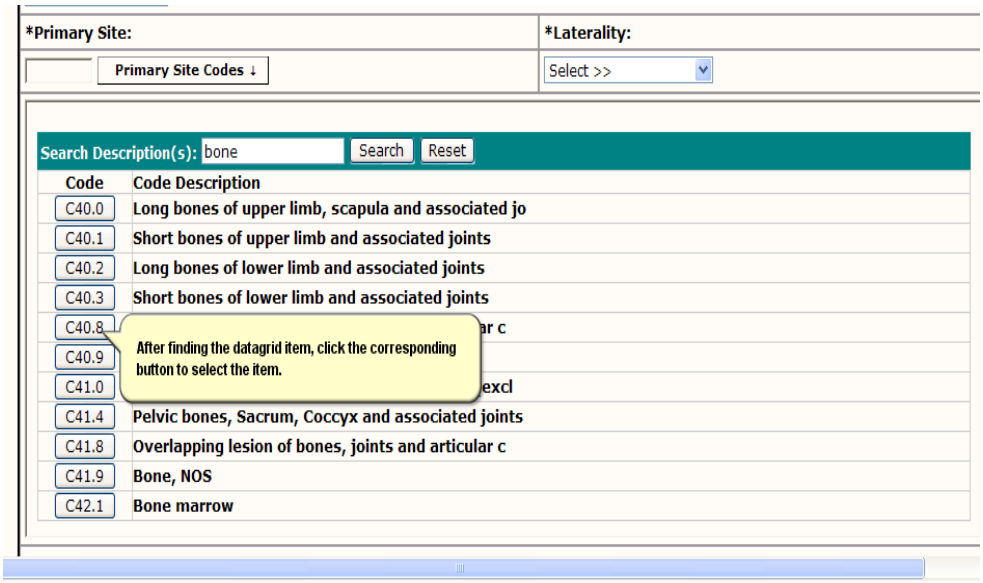
Click in the box to the left of the **Search** tab and type a full or partial description of the **primary site,** i.e. ***bone***. Next click the search button and the ICD-O codes according to the site searched will appear.

This application is built on table relationships; therefore the correct tables will not display if the search component is not activated for the primary site. **Do not manually enter the code.**

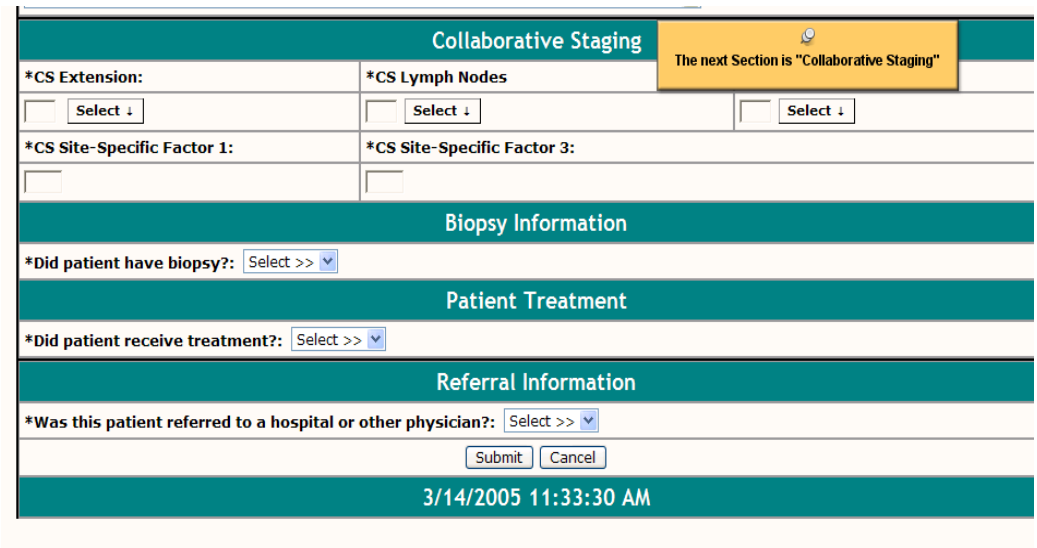


Double click on the code that best describes the primary site and this will pop into the **Primary Site Code** field.

The data fields that contain the word ***Select*** offer a drop down box for selecting the appropriate response. Click on the blue arrow to display all choices.

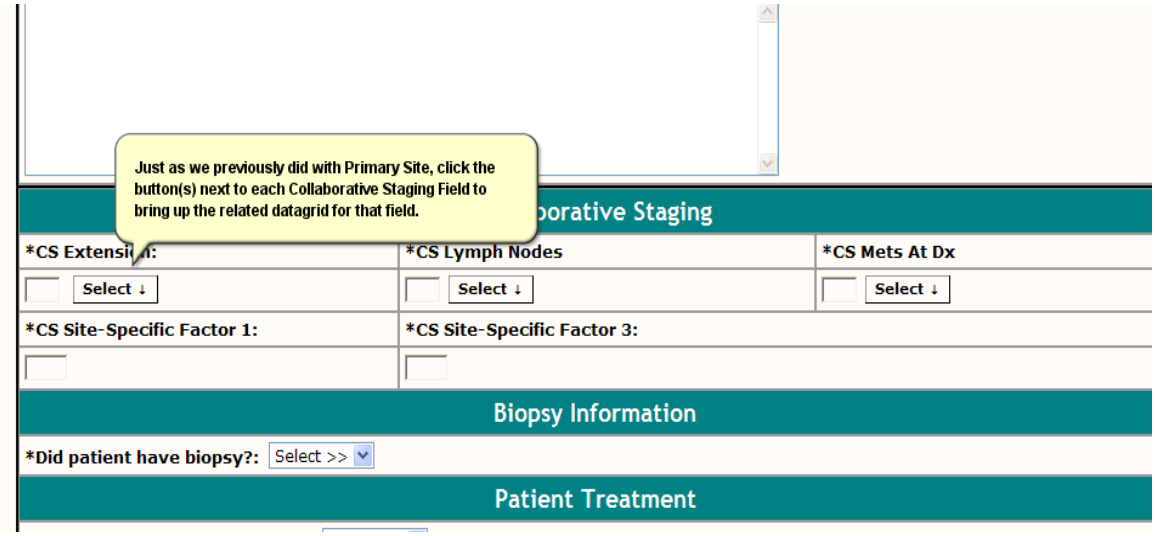


The next section of the Cancer Reporting Form is **Collaborative Staging**.
Collaborative Staging is a selected set of data items that describe how far a cancer has spread at the time of diagnosis.

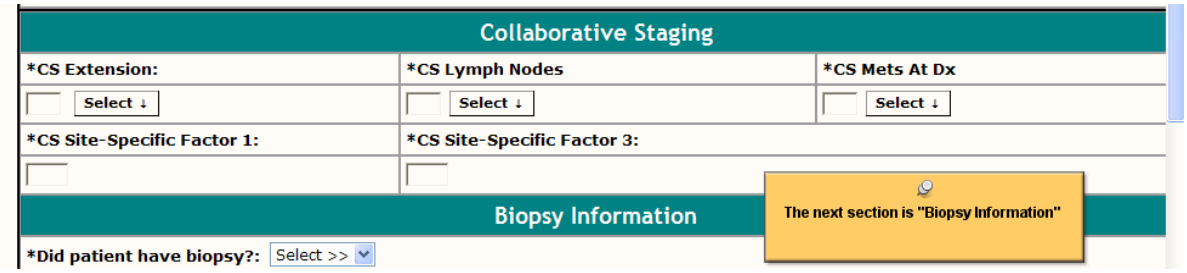


Follow the same directions as with Primary Site for Collaborative Staging. Click the tab next to each Collaborative Staging field to display the related data grid for this field.

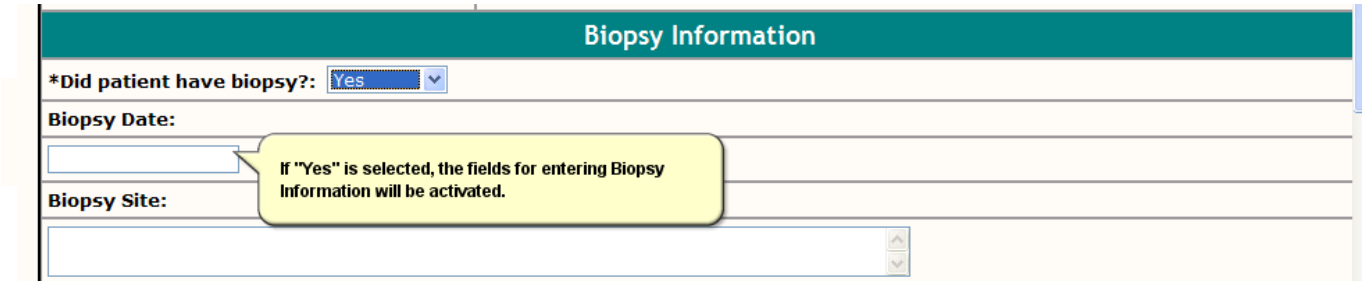
CS Extension, CS Lymph Nodes, and CS Mets at Diagnosis is required to derive SEER Summary Stage 2000. Pleura cancers require CS Site Specific Factor 1. Prostate cancer requires CS Site-Specific Factor 3.



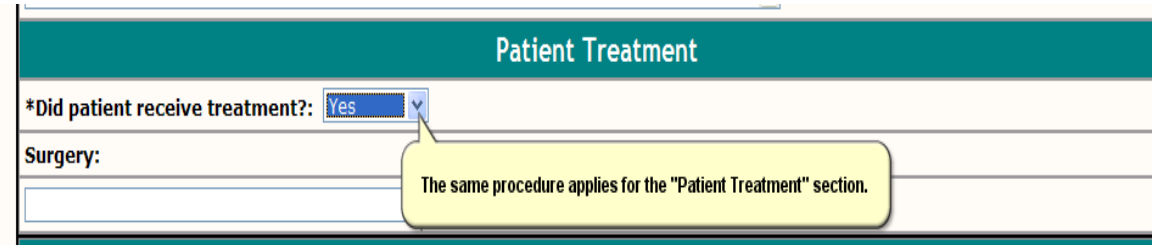
The next section of the Cancer Reporting Form is **Biopsy Information**. Click the blue arrow and select the appropriate response from the drop down box – **Yes, No or Unknown.**



If ***Yes*** is selected the fields for entering ***Biopsy Date*** and ***Biopsy Site*** will be activated. Enter the date and text, describing type of biopsy done.



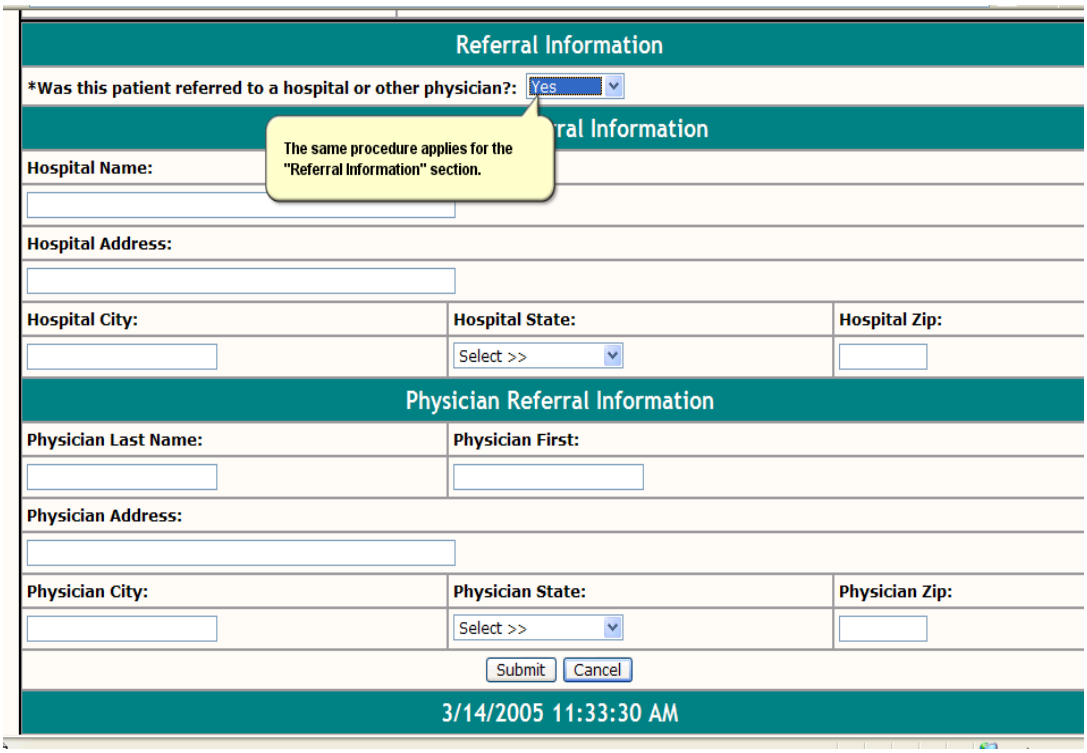
The next section of the Cancer Reporting Form is **Patient Treatment**. Click the blue arrow and select the appropriate response from the drop down box – **Yes, No or Unknown.**



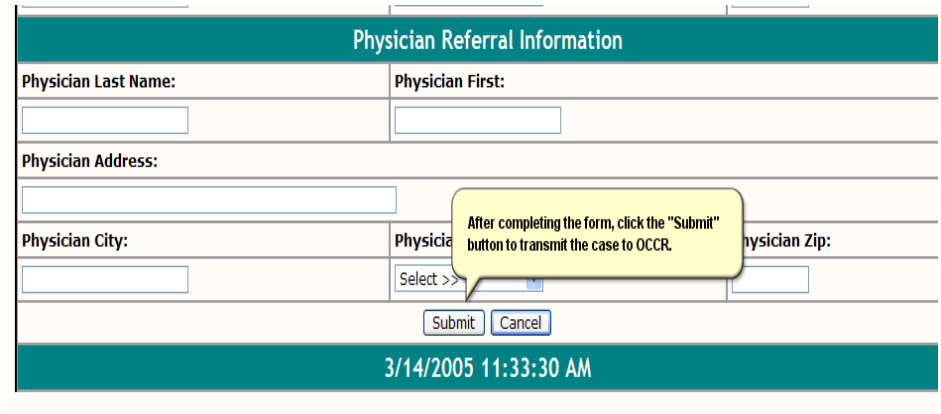
If ***Yes*** is selected the fields for entering ***Surgery/Treatment Date*** and ***Surgery/Treatment Text*** box will be activated. Use text box for surgical procedure performed, chemotherapy and/or radiation. Enter date ***Surgery/Treatment*** was performed.

The next section of the Cancer Reporting Form is **Referral Information**. Click the blue arrow and select the appropriate response from the drop down box – **Yes, No or Unknown.** This section is two fold – **Hospital Referral Information and Physician Referral Information** if applicable.

If ***Yes*** is selected the fields for entering ***Hospital Name, Address, City, State and Zip code*** or ***Physician Last and First Name, Address, City, State and Zip code*** will be activated. Complete if information is available.



Upon completion of the cancer reporting form, click the **Submit** button to transmit the case to OCCR. If any required data fields are missing the form will reappear with data fields highlighted in **red** that need to be corrected. Once the required fields are corrected click the **Submit** button again to transmit the case.



CODING CLUES – (LEARNING FROM OTHERS)

Coding Clues is our way of passing along information from questions referred to OCCR. They will come out in our quarterly newsletter. These are the statements that have been reported prior to publication of this manual.

Reporting text This is a useful tool for everyone to use in an unusual circumstance to clarify information that does not meet the standard coding or reporting, and for verifying accuracy of coded fields.

City names are not to be abbreviated unless the name exceeds twenty (20) characters. FORDS, page 44.

Person's middle name If the person does not have a middle name or initial, or it is unknown, please leave it blank. FORDS, page 41.

Usual Occupation and Text: Usual Industry field should be left blank if the patient's work history is unknown.

Not Married Name of Spouse/Parent field should be left blank if the patient is an unmarried adult.

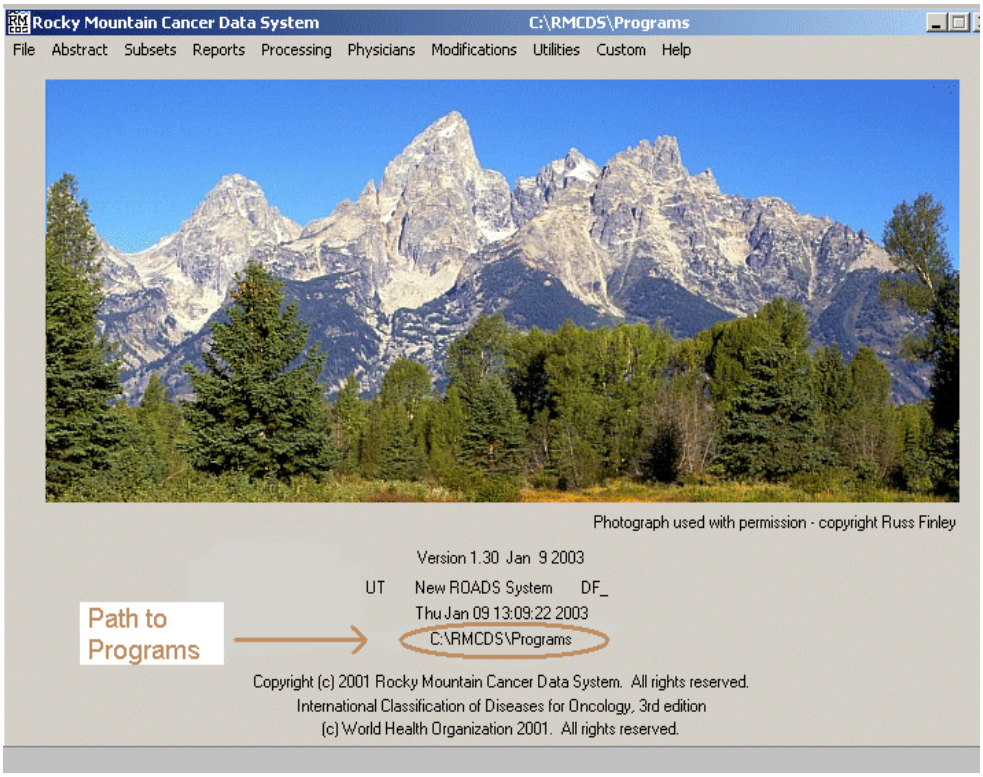
Reporting Frequency: If you have more than 25 cases a month, you must report monthly. Fewer than 25 cases a month can be reported quarterly.

What happens when duplicate cases are reported to the state? The Central Registry computer system automatically consolidates the information into the registry, or else flags the two reports for visual review.

SETTING UP YOUR SYSTEM

Create an RMCDS Icon on Your Desktop

These instructions describe how to create an Icon on your desktop to open the RMCDS programs. Before you begin you will have to have RMCDS loaded and know the path to the programs. The path to the RMCDS programs can be found on the third line below the mountain picture on the RMCDS Main Menu.



The path may not look exactly like the example given above. Some common path examples are:

C:\RMCDS\Programs

N:\Rmcds\Programs

T:\USR\Programs

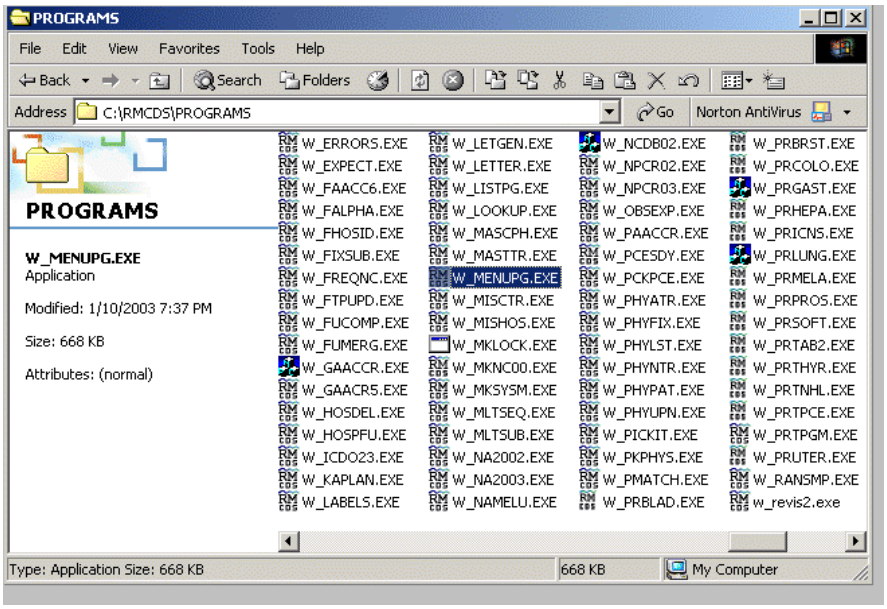
O:\Tumor\Programs

The path does not have to look exactly like any of these, but should end in \Programs. These are just common examples.

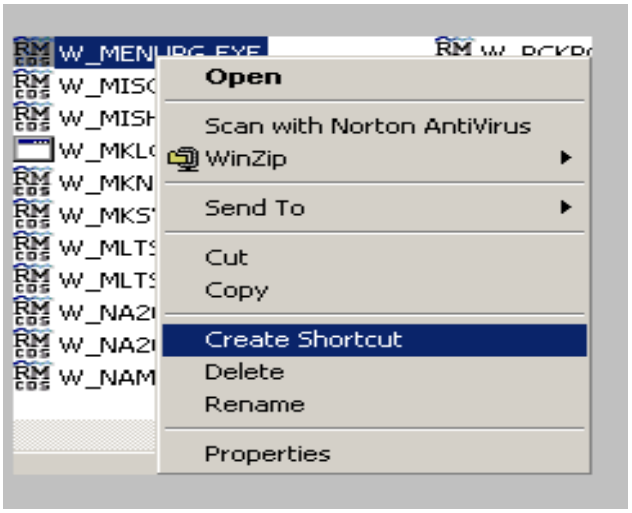
Take note of the path, you will need it to create the shortcut. Two methods to create the shortcut will be described. Method 2 is a shorter procedure, and both create identical icons.

Method 1:

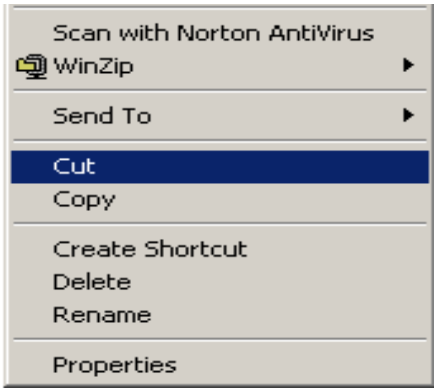
Double click on the **My Computer** icon on your desktop. Find the drive where the RMCDS programs are loaded. In our example it is the **C:** Drive. Double click on the drive and then find the **RMCDS** directory (or the directory where RMCDS is found) and open it. Next find and open the **Programs** directory. Once you are in the **Programs** directory you will need to locate the file called **y_menupg.exe**.



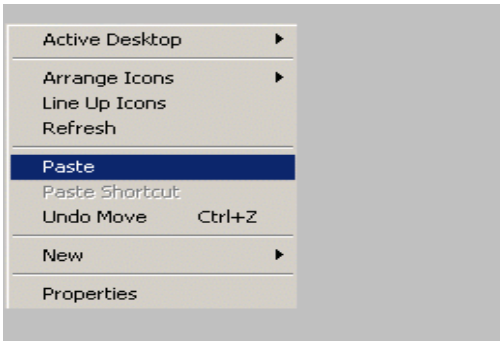
Right click on the **y_menupg.exe** and click on the **Create shortcut** option.



This will create a new file that will be highlighted. It is called **Shortcut to Y_MENUPG.EXE**. Right click on the file and from the pop-up menu choose **Cut**.

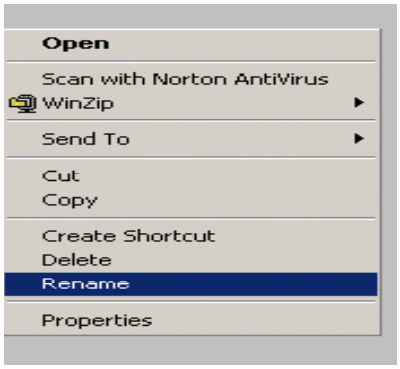


Now you will need to go to your windows desktop. Right click on the desktop, and from the pop-up menu choose **Paste**.



This will add the icon to your desktop.

If you want to rename the icon, right click on the new icon and from the pop-up menu choose **Rename**.



You can name the icon what you want. Some common examples are:

RMCDS

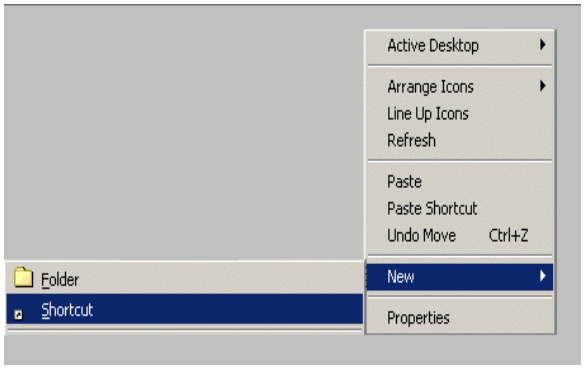
Tumor Registry

Registry Software

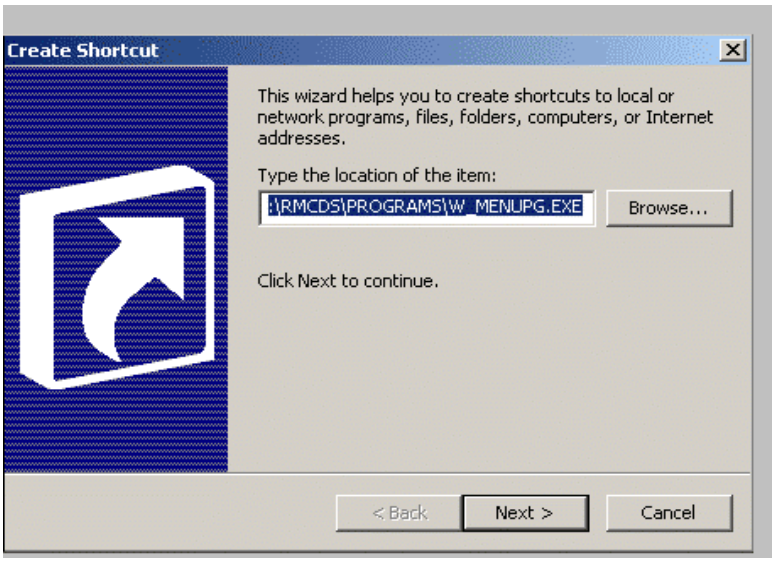
Once the icon is named how you want it, it will be ready to use. Open the RMCDS login by double clicking on the new icon.

Method 2:

Right click on your Windows Desktop and from the pop-up menu choose **New > Shortcut**.



This will open the **Create Shortcut** Wizard. Click on the **Browse...** button and navigate to the file **C:\RMCDS\Programs\y_menupg.exe**. (On your computer the C:\RMCDS\Programs may be called something else. Follow the procedure at the beginning of these instructions to locate the correct path.)

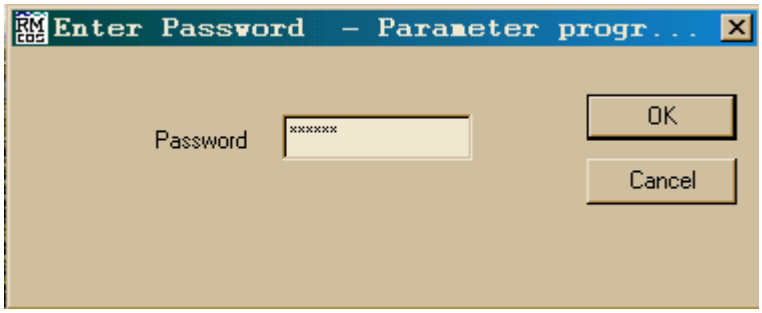


Then next screen asks you to enter a name for the shortcut. Type in a name of your choosing and click on the **Finish** button at the bottom of the screen. The new icon will appear on your desktop and is ready for use.

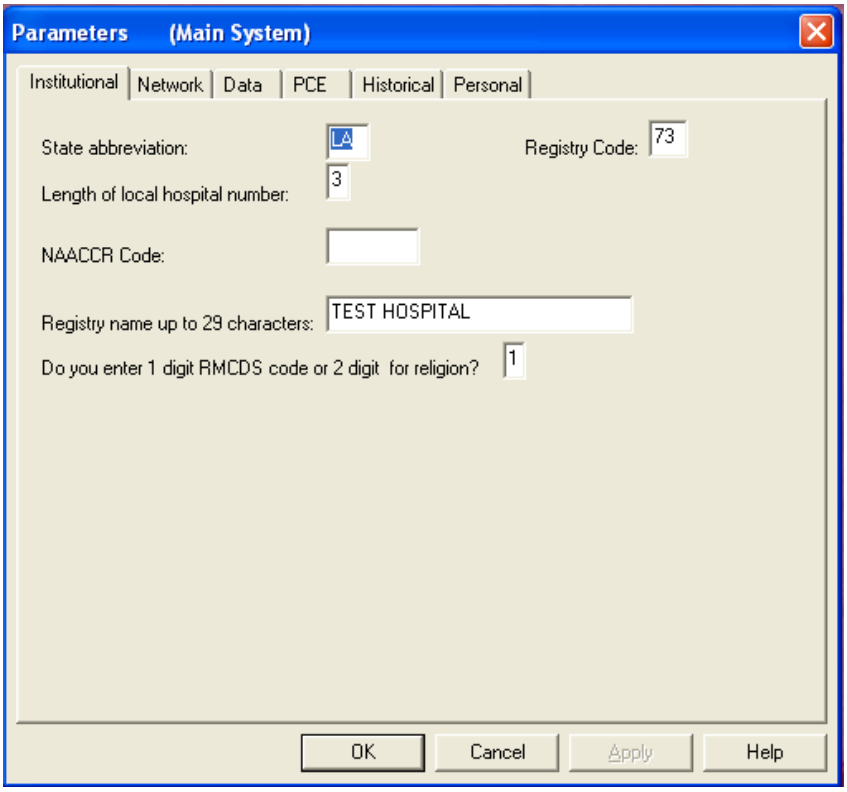
Setting Your Program Parameters

To enter the **parameter** program you will need to go to '**Utilities'** on the Main Menu and choose '**Parameters'**

Once this option is chosen you will be asked for a password. This is '**sysmgr'**.



The parameters screens are set up with tabs at the top to take you to different sections.



The first section is the **Institutional** parameters. Here you can enter your two letter state abbreviation. This will determine your registry code. You will not need to change the Registry Code unless you have special circumstances that RMCDS will inform you of when we send you your installation diskettes.

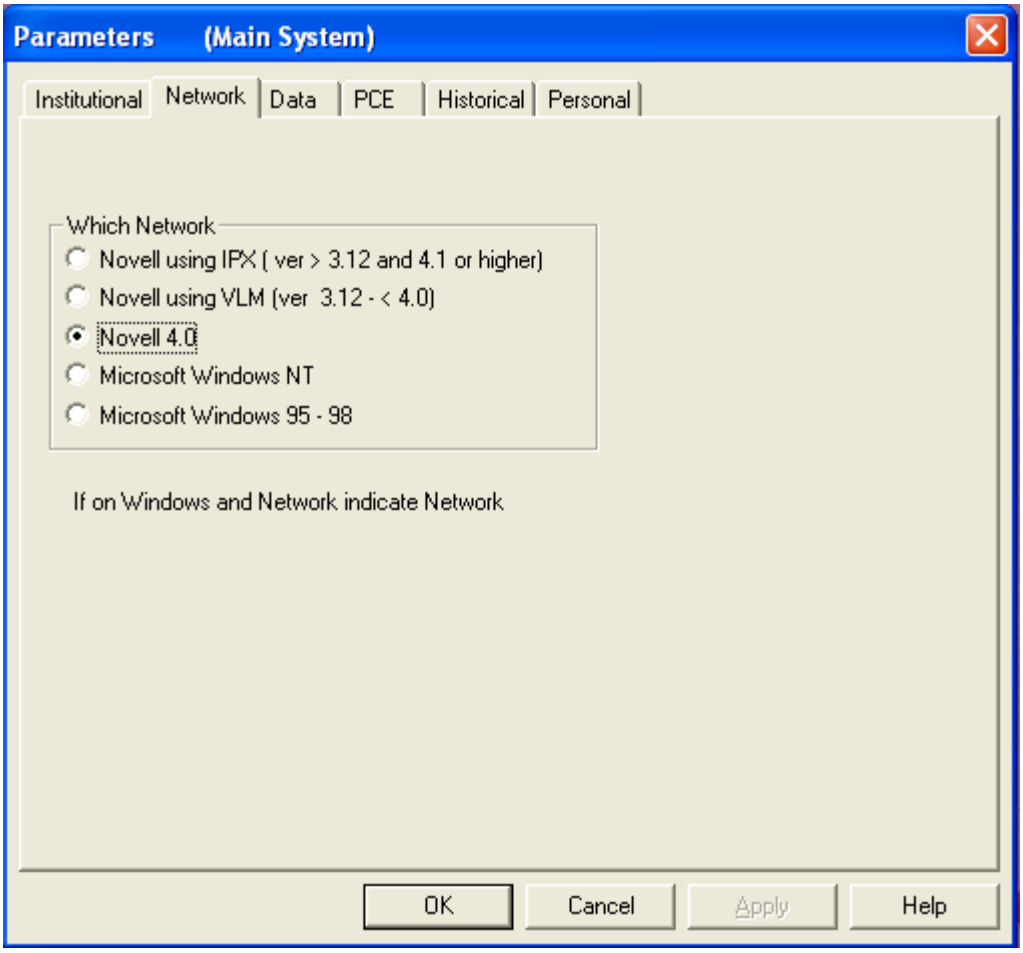
The next box will tell the programs how many digits you are using for your local hospital number. This can be up to a 10-digit number.

You will next be able to enter your Central Registry number; this will be your NAACCR Registry Number. This number can be found in NAACCR vol. II, appendix B.
The next box allows you to enter your facility name with up to 30 characters.

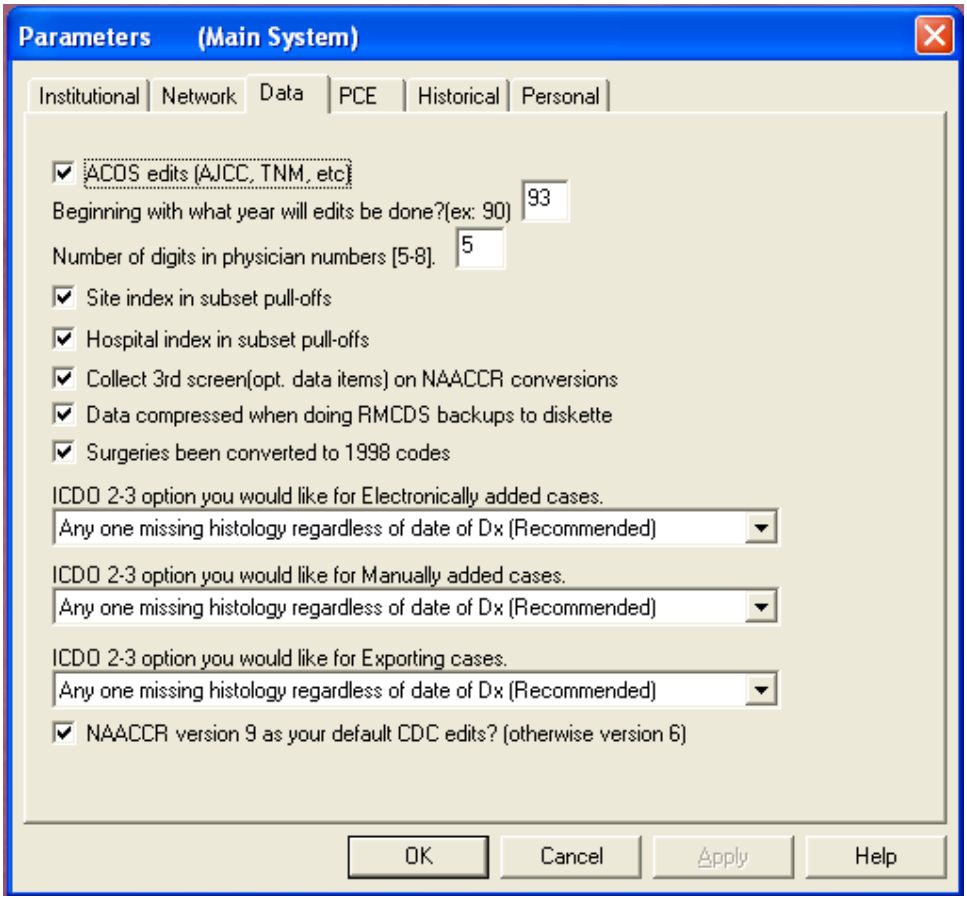
If you are collecting religion you may also choose to enter either the 1-digit RMCDS codes or a 2-digit code.

When you are finished entering this information you will select the Network tab at the top of the window to go on to the **Network** parameter.

The network parameters allow you to tell the programs what type of network you are using. If you are on both a network and Windows you should indicate the network.



The **Data** Parameters give the programs information on how you would like some programs to function.



Checking the box next to ACOS edits you are letting the computer know that you are collecting TNM information and you would like to have this information edit checked when using the RMCDS edits. In the box asking 'Beginning with what year will edit checks be done' you are able to indicate to the computer that you would not like to see TNM edit checks for cases before a certain year.

The next box allows you to indicate how many digits are in your physician number. The standard is 5 but can go as high as 8.

The next two questions deal with whether you wish to have indexes built for site pull-offs (this will speed up a subset creation if site is one of your variables) and hospital number. You will normally check these boxes.

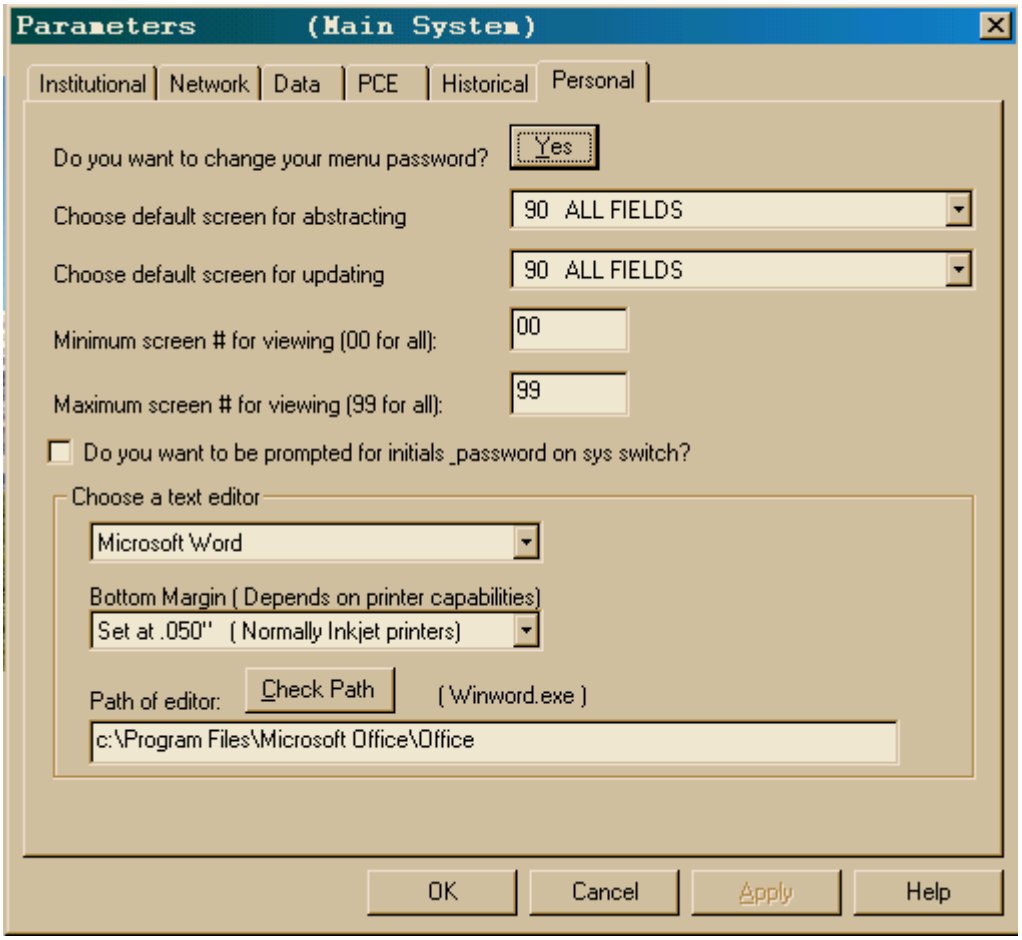
The questions about collecting 3rd screen data items on a NAACCR download is applicable only for facilities that wish to send special variable on a NAACCR download.
You should put a check in the box next to 'Data compressed when doing RMCDS backups to diskette' if you either perform a back up yourself (instead of the network performing a backup) or if you submit to a state registry using the RMCDS format.

If the box next to 'Surgeries been converted to 1998 codes' is not checked, please call RMCDS. If you do not have this box checked and you are collecting surgery information you will not get the correct look-up tables.

The next three options concern the conversion of cases to ICDO-3 or ICDO-2. If you choose not to convert your cases you can use the drop down menu and choose the option for 'No converting to be done'. You can also indicate if you then wish to have the conversion performed when you download cases in the NAACCR format. If you have done the conversion from ICDO-2 to ICDO-3 you can choose to have cases automatically convert when you are adding cases either electronically or manually.

If you are collecting cases diagnosed 2001 or later you will want to check the box next to 'NAACCR 9 as your default CDC edits'. Previous versions of the CDC EDITS program are not set up to handle cases coded using ICDO-3.

The **Personal** parameters are the only set that is individualized for each login. These will need to be set up as new people are assigned login rights to the RMCDS system.



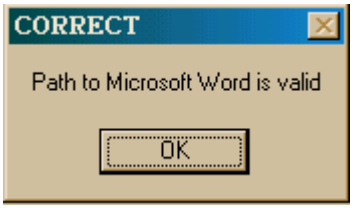
If you are setting up your parameter for the first time we recommend that you change your menu password.

The first line asks 'Do you want to change your menu password?' You should click the 'Yes' button. You will now be taken to the password change screen. You will be asked to type in the new password, up to eight (8) letters and or numbers. You will then need to re-enter the password in the second box for verification. Once you click 'OK' the password has been changed and the new password will need to be used in the future to log in.

Once the password has been changed the user should also choose default screens from the drop-down menu. We recommend that the screen '00' be used.

The 'Minimum' and 'Maximum' screens can be left at the default '00' and '99' respectively.

The user will also need to choose a text editor. The default is set for 'WordPad'. We recommend that this be changed to either 'Microsoft Word' or 'Word Perfect' if available. Most facilities have 'Microsoft Word'. If Word is chosen the user should see a pop-up saying that the 'Path to Microsoft Word is valid'. If the pop-up says that the path is invalid please contact your facility's IT department to find out what the correct path is.



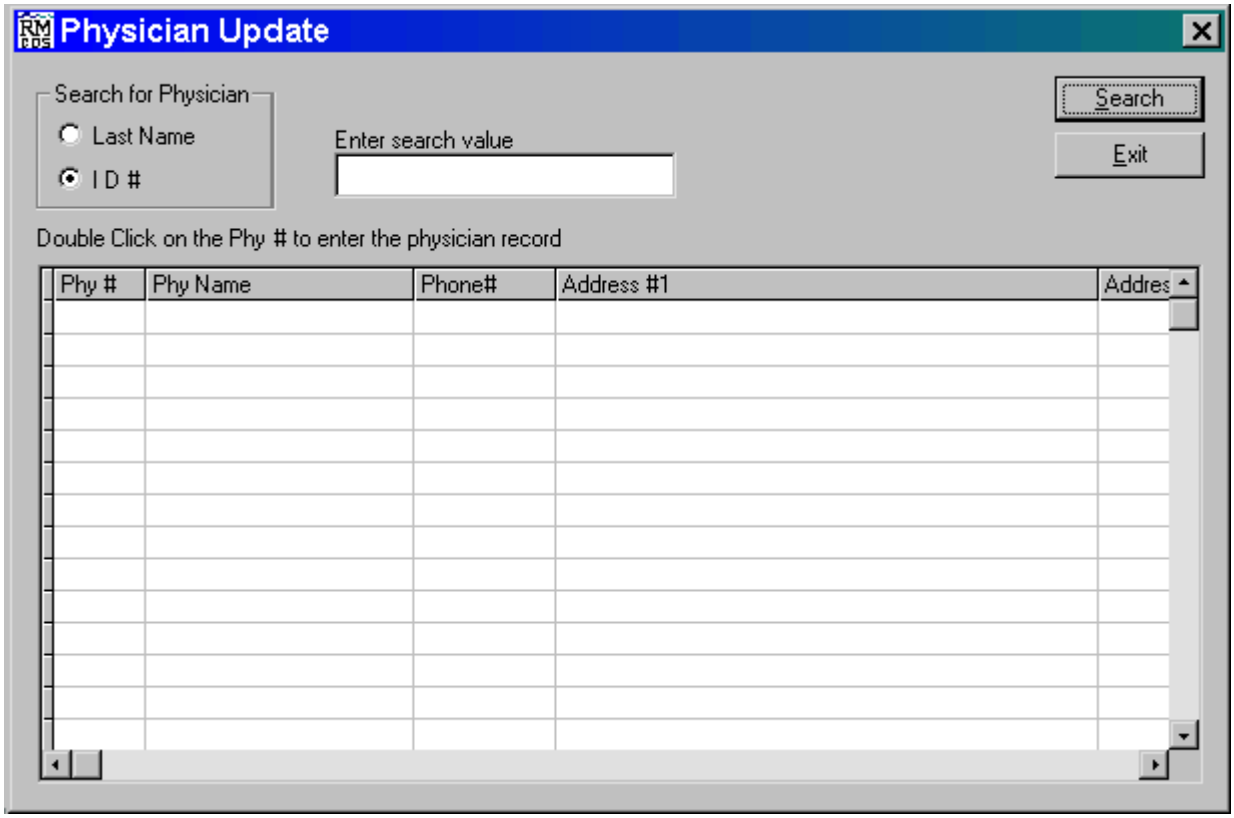
ADDING PHYSICIANS TO YOUR PROGRAM

The state will be using the federal Provider Identifier upon CMS implementation. It will save time later when the conversion of physician numbers is implemented, if the physician license number is utilized at the present time.

These instructions describe how to add a Physician to the RMCDS database. From the Main Menu click on

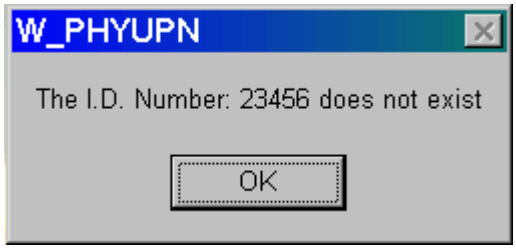
Physicians > Update

This will bring you to the Physician update window.

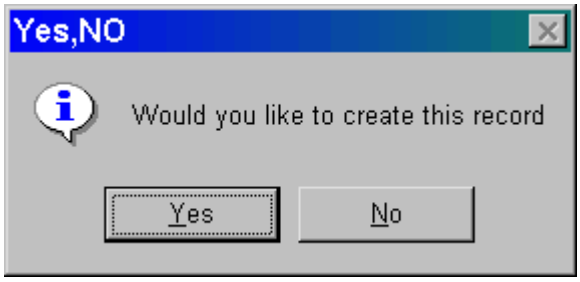


To edit an existing physician, select either **Last Name** or **ID #** in the **Search for Physician** box, then type in the corresponding value for either the name or number in the **Enter search value** text box. When you have finished entering the search value, click on **Search**. This will bring up all the records in your database that match the search criteria. To edit a particular physician record, double click on the **Phy #** box of that physician.

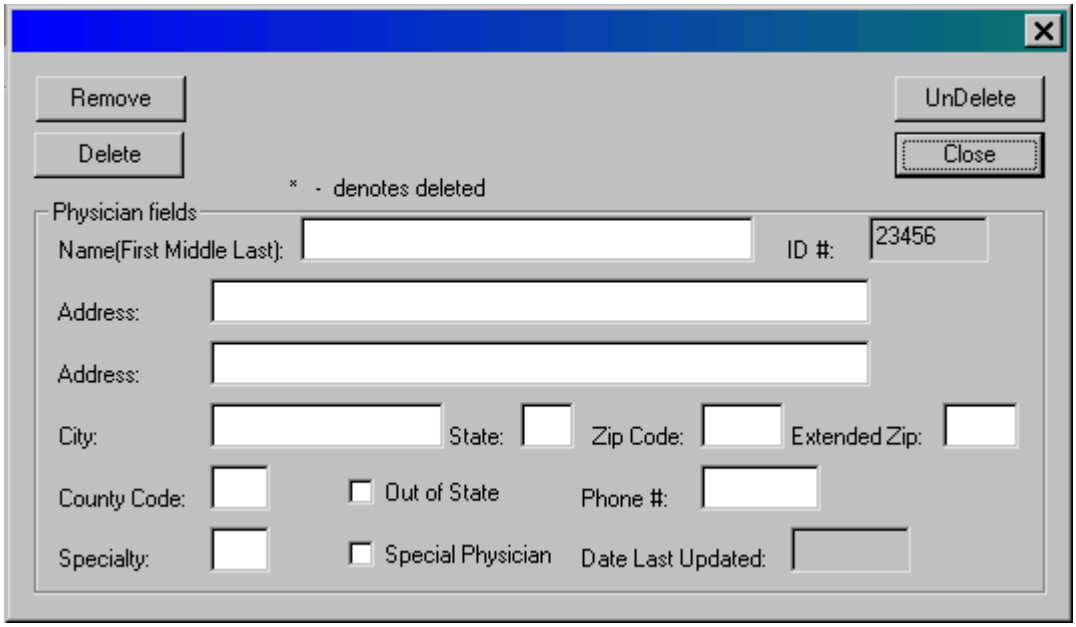
To add a new physician record to the database, first make sure that the **ID #** is selected in the **Search for Physician box**. In the **Enter search value text box**, type in the physician ID number of the new record that you want to enter. Click on the **Search** button. If the number that you entered is not currently in the database the computer will prompt you with a message box similar to the one below



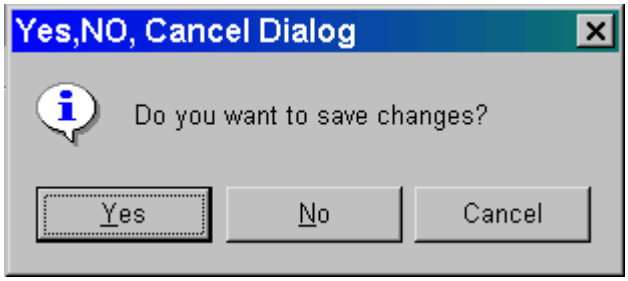
Click **OK**, you will then see the message box



Click **Yes**. This will bring up a data window for the new physician.



Fill in the corresponding data. When finished, click on the **Close** button. You will see a message box that says

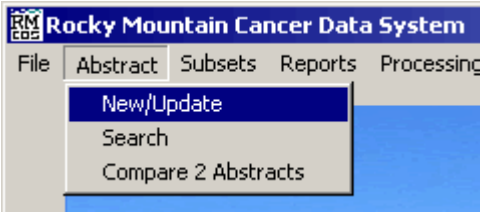


(Click **Yes** to save and exit. Click **No** to not save and exit. Click **Cancel** to return to the Physician data window.)

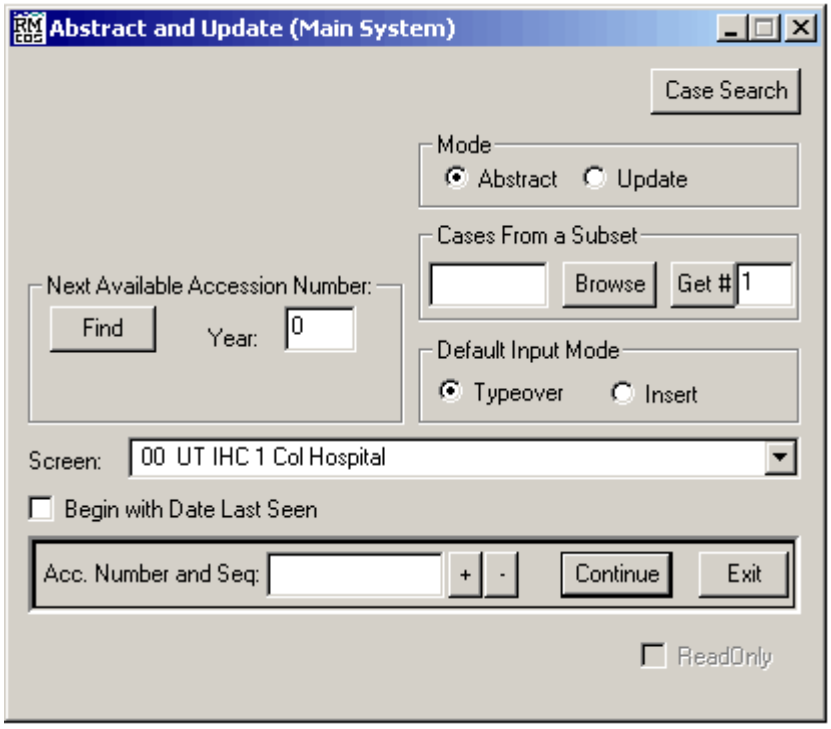
After clicking Yes to save, you will be taken back to the Physician update window where you can type in a new ID # to add another physician or click exit to close the Physician update window and return to the main menu.

OPEN AN ABSTRACT

These instructions describe how to open a patient abstract on the RMCDS system. From the RMCDS Main Menu click on **Abstract > New/Update**



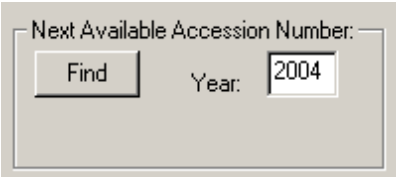
This will open the **Abstract and Update** window.



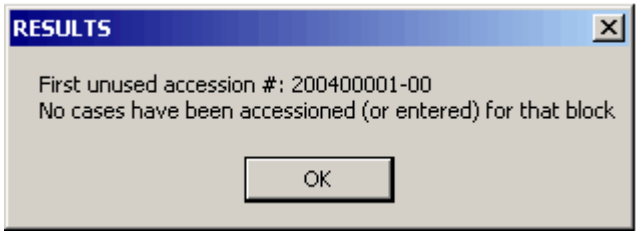
There are several ways to open an abstract from the **Abstract and Update** window.

OPEN A NEW ABSTRACT

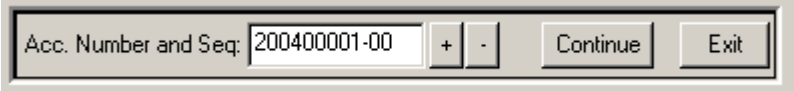
If you want to open a NEW ABSTRACT for a patient, start by finding the next available accession number. In the area labeled **Next Available Accession Number,** type in the four-digit year for this case and click on Find.



A message window will appear indicating the next available accession number on your system



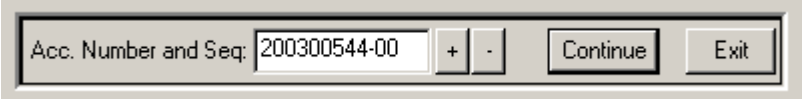
Click on **OK** to close the message window. Notice at the bottom of the Abstract and Update window that the number that appeared in the message box is now in the **Acc. Number and Seq** box.



Click **Continue** to begin a new patient abstract with that number. The abstract will open and the data can be entered.

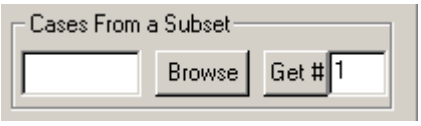
OPEN AN EXISTING ABSTRACT

You Can also open an existing abstract from the **Abstract and Update** window by simply typing the accession and sequence number into the box labeled **Acc. Number and Seq** box and clicking on **Continue**.



OPEN CASES FROM A SUBSET

There is an option to open abstracts from a subset. In the area labeled **Cases From a Subset** there is a text box where you can type in the name of an existing subset. You can also browse for subsets.



Once the subset name is entered in the box, type in the number for the case you would like to open from the subset and press the **Get #** button. For example, if you had to make some changes on a subset of cases, you could type in the subset name and start with the number 1. Press the **Get #** button to open that abstract, make the change, then exit and save changes. You could then proceed to the second abstract in the subset by typing in a 2 and then pressing the **Get #** button. This procedure would continue until all of the relevant changes had been made.

OTHER FUNCTIONS

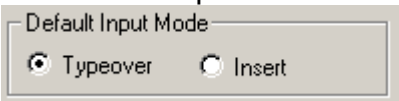
Mode

When opening an abstract you can select if you want to open in it abstract (new cases) or update (existing cases) mode, with the input mode set as type over or insert, set to start on the Date Last Seen field, and you can choose which abstract screen you want to open it with. To set the **Mode**, select either the Abstract or Update radio button.

Simply put, the Abstract mode is used for new cases being abstracted into RMCDS for the first time and Update is used for existing cases that are already in your database. If you forget to

select the correct mode when entering a case, the program will ask if you would like to continue in the correct mode.

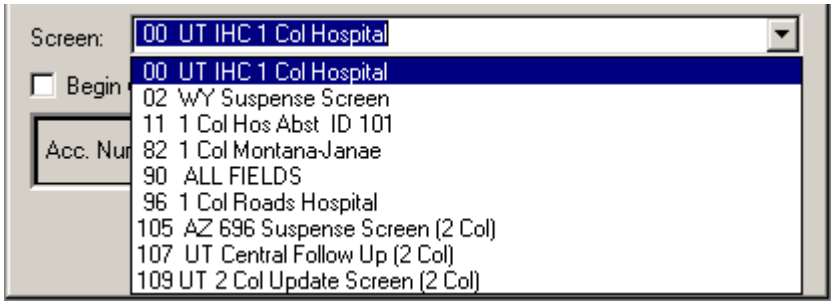
Default Input Mode
The default input mode determines how the field input will operate once you are in the abstract.



Selecting **Type over** will allow the character input to overwrite the existing data in a field. For example, if there is a date in the Date Last Seen field, and you have selected Type over mode, when you start to type the new date will simply overwrite the existing date. Selecting **Insert** mode, however, will require that you first delete the existing data in the field before typing in the new data. **Type over** mode is the default and most commonly used option.

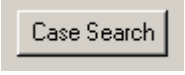
Screen
You can select which abstracting screen you wish to use when entering a case by changing it on the line labeled **Screen**.

The default screen, as defined in your parameter program, will appear in this line when you first open the **Abstract and Update** window. To change the screen to another that is loaded on your computer, simple click on the black down arrow to the right of the Screen box and select an alternate screen.



Begin with Date Last Seen
To open an abstract with the cursor in the Date Last Seen field, simply put a check in the box next to the label **Begin with Date Last Seen.**

Switch to Case Search
From the **Abstract and Update** window you can go directly to the Case Search program by clicking on the **Case Search** button in the top right-hand corner of the window.



For instructions on using the Case Search program click here.

OPEN AN ABSTRACT BY POSITION NUMBER

You can also open an abstract by its Position in the Master File Number. To do this you would type 'M', followed by the Position number, into the **Acc. Num and Seq.** box.

In the example shown, the 1234th record in the database would be opened. (The Position number for an abstract can be found by looking in the **Pos** box at the bottom of the abstract window.)

THE ABSTRACT PROGRAM

THESE INSTRUCTIONS DESCRIBE HOW TO NAVIGATE THROUGH A CASE IN THE ABSTRACT PROGRAM. THE FOCUS IS NOT TO EXPLAIN EACH FIELD OR CODE, BUT TO PROVIDE BASIC OPERATIONS, HELPFUL HINTS, AND A FEW USEFUL TRICKS ON USING THE ABSTRACT PROGRAM.

Open a case in the abstract program. If you are unsure on how to do this, please see the instructions for Opening an Abstract.

When you first open a case in the abstract program you will see a screen similar to the following. **SCREEN 1**

DOE, JOHN C341 #200400001-00 F=04/28/04 U=04/29/04 #=2 UPDATE (Main System)

Print Errors Modify Go To Linked Records Collaborative Stage

ENTER ABSTRACTOR'S INITIALS

Delete Case

Reporting Hospital: 801 XYZ GENERAL HOSPITAL
Date Available: 04/28/2004
Abstracted by: DF
Suspense Case:
Type of Reporting Source:
PATIENT IDENTIFICATION
Accession Number: 200400001
Sequence Number: 00
Medical Record Number:
Social Security #:
Name-Last DOE
Name-First JOHN
Name-Middle
Name-Maiden
Name-Alias
Name-Suffix
Race 1
Race 2
Race 3
Race 4
Race 5
Spanish/Hispanic Origin:

Prev Page Next Page Page 1 of 18 Pos: 3481 Next Page
Save Exit 3 Screen: 00 UT IHC 1 Col Hospital Change

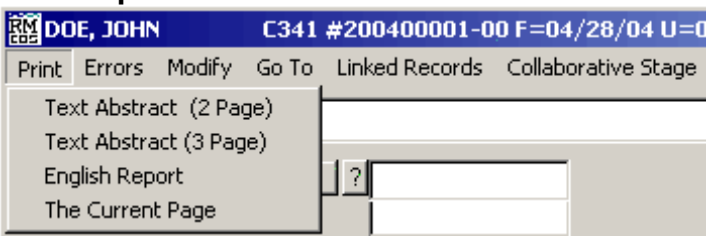
The Abstract / Update window has many various features and functions. For sake of clarity, these instructions will start at the top of the window and explain the different features in the order they appear.

Title Bar

DOE, JOHN #200400001-00 F=04/28/04 U=04/28/04 #=0 UPDATE (Main System)

In the title bar at the top of the window, the patient name and abstract number are listed. Notice in the example, Doe, John is to the left followed by #200400001-00, which is the accession number. The name and abstract number will be the same on each page of the abstract. This is useful in identifying which case you are in at any given time, especially if you have more than one case open at once.

Menu Options

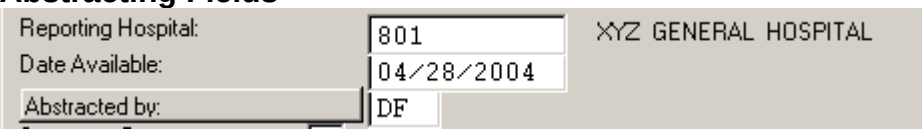


Right below the Title Bar you will find the Menu Options that include **Print, Errors, Modify, Go To, View, Linked Records, Collaborative Stage and Help**. Click on the menu title to see the pull down menu as shown in the example.

Help Prompt and Delete Case

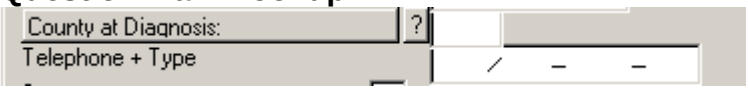
The line box below the Menu Options is the Help Prompt box. If there are special instructions for a particular field they will be displayed here. In the example shown the cursor is on the Abstractor's Initials field and so the Help Prompt gives the instructions to Enter Abstractor's Initials. Some fields that have only a few valid codes may also display the codes in the Help Prompt. To the right of the Help Prompt there is a check box called **Delete Case**. If you want to delete an abstract you would put a check in this box and exit the case. The case would be deleted after you exit the case.

Abstracting Fields



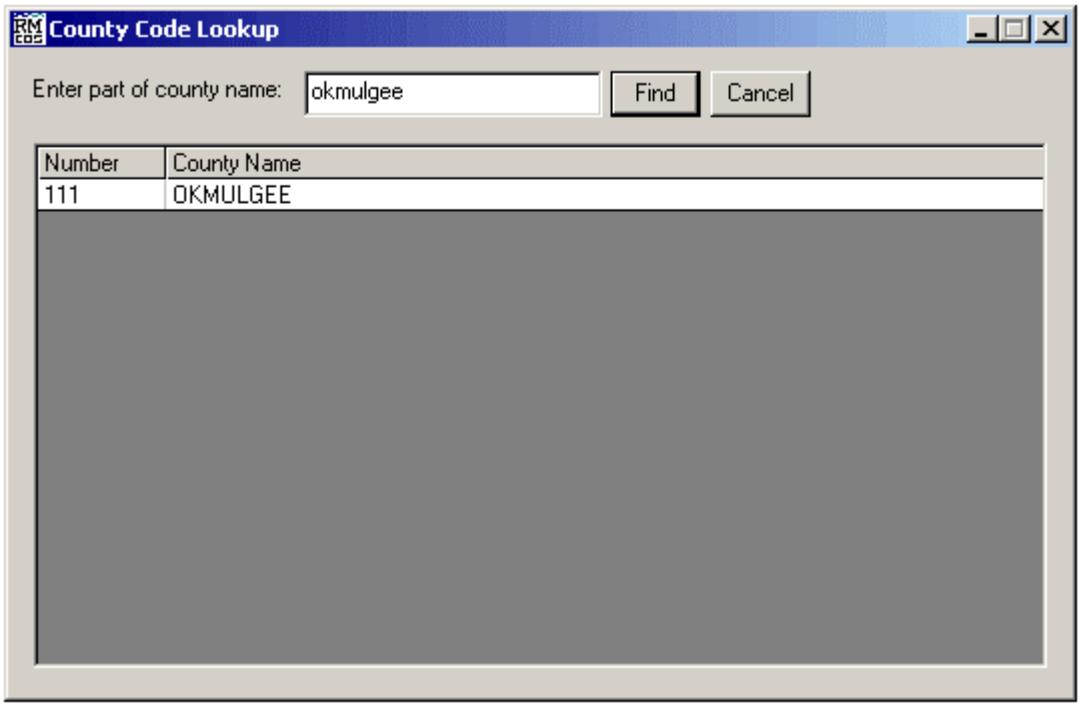
Following the Help Prompt box, the Abstracting Fields begin. Some examples are given here to show some of the features of the abstract fields. Notice in the example above that each field has a Field Name, a Text Entry Box, and an area for English Recode. The first field shown in the example has the name "REPORTING HOSPITAL", the Text Entry Box has "801" in it, and the English Recode is "XYZ GENERAL HOSPITAL." Not all fields in the abstract will have an English Recode, for example, "DATE AVAILABLE" does not need an English Recode because the date is clearly defined by the code. The English Recode will appear after you have entered the code into the Text Entry Box and moved onto the next field. Notice also that the ABSTRACTED BY field is elevated. The field that is currently being coded, or has the cursor in it, is elevated so that it is easy to distinguish which field is active. Some other Abstract Field features follow:

Question Mark Lookup

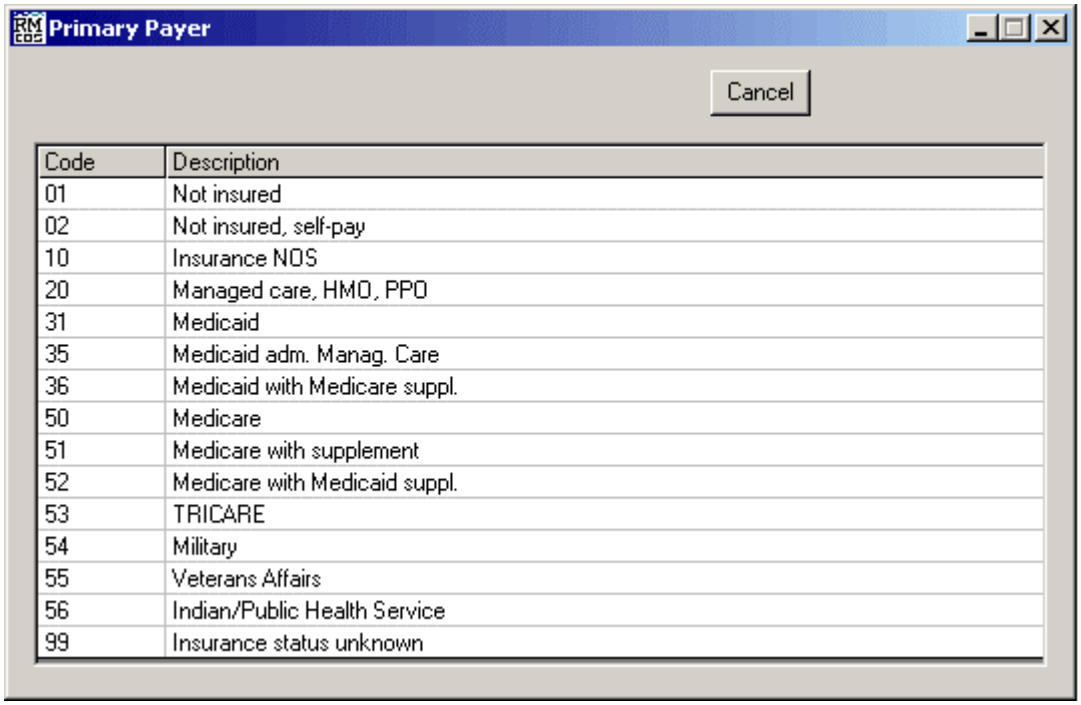


Notice the small question mark button to the right of the COUNTY AT DIAGNOSIS field. This button can be used to look up valid codes for the Active Field (the field that is currently being coded.) The question mark will only appear on the line after the cursor is placed in that field. Not all fields have question mark look ups available. To use the Question Mark Look up, simply click

on the button. One of two types of help windows will open, either a Lookup window or a Code Definition window.



To use the Lookup Window, simply type in part or all of the name you are looking for and press **Find**. If the name is found it will be displayed in the code area. To select a particular code, simply double click on the code under the **Number** Column for the value you want. The window will close and the selected code will automatically be entered into the abstract. If you want to close this window without selecting a code, press Cancel. The second type of Question Mark window is the Code Definition window.



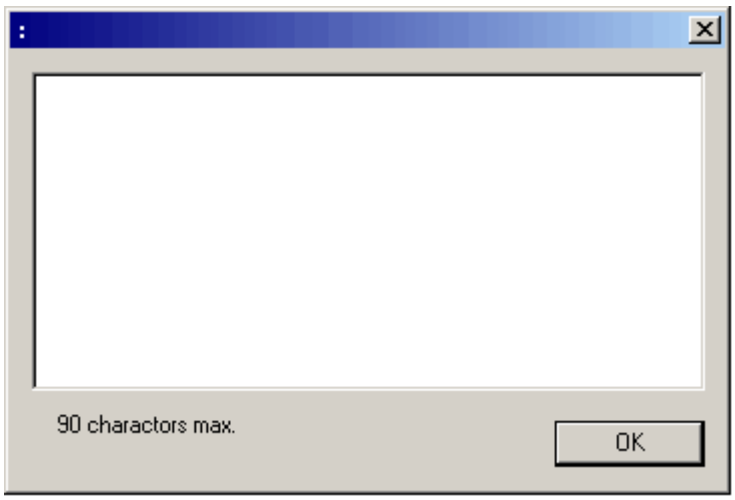
Code	Description
01	Not insured
02	Not insured, self-pay
10	Insurance NOS
20	Managed care, HMO, PPO
31	Medicaid
35	Medicaid adm. Manag. Care
36	Medicaid with Medicare suppl.
50	Medicare
51	Medicare with supplement
52	Medicare with Medicaid suppl.
53	TRICARE
54	Military
55	Veterans Affairs
56	Indian/Public Health Service
99	Insurance status unknown

The Code Definition window simply lists out the codes and their descriptions. To select a particular code, double click on the code under the **Code** Column for the value you want. The window will close and the selected code will automatically be entered into the abstract. If you want to close this window without selecting a code, press Cancel.

Text Box Button

Some text fields have Text Box Buttons that allow for continuous typing and word wrap. If the text field has a Text Box button, you will see the letter T next to the field as seen in the example below

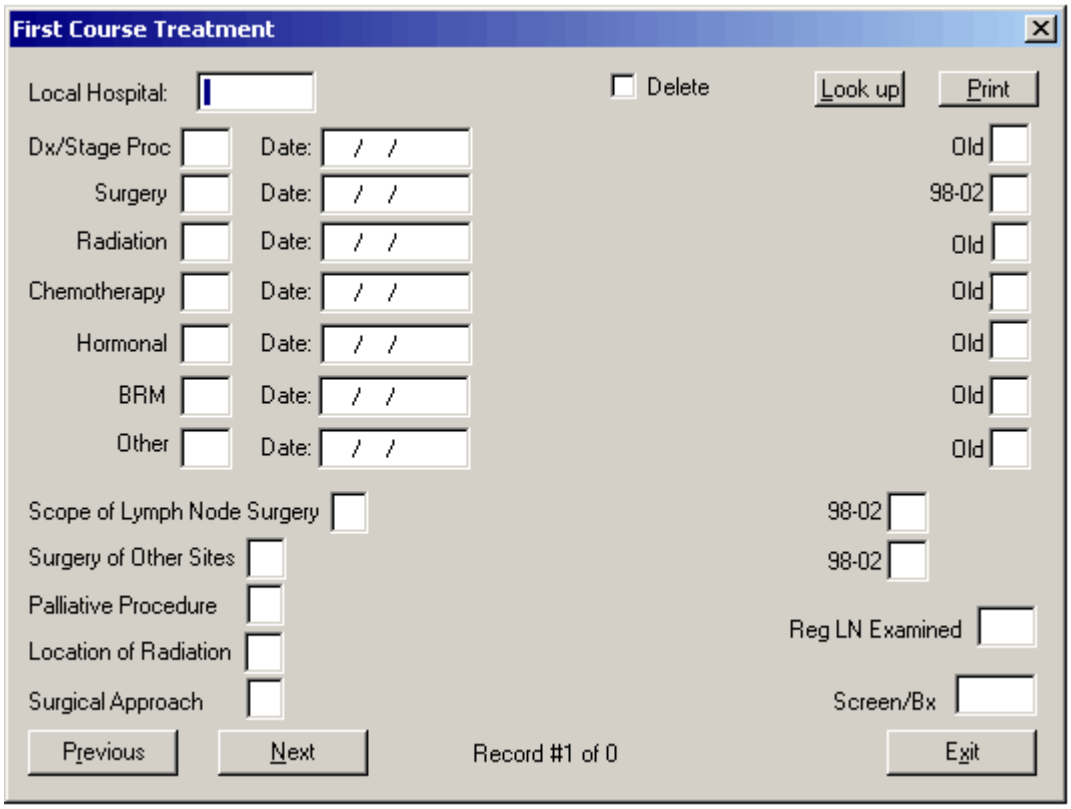
To activate the Text Box Button, click on the T. A new window will open wherein you can type in the text.



Once you have completed typing in the text, click the **OK** button. The text window will close and your text will be entered into your text fields.

Treatment Screen
The screen for Treatment Input can be opened two different ways. The first is to click on the **First Course Treatment** label / button.

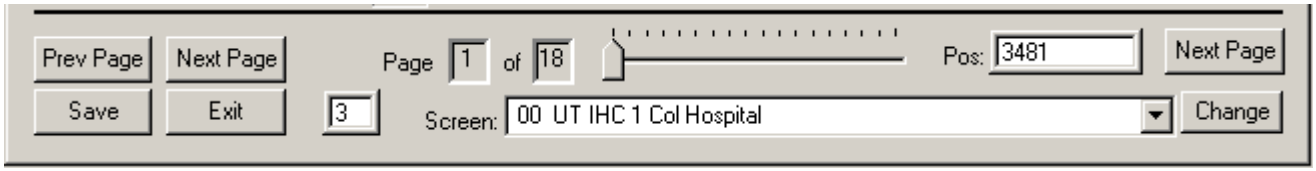
The second way is to press **Alt T** from anywhere within the abstract. (**Alt T** will open the **Subsequent Treatment** window.)



The window for **First Course Treatment** (and Subsequent Treatment) can be navigated in the same manner as the regular Abstract screens. The Treatment window has it's own **Print** option and the **Look up** button can be used by clicking on it while the cursor is in the field for which you want to find a code. The field labeled **Local hospital** is to identify the facility where the treatment being coded took place. If you wish to add treatment performed at other facilities, click on the **Next** button at the bottom of the window and enter the Local Hospital number and treatment for that facility. You can delete a treatment record by putting a check in the **Delete** box and exiting the record.

Navigation Buttons

At the bottom of the **Abstract Window** there are several Navigation buttons.



The **Prev Page** and **Next Page** buttons help you navigate to the previous and next pages while

going through an abstract. The **Save** button is used to save the abstract without exiting the case. It is recommended that you save your work regularly. The **Exit** button will close the Abstract window. When exiting you will be asked if you want to save the case before it closes. To the right of the Exit button is a small box with a number in it. This number tells how many digits the Active Field has available. In our example the Active Field is ABSTRACTOR'S INITIALS, which is a three-digit field. If you were on the SOCIAL SECURITY NUMBER field this box would show a nine, because social security numbers are 9 digits long.

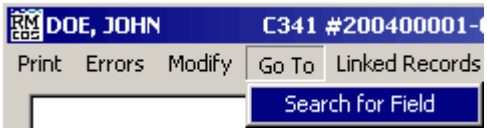
The **Page** box and slider bar are in the center of the Navigation Area. The **Page** box lets you know which page of your abstract screens you are currently on and how many pages there are on these abstract screens. The slider bar can be used to quickly jump to a particular page. To use the slider bar simply click on the pointer and drag it back or forth along the tabs.

To the right of the slider bar is the **Pos** box. This is the Position in Master File Number for the current abstract. It is shown for your reference and can be useful in opening abstracts by their position number.

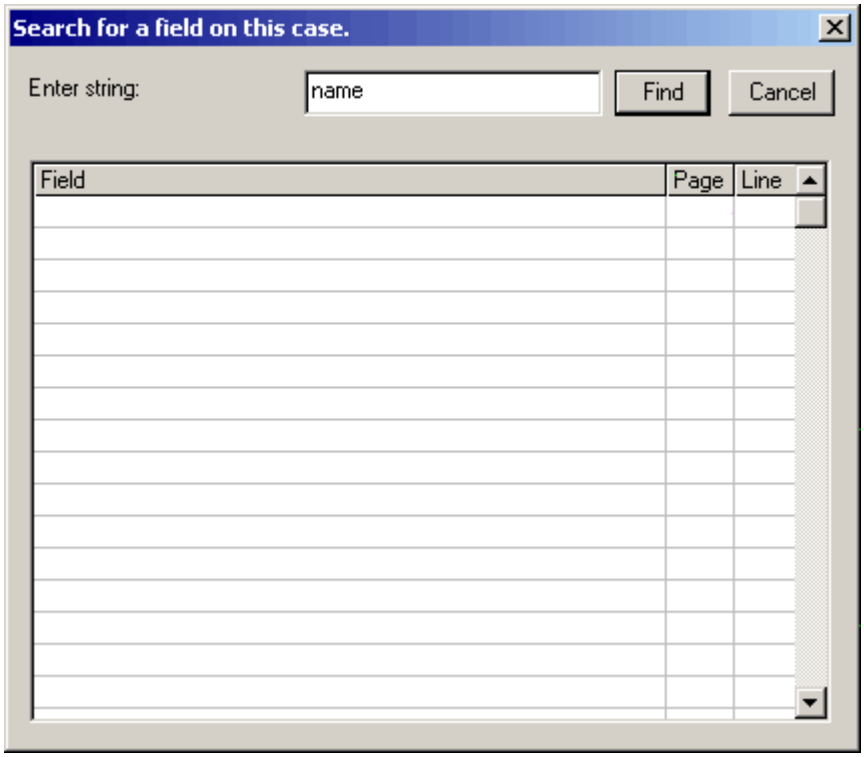
Below the slider bar is the **Screen** box. This box shows you which screen is currently in use and allows you to change to another screen that is currently defined on your computer. To change the current screen simply click on the black arrow to the right of the **Screen** box and select from the available screens shown. After you have selected a screen, click on the **Change** button to switch the abstract to that screen.

Go To

The Go To command allows you to search for a field within the abstract screen and then have the cursor go to that field. To use this command click on **Go To > Search For Field.**



This will bring up the **Search for a field on this case** window.



Type in the name of a field you want to locate and click on **Find**. The search results will appear in the data table.

Field	Page	Line
Name-Last	1	11
Name-First	1	12
Name-Middle	1	13
Name-Maiden	1	14
Name-Alias	1	15
Name-Suffix	1	16
Name-Spouse/Parent:	3	1
Follow-Up Contact-Name:	3	2
Second Contact Name:	3	11

Double click on a field name to go to that field within the abstract. Notice also that the page number and line where the field is found are also listed. NOTE: The Go To command only searches the fields that are available on the current abstract screen. Use screen 90 to search through all available fields.

ABSTRACT SCREEN NAVIGATION AND CONTROL

Navigation through the abstract can be done using the keyboard, the mouse, or a combination of both. (Note: Some fields are computer generated and cannot be modified manually. The text in these fields is blue.)

The navigation control buttons are located at the bottom of the Abstracting window. The controls are simple. Each button has a name and each name has one letter underlined indicating the keyboard shortcut. To utilize the keyboard shortcut, hold down the **Alt** Key and press the letter underlined on the corresponding button. We will discuss each button, it's function and it's shortcut below.

Clicking on any field with the mouse will activate that field.

Clicking on the **Next Page** button will take you to the next page of the abstract (**Alt N**)

Clicking on the **Prev Page** button will take you to the previous page of the abstract (**Alt R**)

Notice that when you move to the next page, the Slider Bar at the bottom moves to the right, and when you move to the previous page the bar move to the right. You can also use the Slider Bar to move to different pages within the abstract. The position bar is a quick way to jump multiple pages or move to the end of an abstract.

There are two boxes to the left of the position bar that tell you which page of the abstract screen you are currently on, and how many pages are in this particular abstract screen.

Clicking on the **Save** button will save the current case but leave the case open (**Alt S**). Regular saving is a good way to safeguard against data loss due to a power glitch, or a computer freezing up.

Clicking on the **Exit** button will exit the current case (**Alt X**). If you have not yet saved the case, it will ask if you would like to do so before exiting. If you do not save, any changes you have made to that case will be lost.

At the bottom right of the window you will find a box labeled **Screen**. This box tells which screen you are currently using, and allows you to change the screen to another one in your system. There are two ways to change screens. 1. Click on the black arrow to the right of the box. This brings up a pop up menu, listing all available screens on your system. Select the screen that you want to switch to. The pop up menu will disappear, but the screen has not yet been changed, you must first click on the **Change** button to the right of the of the screen box. After clicking on the Change button, the screen will be updated and you will be automatically taken to the first field in that screen. 2. To change the screens using the keyboard press **Alt C**, this will activate the screen box. Use the **up arrow and down arrow keys** to select the screen you want to switch to. Once the screen is selected press **Alt H**, to change the screen.

RMCDS ABSTRACTING SHORTCUT KEYS

The following is a list of keyboard shortcuts for quick reference. The items in **BOLD** represent keys, if two are listed in sequence you are to hold down the first key while pressing the second key.

Tab or **Enter** Moves to the next field

Shift Tab Moves to the previous field

Alt N Move to the next page

Alt R Move to the previous page

Alt T Opens the Treatment Screen

Alt Q Opens the Subsequent Treatment Screen

Alt S Save the current case, but do not exit the case

Alt X Exit the current case, (it will ask you if you want to save if you have not done so)

Alt C Allows you to select a different screen to abstract in (must also use Alt H to change screen)

Alt H Changes to the screen that you selected using Alt C

Alt D Marks the case as deleted

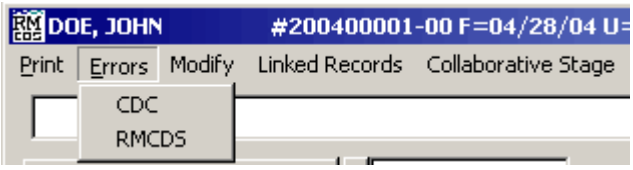
Alt P Pulls up the list of print options

Alt E Pulls up the error report options

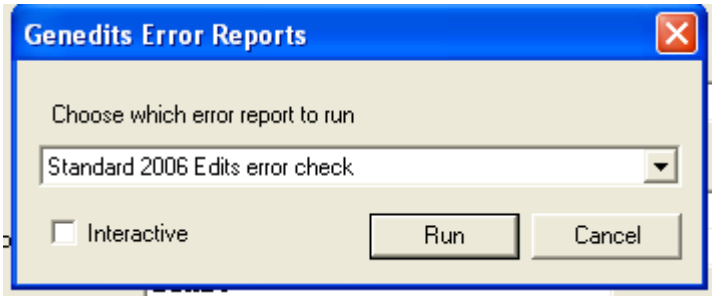
RUNNING ERROR CHECKS FOR AN ABSTRACT

Running EDITS is a very important step in your data submission process. These instructions describe how to run an error check for a patient from the Abstract.

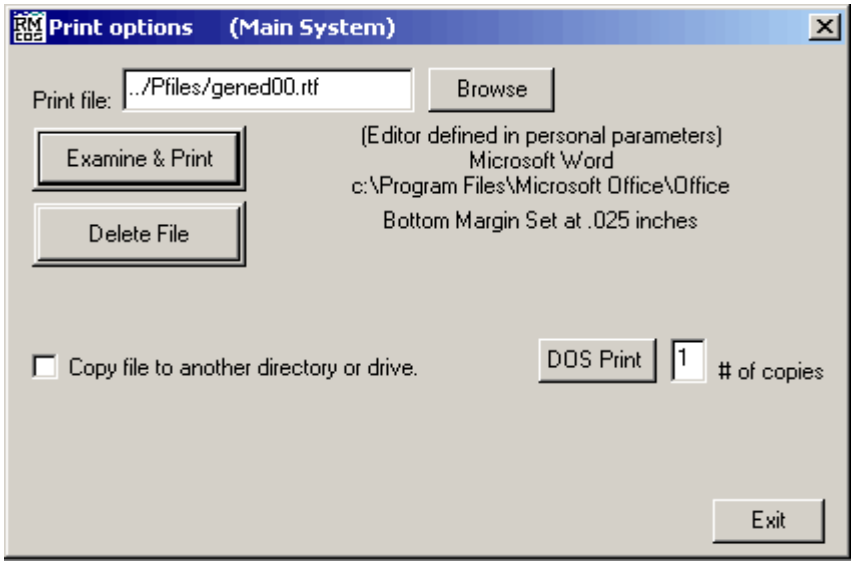
From the patient abstract click on the **Errors** Menu at the top.



From the drop down menu select the type of error report you wish to run, **CDC** or **RMCDS**. OCCR requires **both** error reports ran on each abstract before saving the record. CDC errors report is set to the default error program that should be selected (Standard 2006 Edits error check). Select **Run**.

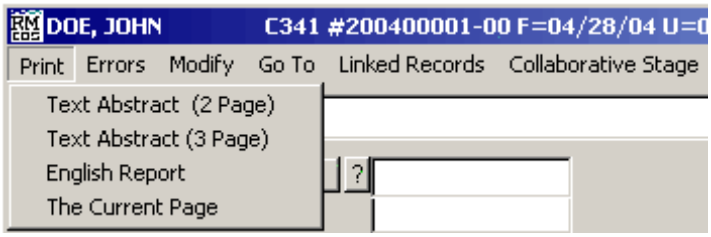


The error program will run and you may see a command window pop up as the error report is being generated. Upon completion, the **Print Options** window will appear. To view the Word document, click on the **Examine & Print** button. Review all errors and resolve any discrepancies generated from each error report before submitting data to the state. Click on **Exit** to close the Examine and Print window.

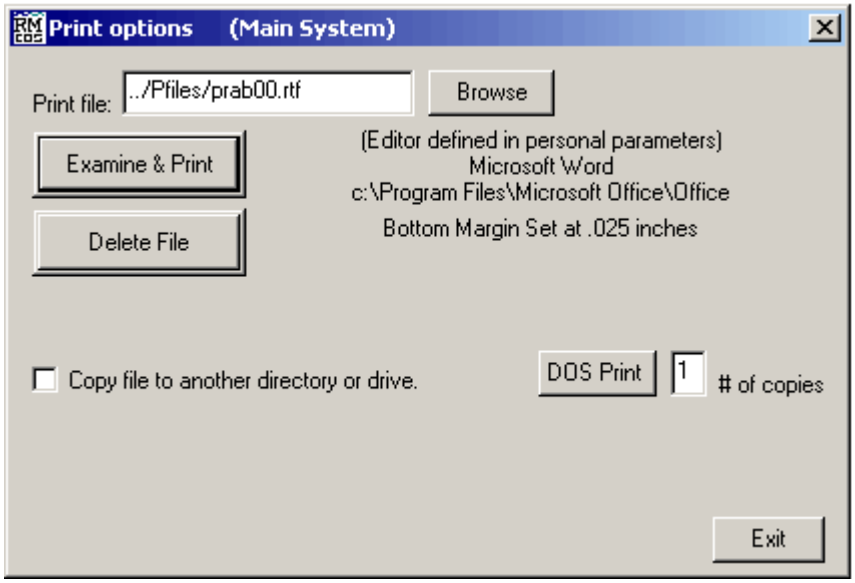


PRINT AN ABSTRACT

These instructions describe how to print an abstract. In order to print an abstract you must first open the abstract that you want to print. Once you are in the patient abstract that you want to print, click on the **Print** Menu at the top of the abstract (or press **Alt P**.)



This will give you a menu with four options: Text Abstract (2 or 3 page), English Abstract Report, or the current page. (Printing the current page will only print out the fields that are on the Abstract Screen at the time you select the Print option.) Select the report you want to print by clicking on it. (If you have not yet saved the case you will get a prompt asking you to save it before you continue on to the print.) Then **Print Options** window will then open.

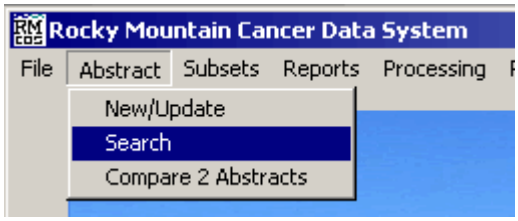


Click **Examine & Print**. The printout will open in the editor defined in your personal parameters. From the editor you can view the abstract or send it to your printer.

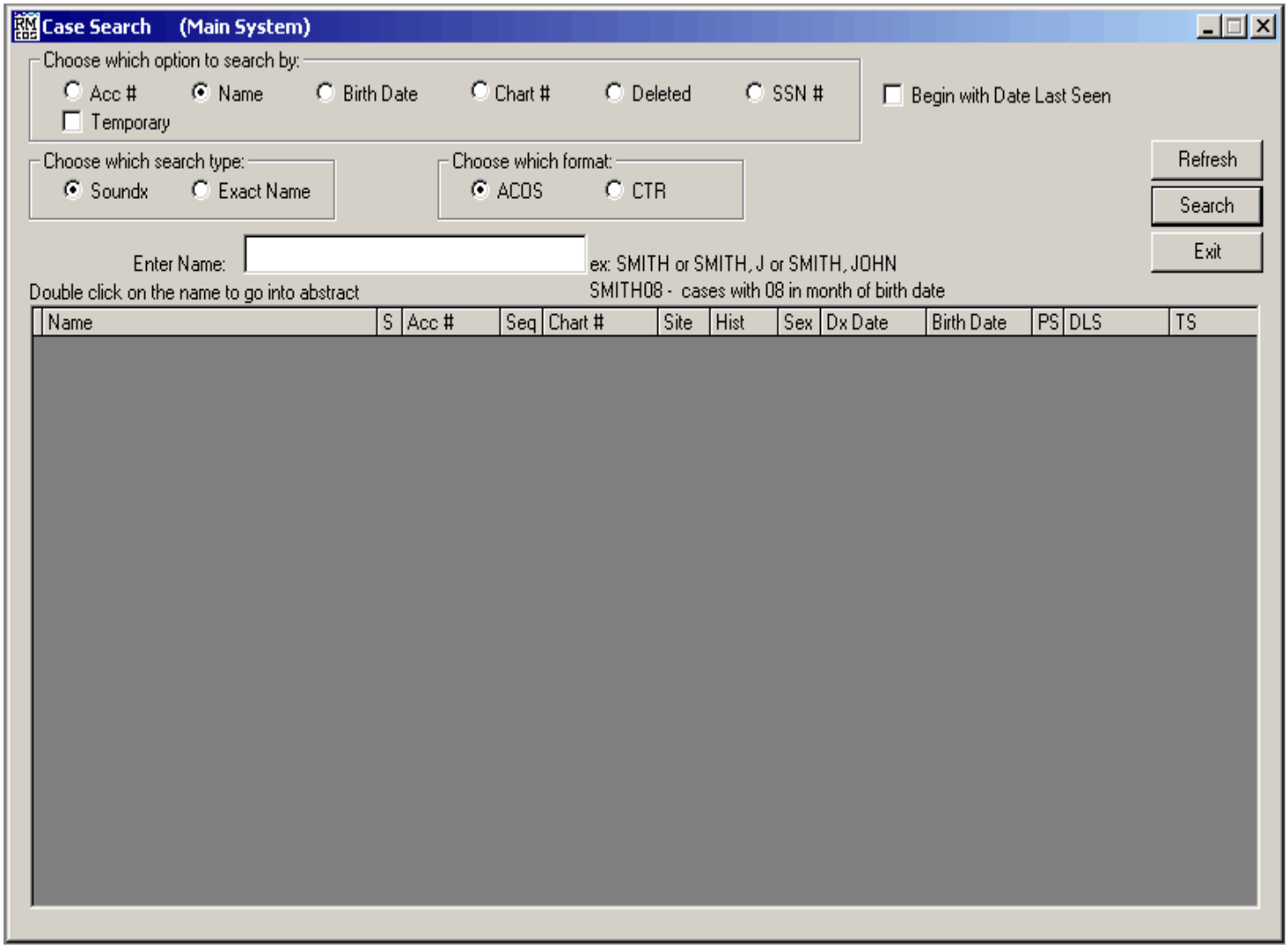
Case Search

These instructions describe how to use the case search program. The case search program searches the database and gives matches to your search criteria. Search criteria that is accepted in the case search program includes: Accession number, Name, Birth Date, Chart Number, Social Security Number and Deleted Cases.

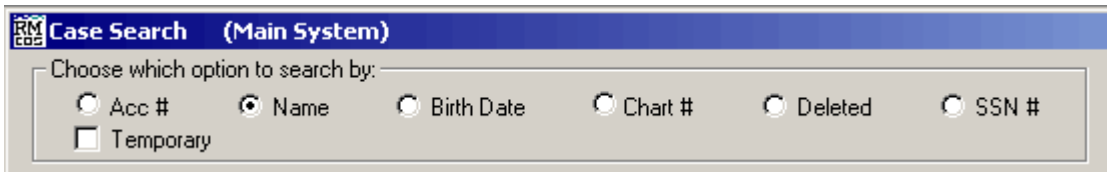
To open the **Case Search** program click on **Abstract > Search**



This will bring up the **Case Search** Window.



At the top of this window is a box labeled **Chose which option to search by:** which allows you to select which type of search you would like to run. You may choose from the following criteria: **Accession Number, Name, Birth Date, Chart Number, Social Security Number** and **Deleted** cases. To select any of the options simply click on the radio button next to the label.



NAME SEARCH

We will first look at the **Name Search**. Make sure the radio button next to **Name** has a black dot in it. You may then select whether you would like to run a **Soundex** or **Exact Name** search.

Soundex name search will give names that exactly match the search criteria and also names that sound like the name entered for the search criteria. For example, if you entered SMITH, JOHN as your search criteria and you selected Soundex, the search results would come back with all of the SMITH names and also those names that sound like Smith, such as SCHMIDT. Exact name search will only display those results that match name exactly as it was entered.

In the box labeled **Enter Name**, type in the name for which you want to search. To do a search on last name only, type in the last name (i.e. SMITH). To search for last name and the first letter of the first name, type in the last name followed by a comma followed by the first letter of the last name (i.e. SMITH, J). To search for last name and first name, type in the last name followed by a comma followed by the first name (i.e. SMITH, JOHN). There is also the ability to search for names of people born in a certain month, to do this you would type in the last name and then the numeric month with no space (i.e. SMITH08 (this will search for all SMITH born in August)).

Once the name is entered in the Enter Name box, click on **Search** button (**Alt S**) to start the search. The search results will appear in the table below. To open a case from the results table, double click on the patient name. That case will open in the abstract program.

OTHER SEARCHES

Searching for a case using any of the other options at the top of the Case Search window is similar to using the Name search. Select the search option by clicking on the radio button next to it. Notice that the label and help prompt by the data input text box changes when you select different options. For example, clicking on **Acc #** will change the label of the text box to **Enter Accession #:** and the help prompt will come up **ex: 199200143 (No Sequence)**. After any search, double clicking on the name of the patient will open that case into the abstract program.

To refresh the current list of cases for a given criteria click on the button labeled **Refresh**. This is useful if you are modifying cases from a set of search results and you then want to update the list after changing a case or two.

To generate a new search, simply enter the new criteria and click **Search**.

To leave the **Case Search** program and close the window, click on the **Exi**t button.

What to keep in mind when using the various search options:

Acc # - Do not add the sequence number on for the search, use only the Accession Number.

Name - Select whether you want Soundex or Exact Name search. Enter last name first Enter a comma (,) between last and first name.

Birth Date - Do not add any delimiters to the birth date, use only numbers in MMDDYYYY format (i.e. use 07251934 not 07/25/1934).

Deleted - Use the same as Name search. This option will only search through those cases that have been marked as deleted. Deleted names can only be searched by Patient Name.

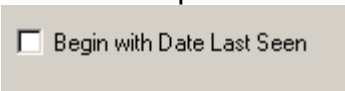
Chart # - Type in the Chart number.

SSN - Type in the Social Security Number without any dashes (i.e. 123456789, not 123-45-6789).

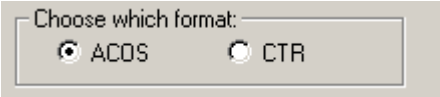
OTHER CASE SEARCH OPTIONS

When the Case Search program is first opened, the default search option is set as **Name**. You can change the search option at any time by clicking on the radio button next to the desired option. After you change the search option all searches will be performed by the selected option until it is changed. If you want to switch search options for one search only and then have the option return to where you had it set originally, put a check in the **Temporary** box after you select the one time use option.

If you want to open an abstract with the cursor in the DATE LAST SEEN field, put a check in the box at the top of the window labeled **Begin with Date Last Seen.**



The **Choose which format** area of the screen can be used to change which data fields are displayed in the Search Results Table. You can choose between **ACOS** and **CTR** format.



An example of the **ACOS** display format:

An example of the **CTR** display format:

Sorting the Search Results

The search results can be sorted by any of the items listed in the display format title bat. To sort the search results by a particular variable, simply click on the label for that column. The search results will be ordered in ascending order (smallest value to largest value.)

Closing the Case Search Window

To close the Case Search Window, simply click on the **Exit** button.

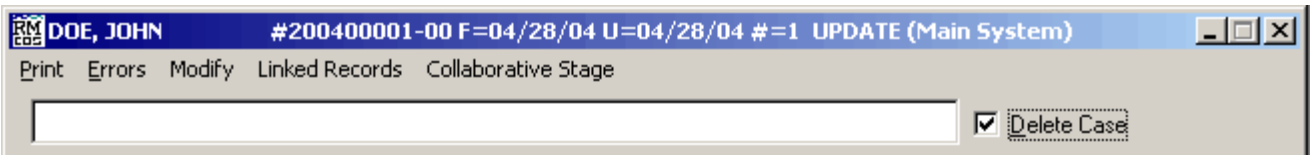
DELETING/UNDELETING A CASE IN RMCDS

Delete a Case

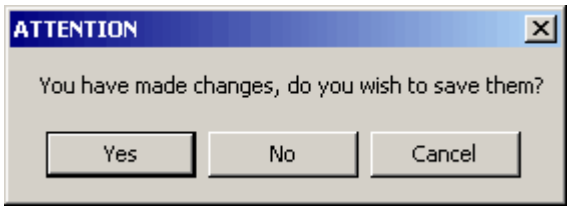
These instructions describe how to delete a patient abstract in the RMCDS system. [Please note: Due to the nature of Cancer Registry operations, the data in a deleted case is not lost when the case is deleted. The deleted cases are flagged and are not included in any subsets, reports, or data submissions. It is possible, however, to run reports on deleted cases, create subsets of deleted cases, and restore deleted cases.]

To delete a patient abstract, you must first open the case in the abstract / update window

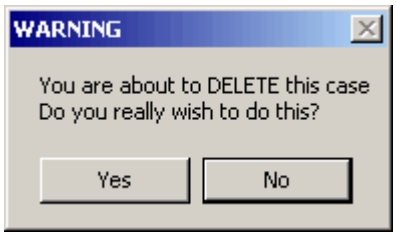
At the top of the patient Abstract window, to the right of the Help Prompt box is a check box labeled **Delete Case.**



If you want to delete a patient abstract, put a check in the **Delete Case** box. After the check is in the Delete Case box click on the **Exit** button at the bottom of the window. A message box will appear saying that changes were made and asking if you want to save the changes. [You may get a Warning message telling you certain lines were not entered. If you do, click YES to continue.]



Click **Yes** to save the changes. You will then get a message reminding you that you marked the case as deleted and asking you to confirm the delete.



Click **Yes** to mark the case as deleted and close the abstract.

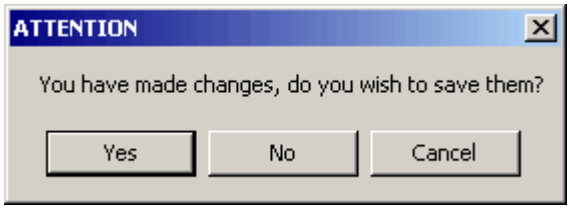
Undelete a Case

The following instructions describe how to undelete a case that has been marked as deleted. Before you can undelete a case, you must first open the case in the abstract program.

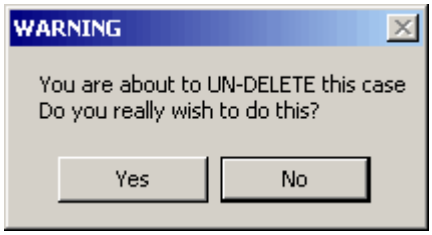
There are a few different ways to open a case that has been marked as deleted. If you happen to know the Master Position Number of the case then you can open the deleted case from the **Abstract and Update** window using the position number. (Note: Position number is not the same as accession number.)

The easiest way to open a case that has been marked as deleted is to use the **Case Search** program and search for the case by patient name. Make sure to click the radio button next to Deleted in the Search by options. Once you have opened the case that you want to undelete simply take the check mark out of the box labeled **Delete Case**.

After the check is removed from the Delete Case box click on the **Exit** button at the bottom of the window. A message box will appear saying that changes were made and asking if you want to save the changes. [You may get a Warning message telling you certain lines were not entered. If you do, click YES to continue.]



Click **Yes** to save the changes. You will then get a message reminding you that you are UN-deleting the case and asking you to confirm the undelete.

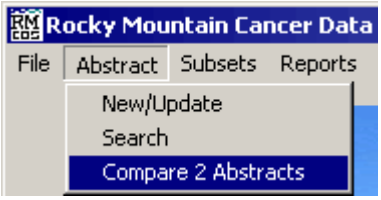


Click **Yes** to undelete the case and close the abstract. The undeleted case will now appear in future reports, subsets, and submissions.

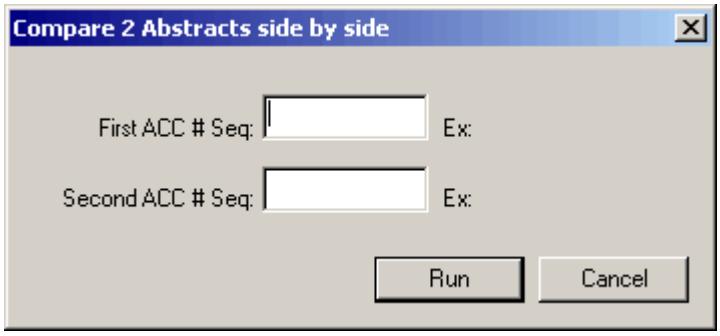
COMPARE TWO ABSTRACTS

These instructions describe how to compare two abstracts in RMCDS. Comparing two abstracts side by side can be useful for multiple sequence cases, or other cases, where you want to see the differences between the data entered in two separate abstracts. It can also be useful if duplicate case checking. To compare two abstracts in RMCDS, you must first know the Accession number and Sequence number for the patient abstracts that you want to compare. If you don't know the accession and sequence numbers you can use Case Search to find them.

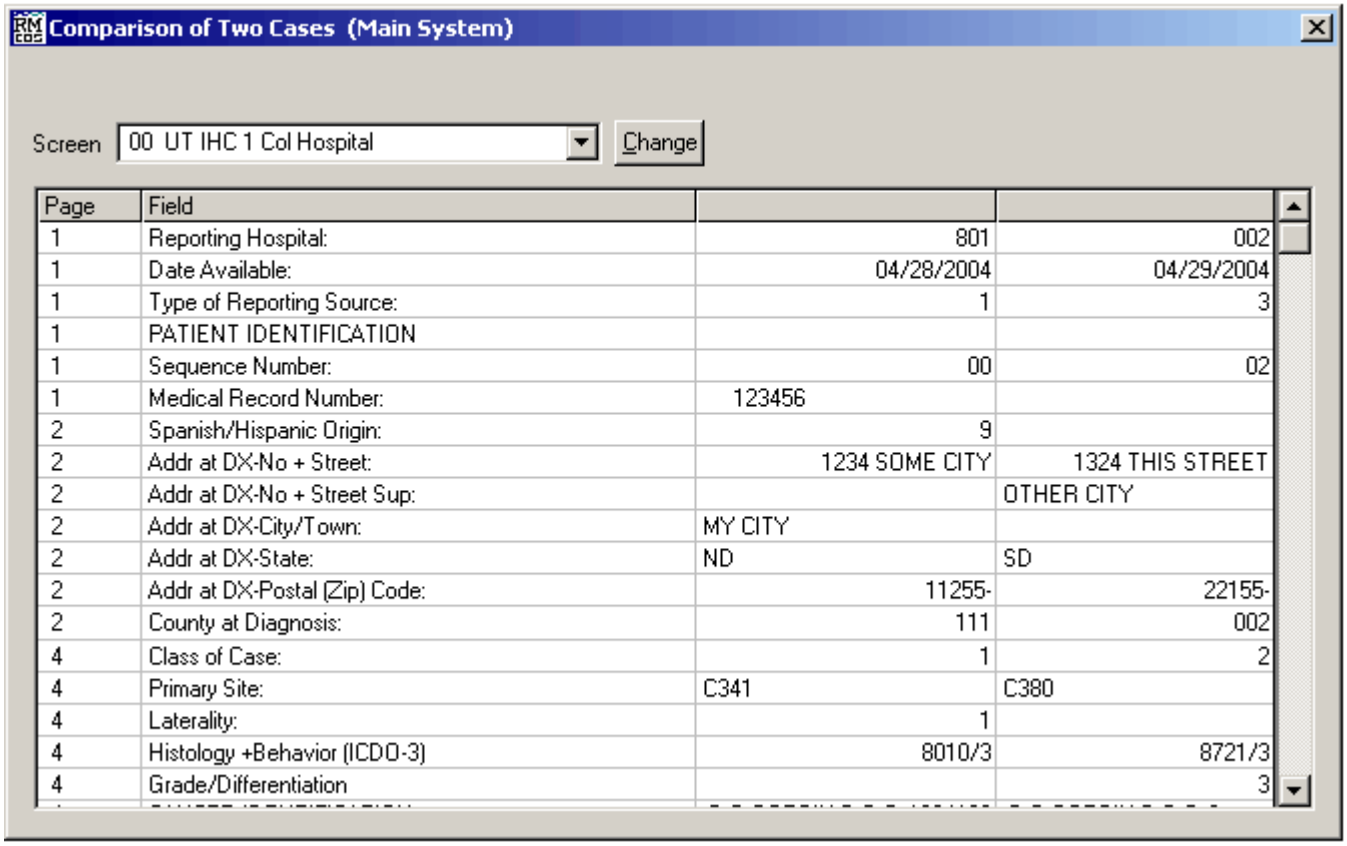
From the RMCDS Main Menu, click on **Abstract > Compare 2 Abstracts**.



This will open the **Compare 2 Abstracts side-by-side** window.



Type in the accession and sequence numbers for the two cases in the boxes labeled **First ACC # Seq** and **Second ACC # Seq**. After the Accession numbers have been entered, click on **Run**. The **Comparison of Two Cases** window will appear.



Page	Field		
1	Reporting Hospital:	801	002
1	Date Available:	04/28/2004	04/29/2004
1	Type of Reporting Source:	1	3
1	PATIENT IDENTIFICATION		
1	Sequence Number:	00	02
1	Medical Record Number:	123456	
2	Spanish/Hispanic Origin:	9	
2	Addr at DX-No + Street:	1234 SOME CITY	1324 THIS STREET
2	Addr at DX-No + Street Sup:		OTHER CITY
2	Addr at DX-City/Town:	MY CITY	
2	Addr at DX-State:	ND	SD
2	Addr at DX-Postal (Zip) Code:	11255-	22155-
2	County at Diagnosis:	111	002
4	Class of Case:	1	2
4	Primary Site:	C341	C380
4	Laterality:	1	
4	Histology +Behavior (ICDO-3)	8010/3	8721/3
4	Grade/Differentiation		3

This window lists the fields that are different between the two cases that are being compared. (Note: Fields that have the same value in both abstracts are not displayed.) This screen displays the **Field** name, the **Page** in the abstract screen where that Field is located, and the data for the two abstracts being compared.

In the example shown, a sequence 00 is being compared to a sequence 02. The two cases are for the same patient with multiple primaries. Notice that for the first primary our patient, John Doe, was at Reporting Hospital 801 but for the second primary Reporting Hospital 002 is listed. The Type of Reporting Source fields are different. Notice also that the addresses are different. The patient could have moved but this discrepancy could also be the result of typographical error. The **Compare Two Abstracts** program can help you find these differences quickly.

Screen

The Compare Two Abstracts program displays the differing Abstract Screen fields for two patient abstracts. By default the program uses the default-abstracting screen. If you want to change which screen is used in the display, and thereby change which abstract fields are being displayed, use the **Screen** selection box. You click on the black arrow to the right of the box to see the available screens on your computer.

After choosing the screen you wish to use click on the **Change** box to update the Compare two Abstracts screen. The variables from the selected screen will then now be displayed.

To close the **Comparison of Two Cases** window, click on the black **X** in the upper right-hand corner.

CHAPTER 12 – ABSTRACTING PATIENT IDENTIFICATION

The software available for cancer reporting is updated routinely and will step you through the requirements for reporting each item. It is recommended that you also refer to the reference manuals or the help resource on your software for proper reporting.

The item reference for NAACCR Manual version 11.1 and FORDS Revised 2004 is recorded to the right of each data item you will be reporting. The number of spaces required for the item is also noted. These should help in clarifying the appropriate response to report. Additional information has been added to help you understand the response that is appropriate. Data items are listed in alphabetical order for easy referencing.

All date fields are recorded in the month, day, year format (MMDDCCYY), with "99" for unknown day or month and "9999" for unknown year. If there is no date it is coded "00000000".

Some data items are required only by Oklahoma, and some are required only if the data is available. Where there is a difference between state requirements and ACoS requirements, the ACoS requirement status is reported in blue.

i.e. Patient Address - Current codes (S) for Oklahoma (FORDS page 46 required).

When they are the same code no distinctive coding is used.

i.e. (R)

Before starting your abstract, it is helpful to read the preliminary information at the beginning of each of the following references:

NAACCR Data Standards and Data Dictionary
FORDS Manual
ICD-O-3
Collaborative Staging Manual

This will help you understand what needs to be considered before you start the first abstract and to refresh information in question later on in abstracting. Anytime this manual is unclear, refer to one of the other references for a better understanding of the requirement.

Many of these sources have a way to refer questions to them to help clarify the requirement. FORDS has a list of questions and answers that have already been referred to them that can be used to help you. Helpful web sites are in Chapter 2 or listed in Appendix G.

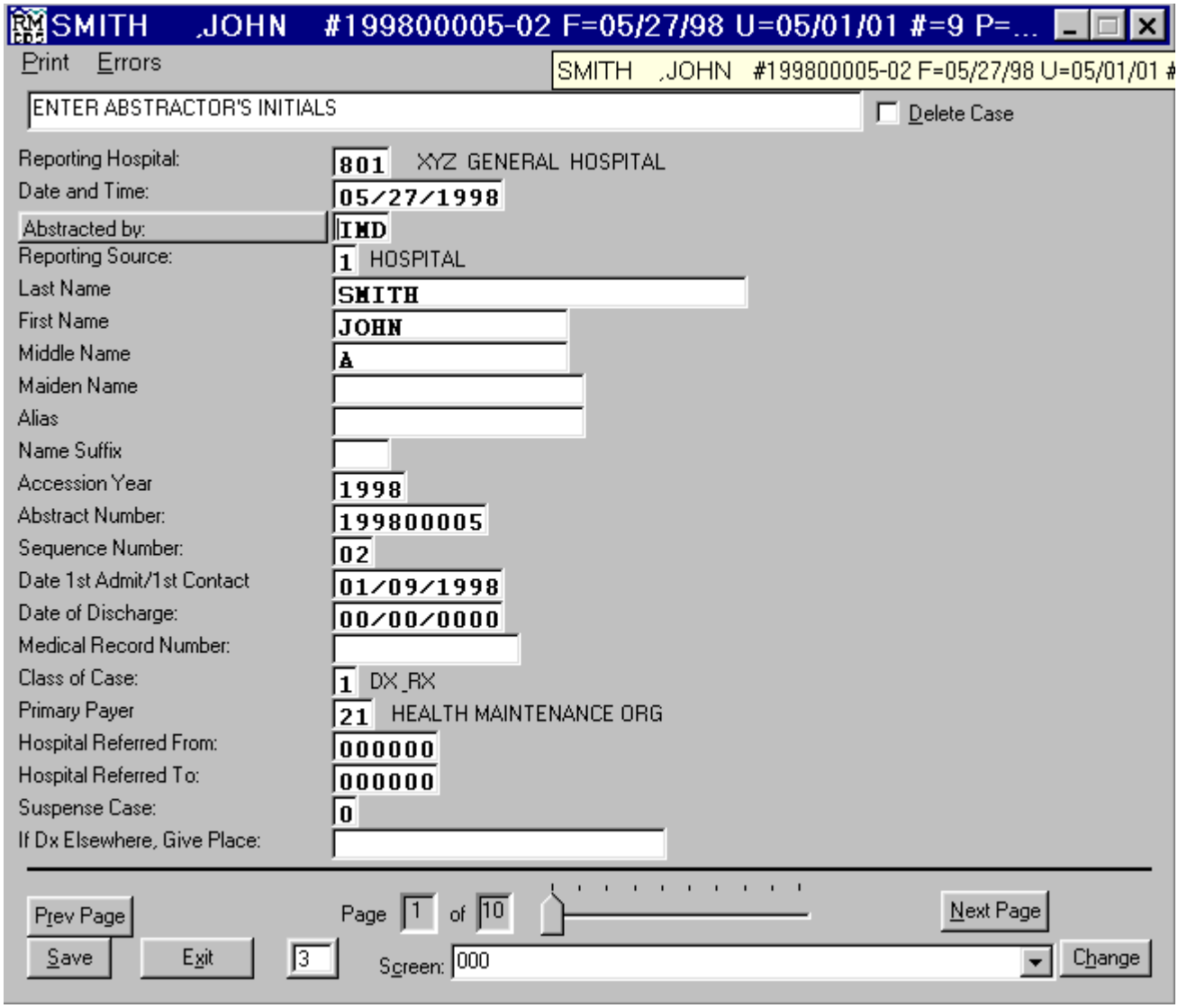
If you cannot find the appropriate RMCDS instruction in this chapter, look in chapter 11, go to their web site or contact OCCR. This chapter includes instructions for "Using the Abstract Program" along with supporting screens that you will use to enter your data.

USING THE ABSTRACT PROGRAM

These instructions describe how to navigate through a case in the Abstract Program. The focus is not to explain each field or code, but to provide basic operations, helpful hints and a few useful tricks on using the abstract program. OCCR is always available to help you or you can call RMCDS at 1-801-581-4307.

Open a case in the abstract program. If you are unsure on how to do this, please refer to the section for Opening an Abstract.

When you first open a case in the abstract program you will see a screen similar to the following.



In the title bar at the top of the window, the name and abstract number is listed. The name and abstract number will be the same on each page of the abstract. This is useful in identifying which case you are in at any given time, especially if you have more than one case open at once.

First, basic navigation will be discussed. Navigation through the abstract can be done using the keyboard, the mouse or a combination of both. Note: Some fields are computer generated and cannot be modified manually.

The navigation controls are located at the bottom of the Abstracting window. The controls are simple and self-explanatory. Each button has a name, and each name has one letter underlined indicating the keyboard shortcut. To utilize the keyboard shortcut, hold down the **Alt** Key and press the corresponding letter. We will discuss each button, it's function and it's shortcut below.

Clicking on any field with the mouse will activate that field.

Clicking on the **Next Page** button will take you to the next page of the abstract (**Alt N**)

Clicking on the **Prev Page** button will take you to the previous page of the abstract (**Alt R**)

Notice that when you move to the next page, the position bar at the bottom moves to the right, and when you move to the previous page the bar moves to the left. You can also use the position bar to move to different pages within the abstract. To move the position bar, simply click and hold the bar while moving the mouse to the left or right. When you release the button, the screen will be updated to the position where you stopped. The position bar is a quick way to jump multiple pages or move to the end of an abstract.

There are two boxes to the left of the position bar that tell you which page of the abstract screen you are currently on, and how many pages are in this particular abstract screen.

Clicking on the **Save** button will save the current case but leave the case open (**Alt S**). Regular saving is a good way to safeguard against data loss due to a power glitch, or a computer freezing up.

Clicking on the **Exit** button will exit the current case (**Alt X**). If you have not yet saved the case, it will ask if you would like to do so before exiting. If you do not save, any changes you have made to that case will be lost.

Notice the box to the right of the **Exit** button. This box contains a number indicating the length of the field that is currently active. For example, if the **Abstracted by:** field is active, the box would read **3**, indicating that the Abstracted by field holds up to three characters of information.

At the bottom right of the window you will find a box labeled **Screen**. This box tells which screen you are currently using, and allows you to change the screen to another one in your system. There are two ways to change screens. **1.** Click on the black arrow to the right of the box. This

brings up a pop up menu, listing all available screens on your system. Select the screen that you want to switch to. The pop up menu will disappear, but the screen has not yet been changed. You must first click on the Change button to the right of the of the screen box. After clicking on the Change button, the screen will be updated, and you will be automatically taken to the first field in that screen. **2.** To change the screens using the keyboard press **Alt C.** This will activate the screen box. Use the up arrow and down arrow keys to select the screen you want to switch to. Once the screen is selected press **Alt H**, to change the screen.

At the top of the window is an unlabeled box. This box contains the help prompt for the active field. Each time a new field is selected, the help prompt is updated to that field.

To the right of the help prompt box is a check box labeled **Delete Case** (**Alt D**) If you want to delete this case, put a check in this box and then exit the record. (Note: the case is not removed from your data base, it is rather marked as a deleted case and will not appear in any subsets or reports unless specified by the user. This feature has been set up as a safeguard and is quite useful. If you wanted to remove all instance of a case from the data base, you would have to manually change each field in the record to be blank. This is not normally done.)

Some fields contain lookup capabilities. If a field has lookup capabilities, a small box with a **?** will appear on the line when the field is activated. To view the look up screen, click on the **?** and a new window containing the codes and description will come up. To close the lookup window without selecting a code, click **Cancel**. To select a code from this list, double click on the code number. The lookup window will close and you will return to the abstract record.

Many files are setup with English re-codes. English re-codes will list the English description of the code entered in the field. For example, on the field, Reporting Source, if you were to select the value 1, when you move to the next field, the label HOSPITAL would appear to the right of the code box.

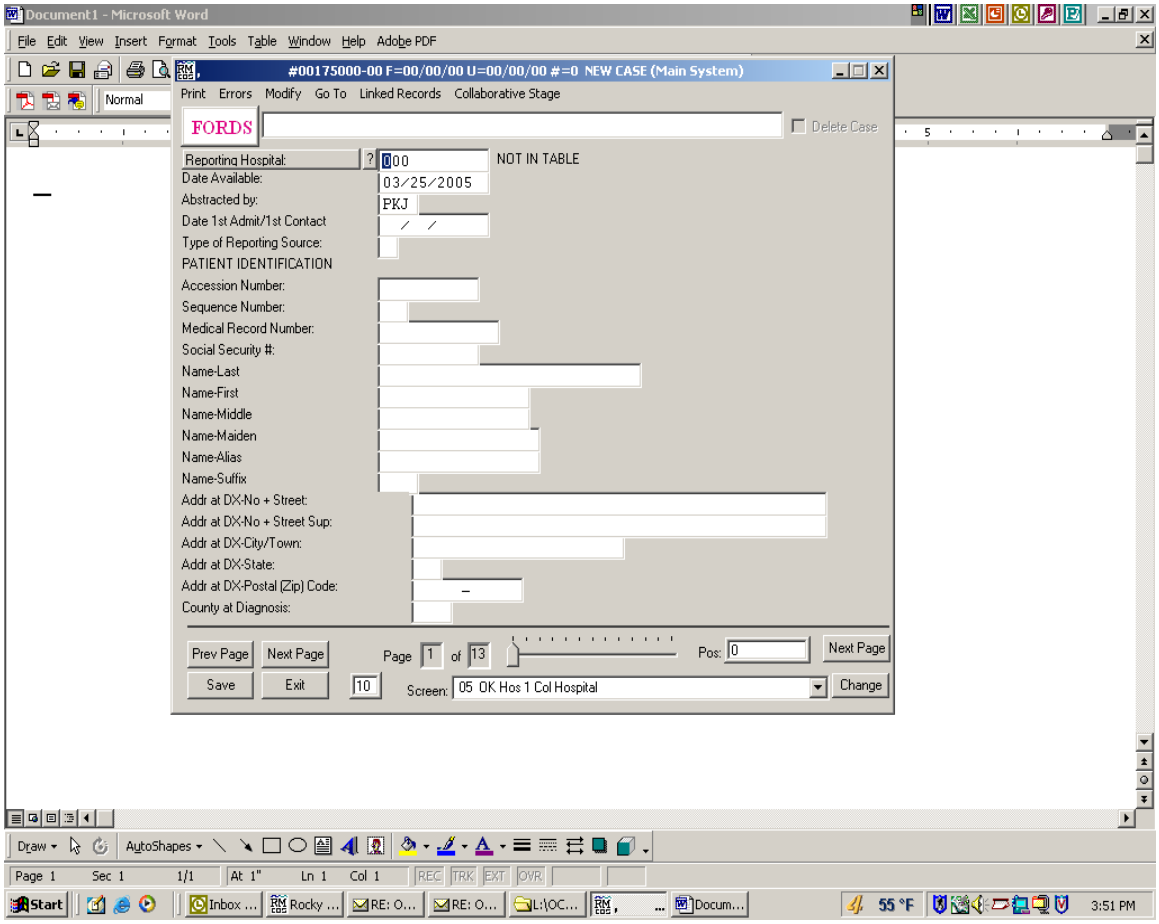
At the top of the window are two pull down menu's. They are labeled **Print** (**Alt P**) and **Errors** (**Alt E**).

Clicking on **Print** (**Alt P**) will bring up a short menu allowing you to print a 2 page text abstract, a 3 page text abstract, or an English Report for the current case. For help on using the print menu that comes up after clicking on any one of these options, please refer to instructions for Print Options Window.

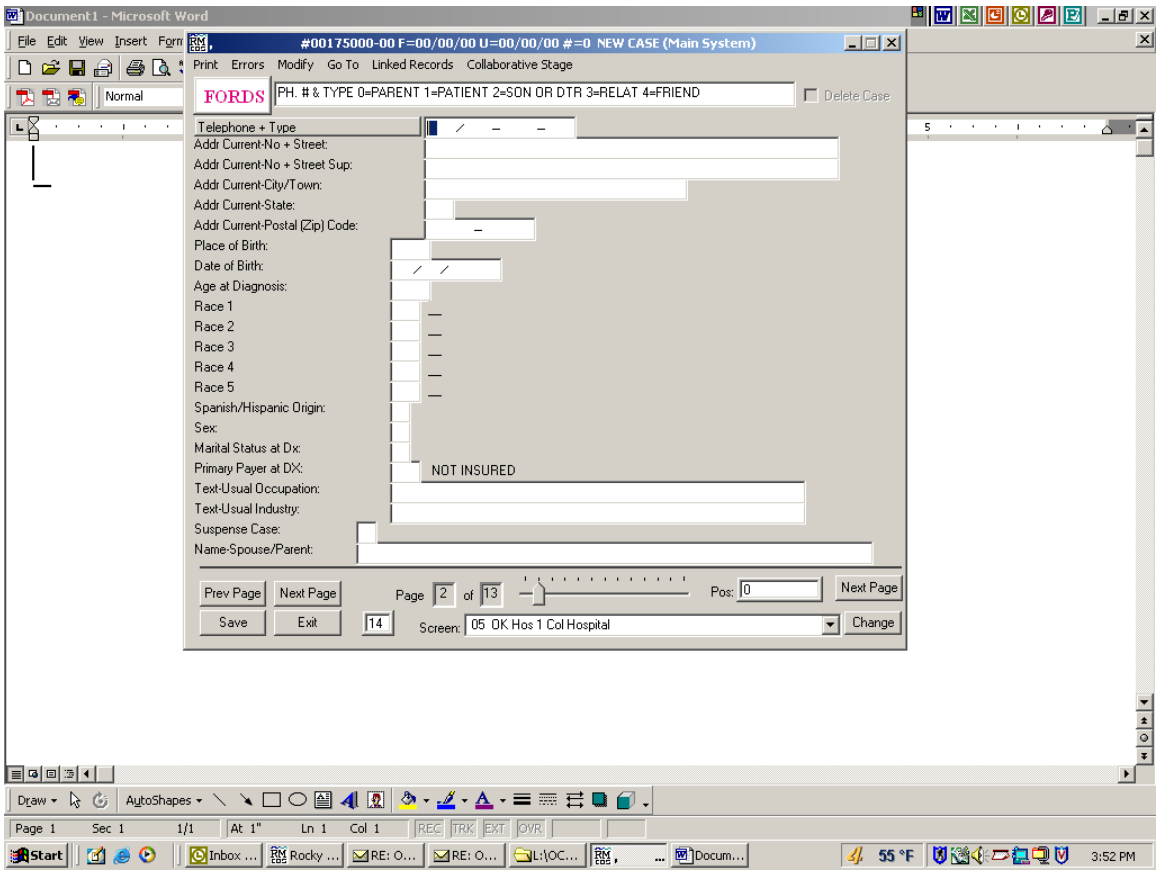
Clicking on **Errors** (**Alt E**) will bring up a menu allowing you to select either CDC edits or RMCDS edits. The edit check will run on the current case and bring up the standard Print Options Window. For help on using the print menu, please refer to the instructions for Print Options Window.

RMCDS SCREENS FOR ABSTRACTING DATA

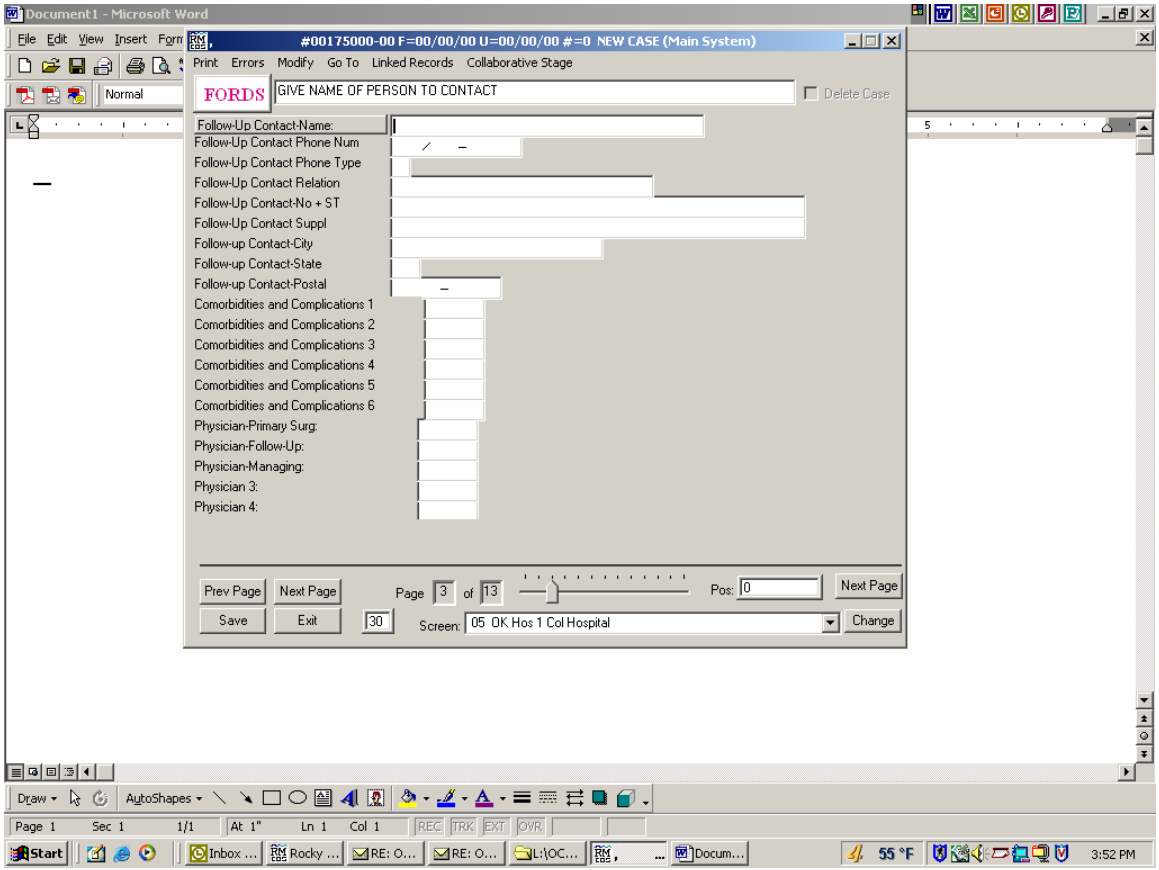
SCREEN 1



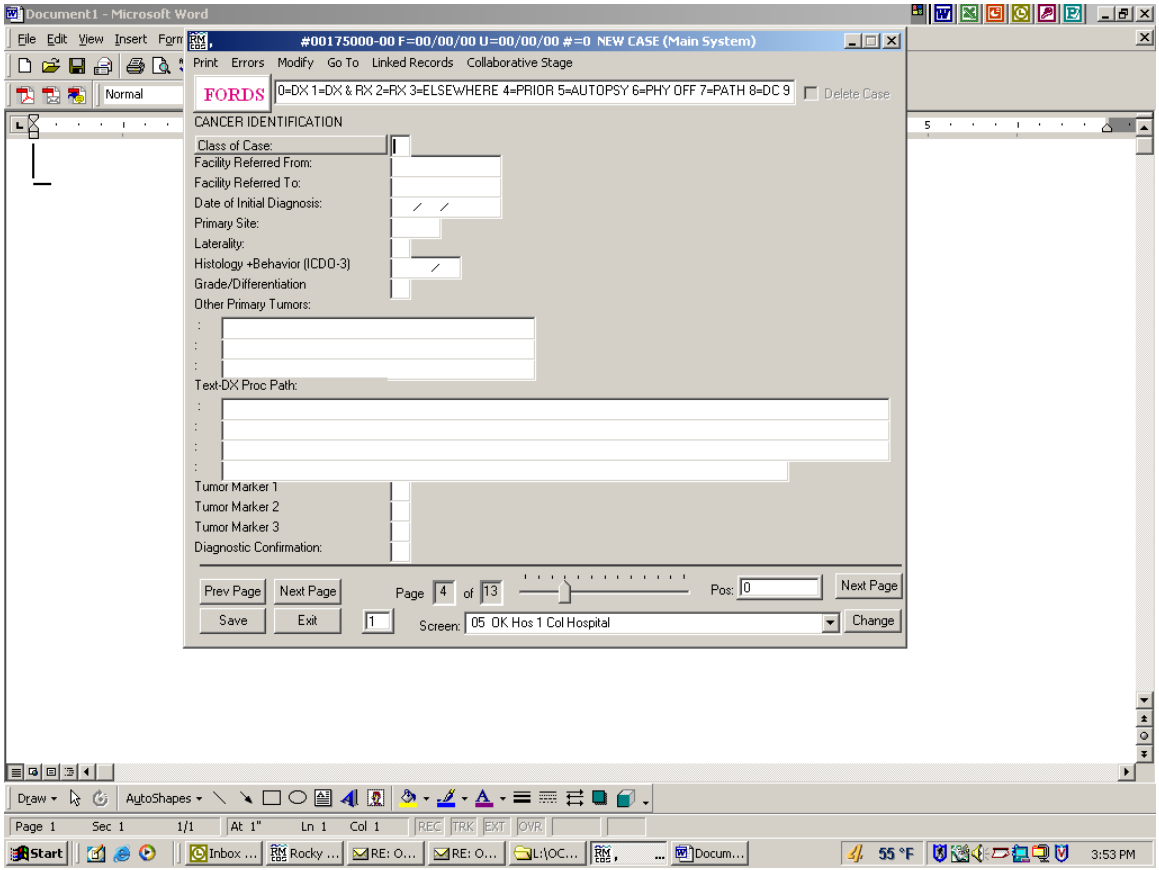
SCREEN 2


Document1 - Microsoft Word
#00175000-00 F=00/00/00 U=00/00/00 #=0 NEW CASE (Main System)
Print Errors Modify Go To Linked Records Collaborative Stage
FORDS
PH. # & TYPE 0=PARENT 1=PATIENT 2=SON OR DTR 3=RELAT 4=FRIEND
Delete Case
Telephone + Type
Addr Current-No + Street:
Addr Current-No + Street Sup:
Addr Current-City/Town:
Addr Current-State:
Addr Current-Postal (Zip) Code:
Place of Birth:
Date of Birth:
Age at Diagnosis:
Race 1
Race 2
Race 3
Race 4
Race 5
Spanish/Hispanic Origin:
Sex:
Marital Status at Dx:
Primary Payer at DX:
NOT INSURED
Text-Usual Occupation:
Text-Usual Industry:
Suspense Case:
Name-Spouse/Parent:
Prev Page
Next Page
Page 2 of 13
Pos: 0
Next Page
Save
Exit
14
Screen: 05 OK Hos 1 Col Hospital
Change

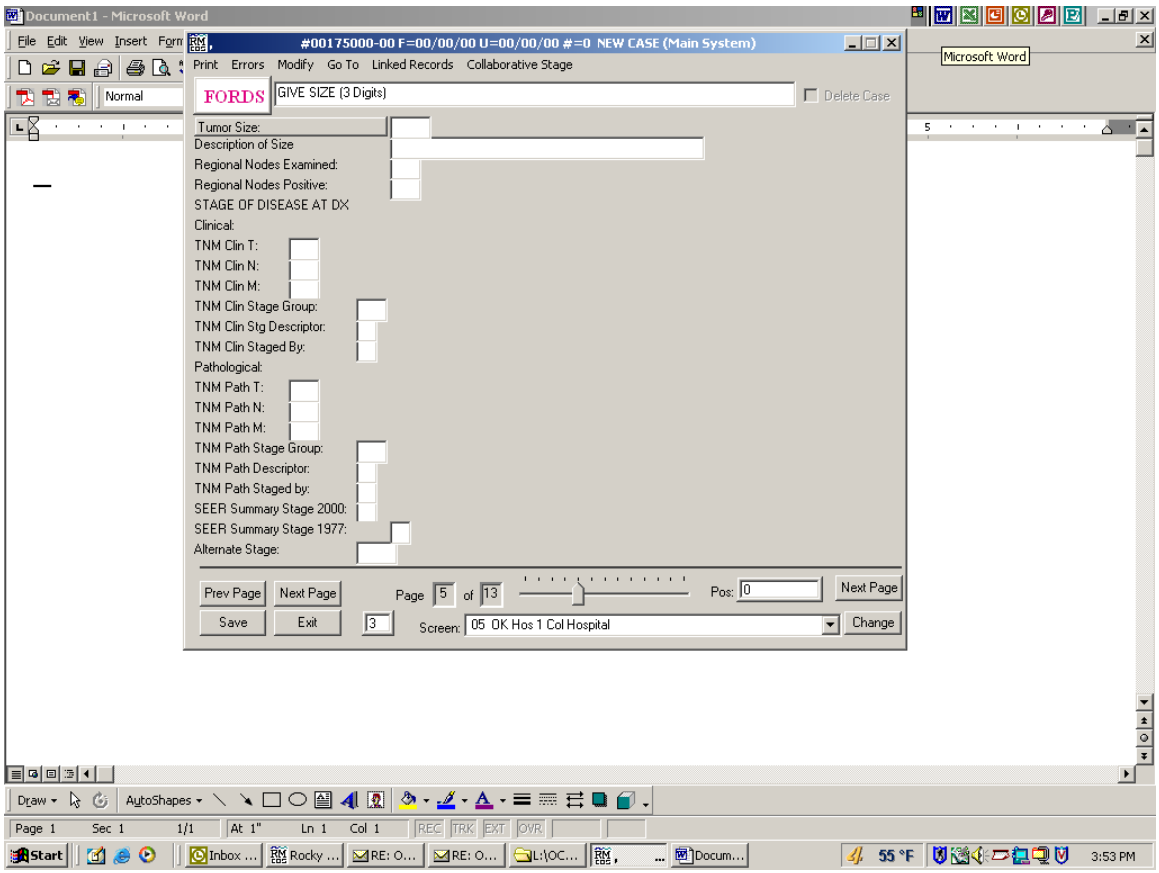
SCREEN 3


Document1 - Microsoft Word
#00175000-00 F=00/00/00 U=00/00/00 #=0 NEW CASE (Main System)
Print Errors Modify Go To Linked Records Collaborative Stage
FORDS
GIVE NAME OF PERSON TO CONTACT
Delete Case
Follow-Up Contact-Name:
Follow-Up Contact Phone Num
Follow-Up Contact Phone Type
Follow-Up Contact Relation
Follow-Up Contact-No + ST
Follow-Up Contact Suppl
Follow-up Contact-City
Follow-up Contact-State
Follow-up Contact-Postal
Comorbidities and Complications 1
Comorbidities and Complications 2
Comorbidities and Complications 3
Comorbidities and Complications 4
Comorbidities and Complications 5
Comorbidities and Complications 6
Physician-Primary Surg:
Physician-Follow-Up:
Physician-Managing:
Physician 3:
Physician 4:
Prev Page
Next Page
Page 3 of 13
Pos: 0
Next Page
Save
Exit
30
Screen: 05 OK Hos 1 Col Hospital
Change

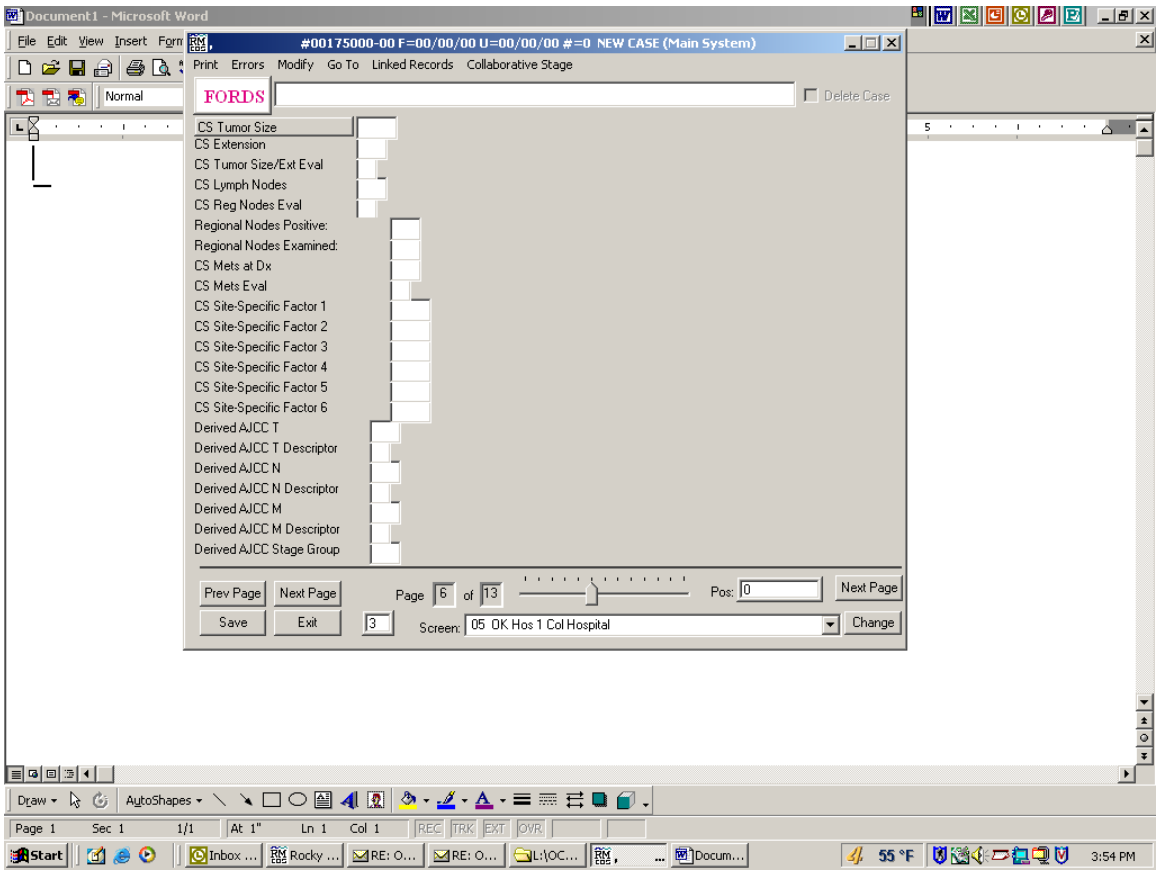
SCREEN 4


Document1 - Microsoft Word
File Edit View Insert Form
#00175000-00 F=00/00/00 U=00/00/00 #=0 NEW CASE (Main System)
Print Errors Modify Go To Linked Records Collaborative Stage
FORDS
0=DX 1=DX & RX 2=RX 3=ELSEWHERE 4=PRIOR 5=AUTOPSY 6=PHY OFF 7=PATH 8=DC 9
Delete Case
CANCER IDENTIFICATION
Class of Case:
Facility Referred From:
Facility Referred To:
Date of Initial Diagnosis:
Primary Site:
Laterality:
Histology +Behavior (ICDO-3)
Grade/Differentiation
Other Primary Tumors:
Text-DX Proc Path:
Tumor Marker 1
Tumor Marker 2
Tumor Marker 3
Diagnostic Confirmation:
Prev Page
Next Page
Page 4 of 13
Pos: 0
Next Page
Save
Exit
Screen: 05 OK Hos 1 Col Hospital
Change
Draw
AutoShapes
Page 1 Sec 1 1/1 At 1" Ln 1 Col 1 REC TRK EXT OVR
Start
55 °F
3:53 PM

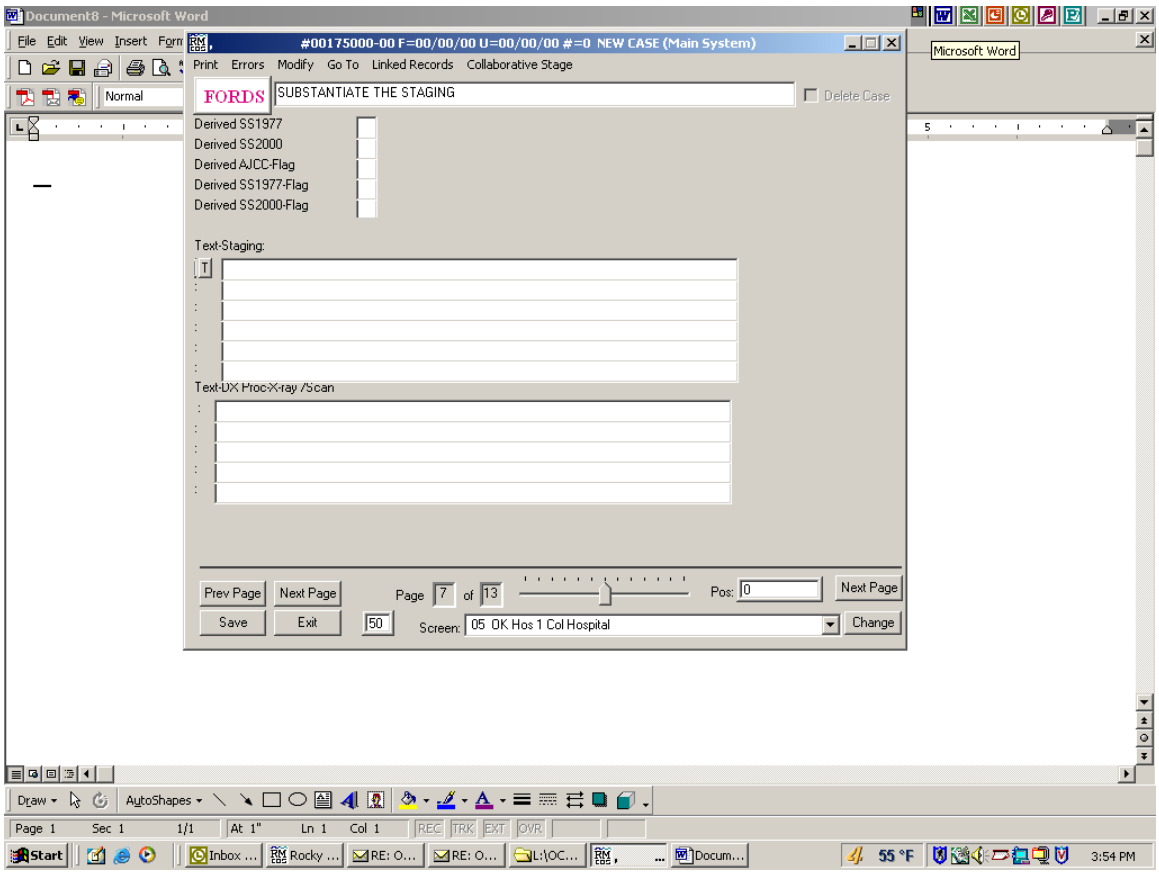
SCREEN 5


Document1 - Microsoft Word
#00175000-00 F=00/00/00 U=00/00/00 #=0 NEW CASE (Main System)
Print Errors Modify Go To Linked Records Collaborative Stage
FORDS
GIVE SIZE (3 Digits)
Delete Case
Tumor Size:
Description of Size
Regional Nodes Examined:
Regional Nodes Positive:
STAGE OF DISEASE AT DX
Clinical:
TNM Clin T:
TNM Clin N:
TNM Clin M:
TNM Clin Stage Group:
TNM Clin Stg Descriptor:
TNM Clin Staged By:
Pathological:
TNM Path T:
TNM Path N:
TNM Path M:
TNM Path Stage Group:
TNM Path Descriptor:
TNM Path Staged by:
SEER Summary Stage 2000:
SEER Summary Stage 1977:
Alternate Stage:
Prev Page
Next Page
Page 5 of 13
Pos: 0
Next Page
Save
Exit
3
Screen: 05 OK Hos 1 Col Hospital
Change
Microsoft Word

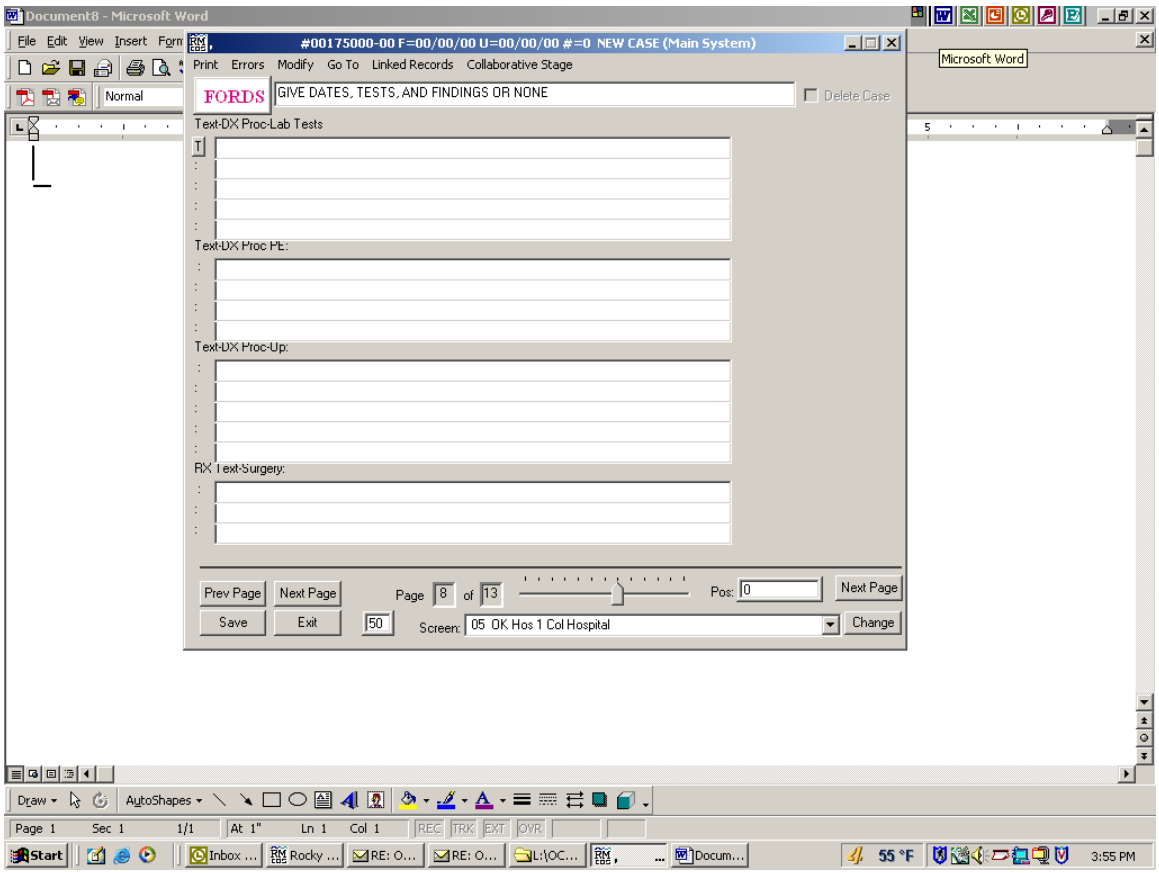
SCREEN 6


Document1 - Microsoft Word
#00175000-00 F=00/00/00 U=00/00/00 #=0 NEW CASE (Main System)
Print Errors Modify Go To Linked Records Collaborative Stage
FORDS
Delete Case
CS Tumor Size
CS Extension
CS Tumor Size/Ext Eval
CS Lymph Nodes
CS Reg Nodes Eval
Regional Nodes Positive:
Regional Nodes Examined:
CS Mets at Dx
CS Mets Eval
CS Site-Specific Factor 1
CS Site-Specific Factor 2
CS Site-Specific Factor 3
CS Site-Specific Factor 4
CS Site-Specific Factor 5
CS Site-Specific Factor 6
Derived AJCC T
Derived AJCC T Descriptor
Derived AJCC N
Derived AJCC N Descriptor
Derived AJCC M
Derived AJCC M Descriptor
Derived AJCC Stage Group
Prev Page
Next Page
Page 6 of 13
Pos: 0
Next Page
Save
Exit
Screen: 05 OK Hos 1 Col Hospital
Change

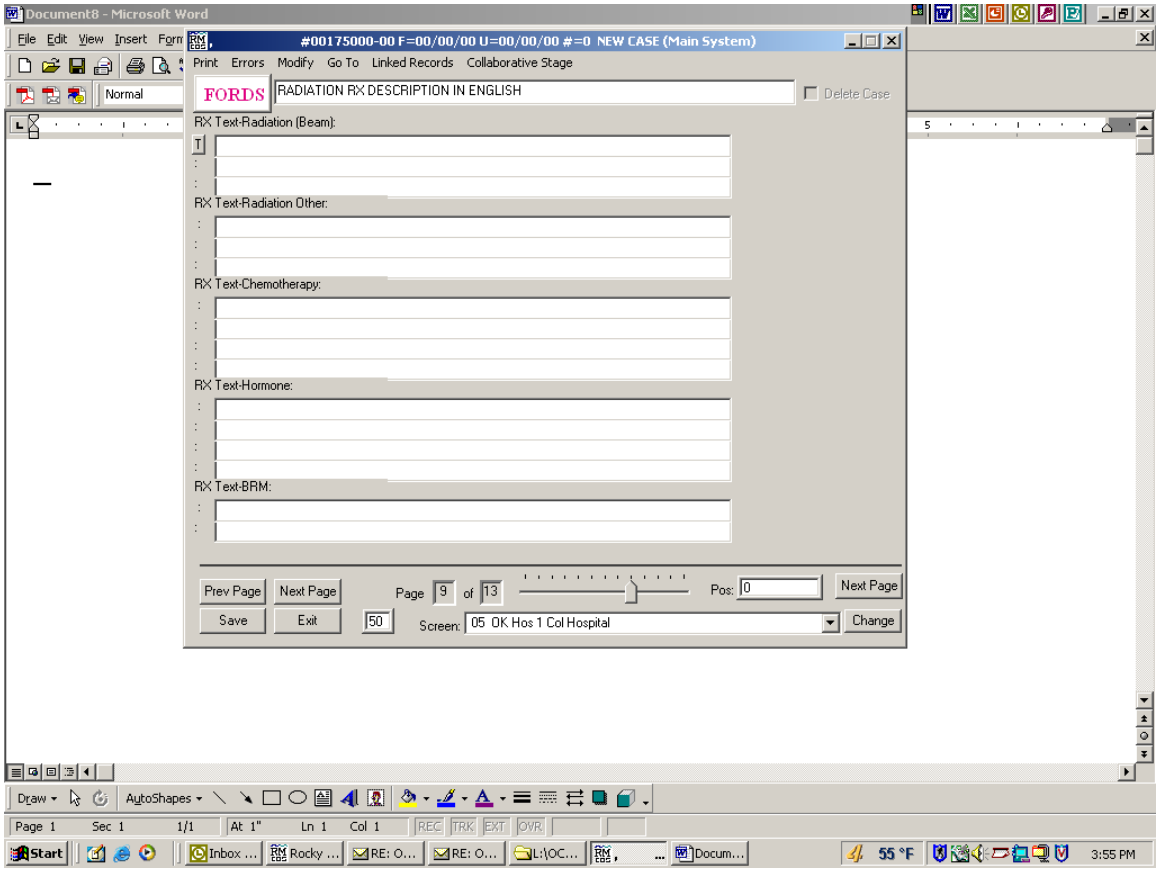
SCREEN 7


Document8 - Microsoft Word
#00175000-00 F=00/00/00 U=00/00/00 #=0 NEW CASE (Main System)
Print Errors Modify Go To Linked Records Collaborative Stage
FORDS
SUBSTANTIATE THE STAGING
Delete Case
Derived SS1977
Derived SS2000
Derived AJCC-Flag
Derived SS1977-Flag
Derived SS2000-Flag
Text-Staging:
Text-DX Proc-X-ray /Scan
Prev Page
Next Page
Page 7 of 13
Pos: 0
Next Page
Save
Exit
50
Screen: 05 OK Hos 1 Col Hospital
Change

SCREEN 8


Document8 - Microsoft Word
#00175000-00 F=00/00/00 U=00/00/00 #=0 NEW CASE (Main System)
Print Errors Modify Go To Linked Records Collaborative Stage
FORDS
GIVE DATES, TESTS, AND FINDINGS OR NONE
Delete Case
Text-DX Proc-Lab Tests
Text-DX Proc-PE:
Text-DX Proc-Up:
RX Text-Surgery:
Prev Page
Next Page
Page 8 of 13
Pos: 0
Next Page
Save
Exit
50
Screen: 05 OK Hos 1 Col Hospital
Change

SCREEN 9


Document8 - Microsoft Word
#00175000-00 F=00/00/00 U=00/00/00 #=0 NEW CASE (Main System)
Print Errors Modify Go To Linked Records Collaborative Stage
FORDS
RADIATION RX DESCRIPTION IN ENGLISH
Delete Case
RX Text-Radiation (Beam):
RX Text-Radiation Other:
RX Text-Chemotherapy:
RX Text-Hormone:
RX Text-BRM:
Prev Page
Next Page
Page 9 of 13
Pos: 0
Next Page
Save
Exit
50
Screen: 05 OK Hos 1 Col Hospital
Change

SCREEN 10

Document8 - Microsoft Word

#00175000-00 F=00/00/00 U=00/00/00 #=0 NEW CASE (Main System)

Print Errors Modify Go To Linked Records Collaborative Stage

FORDS OTHER RX DESCRIPTION IN ENGLISH Delete Case

RX Text-Other:

TREATMENT

First Course Treatment (Alt-T)

Date First Course of Rx:

RX Date-Most Defin Surg

RX Summ-Surgical Margins

RX Date-Surgical Disch

Readm Same Hosp 30 Days

Reason For No Surgery

Rad-Rx Volume (Target)

Rad-Regional Rx Modality

Rad-Regional Dose cGy

Rad-Boost Rx Modality

Rad-Boost Dose cGy

Rad-No of Treatment Vol

RX Summ-Surg/Rad Seq:

RX Date-Radiation Ended

Reason for no Radiation

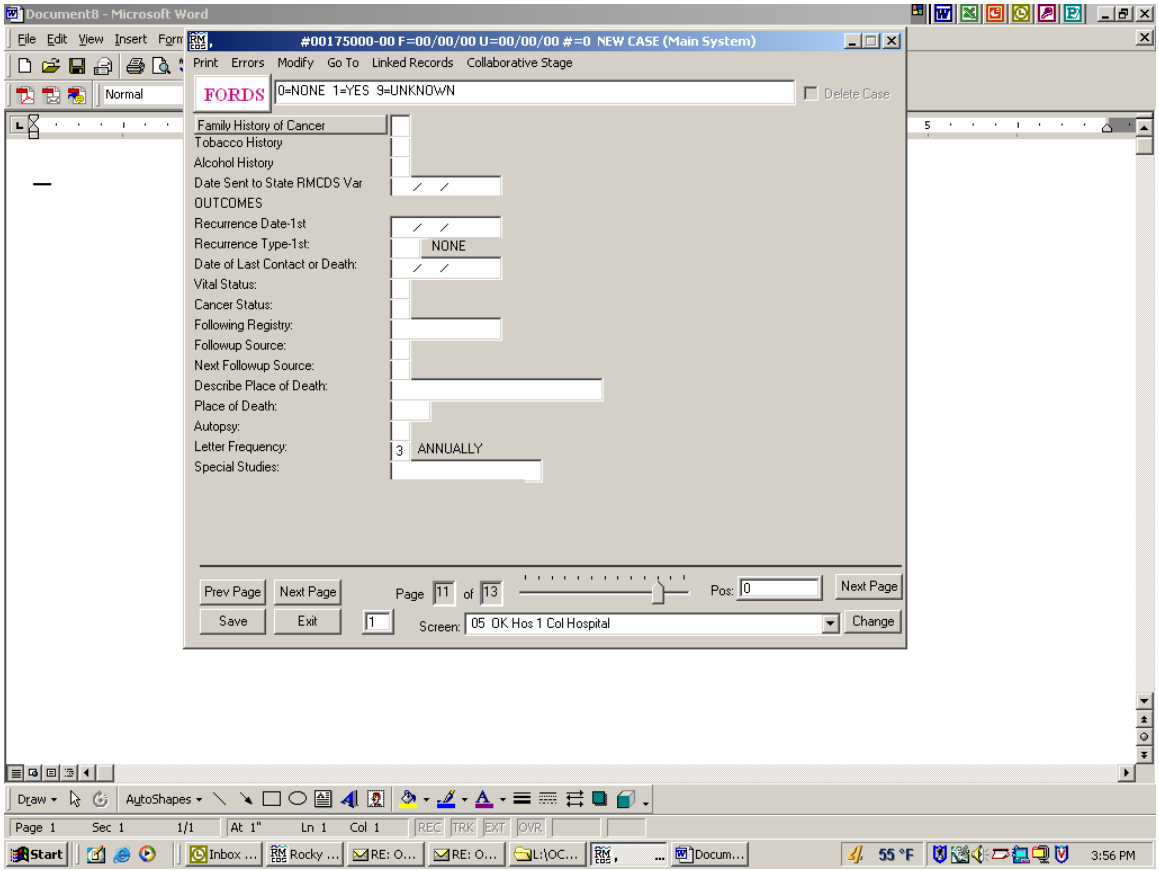
RX Date-Systemic

RX Summ-Transplnt/Endocr NONE

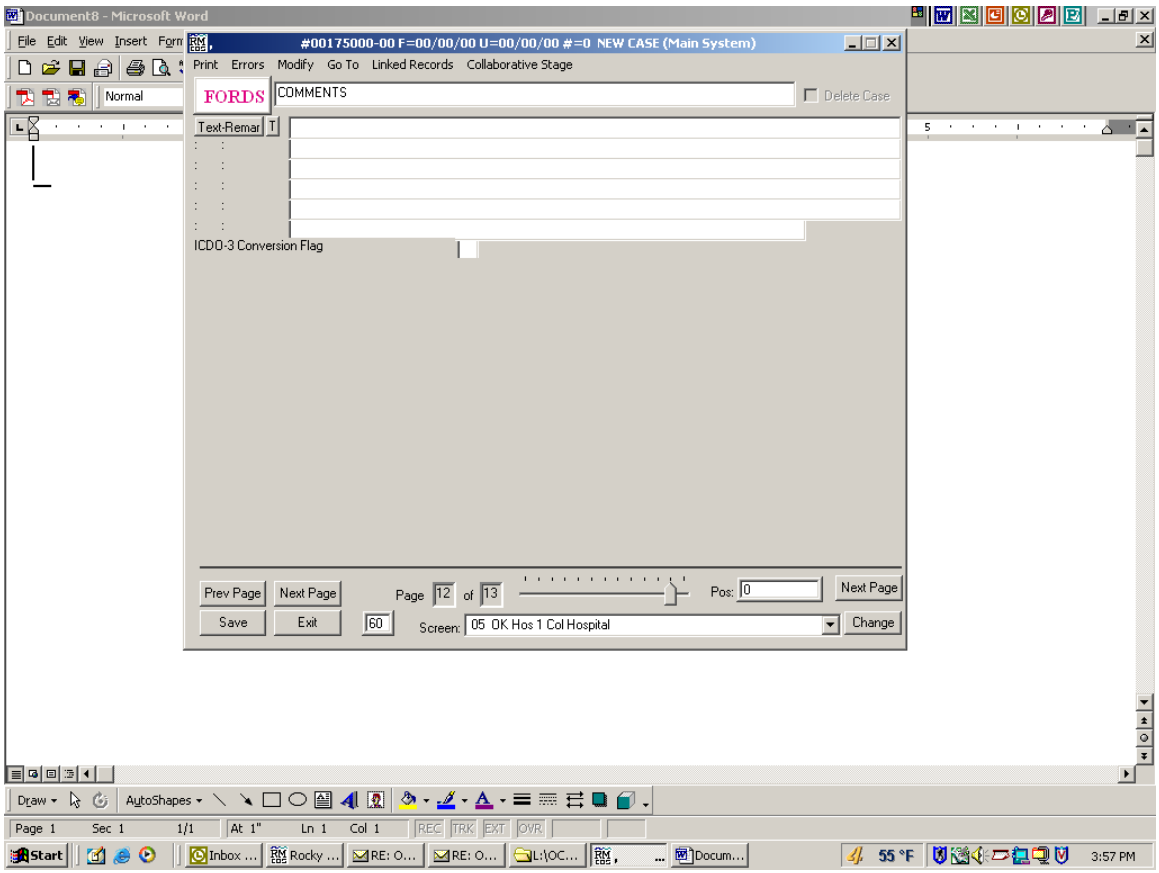
Prev Page Next Page Page 10 of 13 Pos: 0 Next Page

Save Exit 50 Screen: 05 OK Hos 1 Col Hospital Change

SCREEN 11


Document8 - Microsoft Word
#00175000-00 F=00/00/00 U=00/00/00 #=0 NEW CASE (Main System)
Print Errors Modify Go To Linked Records Collaborative Stage
FORDS
0=NONE 1=YES 9=UNKNOWN
Delete Case
Family History of Cancer
Tobacco History
Alcohol History
Date Sent to State RMCDS Var
OUTCOMES
Recurrence Date-1st
Recurrence Type-1st:
NONE
Date of Last Contact or Death:
Vital Status:
Cancer Status:
Following Registry:
Followup Source:
Next Followup Source:
Describe Place of Death:
Place of Death:
Autopsy:
Letter Frequency:
3 ANNUALLY
Special Studies:
Prev Page
Next Page
Page 11 of 13
Pos: 0
Next Page
Save
Exit
Screen: 05 OK Hos 1 Col Hospital
Change

SCREEN 12


Document8 - Microsoft Word
File Edit View Insert Form
#00175000-00 F=00/00/00 U=00/00/00 #=0 NEW CASE (Main System)
Print Errors Modify Go To Linked Records Collaborative Stage
FORDS
COMMENTS
Delete Case
Text-Remar
ICDO-3 Conversion Flag
Prev Page
Next Page
Page 12 of 13
Pos: 0
Next Page
Save
Exit
60
Screen: 05 OK Hos 1 Col Hospital
Change
Draw
AutoShapes
Page 1 Sec 1 1/1 At 1" Ln 1 Col 1 REC TRK EXT OVR
Start
Inbox ...
Rocky ...
RE: O...
RE: O...
L:\OC...
Docum...
55 °F
3:57 PM

Reporting Hospital Number (R)

(NAACCR ITEM #540) (FORDS pg 208) Item Length: 10

Description

This identifies the facility reporting the case.

Explanation

This is used to monitor data submission to National Cancer Data Base (NCDB), ensuring the accuracy of data and to the identify data location for areas of special study.

Coding Instructions

This three-digit number is assigned by OCCR. Call (405) 271-4072.

NOTE: Hospitals working toward becoming an accredited program get an assigned number from ACoS.

ABSTRACTED BY (S-OK)

(NAACCR #570) (**FORDS pg. 207-required**) LENGTH: 3

Description

It records the initials of the person abstracting the case.

Explanation

This item is used to manage a staff of several registrars and for quality control.

Coding Instructions:

Code the three initials of the abstractor.

DATE OF FIRST ADMIT/ FIRST CONTACT (R)

(NAACCR Item #580) (FORDS pg. 87) Line Length: 8

Description

This is the date of the patient's first contact with the reporting facility either an inpatient/outpatient for diagnosis and/or treatment of a reportable tumor. It can be for a diagnostic procedure like a biopsy, x-ray or laboratory test. It can be for preliminary review for administration of treatment, palliative care, or Class of Case "7" (pathology only) read case specimens.

Explanation

This data allows the facility to measure the first contact with the patient. It can be used to measure the time between admission and when the case was abstracted. It can also measure the length of time between the first contact and start of treatment.

Coding Instructions

CODE: MMDDCCYY or 99999999

[Record 2 digits for month, 2 digits for day, 2 digits for century and 2 digits for year]

EXAMPLE: January 2, 2004 01022004

- Punctuation marks (slashes, dashes, etc) are not allowed in any date field.
- A date **must** be entered in this field, either an inpatient or outpatient visit.
- Report the first admission to your facility for diagnosis and/or treatment of this reportable cancer. If the patient was diagnosed previously or treated elsewhere, the date of the first admission to your facility with active cancer or for cancer treatment is the appropriate date.
- If this is an autopsy-only or death certificate-only case, then use the date of death.
- If any portion of the date is unknown use the most accurate guidelines:
- 01992004 – portion of date missing – the day
- 99999999 – all of date unknown
- 04992004 – seasonal description of "Spring" (Summer, Fall,) - use quarterly description
- 12992003 or 01992004 – seasonal description of "Winter" - try to determine if this means the beginning or end of the year. Code January or December as indicated.
- 07992004 - "middle of year"
- Note: If a patient has a biopsy in a physician's office that was sent to the reporting facility and was read as malignant, the date the pathology report was sent to the facility and read would be the appropriate date rather than the date the patient was first admitted to the facility for treatment.

TYPE OF REPORTING SOURCE (R)

(NAACCR ITEM #500) **(FORDS no longer collects)** (SEER pg 66-67) Length: 1

Description

This variable identifies the source document used to abstract the case being reported.

Explanation

This data item indicates the completeness of information available to the abstractor.

Coding Instructions

Use these codes:

CODE	DEFINITION OF REPORTING SOURCES
1	Facility Only
2	Radiation Treatment Centers or Medical Oncology Centers
3	Laboratory Only (Facility or Private)
4	Physician's Office/Private Medical Practitioner
5	Nursing/Convalescent Homes, Hospice
6	Autopsy Only
7	Death Certificate Only
8	Other hospital outpatient units/surgery centers

NOTE: Assign codes in this priority: 1, 2, 8, 4, 3, or 5, if more than one source is used

PATIENT IDENTIFICATION

ACCESSION NUMBER OR REGISTRY NUMBER (S)

(NAACCR ITEM #550) (**FORDS pg 33-required**) Line Length: 9

Description

It is an identifying number used for the new patient being added into the registry. It consists of the year in which the patient was first seen at the reporting facility and the order in which the patient was abstracted.

Explanation

This number protects the identity of the patient and still allows the patient to be identified at the local, state and national level.

Coding Instructions

- The first four numbers specify the year and the last five numbers are the numeric order in which the case was added to the registry database.
- Once a patient is added to your registry, any new primary is coded under the original accession number. The sequence number and the date of diagnosis will distinguish between each primary and when it is diagnosed. **Do not** assign a new registry number to a patient who is already in the registry. Read the next data item "Sequence Number" to explain this. Also review the instructions for adding multiple primaries in Chapter 3.
- When assigning numbers, gaps are allowed in the numbering system
- When a patient is deleted from the database **do not** reassign the number to another patient.
- Sometimes a patient is accessioned into the registry and the registry later changes its reference date, and the patient is no longer shown as diagnosed during your measurable registry data records. If the patient is subsequently accessioned into the registry with a new primary, use the

original accession number associated with the patient and code the data item *Sequence Number* appropriately.

Example: 200500001 This would indicate it is the first 2005 case reported for your facility.

NOTE: Many types of software automatically assign the new registry number. You can override this number if needed.

SEQUENCE NUMBER (S)

(Used for accredited cancer programs)

(NAACCR ITEM #560) **(FORDS pg 34-required**) (SEER pg 64) Item Length: 2

Description

This number refers to the number of malignant and non-malignant tumors over the lifetime of the patient. They do not all have to be diagnosed at your facility to affect the sequence number.

Explanation

This data item identifies the total number of malignant and non-malignant neoplasms a patient has had and the order in which each primary tumor occurred for patients diagnosed with more than one primary. All primaries do not have to be reported from the same facility. It will still affect your sequence number. The sequence number is used in studies to select patients with only one malignant tumor or multiple primaries to analyze factors that are similar.

Coding Instructions

- The **Sequence Number** refers to the number of primaries **in the patient's lifetime.**
- The **Tumor Record Number** refers to the number of primaries for that patient **at your facility.**
- Codes 00-35 and 99 indicate malignant or in situ cases that are reportable. (Behavior equals 2 or 3).
- Codes 60-88 indicate neoplasms of non-malignant (Behavior equals 0 or 1).

  NOTE: CDC and NAACCR require reporting nonmalignant CNS tumors in 2004.
  They are to start with sequence number 60

- When a patient is first added to the registry, the sequence number of the first primary is always coded to "00" (unless the patient has another primary that was diagnosed before your admission – covered later on this page).
- No matter how many primary tumors a patient has in their lifetime, the original Accession Number you established is used to abstract the new primary into the registry.

- If this is a second primary diagnosed at your facility, the first listing was coded to "00." The first primary should be changed from "00" to "01" and the second primary is coded to "02" so the patient's information reflects that there are now two separate tumors reported from your hospital.

- Patients do not always go to the same hospital or live in the same location so not all their primaries will be diagnosed at the same hospital. Any prior reported cancers will affect the sequence number you use at your hospital. The patient admission sheet might reflect a previous cancers, the physicians H&P, consultations or previous admissions.

- The first time you list a patient in your hospital that has a previous primary, you will use your Accession Number and code the sequence number appropriate for the number of primary tumors diagnosed for the patient.

  EXAMPLE: This is the third primary for your patient whose first primary was diagnosed in 2005.
  Code to: 200500008-03

- Sequence numbers should be reassigned if the facility subsequently learns of an unaccessioned tumor that affects sequencing.

  NOTE: Although squamous and/or basal cell carcinoma of the skin (except genital sites) is not reportable, it **is** considered when assigning the appropriate sequence numbers. **HOWEVER,** regardless of the number of squamous and/or basal cell carcinomas of the skin a person may have, it is counted only once when assigning sequence numbers.

- When a patient expires, additional information may be in the medical chart or reported by the Department of Vital Statistic Death List. An additional primary may be listed. The sequence number should be changed to reflect this new information.

- If two or more malignant or in situ primaries are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, either choice is appropriate.

- Any tumor in the patient's past that is reportable or reportable-by-agreement **must** be taken into account when sequencing subsequently accessioned tumors.

	ONE PRIMARY MALIGNANT NEOPLASM
00	One malignant or in situ primary in the patient's lifetime
01	First of two or more independent malignant or in situ primaries
02	Second of two or more independent malignant or in situ primaries
…	Actual sequence of this primary
99	Sequence unknown or Unspecified
	ONE PRIMARY NON-MALIGNANCY NEOPLASM
60	One Primary Only
61	First of two or more primaries

	ONE PRIMARY NON-MALIGNANCY NEOPLASM
62	Second of two or more primaries
63	Third of three or more primaries
…	Actual member of this primary
88	Sequence unknown or unspecified

TUMOR RECORD NUMBER (R)

(NAACCR Item #60) (SEER pg 64) Line Length: 2

Description
This field refers to the number of primaries reported by your facility for the same patient.

Explanation
This data item gives the order in which each primary tumor occurred and how many you have reported for a particular patient.

Coding Instructions
- Only facilities with a cancer registry that maintains an accession register must complete this item.

- For facilities completing this field, "**01" must** be used for the first primary reported from your facility. Each additional primary reported for the same patient must be assigned the next higher tumor record number.

  NOTE: Facilities approved (or seeking approval) by the American College of Surgeon's Commissions on Cancer (ACoS COC) are not required to complete this field for accreditation

MEDICAL RECORD NUMBER (S)

(NAACCR ITEM #2300) (**FORDS pg 36-required**) Line Length: 11

Description
This is the number assigned to the patient's medical record by the reporting facility.

Explanation
This number identifies the individual patients within a reporting facility. It can be used as reference for subsequent reports on the same patient. It can help in identifying patients with the same name.

Coding Instructions
- Record the medical record number.

- **Do not** code the patient's relationship to the military sponsor in this field when a patient enters a military hospital as a family member of a military sponsor, See data item *Military Medical Record Number Suffix* (NAACCR Item #2310).

- If the medical record number is less than 11 characters, right justify the characters and allow leading blanks.

- Use standard abbreviations for departments that do not use "HIM" medical record numbers like RT (Radiology) SU (One-day surgery clinic patient)

- If the medical record number is unknown use "UNK".

SOCIAL SECURITY NUMBER (R)

(NAACCR ITEM#2320) (FORDS pg 37) Line Length: 9

Description
This records the patient's Social Security Number.

Explanation
This data item is used to help identify patients with similar names.

CODE: (Fill spaces)

Coding Instructions
- Record patient's Social Security number (SSN) without dashes.

- Use "999999999" when patient's Social Security Number is not available.

- A patient's Medicare claim number may not always be identical to the person's Social Security number.

- If a Social Security number ends with a "B" or "D", use code "999999999". (The patient is getting benefits under the spouse's Social Security number rather than one of their own)

CHAPTER 13 – ENTERING PATIENT INFORMATION

NAME-LAST (R)

(NAACCR ITEM#2230) (FORDS pg 39) Line Length: 25

Description
This identifies the last name of the patient.

Explanation
This data item is used as a patient identifier.

Coding Instructions

- Enter the last name of the patient in **capital letters**. Blanks, spaces, hyphens, apostrophes, and punctuation marks **are** allowed. Do not use other punctuation.
- If the name is more than 25 spaces, shorten it.
- **Do not** leave blank, code as unknown if the patient's last name is unknown.
- This field should be updated if the last name changes.

  Example: De Leon should be DE LEON
  O'Hara should be O'HARA
  Jan Smith marries Fred Jones and changes her name to SMITH-JONES

NAME-FIRST (R)

(NAACCR ITEM#2240) FORDS pg 40) Line Length: 14

Description
This identifies the first name of the patient.

Explanation
This data item is used by facilities to differentiate between patients with the same last name.

Coding Instructions

- Shorten the name if longer than 14 letters.
- If a patient's first name is not known, NAACCR requires that you code UNKNOWN. ACoS requires that you leave the space blank.

NAME-MIDDLE OR INITIAL (R)

(NAACCR ITEM#2250) (FORDS pg 41) Line Length: 14

Description
This identifies the middle name or middle initial of the patient.

Explanation
This data item helps distinguish between patients with identical first and last names.

Coding Instructions

- Shorten if more than 14 letters.
- Record the middle initial if the name is not given.
- **Do not** use punctuation.
- Leave the space blank if an answer is not available.

ADDRESS AT DIAGNOSIS-NO. & STREET (R-OK)

(NAACCR ITEM# 2330) (FORDS pg 42) Line Length: 40

Description
This identifies the patient's address (number and street) at the time of diagnosis.

Explanation
It allows for the analysis of cancer clusters or environmental studies. The patient's address at the time of the original diagnosis is the residence the patient states he considers his home at the time of the original diagnosis and it is never changed.

If the patient has more than one primary and has moved before the second diagnosis, he will have two addresses listed, one for each primary. Only his current address will ever change.

If there is ever a question as to the rule of residency, registries should follow the rules of the Census Bureau whenever it is possible. Its definition is "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."

Coding Instructions

- Record the number and street of the patient's residence at the time the cancer is diagnosed. This should never be changed.

- Use post office box or rural mailing address **only** when the physical address is not available. Our state has an excess of post office box addresses.

- Punctuation marks are **not** allowed except for the period and slash if necessary to define a specific address. (325.2 Dow Dr) or (325 ½ S Vermont)

- **Rules for determining residence:**
  More Than One Residence: Use address patient specifies.

  Person with No Usual Address: Use the address of the place the patient was staying when the cancer was diagnosed. It could even be the diagnosing facility if the patient states it is.

  Person Away at School: College students are residents of the school area. Below the college age, boarding school students use their parents' address.

  Persons in Institutions: Resident of the institution – incarcerated, nursing home, convalescent homes, rest homes, any residence for the physically disabled, mentally retarded or mentally ill, and long term residents of other hospitals such as the VA hospital.

- If there are more that 25 characters in the address, omit the least important elements, like apartment or a space number.

- **Do not** leave address blank. Record **no address** or **unknown.**

- Use standard address abbreviations listed in *the U.S. Postal Service National ZIP Code and Post Office Directory by the U.S. Postal Service* (USPS).

*The most common address abbreviations used are:

ABBREVIATION	DEFINITION	ABBREVIATION	DEFINITION
APT	Apartment	PLZ	Plaza
AVE	Avenue	PK	Park
BLDG	Building	PKWY	Parkway
BLVD	Boulevard	RD	Road
CIR	Circle	RM	Room
CT	Court	S	South
DEPT	Department	SE	Southeast
DR	Drive	SQ	Square
E	East	ST	Street
FL	Floor	STE	Suite
N	North	SW	Southwest
NE	Northeast	UNIT	Unit
NW	Northwest	W	West

ADDRESS AT DIAGNOSIS-CITY/TOWN (R)

(NAACCR Item # 70) (FORDS pg 47) Item Length: 20

Description

This identifies the name of the city or town where the patient resides at the time the tumor is diagnosed and treated.

Explanation

The city or town data item has many uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Coding Instructions

- If the patient resides in a rural area, record the name of the city or town of the mailing address.
- The patient may have more than one primary; the town or city may be different for each primary.
- **Do not** update this data item if the city or town of residence changes.
- Residency Rules for address apply to city and town.
- If a town is not listed record as **UNKNOWN**. Then document in the note section any information you have.
- **Do not** use punctuation, special characters, or numbers. The USPS prefers the use of capital letters. It also provides consistency in data reporting.
- Do not abbreviate unless the length exceeds 24 charaters

ADDRESS AT DIAGNOSIS -STATE AND TERRITORY CODE (R)

(NAACCR ITEM #80) (FORDS pg 46) Line Length: 2

Description

This identifies the state code for the patient at the time of diagnosis.

Explanation

This allows the analysis of cancer clusters or environmental studies.

Coding Instructions

- Enter the USPS abbreviation for the state, territory, commonwealth, US possession or Canadian province/territory where the patient resides at the time the tumor is diagnosed.

- If the patient is a foreign resident, code XX if a resident of a country other than the US or Canada and the country is known; code YY if a resident of a country other than the US or Canada and the country is unknown.

- The patient may have more than one primary; the state may be different for each primary.

ADDRESS AT DIAGNOSIS - ZIP CODE (R)

(NAACCR ITEM#100) (FORDS pg 47) Line Length: 9

Description:
This identifies the postal code of the patient's address at the time of diagnosis.

Explanation
This data field allows the study of cancer clusters or environmental studies.

Coding Instructions

- Enter the patient's zip code at the time of diagnosis /admission. Enter the nine digit extended zip code if it is known**. Do not** use a dash between the nine digits. Some vendor software will not pass edits if you complete all the 9 digits.

- If the code is not available, refer to the *National Zip Code Director or the USPS Web Site: www.usps.gov*

- When available, enter the postal code for other countries.

- Use code "888888888" in zip code if the patient is a resident of a country other than the Canada, United States or a U.S. possession at the time of diagnosis, and the postal code is unknown.

- Use code "999999999" if resident of the United States or a U.S. possession or of Canada and the postal code is unknown.

- If you need help in finding a zip code use: http://www.usps.com. Go to the Zip +4 button. Search for Oklahoma by searching "O" arrow down 1 and then you can put in the city you want. When you find the information you want, highlight it, copy it and then you can paste it into your abstract.

COUNTY AT DIAGNOSIS-(FIPS CODE) (R)

(NACCR ITEM #90) (FORDS pg 48) Line Length: 3

Description
This identifies the county at the time of the patient's diagnosis.

Explanation
This data item is used for epidemiological studies.

Coding Instructions

- FIPS county codes are codes issued by the Federal Information Standards (FIPS) publication, *Counties and Equivalent Entities of the United States, Its possessions, and associated areas.* The list can be obtained from the I/S. EPA's Envirofacts Data Warehouse and Application Web site at http://www.epa.gov/. This list does change so you must check it or go to the OCCR web site to verify any changes.

- An updated copy of Oklahoma Codes can be found on the central registry web site at: http://www.health.state.ok.us/program/cds/cancerreg.html.

  NOTE: These federal county codes are different from the county codes used for state county divisions

- Enter the appropriate three-digit code for the county of residence.

- Use code "998" for an out-of-state resident.

Do not update this data item if the patient's county of residence changes.

NOTE: If the patient's address is not recorded in the medical chart, enter "999" for unknown.

TELEPHONE NUMBER (S - OK)

(NAACCR ITEM #2360) (**FORDS pg 55-required**) Line Length: 10

Description

This records the current telephone number with area code for the patient.

Explanation

This data item may be used by the hospital registry to contact the patient for follow-up. The number should be changed when the patient gets a new telephone number.

Coding Instructions

- Fill in all the spaces. Number is entered without dashes.

- The telephone number should be the current number with area code of the patient.

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

- Use code "0000000000" of patient does not have a phone number.

- Use code "9999999999" if the telephone number is unavailable or unknown.

ADDRESS CURRENT – NO. & STREET (S - OK)

(NAACCR ITEM#2350) (FORDS pg 42-required) Line Length: 40

Description

This identifies the patient's most current address (number and street) not only at the time of diagnosis but any time the patient address is changed

Explanation

It allows for the analysis of cancer clusters or environmental studies and can be used for a current follow up address.

Coding Instructions

- Record the number and street of the patient's residence at the time the cancer is diagnosed and any time it changes.
- Use post office box or rural mailing address **only** when the physical address is not available.
- Punctuation marks are **not** allowed in this field unless it is the period or slash as discussed under the diagnosis address.
- If more that 25 characters in the address, omit the least important elements, like apartment or space number.
- **Do not** leave address blank; record **no address** or **unknown.**
- Use standard address abbreviations listed in *the U.S. Postal Service National zip Code and Post Office Directory by the U.S. Postal Service* (USPS).

ADDRESS CURRENT - CITY/TOWN (S - OK)

(NAACCR Item # 1810) (FORDS pg 51-required) Item Length: 20

Description

This identifies the name of the city or town where the patient currently resides starting with his diagnosis and anytime he makes a move out of town.

Explanation

The city or town data item has many uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies and for patient follow up.

Coding Instructions

- If the patient resides in a rural area, record the name of the city or town in the mailing address. Change the information when you have a new update.

- Update this data item if the city or town of residence changes.
- See "Residency Rules" for further instructions.
- If the city is not listed record as **UNKNOWN**.
- **Do not** use punctuation, special characters, or numbers unless it is the period or slash as discussed earlier. The use of capital letters is preferred by the USPS. Also provides consistency in data reporting.

ADDRESS CURRENT - STATE AND TERRITORY CODE (S -OK)

(NAACCR ITEM #1820) (FORDS pg 46-Required) Line Length: 2

Description
This identifies the state code for the patient at any time you review the patient information. It should be changed anytime the patient moves out of state.

Explanation
This allows the analysis of cancer clusters or environmental studies and with patient follow up.

Coding Instructions

- The most common **STATE AND TERRITORY ABBREVIATION** codes are listed here. Refer to the ZIP code directory for further listings.
- If the patient is a foreign resident, code XX if a resident of a country other than the US or Canada and the country is known; code YY if a resident of a country other than the US or Canada and the country is unknown. Code ZZ if a resident of the US, NOS, Canada, NOS, and the residence is unknown.

ADDRESS CURRENT - ZIP CODE (S - OK)

(NACCR ITEM#1830) (FORDS pg 47-required) Line Length: 9

Description:
This identifies the postal code of the patient's current address. It is changed whenever you have new information.

Explanation
This data field allows the study of cancer clusters or environmental studies and patient follow up.

Coding Instructions

- Enter the patient's zip code at the time of diagnosis /admission and whenever it changes. Enter the nine digit extended zip code if it is known**. Do not** use a hyphen between the nine digits. Be sure it will pass your vendor edits.

- If the code is not available, refer to the *National Zip Code Director or the USPS Web Site: www.usps.gov*.

- Use code "888888888" in zip code if the patient is a resident of a country other than Canada, the United States or a U.S. providence at the time of diagnosis.

- Use code "999999999" if the patient is a resident of Canada, the United States or a U.S. possession and the postal code unknown.

PLACE OF BIRTH (R)

(NAACCR ITEM#250) (FORDS pg 56-required) Line Length: 3

Description
This identifies the patient's place of birth.

Explanation
Place of birth is used to ascertain ethnicity, identify special populations at risk for certain types of cancer and for epidemiological analysis.

Coding Instructions
- Use the SEER Geo-codes in *Appendix H* to record the patient's place of birth.

- Use "998" if the place of birth was outside of the US, no other detail known.

- Use "999" if place of birth is unknown.

NOTE: At the time SEER assigned Geo-codes in the 1970's, the United States owned or controlled islands in the Pacific. Many of these islands are now independent or controlled by countries other than the United States. The original codes are used for these islands to preserve historic information. The names have been annotated to show the new political designation. The alphabetical list displays the correct code.

DATE OF BIRTH (R)

(NAACCR ITEM#240) (FORDS pg 57; SEER pg 77) Line Length: 8

Description
This identifies the patient's month, day and year of birth.

Explanation
This data item is used to match records.

Coding Instructions
- Punctuation marks (slashes, dashes, etc.) **are not allowed.**

- The patient's date of birth **must be entered.** Case cannot be completed without the date of birth.

- If the month and/or day are not known, use "9999"; the year **must be** coded. Calculate from age of patient.

  Examples:
  1. Patient was born in 1937 – code "99991937" as the date of birth.
  2. Patient date of birth is November 13, 1962, code "11131937" as date of birth.
  3. The patient is 70 years old – code "99991935".

AGE AT DIAGNOSIS (R)

(NAACCR ITEM#230) Line Length: 3

Description
This records the age of the patient at his or her last birthday before diagnosis.

Explanation
This data item is useful for patient identification.

Coding Instructions
This is computer calculated.

RACE 1 THROUGH RACE 5 (R)

(NAACCR ITEM #160, 161, 162, 163, 164) (FORDS pg 59; SEER pgs 79-80) Item Length: 2

Description
This identifies the primary race of the person. Up to 5 races can be declared.

Explanation
This data item is used in research and cancer control activities to compare stage at diagnosis and/or treatment by race. The full coding is used to allow for accurate national data comparison. Since the U.S. Census Bureau allows the reporting of 5 races codes; we **must** report for all 5 race codes.

Even though we are **required** to report all 5 race codes, most hospitals do not have a method for documenting more than one code. The rules are the same for reporting each code. The instructions cover the reporting for codes 2-5 based upon the answer reported under race 1. That is why the instructions were written as one category.

Coding Instructions
- Record in the Race 1 field the two-digit code to identify the primary race code.

- Additional races reported by the patient should be coded in additional Race 2 through 5.

- The Race field and Hispanic/Spanish Origin field (NAACCR Item #161) are analyzed together and **must both** be recorded**.**

- All tumors for the same patient **should** have the same codes recorded.

- If code "99" is used for Race 1, then race 2 through 5 **must** be coded the same.

- For cases diagnosed **prior to January, 2001, Race** 2 through Race 5 **must** be blank. Race 1 was the only field used to compare race data prior to January 1, 2001. **After January 1, 2001,** Race 2 through 5 **must** be coded. If only one Race is coded, Race 2 through Race 5 must be coded to "88". If Race 1 is coded to "99", Race codes 2 through Race 5 **must** be coded to "99".

The race coding is:

CODE	RACE	CODE	RACE
00	White*	20	Micronesian, NOS
01	Black**	21	Chamorran
02	American Indian, Aleutian Eskimo	22	Guamanian, NOS
03	Chinese	25	Polynesian, NOS
04	Japanese	26	Tahitian
05	Filipino	27	Samoan
06	Hawaiian	28	Tongan
07	Korean	30	Melanesian, NOS
08	Asian Indian, Pakistani, Sri Lankan	31	Fiji Islander
09	Vietnamese	32	New Guienean
10	Laotian	88	No further race documented
11	Hmong	96	Other Asian, including Asian, NOS and Oriental, NOA
12	Kampuchean (including Khumer and Cambodian)		
14	Thai	97	Pacific Islander, NOS

*The **White** category includes Mexican, Puerto Rican, Cuban, Arab, and all other Caucasians.

The **Black category includes the designations Negro or African-American.

SPANISH/HISPANIC (R)

(NAACCR Item # 190) (FORDS pg 65) Item Length: 1

Description:
This identifies a person as Spanish or Hispanic origin.

Explanation:

This is used by hospitals or central registries to calculate cancer rates for the Hispanic population because they have different patterns of occurrence of cancer than other populations that may be included in the 01 (white race category).

Coding Instructions

- This is a **required** item and is related to race. The system cannot calculate the race if this information is not reported even though it is not specifically designated in your state reporting list.
- The information is coded from the medical record or is based on the Spanish/Hispanic names.
- Review all sources available to determine the correct code, including stated ethnicity as Hispanic origin on the death certificate, birthplace and information about life history and language spoken.
- If you have a need for a list of Spanish/Hispanic surnames a list can be found at the web site.
- 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 "0" for (non-Spanish; non-Hispanic) for Portuguese and Brazilian persons.
- If the patient has multiple tumors, all records should have the same code.

CODE	DESCRIPTION
0	Non-Spanish; non-Hispanic (includes Portuguese and Brazilian)
1	Mexican (includes Chicano, NOS
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil
5	Other specified Spanish/Hispanic (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 any category of 1-5).
7	Spanish surname only. (The only evidence of the person's Hispanic origin is surname or maiden name and there is no other information the person is not Hispanic).
9	Unknown whether Spanish or not; not stated in patient record.

NOTE: Use code "0" if the patient has a Spanish/Hispanic name and there is no reason to believe he/she is **not** Hispanic e.g., patient is Filipino, patient is a woman known to be non-Hispanic who has a Hispanic married name.

Use codes "1-5" if specific ethnicity is known.

- Use code "6" when you know the patient is Hispanic but cannot classify him/her to codes "1-5".
- Use code "7" if race in medical record is classified as White and he/she has a Spanish/Hispanic last name.

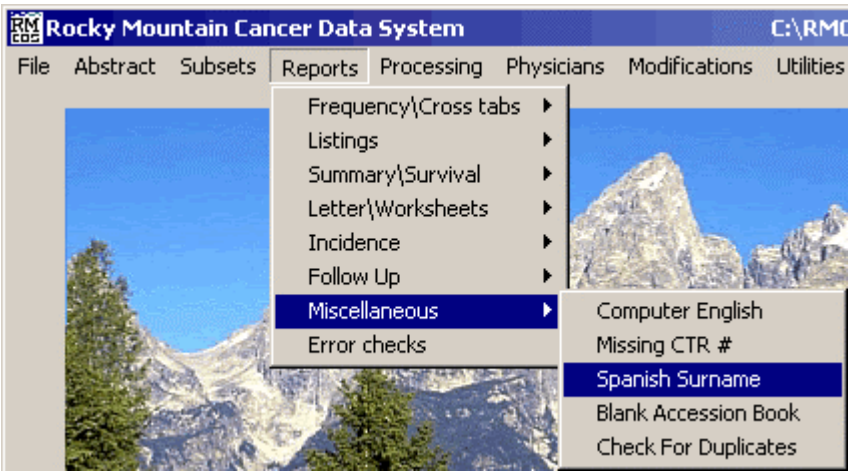
- Use code “9” when Spanish/Hispanic origin is not documented or is unknown.

Spanish surname

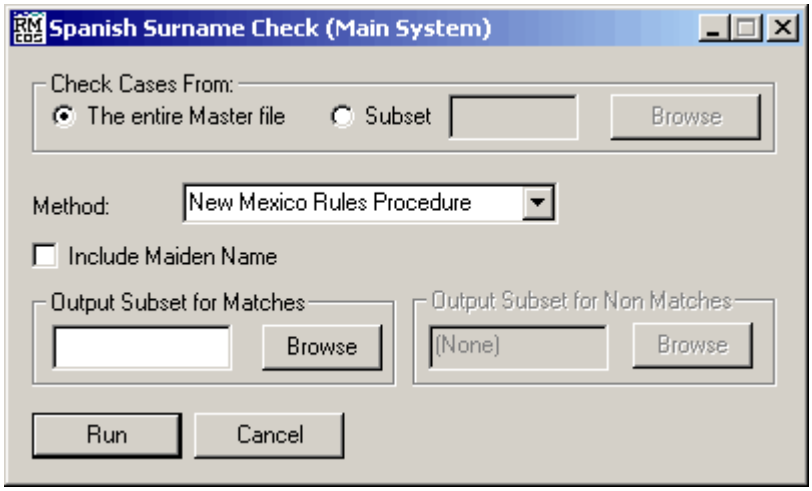
Spanish Surname Report

These instructions describe how to create a Spanish Surname Check in RMCDS.

From the RMCDS Main Menu click on **Reports > Miscellaneous > Spanish Surname.**



This will bring up the **Spanish Surname Check** window.



In the section labeled **Check Cases from,** select whether you want to run this check from **The entire Master file** or from a **Subset** by clicking on the appropriate radio button.

Next select the **Method** for this Spanish Surname check from the drop down selection menu.

If you want to **Include Maiden Name** in the Surname check put a check mark in the box.

In the box labeled **Output Subset for Matches** type in the name of a subset to be created with the cases that the Spanish Surname Check matches as Spanish.

If you are running the check from a subset you can also select an **Output Subset for Non Matches**. This subset will contain those cases that are not selected as Spanish Surname matches.

After you have entered the Output subset name and other options, click on **Run**. The Spanish Surname Check will run. A subset will be created with the name you entered in the **Output Subset for Matches** box and you will return to the RMCDS Main Menu.

SEX (R)

(NAACCR ITEM#220) (FORDS pg 66; SEER pg 83) Line Length: 1

Description
This identifies the gender of the patient.

Explanation
The data code **must** be gender-specific to the primary site:
Example: prostate carcinoma – male
uterine carcinoma – female

Coding Instructions
- Record the patient's gender as indicated in the medical record.

CODE	LABEL
1	Male
2	Female
3	Other (hermaphrodite
4	Transsexual
9	Not stated in patient record

MARITAL STATUS (S)

(NAACCR Item #150) (**FORDS-not required**) Line Length:

Description

This is the patient's marital status at the time of diagnosis for this reported tumor. This may be different if the patient has more than one reported tumor.

Explanation
This is used for follow up purposes

Coding Instructions
- Code with the appropriate code.

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

PRIMARY PAYER (S - OK)

(NAACCR Item #630) (FORDS pg.67-required) Item Length: 2

Description
This identifies the primary payer or insurance carrier at the time of the initial diagnosis or treatment at your facility.

Explanation
This information can be used for financial analysis and as an indicator in evaluating quality and outcome analyses. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires the patient admission page document the type of insurance payment structure that will cover the patient while being cared for at the hospital.

Coding Instructions
- Record the type of insurance reported on the patient's admission.
- If more than one is listed, record the first primary payer or insurance carrier.
- If the primary payer changes at a future date, do not change the original primary payer or insurance carrier.

CODE	PRIMARY PAYER
01	Not Insured
02	Not Insured, self-pay
10	Insurance, NOS
20	Managed Care, HMO, PPO
31	Medicaid
35	Medicaid administered through a Managed Care plan

CODE	PRIMARY PAYER
36	Medicaid with Medicare supplement
50	Medicare
51	Medicare with supplement
53	TRICARE
54	Military
55	Veterans Affairs
56	Indian/Public Health Service
99	Insurance Status unknown

TEXT - USUAL OCCUPATION (R – WHEN AVAILABLE)

(NAACCR Item #310) (**FORDS –not required**) Line Length: 40

Description

This is for text documentation about the patient's usual work occupation, or the usual type of job or work.

Explanation

This is used to identify any type of work-related health hazard; it can also be a measure of socioeconomic status or to identify an occupation group where cancer screening or prevention activities would be beneficial.

Coding Instructions

- This is **required** when the information is available.

TEXT - USUAL INDUSTRY (R – WHEN AVAILABLE)

(NAACCR ITEM #320) (**FORDS-not required**) Line Length: 40

Description

This is for text documentation about the patient's usual industry; also documents the usual kind of business/industry where the patient has worked.

Explanation

This used to identify work-related health hazards, measurement of a socioeconomic status or identify industrial groups or work-related groups where cancer screening or prevention activities would be more beneficial.

Coding Instructions

- This is **required** when available

FAMILY HISTORY OF CANCER (R-OK)

(NAACCR Item #360) (FORDS pg 131) Line Length: 1

TOBACCO USE (R-OK)

(NAACCR Item #340) (FORDS pg 131) Line Length: 1

CHAPTER 14 – ABSTRACTING CANCER INFORMATION

The ICD-O-3 manual is used for coding cancer identification. Before you start abstracting you should read the first 40 pages to familiarize yourself with all the rules of identifying the primary site and the histology of the cancer. The preliminary instructions will be very helpful in determining the primary site, and includes the rules for determining a sub-site.

CANCER IDENTIFICATION

CLASS OF CASE (S)

(NAACCR ITEM # 610) (**FORDS pgs 5-6 or 83-84-required**) Line Length: 1

Description
Class of case identifies the role the facility performed in the patient's diagnosis and treatment.

Explanation
The case records are divided into analytic or non-analytic categories to determine if they should be abstracted. This designation is pertinent only to hospitals with a CoC Approved Cancer Program. There are 10 categories 0-9. The class of case is used in determining which cases should be used in analyzing the facility's cancer diagnosis and treatment. The analytical cases (classes 0, 1 and 2) are cases that were first diagnosed and/or treated at your facility and were involved in the decision-making. Non-analytical cases (classes 3-9) are usually excluded from a facility's cancer analysis because they come to your facility for a cancer recurrence or subsequent therapy not involved in the initial diagnosis.

OCCR is required to collect data on persons who are diagnosed with cancer who, at the time of diagnosis, are **residents** of the geographic area covered by the Statute OS 63-1-551.1. Cases diagnosed on or after January 1, **1997** are reportable to OCCR. Facilities that opened after 1997 have different reporting start dates.

There is no provision in the law to exclude any cases designated by class, nor does state statute reference, (and certainly does not exclude), anything called a "nonanalytic case".

Definitions
The following Class of Case Definitions will define the Analytical and Non-analytical cases and their reporting requirements.

- Analytical Cases – classes 0, 1 and 2: They were diagnosed at the reporting facility and/or received any/or all their first course of treatment at the reporting facility.

  NOTE: If a primary facility runs an outpatient center or facility network clinic off the main facility location, it is the responsibility of the primary facility to report the cases for the outpatient center or facility network clinic.

- Non-analytical Case – classes 3, 4, 5, 6, and 7: They were diagnosed and received all their first course of treatment at another facility. They may have been diagnosed and/or received their treatment at the reporting facility prior to their registry's reference date. (**This applies to ACoS facilities, facilities striving for ACoS certification, or facilities that follow ACoS standards but do not seek certification).**

- Class of Case "8" and "9" is used by the central registry for patients identified from a death certificate or when the class of case is unknown.

CODE	DESCRIPTION
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 elsewhere, and all or part of the first course of treatment was performed elsewhere. Presents at your facility with recurrence or persistent disease.
4	Diagnosis and/or first course of treatment were performed at your reporting facility prior to the reference date of the registry.
5	Diagnosed at autopsy
6	Diagnosis and all of the first course of treatment were 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 excludes tumors diagnosed at autopsy.
8	Diagnosis was established by death certificate only. Used by central registries only.
9	Unknown. Sufficient detail for determining Class of Case is not stated in patient record. Use by central registries only.

FACILITY REFERED FROM (S - OK)

(NAACCR Item #2410) (FORDS pg. 85-required) Item Length: 10

Description

This is the facility that referred the patient to the reporting facility.

Explanation

A facility identification Number (FIN) is assigned for each facility. It is used to document and monitor referral patterns for your facility.

For Class of Case 0 or 1 cases, the appropriate coding is the same as when a "patient is not referred".

CODE	DEFINITION
(fill spaces)	Seven or eight-digit FIN code
0000000000	If the patient was not referred to the reporting facility from another facility.
0099999999	If the patient was referred, but the referring facility's ID number is unknown.

NOTE: A complete list of FIN codes is available on the American College of Surgeons Web site at http://www.facs.org/.

FACILITY REFERRED TO (S - OK)

(NAACCR Item #2420) (**FORDS pg. 85-required**) Item Length: 10

Description
This identifies the facility the patient was referred to for further care after leaving your facility.

Explanation
A facility identification Number (FIN) is assigned for each facility. It is used to document and monitor referral patterns for your facility.

For Class of Case 0 or 1 cases, the appropriate coding is the same as when a "patient is not referred".

CODE	DEFINITION
(fill spaces)	Seven or eight-digit FIN code
0000000000	If the patient was not referred to the reporting facility from another facility.
0099999999	If the patient was referred, but the referring facility's ID number is unknown

NOTE: A complete list of FIN codes is available on the American College of Surgeons Web site at http://www.facs.org/.

DATE OF INITIAL DIAGNOSIS (R)

(NAACCR ITEM #390) (FORDS pgs 89-90; SEER pg. 88) Line Length 8

Description
The date of initial diagnosis is the earliest date this primary cancer is diagnosed by a recognized medical practitioner regardless of whether the diagnosis was made at the reporting facility or elsewhere.

Explanation
The date of initial diagnosis begins the staging and treatment for cancer and is essential in the analysis of cancer staging and treatment.

Coding Instructions

- Date format is MMDDCCYY. The first and second digits are the month, the third and fourth digits are the day, the fifth and sixth digit is the century and the seventh and eighth digits are the year.

- Use the first date of diagnosis whether clinically or histologically confirmed.

- If the first date of diagnosis is clinically diagnosed and then a histological evaluation is done, the clinical diagnosis is still primary and should still be used.

- The date of diagnosis from a pathology report will be the date the specimen was taken, and not the date the pathology report was written.

- If the physician states in retrospect that the patient had cancer at an earlier date, then use the earlier date as the date of diagnosis.

- Refer to the *List of Ambiguous Terms* in Section one Chapter 3 to aid in determining diagnosis of cancer.

- The date of diagnosis for a Class of Case 5 is the date of death.

- In the absence of an exact date of initial diagnosis, **make the best approximation.** If the year is known and the month and day are not known, record "9's" for the month and day, and record the year of the diagnosis. If there is no documentation to make an approximate date of initial diagnosis, record all 9's.

- For vague dates, use these guidelines:

DOCUMENTATION	DATE/CODE FOR DESCRIPTION
Spring	Use April for the month
Summer	Use July for the month
Fall	Use October for the month
Winter	Determine if end of year or beginning of the next year. Use Whichever is appropriate - December (12) or January (1)
Middle of Year	Use July for the month
Recently	Use the month and year of admission and unknown day (99) for the day, if patient was admitted during the first week of a month, use the previous month
Several Months Ago	If the patient was not previously treated or if a course of treatment started elsewhere and was continued at the reporting facility, assume the case was first diagnosed three months before admission with day unknown

PRIMARY SITE (R)

(NAACCR Item # 400) (FORDS pg. 91; SEER pgs. 91-92) Line Length: 1

Description
This identifies the primary site of the cancer.

Explanation
The primary site helps to determine the stage, treatment options, shapes the course of the disease and the prognosis.

Coding Instructions

- Record the code that **most accurately** records the anatomical site of the primary neoplasm, the organ or the tissue of the origin of the tumor.

  NOTE: The exact location of the primary tumor is not always stated in the pathology report or the discharge diagnosis. It is sometimes necessary to review the entire medical record in order to obtain the most precise description of the primary site.

- In the ICD-0-3 book the appropriate site-specific codes are listed in parenthesis after the morphology terms for neoplasm that usually occur in the same site or tissue e.g. pituitary carcinoma. NOS, (C75.1). In general, when a primary site is preceded by *carcinoma of …*, or *malignancy of …*, code that to the primary site.

- The documentation in the medical chart should be carefully reviewed if one of the listed sites is shown as a site being evaluated for cancer. The site may actually be a metastatic site and the primary site must be confirmed. They are:

  Bone
  CNS Sites (Brain, Spinal cord, and Meninges)
  Liver
  Lymph Nodes (excluding Lymphoma)
  Pericardium (excludes Mesothelioma)
  Pleura (excludes Mesothelioma)
  Peritoneum
  Retroperitoneum

GUIDELINES FOR FOUR-CHARACTER SITE CODES

- Some divisions within a particular site code are considered **separate primary sites**. They are:

  Colon (C18.0 – C18.9)
  Rectum, anus and anal canal (C19.9, C20.9, C21.0-C21.8)
  Bone (C40.0-C41.9)

Connective Tissue (C49.0-C49-9)
Peripheral nerves (C47.0-C47.9)
Melanoma of the skin (C44.0-C44.9)

Example: Cecum (C18.0) and ascending colon (C18.2) would be two separate primaries unless it is stated that it is metastatic from one site to the other.

All other four-character codes are sub-sites of a major site.

Example:
Lower-outer quadrant of the breast (C50.5)

ADDITIONAL GUIDELINES FOR CODING PRIMARY SITES

- Approximately 25% of lymphomas originate in extra-nodal sites such as the breast, intestine or stomach. A lymphoma primary originating in an organ or extra-nodal site should be coded to the organ or extra-nodal site. The code for the primary site in some cases may not be the biopsy site. If a specific lymph node is the primary site, code accordingly.

- Malignant lymphoma of stomach, code to "C16.9."

- If two or more lymph node chains and an extra-nodal site are involved, code to "C77.8."

- If no site is indicated for a lymphoma <u>and</u> it is suspected that it is extra-nodal; code to "C80.9" (unknown primary site).

- Leukemias and myelomas are coded to bone marrow "C42.1."

- Malignant histocytosis is coded to bone marrow "C42.1."

- Kaposi's sarcoma is coded to the site in which it originates. If Kaposi's sarcoma originates in skin and another site simultaneously, code to skin "C44._." If no primary site is stated, code to skin "C44.9."

- Mycosis fungoides is coded to skin "C.44._." If a specific site is stated to be the primary, code accordingly.

- A subareolar/retoareolar carcinoma is coded to the central portion of the breast "C50.1" which indicates that the tumor arose in the breast tissue beneath the nipple, not in the nipple itself.

- Code neuroblastoma of ill-defined site to the most likely primary site in each case.

- Code connective, subcutaneous or other soft tissue NOS to "C49.9," if the primary site is unknown.

- Code melanoma, NOS to skin "C44.9."

LATERALITY (R)

(NAACCR Item #410) (FORDS pg 92; SEER pgs. 93-94) Line Length: 1

Description

Laterality identifies the side of a paired organ or the side of the body on which the tumor originated.

Explanation

It aids in staging and determining the extent of disease information. It can also indicate the number of primaries.

Coding Instructions

- Non-paired sites are coded to "0".
- Unknown sites (C80.9) are coded to "0".
- Midline lesions are coded to "9".
- **Do not** code metastatic sites as bilateral involvement.
- For primaries of in situ behavior, if the laterality is not known, code to 3. Laterality for in situ behavior cannot be coded to "9 or 4".

CODE	LATERALITY DESCRIPTION
0	Not a paired site
1	Right origin of primary
2	Left origin of primary
3	Only one side involved, right or left origin of primary not indicated
4	Bilateral involvement; side of origin unknown; stated to be a single primary includes: a. Both ovaries simultaneously involved with a single histology b. Bilateral retinoblastomas c. Bilateral Wilms' tumors
9	Unknown site; paired site, lateral origin unknown; midline tumor

The list below is the primary site bilateral coding list. To find the primary sites that have sub-sites your must refer to the ICD-O-3 manual. If a sub-site is not listed, then code to "0."

ALPHABETICAL LIST OF BILATERAL SITES

PAIRED ORGANS	ICD-0-3 CODES
Adrenal gland (cortex, medulla	C74.0-C74.9
Breast	C50.0-C50.9
Carotid body	C75.4
Conjunctiva, lacrimal gland, orbit, corenea, retina,	C69.0

choroids, ciliary body, iris, sclera, lens, eyeball	
Connective, subcutaneous & other soft tissues of lower limb & hip	C49.2
Connective, subcutaneous & other tissue of upper limb & shoulder	C49.1
Epididymis	C63.0
Fallopian tube	C57.0
Frontal sinus	C31.2
Kidney	C64.9
Long bones of upper limb, scapula & associated joints	C40.0
Long bones of lower limb, & associated joints	C40.2
Short bones of upper limb & associated joints	C40.1
Lung	C34.1-C34.9
PAIRED ORGANS	ICD-0-3 CODES
Main bronchus (excluding carina)	C49.1
Maxillary sinus (antrum)	C31.0
Middle ear (tympanic cavity)	C30.1
Nasal cavity (excluding nasal cartilage & nasal septum code “0”	C30.0
Ovary	C56.9
Overlapping lesion of the eye & adnexa, Eye NOS, eye and lacrimal gland	C69.0-C69.9
Parotid gland	C07.9
Pelvic bones & associated joints (excluding sacrum, coceyx & symphysis	C41.4
Peripheral nerves & autonomic nervous system of lower limb & hip	C47.2
Peripheral nerves & autonomic nervous system of upper limb & shoulder	C47.1
Pleura	C38.4
Renal pelvis	C65.9.
Rib, clavicle, & associated joints (excluding sternum – code “0”)	C41.3
Skin of external ear	C44.2
Skin of eyelid	C44.1
Skin of other & unspecified parts of face (midline code “9”)	C44.3
Skin of upper limb & shoulder	C44.6
Skin of lower limb & hip	C44.7
Skin of trunk (midline code “9”) “Back is a bilateral site”	C44.5
Spermatic cord	C63.1
Sublingual gland Skin of eyelid	C08.1
Submandibular gland	C08.0

Testis	C62.0-C62-9
Tonsil, NOS and operlapping of tonsil	C09.8-C09.9
Tonsillar pillar	C09.0
Ureter	C66.9

BILATERAL SITES BY ICD-0-3 CODE

ICD-0-3 CODES	PRIMARY SITE
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
ICD-0-3 CODES	**PRIMARY SITE**
C09.1	Tonsillar pillar
C09.8-C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum code “0”
C30.1.	Middle ear (tympanic cavity)
C31.0	Maxillary sinus (antrum)
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1-C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb, scapula and associated joints
C40.1	Short bones of upper limb and associated joints
C40.2	Long bones of lower limb and associated joints
C40.3	Short bones of lower limb and associated joints
C41.3	Rib and clavicle (excluding sternum code “0”
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubic code “0”
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face (midline code “9”)
C44.5	Skin of trunk (midline code “9”)
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective subcutaneous, and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C50.0-C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0-C62.9	Testis
C63.0	Epididymis

C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and lacrimal gland
C70.0	Cerebral meningies, NOS
C71.0	Cerebrum
C71.1	Frontal lobe
C71.2	Temporal lobe
C71.3	Parietal lobe
C71.4	Occipital lobe
C72.2	Olfactory nerve
C72.3	Optic nerve
ICD-0-3 CODES	**PRIMARY SITE**
C72.4	Acoustic nerve
C72.5	Cranial nerve, NOS
C74.0-C74.9	Adrenal gland (cortex, medulla)
C75.4	Carotid body

HISTOLOGY CODE & BEHAVIOR CODE (R)

(NAACCR ITEM#522 & 523) (FORDS pgs. 93-94; SEER pgs. 95-100) Line Length: 3 Line Length: 1

Description

This code identifies the microscopic histological anatomy of the cells and the behavior of the tumor being reported.

Explanation

The histology and behavior code is used as the basis for staging the cancer. It helps determine the prognosis, treatment options for a particular type of cancer and the course of the disease.

Coding Instructions

- The Morphology code is a 4-digit code stating the histological component of the cell. It is combined with a 1-digit code that defines the behavior of the cells as in situ (2) or malignant (3) cancer cells.

- Record the morphology code using the ICD-O-3 codes by using either the Numeric Lists/Morphology Section (ICD-0-3, pgs. 69-104) or the Alphabetic Index (ICD-O-3 pgs 105-218).

- Only record in situ tumors with a behavior code of “2”.

- Histology with different behavior codes are coded to the histology associated with the malignant behavior. Code “3” if any invasion is present no matter how limited.

EXCEPTION: *If the histology of the invasive is an NOS term, e.g., carcinoma, adenocarcinoma, melanoma or sarcoma, then use the specific term associated with the in situ component and an invasive behavior code.*

Code	Label	Definition
2	In situ and/or Carcinoma in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk
		Clark level 1 for melanoma (limited to epithelium)
		Comedocarcinoma, non-infiltrating (C50.-)
2	Synonymous with	Confined to epithelium
		Hutchinson melanotic freckle, NOS (C44.-)
		Intracystic, noninfiltrating
		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 involvement
		Papillary, noninfiltrating or intraductal
		Precancerous melanosis (C44.-)
		Queyrat ethroplasia
3	Invasive	Invasive or microinvasive

- Follow the coding rules outlined on pages 20 through 40 of ICD-0-3.

- When coding the cell type of the tumor, use all the related pathology reports to obtain the most accurate coding information. The pathology report from a resection or an excision will more adequately represent the tumor's histology; however, an incisional biopsy is adequate if the tumor is not removed by resection.

- The words **cancer, NOS (8000)** and **carcinoma, NOS (8010)** are **not** interchangeable. Record the appropriate histology code based upon the physician's documentation.

- Code the **final** pathologic diagnosis.

  EXCEPTION: If the final diagnosis is 'Not Otherwise Specified" (carcinoma, NOS; melanoma, NOS; Sarcoma, NOS; lymphoma NOS; or malignant tumor, NOS), then code the histology from the microscopic description or comment if it identified a more specific

histologic type (higher ICD-0-3 code) such as adenocarcinoma, amelanotic melanoma, spindle cell sarcoma.

- Lymphomas may be classified by the Rappaport classification or the Working Formulation. If both systems are used to classify the disease, then the term used to describe the lymphoma may differ. The Working Formulation term should take precedence (ICD-0-3, pgs. 13-18).

HANDLING SINGLE LESION MIXED/MULTIPLE MORPHOLOGY SAME BEHAVIOR CODE

Rule 1: Use a combination code if one exists.

Rule 2: Use the more specific code if one is not otherwise specified (NOS) and one is more specific.

EXAMPLES:
Pathology report says adenocarcinomas with cribiform differentiation. The more specific code is cribiform carcinoma; therefore the morphology code should be coded to 80703.

Pathology report states invasive carcinoma, probably squamous cell type. The more specific code would be 80703.

NOTE: The microscopic description may state mucin-producing, papillary or keratinizing, and the final pathologic diagnosis may simply state carcinoma or adenocarcinoma. Modify the final pathologic diagnosis to include the specific terms as mucin-producing, papillary, etc.

Rule 3: Use the terms that may or may not indicate a majority of tumor if Rule 1 or Rule 2 cannot be applied. 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 to the majority of the tumor.

MAJORITY TUMOR TERMS

MAJORITY	NOT MAJORITY
Predominately	With foci of
With features of	Focal/focus of
Major	Areas of
Type	Elements of
With … differentiation	Component

EXAMPLES: Ductal carcinoma, predominantly **medullary**, code to 85103
Ductal carcinoma with features of **comedocarcinoma**, code to 85013

Code the stated type (subtype) even if the code is lower than 8500. Look for the terms “type,” “subtype” or “variant or terms that indicate the majority of the tumor description.

Rule 4: Code the morphology with the highest code-rule with the lowest priority.

NOTE: Code the histology type of a single tumor with two modifying adjectives with different codes to the numerically higher code when there is no combination code available.

GRADE/DIFFERENTIATION OF TUMOR (R)

(NAACCR Item #440) (FORDS PG 96; SEER pgs. 101-104) Item Length: 1

Description

Grade describes the variance of the cancer tissue from normal tissue.

Explanation

Grade for cancer tumors is measured from well differentiated (Grade I) to undifferentiated (Grade IV). Well differentiated (Grade 1) tumor is most like normal tissue. The process varies for leukemias and lymphomas.

Coding Instructions

- The ICD-0-3 covers the instructions for morphology codes, behavior codes and grading. Refer to it for any answers that you do not find listed here. Only those that have caused difficulty are listed in this section.

- Code grade/differentiation according to ICD-0-3, pgs. 30-31 and 67).

  NOTE: Terms such as “anaplastic,” “well-differentiated”, and “undifferentiated” are used as essential parts of morphologic terms for neoplasms to ICD-0-3 (as well as those used to describe lymphomas). These morphologies must be reported with the appropriate grade code:

- Code the grade or differentiation from the **final** pathologic diagnosis of the primary site. If the differentiation is not stated in the final pathologic diagnosis, use the description from the microscopic information or comments on the report. If these are unavailable, the grade from a biopsy of the primary site or cytology should be used.

- Code to the highest grade recorded on the pathology report if more than one grade is listed. This applies even if it is only a focus. (Rule G, ICD-0-3, p. 21).

- **Do not** code the grade from a metastatic site. Use the grade only from the pathologic exam of the primary tumor.

- If you have no tissue to establish grade, you can use the recorded finding from a magnetic resonance imaging (MRI) or positron emission tomography (PET) that may have been done.

- Code to “9” when the primary site is unknown.

- **Do not** use the term "low grade," "intermediate grade," or "high grade" for lymphomas to code grade/differentiation. These are category terms in the *Working Formulation of Lymphoma Diagnoses* and do not indicate the grade/differentiation.

- Codes 5-8 define the T-cell or B-cell origin for leukemias and lymphomas. T-cell, B-cell or null cell classifications have precedence over grading and differentiation.

- Do not use the WHO grade to code this data item.

- If no grade is given for astrocytomas, then code to "9" (unknown).

- If no grade is given to glioblastoma multiforme, then code to "9" (unknown).

- Information on T-cell B-cell or null cell for lymphomas and leukemias has precedence over their information on grade/differentiation. If the grade/differentiation is stated (moderately differentiated, poorly differentiated, well differentiated) and the cell type is not, use the grade/differentiation information.

- FIGO (International Federation of Obstetrics and Gynecology) grades are not coded.

See the grade tables on page 67 of ICD-0-3 for specific clarification. See also the COC FORDS Manual and the SEER Program Code Manual, Third Edition, for site-specific coding rules and conversions.

The reporting codes are:

CODE	DESCRIPTION
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
	Grade/differentiation unknown, Not stated, or not applicable

- This conversion tables changes a description three-grade system to the required four-grade system:

  When described by terms:

CODE	GRADE	TERMINOLOGY
1	I-II	Low grade, partially differentiated
2	II-III	Medium grade
3	III	Moderately undifferentiated, relatively Undifferentiated
4	III-IV	High grade

CODE	GRADE/CELL	LABEL
1	Grade I,1,i	Well differentiated; differentiated, NOS
2	Grade II,2,ii	Moderately differentiated; moderately well differentiated; intermediate differentiation
3	Grade III,3,iii	Poorly differentiated
4	Grade IV,4,iv III/III or 3/3	Undifferentiated; anaplastic
	For Lynphomas & Leukemias	
5		T cell; T-precursor
6		B Cell; pre-B; B-precursors
7		Null cell; non T-non B
8		NK (natural killer) cell (effective with diagnosis 1/1/95 and after)
	For Use in All Histologies	
9		Cell type not determined, not stated or not applicable; unknown primaries; high grade dysplasia (adenocarcinoma in situ)

OTHER PRIMARY TUMOR - TEXT(R-OK)

Description
This area is text information to support the coding on the abstract. Text reporting **must** be provided, so report what you know.

Explanation
This is for quality clarification of coding that has been generated on the abstract.

Coding
Code the basic information:

- Histology
- Behavior code
- Grade
- Primary Site
- Laterality

OTHER PERTINENT INFORMATION - TEXT- (R-OK)

Description
This area is for documenting pertinent information about the patient's reported case

Explanation
This area data generates to the Central Registry. By making specific notations, the quality of the data will be improved and the number of phone contact to clarify reported information will be reduced.

Coding

Notations can be made to document any specific information that will clarify the coding done by your facility:

- A rare diagnosis
- Additional staging information
- Additional treatment documentation
- History of the disease
- Cause of death
- Expansion of race or sex information

DIAGNOSTIC CONFIRMATION (R)

NAACCR #490 (FORDS pg 99) Line Length: 1

Description

This documents the most accurate method of diagnostic confirmation for the tumor being reported in the patient's history.

Explanation

This is useful in calculating the percent of microscopically confirmed cancers over the lifetime of the patient. The percentage of cases that are clinically diagnosed only is an indication of whether Casefinding is including sources outside of the pathology reports. This ensures that full incidence calculations both clinically and pathologically confirmed cases are being picked up in the Casefinding process.

Coding Instructions

- There is a priority to the code numbers. Each lower number takes priority over higher numbers.

- All the diagnostic reports in the chart must be reviewed to determine the most definitive method used to confirm the diagnosis of cancer. Review of the entire medical history to accurately determine the primary tumor confirmation is sometimes required. The diagnosis confirmation does not have a time frame associated with it. If the diagnosis was prior to your admission the history may identify the previous tests or treatment that was completed.

- If the patient was diagnosed somewhere else, copies of the previous pathology or radiology reports may be included in the medical record.

- Assume the histologic code can be used, if the medical record indicates a biopsy or resection of the tumor has been performed.

- Use code "9" (unknown), **only** if there is no evidence of a definitive diagnostic confirmation.

  NOTE: Change the code to a lower more specific code if more information is received during the course of the disease, **regardless of the time frame.**

CODE	DESCRIPTION
1	Positive histology
2	Positive cytology, no positive histology
4	Positive microscopic confirmation, method not specified
5	Positive laboratory test/marker study
6	Direct visualization without microscopic confirmation
7	Radiography and other imaging techniques without microscopic confirmation
8	Clinical diagnosis only (other than 5, 6 or 7)
9	Unknown whether or not microscopically confirmed

TUMOR SIZE (S - OK)

[NAACCR #780] (FORDS pg 100-101 - required) (SEER EOD pgs. 3-6; SEER pg.117)
Line Length: 3

NOTE: This data field should be coded for cases diagnosed prior to 2004. After 2004, the tumor size should be coded under, *CS Tumor Size* discussed in Chapter 16.

Description
The tumor size is the largest dimension or the diameter of the primary tumor recorded in *millimeters.*

Explanation
Tumor size assists in the prognosis and treatment decision.

Coding Instructions

- Record the size of the tumor from the pathology report if it is recorded. Information on the tumor size from the imaging/radiographic techniques can be used to code size, but it is not as accurate as the pathology report and has a lower priority for use.

- Code the largest dimension or diameter of the tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

- Code the exact size of the primary tumor in **millimeters.** Centimeters (cm) can be converted to millimeters (mm) by moving the decimal point one digit to the right or multiply the centimeters by 10.

  Example: 2.5 cm tumor is recorded as “025” mm.
  A tumor less than 1 mm should be coded as “001.”

  Example: 0.6 mm tumor is recorded as “001.”

EXCEPTION: The depth of invasion is coded for Melanoma of the skin, vulva, scrotum, and conjunctiva. - Code in HUNDREDTHS of a millimeter.

If the depth of invasion is 9.89 mm or greater in depth, code the invasion to "989."

- Round off the size of a tumor to the nearest millimeter.
    - **Example:** A 3.8 mm tumor is recorded as 004.
        - A 3.2 mm tumor is recorded as 003.
- **Do not** code the size of polyps, ulcers, cysts or metastases as the size of the primary tumor.
- **Do not** add pieces or chips together to create a whole; they may not be from the same location or they may represent only a small portion of a large tumor.

  EXCEPTION: Some pathologists state in their pathology report an aggregate or composite size. (It is determined by piecing the tumor together and measuring it). If the tumor has been completely excised, then the size reported can be used.
- If there is both an in-situ and invasive component present and you have a size for either one, always use the invasive tumor size even if it is smaller.
- Use code "998" if the tumor involvement uses any of the following descriptions:

  Esophagus (C15.0-C15.5, C15.8, C15.9): Entire circumference.

  Stomach (C16.0-C16.6, C16.8, C16.9):Diffuse widespread, ¾ or more, linitis plastica.

  Colorectal (C18.0-C20.9 with M-8220/8221 and /2 or /3): Familial/multiple polyposis.

  Lung and main stem bronchus (C34.0-C34-3, C34.8, C34.9): Diffuse, entire lobe or lung.

  Breast (C50.0-C50.6, C50.8, C50.9): Inflammatory carcinoma; diffuse, widespread, ¾ or more of the breast.
- Code the size of the residual tumor if an excisional biopsy is done and the residual tumor at the time of the resection of the primary site is larger than the excisional biopsy.
- Neo-adjuvant (pre-surgical) radiation or systemic therapy (chemotherapy, hormone therapy, and/or immunotherapy) changes the measurement of the tumor. Code the size of the tumor documented prior to the start of first course therapy, code the size of the tumor from the pathology report if any of these pre-surgery treatments are done.

- Code to "999" for these reasons:

  1. For needle biopsy specimen

  2. If only one size is given for a tumor mix of the in-situ and invasive tumor

  3. If the size of the tumor is unknown or not documented in the hospital patient record

  4. For histologies or sites where size is not applicable like:

     Unknown or ill-defined primary (C76.0-C6.8, C80.9)

     Multiple myeloma (9732)

     Letterer-Siwe disease (9754)

     Hematopoietic, reticuloemdothelial, immuneproliferative or myeloproliferate disease (C2.0, C42.1, C42.3, C42.4, and/or M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

CODE	DEFINITION
000	No mass or tumor found, i.e., a tumor of a stated primary site is not found, but the tumor has metastasized.
001-988	Exact size in millimeters.
989	989 millimeters or larger; melanomas greater than or equal to 9.89 mm in depth.
990	Microscopic focus or foci only, no size is given.
998	Tumor involvement of specified esophageal, stomach, colorectal, lung and main stem bronchus, and breast primaries. See Coding Instructions
999	Unknown; size not stated in patient record; not applicable.

DESCRIPTION OF TUMOR SIZE

This text field provides substantiation for the tumor dimensions as quoted in pathology reports, radiology or scan reports. Maximum field size is 100 characters.

PHYSICIAN/PRIMARY SURGEON (R-OK)

(NAACCR #2480) (FORDS pg 77) Line Length: 8

Description

This records the identification number of the physician who performed the most definitive surgical procedure.

Explanation
This is used for administrative, physician and service referral report calculations. This can be used for follow-up purposes.

Coding Instruction

- The registry assigns a unique number to its listed physicians. OCCR recommends use of the physician's state medical license number, for ease in conversion to the National Provider Identifier being implemented by CMS. .
- Once the registry has designated a primary surgeon for the patient, the information should **not** be changed or updated even if the patient receives care from another surgeon.
- **Do not update this data item**.
- The identification number may include numbers and letters.
- Use the code for the doctor that did the most definitive surgery.

CODE	DEFINITION
(fill space)	Use primary surgeon
00000000	Patient had no surgery or no surgical consultation
88888888	If the physician who perform a surgical procedure was not a surgeon (radiation oncologist, diagnostic radiologist or general practitioner)
99999999	The primary surgeon is unknown or an identification number is not assigned.

PHYSICIAN - FOLLOW-UP (R-OK)

(NAACCR #2470) (FORDS pg 76) Line Item #: 8

Description
This is for recording the identification number of the physician currently responsible for the patient's medical care.

Explanation
The following physician is the first contact for obtaining current status and subsequent treatment or cancer recurrences.

Coding Instruction

- The registry assigns a unique number to its physicians. OCCR recommends use of the physician's state medical license number, for ease in conversion to the National Provider Identifier being implemented by CMS. .

- Change this data item when follow up information indicates another physician has taken over the regular care of the patient.

- The identification number may include numbers and letters

CODE	DEFINITION
(fill space)	Use primary surgeon
99999999	The follow-up physician is unknown or an ID number is not assigned.

PHYSICIAN - MANAGING (R-OK)

(NAACCR #2460) (FORDS pg 76) Line Item #: 8

Description

This physician at your facility is responsible for managing the patient's care.

Explanation

This is the physician responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.

Coding Instruction

- The registry assigns a unique number to its listed physicians. OCCR recommends use of the physician's state medical license number, for ease in conversion to the National Provider Identifier being implemented by CMS. .

- Once the registry has designated a managing physician for the patient, the information should **not** be changed or updated even if the patient receives care from another physician.

- The identification number may include numbers and letters.

CODE	DEFINITION
(fill space)	Use physician number
99999999	The physician is unknown or an ID number is not assigned.

PHYSICIAN 3 (R-OK)

(NAACCR #2490) (FORDS pg 78) Line Item #: 8

Description

This is to record the ID number of another physician involved in the case of the patient. The CoC recommends this data item be used to record the physician who performed the radiation therapy.

Explanation

This data items can be used to do service referral reports, identify potential cases that were or could have been treated in your facility or physicians that have stopped referring to your facility.

Coding Instruction

- The registry assigns a unique number to their physicians. OCCR recommends use of the physician's state medical license number, for ease in conversion to the National Provider Identifier being implemented by CMS. .

- If the registry designates this data item to list the primary radiation oncologist, then the information should **not** be changed or updated even if the patient receives care from another oncologist.

  NOTE: Refer to FORDS for more information on using this item and detailed instructions.

- The ID number may include numbers and letters.

CODE	DEFINITION
(fill space)	Use physician number
00000000	None, no additional physician
88888888	If the physician who perform a surgical procedure was not a radiation oncologist (diagnostic radiologist or surgeon) – **Required by NAACCR** if applicable.
99999999	Primary radiation oncologist is unknown or ID number is not assigned.

PHYSICIAN 4 (R-OK)

(NAACCR #2500) (FORDS pg 79) Line Item #: 8

Description

A code to use for another physician involved in the care of the patient. CoC uses this for the Medical Oncologist.

Explanation

This can be used for service referral reports. It can be used for follow-up purposes.

Coding Instruction

- The registry assigns a unique number to the physician. OCCR recommends use of the physician's state medical license number, for ease in conversion to the National Provider Identifier being implemented by CMS. .

- Once the registry has designated a medical oncologist for this data item, the information should **not be changed** or updated even if the patient receives care from another surgeon.

  NOTE: Refer to FORDS for more information on using this item and detailed instruction.

- The identification number may include numbers and letters.

CODE	DEFINITION
(fill space)	Use physician number.
00000000	Patient did not receive systemic therapy or a medical oncologist consultation
88888888	If the physician who gave systemic therapy was not a medical oncologist (radiation oncologist, general practitioner or surgeon) – **Required by NAACCR,** if available.
99999999	Physician is unknown or an ID number is not assigned.

CHAPTER 15 - SEER SUMMARY STAGING

SEER SUMMARY STAGE 2000 (RH)

(NAACCR Item #759) (FORDS pg 124) Item Length: 1

NAACCR requires that all cases be SEER Summary staged; therefore to be in state compliance, all cases must be SEER Summary Staged. Because Oklahoma does not require the reporting of AJCC/TNM staging in place of SEER Summary Staging, to meet this data requirement an additional requirement is made to accredited cancer programs **for cases diagnosed/admitted prior to 2004**.

Since January 1, 2004 when Collaborative Staging (CS) was initiated, six of the Collaborative Staging data items that are required are used to derive the appropriate SEER Summary Stage. From January 01, 2001 through December 31, 2003, the SEER Summary Staging Manual 2000 was the only resource available. It can be found on line at http://www.seer.cancer.gov/Publications/SummaryStage/

Definition
The Summary Stage provides a site-specific description of the extent the cancer has spread from the primary site. It classifies cancer into four categories: in situ, localized, regional and distant. Summary Stages uses all the information available in the medical chart. It does not separate it into clinical and pathological divisions. Both positive and negative statements can be used to help determine the extent of disease.

Explanation
The SEER Summary Staging Manual will take you through each step required to stage for this staging method. **This is only for cases that were diagnosed or admitted prior to 2004.**

Coding

- Any information found that is clinical or pathological can be used in staging the cancer if it is within the first four months.

- When there is doubt about assigning the appropriate stage, assign the lesser stage. Do not over stage.

- These ambiguous terms should be used for Summary Staging:

Confirmation of documented involvement

Adherent	Induration
Apparent(ly)	Infringe/infringing
Appears to	Into
Comparable with	Intrude

Compatible with
Contiguous/continuous with
Encroaching upon
Extension to, into, onto, out onto
Features of
Fixation to another structure
Fixed
Impending perforation of
Impinging upon
Impose/imposing on
Incipient invasion
Invasion to, into, onto, out onto
Most likely
Onto
Overstep
Presumed
Probable
Protruding into (unless encapsulated)
Suspected
Suspicious
To, Up to

Do not consider the following terms as involvement

Abuts
Approaching
Approximates
Attached
Entrapped
Equivocal
Extension to without invasion/involvement of
Kiss/kissing
Matted (except for lymph nodes)
Possible
Cannot be excluded/ruled out
Efface/effacing/effacement
Encased/encasing
Encompass(ed)
Questionable
Reaching
Rule out
Suggests
Very close to
Worrisome

CODE	DESCRIPTION
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**

CHAPTER 16 – ABSTRACTING COLLABORATIVE STAGING

The Collaborative Staging (CS) Task Force was formed in 1998 to address the issue of discrepancies among the three major staging system guidelines (TNM, SEER EOD, and SS). They wanted to develop a way to convert the information into a measurable system. They took unified data items that describe how far the cancer has spread at the time of diagnosis to develop this new staging system. The data set also includes several items derived from the computer algorithms that classify each case in multiple staging systems.

Because this is a new system, much is to be gained by reviewing the COLLABORATIVE STAGING MANUAL AND CODING INSTRUCTIONS version 1.03.000. Order information is in Chapter 2 of this manual. There are Index divider sheets that can be ordered that give a good overview of each site anatomy and minimize your need for additional resources.

As an introduction to CS, SEER offers an instructional "Introduction to Collaborative Staging" training module on its web site – http://seer.cancer.gov.

Because this is new to us all, it is best to refer to the Collaborative Staging Manual. Please read the Introduction, pages 1 – 21. It will give you a better understanding of what you are trying to accomplish with this new process. The OCCR staff is available to help you with any questions you have as you begin using the collaborative staging.

CHANGES IN ABSTRACTING RULES

This new system uses standard staging format to collect all the staging information. The timing for information that you can use for this staging is "all information gathered through completion of surgery(ies) as part of the first course of treatment or all information available within four months of the diagnosis date or the absence of disease progression, whichever is **longer."**

Disease progression is further extension of the disease or distant metastasis that has developed since the original time the staging diagnosis was determined. If the information you have on tumor extension, lymph node involvement, or distant metastasis is after the disease has progressed, it should not be documented. CS combines all information gathered during the time of diagnosis and work-up.

CS **does not** consider a change from unknown evidence of disease to known status of disease (negative or positive) as the disease progresses. A change from negative to positive status is considered progression of the disease. If the treatment plan is discontinued or changed because of the status of the disease, this is considered progression of the disease, and the CS information stops at this point.

> EXAMPLE: A patient has been treated surgically and is asymptomatic. During the follow-up exam to surgery, the patient has developed bone pain and is found to have bone metastases. *This is considered disease progression.*

The CS System introduces a change in the collection of information in documenting the extent of disease. This new system will help to collect clinical information about lymph nodes or distant metastases or sites that could not be clinically evaluated. This will reduce the number of cases requiring "unknown" coding. This will include sites like bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri and ovary.

The CS system allows the recording of regional lymph nodes as negative (based on clinical evaluation) rather than unknown when there is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing or surgical exploration, and the patient receives what would be the usual treatment to the primary site for a patient without lymph node involvement. Physicians have a tendency to mention the abnormal observations rather than normal observations. This is such a benefit to be able to document what is seen from the treatment administered to the patient rather than coding to "unknown", and it is gives a more accurate measurement of the extent of disease. A statement such as "remainder of examination negative" is also sufficient to record regional lymph nodes as clinically negative.

The same is true for clinically recording distant metastasis. Rather than coding "unknown", if the clinician proceeds with a treatment of the primary site that indicates a less invasive cancer, then his actions presuppose that there is no distant metastasis, or he would have increased his treatment. It makes it possible to code this decision to complete the final staging.

HOW THE COLLABORATIVE STAGING SYSTEM WORKS

The data items found in the medical record that are specific to a particular cancer site/histology are coded in the CS System fields. When you have recorded all your data information, the information is saved and then the registrar activates the computer algorithms to derive the values for the items in the TMN and SS systems. The output values are returned as a set of numeric codes designed for storage in the computerized abstract. If any of your information is incorrect, you can go back and make the corrections, then recalculate. In the beginning, you may feel that all that you are doing is – trying again. It won't be too long and you will get the "hang of it". Just stay with it.

The CS System schemas consist of the 15 data fields necessary to derive TNM and SS. The CS Manual provides codes and coding instructions for the process of data entry. To derive the desired TNM and SS, the computer algorithms must be used. This is only for cases diagnosed January 1, 2004 and later. All 15 elements are required for accredited cancer programs. For reporting facilities that are following the central registry requirements, only these data items are required: CS extension, CS Lymph nodes, CS Mets at DX, and CS Site-Specific Factors 1 and 3 based on specific sites.

CODES AND GUIDELINES FOR USING THE COLLABORATIVE STAGING SYSTEM

CS is collected on all cases regardless of whether they are microscopically confirmed. A description of the type of diagnostic confirmation is collected is a separate data item. The diagnostic confirmation fields can be used to exclude non-microscopically confirmed cases during analysis as necessary, since the AJCC Cancer Manual, 6th edition, states: "all cases should be microscopically confirmed". Cases not

microscopically confirmed should be coded from the schema for the site/histology the clinician considers most likely to be the primary.

All lymphomas are coded according to the lymphoma schema, regardless of the organ in which the lymphoma develops.

GENERAL GUIDELINES

All schemas apply to all histologies unless otherwise noted. Derived data fields SS 1977 and SS 2000 are generated for all sites and histologies. The computer algorithms for determining the final TNM elements and Stage Group take into account histologies that are excluded from TNM staging. For excluded histologies, the computer algorithm returns values representing "Not Applicable," meaning the TNM elements and Stage Group are not generated for that site/histology combination.

TIMING THE DATA COLLECTION

The data collected in the CS System is limited to information gathered through completion of surgery(ies) in first course of treatment, OR all information available within four months of the date of diagnosis in the absence of disease progression whichever is **longer.** If metastatic disease is known to have developed after the initial diagnosis and staging was done, the information should be excluded as part of the first course of treatment.

Site-specific and histology-specific guidelines take precedence over general guidelines. Always read the notes pertaining to a specific site or histology schema.

For each field, code the highest applicable number. The codes are ordered in a hierarchy so that increasing numbers generally indicate increasing degrees of tumor involvement. The hierarchies are not the same for the different staging systems, and CS generally follows the hierarchies of the TNM System.

> **EXCEPTION**: Codes for Unknown, Not Applicable, and NOS categories (such as Localized, NOS) do not take priority for more specific codes with lower numbers.
>
> **NOTE**: Combination codes (such as code 35 for "25 plus 30") have been assigned when using the higher number does not result in the appropriate mapping for all three of the stage groups. Combination codes have been omitted when use of a higher number results in correct mapping for all three of the staging systems.

For the fields CS Tumor Size, CS Tumor extension, CS Lymph Nodes and CS Mets at Dx, the CS system records the greatest extent of disease based on combined clinical and operative/pathological assessment to give a more accurate staging process.

> **NOTE**: 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.

> **NOTE**: Clinical information should be reviewed carefully to assure accurate recording of CS data items. Information, such as description of skin involvement for breast cancer and size of the primary lesion and distant lymph nodes for any site, can change the stage.

When the patient does not receive preoperative treatment and the operative/pathology information disproves the clinical information, code the operative/pathology information.

When the patient **does not** receive preoperative treatment, the greatest extent of disease should be recorded, whether that is determined clinically or postoperatively.

> **NOTE**: Preoperative treatment is defined as systemic (chemotherapy, hormone therapy, or immunotherapy) treatment or radiation therapy that is administered as an attempt to reduce the size of the tumor to improve the results of the resection of tumor, or control symptoms before the patient has surgery.

The fields "CS Regional Lymph Nodes Positive" and "Regional Lymph Nodes Examined" are based on pathologic (microscopic) information only.

The fields CS Tumor Size/Extension Evaluation, CS Regional LYMPH Nodes Evaluation, and "CS Metastatic Evaluation" documents how the most extensive tumor was established, as well as whether the patient received preoperative treatment.

Site-Specific Factors (SSFs) are included in every schema. They are incorporated into the staging algorithms when additional information is necessary to derive the TNM Stage Group, or where the SSF is considered to be of clinical or prognostic importance. Information formerly coded as Tumor Markers is coded in SSFs. For sites/histologies where some or all SSFs are not used, they are coded 888 (not applicable). Metastasis known to have developed after the initial extent of disease was established (disease progression) should be excluded when determining the farthest extent of disease at the time of diagnosis.

Autopsy reports are used in coding the CS in the same way as pathology reports, applying the same rules for inclusion and exclusions.

The extent of disease may be described only in terms of TNM characteristics in the medical record. In such cases, research the medical record for the appropriate staging documentation.

The data items listed here are only for reporting to meet NAACCR and Oklahoma requirements.

To meet the accredited COC cancer program requirements, go to the FORDS Manual and the Collaborative Staging and Coding Instruction manual. A list of the additional collaborative staging requirements for COC facilities and the reference page are listed in this section after the required NAACCR data items.

At the end of this chapter is a reference guide from The Collaborative Staging Manual that simplifies the process to follow for all CS elements.

CS TUMOR SIZE –(Accredited program requirement only)
(NAACCR ITEM #2800) (**FORDS pg 125 - Required**) Line Length:2
See the *Collaborative Staging Manual and Coding Instructions. Version 1.0 for site-specific codes and coding rules.*

CS EXTENSION (R)

(NAACCR ITEM #2810) (FORDS pg. 125C) Line Length:2

Description
This describes the primary tumor growth within the organ of origin or its extension into surrounding organs. For certain sites such as ovary, discontinuous metastasis is coded in the CS Extension field.

Explanation
This code uses all the staging systems to develop one code to describe the tumor size.

Coding
See the *Collaborative Staging Manual and Coding Instructions. Version 1.0 for site-specific codes and coding rules.*

CS TUMOR SIZE/EXT EVALUATION–(Accredited program requirement only)
(NAACCR ITEM #2820) (FORDS pg 125E) Line Length: 2
See the *Collaborative Staging Manual and Coding Instructions. Version 1.0 for site-specific codes and coding rules.*

CS LYMPH NODES (R)

(NAACCR ITEM #2830) (FORDS pg125H) Line Length: 2

Description
This is site-specific and identified the regional lymph nodes involved with cancer at the time of diagnosis. It describes extensive detail in describing the disease extension.

Explanation
It accumulates all the information available to describe the lymph node involvement.

Coding
See the *Collaborative Staging Manual and Coding Instructions. Version 1.0 for site-specific codes and coding rules.*

CS REGIONAL NODES EVALUATION – (accredited program requirement only)

(NAACCR ITEM #2840) (FORDS pg 125J) Line Length: 1
See the Collaborative Staging Manual and Coding Instructions. Version 1.0 for site-specific codes and coding rules.

REGIONAL NODES POSITIVE (S)

(NAACCR #820) **(FORDS pg 103-required**) Line Item #2

Description
This is a record of the total number of regional lymph nodes examined by the pathologist and found to have malignant cells. Beginning with cases on/or after January 1, 2004, this item is a component of the Collaborative Staging System (CS).

Explanation
This is necessary for pathologic staging and is a tool in measuring the quality of pathology reports and helps in determining the surgical evaluation and the treatment of the patient.

Coding Instructions

- In this section, record only the number of regional lymph nodes the pathologist examined that contained malignant cells. If distant lymph nodes were removed they should be coded under *CS Mets at DX and not here (*NAACCR Item #2850*).*

- This code information is based on pathology information only, even if it comes from only a biopsy. If no lymph nodes were removed or if no lymph nodes were found in a lymph node drainage area, code to "98."

- A lymph node code **must be** recorded even if the patient received preoperative treatment.

- Record of the total number of regional nodes that were removed and examined by the pathologist.

  NOTE: The number of regional lymph nodes examined is accumulated from all surgical procedures that removed lymph nodes and were documented in pathology report until the completion of the first course of treatment.

- Code "97" is used for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of lymph nodes cannot be determined on the basis of cytology or histology.

- Code "98" if the lymph nodes are aspirated and other lymph nodes are removed.

- Code "99" for these primary sites and histologies:

  Placenta (C58.9)

  Brain and Cerebral Meninges (C70.1, C72.0BC71.9)

Other Parts of the Central Nervous System (C70.1, C70.9, C72.0BC72.5, C72.8BC72.9)

Hodgkin and non-Hodgkin Lymphoma (M-959B972 EXECPT 9700/3 and 9701/3)

Hematopoietic, Reticuloendothelial, Immunoproliferative and Myceloproliferative Neoplasms: (M-9731B9734, 9740 B9742, 9750B9758, 975B9762, 9764B9769, 9800B9801, 9805, 9820, 9823, 9826B827, 9831B9837, 9840, 9860B9861, 9863, 9866B9867, 9870B9876, 9891, 9895B9897, 9910, 9920, 9930B9931, 9940, 9945B9946, 9948, 9950, 9950B9964, 9970, 9975, 9980, 9982B9987, 9989)

Unknown and Ill-Defined Primary Sites: (C42.0BC42.4, C76.0BC76.5, C76.7BC76.8, C77.0BC77.5, C77.8BC77.9, C80.9; NOTE: For C42._ and C77._, other than hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin Lymphomas as listed above, and Kaposi sarcoma 9140/3.)

CODE	DESCRIPTION
00	All lymph nodes examined are negative
01-89	1-89 lymph nodes positive (Code exact number positive)
90	90 or more lymph nodes are positive
95	Positive aspiration of lymph node(s) was performed
97	Positive nodes are documented, but the number is unspecified
98	No lymph nodes were examined
99	It is unknown whether lymph nodes are positive; not applicable; not stated in the medical record

REGIONAL NODES EXAMINED (S)

(NAACCR #830) **(FORDS pg 102-required**) Line Item #2

Description

This records the total number of regional nodes that were removed and examined by the pathologist. On January 1, 2004 this became a component of the Collaborative Staging System (CS).

Explanation

This data item is used as a quality measure for the pathologic and surgical evaluation and the treatment of the patient.

Coding Instruction

- In this section record only the number of regional lymph nodes the pathologist examined that contained malignant cells. If distant lymph nodes were removed they should be coded under *CS Mets at* DX and not here *(*NAACCR Item #2850*).*

- This code information is based on pathology information only, even if it comes only from a biopsy if no lymph nodes were removed, or none were found in a lymph node drainage area; code to "00."

- A Lymph node code **must be** recorded even if the patient received preoperative treatment.

- Record the total number of regional nodes that were removed and examined by the pathologist.

  NOTE: The number of regional lymph nodes examined can be accumulated from any surgical procedure that a pathology report records lymph node removal until first course of treatment is complete.

- If a biopsy is done and the number of lymph nodes removed are not known, code to "96."

- Code to "98" if the lymph nodes are aspirated and other lymph nodes are removed.

- Code "99" for these primary sites and histologies:

  Placenta (C58.9)

  Brain and Cerebral Meninges (C70.1, C72.0B, C72.5, C72.8B, C72.9)

  Hodgkin and non-Hodgkin Lymphoma (M-959B972) EXECPT 9700/3 and 9701/3)

  Hematopoietic, Reticuloendothelial, Immunoproliferative and Myceloproliferative Neoplasms: (M-9731B9734, 9740 B9742, 9750B9758, 975B9762, 9764B9769, 9800B9801, 9805, 9820, 9823, 9826B827, 9831B9837, 9840, 9860B9861, 9863, 9866B9867, 9870B9876, 9891, 9895B9897, 9910, 9920, 9930B9931, 9940, 9945B9946, 9948, 9950, 9950B9964, 9970, 9975, 9980, 9982B9987, 9989)

  Unknown and Ill-Defined Primary Sites: (C42.0BC42.4, C76.0BC76.5, C76.7BC76.8, C77.0BC77.5, C77.8BC77.9, C80.9; NOTE: For C42._ and C77._, other than hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin Lymphomas as listed above, and Kaposi sarcoma 9140/3.)

CODE	DESCRIPTION
00	No nodes were examined
01-89	1-89 lymph nodes were examined (code exact number examined)
90	90 or more lymph nodes were examined
95	No regional lymph node(s) were removed, but aspiration of regional nodes was performed
96	Regional lymph node removal was documented as a sampling and the number of nodes

	is unknown or not stated
97	Regional lymph node removal was documented, and the number of nodes is unknown or not stated.
98	Regional lymph nodes were surgically removed but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown.
99	It is unknown whether nodes were examined; not applicable or negative, not stated in patient record.

CS METASTIS AT DIAGNOSIS (R)

(NAACCR ITEM #2850) (FORDS pg 125L) Line Length: 2

Description
This identified the site(s) of metastatic involvement at the time of diagnosis.

Explanation
The identified metastatic involvement as records by all the stating systems is accumulated into one system to better evaluate the available information.

Coding
See the *Collaborative Staging Manual and Coding Instructions. Version 1.0 for site-specific codes and coding rules.*

CS METASTATIC EVALUATION – (accredited program requirement only)
(NAACCR ITEM #2860) (FORDS pg 125M) Line Length: 1
See the *Collaborative Staging Manual and Coding Instructions. Version 1.0 for site-specific codes and coding rules.*

CS SITE-SPECIFIC FACTOR 1 (RS)

(NAACCR ITEM #2880) (FORDS pg 1250) Line Length: 3

Description
This data item codes the prognostic factors that affect the stage or survival of cancer patients based upon specific factor that influence outcomes.

Explanation
This measures specific prognostic factors based upon the site of the primary tumor. Some sites do not use all these factors.

Coding
See the *Collaborative Staging Manual and Coding Instructions. Version 1.0 for site-specific codes and coding rules.*

CS SITE-SPECIFIC FACTOR 2 – (accredited program requirement only)
(NAACCR ITEM #2890) (FORDS pg 125Q) Line Length: 3
See the *Collaborative Staging Manual and Coding Instructions. Version 1.0 for site-specific codes and coding rules.*

CS SITE-SPECIFIC FACTOR 3 - (RS)
(NAACCR ITEM #2900) (FORDS pg 125R) Line Length: 3

Description
This data item codes the prognostic factors that affect the stage or survival of cancer patients based upon specific factor that influence outcomes.

Explanation
This measures specific prognostic factors based upon the site of the primary tumor. Some sites do not use all these factors.

Coding
See the *Collaborative Staging Manual and Coding Instructions. Version 1.0 for site-specific codes and coding rules*

Accredited COC cancer programs must report these additional data items. The Collaborative Staging Manual and Coding Instruction and the FORDS manual are better resource for accredited programs to follow since they are not included in NAACCR requirements.

The CS Site-specific Factors 1 – 6 all take specific information like Breslow's thickness for melanoma, HIV/AIDS status for lymphoma as part of the measurement factor for treatment outcomes.

CS SITE-SPECIFIC FACTOR 4) – (accredited program requirement only)
(NAACCR ITEM #2910) (FORDS pg 125S) Line Length: 3
See the *Collaborative Staging Manual and Coding Instructions. Version 1.0 for site-specific codes and coding rules.*

CS SITE-SPECIFIC FACTOR 5 – (accredited program requirement only)
(NAACCR ITEM #2920) (FORDS pg 125T) Line Length: 3

See the *Collaborative Staging Manual and Coding Instructions. Version 1.0 for site-specific codes and coding rules.*

CS SITE-SPECIFIC FACTOR 6– (accredited program requirement only)
(NAACCR ITEM #2930) (FORDS pg 125U) Line Length: 3
See the *Collaborative Staging Manual and Coding Instructions. Version 1.0 for site-specific codes and coding rules.*

CS VERSION 1ST

(NAACCR ITEM #2395) Field Length:6
The CS Version number is returned as part of the output of the CS algorithm.

CS VERSION LATEST

(NAACCR ITEM #2936) Field Length:6
The CS Version number is returned as part of the output of the CS algorithm.

HOW TO CODE THE COLLABORATIVE STAGING SYSTEM DATA ELEMENTS

A one page summary of how to code using the Collaborative Staging Manual

NOTE: This procedure focuses on only the Collaborative Staging data fields and assumes other registry operations such as case finding, completion of text fields and other data fields, edit checking and case submission are also being performed appropriately.

1. Before you begin to code using the Collaborative Staging System, read completely the general rules in this manual.

2. Read the medical record carefully to determine the primary site and histology and identify the correct ICD-O-3 codes. While you are reviewing the record, make mental notes about the tissues and lymph nodes that are involved by tumor.

3. If the histology is melanoma (87a20-8790), Kaposi sarcoma (9140), retinoblastoma (9510-9514), lymphoma (9590-9699 and 9702-9729), mycosis fungoides (9700-0701), or hematopoietic and reticuloendothelial system (9731-9989), use the histology-specific schema for the appropriate histology-site combination.

4. Otherwise, turn to the correct site-specific schema in the Part II of the Collaborative Staging Manual. Schemas are in ICD-0-3 order by the first code that uses the schema. Verify that you are in the correct chapter by confirming that the code is in the list at the beginning of the schema.

5. Begin assigning codes for the 15 fields in the Collaborative Staging System. Be sure to read the notes and follow the site/histology-specific instructions at the beginning of each data field. Some schemas may have site-specific factors associated with extension, lymph nodes or metastasis; keep these in mind as you assign the codes.
    a. Code the tumor size in the CS Tumor Size field.
    b. Code how far the tumor has directly spread in the CS Extension field.
    c. Code how the farthest tumor spread was determined in the CS Tumor Size/Ext Eval field.
    d. Code whether regional lymph nodes are involved in the CS Lymph Nodes field.
    e. Code how the farthest regional node spread was determined in the CS Reg Node Eval field.
    f. Code the number of positive regional lymph nodes from the pathology report in the Reg Nodes Pos field.
    g. Code the number of regional lymph nodes examined by the pathologist in the Reg Nodes Exam field.
    h. Code the farthest distant metastasis (including distant lymph nodes) in the CS Mets at Dx field.
    i. Code how the distant metastasis was determined in the CS Mets Eval field.
    j. Code the six site-specific factors. If the first site-specific factor is listed as “Not Applicable,” code 888 in all site specific factors. Otherwise, code the specific information requested for each site specific factor. When the next site-specific factor is 888 Not Applicable, all the remaining site-specific factors will also be 888.

CHAPTER 17 – ABSTRACTING TREATMENT DATA

FIRST COURSE OF TREATMENT

(FORDS PG 28)

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. "No therapy" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given. A treatment plan describes the type or types of treatment intended to modify, control, remove or destroy cancer cells. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more. Any therapy administered after the discontinuation of first course treatment is subsequent treatment. If there is no treatment plan and consultation with a physician is not possible, use the principle: "initial treatment must begin within four months of the date of initial diagnosis."

Exception: Leukemia treatment includes all therapies planned and delivered by the physician(s) during the first diagnosis of leukemia. This includes all treatment that is remission-inducing or remission-maintaining. It may include multiple methods and can last more than a year. After relapse of the first remission, the treatment administered is not considered first course of treatment.

DATE OF INITIAL TREATMENT (R)

(NAACCR Item # 1270) (FORDS pg 129) Line Length: 8

Definition

This is the date of any first course treatment given: surgery, radiation, systemic or other treatment that is started at any facility.

Explanation

It is important to be able to measure the delay between diagnosis and the onset of treatment. This data cannot be calculated from the respective first course of treatment dates if no treatment was given. Therefore, providing information about those instances in which a physician decides not to treat a patient or a patient's family or guardian declines treatment is important

Coding Instruction

- Punctuation marks (i.e., slashes, dashes) are not allowed in any date field.
- Enter the month, day, century and year (MMDDCCYY) of the start of the treatment.

CODE	DESCRIPTION
MMDDCCYY	Date first cancer therapy given
00000000	Diagnosed at autopsy.
99999999	When it was unknown whether any treatment was administered to the patient, the date is unknown or the case was identified by death certificate-only.

RX SUMMARY – SURGERY PRIMARY SITE (R)

(NAACCR Item #1290) (FORDS pg 135) Item Length: 2

Definition

Site-specific code for the type of surgery to the primary site as part of the first course of treatment. This includes treatment from all facilities as part of the first course of treatment.

Explanation

This data item is used to compare the efficiency of different treatment options.

Coding Instruction

- Site-specific codes for this data item are found in FORDS Manual in Appendix B.
- If registry software allows only one procedure to be recorded, record the most invasive surgical procedure of the primary site.
- For codes 00 through79, the response positions are hierarchical. Last-listed responses take precedence over responses listed above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if precise information about the surgery is not available.
- A biopsy that removes all the tumor or leaves only microscopic margins is coded under this item.
- The surgery to remove regional tissue organs is coded under this item as part of the continuity of the primary site, unless it is noted differently under the primary site surgery in the FORDS Manual in Appendix B.
- If the surgery was done to prolong a patient's life by controlling symptoms, to alleviate pain or to make the patient more comfortable, then also record this surgery under Palliative Care (NAACCR Item #3270).
- Brushings, washings, cell aspirations, and hematologic findings (peripheral blood smears are not considered surgical procedures and should not be coded in this item.

CODE	DESCRIPTION
00	None. Diagnosed at autopsy.
10-19	Site-specific codes. Tumor destruction. No pathologic specimen.
20-80	Site-specific codes. Resections
90	A surgical procedure was done, no information is available on what type of surgery was done.
98	Site-specific codes; special. Refer to Appendix B
99	Unknown. Nothing stated about surgery procedure. Death certificate only.

RX SUMMARY-SCOPE OF REGIONAL LYMPH NODE SURGERY (R)

(NAACCR Item #1292) (FORDS pg 138) Item Length # 1

Definition

This includes the removal, biopsy or aspiration of regional lymph nodes at the time of the primary site surgery or during a separate surgical procedure.

Explanation

This information is used to compare and evaluate the extent of the surgical procedure.

Coding Instruction

- The scope of regional lymph node surgery is collected from each surgical event even if the surgery of the primary site is 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.
- Codes 0 – 7 are hierarchical. If only one procedure can be recorded, code procedure that is numerically higher.
- Code 9 for:

  Primaries of the meninges, brain, spinal cord, cranial nerves, and other central nervous system C70.0-C70.9, C71.0-C71.9, C72.0-C72.9).

  Lymphomas (M9590-9596, 9650-9719, 9727-9729) with a lymph node primary site (C77.0-C77.9).

  Unknown or ill-defined primary sites (C76.0-C76.8, C80.9), or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease site (C42.0, C42.1, C42.3, C42.4, or M-9750, 9750-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989).

- Do not code distant lymph nodes removed during surgery to the primary site for this data item. Distant lymph nodes removed are coded in *Surgical Procedure/Other Site (NAACCR #1294).*

- Refer to the SEER Summary Staging Manual 2000, or the current AJCC Cancer Staging Manual for site-specific identification of regional lymph nodes.

  - *For the Summary of Regional Lymph Nodes Examined* codes, the following guidelines apply:

CODE	DESCRIPTION
0	None; diagnosed at autopsy
1	Biopsy or aspiration of regional lymph nodes, NOS
2	Sentinel lymph node biopsy
3	The number of regional nodes removed were unknown or not stated; regional lymph nodes removed, NOS
4	1-3 regional nodes removed*
5	4 or more regional lymph nodes were removed*
6	Sentinel node biopsy and codes 3, 4, or 5 done at the same times
7	Sentinel node biopsy and codes 3, 4, or 5 done at different times
9	Unknown or not applicable

NOTE: It's important to distinguish between codes 4 and 5 so that current data can be compared with previous years of documented data.

RX SUMMARY – SURGERY OTHER REGIONAL /DIST RX CODE (R)

(NAACCR Item #1294) (FORDS pg 142) Line Length: 1

Definition

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

Explanation

This removal of non-primary tissue documents the extent of surgical treatment and is used to evaluate the extent of metastatic involvement.

Coding Instruction

- Assign the highest numbered code that describes the surgical resection of distant lymph nodes(s) and/or regional/distant tissue or organs.

- Incidental removal of tissue or organs is not a "Surgical Procedure/Other Site."

- Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0-76.8, C8039) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9750, 9760-9764, 9800-9820, 9831-9964, 9980-9989).

REASON FOR NO SURGERY (R)

(NAACCR Item #1340) (FORDS pg 147) Line Length: 1

Definition

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

Explanation

This data item provides information related to the quality of care and describes why primary site surgery was not performed.

Coding Instruction

- If *Surgical Procedure of Primary Site (NAACCR Item #1290*) is coded 00, 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 1 if *Surgical Procedure of Primary Site (NAACCR Item #1290*) is coded 98.
- 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.
- Code 9 if the treatment plan offered multiple choices, but it is unknown which treatment, if any was provided.

CODE	DESCRIPTION
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, 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.
9	It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only.

RADIATION – REGIONAL TREATMENT MODALITY (R)

(NAACCR Item #1570) (FORDS pgs 155-156) Line Length: 2

Definition

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.

Explanation

Radiation treatment frequently is delivered in two or more phases that can be summarized as regional and boost treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Coding Instruction

- Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.

- In the event multiple radiation therapy modalities were employed in the treatment of the patients, record only the dominant modality.

- Note that in some circumstances the boost treatment may precede the regional treatment.

- For purposes of this data item, photons and x-rays are equivalent.

CODE	DESCRIPTION
00	No radiation treatment
20	External beam, NOS
21	Orthovoltage
22	Cobalt-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

CODE	DESCRIPTION
43	Gamma Knife
50	Brachytherapy, NOS
51	Brachytherapy, Intracavitary, LDR
52	Brachytherapy, Intracavitary, HDR
53	Brachytherapy, Interstitial, LDR
54	Brachytherapy, Interstitial, HDR
55	Radium
60	Radioisotopes, NOS
61	Strontium-89
62	Strontium-90
80*	Combination modality, specified*
85*	Combination modality, NOS*
98	Other, NOS
99	Unknown

NOTE: For tumors diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation administered to the patient as part of all of the first course of therapy. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to Volume II ROADS, and DAM rules and should only be used to record regional radiation for tumors diagnosed prior to January 1, 2003.

RX SUMMARY - RADIATION/SURGERY SEQUENCE (R)

(NAACCR Item #1380) (FORDS pg 164) Line Length: 1

Definition

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

Explanation

The sequence of radiation and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Coding Instruction

- Surgical procedures include *Surgical Procedure of Primary Site (NAACCR Item #1290); Scope of Regional Lymph Node Surgery (NAACCR Item #1292); Surgical Procedure/Other Site (NAACCR Item #1294*). If all of these procedures are coded 0, then this item should be coded 0.
- If the patient received both radiation therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site, Regional Lymph Node Surgery, or Surgical Procedure/Other Site*, then code this item 2-9 as appropriate.

CODE	DESCRIPTION
0	No radiation therapy and/or surgical procedures.
2	Radiation therapy before surgery
3	Radiation therapy after surgery.
4	Radiation therapy both before and after surgery.
5	Intraoperative radiation therapy
6	Intraoperative radiation therapy with other therapy administered before or after surgery.
9	Sequence unknown, but both surgery and radiation were given.

RX SUMMARY - CHEMOTHERAPY (R)

(NAACCR Item #1390) (FORDS pg 171) Line Length: 2

Definition

Records the type of chemotherapy administered as first course treatment at this and all others 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.

Explanation

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if chemotherapy was not administered.

Coding Instruction

- Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type 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, or 87 to record the reason why it was not administered.

- 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	DESCRIPTION
00	None, chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented in 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 of 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 the patient's record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in the patient's record.

RX SUMMARY - HORMONE THERAPY (R)

(NAACCR Item #1400) (FORDS pg 175) Line Length: 2

Definition

Records the whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given. 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.

Explanation

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy.

Coding Instruction

- 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 simulate 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, or 87 to record the reason why it was not administered.

- 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 88 if hormone therapy was planned, but not started at the time of the most recent follow-up.

- 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	DESCRIPTION
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).

CODE	DESCRIPTION
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in the patient's record.

RX SUMMARY – BRM/IMMUNOTHERAPY (R)

(NAACCR Item #1410) (FORDS pg 179) Line Length: 2

Definition

Records whether systemic immunotherapeutic (biologic response modifiers) agents were administered as first-course treatment at any facility, or the reason they were not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Explanation

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of immunotherapeutic agents as part of the first course of therapy.

Coding Instruction

- 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.

- 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 88 if immunotherapy was planned, but not started at the time of the most recent follow-up.

- 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	DESCRIPTION
00	None, immunotherapy 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 of 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 the 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 the patient's record.

RX SUMMARY - TRANSPLANT AND ENDOCRINE PROCEDURES (R)

(NAACCR Item #3250) (FORDS pg 182) Line Length: 2

Definition

Identifies systemic therapeutic procedures administered as first-course treatment at any facility, or the reason they were not given. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

Explanation

This data item allows the evaluation of patterns of treatment, which involve the alteration of the immune system or change the patient's response to tumor cells but do not involve the administration of antineoplastic agents.

Coding Instruction

- 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.

- Code 87 if the patient refused recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

- Code 88 if transplant or endocrine procedure was planned, but not started at the time of the most recent follow-up.

- Code 99 if it is not known whether 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.

CODE	DESCRIPTION
00	No transplant procedure or endocrine therapy was administered as part of the first course of 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.

CODE	DESCRIPTION
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 of 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 the patient's 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 is not stated in patient record.

RX SUMMARY - OTHER (R)

(NAACCR Item #1420) (FORDS pg 186) Line Length: 1

Definition

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

Explanation

Information on other therapy is used to describe and evaluate the quality of care and treatment practices.

Coding Instruction

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

- Code 8 if other treatment was planned, but not started at the time of the most recent follow-up.

CODE	DESCRIPTION
0	None
1	Other
2	Other – Experimental
3	Other – Double Blind
6	Other – Unproven
7	Refusal
8	Recommended; unknown if administered
9	Unknown

RX SUMMARY – SYSTEMIC/SURGERY SEQUENCE (R)

(NAACCR Item #1639) (FORDS pg 183) Item Length: 1

Definition

Records the sequencing of systemic therapy (*RX Summ-Chemo [1390], RX Summ-Hormone [1400], RX Summ-BRM [1410], and RX Summ-Transplant/Endocrine [3250]*) and surgical procedures given as part of the first course of treatment.

Explanation

The sequence of systemic therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the delivery of treatment to the patient.

Coding Instruction

- Systemic/Surgery Sequence is to be used for patients diagnosed on or after January 1, 2006.
- Code the administration of systemic therapy in sequence with the first surgery performed, described in the items *Date of First Surgical Procedure (NAACCR Item #1200*).
- If none of the following surgical procedures was performed*: Surgical Procedures of Primary Site (NAACCR Item #1290), Scope of Regional Lymph Node Surgery (NAACCR Item #1292), Surgical Procedure/Other Site (NAACCR Item #1294)*, then this item should be coded 0.
- If the patient received both systemic therapy and any one or a combination of the following surgical procedures*: Surgical Procedure of Primary Site (NAACCR Item #1290), Scope of Regional Lymph Node Surgery (NAACCR Item #1292), or Surgical Procedure/Other Site (NAACCR Item #1294*), then code this item 2-9, as appropriate.

CODE	DESCRIPTION
0	No systemic therapy and/or surgical procedures
2	Systemic therapy before surgery
3	Systemic therapy after surgery

CODE	DESCRIPTION
4	Systemic therapy both before and after surgery
5	Intraoperative systemic therapy
6	Intraoperative systemic therapy with other therapy administered before or after surgery
9	Sequence unknown

CHAPTER 18 – ABSTRACTING FOLLOW-UP DATA

DATE OF FIRST RECURRENCE – (R-OK)

(NAACCR ITEM #1860) (FORDS pg.; SEER pg.) Line Length: 8

Definition

Record the date of the first recurrence.

Explanation

This date is used to measure the results of the first course of treatment.

Coding Instructions

- Record the date the physician states the patient had recurrent or metastatic cancer.
- Record the month, day, century and year (MMDDCCYY) the patient was last seen at your facility, date of last contact, or date of death.
- Code month (99), day (99) and year (9999) if any of this information is unknown.
- Punctuation marks (slashes, dashes, etc) are not allowed in any date field.
- If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the **Other Pertinent Information** text area, document that the patient is deceased and the date of death is unknown.
- If the patient has more than one primary tumor, code each primary with the last date of contact or the date of death of the patient.

CODE	DESCRIPTION
MMDDCCYY	Date of information available
00000000	No Date
99999999	Unknown date

Month	Day	Year
01 January	**01**	**Use four-digit year**
02 February	**02**	**9999 Year unknown**
03 March	**99 day unknown**	
04 April		
05 May		
06 June		
07 July		
08 August		
09 September		
10 October		
11 November		
12 December		

For coding information that is not specific, use this guideline for consistency:

DOCUMENTATION	DATE/CODE FOR DESCRIPTION
Spring	Use April for the month
Summer	Use July for the month
Fall	Use October for the month
Winter	Determine if end of year or beginning of the next year. Use Whichever is appropriate - December (12) or January (1)
Middle of Year	Use July for the month
Recently	Use the month and year of admission and unknown day (99) for the day, if patient was admitted during the first week of a month, Use the previous month
Several Months Ago	If the patient was not previously treated or if a course of treatment started elsewhere and was continued at the reporting facility, assume the case was first diagnosed three months before admission with day unknown

DATE OF LAST CONTACT OR DATE OF DEATH (R)

(NAACCR ITEM #1750) (FORDS pg.199; SEER pg. 144) Line Length: 8

Definition

The is the date of last contact with the patient or the date the patient expired

Explanation

In doing statistical evaluations this date is used in calculating outcomes from cancer treatment and survival rates.

Coding Instructions

- Record the month, day, century and year (MMDDCCYY the patient was last seen at your facility, date of last contact, or date of death.

- Punctuation marks (slashes, dashes, etc) are not allowed in any date field.

- If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the **Other Pertinent Information** text area, document that the patient is deceased and the date of death is unavailable.

- If the patient has more than one primary tumor, code each primary with the last date of contact or the date of death of the patient.

CODE	DESCRIPTION
MMDDCCYY	Date of information available
00000000	No Date
99999999	Unknown date

Month	Day	Year
01 January	**01**	**Use four-digit year**
02 February	**02**	**9999 Year unknown**
03 March	**99 day unknown**	
04 April		
05 May		
06 June		
07 July		
08 August		
09 September		
10 October		
11 November		
12 December		

VITAL STATUS (R)

(NAACCR ITEM #1760) (FORDS pg. 200; SEER pg.145) Line Length: 1

Definition

This is a data element records whether the patient is still living or has expired.

Explanation

This information is related to the *Date of Last Contact or of Death* and will not pass edits without being completed. It is used to evaluate the registry follow up index and outcome statistics.

Coding Instructions

- Code the patient's vital status as of the date recorded in the *Date of Last Contact or Death* field. Use the most current and accurate information available.

- If the patient has multiple primaries **simultaneously**, all records should have the same vital status.

CODE	LABEL
0	Dead
1	Alive

CAUSE OF DEATH (R)

(NAACCR ITEM #1910) (FORDS pg. 201-not required) Line Length: 4

Definition

This is the official cause of death as coded from the death certificate in valid ICDA-8, ICD-9, and ICD-10 codes.

Explanation

This information is used to electronically calculate the adjusted survival rate by the life table method. The adjustment corrects for deaths other than cancer.

Coding Instructions

- The Division of Vital Records distributes a death listing with the coded cause of death. You can be added to this distribution by contacting OSDH.
- This data item is **no longer** supported by CoC (as of January 1, 2003).
- If the patient is an Oklahoma resident, use codes:

CODE	DESCRIPTION
0000	Patient alive at last contact
7777	State death certificate not available
7797	State death certificate available but underlying cause of death is not coded

PLACE OF DEATH (S-OK)

(NAACCR #1940) (FORDS –not reported)Line Length: 3

Description

Report the state or country where the patient died and where the death certificate was issued.

Explanation

This helps with death clearance for Oklahoma deaths if the state can match death certificates with hospital-listed patients that expired in your facility.

CODE	DESCRIPTION
--	Use State or County Code
997	Not applicable, patient alive
999	Place of death unknown

TYPE OF FIRST RECURRENCE TYPE– (R)

(NAACCR ITEM #1880) (FORDS pg 197) Line Length: 2

Description
Record the code for the type of first recurrence after a period of documented disease free intermission or remission

CANCER STATUS

(NAACCR ITEM #1770) (FORDS pg 201) Line Length: 1

Description
Report the presence or absence of clinical evidence of the patient's malignant or non-malignant tumor as of the Date of Last Contact [1750]. If the patient has multiple primaries, the values may be different for each primary.

Explanation
This field is used to compute survival analysis (disease-free intervals). By maintaining this data item, central registries can assist hospital registries by sharing this information with other hospital registries that serve the same patients, if the state's privacy laws so permit.

CODE	DESCRIPTION
1	No evidence of this tumor
2	Evidence of this tumor
9	Unknown, indeterminate whether this tumor is present, not stated in patient record

FOLLOWING REGISTRY – (R)

(NAACCR ITEM #2440) (FORDS pg 202) Line Length: 10

Description
Records the registry responsible for following the patient.

FOLLOW-UP SOURCE (R)

(NAACCR ITEM # 1790) (FORDS pg 203) Line Length: 1

Description
Records the source from which the latest follow-up information was obtained.

Explanation
For registries performing follow-up, this field helps evaluate the success rates of various methods of follow-up. It also can be used to report to institutions the source of follow-up information that is sent to them. When there is a conflict in follow-up information, knowing the source can help resolve the inconsistency.

CODE	DESCRIPTION
0	Reported hospitalization
1	Readmission
2	Physician
3	Patient
4	Department of Motor Vehicles
5	Medicare/Medicaid file
7	Death certificate
8	Other
9	Unknown; not stated in patient record

NEXT FOLLOW-UP SOURCE (R)

(NAACCR ITEM #1800) (FORDS pg 204) Line Length: 8

Description
Identifies the method planned for the next follow-up.

CODE	DESCRIPTION
0	Chart requisition
1	Physician letter
2	Contact letter
3	Phone call
4	Other hospital contact
5	Other, NOS
8	Foreign resident (not followed)
9	Not followed, other case for which follow-up of not required

CHAPTER 19 - ABSTRACTING COMPLETION DATA

DATE ABSTRACTED

(NAACCR # 2090) Item length: 8

Definition
This is the date the abstractor completes the edits and shows the abstract complete.

Explanation
This is a measurement tool to see that all cases are abstracted in compliance with the law.

Coding Instructions

- This is electronically posted unless you do a paper abstract.
- Punctuation marks (slashes, dashes, etc) are not allowed in any date field.
- Record the day, month, century and year (MMDDCCYY) the form was completed.
  Some software automatically generates this completion date.

DATA REVIEW GUIDELINES

These simple reviews will help to eliminate common reporting errors:

Is the **primary site** clearly verified in the text?

Is the **histology code, behavior code and grade/differentiation code** correct according to the description in the pathology report?

If this is a **paired organ**, is the laterality code verified in the text?

Is **stage** clearly documented in text on the abstract (tumor size, depth of invasion, lymph nodes examined and lymph nodes positive)?

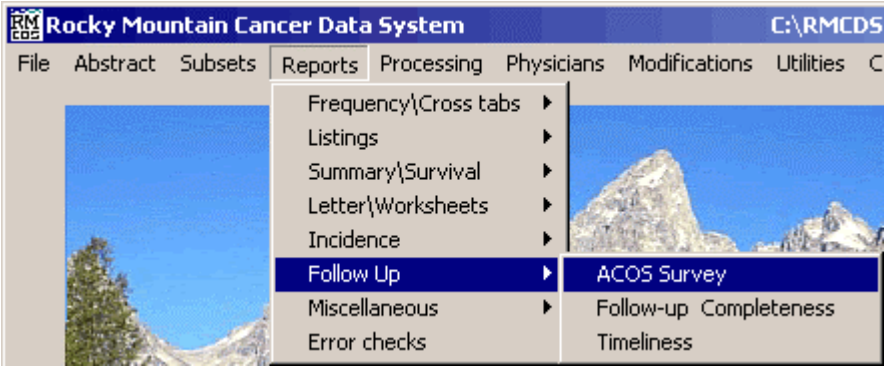
Are **treatment dates, agents/or procedure codes** supported by text?

Do dates make sense when compared to the **date of admission** and **date of diagnosis?**

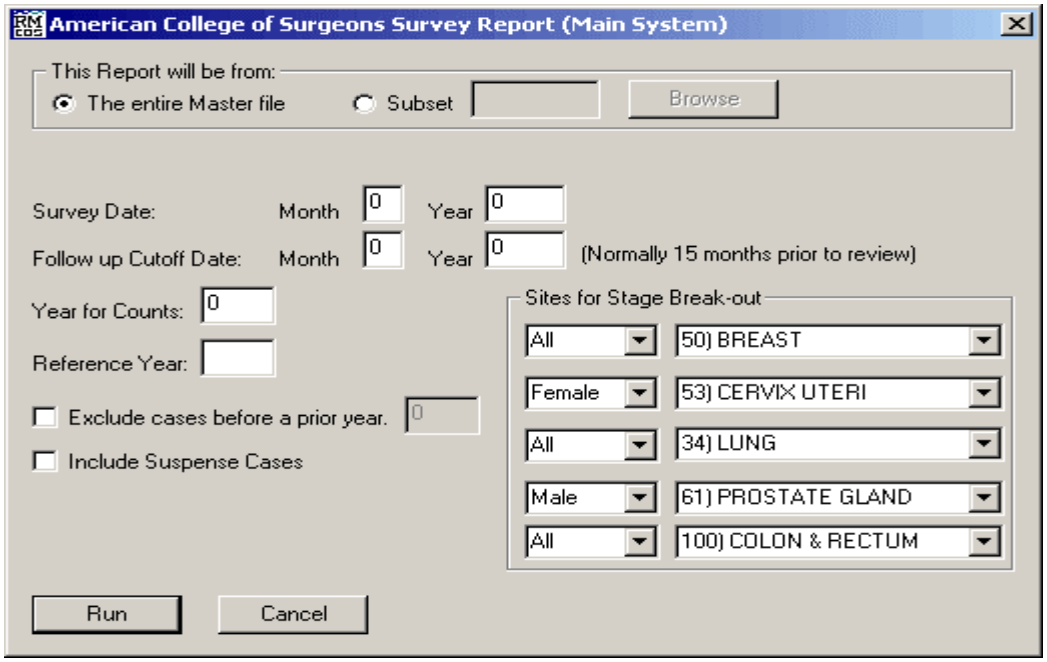
BOTTOM LINE: does the abstract data make sense?

ACOS Survey

These instructions describe how to run an ACOS Survey report from RMCDS. From the RMCDS Main Menu Click on **Reports > Follow up> ACOS Survey**.



This will open a window called **American College of Surgeons Survey Report.**



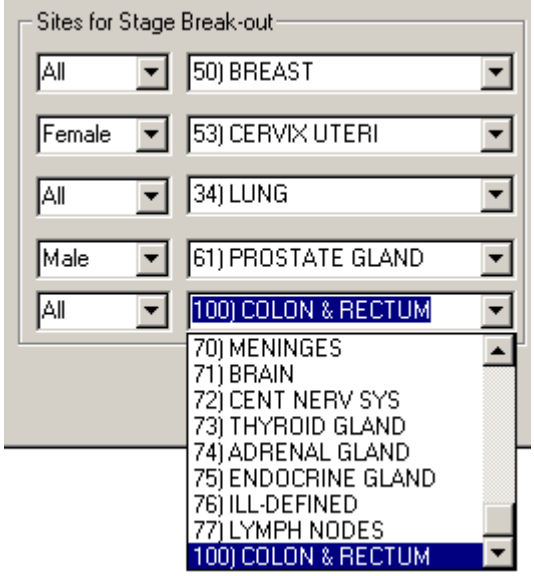
In the section labeled **This Report will be from,** select whether you want to generate this report from **The entire Master file** or from a **Subset** by clicking on the appropriate radio button.

On the line labeled **Survey Date**, enter the **Month** and **Year** for your report. The **Month** and **Year** for the **Follow up Cutoff Date** will be automatically filled in with the date 15 months prior to the Survey Date. You can change the auto filled values if you need to.

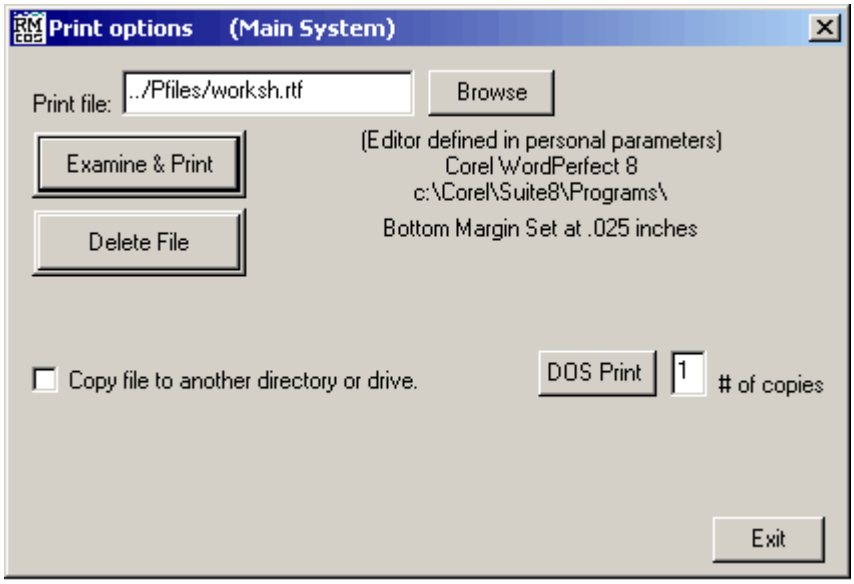
The **Year for Counts** will automatically be filled in when you enter in the Survey date. You can change this year if you need to.

The **Reference Year** is usually the year that the cancer registry began at your facility but may be different.

In the area labeled **Sites for Stage Break-out**, select which options you want by clicking on the drop down menu arrows.



After selecting the desired options click on the **Run** button. The ACOS Survey Report will run and you will get a **Print Options** window.



This window gives you the options to **Examine & Print**, and **Delete File,** the Follow up Worksheets. Clicking on **Examine & Print** will open the report in the editor defined in your personal parameters. You can print the report from your editor by clicking on **File > Print**.

Click **Exit** to close the Print Option Menu and return to the RMCDS Main Menu.

APPENDIX A – REPORTING LAWS

FEDERAL LEGISLATION

106 STAT. 3373 Public Law 102-515 - 102d Congress October 24, 1992

OKLAHOMA CANCER REGISTRY REPORTING

Oklahoma Statute (OS) Title 63. Public Health and Safety Public Health Code Article 5
§63-1-551.1. Tumor registry.

Oklahoma Statute (OS) Title 63. Public Health and Safety Public Health Code Article 17.1 & 17.2 §63-1-1701.1A Penalties.

Oklahoma Statute
Title 63. Public Health and Safety

Public Health Code Article 5

§63-1-551.1. Tumor registry.

A. The State Commissioner of Health shall establish and maintain an up-to-date tumor registry to ensure an accurate and continuing source of data concerning such cancerous, precancerous and tumorous diseases as the State Board of Health may by rule specify. Such registry may include data necessary for epidemiological surveys and scientific research, and other data which is necessary and proper to further the recognition, prevention, control, treatment and cure of cancer, precancerous and tumorous diseases.

B. The Commissioner, pursuant to rules of the State Board of Health, may require any hospital, clinic, laboratory, pathologist, physician or dentist, or any facility providing diagnostic or treatment services, to report any or all data and information necessary for the purposes of this act which may include the following:

1. Patient name, address, age, race, sex, social security number and hospital identifier or other identifier;

2. Patient's residential, family, environmental, occupational and medical histories; and

3. Physician's name, diagnosis, stage of the disease, method of treatment and the name and address of any facility providing treatment.

C. The Commissioner shall protect the identity of the patient and physician involved in any report required by this act, and may not release their identity without written consent, except that:

1. The Commissioner may grant any person involved in a legitimate research activity access to confidential information obtained by the Department concerning individual patients if:

a. the research activity is determined to be in the interest of the public health and welfare,

b. the person conducting the research provides written information about the purpose of the research project, the nature of the data to be collected and how the researcher intends to analyze it, the records the researcher wishes to review, and the safeguards the researcher will take to protect the identity of the patients whose records the researcher will be reviewing,

c. the proposed safeguards are adequate to protect the identity of each patient whose records will be reviewed, and

d. an agreement is executed between the Commissioner of Health and the researcher that specifies the researcher's use of the records and that prohibits the publication or release of the names of individual cancer patients or any facts tending to lead to the identification of individual cancer patients;

2. Researchers may, with the approval of the Commissioner, use the names of individual patients when requesting additional information for research purposes or soliciting an individual patient's participation in a research project. However, if a researcher requests additional information or an individual patient's participation in a research project, the researcher must first obtain the written consent of the patient's attending physician. If the consent of the patient's attending physician is obtained, the researcher must then obtain the individual cancer patient's written consent by having the patient complete a release of confidential medical information form;

3. Data on patients may be shared with other registries, private or governmental, within or without the state, provided that a reciprocal data sharing agreement, approved by the Commissioner, is implemented with that registry. Such agreements must include patient identification confidentiality requirements; and

4. Provided further, that any confidential information released by the Commissioner under this act shall be deemed to be a confidential communication within the meaning of the physician-patient and the psychotherapist-patient privilege.

D. Nothing in this act shall be construed to compel any individual to submit to any medical examination, treatment or supervision of any kind; nor shall anyone providing information in accordance with this act be deemed to be, or held liable for, divulging confidential information. An individual shall have the right to deny registration on religious grounds.

E. The State Board of Health is empowered to adopt reasonable regulations to carry out the provisions of this act.

F. Any person who, in violation of a written agreement to maintain confidentiality, willfully discloses any information provided pursuant to this section shall be denied further access to any confidential information maintained by the Department. That person shall also be deemed guilty of a misdemeanor, and upon conviction thereof shall be punished by a fine of Two Hundred Dollars ($200.00) or imprisonment in the county jail for not more than thirty (30) days, or by both such fine and imprisonment.

[1]
Added by Laws 1987, c. 197, § 1, eff. Nov. 1, 1987. [2]

Oklahoma Administrative Code

Title 310 - Oklahoma State Department of Health
Chapter 567 - State Central Cancer Registry

Subchapter 1 - General Provisions

310:567-1-1. Purpose

This Chapter implements 63 O.S. 1991 §1-551.1 and 1-552 by establishing the State Central Cancer Registry and rules which govern the maintenance of an up-to-date, population based cancer registry. In addition, this Chapter provides rules which ensure an accurate, timely, complete and continuing source of data concerning cancerous, precancerous and tumorous diseases and protects the identity of patients and physicians.

[**Source:** Added at 11 Ok Reg 3959, eff 6-21-94 (emergency); Added at 12 Ok Reg 1691, eff 6-12-95; Amended at 14 Ok Reg 250, eff 11-5-96 through 7-14-97 (emergency); Amended at 14 Ok Reg 3138, eff 7-25-97]

310:567-1-2. Definitions

The following words or terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Cancer diseases" means a general term frequently used to indicate any of various types of malignant neoplasms, most of which invade surrounding tissues, may metastasize to several sites, and are likely to recur after attempted removal and to cause death of the patient unless adequately treated; especially, any such carcinoma or sarcoma, but in ordinary usage, especially the former.

"Clinic" means any licensed facility serving persons on an out-patient basis which provides diagnostic and/or treatment of cancerous diseases and precancerous conditions.

"Commissioner" means the Oklahoma Commissioner of Health.

"Confidentiality pledge" means a legal document acknowledging the confidential and sensitive nature of personal data stored in the State Central Cancer Registry which prohibits the release of registry data without the written consent of the Commissioner of Health.

"Department" means the Oklahoma State Department of Health.

"Dentist" means a person trained in the diagnosis, treatment and prevention of diseases of the teeth and related structures of the oral cavity who is licensed by the Board of Governors Registered Dentists State of Oklahoma and qualified to practice dentistry.

"Diagnostic services" means any service which entails the diagnosis of a cancerous disease or precancerous condition, including such services as those provided by Oncologists, Pathologists, Radiologists, and surgeons.

"Facility" means any licensed or certified medical facility or establishment which provides diagnostic and/or treatment services for cancerous diseases and precancerous conditions.

"Histology" means the microscopic description of the type of cells in the specimen examined pathologically. The components of the histology shall include but not limited to: Morphology, Behavior, and Grade.

"Hospital" means any medical facility licensed by the state to provide medical care on an in-patient or out-patient basis for the diseases of cancer, for precancerous conditions, or for early detection services related to the detection and treatment of cancerous and precancerous conditions.

"Hospital identifier" means a unique code assigned to each hospital in the state which serves to uniquely identify each hospital in the State Central Cancer Registry, to assure the proper assignment of cancer data to the correct hospital.

"In situ" means local within the original place, or a growth of abnormal cells which is detected in its anatomic site of origin.

"Laboratory" means any accredited or certified laboratory which provides cytopathology services for defining the degree of abnormality of cells related to both cancerous and precancerous conditions.

"Pathologist" means any person who is licensed by the State and has board certification to perform pathology and performs the scientific study of the nature of disease, its causes, processes, development, and consequences. This includes the study of the anatomic or functional manifestations of cancerous disease and precancerous conditions.

"Pathology laboratory identifier" means a unique code assigned to an approved medical laboratory which provides cytopathology services for defining the behavior and degree of abnormality of a patient's laboratory specimen.

"Physician" means any person who has completed a course of medical training, has received a degree and is licensed by the Oklahoma State Board of Medical Licensure or the Oklahoma Osteopathic Board of Examiners to practice medicine.

"Precancerous condition" means exhibiting a likelihood of becoming cancerous.

"Registry" means a computerized system for collecting and compiling cancer data in a standard format, with the functional ability to merge data from various sources and perform correlations between a variety of data elements within the system. The Registry is also designed to produce summary reports and statistical analysis reports of the data contained in the Registry.

"Stage of disease" means terms frequently used to describe stage of disease: localized (if limited to the primary site), regional (if the disease has spread to adjacent organs or tissues and/or regional lymph nodes), and distant (if the cancer has spread to distant organs or nodes.)

"TNM" means the summary stage of a tumor, "T" meaning tumor, "N" meaning nodes and "M" meaning metastasis.

"Treatment services" means any type of treatment delivery for cancerous disease or precancerous conditions, performed in a medical facility on an out-patient or in-patient basis.

"Tumorous" means a circumscribed, non-inflammatory growth arising from existing tissue but growing independently of the normal rate or structural development of such tissue and serving no physiological function.

[**Source:** Added at 11 Ok Reg 3959, eff 6-21-94 (emergency); Added at 12 Ok Reg 1691, eff 6-12-95; Amended at 14 Ok Reg 3138, eff 7-25-97; Amended at 17 Ok Reg 2944, eff 7-13-00]

Subchapter 3 – Reporting

310:567-3-1. Reporting requirements

All hospitals, clinics, laboratories, pathologists, physicians, or dentists, or facilities providing diagnostic or treatment services in relation to cancer disease or precancerous conditions, shall report to the Oklahoma Central Cancer Registry the twenty-two cancer minimum data elements for the purpose of maintaining a statewide, population-based cancer data base. Such information shall include, at a minimum, the following elements:

(1) Patient's name, address, age, race, sex, social security number, hospital identifier or pathology laboratory identifier, or any other identifier for facilities providing diagnostic or treatment services for cancerous and precancerous conditions.

(2) Patient's residential, family, environmental, occupational, lifestyle risk factors, exposure to Agent Orange and medical histories.

(3) Physician's name, diagnosis, stage of disease, histology TNM, method of treatment, and name and address of any facility providing diagnostic or treatment services.

(4) Cancer identification of tumor site, laterality, type and behavior, grade, and diagnostic confirmation

(5) First course and subsequent courses of treatment, recurrence, continuous follow-up and death.

[**Source:** Added at 11 Ok Reg 3959, eff 6-21-94 (emergency); Added at 12 Ok Reg 1691, eff 6-12-95; Amended at 14 Ok Reg 250, eff 11-5-96 through 7-14-97 (emergency); Amended at 14 Ok Reg 3138, eff 7-25-97]

310:567-3-2. Diseases to be reported

All types of cancer will be considered as reportable disease. This will include all skin cancers and the following precancerous and in situ cases:
(1) Moderate or greater cervical dysplasia and carcinoma in situ of the cervix uteri.
(2) Carcinoma in situ of the female breast.
[**Source:** Added at 11 Ok Reg 3959, eff 6-21-94 (emergency); Added at 12 Ok Reg 1691, eff 6-12-95]

310:567-3-3. Methods of reporting

(a) The reporting of cancer may be done through automated hospital tumor registries.
(b) If the hospital does not have an automated cancer registry, cancer cases are to be reported manually in the form of case abstracts.
(c) If a biopsy was performed as an out-patient procedure, the pathology laboratory shall report any cases of cancer, or conditions defined in section 310:567-3-2.
(d) By January 1, 1997, all Oklahoma reporting sources shall be initiated. The Oklahoma Central Cancer Registry shall have as its reference date January 1, 1997.
(e) All hospitals, clinics, laboratories, pathologists, physicians or dentists, or all facilities providing diagnostic or treatment services in relation to cancer diseases or precancerous conditions, shall report all cancer cancer within 180 days of diagnosis.
(f) All hospitals, clinics, laboratories, pathologists, physicians or dentists, or all facilities providing diagnostic or treatment services in relation to cancer diseases or precancerous conditions, shall have capability to perform quality edits so that all cancer data reported to the Oklahoma Central Cancer Registry meets the 100% accuracy standard.
[**Source:** Added at 11 Ok Reg 3959, eff 6-21-94 (emergency); Added at 12 Ok Reg 1691, eff 6-12-95; Amended at 14 Ok Reg 250, eff 11-5-96 through 7-14-97 (emergency); Amended at 14 Ok Reg 3138, eff 7-25-97]

Subchapter 5 - Confidentiality and Use of Data

310:567-5-1. Confidentiality of registry data

The Commissioner shall protect the identity of the patient and physician involved in any report required by this act and may not release their identity without written consent, except that: The Commissioner may grant any person involved in a legitimate research activity access to confidential information obtained by the Department concerning individual patients if:
(1) *the research activity is determined to be in the interest of public health and welfare,*
(2) *the person conducting the research provides written information about the purpose of the research project, the nature of the data to be collected and how the researcher intends to analyze it, the records the researcher wishes to review, and the safeguards the researcher will take to protect the identity of patients whose records the researcher will be reviewing,*
(3) *the proposed safeguards are adequate to protect the identity of each patient whose records will be reviewed, and*
(4) *an agreement is executed between the Commissioner of Health and the researcher that specifies the researcher's use of the records and prohibits the publication or release of the names of individual cancer patients or any facts tending to lead to the identification of individual cancer patients* (and their physicians). [63:1-551.1(C)]
[**Source:** Added at 11 Ok Reg 3959, eff 6-21-94 (emergency); Added at 12 Ok Reg 1691, eff 6-12-95]

310:567-5-3. Reciprocity agreements with other registries

(a) The Commissioner may enter into reciprocity agreements with other governmental cancer registries for the purpose of sharing of cancer data.

(b) Shared cancer data cannot be used for any purpose other than non-confidential summary statistics of cancer, or related purposes, without a separate agreement of confidentiality as defined in section 310:567-5-2.
[**Source:** Added at 11 Ok Reg 3959, eff 6-21-94 (emergency); Added at 12 Ok Reg 1691, eff 6-12-95]

310:567-5-4. Cancer control, intervention, and special studies

(a) The Department may make such investigations concerning cancer, the treatment of this disease or impairments and the mortality resulting from them. The results of these investigations may be utilized in concert with communities, counties, or statewide groups to assist in planning, implementation, or evaluation efforts to reduce cancer morbidity or mortality.
(b) The Department may utilize central cancer registry data of non-confidential nature to conduct epidemiological surveys, correlation's between relative survival rates and stage of disease at diagnosis, efficacy of treatment modalities for various types of cancer at various stages of disease, lifestyle factors and other known risks of exposure to chemical agents and physical factors which may initiate or promote the uncontrolled growth of abnormal cells.
[**Source:** Added at 11 Ok Reg 3959, eff 6-21-94 (emergency); Added at 12 Ok Reg 1691, eff 6-12-95; Amended at 14 Ok Reg 3138, eff 7-25-97]

Authority: 63 O.S., §§ 1-551.1 and 1-552]
[**Source:** Codified 6/12/95]

Oklahoma Statute (OS)
Title 63. Public Health and Safety

Public Health Code Article 17.1 & 17.2

.1

A. In addition to any other remedies provided for by law, the Department, pursuant to rules and regulations, may issue a written order to any person whom the Department has reason to believe is presently in violation of any standards or rules promulgated by the State Board of Health and to whom the Department has served, no less than fifteen (15) days previously, a written notice of violation of such standards or rules. The fifteen-day notice period may be reduced as, in the opinion of the Department, may be necessary to render the order reasonably effectual.

B. The written order may require compliance with such standards or rules immediately or within a specified time period or both. The order may also assess an administrative fine for each day or part of a day that such person fails to comply with the order.

C. Any order issued pursuant to this section shall state with specificity the nature of the violation. Any penalty assessed in the order shall not exceed Ten Thousand Dollars ($10,000.00) per day of noncompliance with the order. In assessing such a penalty, the Department shall consider the seriousness of the violation and any efforts to comply with applicable requirements.

D. Any order issued pursuant to the provisions of this section shall become a final order unless, no later than fifteen (15) days after the order is served, the person or persons named therein request an administrative hearing. Upon such request the Department shall promptly conduct the hearing. The Department shall dismiss such proceedings where compliance with the order is demonstrated. A final order following a hearing may assess an administrative fine of an amount based upon consideration of the evidence but not exceeding the amount stated in the written order.

E. Such orders and hearings are subject to the Administrative Procedures Act.

.2 The Department may apply to and obtain from a judge of the district court, an administrative warrant as necessary to enforce access to premises for investigation, inquiry and inspection under the provisions of the Public Health Code and the rules and regulations promulgated by the State Board of Health.

APPENDIX B – MULTIPLE PRIMARIES OF LYMPHATIC & HEMATOPOIETIC DISEASE

Definitions of Single and Subsequent Primaries for Hematologic Malignancies based on ICD-O-3 reportable malignancies, effective with diagnoses 01/01/2001 and after

Cancer registrars are often faced with multiple pathology reports in patients with hematologic malignancies, and the diagnoses reported may require different morphology codes. This is due in part to the fact that more intensive diagnostic study may yield a more specific diagnosis, and in part due to the natural histories of hematopoietic diseases, which may progress from one diagnosis into another.

The following chart, provided to aid the registrar in determining single versus subsequent primaries, employs the following guidelines:

1. “Lymphoma” is a general term for hematopoietic solid malignancies of the lymphoid series. “Leukemia” is a general term for liquid malignancies of either the lymphoid or the myeloid series. While it is recognized that some malignancies occur predominantly (or even exclusively) in liquid or solid form, because so many malignancies can potentially arise as either leukemias or lymphomas (or both), all hematopoietic malignancies are assumed to have this potential.
2. Malignancies of the lymphoid series are considered to be different from those of the myeloid series. Therefore, a lymphoid malignancy arising after diagnosis of a myeloid malignancy (or myelodysplastic or myeloproliferative disorder) would be considered a subsequent primary; however, a myeloid malignancy diagnosed after a previous myeloid malignancy would not count as a subsequent primary. Histiocytic malignancies are considered different from both lymphoid and myeloid malignancies.
3. Hodgkin lymphoma is considered to be different from non-Hodgkin lymphoma (NHL). Among the NHLs, B-cell malignancies are considered different from T-cell/NK cell malignancies. Therefore, a B-cell malignancy arising later in the course of a patient previously diagnosed with a T-cell malignancy would be considered a subsequent primary; however, a T-cell malignancy diagnosed later in the same patient would not be considered a subsequent primary.
4. The sequence of diagnoses affects whether a diagnosis represents a subsequent primary. In some cases, the order of occurrence of the two diagnoses being compared is a factor in the decision whether the second diagnosis is a new primary.

We gratefully acknowledge the assistance of Drs. Charles Lynch, Charles Platz, and Fred Dick of the University of Iowa, Dr. Tim Cote of the SEER Program, Jennifer Seiffert, MLIS, CTR, and Annette Hurlbut, RHIT, CTR, for their assistance with this project.

To use the table, assign the ICD-O-3 code to the first diagnosis and find the row containing that code. Assign the ICD-O-3 code for the second diagnosis and find the column containing that code. In the cell at the intersection of the first diagnosis row and the second diagnosis column, a "**S**" symbol indicates that the two diagnoses are most likely the **same** disease process (prepare/update a single abstract), and a "**D**" indicates that they are most likely **different** disease processes (prepare more than one abstract).

Note 1: If one of the two diagnoses is an NOS (not otherwise specified) term and the other is more specific and determined to be the same disease process, code the more specific diagnosis regardless of the sequence. For example, if a diagnosis of non-Hodgkin lymphoma, NOS is followed by a diagnosis of follicular lymphoma, assign the morphology code for the follicular lymphoma.

Note 2: The table "Single versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases" (pages 2-6) and the "Complete Diagnostic Terms for Table (based on ICD-O-3)" (page 7) display only the ICD-O-3 primary (boldfaced) term associated with the code. Refer to the *International Classification of Diseases, Third Edition* (ICD-O-3) for a complete list of related terms and synonyms.

Prepared by: SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov 02/28/2001

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001
PAGE 1

SECOND DX ACROSS
FIRST DX DOWN

		1. 9590 Malig lymphoma, NOS	2. 9591 NHL, NOS	3. 9596 Compos HD/NHL	4. 9650-9667 Hodgkin lymphoma	5. 9670-9671 ML, small B lymph	6. 9673 Mantle cell lymph	7. 9675-9684 ML, diff large B-cell	8. 9687 Burkitt lymphoma	9. 9689,9699 Marg zn, B-cl lym	10. 9690-9698 Follicular lymphoma
1. Malignant lymphoma, NOS	9590	**S**	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	**S**	D	D	S	S	S	S	S	S
3. Composite HD/NHL	9596	S	S	**S**	S	S	S	S	S	S	S
4. Hodgkin lymphoma	9650-9667	S	D	D	**S**	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	S	D	D	**S**	D	S	D	D	D
6. Mantle cell lymphoma	9673	S	S	D	D	D	**S**	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	S	D	D	S	D	**S**	S	D	S
8. Burkitt lymphoma	9687	S	S	D	D	D	D	D	**S**	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	S	S	D	D	D	D	D	D	**S**	D
10. Follicular lymphoma	9690-9698	S	S	D	D	D	D	S	D	D	**S**
11. Mycos fung, Sezary disease	9700-9701	S	S	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	S	S	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	S	S	D	D	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	S	S	D	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	S	S	D	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	S	S	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	S	S	D	D	S	D	S	D	D	D
21. Waldenstrom macroglob	9761	S	S	D	D	S	D	S	D	D	D
22. Heavy chain disease, NOS	9762	S	S	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	S	S	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	S	S	D	D	D	D	D	S	D	D
25. Acute biphenotypic leukem	9805	S	S	D	D	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	D	D	D	D	D	S	D	S
27. BCLL/SLL	9823	S	S	D	D	S	D	S	D	D	D
28. Burkitt cell leukemia	9826	S	S	D	D	D	D	D	S	D	D
29. Adult T-cell leuk/lymph	9827	S	S	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	S	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	S	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	S	S	D	D	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	S	S	D	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	S	S	D	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	9948	S	S	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	D	D	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	D	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 2 SECOND DX ACROSS FIRST DX DOWN		11. 9700-9701 MF, Sezary disease	12. 9702-9719 T/NK-cell lymphoma	13. 9727 Precurs lym'blas lymph NOS	14. 9728 Precurs lym'blas lymph B-cl	15. 9729 Precurs lym'blas lymph T-cl	16. 9731-9734 Plasma cell tumors	17. 9740-9742 Mast cell tumors	18. 9750-9756 Histiocytos; LCH	19. 9757-9758 Dendritic cell sarc	20. 9760 Immunoprolif dis
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	S	S	S	D	D	D	S	S
3. Composite HD/NHL	9596	S	S	S	S	S	D	D	D	D	S
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D	D	D	S
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	**S**	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	**S**	D	D	D	D	D	D	D	S
13. Precurs lym'blas lymph NOS	9727	D	D	**S**	S	S	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	S	**S**	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	S	D	**S**	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	**S**	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	**S**	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	**S**	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	**S**	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	S	D	D	D	**S**
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	S
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	S
23. Immun sm intest disease	9764	D	D	D	D	D	S	D	D	D	S
24. Leuk/Acute leuk, NOS	9800-9801	D	S	S	S	S	D	D	D	D	D
25. Acute biphenotypic leukem	9805	S	S	S	S	S	D	D	D	D	D
26. Lymphocytic leukem, NOS	9820	S	S	S	S	S	D	D	D	D	S
27. BCLL/SLL	9823	D	D	D	D	D	D	D	D	D	S
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	S	S	S	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	S	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	S	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	9948	D	S	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	D	D	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	D	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001
PAGE 3

SECOND DX ACROSS
FIRST DX DOWN

		21. 9761 Waldenstrom	22. 9762 Heavy chain dis	23. 9764 Imm sm intest dis	24. 9800-9801 Leuk/Acu leuk NOS	25. 9805 Acute biphenotypic leuk	26. 9820 Lym'cyt leuk, NOS	27. 9823 BCLL/SLL	28. 9826 Burkitt leukemia	29. 9827 Adult T-cell leuk/lym	30. 9832 Prolym leuk, NOS
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	S	S	S	S	S	S	S	D
3. Composite HD/NHL	9596	S	S	S	S	D	S	S	S	S	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	D	D	D	S	S	S	D	D	S
6. Mantle cell lymphoma	9673	D	D	D	D	S	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	S	S	D	S	S	S	D	D	S
8. Burkitt lymphoma	9687	D	D	D	S	S	S	D	S	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	S	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	S	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	S	S	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	S	S	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	D	S	S	S	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	D	S	S	S	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	D	S	S	S	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	S	S	S	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	**S**	D	D	D	D	S	S	D	D	D
22. Heavy chain disease, NOS	9762	D	**S**	S	D	D	S	S	D	D	D
23. Immun sm intest disease	9764	D	S	**S**	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	D	D	D	**S**	S	S	D	S	S	D
25. Acute biphenotypic leukem	9805	D	D	D	S	**S**	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	D	S	S	**S**	S	S	S	S
27. BCLL/SLL	9823	D	D	D	D	S	S	**S**	D	D	S
28. Burkitt cell leukemia	9826	D	D	D	S	S	S	D	**S**	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	S	S	D	D	**S**	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	S	S	S	D	D	**S**
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	S	S	S	D	D	S
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	S	S	D	D	S	S
33. Precurs lym'cyt leuk, NOS	9835	D	D	D	S	S	S	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	D	S	S	S	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	D	S	S	S	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	S	S	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	S	S	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	S	S	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	S	S	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	S	S	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	S	S	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	S	S	D	D	D	D	D
43. NK-cell leukemia	9948	D	D	D	S	S	S	D	D	D	D
44. Polycythemia vera	9950	D	D	D	S	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	S	S	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	S	S	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	S	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	S	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	S	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	S	S	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	S	S	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	S	S	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001
PAGE 4

SECOND DX ACROSS / FIRST DX DOWN		31. 9833 Prolym leuk, B-cell	32. 9834 Prolym leuk, T-cell	33. 9835 Precurs leuk, NOS	34. 9836 Precurs leuk, B-cell	35. 9837 Precurs leuk, T-cell	36. 9840-9910 Myeloid leukemias	37. 9920 Therapy rel AML	38. 9930 Myeloid sarcoma	39. 9931 Acute panmyelosis	40. 9940 Hairy cell leukemia	41. 9945 Chr myelomono leu
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	D	D	S	S	S	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	S	S	S	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	D	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	S	S	S	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	S	S	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	S	D	S	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	D	D	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	D	D	S	S	S	S	S	S	D	D	S
25. Acute biphenotypic leukem	9805	S	S	S	S	S	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	S	S	S	D	D	D	D	S	D
27. BCLL/SLL	9823	S	D	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	S	S	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	**S**	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	**S**	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	**S**	S	S	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	**S**	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	**S**	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	**S**	S	S	S	D	S
37. Therapy related AML	9920	D	D	D	D	D	S	**S**	S	S	D	S
38. Myeloid sarcoma	9930	D	D	D	D	D	S	S	**S**	S	D	S
39. Acute panmyelosis	9931	D	D	D	D	D	S	S	S	**S**	D	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	**S**	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	S	S	S	S	D	**S**
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	S	S	S	S	D	S
43. NK-cell leukemia	9948	D	D	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	S	S	S	S	D	S
46. Myelosclerosis	9961	D	D	D	D	D	S	S	S	S	D	S
47. Essen thrombocythem	9962	D	D	D	D	D	S	S	S	S	D	S
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	S	S	S	S	D	S
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	S	S	S	S	D	S
50. Refractory anemias	9980-9986	D	D	D	D	D	S	S	S	S	D	S
51. Therapy related MDS	9987	D	D	D	D	D	S	S	S	S	D	S
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	S	S	S	S	D	S

Codes: S--one primary only; D--presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001
PAGE 5

SECOND DX ACROSS
FIRST DX DOWN

		42. 9946 Juv myelomono leu	43. 9948 NK-cell leukemia	44. 9950 Polycythemia vera	45. 9960 Chr myeloprolif dis	46. 9961 Myelosclerosis	47. 9962 Ess thrombocythem	48. 9963 Chr neutrophil leu	49. 9964 Hypereosin syndr	50. 9980-9986 Refract anemias	51. 9987 Therapy rel MDS	52. 9989 Myelodys syn NOS
1. Malignant lymphoma, NOS	9590	S	S	D	D	D	D	D	D	D	D	D
2. NHL, NOS	9591	D	D	D	D	D	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	D	D	D	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	D	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	D	D	D	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	D	D	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	D	D	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	D	D	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	S	D	D	S	S	D	S	S	D	S	S
25. Acute biphenotypic leukem	9805	S	S	D	S	S	D	D	D	S	S	S
26. Lymphocytic leukem, NOS	9820	D	S	D	D	D	D	D	D	D	D	D
27. BCLL/SLL	9823	D	D	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	D	D	D	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	D	D	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	D	D	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	S	D	D	S	S	S	S	S	D	S	S
37. Therapy related AML	9920	S	D	D	D	S	D	D	D	D	S	S
38. Myeloid sarcoma	9930	S	D	D	S	S	S	S	D	D	S	S
39. Acute panmyelosis	9931	S	D	D	D	S	D	D	D	D	S	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	S	D	D	S	S	D	S	D	D	S	S
42. Juvenile myelomonocy leuk	9946	**S**	D	D	D	S	D	D	D	D	S	S
43. NK-cell leukemia	9948	D	**S**	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	**S**	S	S	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	**S**	S	S	S	D	D	D	D
46. Myelosclerosis	9961	S	D	D	S	**S**	S	S	D	D	S	S
47. Essen thrombocythem	9962	D	D	D	S	S	**S**	S	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	S	S	S	**S**	D	D	D	D
49. Hypereosinophilic syndrome	9964	S	D	D	S	S	D	D	**S**	D	D	D
50. Refractory anemias	9980-9986	S	D	D	S	S	D	D	D	**S**	S	S
51. Therapy related MDS	9987	S	D	D	S	S	D	D	D	S	**S**	S
52. Myelodysplastic syndr, NOS	9989	S	D	D	S	S	D	D	D	S	S	**S**

Codes: S--one primary only; D--presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

COMPLETE DIAGNOSTIC TERMS FOR TABLE (BASED ON ICD-O-3)

1	9590	Malignant lymphoma, NOS
2	9591	Malignant lymphoma, non-Hodgkin, NOS
3	9596	Composite Hodgkin and non-Hodgkin lymphoma
4	9650-9667	Hodgkin lymphoma (all subtypes)
5	9670-9671	Malignant lymphoma, small B lymphocytic
6	9673	Mantle cell lymphoma
7	9675-9684	Malignant lymphoma, diffuse large B-cell
8	9687	Burkitt lymphoma
9	9689, 9699	Marginal zone B-cell lymphoma
10	9690-9698	Follicular lymphoma
11	9700-9701	Mycosis fungoides and Sezary syndrome
12	9702-9719	T/NK-cell non-Hodgkin lymphoma
13	9727	Precursor cell lymphoblastic lymphoma, NOS
14	9728	Precursor B-cell lymphoblastic lymphoma
15	9729	Precursor T-cell lymphoblastic lymphoma
16	9731-9734	Plasma cell tumors
17	9740-9742	Mast cell tumors
18	9750-9756	Histiocytosis/Langerhans cell histiocytosis
19	9757-9758	Dendritic cell sarcoma
20	9760	Immunoproliferative disease, NOS
21	9761	Waldenstrom macroglobulinemia
22	9762	Heavy chain disease, NOS
23	9764	Immunoproliferative small intestinal disease
24	9800-9801	Leukemia, NOS/Acute leukemia, NOS
25	9805	Acute biphenotypic leukemia
26	9820	Lymphoid leukemia, NOS
27	9823	B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma
28	9826	Burkitt cell leukemia
29	9827	Adult T-cell leukemia/lymphoma (HTLV-1 positive)
30	9832	Prolymphocytic leukemia, NOS
31	9833	Prolymphocytic leukemia, B-cell type
32	9834	Prolymphocytic leukemia, T-cell type
33	9835	Precursor cell lymphoblastic leukemia, NOS
34	9836	Precursor B-cell lymphoblastic leukemia
35	9837	Precursor T-cell lymphoblastic leukemia
36	9840-9910	Myeloid leukemias
37	9920	Therapy related acute myelogenous leukemia
38	9930	Myeloid sarcoma
39	9931	Acute panmyelosis with myelofibrosis
40	9940	Hairy cell leukemia
41	9945	Chronic myelomonocytic leukemia, NOS
42	9946	Juvenile myelomonocytic leukemia
43	9948	Aggressive NK-cell leukemia
44	9950	Polycythemia vera
45	9960	Chronic myeloproliferative disease, NOS
46	9961	Myelosclerosis with myeloid metaplasia
47	9962	Essential thrombocythemia
48	9963	Chronic neutrophilic leukemia
49	9964	Hypereosinophilic syndrome
50	9980-9986	Refractory anemias
51	9987	Therapy related myelodysplastic syndrome, NOS
52	9989	Myelodysplastic syndrome, NOS

Version 1.01. Codes corrected for terms in rows 7 and 9 on pages 2-5.

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov 02/28/2001

Criteria for Determining Multiple Primaries of Lymphatic and Hematopoietic Diseases

The following rules are to be used as a guide in identifying lymphomas and leukemias with second primaries. Note that the rules are in terms of general headings followed by the ICD-O morphology codes included in each heading. For specific terms such as "histiocytic," "diffuse," "nodular" and "granulocytic," check the ICD-O Alphabetic List to determine into which general category a specific term falls. Complete instructions for determining subsequent primaries in lymphatic and hematopoietic diseases are available in both the SEER Program Code Manual and the ROADS.

(1) Hodgkin's disease (9650-9667)	
Report as a second primary	***Do not report as a second primary***
Non-Hodgkin's lymphoma (9591-9595, 9670-9686, 9690-9698, 9702-9714) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761) Any leukemia (9800-9940)	Malignant lymphoma, NOS (9590) Hodgkin's disease (9650-9667)

(2) Malignant lymphoma, NOS (9590)	
Report as a second primary	***Do not report as a second primary***
Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) Mast cell tumor (9740, 9741) Acute leukemia, NOS (9801) Non-lymphocytic leukemias (9840-9842, 9860-9910) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	Malignant lymphoma, NOS (9590) Non-Hodgkin's lymphoma (9591-9595, 9670-9686, 9702-9714) Hodgkin's disease (9650-9667) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Waldenstrom's macroglobulinemia (9761) Leukemia, NOS (9800) Chronic leukemia, NOS (9803) Plasma cell leukemia (9830) Lymphoid or lymphocytic leukemia (9820-9827)

APPENDIX C - SEER GEOCODES ALPHABETICAL LIST

For Coding Place of Birth and Place of Death

ALPHABETICAL LISTING

A

585 Abyssinia
629 Aden
583 Afars and Issas
638 Afghanistan
500 Africa
570 Africa, East
510 Africa, North
540 Africa, South
545 Africa, South West
530 Africa, West
580 African Coastal Islands (previously included in 540)
037 Alabama
091 Alaska
481 Albania
224 Alberta
513 Algeria
250 America, Central
265 America, Latin
260 America, North (use a more specific term; see also North America)
300 America, South
121 American Samoa
611 Anatolia
641 Andaman Islands
443 Andorra
520 Anglo-Egyptian Sudan
542 Angola
245 Anguilla
665 Annam
750 Antarctica
245 Antigua
245 Antilles, NOS
245 Antilles, Netherlands
625 Arab Palestine (former)
629 Arabia, Saudi
629 Arabian Peninsula
365 Argentina
087 Arizona
071 Arkansas
611 Armenia (Turkey)
633 Armenia (U.S.S.R.)
245 Aruba
600 Asia, NOS*

680 Asia, East
640 Asia, Mid-East
611 Asia Minor, NOS
610 Asia, Near-East
650 Asia, Southeast
620 Asian Arab Countries
634 Asian Republics of the former U.S.S.R.
109 Atlantic/Caribbean area, other U.S. possessions
100 Atlantic/Caribbean area, U.S. possessions
711 Australia
711 Australian New Guinea
436 Austria
633 Azerbaijan
633 Azerbaizhan S.S.R.
445 Azores

B
247 Bahamas, The
629 Bahrain
443 Balearic Islands
463 Baltic Republic(s), NOS
463 Baltic States, NOS
645 Bangladesh
245 Barbados
245 Barbuda
545 Basutoland
431 Bavaria
545 Bechuanaland
457 Belarus
541 Belgian Congo
433 Belgium
252 Belize
539 Benin
246 Bermuda
456 Bessarabia
643 Bhutan
539 Bioko (Fernando Poo)
452 Bohemia
355 Bolivia
545 Bophuthatswana
673 Borneo
453 Bosnia-Herzogovina
545 Botswana
341 Brazil
226 British Columbia
331 British Guiana
252 British Honduras
245 British Virgin Islands

SEER GEOCODES

245 British West Indies, NOS
671 Brunei
454 Bulgaria
520 Burkina Faso (Upper Volta)
649 Burma (see Myanmar)
579 Burundi
457 Byelorussian S.S.R.

C
543 Cabinda
245 Caicos Islands
097 California
663 Cambodia
539 Cameroon
220 Canada
110 Canal Zone
443 Canary Islands
122 Canton Islands
545 Cape Colony
445 Cape Verde Islands
245 Caribbean, NOS
245 Caribbean Islands, other
123 Caroline Islands
711 Cartier Islands
633 Caucasian Republics of the former U.S.S.R.
245 Cayman Islands
500 Central Africa, NOS
539 Central African Republic
250 Central America
499 Central Europe, NOS
060 Central Midwest States
647 Ceylon (see Sri Lanka)
520 Chad
401 Channel Islands (British)
361 Chile
681 China, NOS
665 China, Cochin
682 China, People's Republic of
684 China, Republic of
723 Christmas Island
545 Ciskei
665 Cochin China
711 Cocos (Keeling) Islands
381 Colombia
083 Colorado
580 Comoros
226 Columbia, British
022 Columbia, District of

SEER GEOCODES

539 Congo, NOS
539 Congo-Brazzaville
541 Congo-Leopoldville
541 Congo, Belgian
539 Congo, French
541 Congo Kinshasa
007 Connecticut
124 Cook Islands
441 Corsica
256 Costa Rica
539 Cote d'Ivoire (Ivory Coast)
471 Crete
453 Croatia
241 Cuba
245 Curacao
495 Cyprus
517 Cyrenaica
452 Czechoslovakia
452 Czech Republic

D
539 Dahomey
453 Dalmatia
017 Delaware
425 Denmark
022 District of Columbia
583 Djibouti
449 Dobruja
245 Dominica
243 Dominican Republic
673 Dutch East Indies
332 Dutch Guiana

E
570 East Africa
680 East Asia
431 East Germany
673 East Indies, Dutch
645 East Pakistan
499 Eastern Europe, NOS
345 Ecuador
519 Egypt
410 Eire
254 El Salvador
125 Ellice Islands
122 Enderbury Islands
401 England
122 Enterbury Islands

SEER GEOCODES

500 Equatorial Africa, NOS
539 Equatorial Guinea (Spanish Guinea)
585 Eritrea
458 Estonia
458 Estonian S.S.R. (Estonia)
585 Ethiopia
499 Europe, NOS*
470 Europe, other mainland

F
425 Faroe (Faeroe) Islands
381 Falkland Islands
431 Federal Republic of Germany
123 Federated States of Micronesia
539 Fernando Poo
721 Fiji
429 Finland
035 Florida
684 Formosa
441 France
545 Free State (Orange Free State)
539 French Congo
333 French Guiana
725 French Polynesia
583 French Somaliland
530 French West Africa, NOS
245 French West Indies
721 Futuna

G
539 Gabon
345 Galapagos Islands
539 Gambia, The
631 Gaza Strip
033 Georgia (U.S.A.)
633 Georgia (U.S.S.R.)
431 German Democratic Republic
430 Germanic Countries
431 Germany
431 Germany, East
431 Germany, Federal Republic of
431 Germany, West
539 Ghana
485 Gibraltar
122 Gilbert Islands
471 Greece
210 Greenland
245 Grenada

245 Grenadines, The
245 Guadaloupe
126 Guam
251 Guatamala
401 Guernsey
331 Guiana, British
332 Guiana, Dutch
333 Guiana, French
539 Guinea
539 Guinea-Bissau (Portuguese Guinea)
539 Guinea, Equatorial
—— Guinea, New (see New Guinea)
539 Guinea, Portuguese
331 Guyana

H
242 Haiti
099 Hawaii
432 Holland
253 Honduras
252 Honduras, British
683 Hong Kong
475 Hungary
421 Iceland
081 Idaho
061 Illinois
641 India
045 Indiana
673 Indies, Dutch East
660 Indochina
673 Indonesia
053 Iowa
637 Iran
627 Iraq
620 Iraq-Saudi Arabian Neutral Zone
410 Ireland (Eire)
410 Ireland, NOS
404 Ireland, Northern
410 Ireland, Republic of
401 Isle of Man
631 Israel
583 Issas
447 Italy
539 Ivory Coast

J
244 Jamaica
423 Jan Mayen

SEER GEOCODES

693 Japan
673 Java
401 Jersey
631 Jewish Palestine
127 Johnston Atoll
625 Jordan
453 Jugoslavia

K
539 Kameroon
663 Kampuchea
065 Kansas
634 Kazakh S.S.R.
634 Kazakhstan
047 Kentucky
575 Kenya
634 Kirghiz S.S.R.
122 Kiribati
695 Korea
695 Korea, North
695 Korea, South
629 Kuwait
634 Kyrgystan
634 Kyrgyz

L
221 Labrador
661 Laos
420 Lapland, NOS
265 Latin America, NOS
459 Latvia
459 Latvian S.S.R. (Latvia)
623 Lebanon
245 Leeward Island, NOS
545 Lesotho
539 Liberia
517 Libya
437 Liechtenstein
122 Line Islands, Southern
461 Lithuania
461 Lithuanian S.S.R. (Lithuania)
073 Louisiana
434 Luxembourg

M
686 Macao
686 Macau
453 Macedonia

SEER GEOCODES

555 Madagascar
445 Madeira Islands
002 Maine
555 Malagasy Republic
551 Malawi
671 Malay Peninsula
671 Malaysia
640 Maldives
520 Mali
491 Malta
224 Manitoba
129 Mariana Islands
221 Maritime Provinces, Canada
131 Marshall Islands
245 Martinique
021 Maryland
005 Massachusetts
520 Mauritania
580 Mauritius
580 Mayotte
490 Mediterranean Islands, Other
721 Melanesian Islands
610 Mesopotamia, NOS
230 Mexico
041 Michigan
123 Micronesian Islands
640 Mid-East Asia
132 Midway Islands
052 Minnesota
249 Miquelon
039 Mississippi
063 Missouri
456 Moldavia
456 Moldavian S.S.R.
456 Moldova
441 Monaco
691 Mongolia
056 Montana
453 Montenegro
245 Montserrat
452 Moravia
511 Morocco
080 Mountain States
553 Mozambique
629 Muscat
649 Myanmar (see Burma)

SEER GEOCODES

N
545 Namibia
133 Nampo-shoto, Southern
545 Natal
723 Nauru
610 Near-East Asia
067 Nebraska
643 Nepal
432 Netherlands
245 Netherlands Antilles
332 Netherlands Guiana
085 Nevada
245 Nevis
221 New Brunswick
725 New Caledonia
001 New England
673 New Guinea, except Australian and North East
711 New Guinea, Australian
711 New Guinea, North East
003 New Hampshire
721 New Hebrides
008 New Jersey
086 New Mexico
011 New York
715 New Zealand
221 Newfoundland
255 Nicaragua
520 Niger
531 Nigeria
715 Niue
510 North Africa, NOS
260 North America, NOS (use more specific term if possible)
240 North American Islands
671 North Borneo (Malaysia)
025 North Carolina
040 North Central States
054 North Dakota
711 North East New Guinea
695 North Korea
010 North Mid-Atlantic States
499 Northern Europe, NOS
404 Northern Ireland
129 Northern Mariana Islands
050 Northern Midwest States
549 Northern Rhodesia
711 Norfolk Island
225 Northwest Territories (Canada)
423 Norway

SEER GEOCODES

998 Not United States, NOS
221 Nova Scotia
227 Nunavut
551 Nyasaland

O
720 Oceania
043 Ohio
075 Oklahoma
629 Oman
223 Ontario
545 Orange Free State
095 Oregon
403 Orkney Islands

P
120 Pacific area, U.S. possessions
720 Pacific Islands
123 Pacific Islands, Trust Territory of the (code to specific islands if possible)
090 Pacific Coast States
639 Pakistan
645 Pakistan, East
639 Pakistan, West
139 Palau (Trust Territory of the Pacific Islands)
625 Palestine, Arab
631 Palestine, Jewish
631 Palestine, NOS
631 Palestinian National Authority--PNA
257 Panama
711 Papua New Guinea
371 Paraguay
014 Pennsylvania
629 People's Democratic Republic of Yemen
682 People's Republic of China
637 Persia
629 Persian Gulf States, NOS
351 Peru
675 Philippine Islands
675 Philippines
122 Phoenix Islands
725 Pitcairn Islands
451 Poland
725 Polynesian Islands
445 Portugal
539 Portuguese Guinea
224 Prairie Provinces, Canada
221 Prince Edward Island
543 Principe

SEER GEOCODES

101 Puerto Rico

Q
629 Qatar
222 Quebec

R
684 Republic of China
545 Republic of South Africa
580 Reunion
006 Rhode Island
547 Rhodesia
549 Rhodesia, Northern
547 Rhodesia, Southern
539 Rio Muni
440 Romance-language Countries
449 Romania
449 Roumania
577 Ruanda
449 Rumania
455 Russia, NOS
457 Russia, White
455 Russian Federation (former U.S.S.R.)
455 Russian S.F.S.R.
577 Rwanda
134 Ryukyu Islands (Japan)

S
520 Sahara, Western (Spanish)
121 Samoa, American
725 Samoa, Western
245 St. Christopher-Nevis
580 St. Helena
245 St. Kitts
245 St. Lucia
249 St. Pierre
245 St. Vincent
447 San Marino
543 Sao Tome
447 Sardinia
224 Saskatchewan
629 Saudi Arabia
420 Scandinavia
403 Scotland
539 Senegal
453 Serbia

SEER GEOCODES

580 Seychelles
403 Shetland Islands
651 Siam
447 Sicily
539 Sierra Leone
643 Sikkim
671 Singapore
450 Slavic Countries
453 Slavonia
452 Slovak Republic
452 Slovakia
453 Slovenia
721 Solomon Islands
581 Somali Republic
581 Somalia
581 Somaliland
583 Somaliland, French
540 South Africa
545 South Africa, Republic of
545 South Africa, Union of
300 South America
380 South American Islands
026 South Carolina
055 South Dakota
695 South Korea
020 South Mid-Atlantic States
545 South West Africa
650 Southeast Asia
030 Southeastern States
499 Southern Europe, NOS
122 Southern Line Islands
070 Southern Midwest States
133 Southern Nampo-shoto
547 Southern Rhodesia
629 Southern Yemen – Soviet Union (see individual republics)
443 Spain
520 Spanish Sahara
647 Sri Lanka (see Ceylon)
520 Sudan (Anglo-Egyptian Sudan)
520 Sudanese Countries
673 Sumatra
332 Suriname
423 Svalbard
135 Swan Islands
545 Swaziland
427 Sweden
435 Switzerland
621 Syria

SEER GEOCODES

634 Tadzhik S.S.R.
684 Taiwan
634 Tajikistan
571 Tanzania
571 Tanganyika
571 Tanzanyika
031 Tennessee
077 Texas
651 Thailand (Siam)
685 Tibet
245 Tobago
023 Virginia
539 Togo
136 Tokelau Islands
725 Tonga
665 Tonkin
625 Trans-Jordan
545 Transkei
545 Transvaal
449 Transylvania
245 Trinidad
517 Tripoli
517 Tripolitania
629 Trucial States
515 Tunisia
611 Turkey
634 Turkmen S.S.R.
634 Turkmenistan
245 Turks Islands
125 Tuvalu

U
573 Uganda
456 Ukraine
456 Ukranian S.S.R.
404 Ulster
545 Union of South Africa
—— Union of Soviet Socialist Republics (U.S.S.R.) (see individual republics)
629 United Arab Emirates
519 United Arab Republic
400 United Kingdom
000 United States
102 U.S. Virgin Islands
999 Unknown
520 Upper Volta
375 Uruguay
579 Urundi
084 Utah

SEER GEOCODES

634 Uzbekistan
634 Uzbek S.S.R.

V
721 Vanuatu
447 Vatican City
545 Venda
321 Venezuela
004 Vermont
665 Vietnam
245 Virgin Islands (British)
102 Virgin Islands (U.S.)

W
137 Wake Island
402 Wales
449 Wallachia
721 Wallis
093 Washington (state)
022 Washington D.C.
530 West Africa, NOS
539 West African Countries, other
631 West Bank
431 West Germany
245 West Indies, NOS (see also individual islands)
639 West Pakistan
024 West Virginia
499 Western Europe, NOS
520 Western (Spanish) Sahara
725 Western Samoa
457 White Russia
245 Windward islands
051 Wisconsin
082 Wyoming

Y
629 Yemen
629 Yemen, People's Democratic Republic of
453 Yugoslavia (former Yugoslavia region)
225 Yukon Territory

Z
541 Zaire
549 Zambia
571 Zanzibar
547 Zimbabwe

APPENDIX D - WEBSITES FOR THE CANCER REGISTRAR

American Association for Cancer Education
http://www.aaceonline.com

American Cancer Society
http://www.cancer.org/docroot/home/index.asp

American College of Surgeons (ACoS) - Commission on Cancer (COC)
http://www.facs.org

Breast Cancer Site
http://www.thebreastcancersite.com

Centers for Disease Control and Prevention (CDC&P)
http://www.cdc.gov/cancer
http://www.cdc.gov/cancer/npcr

Collaborative Staging Manual (download)
http://www.cancerstaging.org/cstage/manuals

Leukemia and Lymphoma Society
http://www.leukemia-lymphoma.org

National Cancer Institute
http://www.nci.nih.gov

National Cancer Registrars Association
http://www.ncra-usa.org

North American Association of Central Cancer Registries (NAACCR)
http://www.naaccr.org

Oklahoma Cancer Registrars Association
http://www.ocra-ok.org

Oklahoma State Health Department
http://www.health.state.ok.us

Surveillance, Epidemiology, and End Results (SEER)
http://www.seer.cancer.gov

APPENDIX E - RMCDS COMPUTER SYSTEM REQUIREMENTS

System Requirements

The RMCDS software can be run on a single user machine or a network. All data and programs are on your local computer or network.

The system has all of the data items required by the SEER program, the North American Association of Central Cancer Registries, the National Program for Cancer Registries (CDC) and the American College of Surgeons. In addition there are a number of fields that can be customized specifically for your registry.

Hardware and Software Specifications for the RMCDS Windows System

Processor: Pentium

Operating System: Windows 98, NT, ME, 2000, XP

Machine speed: 450 MHz or Greater

Memory: 64 MB (Recommend: 128 MB)

Disk Space for Registry: 2 GB for hospitals (This is primarily for future expansion) Central Registries please contact RMCDS.

Monitor: 17" Monitor or larger recommended

Screen Resolution minimum 800x600

CD ROM

Recommend: Internet access

Recommend: Printer - Laser or Inkjet either attached or accessible through the network

We also recommend that users take a training course to learn how to use their email, Microsoft Office products, and Internet browsers.

We also have the ability to interface with both MS Excel and Corel Quattro Pro for graphing purposes. If you are going to be using either of these products, we suggest that you take a training course. RMCDS does not provide software support for third party software