
HISTOLOGY (92-00) ICD-O-2Item Length: 4
NAACCR Item #420**ACR Required Data Item**

For cases diagnosed prior to 1/1/2001.

Description

Codes for the histologic type of the tumor being reported using ICD-O-2.

Rationale

Histology is a basis for staging and the determination of treatment options. It also affects the prognosis and course of the disease.

Instructions for Coding

- Record the histology using the ICD-O-2 codes in the Numeric Lists/Morphology section and/or the Alphabetic Index of ICD-O-2.
- Do not record the “M” preceding the code number.
- Follow the coding rules outlined on pages xv-xliii of ICD-O-2.
- Review all pathology reports.
- Code the final pathologic diagnosis.

Note #1: Refer to p. 93 for more information.

Note #2: Cases diagnosed prior to January 1, 2001 must have the following data items coded related to histology:

Histology (92-00) ICD-O-2 (NAACCR Item #420)

Behavior (92-00) ICD-O-2 (NAACCR Item #430)

Cases diagnosed on or after January 1, 2004, must have the following data items coded related histology:

Histology Type ICD-O-3 (NAACCR Item #522)

Behavior Code ICD-O-3 (NAACCR Item #523)

Note #3: Some software vendors autocode the non-applicable histology and behavior items. For example, the histology for a 2000 case would be entered in NAACCR Items #420 & #430. The vendor may autocode NAACCR Items #522 & #523. Caution: if a change is made in the histology once it has been autocoded, some software vendors may not correct the other histology that is coded.

BEHAVIOR (92-00) ICD-O-2Item Length: 1
NAACCR Item #430**ACR Required Data Item**For cases diagnosed prior to 1/1/2001.

Description

Code for the behavior of the tumor being reported using ICD-O-2.

Rationale

Assists the ACR in calculating timeliness and completeness.

Instructions for Coding

- Valid codes are 0-3. See ICD-O-2, p. 22 for behavior codes and definitions.
- Code “3” if any invasion is present, no matter how limited.
- If the specimen is from a metastatic site, code the histology of the metastatic site and code “3” for behavior.

Note: Refer to p. 94 for more information.

Note #2: Cases diagnosed prior to January 1, 2001 must have the following data items coded related to histology:

Histology (92-00) ICD-O-2 (NAACCR Item #420)

Behavior (92-00) ICD-O-2 (NAACCR Item #430)

Cases diagnosed on or after January 1, 2004, must have the following data items coded related histology:

Histology Type ICD-O-3 (NAACCR Item #522)

Behavior Code ICD-O-3 (NAACCR Item #523)

Note #3: Some software vendors autocode the non-applicable histology and behavior items. For example, the histology for a 2000 case would be entered in NAACCR Items #420 & #430. The vendor may autocode NAACCR Items #522 & #523. Caution: if a change is made in the histology once it has been autocoded, some software vendors may not correct the other histology that is coded.

TUMOR MARKER 1**ACR Required Data Item**

For cases diagnosed prior to 1/1/2004.

Item Length: 1

Allowable Codes: 0-6, 8, 9

Left Justified

NAACCR Item #1150

**ACR Required Data Item
for ERA only**

Description

Records laboratory test results that are considered prognostic indicators for specific sites or histologies.

Rationale

Useful in evaluating the relationships between tumor markers and patients' prognosis.

Instructions for Coding

Enter the code which describes the results of testing for the tumor markers listed below.

- 0 None Done
- 1 Positive/Elevated
- 2 Negative/Normal
- 3 Borderline; undetermined whether positive or negative

Three-tiered system:

- 4 Range 1 (S1)
- 5 Range 2 (S2)
- 6 Range 3 (S3)

- 8 Ordered, but results not in chart
- 9 Unknown or no information

For sites for which Tumor Marker is not collected:

- 9 Not Applicable

TUMOR MARKER 2**ACR Required Data Item**

For cases diagnosed prior to 1/1/2004.

Item Length: 1

Left Justified

NAACCR Item #1160

**ACR Required Data Item
For PRA only**

Description

Records laboratory test results that are considered prognostic indicators for specific sites or histologies.

Rationale

Useful in evaluating the relationships between tumor markers and patients' prognosis.

Instructions for Coding

Enter the code which describes the results of testing for the tumor markers listed below.

- 0 None Done
- 1 Positive/Elevated
- 2 Negative/Normal
- 3 Borderline; undetermined whether positive or negative

Three-tiered system:

- 4 Range 1 (S1)
- 5 Range 2 (S2)
- 6 Range 3 (S3)

- 8 Ordered, but results not in chart
- 9 Unknown or no information

For sites for which Tumor Marker is not collected:

- 9 Not Applicable

SEER SUMMARY STAGE 1977Item Length: 1
NAACCR Item #760**ACR Required Data Item**

For cases diagnosed prior to 1/1/2001.

Description

Code for Summary Stage at the initial diagnosis or treatment of the reportable tumor. This has traditionally been used by central registries to monitor time trends. For hospital registries, the COC requires summary staging in the absence of an AJCC staging scheme.

Note: SEER Summary Stage 1977 is limited to information available within two months of the date of diagnosis. This time period was extended to 4 months for prostate cancer cases diagnosed beginning January 1, 1996.

Rationale

Stage information is important when evaluating the effects of cancer control programs. It is crucial for understanding whether changes over time in incidence rates or outcomes are due to earlier detection of the cancers. In addition, cancer treatment cannot be studied without knowing the stage at diagnosis. To study historical trends in stage, the coding system must be relatively unchanged (stable) over time. AJCCs TNM system is updated periodically to maintain clinical relevance with changes in diagnosis and treatment. Surveillance registries often rely on the Summary Stage, which they consider to be more stable. Summary Stage has been in widespread use either as the primary or secondary staging scheme, in most hospital and central registries since 1977.

Instructions for Coding

Record the code that reflects the summary stage at the time of the initial diagnosis or treatment of the reportable tumor.

- 0 *In situ*
- 1 Localized
- 2 Regional—direct extension only
- 3 Regional—regional lymph nodes only
- 4 Regional—direct extension and regional lymph nodes
- 5 Regional, NOS
- 7 Distant
- 9 Unstaged

Note #1: The year in which the cancer was diagnosed determines which code manual and data item will be used for Summary Stage:

- Cancers diagnosed before January 1, 2001 should be assigned a summary stage according to SEER Summary Staging Guide 1977, and the code should be reported as SEER Summary Stage 1977 (NAACCR data item #760).
- Cancers diagnosed from January 1, 2001 to present should be assigned a summary stage according to the SEER Summary Staging Guide 2000, and the code should be reported in data item #759.
- Cases diagnosed on or after 1/1/2004 will *not* be required to code Summary Stage 2000 (NAACCR Item #759). SS2000 will be based on the Collaborative Stage algorithms and recorded in data item #3020 (Derived Item SS2000). Except as noted below.

Note #2: Effective with cases (NON-ANALYTIC) diagnosed on or after 1/1/2004, the ACR will continue to require Summary Stage 2000 and all TNM elements in addition to Collaborative Staging. Usually non-analytic cases contain incomplete information. On non-analytic cases, physicians are more likely to provide Summary Stage and TNM as opposed to providing the specific information needed for Collaborative Staging. This requirement is necessary in order to provide complete staging information for the State of Arizona.

SITE OF DISTANT MET 1

Item Length: 1

Allowable Codes: 0-9

NAACCR Item #1090

ACR Required Data Item

For cases diagnosed prior to 1/1/2004.

Description

Codes for a site of distant metastasis at the time of initial diagnosis. There are three individual fields, each with a 1-digit code for a site of metastasis.

Rationale

Allows for interfield edits related to staging at reporting facilities and the central registry. Assists in visual quality control related to staging.

Instructions for Coding

Code only the site(s) of distant metastasis identified during initial diagnosis and workup. Do not update this field over the course of the patient's disease. Use the [AJCC Cancer Staging Manual](#) to identify distant sites. Cases with sites of distant metastasis would be coded M1. If there are more than three sites of distant metastasis, code three of the sites. Record a zero if there are no distant metastases. Record "9" if carcinomatosis is present, for disseminated disease, leukemias, and if the site is unknown. Do not code specific sites for unknown primaries.

- 0 None
- 1 Peritoneum
- 2 Lung
- 3 Pleura
- 4 Liver
- 5 Bone
- 6 Central Nervous System
- 7 Skin
- 8 Lymph Nodes (distant)
- 9 Other, generalized, carcinomatosis, disseminated, not specified, unknown

**SITE OF DISTANT METASTASIS #1
(Continued)**

Item Length: 1
Allowable Codes: 0-9
NAACCR Item #1090

ACR Required Data Item

For cases diagnosed prior to 1/1/2004.

Clarification of code definitions:

CODES	DEFINITIONS
0	No distant metastases present.
1	Peritoneum, including peritoneal surfaces within the abdominal cavity and/or positive ascitic fluid.
2	Lung, including the visceral pleura.
3	Pleura, including the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
4	Liver only.
5	Bones other than the primary site.
6	Includes brain and spinal cord, but NOT the external eye.
7	Skin other than the primary site.
8	Includes lymph nodes not classified as regional. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site. (Use the AJCC Cancer Staging Manual to identify distant nodes.)
9	Bone marrow metastases, carcinomatosis, generalized disease, unknown primary.

A biopsy may distinguish the source of distant disease in a patient with multiple primaries. If there is no histologic or cytologic confirmation, consult the physician to help identify which primary has metastasized. If the physician is unable to decide which primary has metastasized, code both primaries as having metastatic disease. If at a later date, the primary is identified, update the codes as appropriate.

SITE OF DISTANT MET 2

Item Length: 1

Allowable Codes: 0-9

NAACCR Item #1100

ACR Required Data Item

For cases diagnosed prior to 1/1/2004.

Description

Codes for a site of distant metastasis at the time of initial diagnosis. There are three individual fields, each with a 1-digit code for a site of metastasis.

Rationale

Allows for interfield edits related to staging at reporting facilities and the central registry. Assists in visual quality control related to staging.

Instructions for Coding

Code only the site(s) of distant metastasis identified during initial diagnosis and workup. Do not update this field over the course of the patient's disease. Use the [AJCC Cancer Staging Manual](#) to identify distant sites. Cases with sites of distant metastasis would be coded M1. If there are more than three sites of distant metastasis, code three of the sites. Record a zero if there are no distant metastases. Record "9" if carcinomatosis is present, for disseminated disease, leukemias, and if the site is unknown. Do not code specific sites for unknown primaries.

- 0 None
- 1 Peritoneum
- 2 Lung
- 3 Pleura
- 4 Liver
- 5 Bone
- 6 Central Nervous System
- 7 Skin
- 8 Lymph Nodes (distant)
- 9 Other, generalized, carcinomatosis, disseminated, not specified, unknown

SITE OF DISTANT MET 3

Item Length: 1

Allowable Codes: 0-9

NAACCR Item #1110

ACR Required Data Item

For cases diagnosed prior to 1/1/2004.

Description

Codes for a site of distant metastasis at the time of initial diagnosis. There are three individual fields, each with a 1-digit code for a site of metastasis.

Rationale

Allows for interfield edits related to staging at reporting facilities and the central registry. Assists in visual quality control related to staging.

Instructions for Coding

Code only the site(s) of distant metastasis identified during initial diagnosis and workup. Do not update this field over the course of the patient's disease. Use the [AJCC Cancer Staging Manual](#) to identify distant sites. Cases with sites of distant metastasis would be coded M1. If there are more than three sites of distant metastasis, code three of the sites. Record a zero if there are no distant metastases. Record "9" if carcinomatosis is present, for disseminated disease, leukemias, and if the site is unknown. Do not code specific sites for unknown primaries.

- 0 None
- 1 Peritoneum
- 2 Lung
- 3 Pleura
- 4 Liver
- 5 Bone
- 6 Central Nervous System
- 7 Skin
- 8 Lymph Nodes (distant)
- 9 Other, generalized, carcinomatosis, disseminated, not specified, unknown

RX HOSP-SURG SITE 98-02**ACR Required Data Item**

For cases diagnosed prior to 1/1/2003.

Item Length: 2

Allowable Codes:

Site-Specific

Numeric

NAACCR Item #746

Description

Describes the surgical procedures used to treat the primary site of the reportable tumor. This item records that portion of the first course of treatment given at the *reporting facility*.

RX SUMM-SURG SITE 98-02**ACR Required Data Item**

For cases diagnosed prior to 1/1/2003.

Item Length: 2

Allowable Codes:

Site-Specific

Numeric

NAACCR Item #1646

Description

Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment. This includes treatment given at *all facilities* as part of the first course of treatment.

For **RX HOSP-SURG SITE 98-02 (Item# 746)** and **RX SUMM-SURG SITE 98-02 (Item# 1646):**

Requirements

All treatment given at the reporting facility and other known treatment given elsewhere is required to be reported. The software vendor used by the reporting facility must provide for the ability to code treatment at your facility and elsewhere.

For cases diagnosed before January 1, 2003, coding the above listed data items is required in addition to coding the current item: "RX SUMM-SURG PRIM SITE," NAACCR Item# 1290 and "RX HOSP-SURG PRIM SITE," NAACCR Item# 670.

Codes

See the ACR Coding Handbook: CoC ROADS Manual, 1998 Supplement, for site-specific codes.

RX HOSP-SCOPE REG 98-02**ACR Required Data Item**

For cases diagnosed prior to 1/1/2003.

Item Length: 1

Allowable Codes:

Site-Specific

Numeric

NAACCR Item #747

Description

Describes the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at the *reporting facility*.

RX SUMM-SCOPE REG 98-02**ACR Required Data Item**

For cases diagnosed prior to 1/1/2003.

Item Length: 1

Allowable Codes:

Site-Specific

Numeric

NAACCR Item #1647

Description

Describes the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at *all facilities*.

For **RX HOSP-SCOPE REG 98-02 (Item# 747)** and **RX SUMM-SCOPE REG 98-02 (Item# 1647)**:

Requirements

All treatment given at the reporting facility and other known treatment given elsewhere is required to be reported. The software vendor used by the reporting facility must provide for the ability to code treatment at your facility and elsewhere.

For cases diagnosed before January 1, 2003, coding the above listed data items is required in addition to coding the current item: “RX SUMM-SCOPE REG LN SURG,” NAACCR Item# 1292 and “RX HOSP-SCOPE REG LN SUR,” NAACCR Item# 672.

Codes

See the ACR Coding Handbook: CoC ROADS Manual, 1998 Supplement, for site-specific codes.

RX HOSP-SURG OTH 98-02**ACR Required Data Item**

For cases diagnosed prior to 1/1/2003.

Item Length: 1
 Allowable Codes:
 Site-Specific
 Numeric
 NAACCR Item #748

Description

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

RX SUMM-SURG OTH 98-02**ACR Required Data Item**

For cases diagnosed prior to 1/1/2003.

Item Length: 1
 Allowable Codes:
 Site-Specific
 Numeric
 NAACCR Item #1648

Description

Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site given at *all facilities* as part of the first course of treatment.

For **RX HOSP-SURG OTH (Item# 748)** and **RX SUMM-SURG OTH 98-02 (Item# 1648)**:

Requirements

All treatment given at the reporting facility and other known treatment given elsewhere is required to be reported. The software vendor used by the reporting facility must provide for the ability to code treatment at your facility and elsewhere.

For cases diagnosed before January 1, 2003, coding the above listed data items is required in addition to coding the current item: “RX SUMM-SURG OTH REG/DIS,” NAACCR Item# 1294 and “RX HOSP-SURG OTH REG/DIS,” NAACCR Item# 674.

Codes

See the ACR Coding Handbook: CoC ROADS Manual, 1998 Supplement, for site-specific codes.

RX SUMM-RECONSTRUCT 1ST**ACR Required Data Item**

For cases diagnosed prior to 1/1/2003.

Item Length: 1

Allowable Codes:

Site-Specific

Numeric

NAACCR Item #1330

Description

Codes for surgical procedures done to reconstruct, restore, or improve the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or cancer-directed therapies. Reconstructive/restorative procedures are coded here when started during the first course of cancer-directed therapy.

Codes

See the ACR Coding Handbook: CoC ROADS Manual, 1998 Supplement, for site-specific codes.

RX SUMM-SURGICAL APPROACH**ACR Required Data Item**

For cases diagnosed prior to 1/1/2003.

Item Length: 2

Allowable Codes:

Site-Specific

Numeric

NAACCR Item #1310

Description

Codes for method used to approach the surgical field for the primary site. CoC requires coding for tumors diagnosed 1996 and forward.

Codes

See the ACR Coding Handbook: CoC ROADS Manual, 1998 Supplement, for site-specific codes.

RX HOSP-REG LN REMOVED**ACR Required Data Item**

For cases diagnosed prior to 1/1/2003.

Item Length: 2

Allowable Codes:

Site-Specific

Numeric

NAACCR Item #676

Description

Describes number of regional lymph nodes removed as part of the first course of treatment. This item reflects that portion of the first course of treatment given at the *reporting facility*.

RX SUMM-REG LN EXAMINED**ACR Required Data Item**

For cases diagnosed prior to 1/1/2003.

Item Length: 2

Allowable Codes:

Site-Specific

Numeric

NAACCR Item #1296

Description

Codes for the number of regional lymph nodes examined in conjunction with surgery performed as part of the first-course treatment. This includes treatment given at *all facilities* as part of the first course of treatment.

For **RX HOSP-REG LN REMOVED (Item# 676)** and **RX SUMM-REG LN EXAMINED (Item# 1296)**:

Requirements

All treatment given at the reporting facility and other known treatment given elsewhere is required to be reported. The software vendor used by the reporting facility must provide for the ability to code treatment at your facility and elsewhere.

For cases diagnosed before January 1, 2003, coding the above listed data items is required in addition to coding the current item: "REGIONAL NODES EXAMINED," NAACCR Item# 830.

Codes

See the ACR Coding Handbook: CoC ROADS Manual, 1998 Supplement, for site-specific codes.

RMCDS FIELD: “OLD-SURG MARGINS”

Found on p. 34 of
Screen: 90 ALL FIELDS

ACR Required Data Item

For cases diagnosed prior to 1/1/2003.

Description

Codes describe the final status of surgical margins after resection of the primary tumor.

Requirements

For cases diagnosed before January 1, 2003, coding the above listed data item is required in addition to coding the current item: “RX SUMM-SURGICAL MARGINS,” NAACCR Item #1320.

Codes

See the ACR Coding Handbook: CoC ROADS Manual, 1998 Supplement, for site-specific codes.