VISUAL EDITING GUIDELINES

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DATA ITEM	DESCRIPTION	REFERENCES
1) County of Residence at Diagnosis	o Is the city in the County?	https://tools.usps.com/go/ZipLookupAction!input.action
2) Behavior	o For cases with in situ and invasive behavior is /3 coded? o If the pathology report states behavior is in situ (/2) and the ICD-0-3 histology lists only a malignant (/3) behavior, is the behavior coded to in situ (/2)? o A behavior code of /2 must be pathologic o If the pathology report states behavior is malignant (/3) and the ICD-0-3 histology lists only an in situ (/2) behavior, is the behavior coded to malignant (/3)? o Are the synonyms for in situ (/2) coded? • AIN III (C211) • Behavior code '2' • Bowen disease (not reportable for C440-C449) • Clark level I for melanoma (limited to epithelium) • Confined to epithelium • Hutchinson melanotic freckle, NOS (C44_) • Intracystic, non-infiltrating(carcinoma) • Intraductal (carcinoma) • Intraepidermal, NOS (carcinoma) • Intraepithelial,NOS (carcinoma) • Involvement up to, but not including the basement membrane • Lentigo maligna (C44_) • LIN III (C320-C329) • Lobular, noninfiltrating (C50_) (carcinoma) • Noninfiltrating (carcinoma)	SEER Program Staging and Coding Manual Volume I, Section V.3.4.2

DATA ITEM	DESCRIPTION	REFERENCES
	• Noninvasive (carcinoma) • No stromal invasion/involvement • Papillary, noninfiltrating or intraductal (carcinoma) • Precancerous melanosis (C44_) • Queyrat erythroplasia (C60_) • SIN III • Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the ▪ lamina propria) ▪ VAIN III (C52.9) ▪ VIN III (C51_) o Is the term microinvasion in the pathology report coded as malignant (/3)? o For intracranial and CNS tumors, the WHO grade cannot be used to code behavior.	
3) Race Fields 1-5	o Required on all cases. Cannot be blank, but can be code 99, Unknown. If no information in medical record, a statement documenting no information should be documented in Remarks. o If Race is coded to code 98, Other, is the specific race code documented in Remarks? o Code 98, Other Race, is not to be used if the Face Sheet states "other" or "other race". If the only information available is these statements, the medical record should be reviewed for a specific race. If no other information is available code 99 should be used. Code 98 should only be used in	Volume 1, Section III.2.9 New Instruction with 2013 Volume I release for "Other Race"

DATA ITEM	DESCRIPTION	REFERENCES
	the event a specified race is identified with no corresponding code. o If there is conflicting Race information, i.e. Last Name vs. Race vs. Place of Birth, is there clarification in Remarks? o Birthplace may be used as one factor to determine race. o If a person's race is a combination of white and any other race(s), the other race(s) should be coded first and white should be coded as the next race field. o If a person's race is a combination of Hawaiian and any other races, Race 1 should be coded as Hawaiian (07) and the other races coded in Race 2, Race 3, Race 4, and Race 5 as appropriate.	
4) Spanish/Hispanic Origin	o Is patient name a Spanish Surname? (See Appendix O). o Review Race and Place of Birth. If a female patient is coded to Hispanic, NOS, a statement documenting that patient is Hispanic must be recorded in Remarks. o If patient is coded to Mexican, and Place of Birth is unknown, a statement documenting that patient is Mexican must be recorded in Remarks.	Volume 1, Section III.2.9.2, Appendix O
5) Date of Diagnosis	o Does the date reflect the earliest date stating malignancy by a physician, surgeon or dentist using reportable terms (Volume I, II.6.1)?	Volume 1, Section III.3.3 – III.3.3.4 and DSQC Memo #2011-04

DATA ITEM	DESCRIPTION	REFERENCES
6) Site/Sub-site*	o Is the primary site coded to where the tumor originated, even if it extends into an adjacent sub-site? o Is the code supported by documentation from the physical exam, x-rays, operative and pathology reports? o Is the primary site consistent with the histologic type? o Is the last digit of the primary site code '8' for overlapping sub-site, breast midline tumors and origin unknown and is it documented in the abstract text? o Is the last digit of the primary site coded '9' for single primaries, when multiple tumors arise in different sub-sites of the same anatomic site and point of origin can't be determined? Is it documented in text from operative findings, pathology or other work-up? o For hematopoietic sites, refer to the Multiple Primary and Histology (MPH) Manual for verification of site codes. o For a metastatic melanoma of unknown primary, is the site coded to C44.9 (Skin, NOS)? o If this is a Gastrointestinal Stromal Tumor (GIST), is it coded to the location where the malignant GIST originates?	Volume I, Section V.1 Volume I, Section V.1.4 SEER Program Coding Staging Manual, Appendix C, Site Specific Coding Modules
7) Diagnostic Confirmation	o Does the code reflect the most conclusive method used to confirm the presence of the cancer being reported? o The lowest numeric number takes precedence when the cancer is confirmed by multiple	Volume 1, Section IV.2

DATA ITEM	DESCRIPTION	REFERENCES
	diagnostic methods. Diagnostic confirmation is NOT limited to the confirmation at the time of diagnosis. o If at ANY TIME during the course of disease the patient has a diagnostic confirmation with a higher priority, change to a lower code. o For cases diagnosed 1/1/2010 and later, code 3 "Positive Histology Plus Positive Immunophenotyping AND/OR Positive Genetic Studies" was added. This code is to be used for hematopoietic and lymphoid neoplasms only (9590/3-9992/3). o Bone marrow aspirations are to be coded 1, Positive Histology. Positive blood count (CBC or peripheral blood) are to be coded to 1, Positive Histology, for leukemia only.	
8) Laterality (Only paired sites listed in Volume I)	o Is Laterality coded using codes **1-9** for all sites listed in Volume I, Section V.2.2 Principal Paired Sites (Laterality Required)**?** o Is Laterality coded for malignant and benign/borderline brain and CNS tumors listed in Volume 1, Section V.2.1? o Is the Laterality code supported by documentation from the physical exam, x-rays, operative and pathology reports? o If the tumor originates in the midline of a paired organ or site, is Laterality coded to 5, midline? o If the laterality is not known but the tumor is confined to a single side of the paired organ, is Laterality coded 3? o Is Laterality coded to 4 – Both sides involved but	Volume I, Section V.2

DATA ITEM	DESCRIPTION	REFERENCES
	origin is unknown. Bilateral Simultaneous for the following tumors: 1) Both ovaries involved simultaneously, single histology 2) Diffuse bilateral lung nodules 3) Bilateral retinoblastomas 4) Bilateral Wilms tumors? o If 1) Laterality is unknown AND 2) there is no statement that only one side of a paired organ is involved, is Laterality coded to 9? o Laterality is coded to 0, Not Paired, for cases with primary site Unknown, C80.9.	
9) Histology – Type (for year of diagnosis)	o Is the histology based on the information from the pathology report? Or in the absence of a report, based on the information from the physician? o Is this a reportable case? o If cytology is reported as "suspicious", do not interpret this as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings. o A cytologically confirmed case with a negative biopsy must be evaluated carefully. If the biopsy rules out the presence of cancer, do not report the case. But if a negative biopsy does not rule out the presence of cancer, the case is considered to be cytologically confirmed and is reportable. o For benign and borderline brain and CNS tumor, is this a reportable histology? o For borderline ovarian tumors, is this a reportable histology?	Volume 1, Section II.1.6.2 and Section II.1.6.3 Volume 1, Section V.3; V.3.1-V.3.3.7 For Benign and Borderline Brain & CNS tumors, Volume 1, Section II.1.9 & Appendix V ICD-O-3 Manual For Borderline Ovarian tumors- ICD-O-3, Appendix 6 Multiple Primary and Histology Coding Rules Manual Hematopoietic and Lymphoid Neoplasms Manual and Database

DATA ITEM	DESCRIPTION	REFERENCES
	o For most histologies, refer to ICD-O-3 manual for the correct codes. o Refer to the MP/H Manual for instructions on coding histology and determining single or multiple primaries. o For hematopoietic and lymphoid neoplasms, DO NOT USE ICD-O-3 to code the histology. Refer to the Hematopoietic Manual and Database for coding histology and determining single or multiple primaries. o For Prostate cancers, acinar adenocarcinoma should be coded as adenocarcinoma, NOS, 8140/3, per MPH manual Rule H10. o Cancer; Malignancy, NOS = 8000/3. o Carcinoma = 8010/3.	
10) Grade	**For solid tumors diagnosed 01/01/2014 forward, see Volume I, Section V.3.7;V3.7.1-V3.7.7** **The following applies for cases diagnosed through 12/31/2013**. o Is the grade justified in the pathology report? o Is the code the highest grade, even if it does not represent the majority of the neoplasm? o Grade given in a histologic specimen takes precedence over one stated in a cytologic specimen.	Volume 1, Section V.3.5 ICD-O-3 Manual Hematopoietic and Lymphoid Neoplasms Manual and Database

DATA ITEM	DESCRIPTION	REFERENCES
	o Grade from an invasive tumor is taken over the grade for an in situ tumor. o Enter the code with the highest number, even if it does not represent the majority of the neoplasm. o If no grade is given, code 9 should be used unless there is a statement of grade in the microscopic description of the report. o Do not code the grade from a metastatic site, which includes a lymph node(s). o Refer to Volume I for special grading systems and priority order for prostate, breast and kidney tumors. o Do not use FIGO Grade or WHO grade to code this field. o **For hematopoietic and lymphoid neoplasms, use the Hematopoietic and Lymphoid Neoplasm Manual's "Grade of Tumor Rules".** o If Primary Site is unknown, then code grade as 9, Unknown. o For in situ bladder cancers histology codes 8120/2 and 8130/2, code grade as 9, Unknown, unless a grade is stated by the pathologist. o If the patient receives neoadjuvant therapy, code the grade from the pathology report prior to treatment. Code 9, Unknown, when the pathology is after neoadjuvant therapy or it is unknown whether the pathology is before or after therapy.	
11) CS Tumor Size**	o Required on all cases. Cannot be blank, but can be coded unknown. Tumor size is not applicable	CS Manual Part 1, Section 1 CS Tumor Size

DATA ITEM	DESCRIPTION	REFERENCES
	for some schemas and should be coded 988. o This field is used primarily to derive the staging basis for the T category in the TNM system. In most circumstances it records how the codes for the two items "CS Tumor Size" and "CS Extension" were determined, based on the diagnostic methods employed. o Document the staging basis for the farthest extension and/or greatest tumor size. **Non-Specific Size Descriptions:** o Codes 991 through 995 are non-specific size descriptions that, for some sites, could still be used to determine a T category. However, if a specific size is given, code the more precise size in the range 001-989. If the tumor is described as "greater than 5 cm" and there is not an applicable code in the site-specific schema, record as 051. **Site-Specific Special Codes**: o Other special codes in the range 996 to 997 are used on a site-specific basis. See the individual site/histology schemas for further information and definitions. **Use of Code 998**: o For certain schemas, the descriptions in code 998 take precedence over any mention of size. Code 000 indicates no mass or no tumor was found at the primary site. Example: Metastatic	

DATA ITEM	DESCRIPTION	REFERENCES
	melanoma, no primary found. Code Tumor Size to 000. Code 990, microscopic focus or foci only and no size is given, should be used when no gross tumor is seen and tumor is only identified microscopically. **Other:** o Justified in text or path text? o Is the largest dimension or diameter of the invasive primary tumor coded in millimeters? o Refer to the site/histology-schema specific instructions (notes before the table) for additional information. o Priority order in coding tumor size: path report, op report, imaging, PE o Do not code the size of an ulcer, polyp or cyst, unless stated to be a cystic mass. o Do not code size from a needle biopsy unless there is no residual tumor found on further resection. o Do not add pieces or chips together to create a whole tumor, unless the pathologist states an aggregate or composite size, then you can use that size. o Record the clinical size of tumor if the patient receives systemic therapy or radiation therapy, unless the size of tumor is larger at surgery.	

DATA ITEM	DESCRIPTION	REFERENCES
	o If there is a difference in size from imaging reports, record the largest size, regardless of which imaging technique reports it. o Document in path text "TS NR" when a definitive surgical procedure to the primary site is performed and there is no mention of tumor size. **CS Tumor Size/Ext Evaluation:** o CS Tumor Size/Ext Evaluation field with CS Tumor Size: The source of the tumor size (radiographs, endoscopy, pathology specimen, etc.) is documented in the CS Tumor Size/Ext Evaluation field when tumor size is the determining factor for the T category. o In the infrequent situation where there is both clinical and pathologic documentation of the same T category, pathologic information takes priority. o For primary sites where tumor size is the primary factor in determining the T category in TNM, code CS Tumor Size/Ext Eval on the basis of how the tumor size was determined. o For primary sites/histologies where tumor size is not a factor in determining the T category in TNM, code CS Tumor Size/Ext Eval on the basis of the CS extension field only. o For primary sites where both tumor size and extension determine the T category in TNM, select the code that best explains how the	CS Manual, Part 1, Section 1 CS Tumor Size/Ext Evaluation

DATA ITEM	DESCRIPTION	REFERENCES
	information in the CS Tumor Size and CS Extension fields were determined. o If the patient had surgery followed by other treatment(s), use code 3. o If the size or extension of the tumor determined prior to treatment was the basis for neoadjuvant therapy, use code 5. o If the size or extension of the tumor was greater after pre-surgical treatment than before treatment, use code 6.	
12) CS Extension**	Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in the CS Extension field. o Is the farthest documented extension of the primary tumor coded? o Did the patient receive neoadjuvant therapy? If so, code extension based on the clinical information unless extension is more extensive post neoadjuvant therapy. o Is all information from pathology, radiology, and PE used to code extension? o Is the extension code based on contiguous (direct) extension of tumor from the site of origin to the organ/structure/tissue? • Exceptions: mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum.	CS Manual, Part 1, Section 1 CS Extension CS Manual Part 1, Section 1 Definitions Adjacent Tissues, Structures

DATA ITEM	DESCRIPTION	REFERENCES
	o Is there ambiguous terminology used to describe extension? o Is the extension code based on using the medical record information? • If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the T category or alternative staging system stated by the physician. • If the only indication of extension in the record is the physician's statement of a T category from the TNM staging system or a stage from a site-specific staging system, such as Dukes C, code the appropriate "Stated as T_, NOS" category or record the numerically lowest equivalent extension code for the site-specific staging system. o Is the highest applicable code used? o Is the extension based on the timing rules? o For prostate cases, is only the clinical information used to code extension? Do not use biopsy information to code extension. Are clinically apparent terms and non-apparent terms used appropriately? Tumor, mass, or nodule are apparent terms.	CS Manual Part 1, Section 1 Ambiguous Terminology CS Manual Part 1, Section 1 Timing Rules
13) CS Lymph Nodes **	Identifies the Regional LNs involved with cancer at time of diagnosis. Criteria for involvement are site-specific and may include location, laterality, size and/or number of involved LNs.	CS Manual Part 1, Section 1 CS Lymph Nodes

DATA ITEM	DESCRIPTION	REFERENCES
	o Involved distant LNs are coded in Mets at Dx. **Ambiguous Terminology:** o For solid tumors the terms: fixed or matted, or mass in hilum, mediastinum, retroperitoneum and/or mesentery (with no specific information as to tissue involved) are considered involvement of LNs. Other terms such as: palpable, enlarged, visible swelling, shotty or lymphadenopathy should be ignored unless there is a statement of involvement by the clinician. **EXCEPTIONS:** • For lymphomas, any positive mention of LNs indicates involvement. • For lymphomas, these are captured in the CS extension field. For a lung primary, if the term mass, enlargement or adenopathy in the hilum or mediastinum is used, consider this involvement of regional LNs; Kaposi sarcoma and malignant lymphoma, where any mention of any of the terms above is considered LN involvement. For solid tumors, the terms “fixed” or “matted” and “mass” in the hilum, mediastinum, retroperitoneum, and/or mesentery (with no specific information as to tissue involved) are considered involvement of lymph nodes.	

DATA ITEM	DESCRIPTION	REFERENCES
	o Record the highest applicable code from information on reports in the following order: pathology report, imaging, physical exam. o Is the farthest involved regional LN from the primary site coded? (may be clinical or pathologically identified). o Is there a discrepancy between clinical info and path info about the same LNs? Path info takes precedence if no pre-op tx given. o Is the primary organ a site where the regional LNs are inaccessible? If there is no statement about regional LNs on imaging or surgery, presume the regional LNs are clinically negative. **Coding 000 vs 999:** o Does the case meet any of the following criteria: o Is there no mention of regional LN involvement in the PE, pre-tx dx testing or surgical exploration? o Does the patient have clinically low stage (T1, T2 or localized) disease? o Did the patient receive what would be usual treatment for the primary site or is offered the usual treatment but refused since it is presumed there are no regional LNs involved that would alter tx? • If the answer is yes to any of these questions, then code Reg LNs to 000	CS Manual, Part 1, Section 1 CS Lymph Node Eval

DATA ITEM	DESCRIPTION	REFERENCES
	o Is there reasonable doubt that the primary tumor is no longer localized and there is no documentation of involved regional LNs or there is no information in the medical record about regional LNS? Use code 999. o Is there direct extension from the primary tumor into a regional LN? Still code the involved LN in this field. o Is the primary a head and neck site? Coding structure for H&N sites vary. Check the specific site in the CS manual for correct codes. o Was neoadjuvant treatment given? Code the farthest involved regional LN based on info prior to surgery. o Is there more extensive regional LN involvement noted at surgery after neoadjuvant treatment was given? Code field based on path report and code the Reg LN Evaluation field to 6. o Is there a statement as to the response to treatment? If not documented, code this field based on the clinical information and Evaluation code as 5. o Is there documentation on the clinical status of lymph nodes? If not and the pathology report states involvement after treatment and clinician states there was a response to adjuvant treatment, code this field 999 and Evaluation 5. o Is there documentation on the clinical status of regional LNs? If not and the pathology reports states involvement and clinician states there was **no** response to treatment, code this field using	

DATA ITEM	DESCRIPTION	REFERENCES
	info from the path report and Evaluation field as 6. o Is it not possible to determine if an involved LN is a regional or distant LN? If not, code 800-LNs, NOS. o Is the extension coded as in-situ/noninvasive? If so, code this field as 000. o Is there an unidentified LN with the resected primary site specimen? Assume it is a regional LN. o Is the size of LN or size of metastasis w/in the LN required for coding? Code the size of the metastasis, not the entire node, unless otherwise stated in the site-specific schema. o Is the only information about regional LNs in the physician's statement of an N category from the TNM staging system? Use the codes in the schema for "stated as N ". **Isolated Tumor Cells (ITCs):** o Is the primary site breast, cutaneous melanoma or Merkel Cell CA? ITC information is needed to code this field. Check specific site schema for information on coding this field **Discontinuous (Satellite) Tumor Deposits peritumoral nodules:** o Is the primary site colon, appendix, rectosigmoid or rectum? Depending on whether there is residual LN structures noted in the specimen, these nodules can either be regional LN	

DATA ITEM	DESCRIPTION	REFERENCES
	involvement or discontinuous spread by the primary tumor. o Were Sentinel LNs removed? Was primary tumor also removed? If primary tumor was not resected, sentinel LNs would be classified as clinical staging and Evaluation code would be coded as 1. **When to use code 988:** o Is the primary site placenta, brain and cerebral meninges, other reportable CNS tumor, intracranial gland, Hodgkin or Non-Hodgkin lymphoma, hematopoietic neoplasm, other and ill-defined primary site or unknown primary site? Use code 988.	
14) Number of Regional Lymph Nodes Positive/Examined	Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with tumors diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage system. o Is the total number of regional lymph nodes removed and examined by the pathologist correct? o Do all the totals of LN levels examined add up correctly? o Are the correct Collaborative Stage codes used? • 00-No regional LNs examined • 01-89 1-89 regional LNs examined	

DATA ITEM	DESCRIPTION	REFERENCES
	• 90-Ninety or more regional LNs examined • 95-No regional LNs removed, but aspiration or core biopsy of regional LN performed • 96-Regional LNs removed, documented as sampling, # LN NR • 97=Regional LNs removed, documented as a dissection and # LN NR • 98-Regional LNs removed, LN # NR and unknown if dissection or sampling • 99-Unknown , not stated, DCO o Is field coded 99 for appropriate sites and/or histologies or Reporting Facility type? o Does the Scope of LN Surgery code correlate with Regional LN **Examined**? o Is the Scope of LN Surgery code correct for LNs **Examined**? o Does the Scope of LN Surgery code correlate with Regional LN **Positive**? o Is the LN biopsy or FNA coded in Scope of LN Surgery?	

DATA ITEM	DESCRIPTION	REFERENCES
15) *CS Metastasis at Diagnosis***	o Required on all cases. Cannot be blank, but can be coded unknown. Some schemas don't use CS METS AT DX and should be coded 98. o Is highest applicable code used, whether the determination was clinical or pathological? o Progression of disease should not be coded in CS Mets at DX. o Primary sites always coded 98: • Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms. • Hodgkin and non-Hodgkin lymphoma • Kaposi Sarcoma • Myeloma and Plasma Cell Disorders • Other and Ill Defined Primary Sites • Unknown primary site o Bone, Brain, Liver or Lung are coded 9 o If CS Mets at DX is coded 00 then CS Mets at DX – Bone, Brain, Liver or Lung are coded 0 o If CS Mets at DX is coded 98 then CS Mets at DX- Bone, Brain, Liver or Lung are coded 8 If CS Mets at DX is coded 99 then CS Mets at DX – • Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms.	CS Manual Part 1, Section 1 CS Mets at Dx

DATA ITEM	DESCRIPTION	REFERENCES
	• Hodgkin and non-Hodgkin lymphoma • Kaposi Sarcoma • Myeloma and Plasma Cell Disorders • Other and Ill Defined Primary Sites • Unknown primary site o If CS Mets at DX is coded 00 then CS Mets at DX – Bone, Brain, Liver or Lung are coded 0 o If CS Mets at DX is coded 98 then CS Mets at DX- Bone, Brain, Liver or Lung are coded 8 o If CS Mets at DX is coded 99 then CS Mets at DX – Bone, Brain, Liver or Lung are coded 9 **CS Metastasis at Diagnosis Evaluation**: o Records how the code for the item "CS Mets at DX" was determined based on the diagnostic methods employed. o Is highest applicable code used? o If there is no mention of distant mets, code CS Mets at DX as 00 and CS Mets Evaluation as 0.	CS Manual Part 1, Section 1 CS Mets Evaluation

DATA ITEM	DESCRIPTION	REFERENCES
16) CS Site Specific Factors 1-25 */**	Collaborative Stage Site Specific Factor (SSF) codes 988, 998, and 999. Codes must be verified in text. **Code 988**: Not applicable: Information not collected for this case • When the SSF is not defined or not used for a schema. • When the SSF is defined, but not required by the CCR. *Note: Do not use this code for a CCR-required SSF.* **Code 998**: Test not done (test was not ordered and was not performed). • The SSF is required by the CCR as indicated in Volume I, Appendix Y and there is a statement that the test was not performed. • When there is knowledge that your facility does not perform a certain test. Refer to DSQC Memo #2011-02 for further instructions. • When there is a case where clinical indicators indicate that a certain test is not needed. • When the SSF is defined, not required by the CCR, but the reporting facility chooses to collect this data item.	CS Manual, Part I, Section 2 CCR-DSQC Statewide Memo 2011-03, SSF Code 988, 998, and 999

DATA ITEM	DESCRIPTION	REFERENCES
	Example: *Breast Schema SSFs 8-14 (HER2 marker studies)* o Use code 998 if you know your facility only uses IHC (SSF 8-9) to test for HER2. A statement such as "IHC only method performed at this facility" is sufficient documentation to code SSF 10-14 to 998. **Code 999**: Unknown; No information; Not documented in patient record. • When 988 and 998 do not apply. • When 988 and 998 do not apply and the SSF is required by the CCR. ***Note***: *Use code 999 when there is no report available in the medical record. Do not assume that the test was not performed.* **Example**: *Breast Schema SSFs 8-14 (HER2 marker studies)* o Use code 999 when there is no documentation of HER2 IHC, FISH, CISH, or other type of HER2 test performed. If one of the tests is done, do NOT assume that the others were not done.	

DATA ITEM	DESCRIPTION	REFERENCES
17) SEER Summary Stage 2000	o Directly assigned SEER Summary 2000 is required from all facilities starting with cases diagnosed 1/1/2015 forward. o Use the appropriate primary site staging scheme. o TIME PERIOD: Use all clinical and pathological assessments through completion of surgery (ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer. o Exclude any metastasis known to have developed *after* the diagnosis was established. o Record the furthest involvement of the primary tumor (in situ, localized, regional by direct extent, regional LN's, regional NOS, distant).	SEER Summary Staging Manual 2000 Codes and Coding Instructions
18) *AJCC* TNM Staging	o Starting with cases diagnosed 1/1/2015 forward, directly assigned AJCC TNM (clinical and pathological) is required from all COC accredited hospitals; others may code and submit. o Use the appropriate primary site scheme and read requirements for clinical vs. pathological. o Read the criteria of what is recorded for the T (Tumor) category as it is site specific. o Lymphoid neoplasms have only stage groups – no T,N,M. o Use the X category when information on a specific component is unknown.	AJCC Cancer Staging Manual, 7th Edition

DATA ITEM	DESCRIPTION	REFERENCES
	o TIME PERIOD: Clinical: includes any information obtained before initiation of definitive treatment or within 4 months after the date of diagnosis, whichever is shorter, as long as the cancer has not clearly progressed during that timeframe. o Pathological: includes any information through completion of definitive surgery as part of first course treatment or within 4 months after the date of diagnosis, whichever is longer, as long as no systemic or radiation therapy initiated or the cancer has clearly not progressed during that time.	

DATA ITEM	DESCRIPTION	REFERENCES
	ALL TREATMENT FIELDS: For cases diagnosed January 1, 2010 and forward, referral to a specialist is considered a recommendation, so code as recommended, unknown if performed. Date of Treatment Procedure Flag: If no treatment was given or date of treatment is unknown, the appropriate Date Procedure Flag must be coded. (See volume 1, section I.1.6.4 and I.1.6.5 for tables on how to enter dates)	
19) RX Date Surgery	o Enter the date of surgery performed for each surgical procedure. o Procedures for this date field include Surgery of the Primary Site, Scope of Regional Lymph Node Surgery or Surgery of Other Regional/Distant Sites. These must be entered in chronological order.	Volume I, Section VI.2.5
19a) Surg Prim 1-3	Cancer-directed surgery includes most procedures that involve removal of a structure (those with the suffix "ectomy") and such procedures as: • Biopsy, excisional (which has microscopic residual disease or no residual disease) • Biopsy, NOS, that removes all tumor tissue • Chemosurgery (Moh's technique) • Conization • Cryosurgery	Volume 1, Section VI.2.1 Volume 1, Appendix Q

DATA ITEM	DESCRIPTION	REFERENCES
	• Desiccation and Curettage for bladder and skin tumors • Electrocautery • Fulguration for bladder, skin, and rectal neoplasms • Laser therapy • Local excision with removal of cancer tissue (including excisional biopsy but excluding incisional biopsy) • Photocoagulation • Splenectomy for lymphoma or leukemia • Surgery removing metastatic malignant tissue • Transurethral resection (TUR) with removal of tumor tissue of bladder or prostatic tumors. o Do not code pre-surgical embolization of hypervascular tumors with particles, coils or alcohol. These pre-surgical embolizations are typically performed to make the resection of the primary tumor easier. Examples where pre-surgical embolization is used include meningiomas, hemangiomas, paragangliomas, and renal cell metastases in the brain.	

DATA ITEM	DESCRIPTION	REFERENCES
	o For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is unavailable. o Enter the procedures in chronological order. If more than three surgical, the earliest surgery and the most definitive surgery must be included.	
19b) Scope LN Proc 1-3	o Record the farthest regional lymph node removed regardless of involvement with disease. There is no minimum number of nodes that must be removed. If a regional lymph node was aspirated or biopsied, code regional lymph node(s) removed, NOS (1).	Volume 1, Section VI.2.2 (see table for codes)
19c) Surg Other Proc 1-3	o Code the removal of non-primary site tissue which the surgeon may have suspected to be involved with malignancy even if the pathology was negative. Do not code the incidental removal of tissue for reasons other than malignancy. These procedures are to be entered in chronological order. If no surgery was performed of other regional or distant sites or distant lymph nodes, leave the fields blank. o Use code 1 if any surgery is performed to treat tumors of Unknown or Ill-defined Primary sites or for Hematopoietic/Reticuloendothelial/Immunoproliferative disease.	Volume 1, Section VI.2.4 (see table for codes)

DATA ITEM	DESCRIPTION	REFERENCES
20) Radiation	o Radiation treatment codes must match treatment text. o If patient received Radiation, determine if it was Beam Radiation or Brachytherapy (implants). o Determine the modality (or type of radiation energy used) for both regional and boost areas. o Cases dx'd 2003> require that Radiation Location be coded. o Record the first date that Radiation Therapy actually started (not the Consult date). o Record the Radiation Therapy and Sequence with Surgery if appropriate. o Be sure to determine that the Radiation Therapy is FIRST course of treatment and not subsequent to other first course treatment.	Volume I, Section VI.3.1-8
21) Chemotherapy	o Chemotherapy codes must match treatment text. o Use SEER*Rx to code cases diagnosed 1/1/2005 forward. o Be sure to verify agents are appropriate for site and type and not considered 'ancillary only'. o RX Date – Record date chemotherapy began at any facility as part of first course treatment. o Chemotherapy at this Hospital – Do not use code 99 if Class of Case is coded to 00, 30, or 31.	Volume I, Section VI.4.1-3 SEER*Rx – Interactive Antineoplastic Drugs Database http://seer.cancer.gov/tools/seerrx// SEER*Rx Summary of Changes http://seer.cancer.gov/tools/seerrx/revisions.html

DATA ITEM	DESCRIPTION	REFERENCES
22) Hormone Therapy	o Hormone therapy codes must match treatment text. o Use SEER*Rx to code cases diagnosed 1/1/2005 forward. o Record surgery performed for hormonal effect (i.e. castration) and radiation for hormonal effect for breast and prostate cancers only. o If steroids (i.e. Prednisone) are combined with chemotherapy, record their use. o RX Date – Record the date hormone therapy began at any facility as part of first course treatment. o Hormone therapy at this hospital – Do not use code 99 if Class of Case is coded 00, 30, or 31.	Volume I, Section VI.5.1-4 SEER*Rx – Interactive Antineoplastic Drugs Database http://seer.cancer.gov/tools/seerrx//
22a) Immunotherapy (Biological Response Modifier Therapy)	o Immunotherapy codes must match treatment text. o Use SEER*Rx to code cases diagnosed 1/1/2005 forward. o Code as immunotherapy for cases diagnosed 1/1/2012 forward: Donor lymphocyte infusion. o RX Date – Record the date immunotherapy began at any facility as part of first course tx. o Immunotherapy at this Hospital – Do not use code 99 if Class of Case is coded 00, 30, or 31.	Volume I, Section VI.6.1 SEER*Rx – Interactive Antineoplastic Drugs Database http://seer.cancer.gov/tools/seerrx//

DATA ITEM	DESCRIPTION	REFERENCES
23) Transplant/Endocrine Procedures	o Systemic therapeutic procedures to be coded in this field include: bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy. o Record the date on which the transplant/endocrine procedure took place at any facility o Transplant Endocrine Procedures at this Hospital – Do not use code 99 if Class of Case is coded 00, 30, or 31.	Volume I, Section, VI.7.1-2
24) Other Therapy	o Definition: Definitive, cancer-directed treatment that cannot be assigned to any other treatment category. Any experimental drug that cannot be classified elsewhere. Unorthodox and unproven treatment. Double blind clinical trials. o For Newly Reportable Hematopoietic Diseases (NRHD) only, specify in text field and use code 1 "Other Therapy" for the following: • Transfusions/Plasmapheresis • Phlebotomy/Blood Removal • Supportive Care • Aspirin • Observation o For cases diagnosed January 1, 2012 and forward, do not collect blood transfusions for any NRHD.	Volume I, Section VI.8

DATA ITEM	DESCRIPTION	REFERENCES
	o Collect phlebotomy for polycythemia vera ONLY. o For collecting blood-thinners and/or anti-clotting agents, refer to this section in Volume I as to which diagnoses are applicable. o Other Therapy at this Hospital – Do not use code 99 if Class of Case is coded 00, 30, or 31.	