SECTION TWO –DATA COLLECTION

I. Determining Reportability

Casefinding

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

The primary sources for case identification include the following records:

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

The following should also be considered as additional sources for case finding:

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

The casefinding list on the next page is intended for use when reviewing the casefinding sources above that use ICD-9-CM diagnosis codes. The list in this manual was compiled by combining two separate casefinding lists from the SEER Training website, one for malignant diagnoses and the other for nonmalignant neoplasms of the brain, central nervous system and other intracranial sites.

The SEER casefinding lists can be downloaded from the SEER Training Web Site at: http://www.training.seer.cancer.gov/module_icdo3/icd_o_3_lists.html.

Nonreportable List

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

ICD-9 Casefinding List

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
042	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)
225.0 – 225.4	Benign neoplasm of brain; cranial nerves; cerebral meninges, NOS; meningioma; spinal cord; cauda equina; spinal meninges
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 gland and craniopharyngeal duct (pouch)
227.4	Benign neoplasm of pineal gland/body
230.0 – 234.9	Carcinoma in situ
237.0	Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct
237.1	Neoplasm of uncertain behavior of pineal gland
237.5	Neoplasm of uncertain behavior of brain and spinal cord
237.6	Neoplasm of uncertain behavior of meninges (NOS, cerebral, spinal)
237.7	Neurofibromatosis 237.70 Unspecified 237.71 Type I (von Recklinghausen's disease) 237.72 Type II (acoustic neurofibromatosis)
237.9	Neoplasm of uncertain behavior of other and unspecified parts of nervous system, cranial nerves
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)
238.6	Extramedullary plasmacytoma (9734/3)
238.7	Chronic myeloproliferative disease (9960/3)
238.7	Myelosclerosis with myeloid metaplasia (9961/3)
238.7	Essential thrombocythemia (9962/3)
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)
239.6 - 239.7	Neoplasms of unspecified behavior (CNS and intracranial sites)
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 neoplasm

Reportable Diagnoses

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

Cases are reportable to the MCR if they are included on the ICD-9CM casefinding list (See page 5-6) and meet the reportable criteria listed below:

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

  Exceptions are the following morphology-site combinations:

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

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

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

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

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

Clinical and Pathologic Cases

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

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

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

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

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

Ambiguous Terminology

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

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

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

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

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

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

Analytic and Nonanalytic Cases

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

Commission on Cancer (CoC) Class of Case Definitions	
Case	**Includes**
Analytic Cases	
Class 0	Diagnosis at the accessioning facility and all of the first course of treatment was performed elsewhere or the decision not to treat was made at another facility. • Patients diagnosed at the accessioning facility who choose to be treated elsewhere. • Patients diagnosed at the accessioning facility who are referred elsewhere for treatment.
Class 1	Diagnosis at the accessioning facility, and all or part of the first course of treatment was performed at the accessioning facility. • Patients diagnosed at the accessioning facility whose treatment plan is either not to treat or watchful waiting. • Patients diagnosed at the accessioning facility who refuse treatment. • Patients diagnosed at the accessioning facility who are not treatable or who were given palliative care only due to age, advanced disease, or other medical conditions. • Patients diagnosed at the accessioning facility for whom it is unknown whether treatment was recommended or administered. • Patients diagnosed at the accessioning facility for whom treatment was recommended, but it is unknown whether it was administered. • Patients diagnosed at a staff physician's office who receive their first course of treatment at the accessioning facility. "Staff physician" refers to any medical staff with admitting privileges at the accessioning facility. • Patients diagnosed at the accessioning facility who received all or part of their first course of treatment in a staff physician's office.
Class 2	• Diagnosis elsewhere, and all or part of the first course of treatment was performed at the accessioning facility. • Diagnosed elsewhere and provided palliative care in lieu of first course treatment, or as part of the first course of treatment, at the accessioning facility.
Nonanalytic Cases	
Class 3	Diagnosis and all of the first course of treatment was performed elsewhere. • Patients treated at the accessioning facility for whom no information on first course of treatment is available. • Patients for whom the accessioning facility developed a treatment plan or provided "second opinion" services, but the diagnosis and treatment was provided elsewhere. • Patients treated for recurrence or progression for a previously diagnosed malignancy.
Class 4	Diagnosis and/or first course of treatment was performed at the accessioning facility prior to the reference date* of the registry. • Patients for whom the accessioning facility manages or treats a recurrence or progression of disease after the reference date. • Patients for whom it is unknown whether the accessioning facility delivered the first course of treatment prior to the reference date.
Class 5	Diagnosed at autopsy. • Prior to autopsy, there was no suspicion or diagnosis of cancer.

Commission on Cancer (CoC) Class of Case Definitions	
Class 6	Diagnosis and all of the first course of treatment was completed by the same staff physician in an office setting. "Staff physician" refers to any medical staff with admitting privileges at the accessioning facility.
Class 7	Pathology report only. Patient does not enter the accessioning facility at any time for diagnosis or treatment. This category excludes cases diagnosed at autopsy.
Class 8	Diagnosis was established by death certificate only. *Used by central registries only*.
Class 9	Unknown. Sufficient detail for determining Class of Case is not stated in patient record. *Used by central registries only*. • Unknown if previously diagnosed. • Unknown if previously treated. • Previously diagnosed, date unknown.

* Reference Date is the start date after which all eligible cases must be included in the registry .

II. Identification of the Primary Neoplasm

To ensure the accurate reporting of cancer incidence in Maine and to stage each cancer properly, it is essential that the primary neoplasm be identified accurately. The primary site, the organ or place in the body where the neoplasm first originated, is always coded. The MCR follows the SEER Program's rules and definitions for determining whether lesions are single or multiple primaries. Basic factors include the site of origin, date of diagnosis, histologic type, behavior of the neoplasm (i.e., benign vs. uncertain vs. malignant) and laterality.

Histology must be taken into account when determining the number of primaries that must be reported. Conversely the number of primaries being reported affect how histology is coded. The two are closely inter-related and cannot be considered separately. This section discusses three major issues: (1) determining multiple primaries for solid malignant tumors; (2) determining multiple primaries for hematopoietic (leukemias and lymphomas) malignancies and (3) determining multiple primaries for non-malignant tumors of the brain, central nervous system.

The primary neoplasm is the original lesion, as opposed to a tumor that has developed as a result of metastasis or extension. It is particularly important that metastatic lesions be distinguished from the primary lesion. Metastatic lesions are the result of the dissemination of tumor cells from the primary site to a remote part of the body. These new lesions do not represent primary tumors. Information regarding the nature of the primary versus metastatic lesions is most often found in pathology reports. The term "secondary" is often used to describe metastatic lesions.

Note: A separate MCR patient abstract must be submitted for each independent primary neoplasm seen at the reporting hospital. Do not code metastatic site(s) of a tumor; report the primary site. If the primary site cannot be identified, code as unknown primary site (C80.9).

Follow the instructions in the ICD-O-3 section, "Coding Guidelines for Topography and Morphology" to code *Primary Site, Histology, Behavior Code* and *Grade/Differentiation*. For cases diagnosed prior to 2001, the ICD-O-2 coding rules must be used. The instructions for coding primary site are found in the "Topography" section (pp 23-26) of the ICD-O-3 "Coding Guidelines for Topography and Morphology." Use the alphabetic index in ICD-O-3 to assign the most specific site.

Certain histologies represent special circumstances. The following guidelines should be followed for consistent analysis of primary site for lymphomas, Kaposi sarcomas and melanomas.

Lymphoma

- Code lymphomas arising in lymphatic tissue or nodes to the site of origin. The lymphatic sites are Lymph Node(s) C77._, Tonsil C09._, Spleen C42.2, Waldeyer's ring C14.2, and Thymus C37.9.

- Code extralymphatic lymphomas (lymphatic cells in nonlymphatic organs such as intestine or stomach) to the organ of origin (Intestine C26.0, Stomach C16.0–C16.9).

- Code mycosis fungoides and cutaneous lymphomas to Skin (C44._).

- Code to Lymph Nodes, NOS (C77.9) when:

  1) the site of origin is not identified for a lymphoma.

  2) a patient has diffuse lymphoma and a primary site is unknown or not specified.

  3) a lymphoma mass is identified as "retroperitoneal," "inguinal," "mediastinal," or"mesentery," and no specific information is available to indicate what tissue is involved.

  4) bone marrow metastases are present and the primary site of a lymphoma is unknown or not specified.

- Code to Lymph Nodes, Multiple Regions (C77.8) when multiple lymph node chains are involved with disease.

  Note: Carefully identify the origin of the tumor. Do not code the biopsy site or a metastatic site as the primary site. Lymphoma may be present in both an extranodal organ and one or more lymph node chains. Code the primary site as the extranodal organ or the lymph nodes as directed by the managing physician or physician advisor.

Kaposi Sarcoma

- Code Kaposi sarcoma to the site in which it arises.

- Code to Skin (C44.9) if Kaposi sarcoma arises simultaneously in the skin and another site or the primary site is not identified.

Melanoma

- Code to Skin, NOS (C44.9) if a patient is diagnosed with metastatic melanoma and the primary site is not identified.

Determining Multiple Primaries: Solid Malignant Tumors

[*SEER Program Coding and Staging Manual* pp. 7-17]

Terms:

For the purposes of determining single vs. multiple primaries, the words "**tumor**," "**neoplasm**," "**mass**" and "**lesion**" are used interchangeably in this section. The terms "**original**" and "**initial**" are synonymous.

Definitions:

Focal: Limited to one specific area.

Foci/focus: The starting point of a disease process, a single cell.

Laterality: Describes the right or left side of the body or the right or left of a paired organ, such as the right kidney or the left kidney. **Unilateral** describes a single organ/side. **Bilatera**l describes both organs/sides.

Metachronous tumors: Multiple tumors or lesions that occur greater than two months from the original/initial diagnosis.

Multicentric: A primary tumor with satellites in surrounding tissue.

Multifocal: Multiple tumors arising from two or more locations.

Multiple primaries: Two or more independent primary reportable neoplasms.

Non-synchronous (Metachronous) tumors: Multiple masses or lesions that occur greater than two months after the original/initial diagnosis.

Paired Organ: Two separate organs, a right and a left. For example, right breast and left breast.

Primary site: The anatomic portion of the body where the cancer originated.

Simultaneous tumors: Multiple tumors identified at the time of diagnosis.

Synchronous tumors: Multiple tumors diagnosed within two months of the original/initial diagnosis.

Single primary: One distinctive reportable cancer.

Single tumor: A single lesion. A single tumor may invade regional organs by traveling along the mucosa or extending through the organ wall into regional tissue or organ. A single tumor may have multiple or mixed histologies.

Same Vs. Different Primary Site Based On ICD-O-3 Topography Code

1. **The third numeric digit after the 'C' describes a subsite of the organ; it is not used to define individual (different) sites.**

   Example: C50_ is the code for breast and the third numeric digit, C505 describes a subsite of the breast, the lower-outer quadrant.

   ***Exceptions*:** For the following sites, a difference in the third numeric digit designates a different primary site:

   Colon (C18_)
   Anus and anal canal (C21_)
   Bones, joints, and articular cartilage (C40_- C41_)
   Melanoma of skin (C44_)
   Peripheral nerves and autonomic nervous system (C47_)
   Connective, subcutaneous and other soft tissues (C49_)

   Example: If the patient has a melanoma on the skin of the scalp (C444) and another melanoma on the calf of the right leg (C447), these are two different primary sites because the third numeric digit of the site code is different.

2. **If the first two numeric digits after the C are identical, it is the same site.**

   Example: If there is a tumor in the lower outer quadrant of the right breast (C505) and a separate tumor in the upper outer quadrant of the right breast, (C504), it is the same site.

   Possible exception: There are specific rules for paired organs. See the Multiple Primary Rules.

3. **If there is any difference in the first two numeric digits after the C, it is a different site.**

   Example: Stomach, NOS (C169) and small intestine, NOS (C179) are different sites because the second numeric digit is not identical.

   ***Exception:* ICD-O-1** and **ICD-O-2/ICD-O-3 groupings**: The second edition of the *International Classification of Diseases for Oncology* (ICD-O-2) split several site codes into categories having differences in the second numeric digit after the C. The second and third edition ICD-O topography codes are identical. The SEER Program continues to use most of the ICD-O-1 subcategory site groupings (See page 15) to prevent artificial changes in site-specific incidence. When the patient has **multiple independent** tumors, any combination of site codes within the same row in the table are the same primary site. Use this table for in situ and/or invasive tumors. (Do not use this table for a single tumor with extension into another site).

SEER Site Grouping Table*

The purpose of this table is to group sites that are treated as a single site when abstracting a case.

ICD-O-3 Code	Site Groupings	Code To
C01 C02	Base of tongue Other and unspecified parts of tongue	C029 Tongue, NOS
C05 C06	Palate Other and unspecified parts of mouth	C069 Mouth, NOS
C07 C08	Parotid gland Other and unspecified major salivary glands	C089 Major salivary glands, NOS
C09 C10	Tonsil Oropharynx	C109 Oropharynx, NOS
C12 C13	Pyriform sinus Hypopharynx	C139 Hypopharynx, NOS
C23 C24	Gallbladder Other and unspecified parts of the biliary tract	C249 Biliary tract, NOS
C30 C31	Nasal cavity and middle ear Accessory sinuses	C319 Accessory sinuses, NOS
C33 C34	Trachea Bronchus and lung	C349 Lung, NOS
C37 C380 C381-3 C388	Thymus Heart Mediastinum Overlapping lesion of heart, mediastinum, and pleura	C383 Mediastinum, NOS
C51 C52 C577 C578-9	Vulva Vagina Other specified female genital organs Unspecified female genital organs	C579 Female genital, NOS
C569 C570 C571 C572 C573 C574	Ovary Fallopian tube Broad ligament Round ligament Parametrium Uterine adnexa	Code C569 (ovary) when ovary is one of the involved sites Code C579 (female genital, NOS) when only non-ovarian sites are involved.
C60 C63	Penis Other and unspecified male genital organs	C639 Male genital, NOS
C64 C65 C66 C68	Kidney Renal pelvis Ureter Other and unspecified urinary organs	Code C649 when one of the involved organs is kidney Code C689 (Urinary system, NOS) when only non-kidney sites are involved
C74 C75	Adrenal gland Other endocrine glands and related structures	C759 Endocrine gland, NOS

**** Note: This table is not identical to the table in ICD-O-3. Two combinations of sites are listed in the ICD-O-3 but not in the SEER table: C19 (rectosigmoid) and C20 (rectum) and C40 (bones of limbs) and C41 (bones of other sites). Multiple tumors in the rectosigmoid and rectum are different sites. Multiple tumors in C40 and C41 are different sites.***

Same Vs. Different Histology Based On ICD-O-3 Histology Codes

If the first three digits of the ICD-O-3 histology codes are the same, it is the same histology.

> ***Exception:*** The ICD-O-3 histology code for non-small cell carcinoma (8046) is a separate morphology group from the small cell histologies (codes 8040 – 8045). Even though the first three digits are the same, they are different histologies.

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

Multiple Primary Rules for Single Tumor

Rule 1: **A single lesion composed of one histologic type is a single primary, even if the lesion crosses site boundaries.**

> ***Example 1:*** A single lesion involving the tongue and floor of mouth is one primary.
>
> ***Example 2*****:** A single, large mucinous adenocarcinoma involving the sigmoid and descending colon segments is one primary.

Rule 2: A single lesion composed of multiple (different) histologic types is a single primary even if it crosses site boundaries.

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

> ***Example 1:*** A single lesion containing both embryonal cell carcinoma and teratoma is a single primary and would be coded to 9081/3, mixed embryonal carcinoma and teratoma.
>
> ***Example 2:*** A single lesion of the liver composed of neuroendocrine carcinoma (8246/3) and hepatocellular carcinoma (8170/3) is a single primary and would be coded to the more specific histology, neuroendocrine carcinoma (8246/3).

Multiple Primary Rules for Multiple Tumors

Rule 3a: Simultaneous multiple lesions of the same histologic type within the same site (i.e., multi*focal* tumors in a single organ or site) are a single primary. If one lesion has a behavior code of in situ /2 and the other lesion has a behavior code of malignant /3, this is a single primary whose behavior is malignant /3.

> ***Example 1****:* At nephrectomy, two separate, distinct foci of renal cell carcinoma are found in the specimen, in addition to the 3.5 cm primary renal cell carcinoma. Abstract as a single primary.

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

Rule 3b: If a new cancer of the same histology as an earlier one is diagnosed in the same site within two months, this is a single primary cancer.

Example: Adenocarcinoma in adenomatous polyp (8210) in sigmoid colon was removed by polypectomy in December 2004. At segmental resection in January 2005, an adenocarcinoma in a tubular adenoma (8210) adjacent to the previous polypectomy site was removed. *Count as one primary.*

Rule 4: If both sides of a paired organ are involved with the same histologic type within two months of the initial diagnosis

a. It is one primary if the physician states the tumor in one organ is metastatic from the other.

   i. Code the laterality to the side in which the primary originated.

   ii. Code the laterality as 4 if it is unknown in which side the primary originated.

   iii. Code as multiple primaries if the physician states these are independent primaries or when there is no physician statement that one is metastatic from the other.

Exception 1: Simultaneous bilateral involvement of the **ovaries** with the same histology is one primary and laterality is coded '4' when it is unknown which ovary was the primary site.

Exception 2: Bilateral **retinoblastomas** are a single primary with laterality of '4'.

Exception 3: Bilateral **Wilms** tumors are always a single primary with laterality of '4.'

Rule 5: If a tumor with the same histology is identified in the same site at least two months after the initial/original diagnosis (metachronous), this is a separate primary.

Example 1*:* Infiltrating duct carcinoma of the upper outer quadrant of the right breast diagnosed March 2004 and treated with lumpectomy. Previously unidentified mass in lower inner quadrant right breast noted in July 2004 mammogram. This was removed and found to be infiltrating duct carcinoma. Abstract the case as two primaries.
Example 2*:* During the workup for a squamous cell carcinoma of the vocal cord, a second squamous cell carcinoma is discovered in the tonsillar fossa. Abstract as two primaries.

Exception 1: This is a single primary only when the physician documents that the initial/original tumor gave rise to the later tumor.

Exception 2: **If an in situ tumor is followed by an invasive cancer in the same site more than two months apart, report as two primaries even if stated to be a recurrence. The invasive primary should be reported with the date of the *invasive* diagnosis.**

Note: The purpose of Exception 2 is to ensure that the case is counted as an incident case

(i.e., invasive) when incidence data are analyzed.

Use the CoC Data Item "*Type of First Recurrence*" to determine multiple primaries when an in situ lesion is followed by an invasive "recurrence" that has to be reported to the MCR as a new invasive primary. The principal codes that must be reviewed are shown below.

16	Local recurrence of an in situ tumor, NOS
17	Both local and trocar recurrence of an in situ tumor
26	Regional recurrence of an in situ tumor, NOS
27	Recurrence of an in situ tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time
36	Both regional recurrence of an in situ tumor in adjacent tissue or organ(s) and/or regional lymph nodes (26 or 27) and local and/or trocar recurrence (16 or 17)
46	Distant recurrence of an in situ tumor

Exception 3: Report as a single primary and prepare a single abstract for the first invasive lesion:

- Multiple invasive adenocarcinomas of the prostate (C619)
- Multiple invasive bladder cancers (C670 - C679) with histology codes 8120-8131

Example 1: A urothelial bladder tumor is removed by transurethral resection of the bladder (TURB). At three month check-up, a new urothelial tumor is removed. Abstract as one primary of the bladder.

Example 2**:** Patient has elevated PSA, and a needle biopsy shows adenocarcinoma in the right lobe of the prostate. Patient and clinician opt for "watchful waiting." Four months later, PSA is higher and patient has a second biopsy, which shows adenocarcinoma in the left lobe. Abstract as one primary of the prostate.

Exception 4: Kaposi sarcoma (9140) is reported only once and is coded to the site in which it arises. Code the primary site to skin (C44_) when Kaposi sarcoma arises in skin and another site simultaneously. If no primary site is stated, code the primary site to skin, NOS (C449).

Rule 6: Multiple synchronous lesions of different histologic types within a single paired or unpaired organ are separate primaries.

Example 1**:** A patient undergoes a partial gastrectomy for adenocarcinoma of the body of the stomach. In the resected specimen, the pathologist finds both adenocarcinoma and nodular non Hodgkin lymphoma. Abstract two primaries.

Exception 1: Multiple lesions in a single site occurring within two months: if one lesion is carcinoma, NOS; adenocarcinoma, NOS; sarcoma, NOS; or melanoma, NOS and the second lesion is more specific, such as large cell carcinoma, mucinous adenocarcinoma, spindle cell sarcoma, or superficial spreading melanoma, abstract as a single primary and code the histology to the more specific term.

Exception 2: For colon and rectum tumors:

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

b. Familial adenomatous polyposis (FAP) (8220) with malignancies arising in polyps in the same or multiple segments of the colon or rectum, abstract as a single primary.

Exception 3: There are certain sites in which multiple foci of tumor and multiple histologic types are commonly found together. These multifocal, multi-histologic tumors occur most frequently in the thyroid (papillary and follicular), bladder (papillary and transitional cell) and breast (combinations of ductal and lobular, and combinations of Paget disease and ductal/intraductal). They are abstracted as a single primary with a mixed histology. In such cases, consult ICD-O-3 for a list of the most frequent histologic combinations.

Example 1*:* A thyroid specimen contains two separate carcinomas – one papillary and the other follicular. In this situation, abstract one primary with the mixed papillary and follicular histology (8340).

Example 2: Abstract one primary when **multiple bladder** tumors are **papillary urothelial** (8130) and/or **transitional** cell (8120).

Example 3: *A* left mastectomy specimen yields lobular carcinoma in the upper inner quadrant and intraductal carcinoma in the lower inner quadrant. Code one primary.

Example 4: A right mastectomy specimen yields Paget in the nipple and a separate underlying ductal carcinoma. Code one primary. Assign the combination code 8543 (Ductal and Paget disease).

Rule 7: Multiple synchronous lesions of different histologic types in paired organs are multiple primaries. If one histologic type is reported in one side of a paired organ and a different histologic type is reported in the other paired organ, these are two primaries unless there is a statement to the contrary.

Example 1: If a ductal tumor occurs in one breast and a lobular tumor occurs in the opposite breast, these are two separate primaries.

Rule 8: Multiple metachronous lesions of different histologic types within a single site are separate primaries.

Rule 9: Multiple lesions of different histologic types occurring in different sites are separate primaries whether occurring simultaneously or at different times.

Example 1: In 1999, the patient had a mucin-producing carcinoma of the transverse colon. In 2002, the patient was diagnosed with an astrocytoma of the frontal lobe of the brain. Abstract as separate primaries.

Example 2: During the workup for a transitional cell carcinoma of the bladder, the patient has a TURP that shows adenocarcinoma of the prostate. Abstract as separate primaries.

Rule 10: Multiple lesions of the same histologic type occurring in different sites are separate primaries unless stated to be metastatic.

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

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

Go to http://seer.cancer.gov/icd-o-3/ to download the SEER table in PDF format. The table can also be found in Appendix A of *FORDS Revised for 2004.*

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

Definitions

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

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

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

Same Vs. Different Histologies Based On Histologic Groupings

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

Histologic Groupings to Determine Same Histology for Non-malignant Brain Tumors

Histologic Group	ICD-O-3 Code
Choroid plexus neoplasm	9390/0, 9390/1
Ependymoma	9383, 9394, 9444
Neuronal and neuronal-glial neoplam	9384, 9412, 9413, 9442, 9505/1, 9506

Neurofibroma	9540/0, 9540/1, 9541, 9550, 9560/0
Neurinomatosis	9560/1
Neurothekeoma	9562
Neuroma	9570
Perineurioma, NOS	9571/0

Instructions for Using Histologic Group Table

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. Basic Concepts of Staging Cancer

Collaborative Staging (CS) is to be used for cases diagnosed on or after January 1, 2004. It is not to be used for cases diagnosed prior to that date. The MCR requires only the collaborative staging data items and derived fields for cases diagnosed on or after January 1, 2004. For Cases diagnosed prior to January 1, 2004, the MCR requires SEER Summary (General Summary) Stage for all cases, and *AJCC* TNM staging is required when applicable.

The Collaborative Staging System is a carefully selected set of data items that describe how far a cancer has spread at the time of diagnosis. Most of the data items have traditionally been collected by cancer registries, including tumor size, extension, lymph node status, and metastatic status. New items were created to collect information necessary for the conversion algorithms, including the evaluation fields that describe how the collected data were determined, and site/histology-specific factors that are necessary to derive the final stage grouping for certain primary cancers. In addition to the items coded by the registrar, this unified data set also includes several data items derived from the computer algorithms that classify each case in multiple staging systems: the sixth edition of the AJCC TNM system (TNM), Summary Stage 1977 (SS77), and SEER Summary Stage 2000 (SS2000).

AJCC TNM staging provides forward flexibility and clinical utility for individual cancer cases. TNM is dynamic and is changed periodically to meet the decision-making needs of clinicians regarding appropriate treatment methods and the evaluation of their results. The AJCC TNM staging system uses three basic descriptors that are then grouped into stage categories. The first component is “T”, which describes the extent of the primary tumor. The next component is “N”, which describes the absence or presence and extent of regional lymph node metastasis. The third component is “M”, which describes the absence or presence of distant metastasis. The final stage groupings (determined by the different permutations of “T”, “N”, “M”) range from Stage 0 through Stage IV. The stage group is generated when specific criteria are met in the TNM system, for example, prostate cancer stage grouping will only be generated for adenocarcinomas. When a case does not meet the criteria for stage grouping, the result will be reported as “Not Applicable”. An example of this type of case is leiomyosarcoma of the uterus, which is specifically excluded from TNM staging in both the uterus and the soft tissue sarcoma chapter. The Collaborative Staging System is based on, and compatible with, the terminology and staging in the sixth edition of the *AJCC Cancer Staging Manual*, published in 2002. The general rules of the TNM system have been incorporated into the general rules for Collaborative Staging.

Summary Staging provides a measure for cancer surveillance with longitudinal stability for population based cancer registries. Summary staging is a single digit system and has only eight categories: in situ, local, regional to lymph nodes, regional by direct extension, both regional lymph nodes and regional extension, regional not otherwise specified, distant, and unknown. It is less complex than other staging systems and was developed for registrars and epidemiologists who want some information on stage but did not wish to collect the more detailed EOD or TNM system. Summary Staging can be useful when a series of cases is so small that only general categories produce enough data for meaningful analysis. The version of Summary Staging commonly used dates from 1977; the site-specific sections were revised and updated in a new edition published in 2001.

The Collaborative Staging System uses a modified EOD format to collect information about each case. The SEER Extent of Disease (EOD) coding system provided longitudinal stability for epidemiological and cancer control studies. More detailed than the Summary Staging System, EOD was developed to assure consistency over time as other staging systems changed. EOD also allows collected data to be collapsed into different and previous staging systems. SEER EOD is a five-field, 10 digit system: tumor size (3 digits), extension of the primary tumor (2 digits), regional lymph node involvement (highest specific lymph node chain involved by tumor) (1 digit), the number of pathologically reviewed regional lymph nodes that are positive (2 digits), and the number of pathologically examined regional lymph nodes (2 digits).

IV. First Course of Treatment/Therapy

Treatment or therapy for cancer should modify, control, remove or destroy proliferating cancer cells. Therapy may be performed to treat cancer tissue in primary or metastatic site(s) regardless of the patient's response to that treatment. The first course of therapy should include all cancer-directed treatments indicated in the initial treatment plan and delivered to the patient after initial diagnosis of cancer. Multiple modalities of treatment may be included and therapy may include regimens of a year or more. Any therapy administered after the discontinuation of first course treatment is subsequent treatment.

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(s) of therapies intended to modify, control, remove, or destroy proliferating cancer cells. The documentation confirming a treatment plan may be found in several different sources; for example, medical or clinic records, consultation reports, and outpatient records.

- All therapies specified in the physician(s) treatment plan are a part of the first course of treatment if they are actually administered to the patient.
- A discharge plan must be part of the patient's record in a JCAHO-approved program and may contain part or all of the treatment plan.
- An established protocol or accepted management guidelines for the disease can be considered a treatment plan in the absence of other written documentation.
- If there is no treatment plan, established protocol, or management guidelines, and consultation with a physician advisor is not possible, use the principle: "initial treatment must begin within four months of the date of initial diagnosis."