

ABSTRACTED BY

Column	413-415
Length	3
Source of Standard	COC

Description:

THIS IS A REQUIRED DATA ITEM

An alphanumeric code assigned by the reporting facility that identifies the individual abstracting the case.

General Guidelines:

Allowable Values and Format: Letters and numbers, no special characters, cannot be all blank.

ABSTRACT PLUS:

The User ID assigned to the individual logged into *Abstract Plus* appears in the *ABTRACTOR* field.

To add, delete, or change a User ID or to change a Password or the Current User, open *Abstract Plus* and enter "AP1" in the User ID box of the Enter User ID window.

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ACCESSION NUMBER – HOSPITAL

Column	402-410
Length	9
Source of Standard	COC

Description:

THIS IS A REQUIRED DATA ITEM

Unique number assigned by the hospital registry to identify the patient.

Rationale:

Hospitals use this number to identify cases. The central registry can refer to the accession number when communicating with the hospital.

General Guidelines:

The first 4 digits identify the year (in the format CCYY) the patient was first seen at the institution for the diagnosis or treatment of cancer. The first 4 digits must be greater than or equal to 1944.

The last five numbers are the numeric order in which the registry entered the case into the database.

Example: The 33rd patient to be accessioned in 2001 will be assigned accession number 200100033.

A patient will have the same accession number for his/her entire lifetime regardless of how many primary malignancies he/she has. Within a registry, if a patient has multiple primary malignancies, each of the primaries will have the same accession number; tumor sequence number identifies the separate primaries.

Example: Jane Doe, accessioned in 1999 with breast cancer
She is the 10th patient accessioned in 1999.
Accession Number – Hospital is 199900010
Year First Seen (AKA: Accession Year) is 1999
Sequence Number is 00*

Jane Doe, accessioned in 2001 with colon cancer
Accession Number – Hospital is 199900010 (the patient's lifetime accession number).
Year First Seen (AKA: Accession Year) is 2001
Sequence Number is 02

***Note:** When the second primary malignancy is diagnosed, the sequence number of the first primary malignancy must be changed to 01. In the previous example, when the colon cancer is diagnosed in 2001, the sequence number of the breast primary must be changed to 01.

The accession number is never reassigned even if a patient is removed from the registry or if the registry changes its reference date.

ACCESSION NUMBER – HOSPITAL (Cont'd)

It is advisable to maintain an accession list. This list will indicate the accession numbers you have assigned and to whom they were assigned. The list can also be used to determine whether a patient and primary have already been accessioned. Items which should be included in an accession registry are as follows:

- Accession Number
- Date Accessioned to the Registry
- Patient Name
- Diagnosis Date
- Primary Site
- Sequence Number

Note: The accession number should not be confused with the accession year (also known as: year first seen). The accession year is based on the year in which the patient was first seen at the institution for diagnosis or treatment of each primary malignancy.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the accession number.

Click OK or press ENTER.

ADDR AT DX--CITY

Column	52-71
Length	20
Source of Standard	COC

Description:

THIS IS A REQUIRED DATA ITEM

Documents the city or town in which the patient resides at the time of diagnosis.

Rationale:

The address is a part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies. Do not update this field if the patient's address changes. Changing this field would destroy its usefulness.

General Guidelines:

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

Use capital letters.

Do not use punctuation or special characters.

Do not update this field if the patient's address changes.

If the patient has multiple tumors, the address may be different for each primary.

If the city is not known, record UNKNOWN.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the name of the city in which the patient resided at the time the reportable cancer was diagnosed. If the city is unknown, type UNKNOWN.

Click OK or press ENTER.

ADDR AT DX – NO & STREET

Column	2108-2147
Length	40
Source of Standard	COC

Description:

THIS IS A REQUIRED DATA ITEM

Documents the patient's address (number and street) at the time of diagnosis.

General Guidelines:

Indicate the patient's address (number and street address or the rural mailing address) at the time the tumor was diagnosed. This is "the place where he or she lives and sleeps most of the time or the place the person says is his or her usual home."

Code the place of usual residence rather than the temporary address for persons temporarily residing with family during cancer treatment.

Use the post office box address only if no street address information is available.

Do not update this field if the patient's address changes.

Only use standard Postal Service abbreviations.

Do not use periods, hyphens, number signs, or any other form of punctuation in the address.

Use capital letters.

If the patient has multiple tumors, address at diagnosis may be different for each primary.

If the address is not known, record UNKNOWN.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the number and street address or the rural mailing address of the patient's residence at the time the reportable cancer was diagnosed.

Click OK or press ENTER.

ADDR AT DX—POSTAL CODE

Column 74-82
Length 9
Source of Standard NAACCR

Description:

THIS IS A REQUIRED DATA ITEM

Documents the postal code for the patient's address at the time of diagnosis.

General Guidelines:

Indicate the postal code for the address of the patient's residence at the time the tumor was diagnosed.

Do not use punctuation or special characters.

Do not update this field if the patient's address changes.

If the patient has multiple tumors, the postal code may be different for each tumor.

For U.S. zip codes, use either the 5-digit or 9-digit extended zip code. Blanks follow the 5-digit code.

For Canadian residents, use the 6-character alphanumeric postal code. Blanks follow the 6-character code.

When available, enter the postal code for other countries.

Codes (in addition to U.S. and Canadian postal codes)	Description
888888888	Resident of country other than United States, U.S. possessions or territories, or Canada AND the postal code is unknown.
999999999	Resident of United States or U.S. possessions, territories, or Canada AND the postal code is unknown: OR Residence is unknown.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the postal code for the patient's residence at the time the reportable cancer was diagnosed.

Click OK or press ENTER.

ADDR AT DX--STATE

Column 72-73
Length 2
Source of Standard NAACCR

Description:

THIS IS A REQUIRED DATA ITEM

Documents the patient's state of residence at the time of diagnosis.

General Guidelines:

Indicate the U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province of the patient's residence at the time the tumor was diagnosed.

Do not update this field if the patient's address changes.

If the patient has multiple primaries, the state of residence may be different for each primary.

See Appendix B, entitled STATE ABBREV., for listing of U.S. Postal Service abbreviations.

Codes (in addition to U.S. Postal Service abbreviations)	Description
XX	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known.
YY	Resident of country other than United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown.
ZZ	Resident of the United States, NOS (including its territories, commonwealths, or possessions) or Canada, NOS; residence unknown.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province in which the patient resided at the time the reportable cancer was diagnosed.

or

ADDR AT DX—STATE (Cont'd)

In the CURRENT VALUE box, begin typing the name of the state, territory, commonwealth, U.S. possession, or Canadian province until the correct state abbreviation is highlighted in the drop-down box.

Click OK or press ENTER.

ADDR AT DX—SUPPLEMENTL

Column	2148-2187
Length	40
Source of Standard	COC

Description:

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex.

Rationale:

In the medical chart, the patient's residence may be listed as the name of a facility instead of a proper street number, name, etc. Having a second street address field to hold address information allows the registry to look up and store the true street address and not lose the facility name due to shortage of space.

General Guidelines:

Indicate the name of the facility/ place of the patient's residence at the time the tumor was diagnosed.

Do not update this field if the patient's address changes.

If the patient has more than one tumor, the address may be different for each primary.

Use capital letters.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the name of the facility/ place in which the patient resided at the time the tumor was diagnosed.

Click OK or press ENTER.

ADDR CURRENT— CITY

Column	1307-1326
Length	20
Source of Standard	COC

Description:

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

Documents the name of the city in which the patient currently resides.

Rationale:

Can be used to measure regional cancer burden (costs, medical needs, etc) and can be used for patient follow-up.

General Guidelines:

Indicate the name of the city or town in which the patient currently resides.

Do not use periods, hyphens, number signs, or any other form of punctuation in the address.

Use capital letters.

Update this field if the patient's address changes.

If the patient has multiple malignancies, the current city or town should be the same for all tumors.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the name of the city or town in which the patient currently resides.

Click OK or press ENTER.

ADDR CURRENT—NO & STREET

Column	2188-2227
Length	40
Source of Standard	COC

Description:

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

Records the patient's current address (number and street).

Rationale:

Can be used to measure regional cancer burden (costs, medical needs, etc) and can be used for patient follow-up.

General Guidelines:

Indicate the patient's current address or rural mailing address.

Only use standard abbreviations as recognized by the Postal Service.

Do not use periods, hyphens, number signs, or any other form of punctuation in the address.

Update this field if the patient's address changes.

Use capital letters.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the number and street address or the rural mailing address of the patient's current residence.

Click OK or press ENTER.

ADDR CURRENT—POSTAL CODE

Column 1329-1337
Length 9
Source of Standard NAACCR

Description:

THIS IS A SUPPLEMENTARY/ RECOMMENDED DATA ITEM

Documents the postal code for the patient's current address.

Rationale:

Can be used to measure regional cancer burden (costs, medical needs, etc) and can be used for patient follow-up.

General Guidelines:

Indicate the Postal code for the patient's current address.

Do not use punctuation or special characters.

Update this field if the patient's address changes.

For U.S. zip codes, use either the 5-digit or 9-digit extended zip code. Blanks follow the 5-digit code.

For Canadian residents, use the 6-character alphanumeric postal code. Blanks follow the 6-character code.

When available, enter the postal code for other countries.

Codes (in addition to U.S. and Canadian postal codes)	Description
888888888	Resident of country other than United States, U.S. possessions or territories, or Canada AND the postal code is unknown.
999999999	Resident of United States or U.S. possessions, territories, or Canada AND the postal code is unknown: OR Residence is unknown.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the postal code for the patient's current residence.

Click OK or press ENTER.

ADDR CURRENT--STATE

Column 1327-1328
Length 2
Source of Standard NAACCR

Description:

THIS IS A SUPPLEMENTARY/ RECOMMENDED DATA ITEM

U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province in which the patient currently resides.

Rationale:

Can be used to measure regional cancer burden (costs, medical needs, etc.) and can be used for patient follow-up.

General Guidelines:

Indicate the U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province of the patient's current residence.

Update this field if the patient's address changes.

See Appendix B, entitled STATE ABBREV., for listing of U.S. Postal Service abbreviations.

Codes (in addition to U.S. Postal Service abbreviations)	Description
XX	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known.
YY	Resident of country other than United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown.
ZZ	Resident of the United States, NOS (including its territories, commonwealths, or possessions) or Canada, NOS; residence unknown.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province in which the patient resided at the time the

ADDR CURRENT—STATE (Cont'd)

reportable cancer was diagnosed.

or

In the CURRENT VALUE box, begin typing the name of the state, territory, commonwealth, U.S. possession, or Canadian province until the correct state abbreviation is highlighted in the drop-down box.

Click OK or press ENTER.

ADDR CURRENT—SUPPLEMENTL

Column	2228-2267
Length	40
Source of Standard	COC

Description:

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex.

Rationale:

In the medical chart, the patient's residence may be listed as the name of a facility instead of a proper street number, name, etc. Having a second street address field to hold address information allows the registry to look up and store the true street address and not lose the facility name due to shortage of space.

General Guidelines:

Indicate the name of the facility/ place of the patient's current residence.

Update this field if the patient's address changes.

Use capital letters.

Do not use periods, hyphens, number signs, or any other form of punctuation in the address.

Use recognized USPS abbreviations.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the name of the facility/ place in which the patient resided at the time the tumor was diagnosed.

Click OK or press ENTER.

AGE AT DIAGNOSIS

Column 119-121
Length 3
Source of Standard SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM.

Documents the age of the patient at the time of diagnosis.

General Guidelines:

Different tumors for the same patient may have different values.

Measure the patient's age in completed years of life, i.e., age at the patient's last birthday.

Codes	Description
000	Less than 1 year.
001	1 year old but less than 2 years.
002	2 years old.
----	(show actual age in completed years).
101	101 years old.

120	120 years old.
999	Unknown age.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the calculated age of the patient at diagnosis.

Click OK or press ENTER.

or

After the patient's date of birth and the date of diagnosis has been entered into the abstract, press F5 for the computer to automatically calculate the age at diagnosis.

BEHAVIOR CODE ICD-O-3

Column	305-305
Length	1
Source of Standard	SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM

Records the behavior of the tumor being reported using *ICD-O-3*. It is the first digit of the morphology code after the slash (/).

Tennessee adopted *ICD-O-3* as the standard coding system for cases diagnosed beginning January 1, 2001 and recommends that prior cases be converted from *ICD-O-2*.

General Guidelines:

Collect malignancies with an in situ /2 and malignant /3 behavior code as described in *ICD-O-3*.

Collect benign /0 and borderline /1 intracranial and CNS tumors for cases diagnosed on or after 1/1/2004.

When submitting a case with a diagnosis of “metastatic carcinoma,” (behavior code 6), verify the primary site and report the behavior code as 3. The primary site is assumed to have the same histologic type as the metastatic site.

The behavior code for juvenile astrocytoma (9421) was changed from 3, in the *ICD-O-2*, to 1, in the *ICD-O-3*. However, juvenile astrocytoma (9421/1) is still reportable. When submitting these cases, code the behavior code as malignant (9421/3).

If any invasion or microinvasion is present, no matter how limited, code the behavior as malignant (3).

Note that in situ is a concept based on histologic evidence. Clinical evidence alone cannot justify the use of this term.

The behavior code associated with each histology code listed in the *ICD-O-3* is the “typical” behavior for that histology. If the pathologist indicates the behavior code is different than the behavior code listed in the *ICD-O-3*, the cancer registrar should submit the case with the behavior code indicated by the pathologist.

The following terms are synonymous with in situ (behavior code 2).

- AIN III (C211)
- Bowen’s disease
- Clark’s Level 1 for melanoma (limited to epithelium)
- Confined to epithelium
- Hutchinson’s melanotic freckle, NOS (C44._)
- Intracystic, noninfiltrating
- Intraductal
- Intraepidermal, NOS
- Intraepithelial, NOS

BEHAVIOR CODE ICD-O-3 (Cont'd)

The following terms are synonymous with in situ (behavior code 2) (Cont'd)

Involvement up to but not including the basement membrane
Lentigo maligna (C44._)
Lobular neoplasia (C50._)
Lobular, noninfiltrating (C50._)
Noninfiltrating
Noninvasive
No stromal invasion/involvement
Papillary, noninfiltrating or intraductal
Precancerous melanosis (C44._)
Queyrat erythroplasia (C60._)
Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria)
Vaginal intraepithelial neoplasia Grade III (C52.9) a.k.a. VAIN III
Vulvar intraepithelial neoplasia Grade II (C51.) a.k.a. VIN III

Codes	Description
0	Benign (Reportable for intracranial and CNS sites only).
1	Uncertain whether benign or malignant, borderline malignancy, low malignant potential, and uncertain malignant potential. (Reportable for intracranial and CNS sites only).
2	Carcinoma in situ; intraepithelial; noninfiltrating; noninvasive.
3	Malignant, primary site (invasive).

Note: For cases diagnosed between 1/1/92 – 12/31/00, please refer to the *ICD-O-2* behavior codes when using the *ICD-O-2* morphology codes.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the behavior or select the behavior code from the drop-down table.

Click OK or press ENTER.

BEHAVIOR CODE (1992 – 2000) ICD-O-2

Column	300-300
Length	1
Source of Standard	SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM

Records the behavior of the tumor being reported using *ICD-O-2*. NAACCR adopted *ICD-O-2* as the standard coding system for cases diagnosed in from January 1, 1992 through December 31, 2000. In addition, NAACCR recommended that cases diagnosed prior to 1992 be converted to *ICD-O-2*.

Codes:

See *ICD-O-2*, page 22 for behavior codes.

Clarification of Required Status:

This data item is required by all standard-setting organizations for cancer cases diagnosed from January 1, 1992 through December 31, 2000, and recommended for cases diagnosed prior to 1992.

When the histologic type is coded according to the *ICD-O-2*, the behavior code must be coded according to the *ICD-O-2* also.

For information on required status for related data items for histologic type and behavior when coded according to *ICD-O-3*, see *HISTOLOGY ICD-O-3* and *BEHAVIOR CODE ICD-O-3*.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the behavior or select the behavior code from the drop-down table.

Click OK or press ENTER.

BIRTH DATE

Column	122-129
Length	8
Source of Standard	SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM

Date of birth of the patient.

General Guidelines:

The birth date is recorded in the month, day, year format (MMDDCCYY).

A zero must precede single-digit months and days.

Estimate date of birth when information is not available.

Calculate the year of birth by subtracting the patient's age at diagnosis from the year of diagnosis.

It is better to estimate than to code as an unknown value.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the date of birth of the patient. Do not type separators ("/", "-").

BIRTHPLACE

Column	130-132
Length	3
Source of Standard	SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM.

Code for place of birth of the patient. All records for a patient should contain the same code.

Rationale:

Place of birth is helpful for patient matching and can be used when reviewing race and ethnicity. In addition, adding birthplace data to race and ethnicity allows for a more specific definition of the population being reported. Careful descriptions of ancestry, birthplace, and immigration history of populations studied are needed to make the basis for classification into ethnic groups clear. Birthplace has been associated with variation in genetic, socioeconomic, cultural, and nutritional characteristics that affect patterns of disease. A better understanding of the differences within racial and ethnic categories can also help states develop effective, culturally sensitive public health prevention programs to decrease the prevalence of high-risk behaviors and increase the use of preventive services.

Codes:

See Appendix A of the TCR manual for the Seer geocodes for coding the place of birth and place of death. Use the most specific code.

ABSTRACT PLUS:

Click in the *BP* code field. Press F4 to display the drop-down table. Select the appropriate code.

or

In the CURRENT VALUE box, type the first few letters of the place of birth until the correct birthplace is highlighted.

Click OK or press ENTER.