

## NAACCR RECORD VERSION

Column 19-19  
Length 1  
Source of Standard NAACCR

### Description:

THIS IS A REQUIRED DATA FIELD

Code for the NAACCR record version used to create the record. This item applies only to record types I, C, A, and M. The correction record has its own record version data item.

Codes	Description
Blank	September 1989 version.
1	1992-1994 Version (Version 2 and Version 3).
4	1995 Version (Version 4.0).
5	1996 and 1997 Version (Version 5.0 or Version 5.1).
6	1998 Version (Version 6).
7	1999 Version (Version 7).
8	2000 Version (Version 8).
9	2001 and 2002 Version (Version 9 and Version 9.1).
A	2003 Version (Version 10 and Version 10.1).

NOTE: Code 4 was assigned to the 1995 Version to synchronize the document version and the layout version numbers. Layout document Version 2 and 3 are coded as 1.

### **ABSTRACT PLUS:**

This data item is generated by the software application.

## **NAME—ALIAS**

Column	2006-2020
Length	15
Source of Standard	COC

### **Description:**

THIS IS A SUPPLEMENTARY/ RECOMMENDED DATA ITEM

Records any alternative name the patient is known by. A patient may use an alias for his first name (i.e. nickname) or his last name. Note that maiden name is entered in a different item.

### **Rationale:**

Used to link reports on patients who are known by multiple names.

### **General Guidelines:**

Capitalize all letters.

Do not include punctuation, spaces, hyphens, or apostrophes.

### ***ABSTRACT PLUS:***

In the CURRENT VALUE box, type the patient's alias.

Click OK or press ENTER.

## **NAME--FIRST**

Column 1972-1985  
Length 14  
Source of Standard NAACCR

### **Description:**

THIS IS A REQUIRED DATA ITEM

First name of patient.

### **General Guidelines:**

Capitalize all letters.

Do not include punctuation, spaces, hyphens, or apostrophes.

### ***ABSTRACT PLUS:***

In the CURRENT VALUE box, type the first name of the patient.

Click OK or press ENTER.

## **NAME--LAST**

Column            1947-1971  
Length            25  
Source of Standard   NAACCR

### **Description:**

THIS IS A REQUIRED DATA ITEM

Last name of the patient

### **General Guidelines:**

Capitalize all letters.

Do not include punctuation, spaces, hyphens, or apostrophes.

### ***ABSTRACT PLUS:***

In the CURRENT VALUE box, type the last name of patient.

Click OK or press ENTER.

## **NAME—MAIDEN**

Column	2021-2035
Length	15
Source of Standard	NAACCR

### **Description:**

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM.

Maiden name of female patients who are or have been married.

### **Rationale:**

This is used to link reports on a woman who changed her name between reports. It is also critical when using Spanish surname algorithms to categorize ethnicity.

### **General Guidelines:**

Capitalize all letters.

Do not include punctuation, spaces, hyphens, or apostrophes.

### ***ABSTRACT PLUS:***

In the CURRENT VALUE box, type the patient's maiden name.

Click OK or press ENTER.

## **NAME--MIDDLE**

Column	1986-1999
Length	14
Source of Standard	COC

### **Description:**

THIS IS A REQUIRED DATA ITEM

Middle name or, if middle name is unavailable, middle initial of the patient.

### **General Guidelines:**

Capitalize all letters.

Do not include punctuation, spaces, hyphens, or apostrophes.

### ***ABSTRACT PLUS:***

In the CURRENT VALUE box, type the middle name of patient.

Click OK or press ENTER.

## **NAME--SUFFIX**

Column            2003-2005  
Length            3  
Source of Standard   COC

### **Description:**

THIS IS A REQUIRED DATA ITEM-WHEN APPLICABLE

Title that follows a patient's last name, such as a generation order or credential status (e.g., "Jr", "MD").

### **General Guidelines:**

Capitalize all letters.

Do not include punctuation, spaces, hyphens, or apostrophes.

### ***ABSTRACT PLUS:***

In the CURRENT VALUE box, type the name suffix of the patient.

Click OK or press ENTER.

## OCCUPATION SOURCE

Column 141-141  
Length 1  
Source of Standard NPCR

### Description:

THIS IS A REQUIRED DATA ITEM

Code that best describes the source of occupation information provided on this patient.

### Rationale:

Occupation information may come from a variety of sources. The most valid and reliable source of occupation information for cancer patients has not yet been determined.

Codes	Description
0	Unknown occupation/no occupation available.
1	Reporting facility records.
2	Death certificate.
3	Interview.
7	Other source.
8	Not applicable--patient less than 14 years of age at diagnosis.
9	Unknown source.
Blank	Not collected.

### ABSTRACT PLUS:

This data item is generated by the software application.

## OVER-RIDE ACCESSION/CLASS/SEQUENCE

Column 1119-1119  
Length 1  
Source of Standard NAACCR

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit: Accession Number, Class of Case, Sequence Number (COC).

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- Data accurate.

### ***ABSTRACT PLUS:***

If warning message "Accession Number, Class of Case, Sequence Number (COC)" occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type "1", in the CURRENT VALUE box.

Click OK or press ENTER.

If this field is coded "1", supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

## OVER-RIDE AGE/SITE/MORPH

Column 1124-1124  
Length 1  
Source of Standard SEER

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Age, Primary Site, Morphology (COC)
- Age, Primary Site, Morphology (NAACCR IF15)
- Age, Primary Site, Morphology (SEER IF15)
- Age, Primary Site, Morphology ICDO3 (COC)
- Age, Primary Site, Morphology ICDO3 (NAACCR IF15)
- Age, Primary Site, Morphology ICDO3 (SEER IF15)

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- An unusual occurrence of a particular age/site/histology combination for a given age group has been reviewed. Data accurate.

### ABSTRACT PLUS:

If one of the error messages listed above occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type "1", in the CURRENT VALUE box.

Click OK or press ENTER.

If this field is coded "1", supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

## OVER-RIDE COC-SITE/TYPE

Column                    1121-1121  
Length                    1  
Source of Standard      NAACCR

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, Morphology-Type Check (COC)  
Primary Site, Morphology-Type Check ICDO3 (COC)

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- Data accurate.

### ***ABSTRACT PLUS:***

If one of the error messages listed above occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type "1", in the CURRENT VALUE box.

Click OK or press ENTER.

If this field is coded "1", supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

## OVER-RIDE HISTOLOGY

Column 1129-1129  
Length 1  
Source of Standard SEER

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Diagnostic Confirmation, Behavior Code (COC)
- Diagnostic Confirmation, Behavior Code (SEER IF31)
- Diagnostic Confirmation, Behavior ICDO3 (COC)
- Diagnostic Confirmation, Behavior ICDO3 (SEER IF31)
- Morph (1973-91) ICDO1 (SEER OMORPnos)
- Morphology—Type&Behavior (COC)
- Morphology—Type&Behavior (SEER MORPH)
- Morphology—Type&Behavior ICDO3 (COC)
- Morphology—Type&Behavior ICDO3 (SEER MORPH)

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- The behavior code of the histology is designated as “benign” or “uncertain” in ICD-O-2 or ICD-O-3, and the pathologist states the primary to be “in-situ” or “malignant”. (Flag for a “Morphology Type & Behavior edit).
2	Reviewed- The behavior code is “in-situ”, but the case is not microscopically confirmed. (Flag for a “Diagnostic Confirmation, Behavior Code” edit).
3	Reviewed- Conditions 1 and 2 above both apply.

### ABSTRACT PLUS:

## **OVER-RIDE HISTOLOGY (Cont'd)**

If one of the error messages listed above occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type the appropriate code 1, 2, or 3 in the CURRENT VALUE.

Click OK or press ENTER.

If this field is coded 1, 2, or 3, supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

## OVER-RIDE HOSP SEQ/DXCONF

Column 1120-1120  
Length 1  
Source of Standard NAACCR

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Diagnostic Confirm, Seq Num—Hosp (COC)

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- Data accurate.

### ***ABSTRACT PLUS:***

If the error message listed above occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type “1” in the CURRENT VALUE box.

Click OK or press ENTER.

If this field is coded “1”, supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

## OVER-RIDE HOSP SEQ/SITE

Column 1122-1122  
Length 1  
Source of Standard NAACCR

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Seq Num—Hosp, Primary Site, Morph (COC)  
Seq Num—Hosp, Primary Site, Morph ICDO3 (COC)

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- Data accurate.

### ***ABSTRACT PLUS:***

If one of the error messages listed above occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type “1” in the CURRENT VALUE box.

Click OK or press ENTER.

If this field is coded “1”, supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

## OVER-RIDE ILL-DEFINED SITE

Column 1131-1131  
Length 1  
Source of Standard SEER

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Seq Num—Central, Primary Site, Morph (NAACCR IF22)  
Seq Num—Central, Primary Site, Morph (SEER IF22)  
Seq Num—Central, Prim Site, Morph ICDO3 (NAACCR)  
Seq Num—Central, Prim Site, Morph ICDO3 (SEER IF22)

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- A second or subsequent primary reported with an ill-defined primary site (C76.0-C76.8, C80.9) has been reviewed a new primary unrelated to previous primaries.

### ABSTRACT PLUS:

This data item will be completed by the central cancer registry.

## OVER-RIDE LEUKEMIA, LYMPHOMA

Column 1132-1132  
Length 1  
Source of Standard SEER

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Diagnostic Confirmation, Histol Typ (COC)  
Diagnostic Confirmation, Histologic Typ (SEER IF48)  
Diagnostic Confirmation, Histol Typ ICDO3 (COC)  
Diagnostic Confirmation, Histology ICDO3 (SEER IF48)

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- A patient was diagnosed with leukemia or lymphoma and the diagnosis was not microscopically confirmed.

### ***ABSTRACT PLUS:***

If one of the error messages listed above occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type "1" in the CURRENT VALUE box.

Click OK or press ENTER.

If this field is coded "1", supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

## OVER-RIDE REPORT SOURCE

Column 1130-1130  
Length 1  
Source of Standard SEER

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Type of Report Srce(DC), Seq Num—Cent (NAACCR IF04)  
Type of Report Srce(DC), Seq Num—Central (SEER IF04)  
Type of Rep Srce (DC), Seq Num—Cent, ICDO3 (NAACCR)  
Type of Rep Srce(DC), Seq Num—Cent, ICDO3 (SEER IF04)

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- A second or subsequent primary with a reporting source of death certificate only has been reviewed and is an independent primary.

### ***ABSTRACT PLUS:***

If one of the error messages listed above occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type “1” in the CURRENT VALUE box.

Click OK or press ENTER.

If this field is coded “1”, supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

## OVER-RIDE SEQUENCE NUMBER/DIAGNOSTIC CONFIRMATION

Column 1125-1125  
Length 1  
Source of Standard SEER

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Diagnostic Confirm, Seq Num – Central (NAACCR IF23)  
Diagnostic Confirm, Seq Num – Central (SEER IF23)

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- Multiple primaries of special sites in which at least one diagnosis has not been microscopically confirmed have been reviewed. Data accurate.

### ABSTRACT PLUS:

This data item will be completed by the central cancer registry.

## OVER-RIDE SITE/BEHAVIOR

Column 1133-1133  
Length 1  
Source of Standard SEER

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Primary Site, Behavior Code (COC)
- Primary Site, Behavior Code (SEER IF39)
- Primary Site, Behavior Code ICDO3 (COC)
- Primary Site, Behavior Code ICDO3 (SEER IF39)

The IF39 edit does not allow “in-situ” cases of nonspecific sites, such as gastrointestinal tract, NOS; uterus, NOS; female genital tract, NOS; male genital organs, NOS; and others. This over-ride indicates that the conflict has been reviewed.

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- A patient has an “in-situ” cancer of a nonspecific site and no further information about the primary site is available.

### ABSTRACT PLUS:

If one of the error messages listed above occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type “1” in the CURRENT VALUE box.

Click OK or press ENTER.

If this field is coded “1”, supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

## OVER-RIDE SITE/EXTENT OF DISEASE/DIAGNOSIS DATE

Column 1134-1134  
Length 1  
Source of Standard SEER

### Description:

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, EOD (SEER IF40)  
Primary Site, EOD, ICDO3 (SEER IF40)

The IF40 edit does not allow “localized” disease with non-specific sites, such as mouth, NOS; colon, NOS (except histology 8220); bone, NOS; female genital system, NOS; male genital organs, NOS; and others. This over-ride indicates that the conflict has been reviewed.

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- A patient had “localized” disease with a nonspecific site and no further information about the primary site is available.

### ABSTRACT PLUS:

If one of the error messages listed above occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type “1” in the CURRENT VALUE box.

Click OK or press ENTER.

If this field is coded “1”, supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

## OVER-RIDE SITE/LATERALITY/EXTENT OF DISEASE

Column 1135-1135  
Length 1  
Source of Standard SEER

### Description:

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, Laterality, EOD (SEER IF41)  
Primary Site, Laterality, EOD, ICDO3 (SEER IF41)

The IF41 edit for paired organs does not allow EOD to be specified as in situ, localized, or regional by direct extension if laterality is coded as “bilateral, side unknown” or “laterality unknown.” This over-ride indicates that the conflict has been reviewed.

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- A patient had laterality coded nonspecifically and EOC coded specifically.

### ABSTRACT PLUS:

If one of the error messages listed above occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type “1” in the CURRENT VALUE box.

Click OK or press ENTER.

If this field is coded “1”, supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

## OVER-RIDE SITE/LATERALITY/MORPHOLOGY

Column 1136-1136  
Length 1  
Source of Standard SEER

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Laterality, Primary Site, Morphology (NAACCR IF42)  
Laterality, Primary Site, Morphology (SEER IF42)  
Laterality, Primary Site, Morphology ICDO3 (NAACCR IF 42)  
Laterality, Primary Site, Morphology ICDO3 (SEER IF42)

The IF42 edit does not allow behavior code of “in situ” with non-specific laterality codes. This over-ride indicates that the conflict has been reviewed.

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- A patient had behavior code of in-situ and laterality is not stated as right; left; or only one side involved, right or left origin not specified.

### ABSTRACT PLUS:

If one of the error messages listed above occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type “1” in the CURRENT VALUE box.

Click OK or press ENTER.

If this field is coded “1”, supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

## OVER-RIDE SITE/LATERALITY/SEQUENCE NUMBER

(Also known as SITE/HISTOLOGY/LATERALITY/SEQUENCE NUMBER OVER-RIDE)

Column 1126-1126  
Length 1  
Source of Standard SEER

### Description:

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used to verify that the same primary is not reported twice for a person.

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- Multiple primaries of the same histology (3 digit) in the same primary site group have been reviewed.

### ABSTRACT PLUS:

If the error message listed above occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type "1" in the CURRENT VALUE box.

Click OK or press ENTER.

If this field is coded "1", supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

## OVER-RIDE SITE/TNM-STAGE GROUP

Column 1123-1123  
Length 1  
Source of Standard NAACCR

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct. This edit checks for code combinations that are possible, but rare.

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- Data accurate.

### *ABSTRACT PLUS:*

This edit is not currently in use.

## OVER-RIDE SITE/TYPE

Column 1128-1128  
Length 1  
Source of Standard SEER

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Primary Site, Morphology-Type Check (SEER IF25)  
Primary Site, Morphology-Type Check ICDO3 (SEER IF25)

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- The coding of an unusual combination of primary site and histologic type has been reviewed. Data accurate

### *ABSTRACT PLUS:*

If one of the error messages listed above occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type "1" in the CURRENT VALUE box.

Click OK or press ENTER.

If this field is coded "1", supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

## OVER-RIDE SURG/DIAGNOSITIC CONFIRMATION

Column 1127-1127  
Length 1  
Source of Standard SEER

### Description:

THIS IS A REQUIRED DATA ITEM

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. Over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

RX Summ—Surg Prim Site, Diag Conf (NAACCR IF76)  
RX Summ—Surg Prim Site, Diag Conf (SEER IF76)  
RX Summ—Surgery Type, Diag Conf (SEER IF46)

### General Guidelines:

An over-ride should only be used after extensive research has proven the data to be accurate.

Codes	Description
Blank	Not reviewed.
1	Reviewed- A patient who had (cancer-directed) surgery, but the tissue removed was not sufficient for microscopic confirmation.

### ***ABSTRACT PLUS:***

If one of the error messages listed above occurs, review the data items in conflict to determine accuracy of the data. If necessary, correct erroneous data. If the data items are correct as reported, type “1” in the CURRENT VALUE box.

Click OK or press ENTER.

If this field is coded “1”, supporting text must accompany the abstract. Supporting text should be entered into any available text field on the abstract.

### PHYSICIAN 3

Column 2579-2586  
Length 8  
Source of Standard COC

#### **Description:**

THIS IS A SUPPLEMENTARY/ RECOMMENDED DATA ITEM.

Code for another physician involved in the care of the patient.

#### **General Guidelines:**

Must use Tennessee assigned physician code.

Do not update this data item.

<b>Codes</b> (in addition to medical license numbers)	<b>Description</b>
00000000	None, no additional physician.
99999999	Physician unknown or ID number not assigned.

#### ***ABSTRACT PLUS:***

In the CURRENT VALUE box, type the code for the physician.

*or*

Click in the *PHYS3* box. Press F4 or press the DQS button in the header to display the Doctor Query System box. Type the last name of the physician into the name box and press ENTER. Double click on the correct physician's name displayed in the physician listing. The physician ID will be transferred to the CURRENT VALUE box.

Click OK or press ENTER.

If the physician's name does not appear in the DQS listing, click CLOSE to exit the DQS. In the CURRENT VALUE box, type 99999999 (Physician ID unknown).

Click OK or press ENTER.

Then click on the MISCELLANEOUS TAB in the TEXT WINDOW. Click on REMARKS. Type the unlisted physician's complete name, city and state. This will enable the TCR staff to assign a physician code for future use.

## PHYSICIAN 4

Column 2587-2594  
Length 8  
Source of Standard COC

### Description:

THIS IS A SUPPLEMENTARY/ RECOMMENDED DATA ITEM.

Code for another physician involved in the care of the patient.

### General Guidelines:

Must use Tennessee assigned physician code.

Do not update this data item.

Codes (in addition to medical license numbers)	Description
00000000	None, no additional physician.
99999999	Physician unknown or ID number not assigned.

### ABSTRACT PLUS:

In the CURRENT VALUE box, type the code for the physician.

*or*

Click in the *PHYS4* box. Press F4 or press the DQS button in the header to display the Doctor Query System box. Type the last name of the physician into the name box and press ENTER. Double click on the correct physician's name displayed in the physician listing. The physician ID will be transferred to the CURRENT VALUE box.

Click OK or press ENTER.

If the physician's name does not appear in the DQS listing, click CLOSE to exit the DQS. In the CURRENT VALUE box, type 99999999 (Physician ID unknown).

Click OK or press ENTER.

Then click on the MISCELLANEOUS TAB in the TEXT WINDOW. Click on REMARKS. Type the unlisted physician's complete name, city and state. This will enable the TCR staff to assign a physician code for future use.

## PHYSICIAN--FOLLOW-UP

Column 2563-2570  
Length 8  
Source of Standard COC

### Description:

THIS IS A SUPPLEMENTARY/ RECOMMENDED DATA ITEM.

Code for the physician **currently** responsible for the patient's medical care.

### General Guidelines:

Must use Tennessee assigned physician code.

Change this data item when patient follow-up becomes the responsibility of another physician.

<b>Codes</b> (in addition to medical license numbers or facility generated codes)	<b>Description</b>
99999999	Follow-up physician unknown or ID number not assigned.

### **ABSTRACT PLUS:**

In the CURRENT VALUE box, type the code for the physician.

*or*

Click in the *PhysFup* box. Press F4 or press the DQS button in the header to display the Doctor Query System box. Type the last name of the physician into the name box and press ENTER. Double click on the correct physician's name displayed in the physician listing. The physician ID will be transferred to the CURRENT VALUE box.

Click OK or press ENTER.

If the physician's name does not appear in the DQS listing, click CLOSE to exit the DQS. In the CURRENT VALUE box, type 99999999 (Physician ID unknown).

Click OK or press ENTER.

Then click on the MISCELLANEOUS TAB in the TEXT WINDOW. Click on REMARKS. Type the unlisted physician's complete name, city and State. This will enable the TCR staff to assign a physician code for future use.

## PHYSICIAN--MANAGING

Column 2555-2562  
Length 8  
Source of Standard COC

### Description:

THIS IS A REQUIRED DATA ITEM.

Code for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.

### General Guidelines:

Must use Tennessee assigned physician code.

<b>Codes</b> (in addition to medical license numbers or facility generated codes)	<b>Description</b>
99999999	Managing physician unknown or ID number not assigned.

### ABSTRACT PLUS:

In the CURRENT VALUE box, type the code for the physician.

*or*

Click in the *PhysManaging* box. Press F4 or press the DQS button in the header to display the Doctor Query System box. Type the last name of the physician into the name box and press ENTER. Double click on the correct physician's name displayed in the physician listing. The physician ID will be transferred to the CURRENT VALUE box.

Click OK or press ENTER.

If the physician's name does not appear in the DQS listing, click CLOSE to exit the DQS. In the CURRENT VALUE box, type 99999999 (Physician ID unknown).

Click OK or press ENTER.

Then click on the MISCELLANEOUS TAB in the TEXT WINDOW. Click on REMAKS. Type the unlisted physician's complete name, city and State. This will enable the TCR staff to assign a physician code for future use.

## PHYSICIAN—PRIMARY SURG

Column 2571-2578  
Length 8  
Source of Standard COC

### Description:

THIS IS A SUPPLEMENTARY/ RECOMMENDED DATA ITEM.

Code for the physician who performed the most definitive surgical procedure.

### General Guidelines:

Must use Tennessee assigned physician code.

Once the registry has designated a primary surgeon for the patient, the information should not be changed or updated even if the patient receives care from another surgeon.

Codes (in addition to state medical license numbers or facility generated codes)	Description
00000000	If the patient had no surgery.
88888888	Physician who performed a surgical procedure was not a surgeon (i.e., radiation oncologist, diagnostic radiologist, or general practitioner).
99999999	Managing physician unknown or ID number not assigned.

### ABSTRACT PLUS:

In the CURRENT VALUE box, type the code for the physician.

*or*

Click in the *PhysPriSurg* box. Press F4 or press the DQS button in the header to display the Doctor Query System box. Type the last name of the physician into the name box and press ENTER. Double click on the correct physician's name displayed in the physician listing. The physician ID will be transferred to the CURRENT VALUE box.

Click OK or press ENTER.

If the physician's name does not appear in the DQS listing, click CLOSE to exit the DQS. In the CURRENT VALUE box, type 99999999 (Physician ID unknown).

## **PHYSICIAN—PRIMARY SURG**

Click OK or press ENTER.

Then click on the MISCELLANEOUS TAB in the TEXT WINDOW. Click on REMARKS. Type the unlisted physician's complete name, city and State. This will enable the TCR staff to assign a physician code for future use.

## PLACE OF DEATH

Column                    1394-1396  
Length                    3  
Source of Standard      NAACCR

### **Description:**

THIS IS A SUPPLEMENTARY/ RECOMMENDED DATA ITEM

Records the State or country where the patient died and where the death certificate is filed.

### **Rationale:**

This field helps carry out death clearance. When a hospital reports a place of death, the information can help in death certificate matching. It can also signal an out-of-state death for which the death certificate is to be requested.

<b>Codes</b>	<b>Description</b>
----	See Appendix A for geocodes for coding the place of birth and place of death.
997	Not applicable, patient alive.
999	Place of death unknown.

### ***ABSTRACT PLUS:***

Click in the DthPlace field.

Press F4 to display the drop-down table listing the geocodes for place of death.

In the SEARCH box, begin typing the first few letters of the place of death until the correct location is highlighted.

Click OK or press ENTER.

## PLACE OF DIAGNOSIS

Column	5875-5924
Length	50
Source of Standard	NAACCR

### **Description:**

THIS IS A SUPPLEMENTARY/ RECOMMENDED DATA ITEM

Text area for information about the facility, physician office, city, state, or county where the diagnosis was made.

### **General Guidelines:**

Approved abbreviations should be utilized.

Do not repeat information from other text fields.

If information is missing from the record, state that it is missing.

### ***ABSTRACT PLUS:***

In the Place of Diagnosis text field, indicate the name and location of the facility where the diagnosis was made.

*Note:* The Place of Diagnosis text field is located under the MISC tab in the Text Fields box.

## PRIMARY SITE

Column	291-294
Length	4
Source of Standard	SEER/COC

### Description:

THIS IS A REQUIRED DATA ITEM

Code identifying the site of origin of the tumor being reported using the *ICD-O-3*. *ICD-O-3* is the standard coding system for cases diagnosed beginning January 1, 2001. The topography (primary site) codes have not changed between *ICD-O-2* and *ICD-O3*.

### Codes:

See the Topography section or the Alphabetic Index of *International Classification of Diseases for Oncology, Third Edition* for the codes for primary site.

### Special Instructions:

For cases diagnosed beginning January 1, 2001, follow the coding rules in the *ICD-O-3* (Rule A-K, p. 20-34).

When completing the primary site data field, code the primary site (site of origin) of the malignancy, not the metastatic site. Do not base the determination solely on the site that is biopsied. Biopsies may be taken of regional or metastatic sites to verify cancer spread; and therefore, do not necessarily represent the site of origin of the tumor.

When a discrepancy occurs between the surgeon and pathologist regarding primary site, it is best to code the primary site identified by the surgeon.

Tumors that overlap the boundaries of two or more contiguous subcategories and whose point of origin cannot be determined should be classified to sub-category "8."

**Example:** A large tumor involving the gastric fundus (C16.1) and the gastric corpus (C16.2) would be coded to C16.8 (overlapping gastric lesion) when no point of origin is stated.

Use subcategory 9 for multiple tumors that originate in one organ.

Code the site as documented in the medical record and ignore the suggested ICD-O-3 code when a primary site is specified in the medical record.

Use the site code suggested by ICD-O-3 when the primary site is the same as the site code suggested or the primary site is unknown.

## PRIMARY SITE (Cont'd)

Code Kaposi Sarcoma to the site where it arises. If it arises in the skin and another site at the same time, code to skin (C44.9). If the primary site is not identified, code to skin (C44.9).

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

The default code for sarcomas of unknown primary site is C499 rather than C809. The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system. They may also arise in the walls of hollow organs and in the viscera covering an organ. Code the primary site to the organ of origin.

**Lymphomas** originate in lymph nodes, lymphatic tissue, and organs. To accurately determine the primary site of a lymphoma, it is imperative that imaging studies be consulted, if available. A biopsy will lead to a diagnosis of lymphoma, but it will only reflect the involvement of the region biopsied and may not be the primary site. Imaging studies will provide additional information about other areas of involvement and must be taken into consideration when determining the primary site.

Lymphomas originating in the lymph nodes (code to C77.\_):

- A. If a lymphoma involves multiple lymph node regions, code to C77.8.
- B. If a lymphoma only involves a single lymph node chain, code to that specific lymph node chain.
- C. If a physician states the lymphoma arose in a specific lymph node chain, code to that specific lymph node chain.
- D. If a mass is identified as “retroperitoneal,” “inguinal,” “mediastinal,” or “mesentery” and no specific information is available to indicate what tissue is involved, code as a lymph node primary (i.e., an inguinal mass would be coded to C77.4)
- E. If a lymphoma is diagnosed from a bone marrow biopsy, but no evidence of lymphoma is found elsewhere, code to C77.9 (Lymph Nodes, NOS).
- F. If the primary cannot be determined, code the lymphoma to C77.9 (lymph nodes, NOS) unless the primary site is suspected to be extranodal.

Lymphomas originating in organs or lymphatic tissues (Extranodal lymphoma):

- A. If a lymphoma originates in an organ, code to the organ (for example, stomach or intestine).
- B. If a lymphoma originates in lymphatic tissue, code to the site of origin (For example, tonsil, spleen, Waldeyer’s ring, or thymus)
- C. If the primary site is not the lymph nodes and it is suspected to be extranodal, code to unknown primary C809.

If a lymphoma is diagnosed in both a lymph node chain and extranodal site, carefully identify the site of origin or consult the managing physician or physician advisor for assistance.

Primary site for multiple myeloma should be bone marrow (C42.1).

Primary site for all leukemias, must be bone marrow (C42.1) since blood cells originate in the bone marrow.

**Exception:** Some leukemias and lymphomas are considered to be the same disease

## PRIMARY SITE (Cont'd)

process in different phases of the disease (example: B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma). In the *ICD-O-3*, each of these disease phases has its own morphology code (9823/3- B-cell, lymphocytic leukemia. 9670/3-small lymphocytic lymphoma). Determination of the primary site for these diseases is based on where the disease is diagnosed. A diagnosis based on blood specimens or bone marrow should have the primary site coded to C42.1 and the morphology code for the leukemia. A diagnosis based on tissue (usually lymph nodes or lymphatic tissues) should have the primary site coded to the tissue involved and the morphology code for the lymphoma. When a diagnosis is made on both tissue and blood/ bone marrow, the sequence of the biopsies is not to be considered. When a diagnosis is made on both tissue and blood/ bone marrow, code the primary site to the tissue involved and the morphology code for the lymphoma.

Myeloid sarcoma consists of a leukemic deposit in an organ or tissue. The primary site should be coded to the site of origin, usually an extramedullary site or bone.

All malignant melanomas must be reported. Each new occurrence of melanoma of the skin is a separate primary UNLESS a physician indicates otherwise. Metastatic melanoma with unknown primary is coded as C44.9 (Skin, NOS).

For cases diagnosed on or after January 1, 2003, if the primary site is skin (C44.-) and the histology is 8000- 8110, the case is no longer reportable to the Central Registry. For all other primary sites with histology codes 8000-8110 and behavior codes 2-3, the cases MUST be reported.

### ***ABSTRACT PLUS:***

In the CURRENT VALUE BOX, type the appropriate primary site code.

*or*

Click in the Psite box. Press F4 to display the drop-down listing of the primary sites and subsites. In the SEARCH box, type the primary site. Highlight the appropriate subsite.

Click OK or press ENTER.