

## SEER CODING SYSTEM -- CURRENT

Column                    1198-1198  
Length                    1  
Source of Standard      NAACCR

### **Description:**

THIS IS A REQUIRED DATA ITEM

This shows the SEER coding system best describing the majority of SEER items as they are in the record (after conversion).

<b>Codes</b>	<b>Description</b>
0	No SEER Coding.
1	1987 SEER Coding Manual.
2	May 1988 SEER Coding Manual.
3	January 1989 SEER Coding Manual.
4	January 1992 SEER Coding Manual.
5	January 1998 SEER Coding Manual.
6	January 2003 SEER Coding Manual.

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

This data item is generated by the computer software and coded to 6.

## SEER CODING SYSTEM – ORIGINAL

Column                    1199-1199  
Length                    1  
Source of Standard      NAACCR

### **Description:**

THIS IS A REQUIRED DATA ITEM

This shows the SEER coding system best describing the way the majority of SEER items in the record were originally coded.

<b>Codes</b>	<b>Description</b>
0	No SEER Coding.
1	1987 SEER Coding Manual.
2	May 1988 SEER Coding Manual.
3	January 1989 SEER Coding Manual.
4	January 1992 SEER Coding Manual.
5	January 1998 SEER Coding Manual.
6	January 2003 SEER Coding Manual.

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

This data item is generated by the computer software and coded to 6.

## SEQUENCE NUMBER -- HOSPITAL

Column	411-412
Length	2
Source of Standard	COC

### Description:

THIS IS A REQUIRED DATA ITEM

Code indicating the sequence of all reportable neoplasms during the lifetime of a patient.

### General Guidelines:

Each reportable neoplasm is assigned a unique number.

The sequence number refers to the chronological order of the diagnoses of independent reportable neoplasms over the lifetime of the patient.

Codes in the 00-35 and 99 range represent reportable neoplasms of malignant and in situ behavior, which are required to be collected. Codes in the 60-88 range represent required non-malignant neoplasms, such as benign brain tumors, and other neoplasms that the State registry or hospital cancer committee has defined as reportable (reportable- by- agreement).

Use code 00 when the patient has a single malignant primary. If the patient develops another malignant primary, change code 00 to 01 and then assign each subsequent malignant primary sequentially.

Use code 60 when the patient has a single non-malignant neoplasm. If the patient develops another non-malignant neoplasm, change code 60 to 61 and then assign each subsequent non-malignant neoplasm sequentially.

If more than one reportable primary is diagnosed on the same date, assign the lowest sequence number to the primary with the worst prognosis. If each primary has the same prognosis, the decision is arbitrary.

All reportable neoplasms occurring during a patient's lifetime are considered when assigning sequence numbers. Even if a reportable neoplasm is not included in a hospital registry, it is allotted a sequence number. Then its sequence number would be taken into account when assigning sequence numbers for other reportable primary neoplasms.

Sequence numbers should be re-evaluated and reassigned if the hospital discovers an unaccessioned tumor that would affect the sequence.

Code 99 should be used only when sequence is truly unknown or if some vague comment such as "multiple cancers reported in the past" is found in the chart.

## SEQUENCE NUMBER – HOSPITAL (Cont'd)

For any reportable in situ or malignant cancer diagnosed in 2004 and forward, count all previous in situ/malignant reportable primaries which occurred over the lifetime of the patient to determine the correct sequence number. A 'reportable' primary refers to the site/histology of the tumor and the years for which its reporting was required.

If there are multiple primaries, sequence the cases chronologically as 01 (first of one or more), 02 (second primary), 03 (third primary), and assign the appropriate sequence number to all cases in the database. All primaries in the database for the patient should be evaluated/changed to reflect the correct sequence number.

**Example:** The patient has a history of breast cancer in 1960. She has colon cancer in 2004. Assign sequence number 02 to the colon cancer.

If there were no prior primaries, the sequence number is 00 unless the patient develops subsequent primaries. If a person has a primary with sequence 00 and then develops another reportable /2 or /3 primary, the sequence number of the first primary is changed from 00 to 01.

**Exception:** There are certain cancers that were only reportable for some years. The following are some examples (not a complete list):

Borderline tumors of the ovary were reported for 1992-2000  
Refractory anemia was reported only for 2001+  
Myelodysplastic syndromes were only reported for 2001+  
Cervix in situ were only required prior to 1996 diagnosis year

**Example:** The patient was diagnosed with carcinoma in situ of the cervix in 1994. In 2004 the patient was diagnosed with lung cancer. The registry assigns a sequence number of 01 to the carcinoma in situ of the cervix and a sequence number of 02 to the lung cancer.

**Example:** The patient was diagnosed with carcinoma in situ of the cervix in 2003. In 2004 the patient was diagnosed with lung cancer. The registry is not required to collect the 2003 carcinoma in situ of the cervix and assigns a sequence number of 00 to the lung cancer.

For any reportable non-malignant tumor of the brain/CNS diagnosed in 2004 and forward, count all previous non-malignant tumors of the brain/CNS primaries in chronological order which occurred over the lifetime of the patient to determine the correct sequence number. The previous and newly diagnosed cancers are restricted to primary site codes C700-C729, C751-C753 with behavior codes of /0 or /1.

If there were no prior non-malignant brain/CNS primary, the sequence number is 60 unless the patient develops subsequent primaries. If a person has a primary with sequence 60 and then develops another non-malignant brain/CNS primary, the sequence number of the first primary is changed from 60 to 61. All subsequent non-malignant brain/CNS primaries should be sequenced chronologically as 61 (if it is the first), 62 (if it is the second), etc.

If a patient has both a non-malignant brain/CNS tumor and a reportable /2 or /3 tumor, they are sequenced independent of each other and their chronology, i.e., the non-malignant tumor has a sequence number of 60 and the reportable /2 or /3 has a sequence number of 00.

## SEQUENCE NUMBER – HOSPITAL (Cont'd)

Assign the lower sequence number to the primary with the worse prognosis when two primaries are diagnosed simultaneously. Base the prognosis decision on the primary site, histology, and extent of disease for each of the primaries. If there is no difference in prognosis, the sequence numbers may be assigned in any order.

### Malignant Tumors (COC-required)

Codes	Description
00	One malignant or in situ primary only in the patient's lifetime.
01	First of two or more independent malignant or in situ primaries.
02	Second of two or more independent malignant or in situ primaries.
--	(Actual sequence of this malignant or in situ primary).
24	Twenty-fourth of twenty-four independent malignant or in situ primaries.
25	Twenty-fifth of twenty-five independent malignant or in situ primaries.
99	Unspecified malignant or in situ sequence number or unknown.

### Non-Malignant Tumors (also Reportable- by- agreement neoplasms)

Codes	Description
60	Only one non-malignant tumor or reportable-by-agreement neoplasm.
61	First of two or more non-malignant tumors or reportable-by-agreement neoplasms.
62	Second of two or more non-malignant tumors or reportable-by-agreement neoplasms.
--	(Consecutive number of non-malignant tumors or reportable-by-agreement neoplasms).
87	Twenty-seventh of twenty-seven non-malignant tumors or reportable-by-agreement neoplasms.
88	Unspecified number of neoplasms in this category.

**SEQUENCE NUMBER – HOSPITAL (Cont'd)**

***ABSTRACT PLUS:***

In the CURRENT VALUE box, type the sequence number.

Click OK or press ENTER.

## SEX

Column                    118-118  
Length                    1  
Source of Standard      SEER/COC

### Description:

THIS IS A REQUIRED DATA ITEM.

Identifies the sex of the patient

Codes	Description
1	Male.
2	Female.
3	Other (hermaphrodite).
4	Transsexual (Surgically altered gender).
9	Not stated/Unknown.

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

In the CURRENT VALUE box, type the sex code of the patient.

*or*

Click on the correct gender code in the drop-down table to highlight it.

Click OK or press ENTER.

## SITE CODING SYSTEM--CURRENT

Column                    307-307  
Length                    1  
Source of Standard      NAACCR

### **Description:**

THIS IS A REQUIRED DATA ITEM.

Code that best describes how the primary site currently is coded. If converted, this field shows the system it is converted to.

<b>Codes</b>	<b>Description</b>
1	ICD-8 and MOTNAC
2	ICD-9
3	ICD-O, 1 <sup>st</sup> edition
4	ICD-O, 2 <sup>nd</sup> edition
5	ICD-O, 3 <sup>rd</sup> edition
6	ICD-10
9	Other

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

Must be coded 5.

## SITE CODING SYS--ORIGINAL

Column                    308-308  
Length                    1  
Source of Standard      NAACCR

### Description:

THIS IS A REQUIRED DATA ITEM.

Code that best describes how the primary site was originally coded. If later converted, this field shows the original codes used.

<b>Codes</b>	<b>Description</b>
1	ICD-8 and MOTNAC
2	ICD-9
3	ICD-O, 1 <sup>st</sup> edition
4	ICD-O, 2 <sup>nd</sup> edition
5	ICD-O, 3 <sup>rd</sup> edition
6	ICD-10
9	Other

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

In the CURRENT VALUE box, type the appropriate code.

Click OK or press ENTER.

## SITE OF DISTANT MET 1

Column 618-618  
Length 1  
Source of Standard COC

### Description

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

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

Codes	Description
0	None.
1	Peritoneum.
2	Lung.
3	Pleura.
4	Liver.
5	Bone.
6	Central nervous system.
7	Skin.
8	Distant lymph nodes.
9	Other, generalized, carcinomatosis, disseminated, not specified, unknown.

### ***ABSTRACT PLUS***

In the CURRENT VALUE box, type the most accurate site of distant metastasis code.

*or*

Select the most accurate site of distant metastasis code from the drop-down tables.

Click OK or press ENTER.

## SITE OF DISTANT MET 2

Column 619-619  
Length 1  
Source of Standard COC

### Description

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

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

Codes	Description
0	None.
1	Peritoneum.
2	Lung.
3	Pleura.
4	Liver.
5	Bone.
6	Central nervous system.
7	Skin.
8	Distant lymph nodes.
9	Other, generalized, carcinomatosis, disseminated, not specified, unknown.

### ***ABSTRACT PLUS***

In the CURRENT VALUE box, type the most accurate site of distant metastasis code.

*or*

Select the most accurate site of distant metastasis code from the drop-down tables.

Click OK or press ENTER.

### SITE OF DISTANT MET 3

Column 620-620  
Length 1  
Source of Standard COC

#### Description

THIS IS A SUPPLEMENTARY/RECOMMENDED DATA ITEM

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

Codes	Description
0	None.
1	Peritoneum.
2	Lung.
3	Pleura.
4	Liver.
5	Bone.
6	Central nervous system.
7	Skin.
8	Distant lymph nodes.
9	Other, generalized, carcinomatosis, disseminated, not specified, unknown.

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

In the CURRENT VALUE box, type the most accurate site of distant metastasis code.

*or*

Select the most accurate site of distant metastasis code from the drop-down tables.

Click OK or press ENTER.

## SOCIAL SECURITY NUMBER

Column                    2099-2107  
Length                    9  
Source of Standard      COC

### **Description:**

THIS IS A REQUIRED DATA ITEM

Indicates the patient's Social Security number.

### **General Guidelines:**

The number is entered without dashes and without any letter suffix.

This is not always identical to the Medicare claim number.

If the Social Security number ends with "B" or "D", the patient is receiving benefits under the spouse's Social Security number and this is the spouse's number. Attempt to identify the patient's Social Security number.

<b>Codes</b> (in addition to a valid Social Security number)	<b>Description</b>
999999999	Unknown

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

In the CURRENT VALUE box, type the patient's Social Security number. DO NOT type dashes.

Click OK or press ENTER.

## SPANISH/HISPANIC ORIGIN

Column	115-115
Length	1
Source of Standard	SEER/COC

### Description:

THIS IS A REQUIRED DATA FIELD WHEN APPLICABLE.

Code identifying persons of Spanish or Hispanic origin.

### Rationale:

This code is used to reflect whether or not the person should be classified as Hispanic for purposes of calculating cancer rates. This information is helpful in analysis because Hispanic populations have different patterns of occurrence of cancer from other populations.

### General Guidelines:

All information resources should be used to determine the correct code:

- A. Stated ethnicity in the medical record
- B. Stated Hispanic origin on the death certificate
- C. Birthplace
- D. Information about life history and/or language spoken found during the abstracting process
- E. Patient's last name or maiden name found on a list of Hispanic names

Use code 0 for Brazilians and Portuguese persons.

Persons of Spanish or Hispanic origin may be of any race. Some races may have Spanish names (Native American, Filipinos, etc), but the persons are not necessarily of Hispanic origin. If a patient has an Hispanic name, but there is reason to believe that is not Hispanic (e.g., the patient is Filipino, or the patient is a woman known to be non-Hispanic who has a Hispanic married name), the code in this field should be 0 (non-Spanish, non-Hispanic).

If the patient has multiple tumors, all records should have the same code.

Assign code 7 if Hispanic ethnicity is based strictly on a computer list or algorithm (unless contrary evidence is available) and also code in *COMPUTED ETHNICITY*. Code 7 was adapted for use effective with 1/1/94 diagnoses.

**SPANISH/HISPANIC ORIGIN (Cont'd):**

<b>Codes</b>	<b>Description</b>
0	Non-Spanish; non-Hispanic.
1	Mexican (includes Chicano.)
2	Puerto Rican.
3	Cuban.
4	South or Central American (except Brazil).
5	Other specified Spanish/Hispanic Origin (includes European).
6	Spanish, NOS. Hispanic, NOS. Latino, NOS. <b>There is evidence, other than surname or maiden name, that the person is Hispanic, but he/she cannot be assigned to any of the categories 1-5.</b>
7	Spanish surname only. <b>The only evidence of the person's Hispanic origin is surname or maiden name and there is no contrary evidence that the patient is not Hispanic.</b>
8	<b>Dominican Republic (effective with diagnosis on or after 1/1/2005).</b>
9	Unknown whether Spanish or not.

**ABSTRACT PLUS:**

In the CURRENT VALUE box, type the code describing the Spanish/ Hispanic Origin of the patient.

*or*

Click on the appropriate code to highlight it.

Click OK or press ENTER.

## **STATE/ REQUESTOR ITEMS**

Column	1447-1946
Length	500
Source of Standard	Varies

### **Description:**

Reserved for use by special studies, or for items defined in individual states or central registries. COC uses this area for Patient Care Evaluation Studies.

### **General Guidelines:**

This field must remain blank for TN State reporting.

## TELEPHONE

Column 2268-2277  
Length 10  
Source of Standard COC

### Description:

THIS IS A SUPPLEMENTARY/ RECOMMENDED DATA ITEM

Records the patient's current telephone number.

### General Guidelines:

Record the patient's current telephone number with the area code.

Do not use special characters (i.e., dashes, or parenthesis).

This field should be updated when the patient's phone number changes.

Codes (in addition to valid telephone numbers)	Description
0000000000	Patient does not have a telephone.
9999999999	Telephone number unavailable or unknown.

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

In the CURRENT VALUE box, type the area code and telephone number for the patient.

Click OK or press ENTER.

## **TEXT -- DIAGNOSTIC PROCEDURES – LAB TESTS**

Column	3345-3594
Length	250
Source of Standard	NAACCR

### **Description:**

THIS IS A REQUIRED TEXT ITEM

Text area for information from laboratory examinations other than cytology or histo-pathology.

### **Rationale:**

Text provides an opportunity for documenting and checking coded values. It is a component of a complete electronic abstract and is used for quality control and special studies.

### **General Guidelines:**

Include any and all pertinent data that supports the diagnosis, staging, and treatment of the malignancy.

Include dates, procedure titles, and findings. Information can include tumor markers.

Record both positive and negative findings. Record positive test results first.

## TEXT -- DIAGNOSTIC PROCEDURES – OP REPORTS

Column	3595-3844
Length	250
Source of Standard	NAACCR

### Description:

THIS IS A REQUIRED TEXT ITEM

Text area for information from operative reports.

### Rationale:

Text provides an opportunity for documenting and checking coded values. It is a component of a complete electronic abstract and is used for quality control and special studies.

### General Guidelines:

Text from operative reports is especially valuable in determining the Summary Stage of the cancer. Frequently, the surgeon will visually examine various organs and make a notation in the operative report regarding the spread of disease. The surgeon may or may not find it necessary to biopsy or resect a metastatic site when he visually confirms the spread of disease.

**Example:** On September 20, 2001 during a partial gastrectomy, the surgeon observed a large, fixed mass on the posterior wall of fundus of stomach invading the spleen. Tumor studdings in the left lobe of liver. Spleen biopsied.

Path report: Final diagnosis- Stomach: Signet ring cell carcinoma. Spleen: Metastatic signet ring cell carcinoma.

**NOTE:** The surgeon did not biopsy the liver tumors since he was certain they represented metastatic disease from the stomach. If only the information from the pathology report is used to code the Summary Stage, the liver metastasis would be missed.

### **Example of how to document the above example in the text field:**

9/20/01 Part gast: Lg fixed mass, post wall fundus invading spleen. Tumor studdings lt lobe liver.

Include any and all pertinent data that supports the diagnosis, staging, and treatment of the reportable primary. Include dates, procedure titles, and findings, such as size of tumor, lymph nodes removed, residual tumor, and evidence of invasion of surrounding areas.

Do not repeat information from other text fields.

Note: Prioritize text data to ensure the most important information is transmitted to the Central Registry during data exchange.



## TEXT – DIAGNOSTIC PROCEDURE – PHYSICAL EXAM

Column	2645-2844
Length	200
Source of Standard	NAACCR

### **Description:**

THIS IS A REQUIRED TEXT ITEM

Text area for information from history and physical examinations.

### **Rationale:**

Text provides an opportunity for documenting and checking coded values. It is a component of a complete electronic abstract and is used for quality control and special studies.

### **General Guidelines:**

Include any and all pertinent data that supports the diagnosis, staging, and treatment of the malignancy. Include dates and symptoms that resulted in the patient seeking medical care leading to the diagnosis of the malignancy, such as tumor location and size, palpable lymph nodes, impression, treatment plan.

Do not repeat information from other text fields.

Record positive and negative clinical findings. Record positive results first.

Note: Prioritize text data to ensure the most important information is transmitted to the Central Registry during data exchange.

### ***Example of documentation one would find in this field:***

7/6/01 Weight loss, diarrhea, rectal bleeding, mass RLQ abd.

## TEXT – DIAGNOSTIC PROCEDURES -- SCOPES

Column                    3095-3344  
Length                    250  
Source of Standard      NAACCR

### **Description:**

THIS IS A REQUIRED TEXT ITEM

Text area for information from endoscopic examinations.

### **Rationale:**

Text provides an opportunity for documenting and checking coded values. It is a component of a complete electronic abstract and is used for quality control and special studies.

### **General Guidelines:**

Endoscopic examinations often lead to the earliest diagnosis date of the malignancy and provide valuable information regarding location and summary stage of the cancer.

Include any and all pertinent data that supports the diagnosis, staging, and treatment of the malignancy. Include dates, procedure titles and findings, such as tumor location and size, lymph nodes.

**Example:**            April 4, 2001                    Bronchoscopy

Normal larynx and pharynx. Trachea has extensive fungating encircling neoplastic-appearing tissue predominantly on left involving distal ¼ of trachea at level of carina. Esophagus: 21 cm from upper anterior alveolar ridge is a circumferential necrotic hard mass with irregular eccentric lumen seen. Scope could not pass lesion.

Impression: Carcinoma of the esophagus with involvement of the trachea.

### **Example of how to document the above example in the text field:**

4/4/01 Bronch: Circumferential CA of esophagus, at 21 cm, with involv of trachea.

Note: Prioritize text to ensure the most important information is transmitted to the Central Registry during data exchange.

Record positive and negative clinical findings. Record positive results first.

## TEXT – DIAGNOSTIC PROCEDURES -- XRAY SCAN

Column                    2845-3094  
Length                    250  
Source of Standard      NAACCR

### **Description:**

THIS IS A REQUIRED TEXT ITEM

Text area for information from diagnostic imaging reports.

### **Rationale:**

Text provides an opportunity for documenting and checking coded values. It is a component of a complete electronic abstract and is used for quality control and special studies.

### **General Guidelines:**

Text from radiological reports is especially valuable in determining the Summary Stage of the cancer, especially when surgery is not performed. Detailed information is found in the body of the report and may or may not be listed as part of the final impression.

Radiological reports often lead to the earliest diagnosis date of a malignancy (i.e.: Mammograms often positively diagnose breast cancer prior to surgery).

Include any and all pertinent data that supports the diagnosis, staging, and treatment of the malignancy. Include dates, procedure titles, and findings such as tumor location and size, lymph nodes, distant disease or metastasis.

*Example:*            Mammogram                    5/24/01

**Report:** 5 x 5cm mass in the upper outer quadrant of the right breast which is consistent with malignancy.

**Impression:** Breast mass consistent with malignancy.

*Example of how to document the above example in the text field:*

5/24/01 Mammo: 5x 5cm UOQ RT breast mass c/w malignancy.

Note: Prioritize text to ensure the most important information is transmitted to the Central Registry during data exchange.

Record positive and negative clinical findings. Record positive results first.

## **TEXT – HISTOLOGY TITLE**

Column	4135-4174
Length	40
Source of Standard	NAACCR

### **Description:**

THIS IS A REQUIRED TEXT ITEM

Text area for information of histologic type, behavior and grade in natural language, including differentiation from scoring systems such as Gleason's Score.

### **Rationale:**

Text provides an opportunity for documenting and checking coded values. It is a component of a complete electronic abstract and is used for quality control and special studies. As the purpose of text information is to provide an opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should not be generated electronically from coded values.

### **General Guidelines:**

Note: Prioritize text to ensure the most important information is transmitted to the Central Registry during data exchange.

### ***Example of histology type text:***

Papillary renal cell carcinoma, grade 2

## **TEXT -- PRIMARY SITE TITLE**

Column	4095-4134
Length	40
Source of Standard	NAACCR

### **Description:**

THIS IS A REQUIRED TEXT ITEM

Text area for information identifying the primary site and laterality in natural language.

### **Rationale:**

Text provides an opportunity for documenting and checking coded values. It is a component of a complete electronic abstract and is used for quality control and special studies. As the purpose of text information is to provide an opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should not be generated electronically from coded values.

### **General Guidelines:**

Note: Prioritize text to ensure the most important information is transmitted to the Central Registry during data exchange.

### ***Example of primary site title text:***

Lt breast, upper outer quadrant (or abbreviate as Lt breast, UOQ)

## **TEXT – REMARKS**

Column	5525-5874
Length	350
Source of Standard	NAACCR

### **Description:**

**THIS IS A REQUIRED TEXT ITEM**

Text area for pertinent miscellaneous information or used as an overflow area from other text fields.

Do not repeat information from other text fields.

Suggested text might include smoking history, family and personal history of cancer, comorbidities, information on sequence numbers if a person was diagnosed with another cancer out-of-state or before the registry's reference date and/or justification of over-ride flags.

## TEXT -- STAGING

Column	4175-4474
Length	300
Source of Standard	NAACCR

### **Description:**

THIS IS A REQUIRED TEXT ITEM

Additional text area for staging information not already entered in the *Text – Dx Procedures* areas.

### **Rationale:**

Text provides an opportunity for documenting and checking coded values. It is a component of a complete electronic abstract and is used for quality control and special studies. As the purpose of text information is to provide an opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should not be generated electronically from coded values.

### **General Guidelines:**

Note: Prioritize text to ensure the most important information is transmitted to the Central Registry during data exchange.

Suggested text might include organs involved by direct extension, size of tumor, margin status, number and sites of positive lymph nodes, sites of distant metastasis, physician's comments.

## TEXT--USUAL INDUSTRY

Column	183-222
Length	40
Source of Standard	NPCR

### Description:

THIS IS A REQUIRED TEXT ITEM.

Text area for information about the patient's usual industry, also known as usual kind of business/industry.

### Rationale:

Both occupation and business/industry are required to accurately describe an individual's occupation. Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or work-site-related groups in which cancer screening or prevention activities may be beneficial.

The data item "usual industry" is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death.

### Abstracting Instructions:

Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among "manufacturing", "wholesale", "retail", and "service" components of an industry that performs more than one of these components.

If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient for facility registrars to record the name of the company (with city or town) in which the patient performed his/her usual occupation. In these situations, if resources permit, a central or regional registry may be able to use the employer name and city/town to determine the type of activity conducted at that location.

In those situations where the usual occupation is not available or is unknown, the patient's current or most recent occupation is recorded. The information for industry should follow suit; and, if the patient's current or most recent occupation rather than usual occupation is recorded, record the patient's current or most recent business/ industry.

If later documentation in the patient's record provides an industry that is more likely to be the usual industry than what was originally recorded, facility registrars are encouraged to update the case abstract with the new information. However, it is **not** the responsibility of facility registrars to update abstracts with industry information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

There should be an entry for *TEXT—USUAL INDUSTRY* if any occupation is recorded. If no information is available regarding the industry in which the reported occupation was carried out, record "unknown".

## **TEXT--USUAL INDUSTRY (Cont'd)**

If the patient was not a student or housewife and had never worked, record "never worked" as the usual occupation.

This data item is usually collected only for patients who are age 14 years or older at the time of diagnosis.

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

In the CURRENT VALUE box, type the industry, if known.

Click OK or press ENTER.

## TEXT--USUAL OCCUPATION

Column	143-182
Length	40
Source of Standard	NPCR

### Description:

THIS IS A REQUIRED TEXT ITEM

Text area for information about the patient's usual occupation, also known as usual type of work or job.

### Rationale:

Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or work-site-related groups in which cancer screening or prevention activities may be beneficial.

The data item "usual occupation" is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death.

### Abstracting Instructions:

Record the patient's usual occupation, i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor.

### Do not record "retired".

If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation.

If later documentation in the patient's record provides an occupation that is more likely to be the usual occupation than what was originally recorded, facility registrars are encouraged to update the case abstract with the new information. However, it is **not** the responsibility of facility registrars to update abstracts with occupation information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

If the patient was a housewife/househusband and also worked outside the home during most of his/her adult life, record the usual occupation outside the home. If the patient was a housewife/househusband and did **not** work outside the home for most of his/her adult life, record "housewife" or "househusband".

If the patient was not a student or housewife and had never worked, record "never worked" as the usual occupation.

If no information is available, record "unknown".

This data item is usually collected only for patients who are age 14 years or older at the time of diagnosis.

**TEXT--USUAL OCCUPATION (Cont'd)**

***ABSTRACT PLUS:***

In the CURRENT VALUE box, type the patient's usual occupation.

Click OK or press ENTER.

## TNM EDITION NUMBER

Column                    593-594  
Length                    2  
Source of Standard      COC

### Description:

THIS IS A REQUIRED DATA FIELD FOR ACOS, COC APPROVED CANCER PROGRAMS

Code indicating the edition of the AJCC manual used to stage the case. This applies to the manually coded AJCC fields-not the Derived AJCC fields.

### Rationale:

TNM codes have changed over time and conversion is not always simple. Therefore, a case-specific indicator is needed to allow grouping of cases for comparison.

### General Guidelines:

This item is coded by the software provider.

<b>Codes</b>	<b>Description</b>
00	Not Staged (Cases that have AJCC staging scheme and staging was not done).
01	First Edition.
02	Second Edition (Published 1983).
03	Third Edition (Published 1988).
04	Fourth Edition (Published 1992), recommended for use for cases diagnosed 1993-1997.
05	Fifth Edition (Published 1997), recommended for use for cases diagnosed 1998-2002.
06	Sixth Edition (Published 2002), recommended for use for cases diagnosed 2003+.
88	Not applicable (Cases that do not have an AJCC staging scheme).
99	Edition Unknown.

**TNM EDITION NUMBER (Cont'd)**

***ABSTRACT PLUS:***

In the CURRENT VALUE box, type the appropriate code.

*or*

In the drop-down box, click on the code to highlight it.

Click OK or press ENTER.

## TYPE OF REPORTING SOURCE

Column                    312-312  
Length                    1  
Source of Standard      SEER

### Description:

THIS IS A REQUIRED DATA ITEM

Code that reflects all source documents used to abstract the cancer being reported. This may or may not be the source of original case finding (for example, if a case is identified through a pathology laboratory report and all source documents used to abstract the case are from the physician's office, the type of reporting source would be coded 4-physician's office).

### Rationale:

The code in this field can be used to explain why information may be incomplete on a case. The field is also used to monitor the success of non-hospital case reporting and follow-back mechanisms. All population-based registries should have some death certificate-only cases where no hospital admission was involved. Too high a percentage can imply that follow-back to uncover missed hospital reports was not complete.

Codes	Description
1	Hospital inpatient/outpatient or clinic.
3	Laboratory only (hospital or private).
4	Physician's office/ private medical practitioner (LMD).
5	Nursing/ convalescent home/ hospice.
6	Autopsy only.
7	Death certificate only.

*Note:* Coding is hierarchical. Within codes 1-5, assign codes in the following priority: 1,4,5,3.

### **ABSTRACT PLUS:**

In the CURRENT VALUE box, type the correct reporting source code.

*or*

Click on the code in the drop-down table to highlight it.

Click OK or press ENTER.

## **VENDOR NAME**

Column	1204-1213
Length	10
Source Standard	NAACCR

### **Description:**

THIS IS A SYSTEM GENERATED TEXT ITEM

Name of the computer services vendor who programmed the system submitting this data.

### **Rationale:**

This is used to track which vendor and which software version submitted the case. It helps define the source and extent of a problem discovered in data submitted by a software provider.

### **General Guidelines:**

Abbreviate as necessary and keep a consistent name throughout all submissions.

Include software version numbers where available.

Code is self-assigned by vendor.

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

System- generated. No need to enter any information.

## VITAL STATUS

Column 1302-1302  
Length 1  
Source of Standard SEER/COC

### Description:

THIS IS A REQUIRED DATA ITEM

Vital status of the patient as of the date entered in the *Date of Last Contact* field.

### Rationale:

Used for follow-up and outcome studies

### General Guidelines:

If the patient has multiple tumors, vital status should be the same for all tumors.

Codes	Description
0	Dead.
1	Alive.

### ABSTRACT PLUS:

In the CURRENT VALUE box, type the patient's vital status.

Click OK or press ENTER.