

Section One:
General Guidelines

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REPORTABILITY

All malignancies diagnosed and/or treated at the reporting facility or one of its affiliates must be reported to the Tennessee Cancer Registry (TCR). Submissions must include inpatient cases and outpatient cases.

Use of the *ICD-O-3* is critical in determining reportable cases. Many diagnoses that do not sound malignant must be reported (i.e., leukemia, lymphoma, melanoma, VIN III, VAIN III, AIN III, etc.).

Cases that are diagnosed based on histological or cytological information are reportable. Cases that are diagnosed solely by clinical information are also reportable (in the absence of a negative biopsy disproving the clinical diagnosis).

REPORTABLE DIAGNOSES

1. In Situ and Malignant/Invasive Histologies

a. All histologies with a **behavior code** of /2 or /3 in the *International Classification of Diseases for Oncology*, Third Edition (ICD-O-3).

Exceptions:

- i. **Skin** primary (C440-C449) with any of the following histologies:
 - Malignant neoplasm (8000-8005)
 - Epithelial carcinoma (8010-8046)
 - Papillary and squamous cell carcinoma (8050-8084)
 - Basal cell carcinoma (8090-8110)
- ii. Carcinoma **in situ** of **cervix** (/2) or cervical intraepithelial neoplasia (CIN III) of the cervix (C530-C539)
- iii. Prostatic intraepithelial neoplasia (**PIN** III) of the prostate (C619)

2. Benign/Non-Malignant Histologies

a. **Pilocytic/Juvenile astrocytomas** are reportable; code the histology and behavior code 9421/3.

b. **Benign** and **borderline** primary **intracranial** and **CNS** tumors with a behavior code of /0 or /1 in ICD-O-3 are collected for the following sites (Effective with cases diagnosed 1/1/2004 and later).

See the following table for required sites.

Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors:

General Term	Specific Sites	ICD-O-3 Topography Code
Meninges	Cerebral meninges	C700
	Spinal meninges	C701
	Meninges, NOS	C709
Brain	Cerebrum	C710
	Frontal lobe	C711
	Temporal lobe	C712
	Parietal lobe	C713
	Occipital lobe	C714
	Ventricle, NOS	C715
	Cerebellum, NOS	C716
	Brain stem	C717
	Overlapping lesion of brain	C718
	Brain, NOS	C719
	Spinal cord, cranial nerves, and other parts of the central nervous system	Spinal cord
Cauda equine		C721
Olfactory nerve		C722
Optic nerve		C723
Acoustic nerve		C724
Cranial nerve, NOS		C725
Overlapping lesion of brain and central nervous system		C728
Nervous system, NOS		C729
Pituitary, craniopharyngeal duct and pineal gland	Pituitary gland	C751
	Craniopharyngeal duct	C752
	Pineal gland	C753

Note: Benign and borderline tumors of the cranial bones (C410) are **not reportable**

AMBIGUOUS TERMINOLOGY

Often times, the medical record clearly indicates the patient has cancer by using specific terms that are synonymous with cancer (i.e., carcinoma, adenocarcinoma, etc.). However, a diagnosis of cancer is not always clearly stated and ambiguous terminology may be used. Ambiguous terminology may appear in any source document, such as pathology report, radiology report, or from a clinical report.

An abstract must be submitted if any ambiguous term which is considered diagnostic of cancer is used (see the following list of ambiguous terms).

Ambiguous terms that are reportable

Apparent(ly)
Appears (effective with cases diagnosed 1/1/1998 and later)
Comparable with (effective with cases diagnosed 1/1/1998 and later)
Compatible with (effective with cases diagnosed 1/1/1998 and later)
Consistent with
Favor(s)
Malignant appearing (effective with cases diagnosed 1/1/1998 and later)
Most likely
Presumed
Probable
Suspect(ed)
Suspicious (for)**
Typical (of)

Ambiguous terms that are NOT reportable

(Do **not** accession cases with a diagnosis based on **only these terms**)

Cannot be ruled out
Equivocal
Possible
Potentially malignant
Questionable
Rule(d) out
Suggests
Worrisome

****Exception:** If a cytology report indicates a specimen is “suspicious”, do not interpret it as a diagnosis of cancer. Abstract the case only if a proven positive cytology, a positive pathology, other diagnostic methods, or the physician’s clinical impression, support the cytology findings.

HOW TO USE AMBIGUOUS TERMINOLOGY FOR CASE ASCERTAINMENT

1. In Situ and Invasive (Behavior codes /2 and /3)

- a. If any of the reportable **ambiguous terms precede** a word that is **synonymous** with an in situ or invasive tumor (e.g.: cancer, carcinoma, malignant neoplasm, etc.), the case is reportable. Report the case.

Example: The pathology report says: Prostate biopsy with markedly abnormal cells that are typical of adenocarcinoma.” Report the case.

Negative Example: The final diagnosis on the outpatient report reads: Rule out leukemia. Do not report the case.

- b. **Discrepancies:** If one section of the medical record(s) uses a reportable term such as

“apparently” and another section of the medical record(s) uses a non-reportable term such as “cannot be ruled out”, accept the reportable term and report the case.

- c. Use these terms when **screening** diagnoses on pathology reports, operative reports, scans, mammograms, and other diagnostic testing other than tumor markers.

Note: If a **word does not appear** on either list, the term is not diagnostic of cancer; unless, the word is a form of a word on the reportable list. Forms of a word are such as: “Favored” rather than Favor(s); “appeared to be” rather than appears. Do not substitute synonyms such as “supposed” for presumed or “equal” for comparable.

Note: If the ambiguous diagnosis is **proven to be not reportable** by biopsy, cytology, or physician’s statement, **do not report** the case.

Example: Mammogram shows calcifications suspicious for intraductal carcinoma. The biopsy of the area surrounding the calcifications is negative for malignancy. Do not report the case.

2. **Benign and borderline primary intracranial and CNS tumors**

- a. Use the “Ambiguous Terms that are Reportable” list to identify benign and borderline primary intracranial and CNS tumors that are reportable.
- b. If any of the reportable **ambiguous terms precede** either the word “**tumor**” or the word “**neoplasm**,” the case is reportable. Report the case.

Example: The mass on the CT scan is consistent with pituitary tumor. Report the case.

- c. **Discrepancies:** If one section of the medical record(s) uses a reportable term such as “apparently” and another section of the medical record(s) uses a non-reportable term such as “cannot be ruled out”, accept the reportable term and report the case.

Exception: Do not report a case based only on suspicious cytology. The case is reported if proven by positive cytology or other diagnostic methods including a physician’s clinical diagnosis.

Note: If a **word does not appear** on either list, the term is not diagnostic of cancer; unless, the word is a form of a word on the reportable list. Forms of a word are such as: “Favored” rather than Favor(s); “appeared to be” rather than appears. Do not substitute synonyms such as “supposed” for presumed or “equal” for comparable.

- d. Use these terms when **screening** diagnoses on pathology reports, scans, ultrasounds, and other diagnostic testing other than tumor markers.

Note: If the **ambiguous** diagnosis is proven to be **not reportable** by biopsy, cytology, or physician’s statement, **do not accession** the case.

CASES DIAGNOSED CLINICALLY ARE REPORTABLE

When a recognized medical practitioner says the patient has a cancer or carcinoma, the case is reportable. Some malignancies are never histologically or cytologically confirmed. A diagnosis of cancer can be made during a diagnostic workup (i.e. scans, tumor markers, blood work, etc.). These cases are reportable based on the **clinical diagnosis**. A clinical diagnosis may be recorded in the final diagnosis on the face sheet or other parts of the medical record.

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

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

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

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CASEFINDING

Casefinding is one of the most important duties a cancer registrar performs. It is vital to the success of the program and adherence to the Tennessee reporting requirements.

Casefinding is a system designed to identify every patient, inpatient or outpatient, who is diagnosed and/or treated with a reportable diagnosis. Every registry must perform casefinding in order to assure that all reportable cases are located, abstracted, and submitted to the Tennessee Cancer Registry. The completeness of reporting at any facility is dependent on the quality and completeness of the casefinding at the facility.

The cancer registrar or a designated employee must review all documents that may contain information leading to the discovery of a patient who was diagnosed and/or treated with a reportable diagnosis. Review of multiple sources is necessary to ensure complete casefinding and reporting.

SPECIMEN CASEFINDING SOURCES

The source documents may vary from one facility to another based on what specialty departments exist, but in general the source documents in a hospital can include, but are not limited to the following:

1. Pathology reports
2. Cytology reports
3. Bone Marrow
4. Autopsy reports
5. Disease indices
6. Radiology reports
7. Medical oncology logs
8. Nuclear medicine & Radiation oncology logs
9. Admission and discharge documents
10. Surgery schedule
11. Outpatient departments

The most effective casefinding system includes reviewing specimen reports (i.e., pathology, cytology, bone marrow, and autopsy) **AND** non-specimen reports (i.e., disease indices, radiology reports, oncology logs, etc).

SPECIMEN SOURCES

Pathology reports: Most cancers are histologically confirmed; therefore, pathology reports are a vital source of casefinding. The cancer registrar or designated personnel should review **ALL** pathology reports. This can be done manually in chronological order, or if the pathology department is computerized and using ICD-O histology codes and behavior codes, a computerized list of reportable diseases can be generated.

Cytology reports: Cytology reports are similar to pathology reports and can be reviewed in the same manner.

Bone Marrow reports: A blood smear and/or a bone marrow specimen may be the sole basis of diagnosis for patients with leukemia/hematopoietic diseases. Bone marrow reports are similar to pathology reports and can be reviewed in the same manner.

Autopsy reports: Autopsy reports are usually filed separately from pathology reports in the pathology department or in the Health Information Management department. Review of autopsy reports is usually beneficial for casefinding and identifies cases of cancer that were not diagnosed prior to death.

NON-SPECIMEN SOURCES

Disease Indices: The disease index is an excellent casefinding source, however, it is **NOT** accurate enough to use as the only source of casefinding. The disease index is a listing of cases by date of discharge and can be arranged in diagnostic groupings. A report can be generated by the health information management (HIM) department specifying a group of ICD-9-CM codes to be reviewed. The cancer-screening list below can be used to narrow the report to appropriate reportable cases.

Cancer-Screening List of ICD-9-CM Codes for Casefinding:

042	AIDS (review cases for AIDS-related malignancies)
140.0-208.9	Malignant neoplasms
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
210.0-229.9	Benign neoplasms
230.0-234.9	Carcinoma in-situ
235.0-238.9	Neoplasms of uncertain behavior
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3); Extramedullary plasmacytoma (9731/3)
238.7	Chronic myeloproliferative disease (9960/3); Myelosclerosis with myeloid metaplasia (9961/3); Essential thrombocythemia (9962/3); Refractory cytopenia with multilineage dysplasia (9985/3); Myelodysplastic syndrome with 5q-syndrome (9986/3); Therapy-related myelodysplastic syndrome (9987/3)
239.0-239.9	Neoplasms of unspecified behavior
273.2	Gamma heavy chain disease; Franklin's disease
273.3	Waldenstrom's macroglobulinemia
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)
284.9	Refractory anemia (9980/3)
285.0	Refractory anemia with ringed sideroblasts (9982/3); Refractory anemia with excess blasts (9983/3); Refractory anemia with excess blasts in transformation (9984/3)
288.3	Hypereosinophilic syndrome (9964/3)
289.8	Acute myelofibrosis (9932/3)

Cancer-Screening List of ICD-9-CM Codes for Casefinding (continued):

V07.3	Other prophylactic chemotherapy (screen for miscoded malignancies)
V07.8	Other specified prophylactic measures
V10.0-V10.9	Personal history of malignancy
V58.0	Admission for radiotherapy
V58.1	Admission for chemotherapy
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation follow-up
V67.2	Chemotherapy follow-up
V71.1	Observation for suspected malignant neoplasm
V76.0-V76.9	Special screening for malignant neoplasm.

Casefinding Codes for Benign Brain and CNS Tumors

225	Benign neoplasm of brain and other parts of central nervous system
225.0	Benign neoplasm of the brain
225.1	Benign neoplasm of the cranial nerves
225.2	Benign neoplasm of the cerebral meninges; cerebral meningioma
225.3	Benign neoplasm of spinal cord, cauda equina
225.4	Benign neoplasm of spinal meninges; spinal meningioma
225.8	Benign neoplasm of other specified sites of nervous system
225.9	Benign neoplasm of nervous system, part unspecified
227.3	Benign neoplasm of pituitary, craniopharyngeal duct, craniobuccal pouch, hypophysis, Rathke's pouch, sella turcica
227.4	Benign neoplasm of pineal gland, pineal body
237	Neoplasm of uncertain behavior of endocrine glands and nervous system
237.0	Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct
237.1	Neoplasm of uncertain behavior of pineal gland
237.5	Neoplasm of uncertain behavior of brain and spinal cord
237.6	Neoplasm of uncertain behavior of meninges: NOS, cerebral, spinal
237.7	Neurofibromatosis
237.70	Neurofibromatosis, Unspecified von Recklinghausen's Disease
237.71*	Neurofibromatosis, Type One von Recklinghausen's Disease
237.72	Neurofibromatosis, Type Two von Recklinghausen's Disease
237.9	Neoplasm of uncertain behavior of other and unspecified parts of nervous system; cranial nerves

*Code 237.71 may not be reportable, however, these diagnosis may indicate a reportable condition and should be reviewed.

Radiology reports: Some patients may be diagnosed on the basis of radiological findings alone and may never be histologically confirmed. **Benign brain tumors are often initially diagnosed through scanning procedures.** Review of radiology reports whose findings indicate the presence of neoplastic disease should be reviewed to prevent missed cases.

Surgery Schedule/ Medical Oncology/ Nuclear medicine/ Radiation Oncology logs: The surgery department, nuclear medicine department, radiation oncology department, and the medical oncology department logs should be reviewed to help ensure complete case ascertainment. These logs often identify cases that are diagnosed at another facility and then referred to a subsequent facility for treatment.

Admission and discharge documents: Routine review of all inpatient and outpatient admissions and discharges should be performed. Cases that are histologically confirmed at one facility and then referred to a subsequent facility for treatment are often identified within these documents.

Outpatient departments: Reviewing pathology reports from outpatient surgeries, radiation, and chemotherapy logs will often yield cases that might otherwise be missed.

ESTABLISHING A CASEFINDING SYSTEM

All facilities should create a casefinding system to ensure all reportable cases are identified. The complexity of the casefinding system, as well as, the personnel involved depends upon the amount of data to be reviewed. In some facilities, the cancer registrar reviews all of the data. He/she reviews all of the pathology, cytology, bone marrow, and autopsy reports on a daily, weekly, biweekly, or monthly basis. He/she also analyzes the non-specimen reports (i.e., disease index, radiology reports, etc.) on a daily, weekly, biweekly, or monthly basis to ensure the identification of all reportable cases. In other facilities, however, the cancer registrar enlists the assistance of individuals in various departments. In some cases, he/she might have someone in the HIM department, laboratory, radiology, and oncology department screen reports and record a list of potential cases.

It is important that all personnel involved in the casefinding be thoroughly familiar with the reportable diagnoses. It is also advisable to perform periodic internal audits to verify the casefinding system is functioning effectively.

USE AS MANY SOURCES AS POSSIBLE TO ASSURE COMPLETE CASE ASCERTAINMENT.

DETERMINING MULTIPLE PRIMARIES: SOLID MALIGNANT TUMORS

(See separate sections for hematopoietic primaries and benign and borderline primary intracranial and central nervous system tumors (CNS))

Terms

The words “**tumor**,” “**neoplasm**,” “**mass**,” and “**lesion**” are used interchangeably throughout this manual.

The terms “**original**” and “**initial**” are synonymous.

Definitions:

Focal: Limited to one specific area

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

Laterality describes the right or left side of the body or the right or left of a paired organ such as the right kidney or the left kidney. Unilateral describes a single organ/side. Bilateral describes both organs/sides.

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

Multicentric: A primary tumor with satellites in surrounding tissue.

Multifocal: Multiple tumors arising from two or more locations.

Multiple primaries describes two or more independent primary reportable neoplasms.

Non-synchronous (Metachronous) tumors are multiple masses or lesions that occur greater than two months from the original/initial diagnosis.

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

Primary site is the anatomical portion of the body where the cancer originated.

Simultaneous tumors are multiple tumors identified at the time of diagnosis.

Synchronous tumors are multiple tumors diagnosed within two months of the original/initial diagnosis.

Single primary describes one distinctive reportable cancer.

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

Example 1: Colon primary: a large tumor originating in the ascending colon with intramucosal spread into the transverse colon. Abstract as a single primary and record the primary site as ascending colon.

Example 2: The patient has multiple papillary urothelial bladder tumors with in situ spread into the ureters. Abstract as a single primary and record the primary site as bladder. (Mucosal spread of a urinary tract tumor may be called “field affect” or “regional diathesis”).

HOW TO DETERMINE SAME VS. DIFFERENT PRIMARY SITE (BASED ON ICD-O-3 TOPOGRAPHY CODE)

1. The **third numeric digit** after the ‘C’ describes a subsite of the organ; it is **not used** to define individual (different) sites. (*See exceptions listed below*)

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

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

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

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

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

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

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

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

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

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

SEER Site Grouping Table

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

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

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

HOW TO DETERMINE SAME VS. DIFFERENT HISTOLOGY (BASED ON ICD-O-3 HISTOLOGY CODES)

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

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

MULTIPLE PRIMARY RULES FOR SOLID TUMORS

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

Definitions

Simultaneous tumors are identified at the time of diagnosis.

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

The multiple primary rules are presented in two formats, text and table. Note that the rule numbers in both formats are identical.

RULES FOR SINGLE TUMOR

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

Example 1: A single lesion involving the tongue and floor of mouth is one primary.

Example 2: A single, large mucinous adenocarcinoma involving the sigmoid and descending colon segments is one primary.

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

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

Example 1: A single lesion containing both embryonal cell carcinoma and teratoma is a single primary and would be coded to 9081/3, mixed embryonal carcinoma and teratoma.

Example 2: A single lesion of the liver composed of neuroendocrine carcinoma (8246/3) and hepatocellular carcinoma (8170/3) is a single primary and would be coded to the more specific histology, neuroendocrine carcinoma 8246/3.

Rules for Multiple Tumors

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

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

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

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

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

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

- a. It is one primary if the physician states the tumor in one organ is metastatic from the other.
 - i. Code the laterality to the side in which the primary originated
 - ii. Code the laterality as 4 if it is unknown which in which side the primary originated
- b. Code as multiple primaries if the physician states these are independent primaries or when there is no physician statement that one is metastatic from the other.

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

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

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

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

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

Example 1: Infiltrating duct carcinoma of the upper outer quadrant of the right breast diagnosed March 2004 and treated with lumpectomy. Previously unidentified mass in left inner quadrant right breast noted in July 2004 mammogram. This was removed and found to be infiltrating duct carcinoma. Abstract the case as two primaries.

Example 2: During the workup for a squamous cell carcinoma of the vocal cord, a second squamous cell carcinoma is discovered in the tonsillar fossa. Abstract as two primaries.

Exception 2: Effective with cases diagnosed January 1995 and later, **if an in situ tumor is followed by an invasive cancer in the same site more than two months apart, report as two primaries even if stated to be a recurrence.** The invasive primary should be reported with the date of the *invasive* diagnosis. (*Note:* The purpose of this guideline is to ensure that the case is counted as an incident case (i.e., invasive) when incidence data are analyzed.)

If the medical record indicates the new tumor is a “recurrence” of a tumor that was originally diagnosed as in situ, and the type of recurrence is listed below, the term “recurrence” should be ignored and the tumor must be reported as a new case.

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

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

- Multiple invasive adenocarcinomas of the prostate (C619)
- Multiple invasive bladder cancers (C670 - C679) with histology codes 8120-8130

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

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

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

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

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

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

Exception 2: For colon and rectum tumors:

- a. When an adenocarcinoma (8140/_; in situ or invasive) arises in the same segment of the colon or rectum as an adenocarcinoma in a polyp (8210/_ , 8261/_ , 8263/_), abstract a single primary and code the histology as adenocarcinoma (8140/_).
- b. Familial adenomatous polyposis (FAP) (8220) with malignancies arising in polyps in the same or multiple segments of the colon or rectum, abstract as a single primary.

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

Example 1: A thyroid specimen contains two separate carcinomas— one papillary and the other follicular. Abstract one primary when the histology is papillary and follicular (8340).

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

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

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

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

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

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

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

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

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

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

Table of Rules to Determine Multiple Primaries for Solid Tumors

Rule	Tumors	Site(s)	Histology	Variables	Timing	Single vs. multiple primary
1	Single	NA	NA		NA	Single
2	Single	NA	Different		NA	Single
3	Multiple	Same	Same	Non-paired or only one side of paired organ	Simultaneous or synchronous	Single
	Multiple	Same	Same	Non-paired or only one side of paired organ	Simultaneous or synchronous	Single
4	Multiple	Same (bilateral)	Same	Both sides of paired organ involved	Simultaneous or synchronous	Multiple unless physician states one is metastatic. <i>Exceptions:</i> Bilateral tumors: Ovary (same histology), retinoblastoma, or Wilms tumor are a single primary
5	Multiple	Same	Same		Synchronous	Multiple unless physician states recurrent or metastatic <i>Exceptions:</i> 1. Report as a single primary: a. Invasive prostate with histology (8140) b. Invasive bladder with histologies (8120-8130) c. Kaposi sarcoma (9140) 2. For all sites: Report as multiple primaries: In situ followed by invasive even if stated to be recurrence.

Rule	Tumors	Site(s)	Histology	Variables	Timing	Single vs. multiple primary
6	Multiple	Same	Different	Single paired or unpaired organ	Simultaneous or synchronous	Multiple Exceptions: The following are single primaries: 1. One histology is a more specific histology than the other (NOS and specific). 2. Colon: a. (Adeno) carcinoma and (adeno) carcinoma arising in a polyp. b. Familial adenomatous polyposis (FAP) with malignancies arising in polyps. 3. Histology combinations commonly found together a. Thyroid (follicular and papillary) b. Bladder (transitional and papillary) 4. Breast: if two lesions in one breast are: a. Lobular and ductal b. Paget disease and ductal or intraductal
7	Multiple	Same	Different	Both sides of paired organ	Simultaneous or synchronous	Multiple Exceptions: Report as single: 1. If stated to be metastatic
8	Multiple	Same	Different		More than 2 months after original/initial tumor	Multiple
9	Multiple	Different	Different		NA	Multiple
10	Multiple	Different	Same		NA	Multiple unless stated to be metastatic Exception: Wilms tumor

Multiple Primary Rules for Solid Tumors - Rule Number Conversion Table

This table displays the current Multiple Primary Rules for Solid Tumors by rule number compared to the rule(s).

Current Rule Number	SPCM 3rd edition Rule Number	Comment
1	1	
2	2	
3a	4a	
3b	3	Former Rule 3 is now two rules: Rule 3b and Rule 5
4a	6a, ii	
4b	6a, i	
4b, exception 1	6a, exception 1	
4b, exception 2	6a, exception 2	Former Rule 6a, exception 2 is now two exceptions: Rule 4b, exception 2 and Rule 4b, exception 3
4b, exception 3	6a, exception 2	Former Rule 6a, exception 2 is now two exceptions: Rule 4b, exception 2 and Rule 4b, exception 3
5	3	Former Rule 3 is now two rules: Rule 3b and Rule 5
5, exception 1	3	
5, exception 2	3, exception 2	
5, exception 3	3, exception 1	
5, exception 4	3, exception 3	
6	5a	
6, exception 1	5, exception 1	
6, exception 2, a	5, exception 1, i and ii	
6, exception 2, b		
7	6b	
8	5a	
9	5b	
10	4b	

DETERMINING MULTIPLE PRIMARIES: HEMATOPOIETIC PRIMARIES
(Lymphoma and Leukemia)

Patients with hematologic malignancies often have multiple pathology reports and the diagnoses reported may require different morphology codes. This is due in part to the fact that more intensive diagnostic testing may yield a more specific diagnosis, and in part due to the nature of hematopoietic diseases, which may progress from one diagnosis into another. If the physician clearly states that a hematopoietic diagnosis is a new primary, use that information. If there is no clear information from the physician, use the Appendix C to determine multiple primaries.

DETERMINING MULTIPLE PRIMARIES:
BENIGN AND BORDERLINE PRIMARY INTRACRANIAL AND CNS TUMORS
(C70.0-C72.9, C75.1-C75.3)

Definitions

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

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

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

HOW TO DETERMINE SAME VS DIFFERENT HISTOLOGIES
(BASED ON HISTOLOGIC GROUPINGS)

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

Histologic groupings to determine same histology for non-malignant brain tumors

Histologic Group	ICD-O-3 Code
Choroid plexus neoplasms	9390/0, 9390/1
Ependymomas	9383, 9394, 9444
Neuronal and neuronal-glial neoplasms	9384, 9412, 9413, 9442, 9505/1, 9506
Neurofibromas	9540/0, 9540/1, 9541, 9550, 9560/0
Neurinomatosis	9560/1
Neurothekeoma	9562
Neuroma	9570
Perineurioma, NOS	9571/0

Instructions for Using Histologic Group Table

1. Both histologies are listed in the table

- a. Histologies that are in the same **grouping** or row in the table are the **same histology**.
- b. **Note:** Histologies that are in the same grouping are a progression, differentiation or subtype of a single histologic category.
- c. Histologies listed in **different groupings** in the table are **different histologies**.

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

- a. If the **ICD-O-3 codes** for both histologies have the **identical** first three digits, the histologies are the **same**.
- b. If the first three digits of the **ICD-O-3** histology code are **different**, the histology types are different.

MULTIPLE PRIMARY RULES FOR BENIGN AND BORDERLINE PRIMARY INTRACRANIAL AND CNS TUMORS

The multiple primary rules are presented in two formats, text and table. Note that the rule numbers in both formats are identical.

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

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

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

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

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

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

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

Table of Rules to Determine Multiple Primaries for Benign and Borderline Primary Intracranial and CNS Tumors

Rule #	Site	Laterality	Histology	Primary(ies)
1	Same	Same	Same	Single
2	Same	Unknown	Same	Single
3	Different	Any	Same	Multiple
4	Same	Different sides of the same site in the CNS	Same	Multiple
5	Any	Any	Different	Multiple

HISTOLOGIC TYPE

The data item Histologic Type describes the microscopic composition of cells and/or tissue for a specific primary. The tumor type or histology is a basis for staging and determination of treatment options. It affects the prognosis and course of the disease.

The *International Classification of Diseases for Oncology*, Third Edition (ICD-O-3) is the standard reference for coding the histology for tumors diagnosed in 2001 and later. Refer to *ICD-O-3* for guidance in coding the histology. See sections *Coding Guidelines for Topography and Morphology*, and *Summary of Principal Rules for Using the ICD-O*, Third Edition. Do not record the ‘M’ that precedes the histology code.

In the rare instance where there is no tissue pathology, code the histology the medical practitioner uses to describe the tumor. The codes for Cancer, NOS (8000) and Carcinoma, NOS (8010) differ, and the terms are NOT interchangeable. If the only diagnosis stated is “cancer”, the histology code must be 8000. If the only diagnosis stated is “carcinoma”, the histology code must be 8010.

The histology can be coded only after the determination of multiple primaries has been made.

Synonyms and Equivalent Terms

Mixed, combined, and complex are usually used as synonyms when describing histology.

Definitions

Cancer, NOS (8000) and carcinoma, NOS (8010) are not interchangeable.

Carcinoma, NOS (8010) and adenocarcinoma (8140) are interchangeable (See ICD-O-3).

Complex (mixed, combined) histology: The pathologist uses **multiple histologic terms** to describe a tumor. The histologic terms are frequently connected by the word “and” (for example ductal and lobular carcinoma).

Different histology: The first three digits of the ICD-O-3 histology code are different.

Different subtypes: The NOS cell types often have multiple subtypes; for example, scirrhous adenocarcinoma (8143), adenocarcinoma, intestinal type (8144), and linitis plastica (8141) are subtypes of Adenocarcinoma, NOS (8140).

Mixed/combined histology: Different cell types in one tumor; terms used interchangeably. In most cases, the terms mixed and combined are used as synonyms; however the term mixed may designate a specific tumor.

Not Otherwise Specified (NOS): “Not Otherwise Specified.”

Definitions (Continued)

Same histology: The first three digits of the ICD-O-3 histology code are identical.

Majority of Tumor:

Terms that mean the majority of tumor	Terms that DO NOT mean the majority of tumor
Predominantly	With foci of
With features of	Focus of/focal
Major	Areas of
Type ¹	Elements of
With Differentiation ¹	Component ¹
Pattern (Only if written in College of American Pathologists [CAP] Protocol) ²	
Architecture (Only if written in College of American Pathologists [CAP] Protocol) ²	

Note: Examples of CAP protocols for specific primary sites may be found on the website - http://www.cap.org/cancerprotocols/protocols_intro.html

Coding Instructions

The histology can only be coded after the determination of multiple primaries has been made. Refer to “Determining Multiple Primaries” section of this manual to determine the number of primaries. Use all of the information for a single primary to code the histology.

1. If there is no tumor specimen, code the histology described by the medical practitioner.

Example 1: The patient has a CT scan of the brain with a final diagnosis of glioblastoma multiforme (9440). The patient refuses all further workup or treatment. Code the histology to glioblastoma multiforme (9440).

Example 2: If the physician says that the patient has carcinoma, code carcinoma, NOS (8010).

2. Use the histology stated in the **final diagnosis** from the pathology report. Use the pathology from the procedure that resected the majority of the primary tumor.

If a more specific histologic type is definitively described in the microscopic portion of the pathology report or the comment, code the more specific diagnosis.

3. Lymphomas may be classified by the **WHO** Classification, **REAL** system, **Rappaport**, or **Working Formulation**. The WHO Classification is preferred. See page 13 in the ICD-O-3 for a discussion of hematologic malignancies.

1 Effective 1/1/1999 diagnosis

2 Effective 1/1/2003 diagnosis

4. If the only pathology specimen is from a metastatic site, code the appropriate histology code and use the malignant behavior code /3. Do not use the metastatic (/6) behavior code. The primary site and its metastatic site(s) have the same basic histology.

Histology Coding Rules for Single Tumor

- **The rules are in hierarchical order. Rule 1 has the highest priority.**
- **Use the rules in priority order.**
- **Use the first rule that applies to the case. (Do not apply any additional rules.)**

1. Code the histology if only **one type** is mentioned in the pathology report.
2. Code the **invasive histology** when both invasive and in situ tumor are present

Example: Pathology report reads infiltrating ductal carcinoma and cribriform ductal carcinoma in situ. Code the invasive histology 8500/3.

Exception: If the histology of the invasive component is an 'NOS' term (e.g., carcinoma, adenocarcinoma, melanoma, sarcoma), then code the histology of the specific term associated with the in situ component and an invasive behavior code.

3. Use a **mixed** histology code if one exists

Examples of mixed codes: (This is not a complete list, these are examples only)

8490 Mixed tumor, NOS
9085 Mixed germ cell tumor
8855 Mixed liposarcoma
8990 Mixed mesenchymal sarcoma
8951 Mixed mesodermal tumor
8950 Mixed Mullerian tumor
9362 Mixed pineal tumor
8940 Mixed salivary gland tumor, NOS
9081 Teratocarcinoma, mixed embryonal carcinoma and teratoma

4. Use a **combination** histology code if one exists

Examples of combination codes: (This is not a complete list; these are examples only)

8255 Renal cell carcinoma, mixed clear cell and chromophobe types
8522 Ductal and lobular carcinoma
8523 Infiltrating duct carcinoma mixed with other types of carcinoma
8524 Infiltrating lobular carcinoma mixed with other types of carcinoma
8560 Adenosquamous carcinoma
8045 Combined small cell carcinoma, combined small cell-large cell

5. Code the **more specific term** when one of the terms is ‘NOS’ and the other is a more specific description of the same histology.

Example 1: Pathology report reads poorly differentiated carcinoma, probably squamous in origin. Code the histology as squamous cell carcinoma rather than the non-specific term “carcinoma.”

Example 2: The pathology report from a nephrectomy reads renal cell carcinoma (8312) (renal cell identifies the affected organ system rather than the histologic cell type) in one portion of the report and clear cell carcinoma (8310) (a histologic cell type) in another section of the report. Code clear cell carcinoma (8310); renal cell carcinoma (8312) refers to the renal system rather than the cell type, so renal cell is the less specific code.

6. Code the **majority** of tumor.
 - a. Based on the pathology report description of the tumor.
 - b. Based on the use of majority terms. See definition for majority terms.
7. Code the **numerically higher** ICD-O-3 code. This is the rule with the lowest priority and should be used infrequently.

Histology Coding Rules for Multiple Tumors with Different Behaviors in the Same Organ Reported as a Single Primary

1. Code the histology of the invasive tumor when one lesion is in situ (/2) and the other is invasive (/3).

Example: At mastectomy for removal of a 2 cm invasive ductal carcinoma, an additional 5 cm area of intraductal carcinoma was noted. Code histology and behavior as invasive ductal carcinoma (8500/3).

Histology Coding Rules for Multiple Tumors in Same Organ Reported as a Single Primary

1. Code the histology when multiple tumors have the same histology.
2. Code the histology to adenocarcinoma (8140/_; in situ or invasive) when there is an adenocarcinoma and an adenocarcinoma in a polyp (8210/_ , 8261/_ , 8263/) in the same segment of the colon or rectum.
3. Code the histology to carcinoma (8010/_; in situ or invasive) when there is a carcinoma

4. Use a **combination** code for the following:
 - a. Bladder: Papillary and urothelial (transitional cell) carcinoma (8130)
 - b. Breast: Paget Disease and duct carcinoma (8541)
 - c. Breast: Duct carcinoma and lobular carcinoma (8522)
 - d. Thyroid: Follicular and papillary carcinoma (8340)
5. Code the more specific term when one of the terms is ‘NOS’ and the other is a more specific description of the same histology.
6. Code all other multiple tumors with different histologies as multiple primaries.

How to determine same vs different histologies for benign and borderline primary intracranial and CNS tumors (C70.0-C72.9, C75.1-C75.3) (Based on histologic groupings)

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

Instructions for Using Histologic Group Table

1. **Both** histologies are listed **in the table**
 - a. Histologies that are in the same **grouping** or row in the table are the **same histology**.
Note: Histologies that are in the same grouping are a progression, differentiation or subtype of a single histologic category.
 - b. Histologies listed in **different groupings** in the table
2. One or both of the **histologies** is **not** listed **in the table** are **different histologies**.
 - a. If the **ICD-O-3 codes** for both histologies have the **identical** first three digits, the histologies are the **same**.
 - b. If the first three digits of the **ICD-O-3** histology code are **different**, the histology types are different.

Histologic groupings to determine same histology for non-malignant brain tumors

Histologic Group	ICD-O-3 Code
Choroid plexus neoplasm	9390/0, 9390/1
Ependymoma	9383, 9394, 9444
Neuronal and neuronal-gliial neoplasm	9384, 9412, 9413, 9442, 9505, 9506
Neurofibroma	9540/0, 9540/1, 9541, 9550, 9560
Neurinomatosis	9560
Neurothekeoma	9562
Neuroma	9570
Perineurioma, NOS	9571

Leukemia/Lymphoma (Chronic Lymphocytic Leukemia [CLL] and Small Lymphocytic Lymphoma [SLL])

Code the diagnosis of chronic lymphocytic leukemia (9823/3) and/or small lymphocytic lymphoma (9670/3) to SLL if there are positive lymph nodes or deposits of lymphoma/leukemia in organs or in other tissue. Code the histology to CLL if there are no physical manifestations of the disease other than a positive blood study or positive bone marrow.

BEHAVIOR CODE

The fifth digit of the morphology code represents the behavior code. It is preceded by a slash (/). See ICD-O-3 (page 66) for a discussion of the behavior code.

All malignancies with in situ /2 and malignant /3 behavior codes as described in ICD-O-3 must be reported. Also, benign /0 and borderline /1 intracranial and CNS tumors for cases diagnosed on or after 1/1/2004 must be reported.

Codes

- 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)

Coding Instructions

Behavior codes 0 (benign) and 1 (borderline) are **reportable for intracranial and CNS sites only**, beginning with January 1, 2004 diagnoses.

Metastatic or Nonprimary Sites

If the only pathology specimen is from a metastatic site, code the appropriate histology code and use the malignant behavior code (/3). Do not use the metastatic (/6) behavior code. The primary site and its metastatic site(s) have the same basic histology. The primary site and its metastatic site(s) have the same basic histology.

In situ

Clinical evidence alone cannot identify the behavior as in situ; the code must be based on pathologic examination and documentation.

In situ and Invasive

Code the behavior as malignant (/3) if **any** portion of the primary tumor is invasive regardless of how limited; i.e., microinvasion.

Example: Pathology from mastectomy: Large mass composed of intraductal carcinoma with a single focus of invasion. Code the behavior as malignant (/3).

ICD-O-3 Histology/Behavior Code Listing

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. See the Morphology and Behavior Code Matrix discussion on page 29 in *ICD-O-3*.

Example: The pathology report says large cell carcinoma in situ. The *ICD-O-3* lists large cell carcinoma as 8013/3; there is only a malignant listing. Change the (/3) to (/2) and code the histology and behavior code to 8013/2 as specified by the physician.

Note: 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).

Synonyms for In situ

AIN III (C211)
Behavior code ‘2’
Bowen disease (not reportable for C440-C449)
Clark level I for melanoma (limited to epithelium)
Confined to epithelium
Hutchinson melanotic freckle, NOS (C44_)
Intracystic, non-infiltrating
Intraductal
Intraepidermal, NOS
Intraepithelial, NOS
Involvement up to, but not including the basement membrane
Lentigo maligna (C44_)
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, colon, or rectal tumors confined to the lamina propria)
VAIN III (C529)
VIN III (C51_)

GRADE, DIFFERENTIATION, OR CELL INDICATOR

Grade, Differentiation (Codes 1, 2, 3, 4, 9)

The grade describes how closely the tumor cells resemble normal tissue. Well differentiated tumor cells closely resemble normal tissue. Poorly differentiated and undifferentiated tumor cells are abnormal looking and do not resemble normal tissue.

Pathologists may define the tumor by describing two levels of similarity (two-grade system); by describing three levels of similarity (three-grade system); or by describing four levels of similarity (four-grade system). These similarities/differences may be based on pattern (architecture), cytology, or nuclear features or a combination of these elements depending upon the grading system that is used. The information from this data item is useful for determining prognosis.

To code the grade in a four-grade system, see the codes below. To code the grade in a two-grade or three-grade system, refer to the corresponding sections on the following pages.

Cell Indicator (Codes 5, 6, 7, 8, 9)

Describes the lineage or phenotype of the cell that became malignant. Cell indicator codes apply to lymphomas and leukemias. **The cell indicator takes precedence over grade/differentiation.**

Codes

- 1 Grade I; grade i; grade 1; well differentiated; differentiated, NOS
- 2 Grade II; grade ii; grade 2; moderately differentiated; moderately well differentiated; intermediate differentiation
- 3 Grade III; grade iii, grade 3; poorly differentiated; dedifferentiated
- 4 Grade IV; grade iv; grade 4; undifferentiated; anaplastic
- 5 T-cell; T-precursor
- 6 B-Cell; Pre-B; B-precursor
- 7 Null cell; Non T-non B
- 8 NK cell (natural killer cell) (effective with diagnosis 1/1/1995 and after)
- 9 Grade/differentiations unknown, not stated, or not applicable

TEXT WRITING

Text is required on all abstracts submitted to the TCR. To meet the minimum requirements, the text must justify the coding for the following data items:

Primary Site
Histology
Grade
Behavior
Stage- CS Tumor size
CS Extension
CS Lymph nodes
CS Mets at diagnosis
Treatment information (if coded)

The central registry is required to perform visual edits on a percentage of all abstracts submitted. Visual editing is a process that verifies the codes and text correlate. Without supporting text, visual editing can not be performed and the central registry is unable to determine the accuracy of the data.

The central registry also uses text to merge information submitted by different hospitals on the same case. On a daily basis, the central registry staff is faced with making decisions about how to handle multiple abstracts submitted for a single patient. Without text it is extremely difficult to decide whether the patient has a single malignancy or multiple primaries.

Example: Hospital A: On Feb. 22, 2001 a patient has a scan that identifies a mass on the adrenal gland. On Feb 24, 2001 the patient undergoes a needle biopsy of the mass. The pathology report confirms an adenocarcinoma in the specimen. Hospital A submits an abstract with the primary site listed as adrenal gland (C74.9) and an unknown summary stage (9).

Hospital B: On March 21, 2001, the patient goes to Hospital B for further workup and resection. A CT scan identifies a mass in the transverse colon that appears to extend into the adrenal gland. The surgeon performs a resection. The pathology report confirms the transverse colon mass to be adenocarcinoma with invasion into the adrenal gland. Hospital B submits an abstract with the primary site listed as transverse colon (C18.4) and the summary stage coded to distant.

If neither hospital includes text on the abstracts, the Central Registry receives the following information:

Patient X:	Hospital A: 2/24/01	Primary site: C 74.9	Stage: 9	Hist: 8140/39
	Hospital B: 3/21/01	Primary site: C 18.4	Stage: 7	Hist: 8140/39

Without text there is no way of knowing these abstracts represent the same malignancy; and, erroneously these abstracts would be entered into the database as two primaries and inflate the incidences of cancer in Tennessee.

WHAT TEXT IS NEEDED

Text writing (abstracting) is the process of condensing a patient's medical chart into a few short lines of information that validate the coding of the data items. To save time and space, standard abbreviations should be used whenever possible (See a listing of common abbreviations included in this chapter.) When justifying staging information it is very important to be specific regarding what tissues or organs are involved. (Example: into the serosa; 4 lymph nodes positive; mets to the liver; in-situ; into the submucosa.) **General statements such as “localized”, “regional”, and “distant” are not specific and should never be used to justify the stage.**

While reviewing a medical report, think: location, size, extension (local, regional, lymph nodes, mets), histology, grade, date and procedure performed. The text worksheets on the following pages can be used as guides for identifying valuable information located in a medical chart and what should be documented in the text fields.

Remember: Almost all reports can be reduced into a few words that justify the coding.

Example: 4/7/01 Cystoscopy; bladder biopsies-

The patient was placed in the lithotomy position. Under satisfactory general anesthesia, the cystoscope was passed into the bladder. At this point, a careful evaluation of the bladder revealed a relatively large, approximately 3cm, tumor on the dome of the bladder. This appeared sessile and it was obviously a malignancy. There was surrounding erythema. The rest of the bladder showed some inflammatory changes with erythema, but no overt lesions were noted.

Example of text for the above report:

4/7/01 Cystoscopy: 3cm sessile tumor, bladder dome. Obvious mal.

Additional examples of text writing are located in Section 2. See the *Text* data items.

Text/ Abstracting Worksheet for: Breast

Text Dx.	<p>PE: Record findings from the physical exam. In which quadrant of the breast was the mass felt? Size? What was the condition of the skin? Document any mention of “inflammation of the skin”, “Peau d’orange”, “erythema”, “skin edema”, “pigskin”. Was there fixation to the chest wall/ rib? Palpable lymph nodes in the axilla? If no mass or no lymph nodes felt, record that information.</p>	Text Rx. / Misc.	<p>Surgery: Record the name(s) and date(s) of all surgical procedures. (Excisional biopsy, lumpectomy, quadrantectomy, modified radical mastectomy, etc.)</p>
	<p>X-ray/Scans: Document location of mass (indicating specific quadrant of the breast), size, and extent of disease from mammogram, ultrasound exams, chest x-rays, bone scans, etc.</p>		<p>Rad (Beam): Record the date beam radiation therapy began, what sites treated, and total dosage.</p>
	<p>Scopes: N/A</p>		<p>Rad (Other): Record the date radiation therapy began, what type of rad given, what sites treated, and total dosage.</p>
	<p>Lab Tests: Report cytology findings from aspirations, if done. Record ERA and PRA, if done.</p>		<p>Chemo: Record the date chemotherapy began and which agent(s) given.</p>
	<p>OP: Record date and name of procedure, observations made by surgeon (size, location, impression regarding involvement of other tissues, distant mets, etc.). Was a sentinel lymph node bx done?</p>		<p>Hormone: Record the date hormone therapy began and which agent(s) given.</p>
	<p>Path: Record the date and name of procedure, path #, site, histology, grade (identify grading scheme, i.e., Mod. Bloom-Richardson), size, lymph nodes involved, lymph nodes exam’d, extent of involvement/spread within the organ or surrounding tissues. If more than one procedure performed, list reports individually.</p>		<p>BRM: Record the date behavior response modifier /immunotherapy began and what agent(s) given.</p>
	<p>Primary Site Title: Indicate the most specific subsite available and laterality.</p>		<p>Other: Record the date “other” therapy began and what the therapy consisted of.</p>
	<p>Histology Title: Record the histology of the primary tumor with the behavior and grade.</p>		<p>Remarks: Use this field as additional space for explanations, add’l information, etc.</p>
	<p>Staging: Document the extent of spread. What tissues/ organs/ lymph nodes were involved? Distant mets?</p>		<p>Place of Diagnosis: List where the patient was diagnosed for this malignancy.</p>
	<p>Local-Use Text: Use this field as additional space for explanations, add’l information, etc.</p>		

Text/ Abstracting Worksheet for: Colon and Rectum

Text Dx.	<p><u>PE:</u> Document findings from rectal exam and examination of abdomen, liver, and peripheral lymph nodes. Document any mention of familial/ multiple polyposis. Document pt symptoms (i.e., rectal bleeding, wt loss).</p>	Text Rx. / Misc.	<p><u>Surgery:</u> Record the name(s) and date(s) of all surgical procedures. (Polypectomy, partial colectomy, hemicolectomy, total colectomy, abdominoperineal resection, lymph node dissections, total proctocolectomy, etc.)</p>
	<p><u>X-ray/Scans:</u> Document site, size, and extent of disease from barium enemas, CT scans, ultrasound exams, chest x-rays, liver scans, etc.</p>		<p><u>Rad (Beam):</u> Record the date beam radiation therapy began, what sites treated, and total dosage.</p>
	<p><u>Scopes:</u> Document location and size of tumor from the colonoscopy/ proctoscopy.</p>		<p><u>Rad (Other):</u> Record the date radiation therapy began, what type of rad given, what sites treated, and total dosage.</p>
	<p><u>Lab Tests:</u> Report cytology findings, if any. (Optional-report CEA, CA-19-9)</p>		<p><u>Chemo:</u> Record the date chemotherapy began and which agent(s) given.</p>
	<p><u>OP:</u> Record date and name of procedure, observations made by surgeon (size, location, impression regarding involvement of other tissues, distant mets, etc). Pay special attention to the liver. Is there direct extension into the liver or is there seeding / mets nodules? Depending on the primary site, this information may affect the Summary Stage.</p>		<p><u>Hormone:</u> Record the date hormone therapy began and which agent(s) given.</p>
	<p><u>Path:</u> Record the date and name of procedure, path #, site, histology, grade, size, lymph nodes involved, lymph nodes exam'd, extent of involvement/spread within the organ or surrounding tissues. If more than one procedure performed, list reports individually.</p>		<p><u>BRM:</u> Record the date behavior response modifier /immunotherapy began and what agent(s) given.</p>
	<p><u>Primary Site Title:</u> Indicate the specific subsite of the colon in which the malignant lesion arose. (Often times, the site indicated from the colonoscopy differs from the site indicated on the resection path report. This could be because it isn't easy to determine exactly where the scope is, but the surgeon has a clear view of the lesion at the time of the resection. Or, there might be multiple separate lesions in the different subsites. Exam the chart carefully to prevent miscoding the site or missing another primary.)</p>		<p><u>Other:</u> Record the date "other" therapy began and what the therapy consisted of.</p>
	<p><u>Histology Title:</u> Record the histology of the primary tumor with the behavior and grade.</p>		<p><u>Remarks:</u> Use this field as additional space for explanations, add'l information, etc.</p>
	<p><u>Staging:</u> Document the extent of spread. What tissues/ organs/ lymph nodes were involved? Distant mets?</p>		<p><u>Place of Diagnosis:</u> List where the patient was diagnosed for this malignancy.</p>
	<p><u>Local-Use Text:</u> Use this field as additional space for explanations, add'l information, etc.</p>		

Text / Abstracting Worksheet for: Lung

Text Dx.	<p><u>PE:</u> Record findings from the physical exam that might indicate spread of disease (i.e., vocal cord paralysis, superior vena cava syndrome, lymphadenopathy or lymph node enlargement in the neck, etc.). Record patient symptoms.</p>	Text Rx. / Misc.	<p><u>Surgery:</u> Record the name(s) and date(s) of all surgical procedures. (Wedge resection, lobectomy, pneumonectomy, lymph node dissections, etc.)</p>
	<p><u>X-ray/Scans:</u> Document location, laterality of mass (es), size, and extent of disease from CT scans, chest x-rays, liver scans, etc. Record presence of multiple masses, pleural effusion, atelectasis, obstructive pneumonitis, presence of mediastinal or hilar mass or lymph nodes, etc.</p>		<p><u>Rad (Beam):</u> Record the date beam radiation therapy began, what sites treated, and total dosage.</p>
	<p><u>Scopes:</u> Document findings from mediastinoscopy and bronchoscopy.</p>		<p><u>Rad (Other):</u> Record the date radiation therapy began, what type of rad given, what sites treated, and total dosage.</p>
	<p><u>Lab Tests:</u> Report cytology findings from brushings/ washings/ sputum/ Fine needle aspirations, if done (i.e., Date/ #: FNA-Pleural fluid-+ for malig cells).</p>		<p><u>Chemo:</u> Record the date chemotherapy began and which agent(s) given.</p>
	<p><u>OP:</u> Record date and name of procedure, observations made by surgeon (size, location, impression regarding involvement of other tissues, distant mets, etc.).</p>		<p><u>Hormone:</u> Record the date hormone therapy began and which agent(s) given.</p>
	<p><u>Path:</u> Record the date and name of procedure, path #, site, histology, grade, size, lymph nodes involved, lymph nodes exam'd, extent of involvement/spread within the organ or surrounding tissues. Note if the tumor involved or penetrated the pleura. If more than one procedure performed, list reports individually.</p>		<p><u>BRM:</u> Record the date behavior response modifier /immunotherapy began and what agent(s) given.</p>
	<p><u>Primary Site Title:</u> Indicate laterality of primary tumor and the lobe in which it arose (i.e., Rt lower lobe, lung).</p>		<p><u>Other:</u> Record the date “other” therapy began and what the therapy consisted of.</p>
	<p><u>Histology Title:</u> Record the histology of the primary tumor with the behavior and grade.</p>		<p><u>Remarks:</u> Use this field as additional space for explanations, add'l information, etc.</p>
	<p><u>Staging:</u> Document the extent of spread. What tissues/ organs/ lymph nodes were involved? Distant mets?</p>		<p><u>Place of Diagnosis:</u> List where the patient was diagnosed for this malignancy.</p>
			<p><u>Local-Use Text:</u> Use this field as additional space for explanations, add'l information, etc.</p>

Text / Abstracting Worksheet for: Lymphoma

Text Dx.	<p>PE: From the physical exam, record any mention of palpable lymph nodes, mass(es), splenomegaly (spleen enlargement), liver enlargement, skin eruptions. Record pt symptoms (i.e., unexplained fever over 38 degrees centigrade, night sweats, unexplained wt loss more than 10% of the body wt within 6 mo. of diagnosis, pruritis, etc.)</p>	Text Rx. / Misc.	<p>Surgery: Record the name(s) and date(s) of all surgical procedures. (Excisional biopsy, bone marrow biopsy/ aspiration, etc.)</p>
	<p>X-ray/Scans: Record findings from CT scans and x-rays indicating the presence of any enlarged lymph nodes or masses.</p>		<p>Rad (Beam): Record the date beam radiation therapy began, what sites treated, and total dosage.</p>
	<p>Scopes: Document findings from endoscopic procedures and mediastinoscopy.</p>		<p>Rad (Other): Record the date radiation therapy began, what type of rad given, what sites treated, and total dosage.</p>
	<p>Lab Tests: N/A</p>		<p>Chemo: Record the date chemotherapy began and which agent(s) given.</p>
	<p>OP: Record date and name of procedure, observations made by surgeon regarding involvement of other tissues.</p>		<p>Hormone: Record the date hormone therapy began and which agent(s) given.</p>
	<p>Path: Record the date and name of procedure, path #, biopsy specimen, histology, cell type, spread within the organ, surrounding tissues, or bone marrow. If more than one procedure performed, list reports individually.</p>		<p>BRM: Record the date behavior response modifier /immunotherapy began and what agent(s) given.</p>
	<p>Primary Site Title: Indicate the primary site in which the lymphoma began. All radiographic information, clinical information, and pathological information must be used in order to determine the primary site. The primary site may be a single chain of lymph nodes, multiple chains of lymph nodes, or an extralymphatic organ.</p>		<p>Other: Record the date “other” therapy began and what the therapy consisted of.</p>
	<p>Histology Title: Record the specific histology of the primary tumor with the behavior and cell type (i.e., B-cell, T-cell, etc.). If no cell type is given, code the “differentiation”. Do not use the “grade” of a lymphoma to determine the 6th digit of the morphology code. The grade of a lymphoma refers to its “type” not its differentiation.</p>		<p>Remarks: Use this field as additional space for explanations, add'l information, etc.</p>
	<p>Staging: Document all lymph nodes, organs, bone marrow involved by the lymphoma.</p>		<p>Place of Diagnosis: List where the patient was diagnosed for this malignancy.</p>
	<p>Local-Use Text: Use this field as additional space for explanations, add'l information, etc.</p>		

Text / Abstracting Worksheet for: Prostate

Text Dx.	<p>PE: Record exactly how the physician describes the prostate (i.e, hard ridge, fixed, nodule, asymmetrical, enlarged, etc). Record finding that might indicate spread of disease (i.e., fixed to pelvic bone). Record any mention of lymph nodes.</p>	Text Rx. / Misc.	<p>Surgery: Record the name(s) and date(s) of all surgical procedures. (Transurethral resection- TURP, radical prostatectomy, etc.)</p>
	<p>X-ray/Scans: Document location (lobe), size, extent of disease, and presence of lymph nodes from rectal ultrasound (TRUS) exams, chest x-rays, bone scans, etc. From the ultrasound, record any mention of “hypoechoic” areas, “streaky densities in fat”, “hypoechoogenicity”, “suspicious”.</p>		<p>Rad (Beam): Record the date beam radiation therapy began, what sites treated, and total dosage.</p>
	<p>Scopes: N/A</p>		<p>Rad (Other): Record the date radiation therapy began, what type of rad given, what sites treated, and total dosage.</p>
	<p>Lab Tests: Report cytology findings, if any. Report PAP, PSA.</p>		<p>Chemo: Record the date chemotherapy began and which agent(s) given.</p>
	<p>OP: Record date and name of procedure, observations made by surgeon (impression regarding involvement of other tissues, distant mets, etc.).</p>		<p>Hormone: Record the date hormone therapy began and which agents given or procedure performed (i.e., bilateral orchiectomy).</p>
	<p>Path: Record the date and name of procedure, path #, site, which lobe(s) involved, histology, grade (identify grading scheme i.e., Gleason’s), size, lymph nodes involved, lymph nodes exam’d, extent of involvement (i.e., involving or penetrating capsule, involving apex, etc.), mets. If more than one procedure performed, list reports individually.</p>		<p>BRM: Record the date behavior response modifier /immunotherapy began and what agent(s) given.</p>
	<p>Primary Site Title: Record the primary site.</p>		<p>Other: Record the date “other” therapy began and what the therapy consisted of.</p>
	<p>Histology Title: Record the histology of the primary tumor with the behavior and grade.</p>		<p>Remarks: Use this field as additional space for explanations, add’l information, etc.</p>
	<p>Staging: Document the extent of spread. What tissues/ organs/ lymph nodes were involved? Distant mets?</p>		<p>Place of Diagnosis: List where the patient was diagnosed for this malignancy.</p>
	<p>Local-Use Text: Use this field as additional space for explanations, add’l information, etc.</p>		

Text / Abstracting Worksheet for: Stomach

Text Dx.	<p>PE: Record findings from the examination of the abdomen, liver, and peripheral lymph nodes. Document patient symptoms.</p>	Text Rx. / Misc.	<p>Surgery: Record the name(s) and date(s) of all surgical procedures. (Partial gastrectomy, Billroth I or II, upper subtotal gastrectomy, lower subtotal gastrectomy, total gastrectomy, lymph node dissection, etc.)</p>
	<p>X-ray/Scans: Document location, size, and extent of disease from upper GI series, CT scans, ultrasound exams, chest x-rays, liver scans, etc.</p>		<p>Rad (Beam): Record the date beam radiation therapy began, what sites treated, and total dosage.</p>
	<p>Scopes: Document location and size of tumor from the gastroscopy examination.</p>		<p>Rad (Other): Record the date radiation therapy began, what type of rad given, what sites treated, and total dosage.</p>
	<p>Lab Tests: Report cytology findings from washings or ascitic fluid, if done. (Optional- report CA-19-9, CEA)</p>		<p>Chemo: Record the date chemotherapy began and which agent(s) given.</p>
	<p>OP: Record date and name of procedure, observations made by surgeon (size, location, impression regarding involvement of other tissues, distant mets, etc.). Pay special attention to the liver. Is there direct extension into the liver or discontinuous seeding or nodules? The summary stage is different under each of these circumstances.</p>		<p>Hormone: Record the date hormone therapy began and which agent(s) given.</p>
	<p>Path: Record the date and name of procedure, path #, site, histology, grade, size, lymph nodes involved, lymph nodes exam'd, extent of involvement/spread within the organ, surrounding tissues, distant mets. Record any statement regarding "linitis plastica" or the disease is "diffuse". If more than one procedure performed, list reports individually.</p>		<p>BRM: Record the date behavior response modifier /immunotherapy began and what agent(s) given.</p>
	<p>Primary Site Title: Indicate the specific subsite of the stomach in which the malignant lesion arose.</p>		<p>Other: Record the date "other" therapy began and what the therapy consisted of.</p>
	<p>Histology Title: Record the histology of the primary tumor with the behavior and grade.</p>		<p>Remarks: Use this field as additional space for explanations, add'l information, etc.</p>
	<p>Staging: Document the extent of spread. What tissues/ organs/ lymph nodes were involved? Distant mets?</p>		<p>Place of Diagnosis: List where the patient was diagnosed for this malignancy.</p>
	<p>Local-Use Text: Use this field as additional space for explanations, add'l information, etc.</p>		

Text/ Abstracting Worksheet: Miscellaneous Sites

Text Dx.	<p>PE: Record the pertinent findings from the physical exam (i.e., Size and location of the tumor. Were lymph nodes palpable?). Also, record what symptoms brought the pt. in to seek medical attention (i.e., rectal bleeding, wt loss).</p>	Text Rx. / Misc.	<p>Surgery: Record the name and date of all surgical procedures performed.</p>
	<p>X-ray/Scans: Record date of scan, type of scan, size and location of tumor, impressions regarding involvement of other tissues, any information regarding lymph nodes, any information regarding mets. Negative information is also helpful (i.e., 3/5/02 Bone scan: neg. bone mets).</p>		<p>Rad (Beam): Record the date beam radiation therapy began, what sites treated, and total dosage. (9/2/02 Head & neck: 4500 cGy)</p>
	<p>Scopes: Record date of procedure, type of procedure, size and location of tumor, impressions regarding involvement of other tissues.</p>		<p>Rad (Other): Record the date radiation therapy began, what type of rad given, what sites treated, and total dosage.</p>
	<p>Lab Tests: Record the date of procedure performed, type performed, report #, and findings (i.e., 1/4/02 CY02551 Bronch wash: malig cells). Record tumor markers, if applicable.</p>		<p>Chemo: Record the date chemotherapy began and which agent(s) given (i.e., 2/4/02 Cyclophosphamide, methotrexate, 5-FU).</p>
	<p>OP: Record date and name of procedure, observations made by surgeon (size, location, impression regarding involvement of other tissues, distant mets. (i.e., 5/4/02 Hemicolectomy/ liver bx: 3.5 cm lesion, ascending colon, liver seeding).</p>		<p>Hormone: Record the date hormone therapy began and which agent(s) given (i.e., 4/8/02 Tamoxifen) or procedures done (i.e., For prostate primary-4/8/02 bilateral orchiectomy).</p>
	<p>Path: Record the date and name of procedure, path #, site, histology, grade (or cell type for lymphomas or leukemias), size, lymph nodes involved, lymph nodes exam'd, extent of involvement/spread within the organ or surrounding tissues (i.e., 8/5/02 SP02-00369 Part. gastrectomy: 2.4 cm mod- diff adenoca fundus of stomach, 4/6 Lns +, invas into spleen. Liver bx: + for mets adenoca.). If more than one procedure performed, list reports individually.</p>		<p>BRM: Record the date behavior response modifier/immunotherapy began and what agent(s) given (i.e., 5/6/03 BCG).</p>
	<p>Primary Site Title: List the most definitive primary site/ subsite available. Indicate laterality, if applicable (i.e., UOQ, R breast).</p>		<p>Other: Record the date "other" therapy began and what the therapy consisted of.</p>
	<p>Histology Title: Record the histology of the primary tumor with the behavior and grade (i.e., mod-diff, signet-ring cell CA).</p>		<p>Remarks: Indicate any addition pertinent information (i.e., prior history of colon cancer).</p>
	<p>Staging: Indicate what tissues/organs/ lymph nodes were involved. Document distant mets (i.e., Through the muscularis propria, 6/8 reg Lns +, brain mets).</p>		<p>Place of Diagnosis: List where the patient was diagnosed for this malignancy.</p>
	<p>Local-Use Text: Use this field as additional space for explanations, add'l information, etc.</p>		

EXAMPLE OF A TYPICAL BREAST ABSTRACT

Text Dx.	<u>PE:</u> 4/1/01 Mass, UOQ lt breast. No LNAD*.	Text Rx. / Misc.	<u>Surgery:</u> 4/15/01 MRM w/ LN dissection
	<u>X-ray/Scans:</u> 4/3/01 Mammo: 2.5cm mass, UOQ lt breast.		<u>Rad (Beam):</u>
	<u>Scopes:</u>		<u>Rad (Other):</u>
	<u>Lab Tests:</u>		<u>Chemo:</u>
	<u>OP:</u> 4/15/01 MRM: Mass UOQ, lt breast. Matted axillary LNs.		<u>Hormone:</u>
	<u>Path:</u> 4/15/01 MRM: Infiltr ductal CA, lt breast, Grade 3, 1/5 axil LNs +. Margins -		<u>BRM:</u>
	<u>Primary Site Title:</u> Lt breast, UOQ		<u>Other:</u>
	<u>Histology Title:</u> Infiltr ductal CA, grade 3		<u>Remarks:</u>
<u>Staging:</u> 1/5 axillary LNs +	<u>Place of Diagnosis:</u> Hospital A		
	<u>Local-Use Text:</u>		

*LNAD= Lymph node adenopathy.

COMMON ABBREVIATIONS

A

A	Allergy
A	Annum
A	Anode
A	Anterior
A	Aortic
A	Artery
A	Axial
AA	Aplastic anemia
AB	Abort (miscarry)
AB	About
AB	Antibody
AB	Asthmatic bronchitis
ABD, ABDOM	Abdomen
ABN	Abnormal
ABP	Arterial blood pressure
ABST	Abstract
AC	Adrenal cortex
AC	Air contrast
AC	Anterior chamber
ACH	Adrenal cortical hormone
ACID PHOS	Acid phosphatase
ACID PTASE	Acid phosphatase
ACTH	Adrenocorticotrophic hormone
ADENOCA	Adenocarcinoma
ADH	Antidiuretic hormone (vasopressin)
ADJ	Adjacent
ADM	Admission
ADM	Admit
ADR	Adverse drug reaction
AFF	Afferent
AFF	Affirmative
AFP	Alpha-fetoprotein
AG	Atrial gallop
AG	Antigen
AG	Argentum (silver, chemical symbol for)
AGL	Acute granulocytic leukemia
A/G RATIO	Albumin-globulin ratio
AGNO3	Silver Nitrate
AIDS	Acquired immunodeficiency syndrome
AIL	Angioimmunoblastic lymphadenopathy
AILD	Angioimmunoblastic lymphadenopathy with dysproteinemia
AIN	Anal intraepithelial neoplasia
AK(A)	Above knee (amputation)
AKA	Also known as

ALB	Albumin
ALCL	Anaplastic large cell lymphoma
ALK PHOS	alkaline phosphatase
ALL	Acute lymphocytic leukemia
AMA	Against medical advice
AMB	ambulatory
AMKL	Acute megakaryocytic leukemia
AML	Acute myelogenous leukemia
AMP	Amputation
ANAP	Anaplastic
ANAT	Anatomy
ANO	Axillary node dissection
ANED	Alive no evidence of disease
ANES(TH)	Anesthesia, anesthetic
ANT	Anterior
ANTE	Before
A&P	Auscultation & percussion
AP	Abdominal perineal
AP	Anteroposterior
AP	Anterior pituitary
AP&LAT	Anteroposterior and lateral
ARMS	Alveolar Rhabdomyosarcoma

B

B	Bacillus
B	Black
B	Blue
B	Born
B	Brother
BA	Bachelor of Arts
BA	Barium (chemical symbol for)
BA	Bronchial asthma
BALT	Bronchial-associated lymphoid tissue
BAS	Basal
BASOS	Basophil(s) (granular leukocyte)
BBB	Blood-brain block
BBB	Bundle-branch block
BBT	Basal body temperature
BC	Birth control
BC	Bone conduction
BC	Buccocervical
BCC	Basal cell carcinoma
B-CELLS Fabricius)	Special lymphocytes formed in bone marrow (derived from bursa of
BCG	Bacillus Calmette-Guerin
BD	Bile duct
BE	Barium enema
B/F	Black female

BIO	Twice a day
BIL	Bilateral
BK(A)	Below knee (amputation)
BM	Bone marrow
BM	Bowel movement
B/M	Black male
BMR	Basal metabolic rate
BMT	Bone marrow transplant
BP	Blood pressure
BPH	Benign prostatic hypertrophy/hyperplasia
BRM	Biological response modifier
BSC	Bone scan
BSE	Breast self examination
BSO	Bilateral salpingo-oophorectomy
BT	Brain tumor
BUN	Blood urea nitrogen
BUS	Bartholin's, uethral & Skene's glands
BX	Biopsy

C

C	Centigrade
Ca	Ca-Journal of the American Cancer Society
C1-C7	Cervical vertebrae
CA	Calcium
CA	Carcinoma
CAT	Computerized axial tomography
CBC	Complete blood count
CBD	Common bile duct
CC	Chief complaint
CC	Cubic centimeter
CCU	Coronary care unit
CEA	Carcinoembryonic antigen
CGL	Chronic granulocytic leukemia
CHF	Congestive heart failure
CHR	Chronic
CIG	Cigarettes
CIN	Cervical intraepithelial neoplasia
CIS	Carcinoma-in situ
CLL	Chronic lymphocytic leukemia
CM	Centimeter
CM	Costal margin
CML	Chronic myeloid/myelocytic leukemia
CMML	Chronic myelomonocytic leukemia
CMV	Cytomegalovirus
CNS	Central nervous system
C/O	Complaining of
CO2	Carbon dioxide
Co60	Cobalt 60

COR	Heart
CR	Complete remission
CRF	Chronic renal failure
CS	Cesium
CSF	Cerebrospinal fluid
CSF	Colony-stimulating factor
C-SPINE	Cervical spine
CTCL	Cutaneous T cell lymphoma
CTR	Certified Tumor Registrar
CT SC	Computerized (axial) tomography scan
CVA	Cerebrovascular accident
CVA	Costovertebral angle
C/W	Consistent with
CX	Cervix
CXR	Chest x-ray
CYSTO	Cystoscopy
CYTO	Cytology

D

D1, D2 ETC	First dorsal vertebra, second, etc.
D&C	Dilatation and curettage
DC	Discharge
DC	Discontinued
DCIS	Ductal carcinoma in situ
DERM	Dermatology
DD	Discharge diagnosis
DDX	Differential diagnosis
DIAM	Diameter
DIFF	Differentiated, differential
DIS, DISCH	Disease; Discharge
DLS	Date last seen
DNA	Deoxyribonucleic acid
DNR	Do not resuscitate
DO	Doctor of Osteopathy
DOA	Dead on arrival
DOB	Date of birth
DOD	Date of death
DOE	Dyspnea on exertion
DR	(Medical) doctor
DS	Discharge
DTR	Deep tendon reflex
DX	Diagnosis

E

ECF	Extended care facility
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ECG, EKG	Electrocardiogram
EEG	Electroencephalogram
EENT	Eyes, ears, nose, & throat
EGD	Esophagogastroduodenoscopy
EMG	Electromyogram
ENL	Enlarged
ENT	Ear, nose & throat
EPA	Erect (standing), posterior, anterior
ER	Emergency room
ER(A)	Estrogen receptor (assay)
ERCP	Endoscopic retrograde cholangiopancreatography
EST	Electroshock therapy
EUA	Exam under anesthesia
EXAM	Examination
EXC	Excision
EXP LAP	Exploratory laparotomy
EXT	Extend, extension
EXT	External; Extremity

F

F	Fahrenheit
FAB	French American and British Classification Scheme for Leukemia
FB	Fingerbreadth
FBS	Fasting blood sugar
FDA	Food and Drug Administration in USA
FIGO	International Federation of Gynecology and Obstetrics
F(M)H	Family (medical) history
FLURO	Fluoroscopy
FOM	Floor of mouth
FP	Flat plate
FU	Follow up
FUO	Fever unknown origin
FX	Fracture
FX	Frozen section

G

GA	Gastric analysis
GB	Gallbladder
GBM	Glioblastoma multiforme
GCT	Germ cell tumor
GE	Gastroenterostomy
GE	Gastroesophageal
GEN	Generalized
GI	Gastrointestinal

GM	Gram
GP	General practitioner
GR	Grade, grain(s)
GU	Genitourinary
GYN	Gynecology

H

HB	Hemoglobin
HCG	Human Chorionic gonadotropin
HCL	Hairy cell leukemia
HCT	Hematocrit
HCVD	Hypertensive cardiovascular disease
HD	Heart disease
HD	Heart disease
HEENT	Head, eyes, ears, nose & throat
HGB	Hemoglobin
HIV	Human immunodeficiency virus
HN2	Nitrogen mustard
H2O	Water
H/O	History of
HORM	Hormone
HOSP	Hospital
H&P	History and physical
HPF	High power field
HPI	History of present illness
HPV	Human papilloma virus
HR(S)	Hour(s)
HRT	Hormone Replacement therapy
HTLV-III	Human T-lymphotrophic virus type III
HVD	Hypertensive vascular disease
HX	History
HYST	Hysterectomy

I

I	Iodine
IARC	International Agency for Research on Cancer
ICD-O-1	International Classification of Diseases for Oncology, 1st Ed., 1976
ICD-O-2	International Classification of Diseases, for Oncology, 2nd Ed., 1992
ICD-O-3	International Classification of Diseases, for Oncology, 3rd Ed., 2000
ICF	Intercellular fluid
ICM	Intercostal margin
ICS	Intercostal space
ICU	Intensive care unit
IG	Immunoglobulin
IM	Intramuscular

IMA	Internal mammary artery
IMP	Impression
INCL	Includes, including
INF	Inferior
INF	Infraction
INF	Infusion
INFILT	Infiltrating
INJ	Injection
INT MED	Internal medicine
INPT	Inpatient
IPPB	Intermittent positive pressure breathing
IT	Intrathecal
IV	Intravenous
IVC	Inferior vena cava
IVP	Intravenous pyelogram

J

JVD	Jugular venous distention
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K

K	Potassium
KG	Kilogram
KJ	Knee jerk
KK	Knee kick
KUB	Kidneys, ureters, bladder
KV	Kilovolt

L

L	Left
L	Liter
L	Lower
L1-L5	Lumbar vertebrae
LNAD	Lymphadenopathy
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-associated virus
LCIS	Lobular carcinoma in-situ
LCM	Left costal margin
LDH	Lactic dehydrogenase
LE	Lower extremity; Lupus erythematosus
LFT	Liver function test
LG	Large

LIF	Left iliac fossa
LINAC	Linear accelerator
LIQ	Lower inner quadrant (breast)
LKS(B)	Liver, kidney, spleen, (bladder)
LLE	Left lower extremity
LLL	Left lower lobe (lung)
LLQ	Left lower quadrant (abdomen)
LMD	Local medical doctor
LMP	Last menstrual period
LN(S)	Lymph node(s)
LOP	Lower outer quadrant (breast)
LP	Lumbar puncture
LPF	Lower power field
LPN	Licensed practical nurse
LS	Lumbosacral
LSK, LKS	Liver, spleen, kidneys
LSO	Left salpingo-oophorectomy
L-SPINE	Lumbar spine
LT	Left
LUE	Left upper extremity
LUL	Left upper lobe (lung)
LUQ	Left upper quadrant (abdomen)
L&W	Living and well

M

M	Monocytes, meter
MAB	Monoclonal antibody
MAL	Malignant
MALT	mucosal-associated lymphoid tissue
MALIG	Malignant
MAND	Mandible
MAST	Mastectomy
M-CSF	Macrophage Colony-Stimulating Factor
MC	Millicurie
MCH	Mean corpuscular hemoglobin
MCHC	Mean corpuscular hemoglobin count
MCL	Mid clavicular line
MCV	Mean corpuscular volume
MD	Medical doctor
MD	Moderately differentiated
MOS	Myelodysplastic syndrome
MET, METS	Metastatic, metastases
MEV	Million electron volts
MH	Marital history
MH	Mental health
MI	Myocardial infarction
MG	Milligram
MICRO	Microscopic

ML	Middle lobe
ML	Milliliter
MM	Millimeter
MOD	Moderate
MOD DIFF	Moderately differentiated
MPNST	Malignant peripheral nerve sheath tumor
MRI	Magnetic resonance imaging
MRM	Modified radical mastectomy
MS	Mitral stenosis
MS	Multiple sclerosis
MSL	Mid sternal line
MX	Microscopic
MX	Maxilla(ry), maximum

N

NA	Not applicable
NBS	Normal bowel sounds
NEC	Not elsewhere classified
NED	No evidence of disease
NEG or -	Negative
NERD	No evidence of recurrent disease
NEURO	Neurology
NHL	Non Hodgkin lymphoma
NK	Natural killer
NL	Normal
NOS	Not otherwise specified
NR	Not recorded
NR	Not reportable
NSCLC	Non small cell lung carcinoma
NSF	N significant findings
NTP	Normal temperature and pressure
N&V	Nausea and vomiting
NVD	neck vein distention

O

OB	Obstetrics
OBST	Obstructed (ing, ion)
OD	Right eye (oculus dexter)
OH	Occupational history
OP	Operation
OP	Outpatient
OPD	Outpatient clinic; department

OPHTH	Ophthalmology
OR	Operating room
ORTH	Orthopedics
OS	Bone
OS	Left eye (oculus sinister)
OS	Mouth
OS	Opening
OSTEO	Osteomyelitis
OT	Occupational therapy
OTO	Otology
OU	Each eye (oculus uterque)
OV	Office visit
OZ	Ounce

P

P	Pulse
P&A	Percussion and auscultation
PA	Posteroanterior
PA	Pulmonary artery
PA	Physician assistant
PALP	Palpable, palpated, palpation
PAP	Papanicolaou smear
PAP	Papillary
PAR	Post anesthesia room
PARA	Number of pregnancies resulting in viable infants
PATH	Pathology
PCV	Packed cell volume
PD	Poorly differentiated
PDR	Physician's Desk Reference
PE	Physical examination
PED	Pediatrics
PEG	Pneumoencephalography
PEG	Percutaneous gastrostomy tube
PERC	Percutaneous
PET	Positron emission tomography
PH	Past or personal history
PI	Present illness
PID	Pelvic inflammatory disease
PIN	Prostatic intraepithelial neoplasia
PLT	Platelets
PM	Post mortem (after death)
PMD	Personal (primary) medical doctor
PMH	Past medical history
PND	Postnasal drip
PNET	Peripheral neuroectodermal tumor (bone tumors)
PNET	Primitive neuroectodermal tumor (CNS tumors)
PO, POSTOP	Postoperative(ly)
POD	Postoperative day

POOR DIFF	Poorly differentiated
POS or +	Positive
POSS	Possible
POST	Posterior
POST	Postmortem examination
POSTOP	Postoperative(ly)
PPD	Purified protein derivative (Tuberculin skin test)
PPD	Packs per day
PR	Partial response
PR(A)	Progesterone receptor (assay)
PREOP	Preoperative(ly)
PROB	Probable(ly)
PSA	Prostate specific antigen
PT	Patient
PT	Physiotherapy
PTA	Prior to examination
PUO	Pyrexia of undetermined origin
PULM	Pulmonary

Q

Q	Quadrant
QID	Four times a day

R

R	Roentgen
R	Respiration
R	Right
RA	Radium
RAD	Radiation
RAD	Radiation Absorbed Dose
RAD	Radical
RAEB (-T)	Refractory anemia with excess blasts (in transformation)
RAIU	Radioactive iodine (I 131) uptake
RARS	Refractory anemia with ringed sideroblasts
RBC	Red blood cells
RCM	Right costal margin
RCS	Reticulum cell sarcoma
REG	Radioencephalogram
RES	Reticuloendothelial system
RESEC	Resection
RESP	Respiratory
RH	Rhesus (monkey) factor in blood
RIA	Radioimmunoassay
RIF	Right iliac fossa
RIQ	Right inner quadrant (abdomen)

RLE	Right lower extremity
RLL	Right lower lobe (lung)
RLQ	Right lower quadrant
RML	Right middle lobe (lung)
RMS	Rhabdomyosarcoma
RN	Registered nurse
RNP	Registered nurse practitioner
RNA	Ribonucleic acid
RO, R/O	Rule out
ROF	Review of outside films
ROM	Range of motions
ROS	Review of slides
ROS	Review of outside slides
ROQ	Right outer quadrant (abdomen)
RSO	Right salpingo-oophorectomy
R-S cells	Reed-Sternberg cells
RT	Radiation therapy
RT	Right
RUE	Right upper extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
R-V	Rectovaginal
RX	Treatment

S

S1S5	Sacral vertebra
SALT	Skin-associated lymphoid tissue
SARC	Sarcoma
SB	Small bowel
SBE	Subacute bacterial endocarditis
SCC	Squamous cell carcinoma
SEER	Surveillance Epidemiology and End Results
SGOT	Serum glutamic oxaloacetic
SGPT	Serum glutamic pyruvic transaminase
SS	Social Security
SH	Serum hepatitis
SM	Small
SMA	Sequential multiple analysis (Biochem profile)
SML BWL	Small bowel
SNF	Skilled nursing facility
SO	Salpingo-oophorectomy
SOB	Shortness of breath
SOL	Solution
S/P	Status post
SPEC	Specimen
SP GR	Specific gravity
S-Q, SQ	Subcutaneous
SQ, SQUAM	Squamous

SQ CELL CA	Squamous cell carcinoma
SR	Sedimentation rate
S-SPINE	Sacral spine
STAPH	Staphylococcus
STAT	Immediately (statim)
STREP	Streptococcus
STSG	Split thickness skin graft
SUBCU	Subcutaneous
SUB-Q, SUBQ	Subcutaneous
SURG	Surgery, surgical
SVC	Superior vena cava
SX	Symptoms
SYMP	Symptoms

T

T	Temperature
T	Thoracic
TA	Toxin-antitoxin
T1-T2	Thoracic vertebra
T&A	Tonsillectomy and adenoidectomy
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy-bilateral salpingo oophorectomy
TB, TBC	Tuberculosis
TCC	Transitional cell carcinoma
TD	Tumor dose
TID	Three times a day
TNM	Tumor, Nodes, Metastasis
TP	Total protein
TPN	Total parenteral nutrition
TPR	Temperature, pulse and respiration
TS	Tumor size
TSH	Thyroid stimulating hormone
T-SPINE	Thoracic spine
TUR	Transurethral resection
TURB	Transurethral resection-Bladder
TURP	Transurethral resection-Prostate
TVH	Total vaginal hysterectomy
TX	Treatment

U

U	Unit
UCHD	Usual childhood diseases
UE	Upper extremity
UGI	Upper gastrointestinal
UIQ	Upper inner quadrant (breast)

ULCC	Undifferentiated large cell carcinoma
UMB	Navel (umbilicus)
UNDIFF	Undifferentiated
UOQ	Upper outer quadrant (abdomen)
UR	Urine
URI	Upper respiratory infection
UROL	Urology
UTI	Urinary tract infection

V

VAG	Vagina, Vaginal
VAG HYST	Vaginal hysterectomy
VAIN	Vaginal intraepithelial neoplasia
VASC	Vascular
VD	Venereal Disease
VIN	Vulvar intraepithelial neoplasia
VS	Vital signs

W

W/	With
WBC	White blood cells
W/D	Well developed
WD, WELL DIFF	Well differentiated
W/F	White female
W/M	White male
WN	Well nourished
WNL	Within normal limits
W/O	Without
WT	Weight
W/U	Work-up

X

XR	X-ray
----	-------

Y

Y/O	Year old
YR	Year

CORRECTIONS

On occasion, circumstances arise that lead to the discovery of additional or more accurate information about a case after it has been submitted to the central registry.

Example 1: Consults from specialty labs, pathology report addendums or comments, or other information have been added to the chart. Reports done during the diagnostic workup and placed on the chart after the registrar abstracted the information may contain valuable information. Whenever these late reports give more specific information about the histology, grade of tumor, primary site, etc., change the affected codes to reflect the better information and notify the TCR of the correction.

Example 2: The primary site was recorded as unknown at the time of diagnosis. At a later date, the physician determines that the cancer is primary to the testis. Change the primary site from unknown to testis and notify the TCR of the correction.

When a correction to a completed abstract must be made, it is not necessary to re-abstract the case. In fact, submitting a second abstract creates confusion and a backlog at the TCR. Corrections should be made either by telephone or via the Tennessee Cancer Registry Correction Form.

Note: Often a change to one data item will impact other data items (i.e. laterality, summary stage, etc.). Please review all data items and note any corrections necessary on the correction form.

To submit a correction via the telephone, please call the TCR at 800-547-3558 or 615-253-5937.

To submit a correction via the Tennessee Cancer Registry Correction Form, please complete the form and mail it to:

Tennessee Cancer Registry
Cordell Hull Building, 6th Floor North
425 Fifth Avenue North
Nashville, TN 37247

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TENNESSEE DEPARTMENT OF HEALTH
Tennessee Cancer Registry
Abstract Correction Request

Section A:

In order to assist the TCR staff in identifying the abstract to be corrected, please complete each data item listed below AS IT APPEARED ON THE ORIGINAL ABSTRACT. Do not make corrections in Section A. Please indicate all corrections in Section B.

Reporting Hospital: _____

Social Security Number: _____

Last Name: _____

First Name: _____

Middle Name: _____

Maiden Name: _____

Date of Birth: _____

Primary Site: _____

Hospital Accession Number: _____

Hospital Sequence Number: _____

Section B:

Please indicate the data field(s) to be corrected and the corrected information in the appropriate areas below. Please include comments if applicable.

CORRECTIONS

1. Data field to be corrected: _____

Change info. to: _____

Comments: _____

2. Data field to be corrected: _____

Change info. to: _____

Comments: _____

Mail to:

Tennessee Cancer Registry, Cordell Hull Building, Sixth Floor North, 425 Fifth Ave North, Nashville, TN 37247-2015

3. Data field to be corrected: _____

Change info. to: _____

Comments: _____

4. Data field to be corrected: _____

Change info. to: _____

Comments: _____

5. Data field to be corrected: _____

Change info. to: _____

Comments: _____

6. Data field to be corrected: _____

Change info. to: _____

Comments: _____

7. Data field to be corrected: _____

Change info. to: _____

Comments: _____

8. Data field to be corrected: _____

Change info. to: _____

Comments: _____

9. Data field to be corrected: _____

Change info. to: _____

Comments: _____