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Public reporting burden of this collection of information is estimated to average one hour per submission, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS-24, Atlanta, GA 30333

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
1. Program and Enrollment Data – Complete for each CCDE record						
1.1	**Program** *Unique identifier for each program.*	3	1	3	001 = Baltimore, MD 002 = St. Louis, MO 003 = State of NE 004 = Stony Brook, NY 005 = Seattle and King County, WA	Valid code for your program.
1.2	**Date of eligibility** *The date that the client was determined to be eligible to be screened in the program. This could be the date of the initial interview or the date that an enrollment form was filled out.*	8	4	11	MMDDYYYY *If just the year is known, blank fill the month and day. If just the year and month are known, blank fill the day (e.g. 04 2006).*	"MMDDYYYY", "MM YYYY" or "YYYY", but not blank.
1.3.1	**Knowledge of program (1)** *Indicates how client learned about the program.*	2	12	13	1 = Doctor 2 = Other health care provider 3 = NBCCEDP 4 = Family member 5 = Friend 6 = Radio 7 = Television 8 = Magazine article 9 = Newspaper 10 = Mailing/flyer 11 = Community event 12 = Other **Right justify**	Range check.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
1.3.2	**Knowledge of program (2)** *Indicates how client learned about the program.* *Use this field if client indicates that he/she learned about the program from more than one source.*	2	14	15	1 = Doctor 2 = Other health care provider 3 = NBCCEDP 4 = Family member 5 = Friend 6 = Radio 7 = Television 8 = Magazine article 9 = Newspaper 10 = Mailing/flyer 11 = Community event 12 = Other **Right justify**	Range check.
1.3.3	**Knowledge of program (3)** *Indicates how client learned about the program.* *Use this field if client indicates that he/she learned about the program from more than two sources.*	2	16	17	1 = Doctor 2 = Other health care provider 3 = NBCCEDP 4 = Family member 5 = Friend 6 = Radio 7 = Television 8 = Magazine article 9 = Newspaper 10 = Mailing/flyer 11 = Community event 12 = Other **Right justify**	Range check.
1.3.4	**Knowledge of program other text field**	25	18	42	If "Knowledge of program" = 12, then enter the description in free text format. **Alphanumeric, left justify**	If 1.3.1, 1.3.2 or 1.3.3 = 12, this field should be completed. Otherwise, leave blank.
	Reserved for future use	10	43	52		Leave blank.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
2. Client and Record Identification- Complete for each CCDE record						
2.1	**Client identifier** *System generated ID for each client and will be consistent for client throughout database.*	15	53	67	If Social Security Number (SSN) is used, it must be encoded. The ID number should be unique and constant for each client in order to track the client over time. This field should not contain any identifiable information, including partial names or dates. **Alphanumeric (no special symbols), left justify** **Alphabetic characters must be entered consistently in uppercase or lowercase for all records for each client.**	
2.2	**Record identifier** *Each CCDE record identifies a unique CRC "cycle" for a client. A client can have multiple "cycles".*	6	68	73	This field will be used to uniquely identify one record among many for a client. This can be a visit date or a sequential record number. **Numeric, right justify**	
	Reserved for future use	10	74	83		Leave blank.
3. Demographic Information – Complete for each CCDE record, and MUST be self-reported by client						
3.1	**Date of birth** *Date of birth for the client.*	8	84	91	MMDDYYYY *If just the year is known, blank fill the month and day. If just the year and month are known, blank fill the day (e.g. 04 2006).*	"MMDDYYYY", "MM YYYY" or "YYYY", but not blank.
3.2	**Gender** *Indicates gender of client.*	1	92	92	1 = Male 2 = Female 9 = Other/unknown	Range check.
3.3	**Hispanic or Latino origin** *Indicates self-reported Hispanic or Latino origin of client.*	1	93	93	1 = Yes 2 = No 9 = Unknown/missing	Range check.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
3.4.1	**Race 1** *The first of five (5) race fields used to capture the self-reported race(s) of a client.*	1	94	94	1 = White 2 = Black or African American 3 = Asian 4 = Native Hawaiian or Other Pacific Islander 5 = American Indian or Alaska Native 9 = Unknown *Note: Racial groups are OMB-defined. No primary race is collected. Race 1 has no significance over Race 2-5, and may simply be the first race mentioned.*	Range check. This field should be populated first. If a client self-identifies more than one race, then each race identified should be reported in a separate race field.
3.4.2	**Race 2** *Complete field if client self-identifies more than one race.*	1	95	95	1 = White 2 = Black or African American 3 = Asian 4 = Native Hawaiian or Other Pacific Islander 5 = American Indian or Alaska Native	Range check. This field should be left blank, unless the client reports more than one race.
3.4.3	**Race 3** *Complete field if client self-identifies more than two races.*	1	96	96	1 = White 2 = Black or African American 3 = Asian 4 = Native Hawaiian or Other Pacific Islander 5 = American Indian or Alaska Native	Range check. This field should be left blank, unless the client reports more than two races.
3.4.4	**Race 4** *Complete field if client self-identifies more than three races.*	1	97	97	1 = White 2 = Black or African American 3 = Asian 4 = Native Hawaiian or Other Pacific Islander 5 = American Indian or Alaska Native	Range check. This field should be left blank, unless the client reports more than three races.
3.4.5	**Race 5** *Complete field if client self-identifies more than four races.*	1	98	98	1 = White 2 = Black or African American 3 = Asian 4 = Native Hawaiian or Other Pacific Islander 5 = American Indian or Alaska Native	Range check. This field should be left blank, unless the client reports more than four races.
3.5	**State of residence** *Client's state of residence*.	2	99	100	2-digit FIPS code (If unknown, blank fill) **Right justify**	Valid FIPS code for state.
3.6	**County of residence** *Client's county of residence.*	3	101	103	3-digit FIPS code (If unknown, blank fill) **Right justify**	Valid FIPS county code for state in 3.5.
	Reserved for future use	10	104	113		Leave blank.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
4. Screening History – Complete for each CCDE record. This information can be self-reported, or can come from information documented in the client's medical record (preferred).						
4.1.1	**Previous take-home CRC fecal test (FOBT/FIT)** *Information on most recent previous take-home CRC fecal testing (FOBT/FIT).*	1	114	114	1 = Yes 2 = No 9 = Unknown	Range check.
4.1.2	**Previous take-home CRC fecal test date** *Most recent date for previous take-home CRC fecal test indicated in 4.1.1. This can be any date that the client remembers.*	6	115	120	MMYYYY *If just the year is known, blank fill the month (e.g., 2006).*	If 4.1.1 = 1, then "MMYYYY" or "YYYY". Leave blank if 4.1.1 = 2, 9
4.1.3	**Previous take-home CRC fecal test result** *Result of most recent previous take-home CRC fecal test indicated in 4.1.1.*	1	121	121	1 = Normal/negative test 2 = Abnormal/positive test result 9 = Unknown	Range check. Leave blank if 4.1.1 = 2, 9
4.2.1	**Previous sigmoidoscopy** *Information on most recent previous sigmoidoscopy.*	1	122	122	1 = Yes 2 = No 9 = Unknown	Range check.
4.2.2	**Previous sigmoidoscopy test date** *Most recent date for previous sigmoidoscopy indicated in 4.2.1.*	6	123	128	MMYYYY *If just the year is known, blank fill the month (e.g., 2006).*	If 4.2.1 = 1, then "MMYYYY" or "YYYY". Leave blank if 4.2.1 = 2, 9
4.2.3	**Result of previous sigmoidoscopy** *Result of most recent previous sigmoidoscopy indicated in 4.2.1.*	1	129	129	1 = Normal/negative/results other than polyp(s), tumor(s), or cancer 2 = Polyp(s)/tumor(s)/cancer 3 = Incomplete 9 = Unknown	Range check. Leave blank if 4.2.1 = 2, 9
4.3.1	**Previous colonoscopy** *Information on most recent previous colonoscopy.*	1	130	130	1 = Yes 2 = No 9 = Unknown	Range check.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
4.3.2	**Previous colonoscopy test date** *Most recent date for previous colonoscopy indicated in 4.3.1.*	6	131	136	MMYYYY *If just the year is known, blank fill the month (e.g., 2006).*	If 4.3.1 = 1, then "MMYYYY" or "YYYY". Leave blank if 4.3.1 = 2, 9
4.3.3	**Result of previous colonoscopy** *Result of most recent previous colonoscopy indicated in 4.3.1.*	1	137	137	1 = Normal/negative/results other than polyp(s), tumor(s), or cancer 2 = Polyp(s)/tumor(s)/cancer 3 = Incomplete 9 = Unknown	Range check. Leave blank if 4.3.1 = 2, 9
4.4.1	**Previous DCBE** *Information on most recent previous DCBE.*	1	138	138	1 = Yes 2 = No 9 = Unknown	Range check.
4.4.2	**Previous DCBE test date** *Most recent date for previous DCBE indicated in 4.4.1.*	6	139	144	MMYYYY *If just the year is known, blank fill the month (e.g., 2006).*	If 4.4.1 = 1, then "MMYYYY" or "YYYY". Leave blank if 4.4.1 = 2, 9
4.4.3	**Result of previous DCBE** *Result of most recent previous DCBE indicated in 4.4.1.*	1	145	145	1 = Normal/negative/results other than polyp(s), tumor(s), or cancer 2 = Polyp(s)/tumor(s)/cancer 3 = Incomplete 9 = Unknown	Range check. Leave blank if 4.4.1 = 2, 9
	Reserved for future use	10	146	155		Leave blank.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
5. Colorectal Cancer Risk Factors – Complete for each CCDE record. This information can be self-reported, or can come from information documented in the client's medical record (preferred).						
5.1.1	**Personal history of CRC** *Has client ever been diagnosed with colorectal cancer?*	1	156	156	1 = Yes 2 = No 9 = Unknown	Range check.
5.1.2	**Year CRC diagnosed** *Year (most recent occurrence) that CRC was diagnosed.*	4	157	160	YYYY	If 5.1.1 = 1, then "YYYY". Leave blank if 5.1.1 = 2,9
5.2.1	**Personal history of polyp(s)** *Has client ever been diagnosed with colorectal polyp(s)?*	1	161	161	1 = Yes 2 = No 9 = Unknown	Range check.
5.2.2	**Largest number of polyps diagnosed during a single procedure**	2	162	163	1 – 49 = Number of polyps 50 = ≥ 50 polyps 91 = < 10 polyps (if exact number not known) 92 = ≥ 10 polyps (if exact number not known) 99 = Unknown **Right justify**	Range check. Leave blank if 5.2.1 = 2, 9
5.2.3	**Were any of these polyps adenomatous?**	1	164	164	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 5.2.1 = 2, 9
5.3	**High risk due to family history of CRC** *Is this client considered to be at high-risk because of a family history of CRC?** ***Each program will have their own documented definition of high-risk due to family history of CRC.*	1	165	165	1 = Yes 2 = No 9 = Unknown	Range check.
	Reserved for future use	10	166	175		Leave blank.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
6. Screening and Diagnostic Tests Provided – Complete for each CCDE record						
6.0	**Initial test recommended** *The initial test recommended to the individual by the program.*	1	176	176	1 = Take-home FOBT 2 = Take-home FIT 3 = Sigmoidoscopy 4 = Colonoscopy 5 = DCBE 9 = Unknown	Range check.
6.1.0	**Indication for 1st test provided** *This is the indication for the actual test provided reported in 6.1.01. "Provided = Paid For" (i.e. could be a screening FOBT mailed, but not returned).*	1	177	177	1 = Screening 2 = Surveillance after a positive colonoscopy 9 = Unknown	Range check.
6.1.01	**1st test provided** *The actual first test provided through the program. "Provided = Paid For" (i.e. could be a screening FOBT mailed, but not returned).*	1	178	178	1 = Take-home FOBT 2 = Take-home FIT 3 = Sigmoidoscopy 4 = Colonoscopy 5 = DCBE	Range check.
6.1.02	**Date of 1st test** *Either the date of the procedure, the date that the take-home FOBT/FIT test was processed, or the date the FOBT/FIT results were received.*	8	179	186	MMDDYYYY *If just the year is known, blank fill the month and day. If just the year and month are known, blank fill the day (e.g. 04 2006).*	"MMDDYYYY", "MM YYYY" or "YYYY", but not blank.
6.1.03	**Provider specialty** *The specialty of the clinician providing the 1st test.*	2	187	188	1 = General practitioner 2 = Internist 3 = Family practitioner 4 = Gastroenterologist 5 = General surgeon 6 = Colorectal surgeon 7 = Licensed practical nurse 8 = Registered nurse 9 = Nurse practitioner 10 = Physician assistant 11 = Administrator, if FOBT/FIT mailed by non-clinician 99 = Unknown **Right justify**	Range check.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
6.1.04	**Clinical practice site** *The type of clinical practice where the 1st test was provided.*	1	189	189	1 = Doctor's office 2 = Ambulatory endoscopy/surgery center 3 = Hospital 4 = Health clinic 5 = Administrator, if FOBT/FIT mailed by non-clinician 9 = Unknown	Range check.
6.1.05	**Results of take-home FOBT/FIT** *This question is answered if 6.1.01 was a take-home FOBT or FIT.*	1	190	190	1 = Normal/negative 2 = Positive 3 = Refused 4 = Did not return card 5 = Pending 9 = Unknown	Range check. Leave blank if 6.1.01 = 3, 4, 5
6.1.06	**Results of endoscopy or DCBE** *This question is answered if 6.1.01 was a colonoscopy, a sigmoidoscopy or a DCBE.*	1	191	191	1 = Normal/negative/diverticulosis/hemorrhoids 2 = Other finding not suggestive of cancer/polyp(s) 3 = Polyp(s)/suspicious for cancer/presumed cancer 4 = No findings/inconclusive 5 = Pending 9 = Unknown *NOTE: If more than one result, report the worst.*	Range check. Leave blank if 6.1.01 = 1, 2
6.1.07	**Was the bowel preparation considered adequate by the clinician performing the endoscopy or DCBE?** *This question is answered if 6.1.01 was a colonoscopy, a sigmoidoscopy or a DCBE.*	1	192	192	1 = Yes* 2 = No 9 = Unknown *Adequacy will be determined by the clinician performing the test.* **Procedure report must explicitly state that the bowel prep was adequate, otherwise report 9 (Unknown).*	Range check. Leave blank if 6.1.01 = 1, 2
6.1.08	**Was the cecum reached during the initial colonoscopy?** *This question is answered if 6.1.01 was a colonoscopy.*	1	193	193	1 = Yes* 2 = No 9 = Unknown **Procedure report must explicitly state that the cecum was reached, otherwise report 9 (Unknown).*	Range check. Leave blank if 6.1.01 = 1, 2, 3, 5
6.1.09	**Complications of endoscopy or DCBE** *This question is answered if 6.1.01 was a colonoscopy, a sigmoidoscopy or a DCBE.*	1	194	194	1 = Yes 2 = No/unknown	Range check. Leave blank if 6.1.01 = 1, 2

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
6.1.10	**Was a biopsy/polypectomy performed during the endoscopy?** *This question is answered if 6.1.01 was a colonoscopy or a sigmoidoscopy.*	1	195	195	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 6.1.01 = 1, 2, 5
6.1.11	**Number of specimens sent to pathology (from endoscopy)** *This question is answered if 6.1.01 was a colonoscopy or a sigmoidoscopy, and a biopsy/polypectomy was performed.* *Includes samples removed entirely or in part. If a single polyp is removed piecemeal you would report the number of specimens (not the number of polyps).*	2	196	197	0 = Biopsy performed, no specimens sent 1 - 97 = Number of specimens 98 = ≥ 98 specimens 99 = Unknown **Right justify**	Range check. Leave blank if 6.1.01 = 1, 2, 5 Leave blank if 6.1.10 = 2, 9
6.1.12	**Completeness of polyp removal (from colonoscopy)** *Were all the polyps completely removed during 1st test if it was a colonoscopy?*	1	198	198	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 6.1.01 = 1, 2, 3, 5 Leave blank if 6.1.06 ≠ 3, 4
6.1.13	**Recommended next follow-up procedure within this cycle after 1st test** *The next follow-up procedure recommended to the client (within the cycle). This can be a diagnostic follow-up test following a positive initial test, or surgery to complete diagnosis.*	1	199	199	1 = Sigmoidoscopy 2 = Colonoscopy 3 = DCBE 4 = Surgery to complete diagnosis* 8 = None (cycle is complete) * ***Diagnosis Information for Surgeries Performed to Complete Diagnosis*** *section must be completed if surgery is recommended.*	Range check. If response = 4 or 8, then 6.2.01, 6.3.01 and 6.4.01 should = 0 (None).

Item	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks / Skip Patterns
6.2.01	**2nd test provided within this cycle** *The actual second test provided through the program.* *"Provided = Paid For"*	1	200	200	0 = None 3 = Sigmoidoscopy 4 = Colonoscopy 5 = DCBE NOTE: FOBT/FIT can not be a second, third or fourth test in a "cycle".	Range check. If response = 0 (None), then 6.2.02 through 6.2.13 should be blank.
6.2.02	**Date of 2nd test** *The date of the procedure.*	8	201	208	MMDDYYYY *If just the year is known, blank fill the month and day. If just the year and month are known, blank fill the day (e.g. 04 2006).*	"MMDDYYYY", "MM YYYY" or "YYYY", but not blank.
6.2.03	**Provider specialty** *The specialty of the clinician providing the 2nd test.*	2	209	210	1 = General practitioner 2 = Internist 3 = Family practitioner 4 = Gastroenterologist 5 = General surgeon 6 = Colorectal surgeon 7 = Licensed practical nurse 8 = Registered nurse 9 = Nurse practitioner 10 = Physician assistant 99 = Unknown **Right justify**	Range check.
6.2.04	**Clinical practice site** *The type of clinical practice where the 2nd test was provided.*	1	211	211	1 = Doctor's office 2 = Ambulatory endoscopy/surgery center 3 = Hospital 4 = Health clinic 9 = Unknown	Range check.
6.2.05	(Item not used for 2nd test in "cycle")					
6.2.06	**Results of endoscopy or DCBE** *This question is answered if 6.2.01 was a colonoscopy, a sigmoidoscopy or a DCBE.*	1	212	212	1 = Normal/negative/diverticulosis/hemorrhoids 2 = Other finding not suggestive of cancer/polyp(s) 3 = Polyp(s)/suspicious for cancer/presumed cancer 4 = No findings/inconclusive 5 = Pending 9 = Unknown *NOTE: If more than one result, report the worst.*	Range check.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
6.2.07	**Was the bowel preparation considered adequate by the clinician performing the endoscopy or DCBE?** *This question is answered if 6.2.01 was a colonoscopy, a sigmoidoscopy or a DCBE.*	1	213	213	1 = Yes* 2 = No 9 = Unknown *Adequacy will be determined by the clinician performing the test.* **Procedure report must explicitly state that the bowel prep was adequate, otherwise report 9 (Unknown).*	Range check.
6.2.08	**Was the cecum reached during the colonoscopy?** *This question is answered if 6.2.01 was a colonoscopy.*	1	214	214	1 = Yes* 2 = No 9 = Unknown **Procedure report must explicitly state that the cecum was reached, otherwise report 9 (Unknown).*	Range check. Leave blank if 6.2.01 = 3, 5
6.2.09	**Complications of endoscopy or DCBE** *This question is answered if 6.2.01 was a colonoscopy, a sigmoidoscopy or a DCBE.*	1	215	215	1 = Yes 2 = No/unknown	Range check.
6.2.10	**Was a biopsy/polypectomy performed during the endoscopy?** *This question is answered if 6.2.01 was a colonoscopy or a sigmoidoscopy.*	1	216	216	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 6.2.01 = 5
6.2.11	**Number of specimens sent to pathology (from endoscopy)** *This question is answered if 6.2.01 was a colonoscopy or a sigmoidoscopy, and a biopsy/polypectomy was performed.* *Includes samples removed entirely or in part. If a single polyp is removed piecemeal you would report the number of specimens (not the number of polyps).*	2	217	218	0 = Biopsy performed, no specimens sent 1 - 97 = Number of specimens 98 = ≥ 98 specimens 99 = Unknown **Right justify**	Range check. Leave blank if 6.2.01 = 5 Leave blank if 6.2.10 = 2, 9

Item	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks / Skip Patterns
6.2.12	**Completeness of polyp removal (from colonoscopy)** *Were all the polyps completely removed during 2nd test if it was a colonoscopy?*	1	219	219	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 6.2.01 = 3, 5 Leave blank if 6.2.06 ≠ 3, 4
6.2.13	**Recommended next follow-up procedure within this cycle after 2nd test.** *The next follow-up procedure recommended to the client (within the cycle). This can be another diagnostic follow-up test or surgery to complete diagnosis.*	1	220	220	1 = Sigmoidoscopy 2 = Colonoscopy 3 = DCBE 4 = Surgery to complete diagnosis* 8 = None (cycle is complete) * ***Diagnosis Information for Surgeries Performed to Complete Diagnosis*** *section must be completed if surgery is recommended.*	Range check. If response = 4 or 8, then 6.3.01 and 6.4.01 should = 0 (None).

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
6.3.01	**3rd test provided within this cycle** *The actual third test provided through the program.* *"Provided = Paid For"*	1	221	221	0 = None 3 = Sigmoidoscopy 4 = Colonoscopy 5 = DCBE NOTE: FOBT/FIT can not be a second, third or fourth test in a "cycle".	Range check. If response = 0 (None), then 6.3.02 through 6.3.13 should be blank.
6.3.02	**Date of 3rd test** *The date of the procedure.*	8	222	229	MMDDYYYY *If just the year is known, blank fill the month and day. If just the year and month are known, blank fill the day (e.g. 04 2006).*	"MMDDYYYY", "MM YYYY" or "YYYY", but not blank.
6.3.03	**Provider specialty** *The specialty of the clinician providing the 3rd test.*	2	230	231	1 = General practitioner 2 = Internist 3 = Family practitioner 4 = Gastroenterologist 5 = General surgeon 6 = Colorectal surgeon 7 = Licensed practical nurse 8 = Registered nurse 9 = Nurse practitioner 10 = Physician assistant 99 = Unknown **Right justify**	Range check.
6.3.04	**Clinical practice site** *The type of clinical practice where the 3rd test was provided.*	1	232	232	1 = Doctor's office 2 = Ambulatory endoscopy/surgery center 3 = Hospital 4 = Health clinic 9 = Unknown	Range check.
6.3.05	(Item not used for 3rd test in "cycle")					
6.3.06	**Results of endoscopy or DCBE** *This question is answered if 6.3.01 was a colonoscopy, a sigmoidoscopy or a DCBE.*	1	233	233	1 = Normal/negative/diverticulosis/hemorrhoids 2 = Other finding not suggestive of cancer/polyp(s) 3 = Polyp(s)/suspicious for cancer/presumed cancer 4 = No findings/inconclusive 5 = Pending 9 = Unknown *NOTE: If more than one result, report the worst.*	Range check.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
6.3.07	**Was the bowel preparation considered adequate by the clinician performing the endoscopy or DCBE?** *This question is answered if 6.3.01 was a colonoscopy, a sigmoidoscopy or a DCBE.*	1	234	234	1 = Yes* 2 = No 9 = Unknown *Adequacy will be determined by the clinician performing the test.* **Procedure report must explicitly state that the bowel prep was adequate, otherwise report 9 (Unknown).*	Range check.
6.3.08	**Was the cecum reached during the colonoscopy?** *This question is answered if 6.3.01 was a colonoscopy.*	1	235	235	1 = Yes* 2 = No 9 = Unknown **Procedure report must explicitly state that the cecum was reached, otherwise report 9 (Unknown).*	Range check. Leave blank if 6.3.0 1 = 3, 5
6.3.09	**Complications of endoscopy or DCBE** *This question is answered if 6.3.01 was a colonoscopy, a sigmoidoscopy or a DCBE.*	1	236	236	1 = Yes 2 = No/unknown	Range check.
6.3.10	**Was a biopsy/polypectomy performed during the endoscopy?** *This question is answered if 6.3.01 was a colonoscopy or a sigmoidoscopy.*	1	237	237	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 6.3.01 = 5
6.3.11	**Number of specimens sent to pathology (from endoscopy)** *This question is answered if 6.3.01 was a colonoscopy or a sigmoidoscopy, and a biopsy/polypectomy was performed.* *Includes samples removed entirely or in part. If a single polyp is removed piecemeal you would report the number of specimens (not the number of polyps).*	2	238	239	0 = Biopsy performed, no specimens sent 1 - 97 = Number of specimens 98 = ≥ 98 specimens 99 = Unknown **Right justify**	Range check. Leave blank if 6.3.01 = 5 Leave blank if 6.3.10 = 2, 9

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
6.3.12	**Completeness of polyp removal (from colonoscopy)** *Were all the polyps completely removed during 3rd test if it was a colonoscopy?*	1	240	240	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 6.3.01 = 3, 5 Leave blank if 6.3.06 ≠ 3, 4
6.3.13	**Recommended next follow-up procedure within this cycle after 3rd test.** *The next follow-up procedure recommended to the client (within the cycle). This can be another diagnostic follow-up test or surgery to complete diagnosis.*	1	241	241	1 = Sigmoidoscopy 2 = Colonoscopy 3 = DCBE 4 = Surgery to complete diagnosis* 8 = None (cycle is complete) * ***Diagnosis Information for Surgeries Performed to Complete Diagnosis*** *section must be completed if surgery is recommended.*	Range check. If response = 4 or 8, then 6.4.01 should = 0 (None).

Item	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks / Skip Patterns
6.4.01	**4th test provided within this cycle** *The actual fourth test provided through the program.* *"Provided = Paid For".*	1	242	242	0 = None 3 = Sigmoidoscopy 4 = Colonoscopy 5 = DCBE NOTE: FOBT/FIT can not be a second, third or fourth test in a "cycle".	Range check. If response = 0 (None), then 6.4.02 through 6.4.13 should be blank.
6.4.02	**Date of 4th test** *The date of the procedure.*	8	243	250	MMDDYYYY *If just the year is known, blank fill the month and day. If just the year and month are known, blank fill the day (e.g. 04 2006).*	"MMDDYYYY", "MM YYYY" or "YYYY", but not blank.
6.4.03	**Provider specialty** *The specialty of the clinician providing the 4th test.*	2	251	252	1 = General practitioner 2 = Internist 3 = Family practitioner 4 = Gastroenterologist 5 = General surgeon 6 = Colorectal surgeon 7 = Licensed practical nurse 8 = Registered nurse 9 = Nurse practitioner 10 = Physician assistant 99 = Unknown **Right justify**	Range check.
6.4.04	**Clinical practice site** *The type of clinical practice where the 4th test was provided.*	1	253	253	1 = Doctor's office 2 = Ambulatory endoscopy/surgery center 3 = Hospital 4 = Health clinic 9 = Unknown	Range check.
6.4.05	(Item not used for 4th test in "cycle")					
6.4.06	**Results of endoscopy or DCBE** *This question is answered if 6.4.01 was a colonoscopy, a sigmoidoscopy or a DCBE.*	1	254	254	1 = Normal/negative/diverticulosis/hemorrhoids 2 = Other finding not suggestive of cancer/polyp(s) 3 = Polyp(s)/suspicious for cancer/presumed cancer 4 = No findings/inconclusive 5 = Pending 9 = Unknown *NOTE: If more than one result, report the worst.*	Range check.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
6.4.07	**Was the bowel preparation considered adequate by the clinician performing the endoscopy or DCBE?** *This question is answered if 6.4.01 was a colonoscopy, a sigmoidoscopy or a DCBE.*	1	255	255	1 = Yes* 2 = No 9 = Unknown *Adequacy will be determined by the clinician performing the test.* **Procedure report must explicitly state that the bowel prep was adequate, otherwise report 9 (Unknown).*	Range check.
6.4.08	**Was the cecum reached during the colonoscopy?** *This question is answered if 6.4.01 was a colonoscopy.*	1	256	256	1 = Yes* 2 = No 9 = Unknown **Procedure report must explicitly state that the cecum was reached, otherwise report 9 (Unknown).*	Range check. Leave blank if 6.4.01 = 3, 5
6.4.09	**Complications of endoscopy or DCBE** *This question is answered if 6.4.01 was a colonoscopy, a sigmoidoscopy or a DCBE.*	1	257	257	1 = Yes 2 = No/unknown	Range check.
6.4.10	**Was a biopsy/polypectomy performed during the endoscopy?** *This question is answered if 6.4.01 was a colonoscopy or a sigmoidoscopy.*	1	258	258	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 6.4.01 = 5
6.4.11	**Number of specimens sent to pathology (from endoscopy)** *This question is answered if 6.4.01 was a colonoscopy or a sigmoidoscopy, and a biopsy/polypectomy was performed.* *Includes samples removed entirely or in part. If a single polyp is removed piecemeal you would report the number of specimens (not the number of polyps).*	2	259	260	0 = Biopsy performed, no specimens sent 1 - 97 = Number of specimens 98 = ≥ 98 specimens 99 = Unknown **Right justify**	Range check. Leave blank if 6.4.01 = 5 Leave blank if 6.4.10 = 2, 9

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
6.4.12	**Completeness of polyp removal (from colonoscopy)** *Were all the polyps completely removed during 4th test if it was a colonoscopy?*	1	261	261	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 6.4.01 = 3, 5 Leave blank if 6.4.06 ≠ 3, 4
6.4.13	**Recommended next follow-up procedure after 4th test.** *The next follow-up procedure recommended to the client. This can be another diagnostic follow-up test or surgery to complete diagnosis.*	1	262	262	4 = Surgery to complete diagnosis* 8 = None (cycle is complete) * ***Diagnosis Information for Surgeries Performed to Complete Diagnosis*** *section must be completed if surgery is recommended.*	Range check.
	Reserved for future use	10	263	272		Leave blank.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7. Diagnosis Information for All Polyps/Lesions – Complete for each CCDE record						
7.0	**Total number of polyps/lesions** *Total number of unique polyps/lesions identified through all colonoscopies and/or sigmoidoscopies during the client's "cycle".*	2	273	274	0 = No polyps/lesions 1 – 96 = Number of polyps/lesions 97 = ≥ 97 polyps/lesions 98 = At least one polyp/lesion, exact number not known 99 = Unknown *Specimens from surgical resections do not belong in this section.* **Right justify**	Range check.
7.01.1	**Location of 1st polyp/lesion** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.*	2	275	276	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown *Location will generally be found on the endoscopy report.* **Right justify**	Range check. Leave blank if 7.0 = 0
7.01.2	**Size of 1st polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	277	278	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.01.3.1	**Procedure for removal of 1st polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	279	279	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.01.3.2	**Procedure for removal of 1st polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	280	280	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*
7.01.3.3	**Procedure for removal of 1st polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	281	281	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.01.4	**Was 1st polyp/lesion completely removed?**	1	282	282	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.01.5	**Histology of 1st polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	283	284	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.02.1	**Location of 2nd polyp/lesion** *Complete only if more than one polyp/lesion was removed.* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.*	2	285	286	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown *Location will generally be found on the endoscopy report.* **Right justify**	Range check. Leave blank if 7.0 = 0
7.02.2	**Size of 2nd polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	287	288	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0
7.02.3.1	**Procedure for removal of 2nd polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	289	289	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.02.3.2	**Procedure for removal of 2nd polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	290	290	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*
7.02.3.3	**Procedure for removal of 2nd polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	291	291	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.02.4	**Was 2nd polyp/lesion completely removed?**	1	292	292	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.02.5	**Histology of 2nd polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	293	294	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.03.1	**Location of 3rd polyp/lesion** *Complete only if more than two polyps/lesions were removed.* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.*	2	295	296	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown *Location will generally be found on the endoscopy report.* **Right justify**	Range check. Leave blank if 7.0 = 0
7.03.2	**Size of 3rd polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	297	298	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0
7.03.3.1	**Procedure for removal of 3rd polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	299	299	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.03.3.2	**Procedure for removal of 3rd polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	300	300	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*
7.03.3.3	**Procedure for removal of 3rd polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	301	301	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.03.4	**Was 3rd polyp/lesion completely removed?**	1	302	302	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.03.5	**Histology of 3rd polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	303	304	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.04.1	**Location of 4th polyp/lesion** *Complete only if more than three polyps/lesions were removed.* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.*	2	305	306	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown *Location will generally be found on the endoscopy report.* **Right justify**	Range check. Leave blank if 7.0 = 0
7.04.2	**Size of 4th polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	307	308	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0
7.04.3.1	**Procedure for removal of 4th polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	309	309	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.04.3.2	**Procedure for removal of 4th polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	310	310	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*
7.04.3.3	**Procedure for removal of 4th polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	311	311	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.04.4	**Was 4th polyp/lesion completely removed?**	1	312	312	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.04.5	**Histology of 4th polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	313	314	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.05.1	**Location of 5th polyp/lesion** *Complete only if more than four polyps/lesions were removed.* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.* *Location will generally be found on the endoscopy report.*	2	315	316	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown **Right justify**	Range check. Leave blank if 7.0 = 0
7.05.2	**Size of 5th polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	317	318	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0
7.05.3.1	**Procedure for removal of 5th polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	319	319	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.05.3.2	**Procedure for removal of 5th polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	320	320	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.05.3.3	**Procedure for removal of 5th polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	321	321	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.05.4	**Was 5th polyp/lesion completely removed?**	1	322	322	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.05.5	**Histology of 5th polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	323	324	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.06.1	**Location of 6th polyp/lesion** *Complete only if more than five polyps/lesions were removed.* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.*	2	325	326	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown *Location will generally be found on the endoscopy report.* **Right justify**	Range check. Leave blank if 7.0 = 0
7.06.2	**Size of 6th polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	327	328	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0
7.06.3.1	**Procedure for removal of 6th polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	329	329	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.06.3.2	**Procedure for removal of 6th polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	330	330	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*
7.06.3.3	**Procedure for removal of 6th polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	331	331	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.06.4	**Was 6th polyp/lesion completely removed?**	1	332	332	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.06.5	**Histology of 6th polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	333	334	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.07.1	**Location of 7th polyp/lesion** *Complete only if more than six polyps/lesions were removed.* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.*	2	335	336	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown *Location will generally be found on the endoscopy report.* **Right justify**	Range check. Leave blank if 7.0 = 0
7.07.2	**Size of 7th polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	337	338	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0
7.07.3.1	**Procedure for removal of 7th polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	339	339	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.07.3.2	**Procedure for removal of 7th polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	340	340	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*
7.07.3.3	**Procedure for removal of 7th polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	341	341	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.07.4	**Was 7th polyp/lesion completely removed?**	1	342	342	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.07.5	**Histology of 7th polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	343	344	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.08.1	**Location of 8th polyp/lesion** *Complete only if more than seven polyps/lesions were removed.* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.*	2	345	346	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown *Location will generally be found on the endoscopy report.* **Right justify**	Range check. Leave blank if 7.0 = 0
7.08.2	**Size of 8th polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	347	348	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0
7.08.3.1	**Procedure for removal of 8th polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	349	349	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.08.3.2	**Procedure for removal of 8th polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	350	350	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*
7.08.3.3	**Procedure for removal of 8th polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	351	351	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.08.4	**Was 8th polyp/lesion completely removed?**	1	352	352	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.08.5	**Histology of 8th polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	353	354	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.09.1	**Location of 9th polyp/lesion** *Complete only if more than eight polyps/lesions were removed.* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.*	2	355	356	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown *Location will generally be found on the endoscopy report.* **Right justify**	Range check. Leave blank if 7.0 = 0
7.09.2	**Size of 9th polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	357	358	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0
7.09.3.1	**Procedure for removal of 9th polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	359	359	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.09.3.2	**Procedure for removal of 9th polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	360	360	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*
7.09.3.3	**Procedure for removal of 9th polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	361	361	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.09.4	**Was 9th polyp/lesion completely removed?**	1	362	362	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.09.5	**Histology of 9th polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	363	364	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.10.1	**Location of 10th polyp/lesion** *Complete only if more than nine polyps/lesions were removed.* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.*	2	365	366	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown *Location will generally be found on the endoscopy report.* **Right justify**	Range check. Leave blank if 7.0 = 0
7.10.2	**Size of 10th polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	367	368	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0
7.10.3.1	**Procedure for removal of 10th polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	369	369	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.10.3.2	**Procedure for removal of 10th polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	370	370	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*
7.10.3.3	**Procedure for removal of 10th polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	371	371	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.10.4	**Was 10th polyp/lesion completely removed?**	1	372	372	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.10.5	**Histology of 10th polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	373	374	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.

Item	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.11.1	**Location of 11th polyp/lesion** *Complete only if more than ten polyps/lesions were removed.* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.*	2	375	376	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown *Location will generally be found on the endoscopy report.* **Right justify**	Range check. Leave blank if 7.0 = 0
7.11.2	**Size of 11th polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	377	378	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0
7.11.3.1	**Procedure for removal of 11th polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	379	379	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.11.3.2	**Procedure for removal of 11th polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	380	380	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*
7.11.3.3	**Procedure for removal of 11th polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	381	381	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.11.4	**Was 11th polyp/lesion completely removed?**	1	382	382	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.11.5	**Histology of 11th polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	383	384	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.12.1	**Location of 12th polyp/lesion** *Complete only if more than eleven polyps/lesions were removed.* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.*	2	385	386	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown *Location will generally be found on the endoscopy report.* **Right justify**	Range check. Leave blank if 7.0 = 0
7.12.2	**Size of 12th polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	387	388	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0
7.12.3.1	**Procedure for removal of 12th polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	389	389	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.12.3.2	**Procedure for removal of 12th polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	390	390	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*
7.12.3.3	**Procedure for removal of 12th polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	391	391	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.12.4	**Was 12th polyp/lesion completely removed?**	1	392	392	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.12.5	**Histology of 12th polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	393	394	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.13.1	**Location of 13th polyp/lesion** *Complete only if more than twelve polyps/lesions were removed.* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.*	2	395	396	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown *Location will generally be found on the endoscopy report.* **Right justify**	Range check. Leave blank if 7.0 = 0
7.13.2	**Size of 13th polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	397	398	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0
7.13.3.1	**Procedure for removal of 13th polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	399	399	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.13.3.2	**Procedure for removal of 13th polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	400	400	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*
7.13.3.3	**Procedure for removal of 13th polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	401	401	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.13.4	**Was 13th polyp/lesion completely removed?**	1	402	402	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.13.5	**Histology of 13th polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	403	404	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.14.1	**Location of 14th polyp/lesion** *Complete only if more than thirteen polyps/lesions were removed*. *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.*	2	405	406	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown *Location will generally be found on the endoscopy report.* **Right justify**	Range check. Leave blank if 7.0 = 0
7.14.2	**Size of 14th polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	407	408	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0
7.14.3.1	**Procedure for removal of 14th polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	409	409	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Column Begin	Column End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.14.3.2	**Procedure for removal of 14th polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	410	410	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*
7.14.3.3	**Procedure for removal of 14th polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	411	411	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.14.4	**Was 14th polyp/lesion completely removed?**	1	412	412	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.14.5	**Histology of 14th polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	413	414	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.15.1	**Location of 15th polyp/lesion** *Complete only if more than fourteen polyps/lesions were removed.* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps.*	2	415	416	1 = Rectum 2 = Rectosigmoid junction 3 = Sigmoid 4 = Descending 5 = Splenic flexure 6 = Transverse 7 = Hepatic flexure 8 = Ascending 9 = Cecum 10 = Appendix 11 = Overlapping lesions 99 = Unknown *Location will generally be found on the endoscopy report.* **Right justify**	Range check. Leave blank if 7.0 = 0
7.15.2	**Size of 15th polyp/lesion** *This is the diameter of the polyp/lesion in millimeters (mm) or the longest dimension of the polyp/lesion if asymmetric.* *NOTE: This should be the size of the actual polyp and not the size of the biopsy specimen submitted for pathology.*	2	417	418	0 = < 1 mm 1 – 97 = Size of polyp/lesion in mm 98 = ≥ 98 mm 99 = Unknown **Right justify** *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy report and pathology report in order to "match up" the correct polyps. Size may be found on both the endoscopy and pathology reports, but size from the endoscopy report is preferred. If the specimen is not intact when sent to the pathology lab do NOT report specimen size from the pathology report.*	Range check. Leave blank if 7.0 = 0
7.15.3.1	**Procedure for removal of 15th polyp/lesion (1)** *This is the first procedure performed during removal/biopsy of the polyp/lesion.*	1	419	419	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 7 = Not biopsied or removed 9 = Unknown	Range check. Leave blank if 7.0 = 0

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
7.15.3.2	**Procedure for removal of 15th polyp/lesion (2)** *This is the second procedure performed during removal/biopsy of the polyp/lesion.*	1	420	420	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than one procedure was performed during the polyp/lesion removal.*
7.15.3.3	**Procedure for removal of 15th polyp/lesion (3)** *This is the third procedure performed during removal/biopsy of the polyp/lesion.*	1	421	421	1 = Snare polypectomy 2 = Hot biopsy forceps or cautery 3 = Cold biopsy 4 = Ablation 5 = Submucosal injection 6 = Control of bleeding 9 = Unknown	Range check. Leave blank if 7.0 = 0 *NOTE: This field should only be completed if more than two procedures were performed during the polyp/lesion removal.*
7.15.4	**Was 15th polyp/lesion completely removed?**	1	422	422	1 = Yes 2 = No 9 = Unknown	Range check. Leave blank if 7.0 = 0
7.15.5	**Histology of 15th polyp/lesion** *This is the histology of the polyp/lesion. If polyp was submitted to pathology as piecemeal fragments and more than one histological diagnosis was reported, report the worst (the response options are listed in general order of severity).* *NOTE: The individual translating clinical data into the CCDEs will need to carefully compare the endoscopy and pathology reports in order to "match up" the correct lesions.*	2	423	424	1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed ***Histologies for all polyps/lesions should be reviewed and a final diagnosis recorded in Item 9.2.*** **Right justify**	Range check. Leave blank if 7.0 = 0 Do not update/change this variable if polyp with high grade dysplasia is determined to be cancer during a subsequent surgery.
	Reserved for future use	30	425	454		Leave blank.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
8. Diagnosis Information for Surgeries Performed to Complete Diagnosis						
8.1	**Histology from surgical resection** *This is the worst histopathological diagnosis made from surgical resection (the response options are listed in general order of severity).*	2	455	456	0 = Surgery recommended but not performed 1 = Normal or other non-polyp histology 2 = Non-adenomatous polyp (inflammatory, hamartomatous, etc.) 3 = Hyperplastic polyp 4 = Adenoma, NOS (no high grade dysplasia noted) 5 = Adenoma, tubular (no high grade dysplasia noted) 6 = Adenoma, mixed tubular villous (no high grade dysplasia noted) 7 = Adenoma, villous (no high grade dysplasia noted) 8 = Adenoma, serrated (no high grade dysplasia noted) 9 = Adenoma with high grade dysplasia (includes in situ carcinoma) 10 = Adenocarcinoma, invasive 11 = Carcinoma, other 99 = Unknown/other lesions ablated, not retrieved or confirmed *Use histology from surgical resection in conjunction with all of the polyp/lesion histologies in the **Diagnosis Information for All Polyps/Lesions** section, to report the "Final diagnosis" (9.2).* **Right justify**	Range check. If surgery was recommended in 6.1.13, 6.2.13, 6.3.13 or 6.4.13 but was not completed, code 0 (Surgery recommended but not performed). If no surgery was recommended in 6.1.13, 6.2.13, 6.3.13 or 6.4.13, leave blank.
8.2	**Date surgery performed** *The date of the surgical procedure used to complete diagnosis (recommended in 6.1.13, 6.2.13, 6.3.13 or 6.4.13).*	8	457	464	MMDDYYYY *If just the year is known, blank fill the month and day. If just the year and month are known, blank fill the day (e.g. 04 2006).*	"MMDDYYYY", "MM YYYY", or "YYYY". If 6.1.13, 6.2.13, 6.3.13 or 6.4.13 = 4 (Surgery to complete diagnosis), then date must be completed. If no surgery was recommended in 6.1.13, 6.2.13, 6.3.13 or 6.4.13, then leave blank. If 8.1 = 0, then leave blank.
	Reserved for future use	10	465	474		Leave blank.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
9. Final Diagnosis – Completed for all CCDE records						
9.1	**Status of diagnosis** *After all screening and diagnostic tests were performed /offered to the client, what is the status of the client's care?*	1	475	475	1 = Complete (final diagnosis made) 2 = Pending final diagnosis 3 = Verbal/written refusal for any test needed to obtain a final diagnosis*[Ŧ] 4 = Client moved before final diagnosis was made[Ŧ] 5 = Client died before final diagnosis was made[Ŧ] 6 = Lost to follow-up*[Ŧ] 9 = Unknown *Programs must have a policy in place to define how much time can elapse before the client is deemed refused or lost to follow-up. [Ŧ]These items should have an administrative close-out date reported in 9.3 "Date of diagnosis".	Range check. If a client receives a single screening test which is normal/negative, then complete this field as 1 (Complete).
9.2	**Final diagnosis** *This is the final diagnosis after all procedures have been completed (including surgery, if done) that will determine the re-screening or surveillance test recommendation.*	1	476	476	1 = Normal/negative 2 = Polyp, no high grade dysplasia[2] 3 = Polyp with high grade dysplasia[1,2] 4 = Cancer[1,2] [1]***Diagnosis Information for Cancer/High Grade Dysplasia*** *section must be completed if 9.2 "Final diagnosis" = 3, 4.* [2]*Treatment section must be completed if 9.2 "Final diagnosis" = 2, 3, 4.*	Range check. If the only test performed in cycle was FOBT or FIT, then complete this field as 1 (Normal/negative).
9.3	**Date of diagnosis** *This can be the date of the final pathology report, the date of the 'normal' screening test, or when the client refused or was determined to be lost to follow-up.*	8	477	484	MMDDYYYY *If just the year is known, blank fill the month and day. If just the year and month are known, blank fill the day (e.g. 04 2006).*	If 9.1 = 1, 3-6, then "MMDDYYYY", "MM YYYY" or "YYYY". If 9.1 = 3-6, then an administrative close-out date will be necessary. Leave blank if 9.1 = 2, 9

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
9.4	**Recommended screening or surveillance test for next cycle** *The next screening or surveillance test recommended to the client at the end of the cycle. This can be a surveillance colonoscopy following a previous abnormal colonoscopy and/or surgery, or the next screening test recommended to the client following a normal/negative test.*	1	485	485	1 = Take-home FOBT 2 = Take-home FIT 3 = Sigmoidoscopy 4 = Colonoscopy 5 = DCBE 6 = None 9 = Unknown	Range check. If client is terminally ill or for other reasons no further tests are recommended, then code this as 6 (None). Leave blank if 9.1 ≠ 1
9.5	**Indication for screening or surveillance test for next cycle** *The indication for the next screening or surveillance test recommended to the client.*	1	486	486	1 = Screening 2 = Surveillance after a positive colonoscopy and/or surgery	Range check. Leave blank if 9.1 ≠ 1 Leave blank if 9.4 = 6, 9
9.6	**Number of months before screening or surveillance test for next cycle** *The number of months recommended between Date of diagnosis (9.3) and next recommended screening or surveillance test.*	3	487	489	12 – 180 = Actual number of months 999 = Unknown **Right Justify**	Range check. Leave blank if 9.1 ≠ 1 Leave blank if 9.4 = 6, 9
	Reserved for future use	10	490	499		Leave blank.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
10. Diagnosis Information for Cancer/High Grade Dysplasia – Complete this section when Final Diagnosis (9.2) = 3 or 4						
10.1	**Stage at diagnosis/treatment** *AJCC cancer stage used as a basis for clinical decisions. This can be based on clinical and/or pathological information.*	1	500	500	0 = Stage 0 (high grade dysplasia, severe dysplasia, or in situ) 1 = Stage I 2 = Stage II 3 = Stage III 4 = Stage IV 9 = Unknown/unstaged	Range check. If "Final diagnosis" (9.2) = 3 (High grade dysplasia) or 4 (Cancer), then 10.1 must be completed.
10.2	**Recurrent cancers** *Is this cancer a new primary or a recurrent cancer?*	1	501	501	1 = New CRC primary 2 = Recurrent CRC 3 = Non-CRC primary (metastasis from another organ) 9 = Unknown	Range check.
10.3	**Registry linkage status** *Has this record been linked to the state cancer registry?*	1	502	502	1 = Pending linkage 2 = Linked, matched 3 = Linked, not matched	Range check.
10.4	**Registry primary site** *Primary site [NAACCR data item #400] obtained from the central cancer registry.* *See SEER Program Coding and Staging Manual (pg 73):* *http://seer.cancer.gov/manuals/SPM2004.pdf*	4	503	506	C000-C999 *NOTE: The 'C' must be included as part of the variable response in the CCDE file. For example Cecum = C180. A complete list of valid values/labels will be provided for reference in the CCDE User's Manual.* **Alphanumeric, left justify**	Range check. Leave blank if 10.3 = 1, 3
10.5	**Registry CS-derived SS2000** *Collaborative stage (CS)-derived summary stage 2001 [NAACCR data item #3020] obtained from the central cancer registry database.* *See CS Staging Manual (pg 67) & SEER Summary Staging Manual:* *http://www.cancerstaging.org/cstage/csmanualpart1.pdf* *http://seer.cancer.gov/tools/ssm/*	1	507	507	0 = In situ 1 = Localized 2 = Regional, direct extension only 3 = Regional, regional lymph nodes only 4 = Regional, extension and nodes 5 = Regional, NOS 7 = Distant 8 = Not applicable 9 = Unknown/unstaged	Range check. Leave blank if 10.3 = 1, 3

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
10.6	**Registry CS-derived AJCC stage group** *Collaborative stage (CS)-derived AJCC stage [NAACCR date Item #3000] obtained from the central cancer registry database WHEN AVAILABLE.* *See CS Staging Manual (pg 65): http://www.cancerstaging.org/cstage/csmanualpart1.pdf*	2	508	509	Range: 00-99 *Valid values for CS-derived AJCC stage include: 00-02, 10-24, 30-43, 50-63, 70-74, 88, 90, 99.* *A complete list of valid values/labels will be provided for reference in the CCDE User's Manual.*	Range check. Leave blank if 10.3 = 1, 3
10.7	**Registry CS extension** *Collaborative stage (CS) extension [NAACCR data item #2810] obtained from the central cancer registry database.* *See CS Staging Manual (pg 272): http://www.cancerstaging.org/cstage/csmanualpart2.pdf*	2	510	511	Range: 00-99 *Valid values for CS extension include: 00, 05, 10-16, 20, 30, 40, 42, 45, 46, 50, 55, 57, 60, 65, 66, 70, 75, 80, 95, 99.* *A complete list of valid values/labels will be provided for reference in the CCDE User's Manual.*	Range check. Leave blank if 10.3 = 1, 3
10.8	**Registry CS lymph nodes** *Collaborative stage (CS) lymph nodes [NAACCR data item #2830] obtained from the central cancer registry database.* *See CS Staging Manual (pg 274): http://www.cancerstaging.org/cstage/csmanualpart2.pdf*	2	512	513	Range: 00-99 *Valid values for CS lymph nodes include: 00, 10, 20, 30, 80, 99.* *A complete list of valid values/labels will be provided for reference in the CCDE User's Manual.*	Range check. Leave blank if 10.3 = 1, 3
10.9	**Registry CS mets at diagnosis** *Collaborative stage (CS) mets at diagnosis [NAACCR data item #2850] obtained from the central cancer registry database.* *See CS Staging Manual (pg 275): http://www.cancerstaging.org/cstage/csmanualpart2.pdf*	2	514	515	Range: 00-99 *Valid values for CS mets at diagnosis include: 00, 08, 10, 40, 50, 99.* *A complete list of valid values/labels will be provided for reference in the CCDE User's Manual.*	Range check. Leave blank if 10.3 = 1, 3
	Reserved for future use	10	516	525		Leave blank.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
11. Treatment Information - Complete this section when Final Diagnosis (9.2) = 2, 3 or 4						
11.1	**Status of treatment** *In some cases, a polypectomy may be considered both diagnostic and treatment. In other cases surgery may be considered both diagnostic and start of treatment.*	1	526	526	1 = Treatment started and/or completed 2 = Treatment pending 3 = Treatment not indicated‡ 4 = Verbal/written refusal of treatment*‡ 5 = Client moved‡ 6 = Deceased‡ 7 = Lost to follow-up*‡ 9 = Unknown *Programs must have a policy in place to define how much time can elapse before the client is deemed refused or lost to follow-up. ‡These items should have an administrative close-out date reported in 11.2 "Date of treatment".	Range check. If "Final diagnosis" (9.2) = 2, 3, 4, then 11.1 must be completed.
11.2	**Date of treatment** *Can be the date treatment began, when the client refused, or was determined to be lost to follow-up. Date that treatment began **may** be the date of one of the tests. For instance, if a polypectomy was done and cancer was found **and removed**, the date that the polyp(s) was removed would also be the date that treatment began.*	8	527	534	MMDDYYYY *If just the year is known, blank fill the month and day. If just the year and month are known, blank fill the day (e.g. 04 2006).*	If 11.1 = 1, 3-7, then "MMDDYYYY", "MM YYYY" or "YYYY". If 11.1 = 3-7, then an administrative close-out date will be necessary. Leave blank if 11.1 = 2, 9
11.3	**Who paid for treatment?** *This is the primary source of payment for treatment.*	1	535	535	1 = Medicaid 2 = Other, State 3 = Medicare 4 = Self-Pay (by client) 5 = Charity care/uncompensated 6 = Other 9 = Unknown	Range check. Leave blank if 11.1 ≠ 1 (Treatment started).
	Reserved for future use	10	536	545		Leave blank.

Item	Variable Name	Column Length	Begin	End	Codes / Format / Comments	Edit Checks / Skip Patterns
12. Record Information – Completed for each CCDE record						
12.1	**CCDE version**	3	546	548	100 = For all data currently collected/reported	Range check.
12.2	**End of record mark**	2	549	550	The record ends with a carriage return-line feed (CR-LF).	