

CODE MANUAL  
THE SEER PROGRAM

DEMOGRAPHIC ANALYSIS SECTION  
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Revision: 05/01/84  
Effective Date: Cases  
First Diagnosed 1/1/83



## PREFACE

### Description:

The SEER Program Code Manual is intended to be a loose-leaf publication so that revisions can be substituted easily. Pages within each segment are numbered independently using a decimal notation, the integer part indicating the field number and the decimal part indicating the pages for that particular field. Future revisions will replace entire page(s).

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### References:

- SEER Program, Abstracting Instructions: Extent of Disease and Diagnostic Procedures, April 1977
- SEER Program, Extent of Disease--Codes and Coding Instructions, April 1977
- SEER Program, Geocoding for Place of Birth, April 1977
- International Classification of Diseases for Oncology (ICD-O), World Health Organization, Geneva, 1976.

The format of the data to be submitted on magnetic tape to the National Cancer Institute by the participants in the SEER Program is as follows:

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Basic Identification			
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The SEER Code Manual is a limited explanation of the format and definitions of the computerized record routinely submitted by each SEER Participant to the NCI SEER Staff for analysis of the pooled data. It is, therefore, concerned only with providing description in detail sufficient to achieve consensus in coding the routinely required data. In no way does this code manual imply any restriction on the type or degree of detailed information collected, classified, or studied at the local level.

The SEER Program is a continuation of two preceding NCI programs, the End Results Group and the Third National Cancer Survey. The working or operational definitions in these two large studies were not identical in all respects. One of the reasons for this manual is to spell out the definitions in areas where the traditions were different. Whether or not there is theoretical agreement regarding the best or proper interpretation of a particular concept, there should be a clear understanding of what has been agreed upon as a basis for common data. The interpretations presented here represent the decisions in force at this time.

#### "What is a Diagnosis of Cancer?"

The simplest way to state the answer is that a patient has cancer if a recognized medical practitioner says so. Then the question changes to "How can one tell from the medical record that the physician has stated a cancer diagnosis?" In most cases the patient's record clearly presents the diagnosis by use of specific terms which are synonymous with cancer. However, not always is the physician certain or the recorded language definitive. SEER rules concerning the usage of vague or inconclusive diagnostic language are as follows:

The ambiguous terms "probable," "suspect," "suspicious," "compatible with," or "consistent with" ARE to be interpreted as involvement by tumor.

The ambiguous terms "questionable," "possible," "suggests," or "equivocal" ARE NOT to be interpreted as involvement by tumor.

#### "How Unchangeable are the Diagnosis Items?"

Most of the diagnostic information items are restricted to information available or procedures performed within the time limits defined for each item. However, with the passage of time the patient's medical record gets more complete in regard to information originally missing or uncertain. It is therefore established practice to accept the thinking and information about the case at the time of the latest submission, or the most complete or detailed information. Thus, there may be changes in the coding of primary site, histology, extent of disease, residence, etc., as the information becomes more certain. There may be cases reported originally as cancer, especially if the initial report was a death certificate or one with ambiguous terms as listed above, which later information indicates never was a malignancy. These cases must be deleted from the file.

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"What is CANCER so far as Reporting to SEER is Concerned?"

The SEER Program definition of cancer is explicitly defined in Field 18, Histologic Type, as follows:

All cases with a behavior code of "2" or "3" in the International Classification of Diseases for Oncology (ICD-O) are reportable neoplasms with the following exclusions for cancers of the skin (Sites 173.0 - 173.9) only:

8000-8004	Neoplasms, malignant, NOS of the skin
8010-8043	Epithelial carcinomas of the skin
8050-8082	Papillary and Squamous cell carcinomas of the skin
8090-8110	Basal cell carcinomas of the skin

Note that the above lesions ARE reportable for skin of the genital sites, such as: vagina, clitoris, vulva, prepuce, penis, and scrotum (Sites 180.0, 184.1, 184.2, 184.3, 184.4, 187.1, 187.4, 187.7). |

Note also that if a "0" or "1" behavior code term in ICD-O is verified as in situ, "2," or malignant, "3," by a pathologist, these cases are reportable.

"What is the Policy when there is More Than One Cancer?"

The determination of how many primary tumors a patient has is, of course, a medical decision, but operational rules are needed in order to ensure consistency of reporting by all participants. Basic factors include the site of origin, the date of diagnosis, the histologic type, the behavior of the neoplasm (i.e., in situ vs. malignant), and laterality.

In general, if there is a difference in the site where the tumor originates, it is fairly easy to determine whether it is a separate primary, regardless of dates of detection and of differences in histology.

Likewise, if there is a clear-cut difference in histology, other data such as site and time of detection are not essential. In some neoplasms, however, one must be careful since different histologic terms are used to describe progressive stages or phases of the same disease process.

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The following definitions and rules are used to determine the number of independent primary tumors:

DEFINITIONS:

1. **Site:** For colon, rectum, bone, connective tissue, and skin, each subcategory as delineated in the International Classification of Diseases for Oncology (ICD-O) is considered to be a separate site. For all other sites, each category as delineated in ICD-O is considered to be a separate site. For example, Transverse colon (ICD-O code 153.1) and Descending colon (153.2) are each considered to be sites while Trigone of urinary bladder (188.0) and Lateral wall of urinary bladder (188.2) are considered to be subsites of the urinary bladder. Each side of a paired site is considered to be a separate site unless metastatic. Code a lymphoma to an extranodal site when there is no nodal involvement of any kind or it is stated that the origin was in an extranodal site, i. e., stomach, skin, lung.
2. **Histologic type:** Differences in histologic type refer to differences in the FIRST THREE digits of the morphology code as delineated in ICD-O.
3. **Simultaneous:** Diagnoses within two months of each other.

RULES:

1. A single lesion of one histologic type is considered a single primary even if the lesion crosses site boundaries.
2. A single lesion with multiple histologic types is to be considered as a single primary and is coded to the highest histology code number in the absence of an appropriate "mixed histology code" including those given in the rules below.
3. If a new cancer of the same histology as an earlier one is diagnosed in the same site within two months, consider this to be the same primary tumor. If a new cancer of the same histology is diagnosed in the same site after two months, consider this new cancer a separate primary unless stated to be recurrent or metastatic.

EXCEPTION: Bladder cancers, site codes 188.0-188.9, with morphology codes 8120-8130, are the only exception to the above rule. For these bladder cancers, a single abstract is required for the first lesion only.

4. Simultaneous multiple lesions of the same histologic type within the same primary site will be considered a single primary. Further, if one lesion has a behavior code of in situ and another a behavior code of malignant, still consider this to be a single primary whose behavior is malignant. Multiple lesions of the same histologic type occurring in different sites are considered to be separate primaries unless stated to be metastatic.

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5. Multiple lesions of different histologic types within a single site are to be considered separate primaries whether occurring simultaneously or at different times. Similarly, multiple lesions of different histologic types occurring in different sites are considered separate primaries whether occurring simultaneously or at different times. The following are exceptions to this rule:

- a) For multiple lesions within a single site occurring within two months, if one lesion is stated to be (adeno)carcinoma, NOS and the second lesion is stated to be a more specific (adeno)carcinoma, consider this to be a single primary and code to the more specific (adeno)carcinoma.

The ONLY EXCEPTIONS are "adenocarcinoma in an adenomatous polyp" (8210/39) and "adenocarcinoma" (not arising in a polyp) (8140/39). By definition, "adenocarcinoma in an adenomatous polyp" is an earlier stage of disease than is a frank "adenocarcinoma." This latter tumor is the one the physicians will be concerned with and the one which will determine the treatment. Therefore, when both an "adenocarcinoma" and "adenocarcinoma in an adenomatous polyp" arise in the same segment of the colon within two months of diagnosis, code as "adenocarcinoma" (8140/39).

- b) Within each breast the following combinations of ductal and lobular carcinoma occurring within two months of each other are to be considered a single primary and the histology coded accordingly.

- 1) Infiltrating duct carcinoma (8500/3) and lobular carcinoma (8520/3) code to histology 8522/3
- 2) Infiltrating duct carcinoma (8500/3) and lobular carcinoma-in situ (8520/2) code to histology 8523/3
- 3) Intraductal carcinoma (8500/2) and lobular carcinoma (8520/3) code to histology 8524/3
- 4) Intraductal carcinoma (8500/2) and lobular carcinoma-in situ (8520/2) code to 8522/2

Note that if the ductal and lobular lesions for the female breast are reported to occur in different quadrants of the same breast, the appropriate site code is 174.9. If the ductal lesion occurs in one breast and the lobular lesion occurs in the opposite breast, these are considered to be two primaries whether diagnosed within two months or not.

- c) Within each breast, a combination of Paget's disease with intraductal carcinoma should be coded to 8543/3.



6. If only one histologic type is reported and if both sides of a paired site are involved within two months of diagnosis, a determination must be made as to whether the patient has one or two independent primaries. (This determination is generally made by the pathologist based on whether areas of in situ are seen on each side of the pair.) If it is determined that there are two independent primaries, two records are to be submitted, each with the appropriate laterality and extent of disease information. If it is determined that there is only one primary, laterality should be coded according to the side in which the single primary originated and a single record submitted. If it is impossible to tell in which of the pair the single primary originated, laterality should be coded as a "4" and a single record submitted.

There are two exceptions to this rule. Bilateral involvement of the ovaries in which only a single histology is reported and bilateral retinoblastomas are always considered to be single primaries, and laterality (Field 16) is coded as "4."

#### 7. SUBSEQUENT DIAGNOSES FOR LYMPHOMAS, LEUKEMIAS, AND MULTIPLE MYELOMA

Purpose: To identify those lymphomas and leukemias with second primaries. Note that the lists are in terms of general headings followed by the ICD-0 numbers included in each heading. For specific terms such as "histiocytic," "diffuse," "nodular," and "granulocytic," check the ICD-0 Alphabetic List to determine into which general category a specific term falls.

##### Hodgkin's Lymphoma (9650-9662)

Report any SUBSEQUENT leukemia (9800-9940) or non-Hodgkin's lymphoma (9590-9642, 9690-9701, 9750) as a second primary.

Report any SUBSEQUENT multiple myeloma (9730) as a second primary.

##### Non-Hodgkin's Lymphoma (9590-9642, 9690-9701, 9750)

Report a SUBSEQUENT Hodgkin's lymphoma (9650-9662) as a second primary.

Report a SUBSEQUENT multiple myeloma (9730) as a second primary.

Report any SUBSEQUENT non-lymphocytic leukemias listed below as second primaries:

Plasma cell leukemia (9830)  
Erythroleukemia (9840-9842)  
Myeloid leukemia (9860-9866)

Mast cell leukemia (9900)  
Megakaryocytic leukemia (9910)  
Megakaryocytic myelosis (9920)  
Myeloid sarcoma/chloroma (9930)

Basophilic leukemia (9870)  
Eosinophilic leukemia (9880)  
Monocytic leukemia (9890-9894)

Leukemia, NOS (9800)  
Acute leukemia, NOS (9801)  
Subacute leukemia, NOS (9802)  
Aleukemic leukemia, NOS (9804)

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Non-Hodgkin's Lymphoma (9590-9642, 9690-9701, 9750) con't

Report a SUBSEQUENT leukemia as second primary except for:

Chronic leukemia, NOS (9803)  
Lymphoid (lymphocytic) leukemia (9820-9825)  
Compound leukemia (9810)  
Hairy cell leukemia (9940)

Do NOT report a SUBSEQUENT non-Hodgkin's lymphoma as a second primary except for:

Mycosis fungoides (9700-9701)  
Burkitt's lymphoma (9750)

Leukemia (9800-9940)

Report a SUBSEQUENT leukemia that has a clearly different histologic type from the first primary leukemia as a second primary. For example, the following would be reported as two primaries:

Lymphocytic leukemia (9820-9825) followed by myeloid leukemia (9860-9866)  
Myeloid leukemia (9860-9866) followed by erythroleukemia (9840-9842)  
Lymphocytic leukemia (9820-9825) followed by monocytic leukemia (9890-9894)  
Lymphocytic leukemia (9820-9825) followed by acute non-lymphocytic leukemia (9801)

Report a SUBSEQUENT Hodgkin's lymphoma following leukemia as a second primary.

Consider a SUBSEQUENT non-Hodgkin's lymphoma (9590-9642, 9690-9701, 9750) as part of the initial primary disease unless the lymphoma follows a non-lymphocytic leukemia such as myeloid (9860-9866) or monocytic (9890-9894) leukemia or erythroleukemia (9840-9842).

Multiple Myeloma (9730)

Consider plasma cell leukemia (9830) as part of the initial diagnosis of multiple myeloma (9730); otherwise report all leukemias (9800-9940) as well as Hodgkin's (9650-9662) and non-Hodgkin's (9590-9642, 9690-9701, 9750) lymphomas as second primaries.

These guidelines supersede any previous guidelines such as the resolved questions in the SEER Inquiry System or previous Tech Notes.

8. SIMULTANEOUS DIAGNOSES OF LEUKEMIA AND LYMPHOMA: Simultaneous diagnoses of malignant lymphoma, lymphocytic (small cell type) with chronic lymphocytic leukemia is coded to chronic lymphocytic leukemia.

EFFECTIVE DATE: Begin using these guidelines January 1, 1984 on all cases. Pick up any second primaries noted on follow up or submitted as new cases. Do not go back and review past years.

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Field Number	Character Position	Code	Description
Basic Identification			
1	1- 2		SEER Participant A specific two-digit identification of each participant in the SEER Program.
		01	San Francisco-Oakland SMSA
		02	Connecticut
		20	Metropolitan Detroit
		21	Hawaii
		22	Iowa
		23	New Mexico
		24	Metropolitan New Orleans
		25	Seattle (Puget Sound)
		26	Utah
		27	Metropolitan Atlanta
		28	Puerto Rico
		33	Arizona Indians
		34	New Jersey
		37	Rural Georgia
2	3- 9		Case Number and Check Digit A six-digit number assigned by the participating SEER registry followed by a seventh digit, i.e., check digit, calculated according to an algorithm acceptable to the SEER staff.
3	10		Type of Reporting Source
		1	Hospital Inpatient
		2	Clinic (Hospital or Private)
		3	Laboratory (Hospital or Private)
		4	Private Medical Practitioner (LMD)
		5	Nursing/Convalescent Home
		6	Autopsy Only (Diagnosed at Autopsy)
		7	Death Certificate Only (Including no information on follow-back)
		Note: Codes 1-2 take precedence over codes 3-5; code 6 takes precedence over code 7.	
Demographic Information			
4	11-19		Place of Residence at Diagnosis
	11-13		County Code
	14-19		Census Tract
5	20		Residence Summary
		0	Non-resident of Incidence Reporting Area
		1	Resident of Incidence Reporting Area

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Field Number	Character Position	Code	Description
Demographic Information (continued)			
6	21-23		Place of Birth See SEER booklet "SEER Program Geocoding for Place of Birth."
7	24-25		Year of Birth Last two digits of birth year -- Unknown
8	26-27		Age at Diagnosis (Age at last Birthday) 00 Less than one year old 01 One year old, but less than two years . . . 98 Ninety-eight years old or older 99 Unknown Age
9	28		Race/Ethnicity 0 Caucasian, NDS 1 Caucasian of Spanish surname or origin 2 Black 3 American Indian or Alaskan native 4 Chinese 5 Japanese 6 Filipino 7 Hawaiian 8 Other 9 Unknown
10	29		Sex 1 Male 2 Female 3 Other (Hermaphrodite) 4 Transsexual 9 Not Stated
11	30		Marital Status at Diagnosis 1 Single (never married) 2 Married 3 Separated 4 Divorced 5 Widowed 9 Unknown

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Field Number	Character Position	Code	Description
			Description of this Neoplasm
12	31-34		Date of Diagnosis
	31-32	Month 01-12 Month 99 Unknown	
	33-34	Year Last two digits of year 99 Year Unknown	
13	35-38		Diagnostic Information
	35-37	Blank	
	38	Description of Pathologic Investigation	
14	39		Sequence Number
		0 One primary only	
		1 First of two or more primaries	
		2 Second of two or more primaries	
		.	
		.	
		8 Eighth or later primary	
		9 Unspecified sequence number	
15	40-43		Primary Site
	40-42	See the International Classification of Diseases for Oncology (ICD-O, 1976) Topography section for the primary site. Place the last 3 digits in CP 40-42, i.e., drop the 1st digit, "1," and the decimal point.	
	43	Blank	
16	44		Laterality at Diagnosis
		0 Not a paired site	
		1 Right: origin of primary	
		2 Left: origin of primary	
		3 Only one side involved, right or left origin unspecified	
		4 Bilateral involvement, lateral origin unknown: stated to be single primary	
		Both ovaries involved simultaneously	
		9 Paired site, but no information concerning laterality	
17	45	Blank	

Field Number	Character Position	Code	Description
Description of This Neoplasm (continued)			
18	46-51		Histologic Type
			See the International Classification of Diseases for Oncology (ICD-O) Morphology Section for histologic type including behavior and grading.
	46-49		First four digits of M code number
	50		Behavior code--see p. 20 of ICD-O
	51		Grading or Differentiation--see p. 20 of ICD-O
19	52		Diagnostic Confirmation
		1	Positive histology
		2	Positive exfoliative cytology, no positive histology
		4	Positive microscopic confirmation, method not specified
		6	Direct visualization without microscopic confirmation
		7	Radiography without microscopic confirmation
		8	Clinical diagnosis only
		9	Unknown whether or not microscopically confirmed
20	53-68		Extent of Disease (EOD)
			There are four EOD schemes as indicated in the following format by Fields 20A, 20B, 20C, and 20D. Please see 20.1 - 20.6 for the more specific EOD coding schemes.
20A	53-68		SEER Non-Specific EOD Scheme
	53-66		Blank
	67-68		Non-Specific Code
OR			
20B	53-68		SEER Two-Digit Site-Specific EOD Scheme
	53-66		Blank
	67-68		SEER Two-Digit Site-Specific Code
OR			
20C	53-68		SEER Expanded Site-Specific EOD Scheme
	53-65		SEER Expanded Site-Specific Code
	66-68		Blank
OR			
20D	53-68		SEER Four-Digit EOD Scheme
	53-54		Tumor Size
	55		Extension
	56		Lymph Nodes
	57-68		Blank

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Field Number	Character Position	Code	Description
			First Course of Cancer-Directed Therapy
21	69-72		Date Therapy Initiated
		0000	No cancer-directed therapy
	69-70		Month
		01-12	Month
		99	Unknown
	71-72		Year
			Last two digits of year
		99	Unknown
22	73-79		Cancer-Directed Therapy
		0000000	Only symptomatic or supportive therapy
	73		Surgery
		0	None
		1	Surgical Resection
		8	Surgery recommended, unknown if performed
		9	Unknown
	74		Radiation
		0	None
		1	Beam Radiation
		2	Other Radiation
		3	Combination of 1 and 2
		7	Radiation, NOS
		8	Radiation recommended, unknown if administered
		9	Unknown
	75		Radiation Sequence with Surgery
			If treatment consisted of both surgery and radiation, i.e., CP 73 = 1 AND CP 74 = 1,2,3, or 7, code:
		2	Radiation before surgery
		3	Radiation after surgery
		4	Radiation both before and after surgery
		9	Sequence unknown, but both were given.
			All other cases, code:
		0	Not applicable. This includes the following combinations of CP 73 and CP 74:
		CP 73	CP 74
		0,8,9	0-9
		1	0,8,9

Field Number	Character Position	Code	Description
First Course of Cancer-Directed Therapy (continued)			
	76	Chemotherapy	
		0	None
		1	Chemotherapy
		8	Chemotherapy recommended, unknown if administered
		9	Unknown
	77	Hormonal Therapy	
		0	None
		1	Hormones (including NOS)
		2	Endocrine Surgery (if cancer is of another site)
		3	Combination of 1 and 2
		4	Endocrine Radiation (if cancer is of another site)
		5	Combination of 1 and 4
		6	Combination of 2 and 4
		7	Combination of 1 and 2 and 4
		8	Hormonal therapy recommended, unknown if administered
		9	Unknown
	78	Biological Response Modifiers	
		0	None
		1	Biological response modifiers
		8	Biological response modifiers recommended, unknown if administered
		9	Unknown
	79	Other Cancer-Directed Therapy	
		0	None (No cancer-directed therapy except as coded in CP 73-78)
		1	Other cancer-directed therapy (including dermoplaning hyperbaric oxygen as adjunct, etc.)
		2	Experimental cancer-directed therapy (not included in CP 73-78)
		3	Double-blind study, code not yet broken
		7	Unproven therapy (including laetrile, krebiozen, etc.)
		8	Other cancer-directed therapy recommended, unknown if administered
		9	Unknown
23	80	Blank	



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Field Number	Character Position	Code	Description
Follow-Up Information			
24	81-84		Date of Last Follow-Up or Death
	81-82	Month 01-12 Month 99 Unknown	
	83-84	Year Last two digits of year	
		Note: There should be NO use of code for unknown year in Field 24.	
25	85		Follow-Up Status
		1 Alive	
		4 Dead	
26	86-90		Cause of Death (According to Death Certificate)
	86-89		Cause of Death (four digits). Also use the following special codes with 7th, 8th or 9th Revision:
		0000	Patient alive at last contact
		7777	Death certificate not available
		7969	Death certificate available but cause of death not coded.
	90		Blank
27	91		ICD Code Used for Cause of Death (Field 26)
		0	Patient Alive at Last Follow-Up
		7	Seventh Revision of ICD
		8	Eighth Revision of ICDA
		9	Ninth Revision of ICD

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Field Number	Character Position	Code	Description
Administrative Codes			
28	92		Type of Follow-Up Expected
		1	Case not in active follow-up--"Autopsy Only" and "Death Certificate Only" cases
		2	Case is (or was) in active follow-up
		3	"In situ" cases of the cervix uteri only
		4	Cases which were not originally in active follow-up, but are in active follow-up now (San Francisco-Oakland only)
29	93		Coding System for Extent of Disease (Field 20)
		0	SEER Non-Specific EOD Code in CP 67-68; blanks in CP 53-66
		1	Two-Digit Site-Specific EOD Code in CP 67-68; blanks in CP 53-66
		2	SEER Expanded Site-Specific EOD Code in CP 53-65 (only for authorized sites); blanks in CP 66-68
		3	SEER Four-Digit Site-Specific EOD Code for all sites in CP 53-56; Blanks in CP 57-68. Scheme D in Field 20 was used to code EOD.
30	94-96		Inter-Field Review
	94		Site-Type Edit
		1	Reviewed: there is an apparent anomaly between the coding of primary site and histologic type; no need to review again.
	95		Histology
		1	Reviewed: the behavior code of the histology is designated as benign or uncertain in ICD-O, but upon review the behavior code remains as in situ or malignant.
	96		Blank
31	97		Site-Specific Surgery (A one-digit code for the major sites only)

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Each registry participating in the SEER Program is assigned a specific two-digit number.

CP 1-2

Code	Contractor	Area Covered/ Year Reporting Started	Name
01	California State Department of Health	5 counties/ 1973	San Francisco- Oakland SMSA
02	Connecticut State Department of Health	Entire state/ 1973	Connecticut
20	Michigan Cancer Foundation	3 counties/ 1973	Metropolitan Detroit
21	Hawaii Medical Association	Entire state/ 1973	Hawaii
22	University of Iowa	Entire state/ 1973	Iowa
23	University of New Mexico	Entire state/ 1973	New Mexico
24	Louisiana Health, Social and Rehabilitation Service Administration	3 parishes/ 1974	Metropolitan New Orleans
25	Fred Hutchinson Cancer Research Center	13 counties/ 1974	Seattle (Puget Sound)
26	University of Utah	Entire state/ 1973	Utah
27	Atlanta Cancer Surveillance Center	5 counties/ 1975	Metropolitan Atlanta
28	Puerto Rico Department of Health	Entire commonwealth/ 1973	Puerto Rico
33	University of New Mexico	Arizona 1973	Arizona Indians
34	State of New Jersey Department of Health	Entire state/ 1979	New Jersey
37	Atlanta Cancer Surveillance Center	10 counties/ 1978	Rural Georgia

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The first six digits of Field 2, CP 3-8, are reserved for the case number used by the SEER Participant to identify the patient. The seventh digit, CP 9, is for a check-digit referring to that case number.

Each computer record pertaining to the same patient should have an identical entry in Field 2.

CP 3-8      Case Number:

If the case number is less than six digits, enter leading zeros to create a six-digit entry. For example, Case #7034 will be coded as 007034.

Use no blanks in any of the positions CP 3-8.

CP 9      Check-Digit:

For our purposes, a check-digit is a number derived from the elements of a numerical code and is then appended to that code. In a sense, it becomes part of the code.

The entire field, including the check-digit, is checked by recalculating the check-digit. If the newly calculated check-digit does not match the recorded check-digit, an error of some kind is indicated. While not all errors can be detected by this type of rechecking, most transposing and many transcribing errors will be picked up.

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Code:

- 1 Hospital Inpatient
- 2 Clinic (Hospital or Private)
- 3 Laboratory (Hospital or Private)
- 4 Private Medical Practitioner (LMD)
- 5 Nursing/Convalescent Home
- 6 Autopsy Only (Diagnosed at Autopsy)
- 7 Death Certificate Only (Including no information on follow-back and Coroners' cases)

## General:

This field helps explain why some records are incomplete. Probably the most important use for Field 3 is to identify those cases coded 6 or 7 which are excluded from studies of survival, but included in studies of incidence.

## Specific:

Codes 1 and 2 take precedence over codes 3 through 5 if there are several reporting sources. In other words, the hospital record for an inpatient with a cancer diagnosis (before death) takes precedence over all other types of reports.

Code 6, Autopsy Only, means that the cancer was not diagnosed even as a clinical diagnosis while the patient was alive. If the patient was an inpatient with another admitting diagnosis and the autopsy at the same hospital disclosed the cancer for the first time, code 6 is proper. Autopsy findings take precedence over death certificate information, i.e., code 6 takes precedence over code 7. However, a clinical diagnosis of cancer at any of the sources coded 1-5 has priority over confirmation at autopsy.

Code 7, Death Certificate Only, is used only when "follow-back" activities have produced no other medical reports--the death certificate is truly the only source of information. Often a case is reported first via the death certificate, but later registry action yields missing or additional medical reports. Such additional reports take precedence. For Death Certificate Only cases, Date of Diagnosis (Field 12) should be the date of death; Diagnostic Information (Field 13) should be left blank; Diagnostic Confirmation (Field 19) should be coded "9"; Extent of Disease (Field 20, CP 53-56) should be coded "9999"; and Coding System used for Extent of Disease (Field 29) should be coded "3."

-----

Field 4 provides nine digits (CP 11-19) for the coding of residence at diagnosis. The Field is divided into two subfields, the first (CP 11-13) to indicate County, and the second (CP 14-19) to indicate Census Tract. Census Bureau statistics by census tract provide much of the socioeconomic data easily available for evaluation studies. The most meaningful data are provided for census tracts within a SMSA (Standard Metropolitan Statistical Area), but a SEER Participant may cover an area with more than one SMSA. Therefore, the County Code is provided for identification of the SMSA and its component census tracts. It may also be useful in the coding of residents of the covered area outside a specific SMSA.

Census tract should be right justified. Assume that the decimal point is located between CP 17 and CP 18. Thus, census tract 409.6 would be coded 040960 in CP 14-19.

There is enough coding space in Field 4 to accommodate the coding of residence for non-residents of the SEER area. However, there are no requirements at this time for such coding.

Specific:

CP 11-13 County code

CP 14-19 Census tract: If not reporting this field,  
CP 14-19 = 000000.

If a person is known to be a resident of a particular SEER area, but the exact county is unknown, code 999 in CP 11-13.

The following are the valid county codes (CP 11-13).

SEER Area	County Code	County
California	001	Alameda
	013	Contra Costa
	041	Marin
	075	San Francisco
	081	San Mateo
Connecticut	001	Fairfield
	003	Hartford
	005	Litchfield
	007	Middlesex
	009	New Haven
	011	New London
	013	Tolland
	015	Windham

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Georgia	063	Clayton
Metropolitan	067	Cobb
Atlanta	089	De Kalb
	121	Fulton
	135	Gwinnett
Georgia	125	Glascock
Rural Counties	133	Greene
	141	Hancock
	159	Jasper
	163	Jefferson
	211	Morgan
	237	Putnam
	265	Taliaferro
	301	Warren
	303	Washington
Hawaii	001	Hawaii
	003	Honolulu
	007	Kauai
	009	Maui
Iowa	001	Adair
	003	Adams
	005	Allamakee
	007	Appanoose
	009	Audubon
	011	Benton
	013	Black Hawk
	015	Boone
	017	Bremer
	019	Buchanan
	021	Buena Vista
	023	Butler
	025	Calhoun
	027	Carroll
	029	Cass
	031	Cedar
	033	Cerro Gordo
	035	Cherokee
	037	Chickasaw
	039	Clarke
	041	Clay
	043	Clayton
	045	Clinton
	047	Crawford
	049	Dallas
	051	Davis
	053	Decatur

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Iowa (continued)	055	Delaware
	057	Des Moines
	059	Dickinson
	061	Dubuque
	063	Emmet
	065	Fayette
	067	Floyd
	069	Franklin
	071	Fremont
	073	Greene
	075	Grundy
	077	Guthrie
	079	Hamilton
	081	Hancock
	083	Hardin
	085	Harrison
	087	Henry
	089	Howard
	091	Humbolt
	093	Ida
	095	Iowa
	097	Jackson
	099	Jasper
	101	Jefferson
	103	Johnson
	105	Jones
	107	Keokuk
	109	Kossuth
	111	Lee
	113	Linn
	115	Louisa
	117	Lucas
	119	Lyon
	121	Madison
	123	Mahaska
	125	Marion
	127	Marshall
	129	Mills
	131	Mitchell
	133	Monona
	135	Monroe
	137	Montgomery
	139	Muscatine
	141	O'Brien
	143	Osceola
	145	Page
	147	Palo Alto
	149	Plymouth
	151	Pocahontas
	153	Polk
	155	Pottawattamie



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Iowa (continued)	157	Poweshiek
	159	Ringgold
	161	Sac
	163	Scott
	165	Shelby
	167	Sioux
	169	Story
	171	Tama
	173	Taylor
	175	Union
	177	Van Buren
	179	Wapello
	181	Warren
	183	Washington
	185	Wayne
	187	Webster
	189	Winnebago
	191	Winneshiek
	193	Woodbury
195	Worth	
197	Wright	
Louisiana	051	Jefferson
	071	Orleans
	087	St. Bernard
Michigan	099	Macomb
	125	Oakland
	163	Wayne
New Jersey	001	Atlantic
	003	Bergen
	005	Burlington
	007	Camden
	009	Cape May
	011	Cumberland
	013	Essex
	015	Gloucester
	017	Hudson
	019	Hunterdon
	021	Mercer
	023	Middlesex
	025	Monmouth
	027	Morris
	029	Ocean
	031	Passaic
	033	Salem
035	Somerset	
037	Sussex	
039	Union	
041	Warren	

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New Mexico	001	Bernalillo
	003	Catron
	005	Chaves
	006	Cibola
	007	Colfax
	009	Curry
	011	De Baca
	013	Dona Ana
	015	Eddy
	017	Grant
	019	Guadalupe
	021	Harding
	023	Hidalgo
	025	Lea
	027	Lincoln
	028	Los Alamos
	029	Luna
	031	McKinley
	033	Mora
	035	Otero
	037	Quay
	039	Rio Arriba
	041	Roosevelt
	043	Sandoval
	045	San Juan
	047	San Miguel
	049	Santa Fe
	051	Sierra
	053	Socorro
	055	Taos
	057	Torrance
	059	Union
	061	Valencia
Univ. of New Mexico	001	Apache
Arizona Indians	003	Cochise
	005	Coconino
	007	Gila
	009	Graham
	011	Greenlee
	013	Maricopa
	015	Mohave
	017	Navajo
	019	Pina
	021	Pinal
	023	Santa Cruz
	025	Yavapai
	027	Yuma

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Utah	001	Beaver
	003	Box Elder
	005	Cache
	007	Carbon
	009	Daggett
	011	Davis
	013	Duchesne
	015	Emery
	017	Garfield
	019	Grand
	021	Iron
	023	Juab
	025	Kane
	027	Millard
	029	Morgan
	031	Piute
	033	Rich
	035	Salt Lake
	037	San Juan
	039	Sanpete
	041	Sevier
	043	Summit
	045	Tooele
	047	Uintah
	049	Utah
	051	Wasatch
	053	Washington
	055	Wayne
	057	Weber
Washington	009	Clallam
	027	Grays Harbor
	029	Island
	031	Jefferson
	033	King
	035	Kitsap
	045	Mason
	053	Pierce
	055	San Juan
	057	Skagit
	061	Snohomish
	067	Thurston
	073	Whatcom
Puerto Rico	001	Entire Commonwealth

-----  
Field 5 refers to the residence of this patient at diagnosis for this cancer.

## Code:

0 Non-resident of Reporting Area

1 Resident of Reporting Area

-----  
Field 6 indicates place of birth. It includes states within the United States as well as foreign countries.

Code:

See "SEER Program Geocoding for Place of Birth" for coding this three-digit field.

-----  
Field 7 indicates the year of the patient's birth.

Code:

Last 2 digits of the patient's birth year.

-- Unknown

If age at diagnosis and year of diagnosis are known, but year of birth is unknown, then year of birth should be calculated and so coded.

-----

Field 8 represents the age of the patient at diagnosis for this cancer. Age is measured in completed years of life, i.e., age at last birthday.

Code:

Number of years of age at last birthday

00	Less than one year old
01	One year old, but less than two years old
.	
.	
.	
97	Ninety-seven years old, but less than ninety-eight
98	Ninety-eight years old or older
99	Unknown age

If year of birth and year of diagnosis are known, but age is unknown, calculate age at diagnosis.

-----  
Code:

- 0 Caucasian NOS
- 1 Caucasian of Spanish surname or Spanish origin
- 2 Black
- 3 American Indian or Alaskan Native
- 4 Chinese
- 5 Japanese
- 6 Filipino
- 7 Hawaiian
- 8 Other
- 9 Unknown



-----  
Code:

- 1 Male
- 2 Female
- 3 Other (Hermaphrodite)
- 4 Transsexual
- 9 Not stated

-----  
Field 11 indicates the marital status of the patient at diagnosis for this cancer.

## Code:

- 1 Single (never married)
- 2 Married
- 3 Separated
- 4 Divorced
- 5 Widowed
- 9 Unknown

-----  
Code:

CP 31-32

Month

01	January
02	February
03	March
04	April
05	May
06	June
07	July
08	August
09	September
10	October
11	November
12	December
99	Unknown

CP 33-34

Year

Last two digits of year

99 Unknown

## Definition:

The date in Field 12 refers to the first diagnosis of this cancer by any recognized medical practitioner. This is often a clinical diagnosis and may not ever be confirmed histologically. Even if confirmed later, the date in Field 12 refers to the date of the first clinical diagnosis and not to the date of confirmation. If upon medical and/or pathological review of a previous condition the patient is deemed to have had cancer at an earlier date, then the earlier date is the date of diagnosis, i.e., the date of diagnosis is back-dated.

## General:

In the ABSENCE OF AN EXACT DATE OF DIAGNOSIS, the best approximation is acceptable. Approximation is preferred to coding the month and/or year as unknown.

- 
- a) If the only information is "Spring of," "Middle of the year," "Fall," approximate these as April, July, and October, respectively. For "Winter of" it is important to discover whether the beginning or end of the year is meant before approximating the month. |
  - b) If there is no basis for an approximation, code the month of diagnosis as 99 in CP 31-32. |
  - c) If necessary, approximate the year. If no approximation is possible, code year of diagnosis as 99 in CP 33-34. If code 99 is used in CP 33-34, code 99 should also be used in CP 31-32. |
  - d) Date of first cancer-directed therapy may be used as the date of diagnosis if the cancer-directed therapy has been initiated and cancer is later confirmed, but prior to therapy the diagnosis was not definitive. |
  - e) The date of diagnosis for "Death Certificate Only" cases is the date of death. If later follow-back results in more definitive information on the date of diagnosis, this date should be changed, and then this case is no longer a "Death Certificate Only" case. |

-----  
CP 35-37    Blank

CP 38        Description of Pathologic Investigation

Procedures requiring observation of tissue and cells for the following sites: stomach, colon/rectum, bronchus and lung, skin (malignant melanoma), breast, cervix uteri, corpus uteri, prostate, bladder, lymph nodes and lymphoid tissue (Hodgkin's disease and non-Hodgkin's lymphoma)

General:

This field evaluates the relative reliability of Extent of Disease information on the basis of the pathologic examinations. It should be limited, just as is extent of disease, to all pathologic examinations by the end of the first hospitalization for definitive SURGICAL resection if done within two months of diagnosis, or two months after diagnosis for ALL OTHER CASES--both treated and untreated. However, metastasis known to have developed after the original diagnosis was made should be excluded. |

If a patient has radiation therapy followed by definitive surgery within two months of diagnosis, include all information available through definitive surgery.

If an excisional biopsy, D and C, cone biopsy, lymphadenectomy, TUR (prostate or bladder), or a polypectomy is followed by further definitive therapy within two months of diagnosis, include all information available through the definitive therapy.

For example, a melanoma excised in the doctor's office is coded 2 in col. 38. If the patient is then admitted for wide excision and lymphadenectomy within two months of diagnosis, the proper code is 6. |

Specific:

Only the sites specified above are to be coded in CP 38. For all other sites this field is to be left blank. The site-specific codes follow.

For all sites, "autopsy only" and Death certificate only" cases are to be left blank in these fields. |

-----  
STOMACH

151.0-151.6, 151.8-151.9

- 0 None
- 1 Cytology of primary site (including brushings and washings)
- 2 Biopsy of primary site (includes biopsy, incisional and excisional, done during endoscopy or exploratory surgery)
- 3 Biopsy or resection of direct extension and/or regional node(s)
- 4 (3) and (2)
- 5 Resected primary site
- 6 Resected primary site and regional node(s)
- 7 Cytology of distant site
- 8 Biopsy or resection of distant site and/or distant node(s)
- 9 (7 or 8) with any of (2-4)
- & (7 or 8) with (5 or 6)

COLON AND RECTUM

153.0-153.9, 154.0-154.1

- 0 None
- 1 Cytology of primary site (including washings)
- 2 Biopsy of primary site (includes biopsy, incisional and excisional, done during endoscopy or exploratory surgery)
- 3 Biopsy or resection of direct extension and/or regional node(s)
- 4 (3) and (2)
- 5 Resected primary site
- 6 Resected primary site and regional node(s)
- 7 Cytology of distant site
- 8 Biopsy or resection of distant site and/or distant node(s)
- 9 (7 or 8) with any of (2-4)
- & (7 or 8) with (5 or 6)

-----  
BRONCHUS AND LUNG

162.2-162.5, 162.8-162.9

- 0 None
- 1 Cytology of primary site (including sputum, brushings, and washings)
- 2 Biopsy of primary site (includes biopsy done during endoscopy or exploratory surgery); wedge resection, lingulectomy, segmentectomy (less than a lobectomy)
- 3 Biopsy or resection of direct extension and/or regional node(s)
- 4 (3) and (2)
- 5 Resected primary site
- 6 Resected primary site and regional node(s)
- 7 Cytology of distant site
- 8 Biopsy or resection of distant site and/or distant node(s)
- 9 (7 or 8) with any of (2-4)
- & (7 or 8) with (5 or 6)

Note: Removal of ribs is not a diagnostic procedure unless tissue is involved by tumor.

## MALIGNANT MELANOMA OF SKIN

173.0-173.9

HISTOLOGY: 8720 thru 8790

- 0 None
- 1 Cytology of primary site
- 2 Biopsy of primary site; excisional biopsy
- 3 Biopsy or resection of direct extension (including satellite tumors) and/or regional node(s)
- 4 (3) and (2)
- 5 Resected primary site (wide excision/resection)
- 6 Resected primary site (wide excision/resection) and regional nodes(s)
- 7 Cytology of distant site
- 8 Biopsy or resection of distant site and/or distant node(s)
- 9 (7 or 8) with any of (2-4)
- & (7 or 8) with (5 or 6)

-----  
BREAST

174.0-174.6, 174.8-174.9 Female; 175.9 Male

- 0 None
- 1 Cytology of primary site
- 2 Biopsy of primary site (including aspiration biopsy/  
frozen section; excisional biopsy; lumpectomy)
- 3 Biopsy or resection of direct extension and/or regional  
node(s)
- 4 (3) and (2)
- 5 Resected primary site (incl. subcutaneous mastectomy)
- 6 Resected primary site and regional node(s)
- 7 Cytology of distant site
- 8 Biopsy or resection of distant site and/or distant  
node(s)
- 9 (7 or 8) with any of (2-4)
- & (7 or 8) with (5 or 6)

CERVIX UTERI

180.0-180.9

- 0 None
- 1 Cytology of primary site (Pap smear)
- 2 Biopsy of primary site, conization, D & C of endo-  
cervix only
- 3 Biopsy or resection of direct extension and/or regional  
node(s), D & C of endometrium only
- 4 (3) and (2)
- 5 Resected primary site
- 6 Resected primary site and regional node(s)
- 7 Cytology of distant site
- 8 Biopsy or resection of distant site and/or distant  
node(s)
- 9 (7 or 8) with any of (2-4)
- & (7 or 8) with (5 or 6)

Note: Removal of tube(s) and/or ovary(ies) is not a diagnostic pro-  
cedure unless tissue is involved by tumor.



-----  
CORPUS UTERI

182.0-182.1, 182.8

- 0 None
- 1 Cytology of primary site (Pap smear)
- 2 Biopsy of primary site, D & C
- 3 Biopsy or resection of direct extension and/or regional node(s), conization
- 4 (3) and (2)
- 5 Resected primary site
- 6 Resected primary site and regional node(s)
- 7 Cytology of distant site
- 8 Biopsy or resection of distant site and/or distant node(s)
- 9 (7 or 8) with any of (2-4)
- & (7 or 8) with (5 or 6)

Note: Removal of tube(s) and/or ovary(ies) is not a diagnostic procedure unless tissue is involved by tumor.

## PROSTATE

185.9

- 0 None
- 1 Cytology of primary site (including urinary sediment and/or prostatic fluid after massage)
- 2 Biopsy (incl. needle biopsy) of primary site and/or TUR\*
- 3 Biopsy or resection of direct extension and/or regional node(s)
- 4 (3) and (2)
- 5 Prostatectomy (excluding TUR)
- 6 Prostatectomy (excluding TUR) and regional node(s)
- 7 Cytology of distant site
- 8 Biopsy or resection of distant site and/or distant node(s)
- 9 (7 or 8) with any of (2-4)
- & (7 or 8) with (5 or 6)

\*TUR is to be coded as treatment in Field 22, First Course of Cancer-Directed Therapy.

Note: Orchiectomy is not a diagnostic procedure unless tissue is involved by tumor.

-----  
BLADDER

188.0-188.6, 188.8-188.9

- 0 None
- 1 Cytology of primary site
- 2 Biopsy of primary site (including polypectomy) and/or TUR\*
- 3 Biopsy or resection of direct extension and/or regional node(s)
- 4 (3) and (2)
- 5 Resected primary site
- 6 Resected primary site and regional node(s)
- 7 Cytology of distant site
- 8 Biopsy or resection of distant site and/or distant node(s)
- 9 (7 or 8) with any of (2-4)
- & (7 or 8) with (5 or 6)

\*TUR is to be coded as treatment in Field 22, First Course of Cancer-Directed Therapy.

HODGKIN'S DISEASE and NON-HODGKIN'S LYMPHOMA of ALL SITES

Histology: 9590 thru 9698, 9740-9750

- 0 Single nodal/site biopsy and/or resection or clinical impression
- 1 Multiple nodal/site biopsies and/or resections
- 2 Splenectomy with or without nodal site biopsies and/or resections
- 3 Bone marrow examination (aspiration and/or biopsy)
- 4 (3) and (1)
- 5 (3) and (2)
- 6 Liver biopsy
- 7 (6) and (1)
- 8 (6) and (2)
- 9 (6) and (3)
- & (6) and (4)
- (6) and (5)

Includes lymphoma (nodular, diffuse, and follicular), reticulosarcomas, and Hodgkin's disease

-----  
Code:

- 0 One primary only
- 1 First of two or more primaries
- 2 Second of two or more primaries
- 3 Third of three or more primaries
- 4 Fourth of four or more primaries
- 5 Fifth of five or more primaries
- 6 Sixth of six or more primaries
- 7 Seventh of seven or more primaries
- 8 Eighth or later primary
- 9 Unspecified sequence number

## Specific:

Sequence Number, Field 14, codes the chronological appearance of all primary malignant and/or in situ tumors as defined on page vi of this manual. Even if the first primary tumor was experienced by the patient before becoming a resident of the area covered or prior to the date each participant entered the SEER Program, it would be considered as sequence number "1" if later primaries are known to the SEER participant.

If two or more independent primaries are diagnosed simultaneously, the lowest sequence number will be assigned to the diagnosis with the worst prognosis. This means consideration of stage or extent of disease and also the grade or degree of malignancy. Therefore, look first at the difference in EOD, then give priority to the diagnosis with the highest terminal digit (omitting 6 and 9) in the histology code (Field 18). If no difference in prognosis is evident, the decision must be arbitrary.

## Determination of Primary Tumors, Operational Rules:

The discussion above is secondary to a determination of how many primary tumors the patient has. The rules given on page vii of this manual are used to make this determination. Sequence number can then be assigned accordingly.

-----  
Code:

CP 40-42 From the International Classification of Diseases for  
Oncology (ICD-O), Topography, Numerical List (see below)

CP 43 Blank

## Specific:

The Topography section of the International Classification of Diseases for Oncology (ICD-O) is used for coding the Primary Site of all tumors reported to SEER. For all site codes in ICD-O, the SEER Program drops the first digit, "1," and the decimal point.

In ICD-O, site codes may be found in the Topography, Numerical List, section (pp. 1-19) or in the Alphabetic Index (pp. 47-128) which includes both Topography and Morphology terms. In the Alphabetic Index all site (Topography) codes are indicated by a "T-" preceding the code number. The "T-" should not be coded.

Example: A patient's record states the primary site is "cardia of stomach." This site is looked up in the Alphabetic Index, either under "cardia" or "stomach" and is found to be T-151.0. In coding for SEER, drop the T-, the first 1, and the decimal point; then enter the three-digit code, 510, in CP 40-42.

## DEFINITIONS

## Primary vs Secondary:

The major emphasis within the SEER Program is that the primary site be identified and NOT a metastatic site. If the site of origin cannot be determined exactly, it may be possible to use the NOS category of an organ system or the Ill-Defined Sites codes (950-958) (see p. ix of ICD-O) instead of code 999 which denotes a completely unknown site. However, it is proper to code 999 in CP 40-42 if the only information available pertains to a secondary site.

Where the record is not entirely explicit, it is suggested that a physician determine whether the cancer site is primary or secondary and which Topography code would be the most definitive one to use.

Code a lymphoma to an extranodal site when there is no nodal involvement of any kind or it is stated that the origin was in an extranodal site.

-----

In the Introduction of ICD-O (p. xvii) the topic of "Site-Specific Morphology Terms" is discussed. If the patient record has a morphologic term with a T number listed in ICD-O, use this T number if no definite site is given or if only a metastatic site is given. For example, if the diagnosis is Hepatoma (M-8170/3) with no other statement about topography, code to primary site T-155.0 (liver) as this morphology is always indicative of a primary malignancy in the liver.

**Multiple Subsites:**

Each three-digit site of colon (153.0-153.7), rectum (154.0-154.1), bone (170.0-170.8), connective tissue (171.0-171.7), and skin (173.0-173.7) is considered to be a major primary site (Definition, p. vii of the SEER Program Code Manual) whereas all other three-digit site codes are considered to be subsites of a major two-digit site. For example 174.2, upper-inner quadrant of the breast, is considered to be a subsite of female breast, 174.\_. The rules on pages vii and viii should be used in determining the number of primary cancers to be reported and the appropriate site code for each.

-----

Field 16 describes this primary site only and should be coded for each primary independently.

## Code:

- 0 Not a paired site
- 1 Right: origin of primary
- 2 Left: origin of primary
- 3 Only one side involved, right or left origin unspecified
- 4 Bilateral involvement, lateral origin unknown: stated to be single primary  
Both ovaries involved simultaneously
- 9 Paired site, but no information concerning laterality

## Specific:

Laterality codes of 1-9 must be used for the following sites except as noted. Only major headings are listed. However, laterality should be coded for all subheadings included in ICD-O unless specifically excluded. Such exclusions must be coded "0."

- 142.0 Parotid gland
  - 142.1 Submandibular gland
  - 142.2 Sublingual gland
  - 146.0 Tonsil, NOS
  - 146.1 Tonsillar fossa
  - 146.2 Tonsillar pillar
  - 160.0 Nasal cavity (excluding Nasal cartilage, Nasal septum)
  - 160.1 Middle ear
  - 160.2 Maxillary sinus
  - 160.4 Frontal sinus
  - 162.2 Main bronchus (excluding Carina)
  - 162.3 Upper lobe, lung
  - 162.4 Middle lobe, lung
  - 162.5 Lower lobe, lung
  - 162.8 Other parts of lung or bronchus
  - 162.9 Lung, NOS
  - 163.0-163.1, 163.8-163.9 Pleura
  - 170.3 Rib, Clavicle (excluding Sternum)
  - 170.4 Long bones of upper limb, Scapula
  - 170.5 Short bones of upper limb
  - 170.6 Pelvic Bones (excluding Sacrum, Coccyx, & Symphysis pubis)
  - 170.7 Long bones of lower limb
  - 170.8 Short bones of lower limb
- (continued)

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171.2 Connective, Subcutaneous, and other Soft tissues of upper limb and shoulder  
171.3 Connective, Subcutaneous, and other Soft tissues of lower limb and hip  
173.1 Skin of eyelid  
173.2 Skin of external ear  
173.3 Skin of other and unspecified parts of face  
173.5 Skin of trunk  
173.6 Skin of arm and shoulder  
173.7 Skin of leg and hip  
174.0-174.6, 174.8-174.9 Female breast  
175.9 Male breast  
183.0 Ovary  
183.2 Fallopian tube  
186.0 Undescended testis  
186.9 Testis, NOS  
187.5 Epididymis  
187.6 Spermatic cord  
189.0 Kidney, NOS  
189.1 Renal pelvis  
189.2 Ureter  
190.0-190.9 Eye and lacrimal gland  
194.0 Suprarenal gland  
194.5 Carotid body

Note: Laterality may be submitted for sites other than those required above.

-----  
A blank should be submitted in this field.



-----

The histologic type is a six-digit code. It consists of three parts:

- CP 46-49 The 4-digit histologic type of ICD-O--Morphology Section
- CP 50 The Behavior code for Neoplasms of ICD-O (See p. 20 of ICD-O.)
- CP 51 The Grading or Differentiation code of ICD-O. (See p. 20 of ICD-O.)

The Morphology Section of the International Classification of Diseases for Oncology (ICD-O) published by the World Health Organization is to be used for coding all histologic types of tumors reported to SEER. The first four digits before a slash (/) are Histologic Type followed by the Behavior code in the fifth digit and the Grading or Differentiation code in the sixth digit.

#### Histologic Type

In coding histology, all pathology reports for the case for a particular site should be used. Although the material from the most representative tissue is usually the best, sometimes all of the positive material may be removed at biopsy. For example:

Skin biopsy: Superficial malignant melanoma  
Wide excision: No residual tumor

This should be coded Superficial malignant melanoma (872039).

Sometimes more detail is found in the microscopic description than in the final pathologic diagnosis; for example, the microscopic description may say the tumor is "mucin-producing," "papillary," or "keratinizing," but the final pathologic diagnosis may read only "carcinoma" or "adenocarcinoma." Do not modify the final pathologic diagnosis to pick up specific terms such as "mucin-producing." Code only the final pathologic diagnosis.

Do not use the ICD-O histology code M-9990, "no microscopic confirmation, clinically malignant tumor." Use code 8000 for terms such as "malignant tumor," "malignant neoplasm," or "cancer." If the physician is more specific, use the more specific histology code. Field 19, Diagnostic Confirmation, will indicate whether or not the diagnosis was microscopically confirmed.

-----  
Behavior Code

Only tumors ending in the Behavior code /2 (in situ) or /3 (malignant) are to be reported to SEER. All neoplasms are listed in both the numeric and alphabetic indices of ICD-O with their usual behavior code. However, as explained on pages xiv and xv of the ICD-O Introduction, if a pathologist calls a tumor in situ (/2) or malignant (/3) which is not listed as such in ICD-O, the appropriate behavior code is to be coded and reported to SEER. For example, see Table 1 in ICD-O. An edit review of all such cases will take place unless a "1" is coded in CP 95. SEER does not accept tumors with behavior codes /0, /1, /6, or /9. If the only specimen on which the histologic diagnosis is made was from a metastatic site, code the histologic type of the metastatic site with a /3 for the behavior code. Assume the primary site had the same histology as the metastatic site.

For the purposes of this program, the meaning of "different histologies" refers to a difference in the first three digits of the histology code. However, the Behavior code (fifth digit) should always be taken into consideration. In the event there are two histologies in the same lesion, and the behavior code is the SAME, select the higher histology code, if no combined histology exists.

- A. Biopsy: Squamous cell carcinoma of cervix (8070/39)  
Surgery: Squamous cell carcinoma, keratinizing type,  
of cervix (8071/39)

This should be coded to the higher morphology (8071/39).

- B. Path report: Transitional cell epidermoid carcinoma

"Transitional cell carcinoma, NOS" has a code of M-8120/39 in ICD-O and "Epidermoid carcinoma, NOS" has a code of M-8070/39. Code this case to the higher code (8120/39). (See further discussions in ICD-O, p. xviii.)

If a combined histology code exists, select the combination code.

Path report: Mixed adenocarcinoma and squamous cell carcinoma of cervix

Code this to the combination code for adenosquamous carcinoma (8560/39).

If the Behavior code is NOT THE SAME, select the morphology code of the higher Behavior code (the invasive tumor).

- Report 1: Invasive carcinoma of cervix (8010/39)  
Report 2: Squamous cell carcinoma-in situ of cervix (8070/29)

This should be coded to the report of the invasive tumor (8010/39).

-----

Note that "in situ" is a concept based upon histologic evidence. Therefore, clinical evidence alone cannot justify the usage of this term. In addition, any pathological diagnosis qualified as "micro-invasive" is not acceptable as "carcinoma-in situ"; such a diagnosis must be coded to one of the "localized" categories.

#### Grading or Differentiation Code

The grading or differentiation code is to be placed in CP 51 of Field 18 and can be found on page 20 of ICD-O.

If a diagnosis indicates two different degrees of grade or differentiation (e.g., "well and poorly differentiated" or "grade II-III"), code to the higher grade code (Rule 10, p. xxiii in ICD-O).

If the final pathologic diagnosis indicates a degree of differentiation or grade different from the microscopic diagnosis, code the final pathologic diagnosis since this is the most representative diagnosis. For example:

Micro: Moderately differentiated squamous cell carcinoma with poorly differentiated areas

Final: Moderately differentiated squamous cell carcinoma

Code to the final diagnosis: Moderately differentiated (807032).

Usually there will be no statement as to grade for in situ lesions. However, if a grade is stated, it should be coded.

When there is variation in the usual terms for degree of differentiation, code to the higher grade as specified below:

Term	Grade	Code
Low grade	I-II	2
Medium grade	II-III	3
High grade	III-IV	4
Partially well differentiated; intermediate differentiation	I-II	2
Moderately undifferentiated	III	3
Relatively undifferentiated	III	3

-----

In ICD-O synonymous terms for in situ (behavior code 2) are (adeno)carcinomas described as:

noninvasive  
intraepithelial, NOS  
intraepidermal, NOS  
intraductal, NOS or noninfiltrating  
intracystic, noninfiltrating  
papillary, noninfiltrating  
papillary, noninfiltrating intraductal  
lobular, noninfiltrating (T-174.\_)  
comedocarcinoma, noninfiltrating (T-174.\_)  
Hutchinson's melanotic freckle, NOS (T-173.\_)  
lentigo maligna (T-173.\_)  
precancerous melanosis (T-173.\_)  
Queyrat's erythroplasia (T-187.\_)  
Bowen's disease

In addition to these terms in ICD-O, there are:

lobular neoplasia (T-174.\_) See Cancer, Vol. 42, No. 2, August 1978 (pp. 737-769).

(adeno)carcinoma in an adenomatous polyp with NO invasion of stalk.

CIN Grade III (T-180.\_)  
Stage 0 (T-180.\_).

-----

Field 19 indicates whether AT ANY TIME during the patient's medical history there was microscopic confirmation of the malignancy of this cancer. Field 19 indicates not only the fact of microscopic confirmation, but the nature of the best evidence available. Thus, this is a priority series with code 1 taking precedence. Each number takes priority over all higher numbers.

Code:

Microscopic Proof

- 1 Positive histology
- 2 Positive exfoliative cytology, no positive histology
- 4 Positive microscopic confirmation, method not specified

Not Microscopically Confirmed

- 6 Direct visualization without microscopic confirmation
- 7 Radiography without microscopic confirmation
- 8 Clinical diagnosis only
- 9 Unknown whether or not microscopically confirmed

Specific:

Code 1: Microscopic diagnoses based upon specimens from biopsy, frozen section, surgery, autopsy, or D and C. Positive hematologic findings relative to leukemia are also included. Bone marrow specimens (including aspiration biopsies) are coded as "1."

Code 2: Cytologic diagnoses based on microscopic examination of cells as contrasted with tissues. Included are smears from sputum, bronchial brushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, and urinary sediment. Cervical and vaginal smears are common examples. Also included in code 2 are diagnoses based upon paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.

Code 4: Cases which are stated to be microscopically confirmed but with no detailed information on method.

Code 6: Visualization includes diagnosis made at surgical exploration or by use of the various endoscopes (including colposcope, mediastino-peritoneoscope). However, use code 6 only if such visualization is not supplemented by positive histology or positive cytology reports. Code 6 is also used when gross autopsy findings were the only positive information.

-----  
Code 7: Cases with diagnostic radiology for which there is not also a positive histology or a positive cytology report. This will include all "scans" not also microscopically confirmed.

Code 8: Cases diagnosed by clinical methods not mentioned above and for which there were no positive microscopic findings.

Code 9: Cases for which the method of confirmation is unknown. "Death Certificate Only" cases are coded "9."

General:

Note that, since Field 19 covers the patient's ENTIRE medical history, follow-up information may change the coding in this field for any case not coded "1."

-----

There are four extent of disease schemes:

- A Non-specific
- B Two-digit site-specific
- C Expanded (13-digit) site-specific
- D Four-digit site-specific (all sites).

USE SCHEME D for CASES DIAGNOSED AS OF JANUARY 1, 1983 AND LATER. This code replaces the other three extent of disease schemes (A, B, and C). However, continue to use schemes A, B, and C for cases diagnosed prior to January 1, 1983.

TABLE: Appropriate EOD Code for Schemes A, B, and C

This table, given in primary site code order, specifies which EOD scheme is required and where the EOD codes are located for a particular site for cases diagnosed before January 1, 1983.

Exception for schemes A, B, and C: If a case is reported via "Death Certificate Only," use the Non-specific scheme and code "--" (unstaged) in CP 67-68.

Primary Site Code	EOD Scheme Required	Page(s) in EOD Manual*
140.0	B	Buff pages
140.1	B	Buff pages
140.3	B	Buff pages
140.4	B	Buff pages
140.5	A	ii
140.6	B	Buff pages
140.8	A	ii
140.9	A	ii
141.0	B	Buff pages
141.1-141.4	B	Buff pages
141.5	A	ii
141.6 (hist 959-969, 975)	C	74-77
141.6 (excl. hist 959-969, 975)	B	Buff pages
141.8	A	ii
141.9	A	ii
142.0	B	Buff pages
142.1	B	Buff pages
142.2	A	ii
142.8	A	ii
142.9	A	ii
143.0	B	Buff pages

\*This column refers to pages or sections of the SEER Program manual Extent of Disease--Codes and Coding Instructions, April 1977.

TABLE: Appropriate EOD Code (continued)

Primary Site Code	EOD Scheme Required	Page(s) in EOD Manual*
143.1	B	Buff pages
143.8	A	ii
143.9	A	ii
144.0-144.9	B	Buff pages
145.0-145.1	B	Buff pages
145.2	B	Buff pages
145.3, 145.4	B	Buff pages
145.5	A	ii
145.6	B	Buff pages
145.8	A	ii
145.9	A	ii
146.0 (hist 959-969, 975)	C	74-77
146.0 (excl hist 959-969, 975)	B	Buff pages
146.1-146.9	B	Buff pages
147.0	B	Buff pages
147.1 (hist 959-969, 975)	C	74-77
147.1 (excl hist 959-969, 975)	B	Buff pages
147.2-147.9	B	Buff pages
148.0-148.9	B	Buff pages
149.0	A	ii
149.1 (hist 959-969, 975)	C	74-77
149.1 (excl hist 959-969, 975)	A	ii
149.8	A	ii
149.9	A	ii
150.0-150.5	B	Buff pages
150.8	A	ii
150.9	A	ii
151.0 (cardia only)	C	8-11
151.0 (excluding cardia)	A	ii
151.1-151.9	C	8-11
152.0	B	Buff pages
152.1	B	Buff pages
152.2	B	Buff pages
152.3	A	ii
152.8	A	ii
152.9	A	ii
153.0-153.1	C	20-23
153.2	C	24-27
153.3	C	28-31
153.4	C	12-15
153.5	A	ii

\*This column refers to pages or sections of the SEER Program manual Extent of Disease--Codes and Coding Instructions, April 1977.



TABLE: Appropriate EOD Code (continued)

Primary Site Code	EOD Scheme Required	Page(s) in EOD Manual*
153.6	C	16-19
153.7	C	20-23
153.8	A	ii
153.9	A	ii
154.0	C	32-35
154.1	C	36-39
154.2-154.3	B	Buff pages
154.8	A	ii
155.0-155.1	B	Buff pages
156.0	B	Buff pages
156.1-156.2	B	Buff pages
156.8	A	ii
156.9	A	ii
157.0	B	Buff pages
157.1-157.2	B	Buff pages
157.3	A	ii
157.4	A	ii
157.8	A	ii
157.9	A	ii
158.0	A	ii
158.8	A	ii
158.9	A	ii
159.0	A	ii
159.8	A	ii
159.9	A	ii
160.0-160.5, 160.8-160.9	A	ii
161.0	B	Buff pages
161.1	B	Buff pages
161.2	B	Buff pages
161.3	A	ii
161.8	A	ii
161.9	A	ii
162.0	A	ii
162.2 (carina only)	A	ii
162.2-162.5, 162.8-162.9 (excluding carina)	C	40-45
163.0	A	ii
163.1	A	ii
163.8	A	ii
163.9	A	ii
164.0 (hist 959-969, 975)	C	74-77
164.0 (excl hist 959-969, 975)	A	ii
164.1-164.3, 164.8-164.9	A	ii

\*This column refers to pages or sections of the SEER Program manual Extent of Disease--Codes and Coding Instructions, April 1977.

TABLE: Appropriate EOD Code (continued)

Primary Site Code	EOD Scheme Required	Page(s) in EOD Manual*
165.0, 165.8, 165.9	A	ii
169.0-169.1	A	ii
169.2 (hist 959-969, 975)	C	74-77
169.2 (excl hist 959-969, 975)	A	ii
169.3	A	ii
169.9	A	ii
170.0-170.9	B	Buff pages
171.0, 171.2-171.9	A	ii
173.0-173.7 (hist 872-879)	C	46-49
173.0-173.7 (excl hist 872-879)	B	Buff pages
173.8	A	ii
173.9	A	ii
174.0-174.9, 175.9	C	50-54
179.9	A	ii
180.0-180.9	C	55-59
181.9	A	ii
182.0-182.1, 182.8	C	60-64
183.0	B	Buff pages
183.2	B	Buff pages
183.3	A	ii
183.4	A	ii
183.5	A	ii
183.8	A	ii
183.9	A	ii
184.0	B	Buff pages
184.1-184.4 (hist 872-879)	C	46-49
184.1-184.4 (excl hist 872-879)	B	Buff pages
184.8	A	ii
184.9	A	ii
185.9	C	65-69
186.0, 186.9	B	Buff pages
187.1-187.2, 187.4 (hist 872-879)	C	46-49
187.1-187.2, 187.4 (excl hist 872-879)	B	Buff pages
187.3	A	ii
187.5	A	ii
187.6	A	ii

\*This column refers to pages or sections of the SEER Program manual Extent of Disease--Codes and Coding Instructions, April 1977.

TABLE: Appropriate EOD Code (continued)

Primary Site Code	EOD Scheme Required	Page(s) in EOD Manual*
187.7 (hist 872-879)	C	46-49
187.7 (excl hist 872-879)	A	ii
187.8	A	ii
187.9	A	ii
188.0-188.6	C	70-73
188.7	A	ii
188.8-188.9	C	70-73
189.0	B	Buff pages
189.1-189.2	B	Buff pages
189.3	A	ii
189.4	A	ii
189.8	A	ii
189.9	A	ii
190.0-190.9	A	ii
191.0-191.9	A	ii
192.0-192.3, 192.8-192.9	A	ii
193.9	B	Buff pages
194.0-194.1, 194.3-194.6, 194.8-194.9	A	ii
195.0-195.5, 195.8	A	ii
196.0-196.9 (hist 959-969, 975)	C	74-77
196.0-196.9 (excl hist 959-969, 975)	A	ii
199.9	A	ii

\*This column refers to pages or sections of the SEER Program manual Extent of Disease--Codes and Coding Instructions, April 1977.

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The three Extent of Disease schemes are coded according to the following general format:

		CP	Description
A	Non-Specific EOD scheme:	53-66	Blank
		67-68	Non-specific code
B	Two-digit Site-Specific EOD scheme:	53-66	Blank
		67-68	Two-digit code
C	Expanded Site-Specific EOD scheme:	53-54	Tumor size
		55	- except for lymphomas
		56-59	Direct extension of primary tumor
		60	Site-specific information
		61-62	Regional lymph node involvement
		63-64	Distant lymph node involvement
		65	Distant site involvement
D	Four-digit EOD scheme:	53-54	Tumor Size
		55	Extension
		56	Lymph Nodes

Discussion:

Extent of Disease should be limited to all information available by the end of the first hospitalization for surgical resection if done within two months of diagnosis or two months after diagnosis for all other cases, both treated and untreated. However, metastasis known to have developed after the original diagnosis was made should be excluded.

If a patient has radiation therapy followed by definitive surgery within two months of diagnosis, include all information available through definitive surgery in determining the Oper/Path assessment of extent of disease. The separate clinical evaluation will be limited to procedures up to the initiation of definitive therapy.

If an excisional biopsy, D and C, cone biopsy, lymphadenectomy, TUR (prostate or bladder), or a polypectomy is followed by further definitive therapy within two months of diagnosis, include all information available through the definitive surgery in determining extent of disease.

For "Death Certificate Only" cases, after January 1, 1983, code "9999."

For non-specific codes only, use page 1 of the SEER Summary Staging Guide, April 1977, for a description of summary definitions.

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This is a four-digit field representing the date of initiation of the patient's first cancer-directed treatment for this cancer. The first two digits indicate the month; the last two digits identify the year.

Code:

Code 0000 if there was no cancer-directed therapy. Otherwise:

CP 69-70	Month
01	January
02	February
03	March
04	April
05	May
06	June
07	July
08	August
09	September
10	October
11	November
12	December
99	Unknown

CP 71-72	Year
	Last two digits of year
99	Unknown

Code 0000 for "Autopsy Only" cases. |

Code 9999 for "Death Certificate Only" cases. |

General:

In the ABSENCE OF AN EXACT DATE OF TREATMENT, the date of admission for that hospitalization during which the first cancer-directed therapy was begun is an acceptable entry in Field 21. If cancer-directed treatment was first received on an outpatient basis, code the date (month/year) that cancer directed-therapy was started. Should there be a case with unknown year of cancer-directed therapy, the entire field should be coded 9999. |

When an unproven therapy (e.g., laetrile) is the first course of therapy, the date the patient started taking that therapy is the date therapy was initiated.

-----  
CP Code

## 73 Surgery

- 0 None
- 1 Surgical Resection
- 8 Surgery recommended, unknown if performed
- 9 Unknown

## 74 Radiation

- 0 None
- 1 Beam Radiation
- 2 Other Radiation
- 3 Combination of 1 and 2
- 7 Radiation, NOS--method or source not specified
- 8 Radiation recommended, unknown if administered
- 9 Unknown

## 75 Radiation Sequence with Surgery

If treatment consisted of both surgery and radiation,  
i.e., CP 73 = 1 AND CP 74 = 1,2,3 or 7, code:

- 2 Radiation before surgery
- 3 Radiation after surgery
- 4 Radiation both before and after surgery
- 9 Sequence unknown, but both surgery and radiation were given |

All other cases, code:

- 0 Not applicable--This includes the following combinations of CP 73 and CP 74:

CP 73	CP 74
0,8,9	0-9
1	0,8,9

## 76 Chemotherapy

- 0 None
- 1 Chemotherapy
- 8 Chemotherapy recommended, unknown if administered
- 9 Unknown

## 77 Hormonal Therapy

- 0 None
- 1 Hormones (including NOS and antihormones) |
- 2 Endocrine Surgery (if cancer is of another site)
- 3 Combination of 1 and 2
- 4 Endocrine Radiation (if cancer is of another site)
- 5 Combination of 1 and 4
- 6 Combination of 2 and 4
- 7 Combination of 1 and 2 and 4
- 8 Hormonal therapy recommended, unknown if administered
- 9 Unknown

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CP	Code		
78		Biological response modifier	
	0	None	
	1	Biological response modifier	
	8	Biological response modifier recommended, unknown if administered	
	9	Unknown	
79		Other Cancer-Directed Therapy	
	0	None (No cancer-directed therapy except as coded in CP 73-78)	
	1	Other cancer-directed therapy (including dermoplaning, hyperbaric oxygen as adjunct, etc.)	
	2	Experimental cancer-directed therapy (not included in CP 73-78)	
	3	Double-blind study, code not yet broken	
	7	Unproven therapy (including laetrile, krebiozen, etc.)	
	8	Other cancer-directed therapy recommended, unknown if administered	
	9	Unknown	

For the SEER Program the concept of definitive treatment is limited to procedures directed toward cancer tissues whether of the primary site or metastases. If a specific therapy normally affects, controls, definitive treatment even if it cannot be considered curative for a particular patient in view of the extent of disease, incompleteness of treatment, lack of apparent response, size of dose, operative mortality, or other criteria.

DEFINITION OF "FIRST COURSE" FOR ALL MALIGNANCIES EXCEPT LEUKEMIAS

1. For all cases, the first course of therapy includes cancer-directed treatment received by the patient within the first four months of initiation of therapy. All modalities of treatment are included regardless of sequence or the degree of completion of any component method.
2. EXCEPTION: Should there be a change in therapy due to apparent failure of the original planned and administered treatment or because of progression of the disease, the new therapy should be EXCLUDED from the first course and considered part of a second course of therapy.

-----  
DEFINITIONS OF "FIRST COURSE" FOR LEUKEMIAS

The basic time period is two months after the date of initiation of therapy. When precise information permits, the first course of definitive treatment is to be related to the first "remission" as follows--even in violation of the two-month rule:

- A. If a remission complete or partial is achieved during the first chemotherapeutic attack upon the leukemic process, include:
  - 1. All definitive therapy considered as "remission-inducing" for the first remission, and
  - 2. All definitive therapy considered as "remission-maintaining" for the first remission, i.e., irradiation to the central nervous system.
- B. Disregard all treatment received by the patient after the lapse of the first remission.
- C. If no remission is attained during the first course of chemotherapy, use the two-month rule.

## DEFINITIONS OF CANCER-DIRECTED THERAPY

"Cancer tissue" means proliferating malignant cells or an area of active production of malignant cells. In some instances, malignant cells are found in tissues in which they did not originate and in which they do not reproduce. A procedure removing malignant cells but not attacking a site of proliferation of such cells is NOT to be considered cancer treatment for the purpose of this program.

The definition includes only cancer-directed definitive therapy and excludes therapy which treats the patient but has no effect on malignant tissue. Treatment solely for the relief of symptoms is therefore excluded.

The term "palliative" is normally used in two senses: (a) as meaning non-curative and (b) as meaning the alleviation of symptoms. Thus, some of the treatments termed palliative fall within the definition of cancer-directed treatment and some are excluded as treating the patient but not the cancer.



-----  
SURGERY (CP 73):

The removal of cancer tissue by operative procedures. Included are:

- Local Excision with removal of cancer tissue (including excisional biopsy and excluding incisional biopsy)
- Hysterectomy for uterine cancer
- Mastectomy for breast cancer
- Gastrectomy for stomach cancer
- TUR (transurethral resection) with removal of cancer tissue for bladder and prostate neoplasms
- Dessication and Curettage for bladder and skin neoplasms
- Fulguration for bladder, skin and rectum neoplasms
- Electrocautery
- Photocoagulation
- Cryosurgery
- Chemosurgery (Moh's technique)
- Conization for carcinoma-in situ of the cervix uteri
- Dilatation and Curettage for carcinoma-in situ of the endocervix or carcinoma-in situ of the corpus uteri
- Surgery removing metastatic malignant tissue
- Laser therapy

RADIATION (CP 74):

Beam Radiation (code "1") directed to cancer tissue regardless of source of radiation. Included is treatment via:

- X-ray
- Cobalt
- Linear accelerator
- Neutron beam
- Betatron
- Spray radiation.

Radiation other than Beam Radiation directed to cancer tissue. Included is treatment via:

- Internal use of radioactive isotopes whether given orally, intracavitarily, interstitially, or by intravenous injection.

- All implants, molds, seeds, needles, applicators of radioactive material such as radium, radon, radioactive gold, etc.

RADIATION SEQUENCE WITH SURGERY (CP 75):

See page 22.1 of this manual.

-----  
CHEMOTHERAPY (CP 76):

Any chemical which is administered to attack or treat cancer tissue and which is not considered to achieve its effect through change of the hormone balance. Only the agent, not the method of administration of the drug, is to be considered in coding.

## ENDOCRINE (HORMONE/STEROID) THERAPY (CP 77):

The use (primary or secondary) of any type of therapy which exercises its effect on cancer tissue via change of the hormone balance of the patient. Included are the administration of hormones, antihormones, or steroids, surgery for hormonal effect on cancer tissue, and radiation for hormonal effect on cancer tissue.

## Specifically:

Hormones and antihormones (cancer-directed only) are to be coded for all sites (primary and metastatic).

Adrenocorticotrophic hormones (cancer-directed only) are coded for leukemias, lymphomas, multiple myelomas, breast, prostate. Exception: Prednisone given in combination with chemotherapy, e.g., MOPP or COPP, is coded as hormone therapy for any site.

Endocrine surgery is to be coded for breast and prostate only:

Oophorectomy (breast)	Adrenalectomy
Orchiectomy (prostate)	Hypophysectomy

Both glands or the remaining gland of paired glands must be removed for the procedure to be considered endocrine surgery.

Endocrine radiation is to be coded for breast and prostate only. The same rules apply as for endocrine surgery.

## BIOLOGICAL RESPONSE MODIFIERS (CP 78):

Biological response modifier (BRM) is a generic term which covers everything that is done to the immune system to alter it or change the host response (defense mechanism) to the cancer. BRM includes:

## Specifically:

## Biological response modifier

Allogeneic cells	Levamisole	Vaccine therapy
BCG	MVE2	Virus therapy
C-Parvum	Thymosin	Bone marrow transplant
Interferon	Pyran copolymer	
Vitamin A	13-cis Vitamin A acid	

-----  
OTHER CANCER-DIRECTED THERAPY (CP 79):

Any and all cancer-directed therapy that is not appropriately assigned to the other specific treatment codes, including an experimental or newly developed method of treatment differing greatly from proven types of cancer therapy. Examples are:

Dermoplaning or wire brush surgery (multiple skin cancer)  
Hyperbaric oxygen (as adjunct to definitive treatment)  
Hyperthermia.

Double-Blind Clinical Trial information: After the code is broken, code Field 22 according to the treatment actually administered.

NO CANCER-DIRECTED THERAPY (CP 73-79):

If patient receives only symptomatic or supportive therapy, this is classified as "no cancer-directed therapy." Field 22 would be coded as 000000 for such a case.

AUTOPSY ONLY AND DEATH CERTIFICATE ONLY CASES (CP 73-79):

Code 000000 for "Autopsy Only" cases.

Code 9909999 for "Death Certificate Only" cases.

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A blank should be submitted in this field.

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Field 24 indicates the date of last follow-up or the date of death. The first two digits indicate the appropriate month and the last two digits identify the year. This field pertains to the date of the actual information and not the date the follow-up inquiry was forwarded or the date the follow-up report was received.

## Code:

CP 81-82

Month

01	January
02	February
03	March
04	April
05	May
06	June
07	July
08	August
09	September
10	October
11	November
12	December
99	Unknown

CP 83-84

Year

Last two digits of the year of last follow-up or death

Note: There should be NO use of code for unknown year, "99," in this field.

## General:

If there is no new follow-up information, the entry in Field 24 is the same as that of the previous follow-up for this patient. If no follow-up information is ever received, code the date of first hospital discharge.

Remember, this field pertains to the patient and not to the cancer. Thus, for a patient with more than one malignancy, all records for that patient should have the same code in Field 24.

-----

Field 25 summarizes the best available information concerning the vital and cancer status of the patient as of the date of last follow-up or death. Detailed information from autopsies, when available, should be used in coding this field.

Code:

1    Alive

4    Dead

General:

If there is no new follow-up information, the code in Field 25 is the same as on the previous follow-up for this patient. If no follow-up information is ever received, the patient's status at first discharge from the hospital should be coded in Field 25.

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Field 26 indicates the primary or underlying cause of death as found on the death certificate or on a listing giving the code number of the underlying cause of death. Even when the death certificate is believed to be in error, the entry as coded by a State Health Department on the death certificate is to be used. The Eighth ICDA, International Classification of Diseases, Adapted for use in the United States, which was published by the U.S. Government Printing Office as Public Health Service Publication No. 1693 was used through December 31, 1978. Beginning with deaths occurring on January 1, 1979, and thereafter, the Ninth Revision, International Classification of Diseases, published by the World Health Organization in 1977, is to be used for all deaths.

## CP 86-89

Cause of Death Codes as coded on the Death Certificate by the State Health Departments are usually four digits. There are some ICD-9 code numbers that have an optional fifth digit. Ignore the fifth digit.

Through December 31, 1978 the death certificates were coded according to the 8th Revision of the International Classification of Diseases, Adapted. Use E series for violent or accidental deaths. If there is not a fourth digit for the underlying cause of death, use "9" in the fourth digit in CP 89, regardless of whether "x," "blank," or "-" was used.

In some cases a computer listing with causes of death may be supplied by the health departments. Be sure to enter the selected underlying cause of death. States using the ACME (Automated Classification of Medical Entities) program usually have several codes on the printouts and then one at the end of the line which the computer has selected as the underlying cause.

As stated above, beginning January 1, 1979, all deaths will be coded by the 9th Revision of ICD. In this volume, "the E code is a supplemental code but will be used as the primary code if, and only if, the morbid condition is classifiable to Chapter XVII (Injury and Poisoning)." Do not include the "E" in the code submitted to SEER.

It is not necessary to have possession of a copy of the death certificate as long as the official code for the underlying cause of death is available. For example, a computer listing may give the underlying cause of death. If the underlying cause is not available, do not attempt to code it; use code 7969. The following SEER codes are considered part of the 7th, 8th, and 9th Revisions for coding Field 26:

	CP 86-89
Patient alive at last contact	0000
Death certificate or listing not available	7777
Death certificate or listing available, but underlying cause of death not coded.	7969

Field 26  
CP 86-90

CAUSE OF DEATH

SEER Program

-----  
Examples:

Underlying Cause of Death	ICDA-8 or ICD-9	CP 86-89
Cancer of the thyroid	193	1939
Acute appendicitis with peritonitis	540.0	5400
Adenocarcinoma of stomach	151.9	1519
Fall on ice	E885	8859

CP 90 Blank



-----  
Field 27 indicates which revision of the ICD has been used in coding Field 26.

## Code:

- 0 Patient Alive at Last Follow-Up
- 7 Seventh Revision of ICD
- 8 Eighth Revision of ICDA
- 9 Ninth Revision of ICD

-----  
Code:

- 1 Case is not in active follow-up
- 2 Case is (or was) in active follow-up
- 3 "In situ" cases of the cervix uteri only |
- 4 Cases which were not originally in active follow-up, but are in |  
active follow-up now. (San Francisco-Oakland only) |

## Specific:

Code 1: "Autopsy Only" or "Death Certificate Only" cases

Code 2: Even if the information is incomplete at the time of coding, if the case is being actively followed so that more data will probably become known to the registry, use code "2." Cases coded "2" will be the source data for survival evaluation studies.

Note: All alive cases must be actively followed at least annually except for carcinoma-in situ cases of the cervix uteri which are NOT followed. |

-----  
Code:

USE CODES 0, 1, and 2 for CASES DIAGNOSED PRIOR TO JANUARY 1, 1983. |

0 Non-Specific EOD Code in CP 67-68; blanks in CP 53-66. Scheme A  
in Field 20 was used to code EOD information.

Note: Code "0" is obligatory for all "Death Certificate  
Only" cases.

1 Site-Specific Two-Digit Code in CP 67-68; blanks in CP 53-66.  
Scheme B in Field 20 was used to code EOD information.

2 SEER Expanded Site-Specific EOD Code for a specific primary site  
in CP 53-65; blanks in CP 66-68. Scheme C in Field 20 was used  
to code EOD information.

3 SEER Four-Digit Site-Specific EOD Code for all sites in CP 53-56;  
blanks in CP 57-68. Scheme D in Field 20 was used to code  
EOD information. |

USE CODE 3 for CASES DIAGNOSED AS OF JANUARY 1, 1983 AND LATER. |

-----

The purpose of this field is to indicate those combinations of codes in different fields of this record which have already been reviewed for possible error. In effect, coding in this field identifies the improbable combinations which have been found possible. The major utility of Field 30 is to prevent the continuing selection of the case for review after it has already been checked at least once.

The Field is designated as a five-digit field, but at present only CP 94 and 95 are in use. Blanks are to be used in CP 94-96 unless a specific "flag" is warranted.

CP Code

94 Site-Type Edit

- 1 Reviewed: there is an apparent anomaly between the coding primary site and histologic type; no need to review again.

95 Histology

- 1 Reviewed: the behavior code of the histology is designated as benign or uncertain in ICD-O, but upon review the behavior code remains as in situ or malignant.

-----  
GENERAL INSTRUCTIONS FOR CODING SITE-SPECIFIC SURGERY

The site-specific surgery schemes are composed of a one-digit code (0-9 in CP 97) for each of these major sites:

<u>ICD-0</u>	<u>Site</u>
151.0-151.6, 151.8-151.9	Stomach
153.0-153.9	Colon
154.0-154.1	Rectosigmoid, Rectum
162.2-162.5, 162.8-162.9	Bronchus and Lung
173.0-173.9	Malignant Melanoma of Skin
(Histology: 8720-8790)	
174.0-174.6, 174.8-174.9, 175.9	Breast
180.0-180.1, 180.8-180.9	Cervix Uteri
182.0-182.8	Corpus Uteri
183.0	Ovary
185.9	Prostate
188.0-188.9	Bladder
189.0-189.2	Kidney, Renal Pelvis, and Ureter

This code will apply to all cases diagnosed January 1, 1983 and later.

If surgery was not performed, or if it is unknown that surgery was done, code 0 in CP 97 for above sites.

Once it is determined that cancer-directed surgery was performed (code 1 in CP 73), use the best information in the operative/path reports to determine the operative procedure. Do NOT depend on the title of the operative report since it may be incomplete.

If the operative procedure is unclear as to what was excised, or if there is a discrepancy between the operative and the path reports, use the path report unless there is reason to doubt its accuracy.

If a surgical procedure removes the remaining portion of an organ which had been partially resected previously for any condition, code as total removal of the organ. For example, 1) resection of a stomach which had been partially excised previously, 2) removal of a cervical stump, or 3) lobectomy of a lung with a previous wedge resection would be coded as total removal of the stomach, uterus, and lobe, respectively. If none of the primary organ remains, the code should indicate that this is the case.

Ignore diagnostic biopsies; ignore diagnostic lymph node dissection if that was the only surgery done unless the nodes were positive. Code "with dissection of lymph nodes" if nodes were removed at the time of the surgery to the primary site, or within four months of the date treatment began.

-----

If an excisional biopsy is followed by "re-excision" or "wide excision" within the four-month time period, include that later information in coding site-specific surgery.

If multiple primaries are excised at the same time, code the appropriate surgery for each site. For example, 1) if a total abdominal hysterectomy was done for a patient with two primaries, one of the cervix and one of the endometrium, code each as having had a total abdominal hysterectomy. 2) If a total colectomy was done for a patient with multiple primaries in several segments of the colon, code total colectomy for each of the primary segments.

#### Definition of "First Course for All Malignancies" Except Leukemias

1. For all cases, the first course of therapy includes cancer-directed treatment received by the patient within the first four months of initiation of therapy. All modalities of treatment are included regardless of sequence or degree of completion of any component method.
2. EXCEPTION: Should there be a change in therapy due to apparent failure of the original planned and administered treatment, or because of progression of the disease, the new therapy should be EXCLUDED from the first course and considered part of a second

-----

STOMACH  
151.0-151.6, 151.8-151.9

- 0 No surgery; unknown if surgery done
- 1 Local excision (incl. polypectomy, excision of ulcer, other lesions, or stomach tissue with evidence of tumor)
- 2 Partial\*/subtotal/hemi- gastrectomy: Upper (proximal) portion (may include part of esophagus, i.e., esophagogastrectomy)
- 3 Partial\*/subtotal/hemi- gastrectomy: Lower (distal) portion (may include part of duodenum, i.e., gastropylorctomy); Billroth I (indicates anastomosis to duodenum--duodenostomy); Billroth II (indicates anastomosis to jejunum--jejunostomy), antrectomy (resection of pyloric antrum of stomach)
- 4 Partial\*/subtotal/hemi- gastrectomy, NOS or NEC; resection of portion of stomach, NOS
- 5 Total/near\*\* total gastrectomy (incl. resection with pouch left for anastomosis, total gastrectomy following previous partial resection for another cause)
- 6 Gastrectomy, NOS
- 7 Gastrectomy (partial, total, radical) PLUS partial or total removal of other organs
- 8 Surgery of regional and/or distant site(s)/nodes ONLY
- 9 Surgery, NOS

\*Includes sleeve resection of stomach

\*\*Near total gastrectomy means 80 percent or more.

Note: Codes 1-7 take priority over codes 8-9.  
Codes 1-7 may include removal of spleen, nodes and/or omentum, mesentery, or mesocolon.  
Ignore incidental removal of gallbladder and bile ducts, appendix, and/or vagus nerve.

-----

COLON (excludes rectosigmoid, rectum)  
153.0-153.9

- 0 No surgery: unknown if surgery done |
- 1 Local tumor destruction (incl. cryosurgery, electrocautery,  
fulguration, laser surgery (vaporized--no path specimen))
- 2 Local excision (incl. polypectomy, snare, laser surgery  
(with path specimen))
- 3 Partial/subtotal colectomy, but less than hemicolectomy (incl.  
segmental resection, e.g., cecectomy, appendectomy, sigmoidectomy,  
transverse colon and flexures, ileocollectomy, enterocollectomy,  
and partial/subtotal colectomy, NOS)
- 4 Hemicolectomy or greater (but less than total), right/left  
colectomy (all of right or left colon beginning at mid-  
transverse)
- 5 Total colectomy (beginning with cecum and ending with  
sigmoid/rectum or part of rectum)
- 6 Colectomy, NOS
- 7 Colectomy (subtotal, hemicolectomy or total) PLUS partial or total |  
removal of other organs
- 8 Surgery of regional and/or distant site(s)/nodes ONLY |
- 9 Surgery, NOS

Note: Codes 1-7 take priority over codes 8-9.

Codes 3-7 may include removal of lymph nodes, a portion of  
terminal ileum, and/or omentum.

Ignore incidental removal of appendix, gallbladder  
and bile ducts, and/or spleen.

If not clear from either the operative or path report what was  
removed, but the title of the operative report is  
hemicolectomy, code as hemicolectomy.



-----

RECTOSIGMOID, RECTUM  
154.0-154.1

- 0 No surgery; unknown if surgery done
- 1 Local tumor destruction (incl. cryosurgery, electrocautery, fulguration, laser surgery (vaporized--no path specimen))
- 2 Local excision (incl. polypectomy, snare, laser surgery (with path specimen))
- 3 Anterior/posterior resection, wedge or segmental resection, transsacral rectosigmoidectomy, Hartmann resection, partial proctectomy, rectal resection, NOS
- 4 Pull-through resection WITH sphincter preservation (e.g., Turnbull and Swenson's operations, Soave submucosal resection, Altemeier operation, Duhamel resection)
- 5 Abdominal perineal resection (e.g., Miles and Rankin procedures), complete proctectomy.
- 6 Any of codes 3-5 PLUS partial or total removal of other organs
- 7 Pelvic Exenteration (partial or total)
  - Posterior exenteration (incl. rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes)
  - Total exenteration: all pelvic contents and pelvic lymph nodes
  - Extended exenteration: includes pelvic blood vessels or bony pelvis
- 8 Surgery of regional and/or distant site(s)/nodes ONLY
- 9 Surgery, NOS

Note: Codes 1-7 take priority over codes 8-9.  
 Codes 3-7 may include removal of lymph nodes and/or removal of section of colon.  
 Ignore incidental removal of gallbladder and bile ducts and/or appendix.

---

BRONCHUS AND LUNG  
162.2-162.5, 162.8-162.9

- 0 No surgery; unknown if surgery done
- 1 Local excision or destruction of lesion
- 2 Wedge resection(s), segmental resection(s), lingulectomy,  
partial lobectomy, sleeve resection (bronchus only)
- 3 Lobectomy (incl. lobectomy plus segmental/sleeve resection,  
bilobectomy, radical lobectomy, partial pneumonectomy)  
WITHOUT dissection of lymph nodes
- 4 Lobectomy WITH dissection of lymph nodes
- 5 Complete/total/standard pneumonectomy; pneumonectomy, NOS
- 6 Radical pneumonectomy (complete pneumonectomy plus dissection of  
hilar/mediastinal lymph nodes)
- 7 Extended radical pneumonectomy (incl. parietal pleura,  
pericardium and/or chest wall (incl. diaphragm) plus nodes)
- 8 Surgery of regional and/or distant site(s)/nodes ONLY  
(incl. removal of mediastinal mass ONLY)
- 9 Resection of lung, NOS; surgery, NOS

Note: Codes 1-7 apply to unilateral resection of primary tumor  
and take priority over codes 8-9.  
Ignore incidental removal of rib(s) (operative approach).

---

MALIGNANT MELANOMA OF SKIN  
173.0-173.9  
Histology: 8720-8790

- 0 No surgery; unknown if surgery done
- 1 Local tumor destruction (cryosurgery, fulguration, electrocauterization, laser surgery (vaporized--no path specimen))
- 2 Excisional biopsy, local excision, wedge resection, simple excision, laser surgery (with path specimen); excision, NOS
- 3 Shave/punch biopsy followed by excision of lesion (not a wide excision)
- 4 Wide/radical excision/re-excision or minor (local) amputation (incl. digits, ear, eyelid, lip, nose)
- 5 1-4 WITH dissection of lymph nodes
- 6 Amputation (other than in code 4) WITHOUT dissection of lymph nodes, amputation, NOS
- 7 Amputation (other than in code 4) WITH dissection of lymph nodes
- 8 Surgery of regional and/or distant site(s)/nodes ONLY
- 9 Surgery, NOS

Note: Codes 1-7 take priority over codes 8-9.

## BREAST

174.0-174.6, 174.8-174.9 Female; 175.9 Male

- 
- 0 No surgery; unknown if surgery done
  - 1 Partial/less than total mastectomy (incl. segmental mastectomy, lumpectomy, quadrantectomy, tylectomy, wedge resection, nipple resection, excisional biopsy, or partial mastectomy, NOS)  
WITHOUT dissection of axillary lymph nodes
  - 2 Code 1 WITH dissection of axillary lymph nodes
  - 3 Subcutaneous mastectomy WITH/WITHOUT dissection of axillary lymph nodes
  - 4 Total (simple) mastectomy (breast only)  
WITHOUT dissection of axillary lymph nodes
  - 5 Total (simple)/modified radical mastectomy  
(may include portion of pectoralis major)  
WITH dissection of axillary lymph nodes
  - 6 Radical mastectomy  
WITH dissection of all of pectoralis major  
WITH dissection of axillary lymph nodes
  - 7 Extended radical mastectomy (code 6 + internal mammary node dissection; may include chest wall and ribs)
  - 8 Surgery of regional and/or distant site(s)/nodes ONLY
  - 9 Mastectomy, NOS; Surgery, NOS

Note: Codes 1-7 apply to unilateral resection of primary tumor and take priority over codes 8-9.

Ignore removal of fragments or tags of muscle.

Ignore removal of pectoralis minor.

Ignore resection between pectoral muscles.

Ignore resection of fascia with no mention of muscle.

Oophorectomy, adrenalectomy, and hypophysectomy will be coded as hormone therapy in col. 77.

## CERVIX AND CORPUS UTERI

180.0-180.1, 180.8-180.9, 182.0-182.1, 182.8

- 
- 0 No surgery; unknown if surgery done
  - 1 Cryosurgery, laser surgery (vaporized--no path specimen): for cervix D & C (in situ ONLY), polypectomy, myomectomy, simple excision: corpus
  - 2 Local excision and/or conization, excisional biopsy, trachel-ectomy, amputation of cervix, laser (with path specimen), endocervical curettage (in situ only): cervix uteri  
Subtotal hysterectomy, supracervical hysterectomy, fundectomy (cervix left in place with/without removal of tubes and ovaries): corpus uteri
  - 3 Total/simple hysterectomy (incl. both corpus and cervix uteri) WITHOUT removal of tubes and ovaries  
WITHOUT dissection of lymph nodes
  - 4 Total/simple/pan- hysterectomy WITH removal of tube(s) and ovary(s) WITHOUT dissection of lymph nodes
  - 5 Modified radical/extended hysterectomy (incl. uterus, tubes and ovaries, and (upper) vaginal cuff and para-aortic/pelvic nodes)  
Radical hysterectomy (incl. uterus, tubes and ovaries, vagina, and all parametrial and paravaginal tissue and para-aortic and pelvic lymph nodes)  
Wertheim operation
  - 6 Hysterectomy, NOS (abdominal or vaginal)
  - 7 Pelvic Exenteration (partial or total)  
Anterior exenteration (incl. bladder, distal ureters, genital organs with their ligamentous attachments and pelvic lymph nodes)  
Posterior exenteration (incl. rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes)  
Total exenteration: all pelvic contents and pelvic lymph nodes  
Extended exenteration: incl. pelvic bl. vessels/bony pelvis
  - 8 Surgery of regional and/or distant site(s)/nodes ONLY
  - 9 Surgery, NOS

Note: Codes 1-7 take priority over codes 8-9.

Codes 3 and 4 may include a portion of "vaginal cuff."

Ignore incidental removal of appendix.

---

 OVARY  
183.0

- 0 No surgery; unknown if surgery done |
- 1 Subtotal/partial or unilateral (salpingo)-oophorectomy  
WITHOUT hysterectomy
- 2 Subtotal/partial or unilateral (salpingo)-oophorectomy  
WITH hysterectomy
- 3 Bilateral (salpingo)-oophorectomy WITHOUT hysterectomy;  
(Salpingo)-oophorectomy, NOS |
- 4 Bilateral (salpingo)-oophorectomy WITH hysterectomy
- 5 Omentectomy with unilateral/bilateral (salpingo)-oophorectomy  
with or without hysterectomy |
- 6 Debulking of ovarian tumor mass (may include ovarian tissue) |
- 7 Pelvic Exenteration (partial or total)  
Anterior exenteration (incl. bladder, distal ureters,  
genital organs with their ligamentous attachments and  
pelvic lymph nodes)  
Posterior exenteration (incl. rectum and rectosigmoid with  
ligamentous attachments and pelvic lymph nodes)  
Total exenteration: all pelvic contents and pelvic lymph nodes  
Extended exenteration: includes pelvic blood vessels or  
bony pelvis.
- 8 Surgery of regional and/or distant site(s)/nodes ONLY |
- 9 Surgery, NOS

Note: Codes 1-7 take priority over codes 8-9.  
Ignore incidental removal of appendix.

-----  
PROSTATE  
185.9

- 0 No surgery; unknown if surgery done
- 1 Cryoprostectomy  
Transurethral resection, local excision of lesion  
WITHOUT lymph node dissection
- 2 Code 1 WITH dissection of lymph nodes
- 3 Subtotal/simple prostatectomy (segmental resection or  
enucleation leaving capsule intact)  
WITHOUT dissection of lymph nodes
- 4 Subtotal/simple prostatectomy (segmental resection or  
enucleation) WITH dissection of lymph nodes
- 5 Radical/total prostatectomy (excised prostate with capsule,  
ejaculatory ducts (ductus deferens), and seminal vesicles)  
WITHOUT dissection of lymph nodes
- 6 Radical/total prostatectomy (excised prostate, ejaculatory  
ducts (ductus deferens), and seminal vesicles)  
WITH dissection of lymph nodes
- 7 Cystoprostatectomy, radical cystectomy, pelvic exenteration  
WITH or WITHOUT dissection of lymph nodes
- 8 Surgery of regional and/or distant site(s)/nodes ONLY
- 9 Prostatectomy, NOS; Surgery, NOS

Note: Codes 1-7 take priority over codes 8-9.  
Orchiectomy will be coded as hormone therapy in col. 77.  
Ignore surgical approach.

BLADDER  
188.0-188.6, 188.8-188.9

- 0 No surgery; unknown if surgery done
- 1 Local transurethral destruction (electrocoagulation, fulguration, cryosurgery), transurethral resection; excisional biopsy
- 2 Partial/subtotal cystectomy (incl. segmental resection) WITHOUT dissection of pelvic lymph nodes
- 3 Partial/subtotal cystectomy (incl. segmental resection) WITH dissection of pelvic lymph nodes
- 4 Complete/total/simple cystectomy WITHOUT dissection of lymph nodes
- 5 Complete/total/simple cystectomy WITH dissection of lymph nodes
- 6 Cystectomy, NOS
- 7 Radical cystectomy (removal of bladder, prostate, seminal vesicles and surrounding perivesical tissues and distal ureters in men; removal of bladder, uterus, ovaries, fallopian tubes and surrounding peritoneum and sometimes urethra and vaginal wall in women)
- Pelvic Exenteration (partial, total, or extended)  
Anterior exenteration (incl. bladder, distal ureters, genital organs with their ligamentous attachments and pelvic lymph nodes)  
Posterior exenteration (incl. rectum and rectosigmoid with ligamentous attachments and pelvic lymph nodes)  
Total exenteration: all pelvic contents and pelvic lymph nodes  
Extended exenteration: includes pelvic blood vessels or bony pelvis.
- 8 Surgery of regional and/or distant site(s)/nodes ONLY
- 9 Surgery, NOS

Note: Codes 1-7 take priority over codes 8-9.  
Ignore partial removal of ureter in coding cystectomy.  
Ignore surgical approach.



-----  
KIDNEY AND URETER  
189.0-189.2

- 0 No surgery; unknown if surgery done |
- 1 Partial/subtotal nephrectomy (incl. local excision, wedge resection,  
and segmental resection) |  
Partial ureterectomy |
- 2 Complete/total nephrectomy--for kidney parenchyma  
Nephroureterectomy (incl. bladder cuff)--for renal pelvis and ureter  
WITHOUT dissection of lymph nodes
- 3 Complete/total nephrectomy--for kidney parenchyma  
Nephroureterectomy (incl. bladder cuff)--for renal pelvis and ureter  
WITH dissection of lymph nodes
- 4 Radical nephrectomy (incl. removal of vena cava or adrenal  
gland(s), or Gerota's fascia, perinephric fat, partial ureter)  
WITHOUT dissection of lymph nodes
- 5 Radical nephrectomy (incl. removal of vena cava or adrenal  
gland(s) or Gerota's fascia, perinephric fat, partial ureter)  
WITH dissection of lymph nodes
- 6 Nephrectomy, NOS  
Ureterectomy, NOS
- 7 2-6 PLUS other organs (e.g., bladder, colon)
- 8 Surgery of regional and/or distant site(s)/nodes ONLY |
- 9 Surgery, NOS

Note: Codes 1-7 apply to unilateral resection of primary tumor and  
take priority over codes 8-9.  
Ignore incidental removal of rib(s).

## STOMACH

Billroth I: Partial resection of the stomach with anastomosis of the stomach to the duodenum

Billroth II: Partial removal of the stomach with anastomosis of the stomach to the jejunum

Hofmeister-Finsterer Operation: Gastrectomy with pouch left for |  
Anastomosis

## COLON-RECTUM

Bacon: Proctosigmoidectomy by combined method

Duhamel operation: Modification of a pull-through procedure and establishment of a longitudinal anastomosis between the proximal ganglionated segment of the colon and the rectum, leaving the latter in-situ

Hartmann: Resection of primary rectal cancer with permanent colostomy. It is a one-stage procedure in which the lower part of the sigmoid or the upper part of the rectum is resected distal to the neoplasm. The bowel is then divided in the region of the descending colon. After the intervening segment of bowel has been removed, the proximal end of the descending colon is brought to the surface, as in the performance of a single-barreled colostomy. The proximal end of the distal segment is oversewn and left in place leaving a blind rectal pouch.

Miles operation: Abdominoperineal resection for cancer of the lower sigmoid and rectum which includes permanent colostomy, removal of the pelvic colon, mesocolon, and adjacent lymph nodes and wide perineal excision of the rectum and anus

Pull-through operation: Permits removal of desired portion of bowel (may include rectum, sigmoid, and when indicated, descending colon and part of transverse colon) in one-stage with retained sphincters, and end-to-end anastomosis. This operation is performed largely through the abdomen and does not require resection or removal of any part of the bony pelvis.

Rankin: Abdominoperineal resection of rectum

Swenson: Pull-through resection with sphincter preservation

Swenson procedure: Abdomino-anal pull-through with partial internal sphincterectomy

Turnbull: Pull-through resection with sphincter preservation

## CERVIX AND CORPUS UTERI

Wertheim's operation: Radical abdominal hysterectomy, an operation for cancer of the cervix in which there is removed with the uterus as much of the parametrial tissue as possible and a wide margin of the vagina |

## BREAST

Halsted: Developed the radical mastectomy, that is, en bloc dissection of entire breast and skin together with pectoralis major and minor muscles and contents of axilla

Patey and Dyson: Modified radical mastectomy, that is, removal of breast, pectoralis minor and axillary contents, but leaving pectoralis major intact

Urban: Extended radical mastectomy, that is, radical mastectomy plus excision of internal mammary nodes

SEER CODE MANUAL  
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