Oklahoma Central Cancer Registry

OKLAHOMA
State Department
of Health

Rocky Mountain Cancer Data Systems User Manual for Facility Abstractors

(Based on RMCDS Version 22)

Updated June 2022

Table of Contents

Table of Contents

Table of Contents

Table of Contents

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Section I

Core Reporting Instructions for Facility Abstractors

Electronic Coding Manuals/Databases

International Classification of Diseases for Oncology (ICD-O) Manual, Third Edition

Use**:** To determine applicable codes for primary site (topography), and histology (morphology).
The ICD-O-3 book (purple book) has three main sections: topography, morphology and the alphabetic index. There is also a brief listing of behavior codes and grades. The alphabetic index contains both topography and morphology codes which make it an excellent starting point when looking for key words within a diagnosis or primary site. Codes in the alphabetic index can be looked up in the topography and morphology sections for additional terms which qualify for a specific code.

The World Health Organization (WHO) publishes the ICD-O manuals. There is updated content for ICD-O-3.2 with an updated list of histology codes. The completion of a new manual has been delayed due to the COVID-19 pandemic. However, there are instructions and spreadsheets listing the updates. All updates to ICD-O terms and codes are issued through the North American Association of Central Cancer Registries (NAACCR). Abstractors should refer to the following updates to determine ICD-O codes.

ICD-O-3.1
Use for General Instructions and primary site codes only. Do not use this manual for histology codes since it is out-of-date.
https://apps.who.int/iris/handle/10665/96612

ICD-O-3
Effective January 1, 2022
https://www.naaccr.org/icdo3/

2022 ICD-O-3 Update to be used jointly with ICD-O-3.2, Solid Tumor Rules, and Hematopoietic and Lymphoid Neoplasm Database

The 2022 ICO-O-3.2 Update Guidelines includes comprehensive tables listing all changes to ICD-O-3 including new ICD-O codes, terminology and reportability changes effective for cases diagnosed 01/01/2022 and forward. The 2022 update represents changes identified in recently published 5th Ed WHO Classification of Tumors books. Included in these guidelines are instructions for using the tables together with ICD-O-3.2. ***This update includes important information on reportable versus non-reportable high grade dysplasia in gastrointestinal sites.***

Do not use the ICD-O tables to code hematopoietic or lymphoid neoplasms. Refer to the online Hematopoietic Database and Coding Manual for these cases. (Histology codes 9590/3 – 9992/3)

Standards for Oncology Registry Entry (STORE) Manual

https://www.facs.org/media/weqje4pk/store-2022-12102021-final.pdf

Use: To provide current data standards for the collection of cancer registry data. This manual provides instructions and standards for coding all required data items and should be the first manual referenced to determine applicable codes, unless indicated otherwise.

SEER Program Coding & Staging Manual 2022
https://seer.cancer.gov/tools/codingmanuals/index.html

Use: To provide additional data standards for the collection of cancer registry data. This manual provides instructions and standards for coding all required data items and should be used as the secondary manual referenced to determine applicable codes, unless indicated otherwise.

NAACCR Edit Detail Report
https://www.naaccr.org/wp-content/uploads/2022/03/Edit-Detail-Report-v22B.pdf

Use: To help understand and resolve edits. The NAACCR Edit Detail Report is an index of errors abstractors may encounter when running data edits on an abstract. If an error occurs, this file can be helpful in understanding why it occurred and how to resolve it. (See Section 2, page 48 for more details on how to clear errors)

Grade Coding Instructions and Tables Manual
https://www.naaccr.org/wp-content/uploads/2021/08/Grade-Manual_v-2.1-2022.pdf?v=1647360617
Published August 2021, Version 2.01 Effective with cases diagnosed 01/01/2018 and forward

Use: used to code grade clinical, grade pathological, grade post therapy (yc) and grade post therapy (yp).

Site-Specific Data Items (SSDI) Manual
https://www.naaccr.org/wp-content/uploads/2021/09/SSDI-Manual_v-2.1-2022.pdf?v=1647360617
Published September 2021, Version 2.1 Effective with cases diagnosed 01/01/2018 and forward

Use: To determine codes for site-specific data items (SSDIs). SSDIs identify additional information needed to generate stage or provide predictive/prognostic factors that have an effect on stage or survival.

Solid Tumor Rules (STR)
https://seer.cancer.gov/tools/solidtumor/STM.pdf
Updated 09/17/2021 and Effective with cases diagnosed 01/01/2018

Use: To determine if a tumor is considered one or multiple primaries based on its site and histology, and to determine histology codes for solid tumors.

The STR manual provides general instructions and site-specific rules. It is highly recommended that the general instructions be entirely reviewed prior to utilizing the site-specific rules. There are two separate sets of rules. The multiple primary rules are used to determine the number of primaries. The histology coding rules are used to determine histology. The rules are hierarchical and must be followed in order. Use the first rule that applies and then stop, do not go any further. *Note:* The rules do not apply to hematopoietic primaries (lymphoma and leukemia) of any site. Use the Hematopoietic Coding Manual for determining multiple primaries and histology.

Hematopoietic Database and Manual
https://seer.cancer.gov/seertools/hemelymph/

Use: used for coding leukemia, lymphoma and myeloid neoplasm histology

https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

Use: determining multiple primaries and histologies for leukemia, lymphoma and myeloid neoplasm

Steps for Using the Heme DB and Hematopoietic Coding Manual see page 23 in the manual. SEER*Educate provides training on how to use the Heme Manual and DB. Step-by-step instructions are provided for each case scenario to learn how to use the application and manual to arrive at the answer provided.

SEER Rx-Interactive Antineoplastic Drugs Database
https://seer.cancer.gov/seertools/seerrx/

Use**:** database of systemic therapy drugs, i.e., chemotherapy, hormone therapy, immunotherapy and chemotherapy regimens.

Other Resources

SEER Training Modules
http://training.seer.cancer.gov/ and http://seer.cancer.gov/tools/heme/training/

NAACCR Data Dictionary
http://datadictionary.naaccr.org/default.aspx?c=10&Version=22

Use: Provides a general description, specific codes and definitions for cancer registry data items.

Oklahoma Cancer Registrars Association (OCRA) Helpful Links
http://ocra-ok.org/links.asp

SEER Glossary for Registrars
https://seer.cancer.gov/seertools/glossary/

Use: The glossary features definitions for terms used by cancer registrars. Each entry includes information on where the term is used, as well as any applicable alternate names, abstractor notes, histology, and primary sites.

Submission Schedule

Date of 1st contact for Diagnosis, Treatment or Recurrence/Persistence of cancer:	Required to be Submitted to OCCR in:
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

Reportable Conditions List

REPORTABLE CONDITIONS as of 01/01/2021

Malignancies with an ICD-O-3 behavior code of 2 (in-situ) or 3 (malignant) are reportable for all sites with the following **exceptions**:

	Condition	Reportable/Not reportable
Melanoma	Early or evolving melanoma in situ, or any other early or evolving melanoma effective with cases diagnosed 01/01/2021 and forward.	Reportable
Gastrointestinal Stromal Tumor	All GIST tumors are reportable effective with cases diagnosed 01/01/2021 and forward. The behavior code is /3 in ICD-O-3.2.	Reportable
Thymoma	Nearly all thymomas are reportable effective with cases diagnosed 01/01/2021 and forward. The behavior code is /3 in ICD-O-3.2. ***Exceptions:*** microscopic thymoma or thymoma benign (8580/0), micronodular thymoma with lymphoid stroma (8580/1), and ectopic hamartomatous thymoma (8587/0).	Reportable with exceptions
Teratoma	Mature teratoma of the testis in adults is malignant (assign 9080/3) but continues to be non-reportable in prepubescent children (9080/0). Report only if pubescence is explicitly stated in the medical record. ***Do not report if there is no mention of pubescence in the medical record.***	Reportable with exceptions
Astrocytoma	Juvenile astrocytoma, pilocytic astrocytoma, or piloid astrocytoma listed as 9421/1 in ICD-O-3. (Assign code 9421/3).	Reportable
Carcinoid Tumor of Appendix	Code 8240/1 for carcinoid tumor, NOS of appendix is obsolete. Carcinoid tumors of the appendix (C18.1) **must be coded to 8240/3** effective with cases diagnosed 1/1/2015 and forward.	Reportable
Appendiceal Mucinous Neoplasm	Low-grade appendiceal mucinous neoplasm (LAMN) behavior changed to 2 effective 2022. High-grade appendiceal mucinous neoplasm (HAMN) behavior changed to 3 effective 2022 effective with cases diagnosed 1/1/2022 and forward.	Reportable
Intraepithelial Neoplasia	Vulvar intraepithelial neoplasia (VIN III), vaginal intraepithelial neoplasia (VAIN III), anal intraepithelial neoplasia (AIN III) with a behavior code of 2 in ICD-O-3	Reportable
Breast Neoplasia	Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast C500-C509 effective with cases diagnosed 2016+.	
Non-Reportable Skin	Malignant primary skin cancers (C44._) with histology codes 8000-8110. (Examples: squamous cell carcinoma (8070) and basal cell carcinoma (8090) of skin are not reportable).	Not Reportable
Non-Reportable In Situ & Intraepithelial neoplasia	Carcinoma in situ (CIS) of the cervix, squamous intraepithelial neoplasia (SIN III), cervical intraepithelial neoplasia grade III (CIN III), and prostatic intraepithelial neoplasia (PIN III).	Not Reportable
Non-Malignant Primary Intracranial and Central Nervous System Tumors		
diagnosed on or after 1/1/04 with an ICD-O-3 behavior code of 0 or 1 are reportable for the following sites		
Meninges (C70._)		
Brain (C71._)		
Spinal cord, cranial nerves, and other parts of the central nervous system (C72._)		
Pituitary gland (C75.1)		
Craniopharyngeal duct (C75.2)		
Pineal gland (C75.3)		

Casefinding

Case-finding is the means by which a facility identifies patients with a reportable tumor. The following case-finding list(s) should be used by your facility to identify these patients. It is suggested that you use the reportable list as a filter and generate a report listing all discharged patients with a diagnosis of a reportable tumor. The report should be sorted alphabetically to group patients with multiple encounters. All patients on the report will be reviewed to determine their eligibility for reporting. Patients admitted to your facility for an eligible tumor diagnosis, or for tumor-directed treatment must be reported and a tumor abstract completed. No tumor abstract is necessary if it is determined that a patient was admitted with only a history of a malignancy or with a history of benign intracranial/central nervous system tumor (i.e., no procedure done, no treatment tumor-directed).

The patient discharge report should include the following:

- Patient last name
- Patient first name
- Patient middle name
- Medical record number
- Date of birth
- Social security number
- Date of service
- ICD-10 codes
- Type of encounter

An electronic version of the case-finding list is available on the SEER website.
https://seer.cancer.gov/tools/casefinding/

Comprehensive ICD-10-CM Case-finding Code List for Reportable Tumors

Effective October 1, 2020 – September 30, 2021

ICD-10-CM Code	Explanation of ICD-10-CM code
C00._- C43.-, C4A.-, C45._- C48._, C49._-C96._	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site), and certain specified histologies *NEW for FY2018: C96.20 Malignant mast cell neoplasm, unspecified, C96.21 Aggressive systemic mastocytosis, C96.22 Mast cell sarcoma, C96.29 Other malignant cell neoplasm*
C00.- - C43.-, C4A.-, C45.- - C48.-, C49.- - C96.-	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies **Note:** The following neoplasm codes are **new for FY2022** (10/1/2021) C56.3: Malignant neoplasm of bilateral ovaries C79.63: Secondary malignant neoplasm of bilateral ovaries C84.7A: Anaplastic large cell lymphoma, ALK-negative, breast
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.10-, C44.19-	Unspecified/other malignant neoplasm of skin of eyelid
C44.13-	Sebaceous cell carcinoma of skin of eyelid, including canthus
C44.20-, C44.29-	Unspecified/other malignant neoplasm skin of ear and external auricular canal

C44.30-, C44.39-	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.40, C44.49	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50-, C44.59-	Unspecified/other malignant neoplasm of skin of trunk
C44.60-, C44.69-	Unspecified/other malignant neoplasm of skin of upper limb, incl. shoulder
C44.70-, C44.79-	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin
C49.A-	Gastrointestinal Stromal Tumors Note: All GIST tumors are now reportable starting in 2021 (per ICD-O-3.2), including GIST, NOS
D00.- - D09.-	In-situ neoplasms Note 1: Excludes carcinoma in situ of the cervix (D06._) Note 2: Excludes prostatic intraepithelial neoplasia (PIN III-8148/2) of the prostate. Other prostate in situ histologies are reportable. Note 3: For D04 (carcinoma in situ of the skin), excludes basal and squamous cell in situ lesions.
D13.7	Benign neoplasm of endocrine pancreas Note: Effective 1/1/2021: Review this code to look for the following which were previously a benign tumor of the pancreas, but is now malignant per ICD-O-3.2 • Islet cell adenoma • Nesidioblastoma • Islet cell adenomatosis • Insulinoma • Beta cell adenoma
D18.02	Hemangioma of intracranial structures and any site
D21.4, D48.1	Benign neoplasm of connective and other soft tissue of abdomen Note: Effective 1/1/2021: Review this code to look for the following which were previously a benign tumor of the pancreas, but is now malignant per ICD-O-3.2 • Gastrointestinal stromal tumor, NOS/GIST, NOS/Gastrointestinal autonomic nerve tumor/GANT/Gastrointestinal pacemaker cell tumor (8936/1, now 8936/3)
D23.9	Other benign neoplasm of skin Benign carcinoid tumors of other sites Note: Effective 1/1/2021: Review these code to look for the following which were previously benign and borderline tumors, but are now malignant per ICD-O-3.2 • Aggressive digital papillary adenoma (c44_) (8408/1, but now 8408/3)
D3A._	Benign carcinoid tumors of other sites Note: Effective 1/1/2021: Review these codes to look for the following which were previously benign and borderline tumors, but are now malignant per ICD-O-3.2 • Carcinoid tumor, argentaffinoma, NOS (8240/1, now 8241/3) • Enterochromaffin-like cell carcinoid, NOS (8242/1, now 8241/3)
D32.-	Benign neoplasm of meninges (cerebral, spinal and unspecified)

D33.-	Benign neoplasm of brain and other parts of central nervous system
D35.00 – D35.02	Benign neoplasm of adrenal gland Note: Effective 1/1/2021: Review this code to look for the following which was previously a benign (8700/0) tumor of the adrenal gland, but is now malignant per ICD-O-3.2 (8700/3) • Pheochromocytoma • Adrenal medullary paraganglioma • Chromaffin paraganglioma • Chromaffin tumor • Chromaffinoma
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D37.8	Neoplasm of uncertain behavior of other specified digestive organs (includes uncertain behavior of pancreas) Note: Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Pancreatic endocrine tumor, NOS (C259, 8150/1, now 8150/3) • Islet cell tumor, NOS (C259, 8150/1, now 8150/3) • Glucagonoma, NOS (C259, 8152/1, now 8152/3) • Alpha cell tumor, NOS (C259, 8152/1, now 8152/3) • Glucagon-like peptid-producing tumor (C259, 8152/1, now 8152/3) • Somastostatinoma, NOS (8156/1, now 8156/3) • Somatostatin cell tumor, NOS (8156/1, now 8156/3) • Endocrine tumor, functioning, NOS (8158/1, now 8158/3) • ACTH-producing tumor (8158/1, now 8158/3)
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D44.6	Neoplasm of uncertain behavior of carotid body Note: Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Carotid body tumor/Carotid body paraganglioma (8692/1, now 8692/3)
D44.7	Neoplasm of uncertain behavior of aortic body and other paraganglia Note: Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Paraganglioma, NOS (8680/1, now 8680/3) • Sympathetic paraganglioma (8681/1, now 8681/3) • Parasympathetic paraganglioma (8682/1, now 8682/3) • Glomulus jugulare tumor, NOS/jugular paraganglioma/juglotympanic paraganglioma (8690/1, now 8690/3) • Aortic body tumor/aortic body paraganglioma/aorticopulmonary paraganglioma (8691/1, now 8691/3) • Extra-adrenal paraganglioma, NOS/nonchromaffin paraganglioma, NOS/chemodectoma (8693/1, now 8693/3)
D45	Polycythemia vera (9950/3) ICD-10-CM Coding instruction note: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)
D46.-	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D47.02	Systemic mastocytosis

D47.1	Chronic myeloproliferative disease (9963/3, 9975/3) ICD-10-CM Coding instruction note: Excludes the following: Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_) Chronic myeloid leukemia BCR/ABL-positive (C92.1_) Myelofibrosis & Secondary myelofibrosis (D75.81) Myelophthisic anemia & Myelophthisis (D61.82)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia
D47.4	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis Myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D47.Z-	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3) **Note**: Effective 1/1/2021, PTLD (9971/3) is no longer reportable (9971/1)
D48.0	Neoplasm of uncertain behavior of bone and articular cartilage Note: Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Clear cell odontogenic tumor (9341/1, now 9341/3)
D49.2	Neoplasm of unspecified behavior of digestive organs (includes unspecified behavior of pancreas)Note: Review this code to look for the following which were previously unknown behavior tumors of the pancreas, but are now malignant tumors per ICD-O-3.2 (Histology 8150/3) • Pancreatic endocrine tumor, NOS • Islet cell tumor, NOS
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
D72.110	Idiopathic hypereosinophilic syndrome [HES] (9964/3) Effective 10/1/2020 Note: Previous code (FY 2015- FY 2020): D72.1: Eosinophilia
D72.111	Lymphocytic Variant Hypereosonophilic Syndrome [LHES] (9964/3) Effective 10/1/2020 Note: Previous code (FY 2015- FY 2020): D72.1: Eosinophilia Syndrome [LHES]
D72.118	Other Hypereosonophilic syndrome (9964/3) Effective 10/1/2020 Note: Previous code (FY 2015- FY 2020): D72.1: Eosinophilia
D72.119	Hypereosonophilic syndrome (9964/3) Effective 10/1/2020 Note: Previous code (FY 2015- FY 2020): D72.1: Eosinophilia
K31.A22	Gastric intestinal metaplasia with high grade dysplasia
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina

Ambiguous Terminology for Determining Reportability

As part of case-finding activities, all diagnostic reports (radiology, pathology, autopsy, history and physical, discharge summary) should be reviewed to confirm whether a case is required to be reported. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be reported.

Ambiguous Terms that Constitute a Reportable Diagnosis	
Apparent(ly)	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect(ed)
Consistent with	Suspicious (for)
Favor(s)	Typical of
Malignant appearing	
Additional Terms that Constitute a Reportable Diagnosis for **Nonmalignant Primary Intracranial and Central Nervous System Tumors Only***	
Neoplasm	Tumor
*Beginning with diagnosis year 2004 and only for C70.0-C72.9 and C75.1-C75.3	

Note 1: Do not substitute synonyms such as 'supposed' for 'presumed', or 'equal' for 'comparable'. Do no substitute 'likely' for 'most likely'. Use only the exact words on the list or their conjugate forms, for example, "favored" is allowed as a substitute for "favor."

Note 2: If a **cytology report** uses only an ambiguous term for the diagnosis, do not interpret it as a diagnosis of cancer. Do not report ambiguous cytology *unless* a physician makes a statement of malignancy or if the patient receives cancer-directed therapy. If a tissue diagnosis confirms ambiguous cytology, use the cytology date as the date of diagnosis.

Note 3: The ambiguous terms list is applicable to hematopoietic and lymphoid neoplasms for determining **reportability only**. The use of ambiguous terms for assigning and reporting histology is covered in the Hematopoietic and Lymphoid Neoplasms Coding Manual.

https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf

Ambiguous Terms that **DO NOT** Constitute a Reportable Diagnosis	
Cannot be ruled out	Questionable
Equivocal	Rule out
Possible	Suggests
Potentially malignant	Worrisome

Examples listed on the following page

Examples of Ambiguous Diagnostic Terms

Do report – Mammogram report states breast mass is **suspicious** for malignancy. Suspicious for malignancy is reportable ambiguous terminology. Please note, BI-RADS terms are not considered diagnostic on their own. For example, BI-RADS 4, suspicious abnormality, does not constitute a diagnosis.

Do report – Discharge summary final diagnosis states **probable** primary lung malignancy. Probable primary lung malignancy is reportable ambiguous terminology.

Do not report – An outpatient CT scan of the chest documents a right lower lobe lung nodule, **possible** malignancy. The patient has no other encounters with your facility. Possible is not a reportable ambiguous term.

Do not report – **Cytology** from bronchial washings, final diagnosis: **Suspicious** for malignancy. Suspicious is an ambiguous reportable term, but cytology is the exception (see Note 2).

Differential Diagnosis

A **differential** diagnosis is made when a physician does not have enough information to assign a **definitive** diagnosis. Only report cases with a differential diagnosis if all possible disease processes are reportable.

Do report – CT exam of the chest shows a nodule in the left lower lung. The radiologist report has a differential diagnosis of **suspicious** for lung cancer vs **metastatic** lung lesion. Both are reportable terms.

Do report – Pathology report of brain tissue states **CNS lymphoma** vs **CNS metastasis** from unknown primary. Both are reportable conditions.

Do not report – MRI of the left thigh says deep tissue mass consistent with **atypical lipoma** or **liposarcoma**. The patient does not return to your facility. Atypical lipoma is not a reportable condition.

Do not report – Bone survey states patient has a solitary lesion in the right humerus compatible with a **bone island** or **solitary plasmacytoma**. "Compatible" is a reportable ambiguous term, but a bone island is not a reportable condition.

Class of Case

Class of case reflects the facility's relationship to the patient and its role in the diagnosis and/or treatment of the cancer. Code the Class that most precisely describes the patient's relationship to your facility.
Classes of Case 00 - 14 indicate that the patient was diagnosed at your facility or in the office of a physician with admitting privileges at your facility.
Classes of Case 20 - 22 indicate that the patient was diagnosed somewhere else (not at your facility and not in the office of a physician with admitting privileges at your facility).

Class of Case

Analytic Cases		R=Required N=Not Required
Initial diagnosis at the reporting facility or in a staff physician's office		**R**
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere *Note: 00 only applies when it is known that the patient went elsewhere for treatment. If you do not know this information, you should code Class of Case 10.*	**R**
10	Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS	**R**
11	Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility	**R**
12	Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility	**R**
13	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere	**R**
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility	**R**
Initial diagnosis elsewhere		**R**
20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS	**R**
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.	**R**
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility	**R**
Non–analytic Cases		
Patient appears in person at reporting facility		
30*	Initial diagnosis and all first course treatment elsewhere AND reporting facility performed a confirmation biopsy after being diagnosed on imaging elsewhere. ***Note**: only reportable for confirmation biopsy of initial diagnosis. You must know the patient was clinically diagnosed elsewhere on imaging or physician statement and document such in text. ***DO NOT** report consult only, treatment plan only, staging workup only after initial diagnosis elsewhere)*	**R**
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement)	**N**
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility for diagnosis or treatment of disease recurrence or persistence (active disease). *Note: 32 includes patients that expire at the reporting facility with a reportable active disease that does not meet the criteria for an analytic Class of Case.*	**R**
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active)	**N**
34*	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility ***Reportable only for the following histology and primary sites: squamous intraepithelial neoplasia, grade III (8077/2) to include AIN III (C21.1), VIN III (C51.*) VAIN III (C52.*)***	**R**
35	Case diagnosed before facility's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility	**N**

36*	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility ***Reportable only for the following histology and primary sties: squamous intraepithelial neoplasia, grade III (8077/2) to include AIN III (C21.1), VIN III (C51.*) VAIN III (C52.*)***	**R**
37	Case diagnosed before facility's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility	**N**
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death ***Note: 38 should only be used if the reporting facility performs autopsies***	**R**
Patient does not appear in person at reporting facility		
40	Diagnosis AND all first course treatment given at the same staff physician's office	**N**
41	Diagnosis and all first course treatment given in two or more different offices of physicians with admitting privileges	**N**
42	Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)	**N**
43	Pathology or other lab specimens only	**N**
49	Death certificate only (central registry only)	**N**
99	Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).	**N**

Additional explanation:

Class of Case 00 can be used only if the patient was diagnosed at your facility, and you know the patient received treatment elsewhere. If, after diagnosis at your facility, it is unknown if the patient received any treatment, you must code *Class of Case* as 10.

'No therapy' is considered treatment (i.e., patient refuses treatment, patient expires before treatment is given, or treatment is contraindicated). If a decision of no treatment is made at your facility, *class of case* should reflect 'treatment was done at your facility'.

Examples of class of case:

1. Patient admits to the reporting facility with rectal bleeding. Colonoscopy performed after admission shows the patient has colon cancer. Two days later, the patient has a hemicolectomy to remove the cancer. The surgeon states the cancer is Stage I and no further treatment is necessary.
    - This is a *class of case* 14 – initial diagnosis at your reporting facility and all first course of treatment was done at your facility.

2. 90-year-old patient with multiple comorbidities admits to the reporting facility with shortness of breath. Lung biopsy is positive for small cell carcinoma. Patient opts to receive no treatment.
    - This is a *class of case* 14 – initial diagnosis and all first course treatment done at your facility. ('No treatment' is treatment).

3. Patient presents to the reporting facility's ER having a cardiovascular event and a history of colon cancer. During the hospitalization it is determined that the patient has a newly

diagnosed liver lesion confirmed to be metastasis from colon cancer on pathology examination. The reporting facility does not treat this metastasis.

- This is a *class of case* 32- diagnosis of recurrence or progression of disease. All first course treatment administered elsewhere AND patient presents to the reporting facility with disease recurrence or persistence (active disease). This case is reportable since progression of disease was diagnosed at the reporting facility.

4. Patient presents to the reporting facility for right upper quadrant pain. A CT of the abdomen and pelvis is performed. The impression on the report states 3.2 cm mass in the liver is highly suspicious for hepatocellular carcinoma. The patient is transferred to another hospital for a higher level of care. It is unknown if the patient received treatment.
    - This is *class of case* 10 – diagnosed at the reporting facility and unknown if the patient received treatment elsewhere. The patient was diagnosed at the reporting facility on CT with ambiguous terms that constitute a diagnosis. There is no mention in the medical record of any cancer treatment the patient received at the outside facility.

Laterality

Laterality must be recorded for the following paired organs as 1-5 or 9. Organs that are not paired, unless they are recorded as "right" or "left" laterality, are coded 0. Midline origins are coded 5. "Midline" in this context refers to the point where the "right" and "left" sides of paired organs come into direct contact and a tumor forms at that point. Most paired sites cannot develop midline tumors. For example, skin of trunk can have a midline tumor, but the breasts cannot.

Code	Definition
0	Organ is not a paired site
1	Origin of primary is right
2	Origin of primary is left
3	Only one side involved, right or left origin not specified
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5	Paired site: midline tumor
9	Paired site, but no information concerning laterality

List of Paired Organs

ICD-O-3 Code	Paired Site
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland

C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1-C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bone of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum)
C41.4	Pelvic bones (excluding sacrum, coccyx and symphysis pubis)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face
C44.4	Skin of Scalp and Neck
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous and other soft tissues of lower limb and hip
C50.0-C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0-62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges, NOS
C71.0	Cerebrum
C71.1	Frontal lobe
C71.2	Temporal lobe
C71.3	Parietal lobe

Diagnostic Confirmation

Solid Tumors

Diagnostic confirmation is an indicator of the precision of diagnosis.

The codes for diagnostic confirmation are in priority order; code 1 has the highest priority. Codes 1, 2, and 4 indicate that the diagnosis of cancer was microscopically confirmed. The cancer diagnosis will be confirmed in a pathology report for codes 1, 2 and 4.

Codes 5, 6, 7 and 8 indicate that the diagnosis was clinically confirmed. There will be no pathology report associated with this diagnosis of cancer. The confirmation will be a physician statement using either definitive terminology or ambiguous terminology. The physician statement may be in a discharge summary, progress note, radiology report, history and physical examination, or other physician note. Code 5 will rarely be used as a means of diagnostic confirmation since laboratory tests/tumor markers are not usually diagnostic of cancer.

Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods.

Codes for Solid Tumors

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. Examples include alpha-fetoprotein for liver primaries. Elevated PSA is not diagnostic of cancer. However, if the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only, other than 5, 6 or 7	The malignancy was reported by the physician in the medical record.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).

Examples of diagnostic confirmation:

1. Patient admitted to the reporting facility with shortness of breath and productive cough. CT scan of the chest demonstrates a right upper lobe lung mass with enlarged mediastinal lymph nodes. The patient refuses any additional work-up. On the discharge summary, the attending physician states the final diagnosis is lung cancer.
    - The diagnostic confirmation code assigned is 8 – clinical diagnosis only. The physician gave a definitive diagnosis in the discharge summary.

2. Patient referred to the reporting facility for a breast biopsy. The biopsy is performed, and the pathologic diagnosis is infiltrating duct carcinoma of the right breast.
    - The diagnostic confirmation code assigned is 1 – positive histology. There is a pathology report with a histologic diagnosis of cancer.

Hematopoietic or Lymphoid Neoplasms (9590-9992)

Other than microscopic confirmation (1-4) taking priority over clinical diagnosis on (5-8), there is no priority hierarchy for coding Diagnostic Confirmation for hematopoietic and lymphoid neoplasms.

Use the Hematopoietic and Lymphoid Neoplasm Coding Manual pages 16-20 for specific rules in assigning diagnostic confirmation.

1. Assign **Code 1** when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy or bone marrow specimens (aspiration and biopsy). For leukemia only, code 1 when the diagnosis is based on Complete Blood Count (CBC), White Blood Count (WBC) or peripheral blood smear. Note: A registrar may not abstract a hematopoietic neoplasm based on a CBC or WBC with abnormal counts alone. There must be a diagnosis of a reportable Heme neoplasm on the CBC or WBC report or a subsequent physician diagnosis based on the WBC or CBC.

2. Assign **Code 2** when the microscopic diagnosis is based on cytologic examination of cells, although these methods are rarely used for hematopoietic or lymphoid neoplasms.

3. Assign **Code 3** when there is histology positive for cancer AND positive immunophenotyping and/or positive genetic testing.

Codes for Hematopoietic and Lymphoid Neoplasms

Microscopically Confirmed

Code	Description
1	Positive Histology Includes: peripheral blood smear only
2	Positive Cytology
3	Positive Histology PLUS: Positive immunophenotyping AND/OR Positive genetic studies Includes: peripheral blood smear followed by flow cytometry *(Effective for cases diagnosed 01/01/2010 and later)*
4	Positive microscopic confirmation, method not specified

Not Microscopically Confirmed

Code	Description
5	Positive laboratory test/marker study ***Note: :*** Includes cases with positive immunophenotyping or genetic studies and ***no*** histological confirmation ***Note 2:*** This does **not** include cases where a peripheral blood smear is done (code 1) and peripheral blood smear followed by flow cytometry (code 3)
6	Direct visualization without microscopic confirmation
7	Radiology and other imaging techniques without microscopic confirmation
8	Clinical diagnosis only (other than 5, 6 or 7)

Confirmation Unknown

Code	Description
9	Unknown whether or not microscopically confirmed; death certificate only

Examples of Diagnostic Confirmation

1. Patient has bone marrow examination which is positive for acute myeloid leukemia (AML) (9861/3). Genetic testing shows AML with inv(16)(p13.1q22) (9871/3).
   Assign **Code 3**, positive histology PLUS positive genetic studies.

2. Patient has a bone marrow biopsy that is positive for chronic lymphocytic leukemia.
   Assign **Code 1**, positive histology per the instructions

Grade

Solid tumors - Grade, Differentiation
Pathologic examination determines the grade, or degree of differentiation of the tumor. Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers.

Beginning with cases diagnosed in 2018, the definition of grade has been expanded, and classification of grade now varies by tumor site and/or histology. The grading system for a cancer type may have two, three or four grades. No longer will grades be converted to a four-grade system. Beginning with cases diagnosed in 01/01/2021 grade has been expanded to included grade post therapy clinical (yc) and grade post therapy path (yp). Detailed coding instructions for grade can be found here:
https://www.naaccr.org/wp-content/uploads/2021/03/Grade-Manual_v-2.01.pdf?v=1620765368

The *Grade* data item has been stratified into four new data items: Grade Clinical, Grade Pathological and Grade Post Therapy Clinical (yc) and Grade Post Therapy Path (yp).

- ***Grade Clinical*** is defined as the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant). Record the grade of the primary tumor from the biopsy specimen.
  Note: Benign Brain, CNS and Other Intracranial gland: For benign tumors ONLY (behavior 0), code 1 can be automatically assigned for all histologies. This was

confirmed by the CAP Cancer Committee

- ***Grade Pathological*** is defined as the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. Record the highest grade documented from any microscopic specimen of the primary site whether from the clinical work-up or the surgical resection.

- ***Grade Post Therapy Clinical (yc),*** New beginning in 2021. Defined as the grade of a solid primary tumor that has been microscopically sampled (biopsy) following neoadjuvant therapy or primary systemic/radiation therapy. Record the highest grade documented from the microscopically sampled specimen of the primary site following neoadjuvant therapy or primary systemic/radiation therapy.

- ***Grade Post Therapy Path (yp)*** is defined as the grade of a solid primary tumor that has been resected following neoadjuvant therapy. Record the highest grade documented from the surgical treatment resection specimen of the primary site following neoadjuvant therapy.

Note: If there is only one grade available and it cannot be determined if it is clinical or pathological, assume it is a Grade Clinical and code appropriately per Grade Clinical categories for that site, and then code unknown (9) for Grade Pathological, and blank for Grade Post Therapy Clin (yc) and Grade Post Therapy Path (yp).

Hematopoietic and Lymphoid Neoplasms - Cell Indicator
Historically the cell lineage indicator (B-cell, T-cell, Null cell, NK-cell) was collected in the Grade data item. Cell lineage indicator/grade for hematopoietic and lymphoid neoplasms will **no longer be collected for cases diagnosed 1/1/18 and forward**.

For cases with histologies 9590/3-9992/3, the clinical and pathological grades must be coded to '8'. Grade post therapy clinical and post therapy grade must be blank.

OCCR Standardized Text Format

Overview

Text documentation that is comprehensive and detailed helps minimize confusion and is essential to the central registry when consolidating multiple records. The purpose of text fields is to justify the codes within the abstract and **every code and date MUST be supported with clear and concise text documentation**. Additionally, proper use of recommended abbreviations can shorten the amount of text needed for accurate documentation.

Provide the following information:

- Dates or date ranges of procedure, exam or treatment
- Facility at which said procedure or exam was done
- Name of procedure, exam method or treatment
- Names of drugs administered
- Pertinent abnormal findings
- Measurements of tumors or lymph nodes
- If dates are estimated, please follow date with, (Est Date)
- Information to support Summary Stage 2018
- Additional pertinent information to justify code/date fields

*DO NOT leave text fields blank when information is unknown or not applicable, record 'N/A' or 'Unknown'.

*Further clarification of specific text fields can be found in the NAACCR Standards for Cancer Registries Data Dictionary.

Recommended Abbreviations

Abbreviations are used by abstractors to limit the amount of text but can often generate confusion. Since abbreviations can vary among different institutions and even between different specialties, standardization is necessary. To be useful, an abbreviation must be clearly understood by any individual who encounters it. Consequently, the use of abbreviations is beneficial only when universally recognized and understood. NAACCR has developed a listing of recommended abbreviations for abstractors to use and can be found in *Appendix G* of the NAACCR Standards for Cancer Registries and Data Dictionary. The listings are not exhaustive, but many of the most commonly used terms are included. A web link to the *Appendix G* listing is provided below.

http://datadictionary.naaccr.org/default.aspx?c=17&Version=22

Required Site-Specific Data Items (SSDIs)

The following table includes only those SSDIs required by the OCCR.

Site	NAACCR Item #	Item Name	Primary Site(s)	Histologies
Brain	3816	Brain Molecular Markers	C700, C710-C719	8000-8700, 8720-8790, 8802, 8810, 8815, 8850, 8890, 8900, 9064, 9070-9071, 9080, 9084-9085, 9100-9105, 9120, 9133, 9140, 9180, 9220, 9362, 9364, 9380-9540, 9680, 9699, 9702-9715, 9751-9759; *Behavior 3*
			C700, C710-C719	8000-9993; *Behavior 0,1*
Melanoma Skin	3817	Breslow Tumor Thickness	C000-C002, C006, C440-C449, C500, C510-C512, C518-C519, C600-C602, C608-C609, C632	8720-8790
	3932	LDH Lab Value		
Breast	3827	Estrogen Receptor Summary	C500-C506, C508-C509	8000-8700, 8982-8983
			C501-C506, C508-C509	8720-8790
	3915	Progesterone Receptor Summary	C500-C506, C508-C509	8000-8700, 8982-8983
			C501-C506, C508-C509	8720-8790
	3855	HER2 Overall Summary	C500-C506, C508-C509	8000-8700, 8982-8983
			C501-C506, C508-C509	8720-8790
Liver	3835	Fibrosis Score	C220	8000-8700, 8720-8790
Prostate	3838	Gleason Patterns Clinical	C619	8000-8700, 8720-8790
	3840	Gleason Score Clinical		
	3839	Gleason Patterns Pathological		
	3841	Gleason Score Pathological		
	3842	Gleason Tertiary Pattern		
	3920	PSA Lab Value		
Colon & Rectum	3890	Microsatellite Instability (MSI)	C180, C182-C189, C199, C209	8000-8149, 8154, 8160-8231, 8243-8248, 8250-8682, 8690-8700, 8720-8790
Cervix	3956	p16	C530-C531, C538-C539	8000-8700, 8720-8790, 8980, 9110 Year of Diagnosis: 2021-9998, 9999
Esophagus & EG J (Squamous)	3829	Esophagus and EGJ Tumor Epicenter New for OCCR 2022+	C150-C155, C158-159 C160	8050-8054, 8020, 8070, 8074, 8077, 8083, 8560

Estimating Dates

If an exact date is not available, use all the information available to calculate the month and year. After applying these rules you should rarely have a blank date.

Documentation	Date Code/Description
Spring	April (04)
Summer or Middle of the Year	July (07)
Fall or Autumn	October (10)
Winter	Determine if this means the beginning or end of the year. Use December (12) or January (01) as determined.
Early in the Year	January (01)
Late in the Year	December (12)
Recently	Use the year and month of admission and leave the day blank. If patient was admitted during the first week of a month, use the previous month.
Several Months Ago	If the patient was not previously treated or if first course treatment started elsewhere was continued at the reporting facility, assume the case was first diagnosed three months before admission with day unknown (blank).
A Couple of Years	Code two years earlier
A Few Years	Code three years earlier

Example 1:
A patient was admitted to your facility on June 15, 2018. The History and Physical states the patient has lung carcinoma diagnosed about two months ago. Record the date of diagnosis as 04/__/2018.

Example 2:
A patient was admitted to your facility on October 30, 2019. The History and Physical states the patient has bone metastasis from prostate cancer diagnosed in the spring. Record the date of diagnosis as 04/__/2019.

Section 2

RMCDS Training Narrative

Abstracting Notes

Note 1: All dates are entered using the following format: MMDDYYYY. Make every effort to locate a date or estimate the date if unknown. Instructions for estimating dates are on page 24. If the day is unknown, leave blank (MM/_ _/YYYY). If the month and day are both unknown, leave both blank (_ _/ _ _/YYYY). If the entire date is unknown, leave field blank and enter flag code discussed in Note 4. Blank dates should be an absolute last resort.

Note 2: When selected, some text fields have a 'T' button  . Select this button to display the free text box. This box provides the ability to have word wrap. Select the 'OK' button after entering information to place text in the abstract.

Note 3: When selected, some fields have a help button  . Select the help button to display a search/list of available choices for coding.

Note 4: When selected, date fields have a flag button  . Select the flag button when no appropriate value in the corresponding date field can be given. Choose the appropriate code from the available options. See page 42 for further explanation of each flag option.

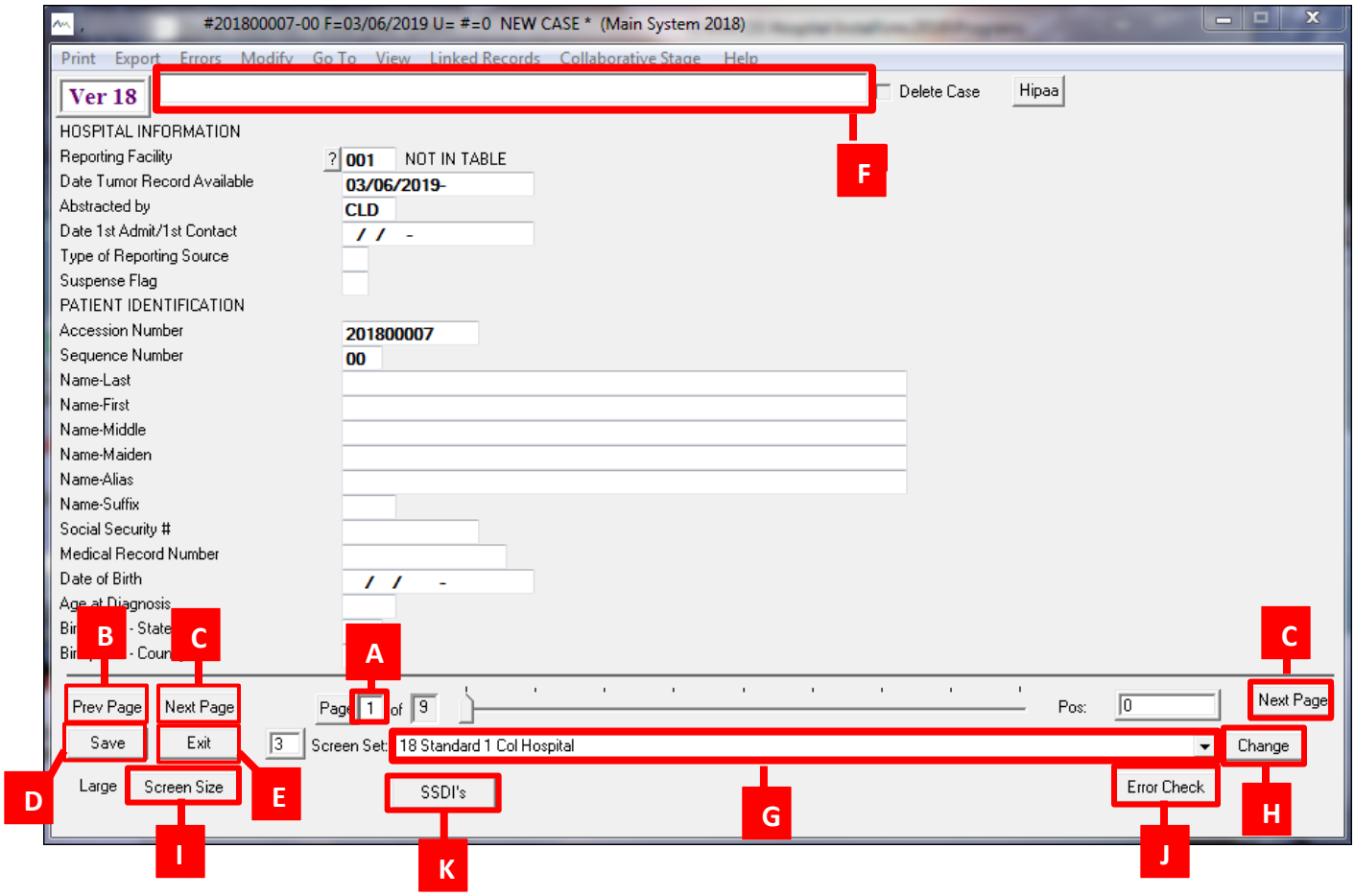
Note 5: When selected, some fields will have coding options or instructions listed in the prompt box at the top of the abstract.

Note 6: At the bottom of the page, the Screen Set should automatically be set to: 18 OK Hospital. If not, please refer to instructions on Setting Parameters in Section 3, page 54.

Note 7: Further explanations and instructions for abstract fields can be found within the STORE Manual and the SEER Coding Manual. Fields which may require specific manuals to be utilized will be indicated in these instructions with an asterisk (*). A guide to referenced manuals can be found in Section 1, pages 2-5.

Note 8: Click "Save" often while abstracting cases. Information will be lost if a case is closed, or an error occurs before saving.

Abstract Navigation



Navigation Parts:

A. **Page Number:** Displays the page number that is being viewed

B. **Prev Page:** Navigates to the previous page

C. **Next page:** Navigates to the next page

D. **Save:** Saves the abstract

E. **Exit:** Closes the abstract

F. **Prompt Box:** Displays information about currently selected fields

G. **Screen Set Menu:** Displays dropdown menu for screen sets

H. **Screen Set Change Button:** Changes screen set, once selection has been made

I. **Screen Size Button:** Changes the abstracting screen size to a larger view

J. **Error Check Button:** Runs the error check in one step. Must be set up in personal parameters.

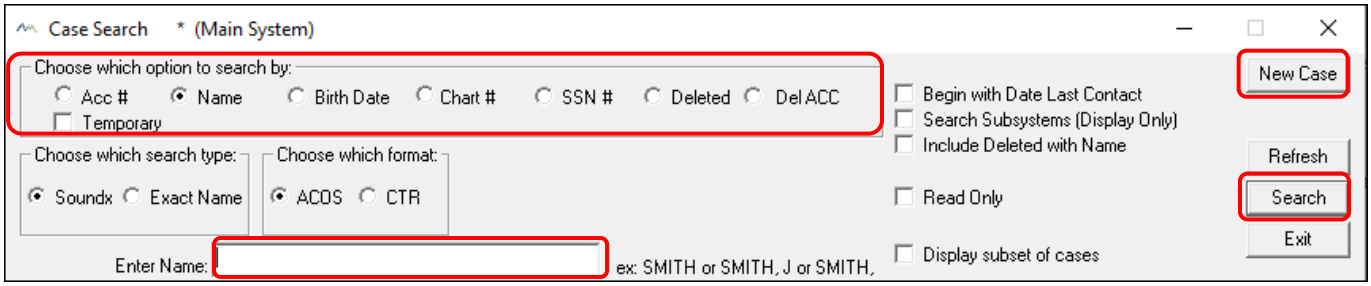
K. **SSDIs:** Opens the Site Specific Data Items coding box

Enter New Abstract

Search RMCDS Facility Database for Existing Accession Number for Patient

1. Select ‘Case Search’ from the Quick Launch Buttons on the RMCDS main screen.

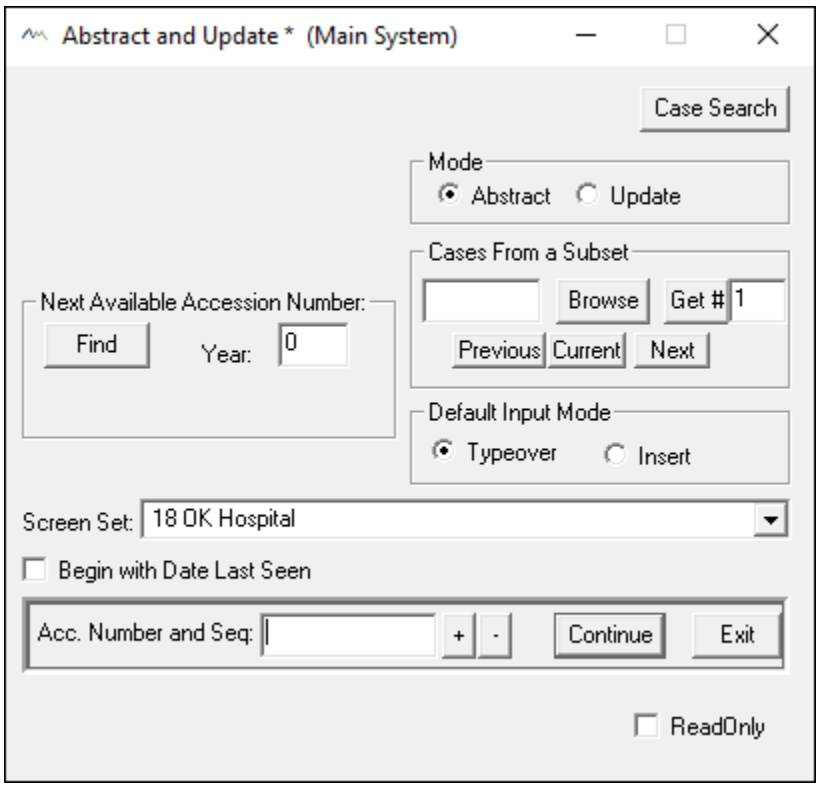
2. From the Case Search box, various criteria can be chosen to search for the patient such as date of birth, SSN#, Chart Number and Accession Number. It is suggested to search for a patient using multiple criteria to make sure the patient does not already have an Accession Number assigned to them.



3. If the patient is not found in the database, please continue to the next page for instructions on assigning a new Accession Number. If the patient has an existing Accession Number, follow the instructions on page 26 to create a new abstract using a previously assigned accession number.

Assigning a New Accession Number in RMCDS

1. In Case Search after confirming the patient does not already have an assigned accession number, click the New Abstract button in the top right.
2. Select ‘Abstract’ under the Mode options.
3. In the dialog box, go to the Next Available Accession Number group and type in the year the patient was first seen at your facility with this primary. After typing in the year in XXXX format, select the ‘Find’ button.
4. A dialog box will appear indicating the next ‘First Available Accession #’. Click ‘OK.’
5. After you click ‘OK’, the next ‘Acc. Number and Seq’ number will automatically generate in the box at the bottom of the dialog box.
6. Now select the ‘Continue’ button located at the bottom right corner of the dialog box. This will take you into a new abstract.



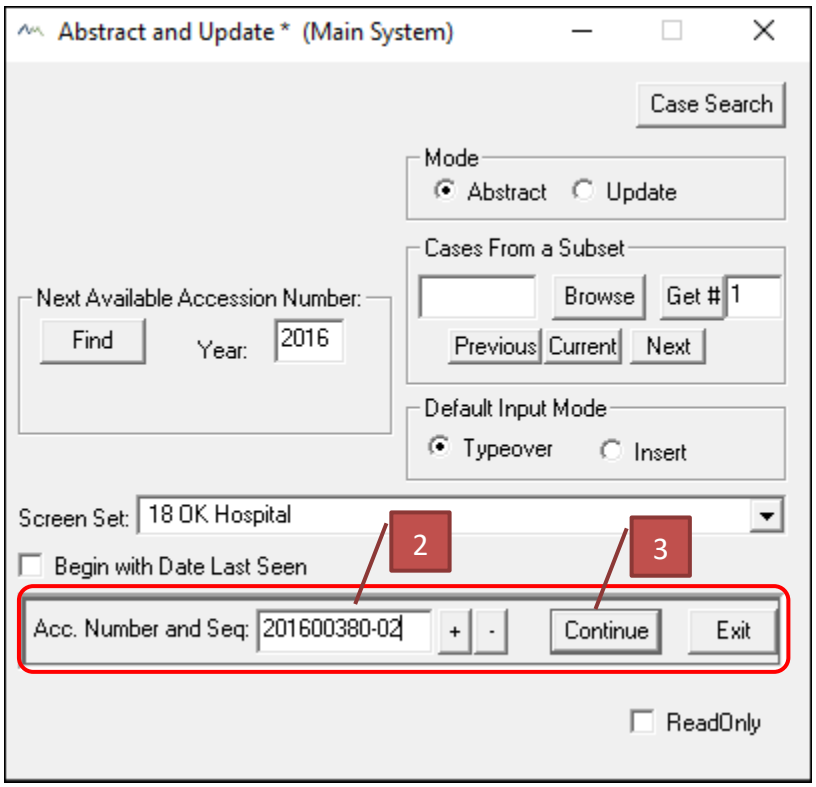
Creating a New Abstract Using a Previously Assigned Accession Number

1. In Case Search after confirming the patient already has an assigned accession number, click the New Abstract button in the top right.

2. Enter the patient's previously assigned Accession Number and Sequence number in the 'Acc. Number and Seq' text field in the format as shown in the example below. Manually enter the correct Sequence Number or select the '+' button adjacent to the field to increase the digit to the correct sequence number.

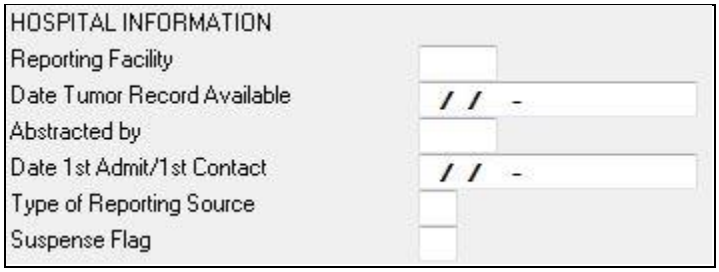
   Note: If the patient has a previous cancer, the lowest sequence number (the number after the dash) that can be assigned to a new abstract is '02'. Since this patient has a previous Accession number this must be, at the very least, their second cancer. Refer to the patient's medical record and previously abstracted cases to determine what sequence this new abstract should be.

3. Select the 'Continue' button located at the bottom right corner of the dialog box. This will take you into a new abstract. Previously entered patient information from this patient's first abstract will be auto filled.



Hospital Information

Page 1



Reporting Facility:
Unique number assigned by OCCR. Data item is auto-coded.

Date Tumor Record Available:
Date the case was created. Data item is auto-coded.

Abstracted By:
Initials of person logged into RMCDS. Data item is auto-coded.

***Date of 1st Admit/1st Contact:**
Date of first patient contact, inpatient or outpatient, for the diagnosis and/or treatment of the tumor. The date may represent an outpatient visit for biopsy, x-ray, scan or laboratory test.

- If the patient is diagnosed at the reporting facility, the date of diagnosis and the date of first contact will be the same.
- If the patient was diagnosed at an outside facility, the date of first contact will be the date

treatment starts at reporting facility. (Treatment is surgery, chemotherapy, radiation therapy, hormone therapy, or palliative therapy).

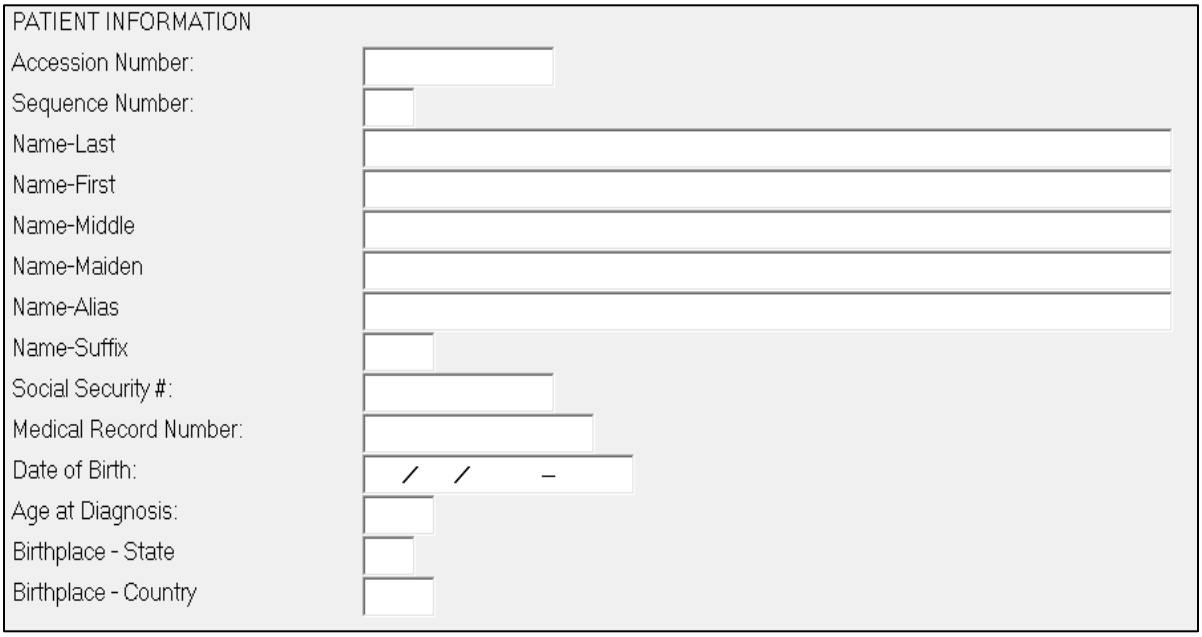
***Type of Reporting Source:**
Choose the appropriate option for your facility. Use the help button to select the appropriate code to record type of reporting source.

Suspense Flag:
Place a '1' in this box if the case needs to be withheld from file submission. This is not a required field.

Example: Waiting on physician clarification. Case will not be complete before file submission. Place '1' in this box until it is ready for submission.

Patient Identification

Page 1



Accession Number:
A unique identifier (9-digit number) for the patient; consists of the year in which the patient was first seen at the reporting facility, as well as the consecutive order in which the patient was abstracted. A patient will have only one accession number in their lifetime. This data item is auto-coded.

Sequence Number:
Indicates the sequence of all malignant and non-malignant neoplasms over the lifetime of the patient.

4. Sequence number 00 indicates that a patient has only one malignant neoplasm in a lifetime. If this same patient is diagnosed with a second malignant neoplasm, the sequence number for the first neoplasm is changed to 01, while the sequence number for the second neoplasm is coded 02.

5. Sequence number 60 indicates that a patient has only one non-malignant reportable neoplasm in a lifetime. If this same patient is diagnosed with a second non-malignant reportable neoplasm, the sequence number for the first neoplasm is changed to 61, while the sequence number for the second neoplasm is coded 62. Do not mix malignant and non-malignant sequence numbers.

***Name - Last:**
Record the last name of the patient. Blanks, spaces, hyphens and apostrophes ARE allowed. Do not use other punctuation. Do not leave blank. If the last name is unknown, record as UNKNOWN.

Examples: *Record with space 'Mc Donald'; record with a hyphen 'Smith-Jones'*

***Name - First:**
Record the first name of the patient. Blanks, spaces, hyphens and apostrophes ARE allowed. Do not use other punctuation. If the first name is unknown, leave blank.

***Name - Middle:**
Record the middle name of the patient. Blanks, spaces, hyphens and apostrophes ARE allowed. Do not use other punctuation. If only a middle initial is known, record the letter only. If the middle name is unknown, leave blank.

Name – Birth Surname:
Record patient's last name (surname) at birth, regardless of gender or marital status. If birth surname is unknown or not applicable, leave blank. Beginning 01/01/2021 Name –Birth Surname replaces Name – Maiden.

Name - Alias:
Record here if the patient is called by a name other than their first name. If alias is unknown or not applicable, leave blank.

Example: Patient name is Robert but goes by Bob. Record Bob in this field.

Name - Suffix:
Record the title that follows a patient's last name, such as generation order or credential status. (e.g., Jr or MD). If name suffix is unknown or not applicable, leave blank.

***Social Security No:**
Record the patient's social security number without dashes. If social security number is unknown or the patient does not have one, code as 999999999. If a partial social security only is known (i.e., last 4 digits), code the social security number as 88888XXXX where X represents the known last four digits.

***Medical Rec No:**
Record the medical record number, usually assigned by the reporting facility's health information management (HIM) department. If medical record number is unknown, leave blank.

*Date of Birth:
Record the patient's date of birth. If the date of birth is unknown, but the age at diagnosis and date of diagnosis are known, calculate the year of birth by subtracting the patient's age at diagnosis from the year of diagnosis. Leave the month and day blank. *Refer to Note 1 on page 22 for specific date format. Leave the year, month and/or day blank and use the flag button when date cannot be estimated or is unknown. Refer to estimating dates

*Age at Diagnosis:
Do not code/enter age. This field will automatically derive once the Date of Birth and Diagnosis Date are entered.

*Birthplace State:
Required when available
Use the help button to search for the state in which the patient was born. If unknown, select 'ZZ' for unknown.

*Birthplace Country:
Required when available
Use the help button to search for the country in which the patient was born. If unknown, select 'ZZU' for unknown.

Patient Identification
Page 2

*Sex:
Use the help button to select the appropriate code to record the sex of the patient.

*Race 1-5:
Use the help button to select the appropriate code to record the patient's race. Race codes 1-5 must ALL be completed, even if race is unknown.

- If the patient is multiracial, record the minority race in Race 1 and other race in Race 2.
- code 88 = no additional races
- code 99 = unknown

Examples:

Patient is Caucasian only:	Patient is Black and Caucasian:	Patient race is Unknown:
Race 1: 01	Race 1: 02	Race 1: 99
Race 2: 88	Race 2: 01	Race 2: 99
Race 3: 88	Race 3: 88	Race 3: 99
Race 4: 88	Race 4: 88	Race 4: 99
Race 5: 88	Race 5: 88	Race 5: 99

*Spanish/Hispanic Origin:

Use the help button to select the patient's Hispanic ethnicity. If ethnicity is unknown, select '9' for unknown. Do not leave blank.

*Medicare Beneficiary Identifier (MBI):

Required when available

MBI is a randomly generated number that replaces the Social Security Number on Medicare cards. This identifier is used to facilitate transactions, such as medical billing, determining eligibility status and claim status.

*Primary Payer at DX:

Required when available

Use the help button and select the code that describes the primary payer or insurance carrier at the time of the initial diagnosis and/or treatment. If primary payer is unknown, select '99' for unknown.

*Text-Usual Occupation:

Required when available

Record the patient's longest held occupation. Record Unknown if occupation is unknown. Do not record 'Retired'. Refer to A Cancer Registrar's Guide to Collecting Industry and Occupation for help with entering occupation and industry.

*Text- Usual Industry:

Required when available

Record the patient's longest held industry. Record Unknown if industry is unknown. Do not record 'Retired'. Refer to A Cancer Registrar's Guide to Collecting Industry and Occupation for help with entering occupation and industry.

*Tobacco Use Smoking Status:

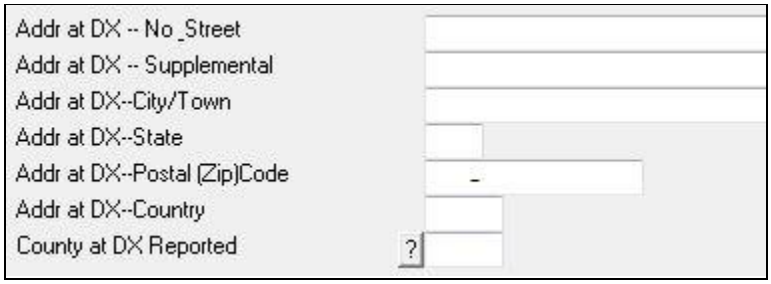
Required when available, New for 2022+

Record the patient's past or current use of tobacco (cigarette, cigar and/or pipe). Tobacco smoking history can be obtained from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats or Nursing Assessment section, or other available source from the patient's hospital medical record or physician office record. *Do not*

- Do not record the patient's past or current use of e-cigarette vaping devices
- If there is evidence in the medical record that the patient quit recently (within 30 days prior to diagnosis), assign code 1, current smoker. The 30 days prior information, if available, is intended to differentiate patients who may have quit recently due to symptoms that lead to a cancer diagnosis.
- Assign **code 9** when the medical record only indicates **"No"**

Patent Address Information

Page 3



***Addr at Dx No + Street:**
Record the **physical address** of the patient at the time of diagnosis.

***Addr DX Supplemental:**
Record additional information listed for the patient's address at diagnosis, including nursing home, post office box, etc. If supplemental address is unknown or not applicable, leave blank.

***Addr at Dx - City/Town:**
Record the city of patient's physical address at the time of diagnosis.

***Addr at Dx - State:**
Use the help button and search for the patient's state of residence at the time of diagnosis.

***Addr at Dx - Postal (Zip) Code:**
Record the extended 9-digit code or the short 5-digit code for the patient's address at the time of diagnosis.

***County at Diagnosis Reported:**
Use the help box to search for the county of the patient's residence at the time of diagnosis. The website Zip Express www.getzips.com/zip.htm may be used to determine county. You can also search for the county by using your internet browser search.

Addr Current No + Street:
Record the patient's current physical address. This address may be the same or different from the patient's address at diagnosis.

Addr Current No + Street Sup:
Record additional information listed for the patient's current address, including nursing home, post office box, etc. If current supplemental address is unknown or not applicable, leave blank.

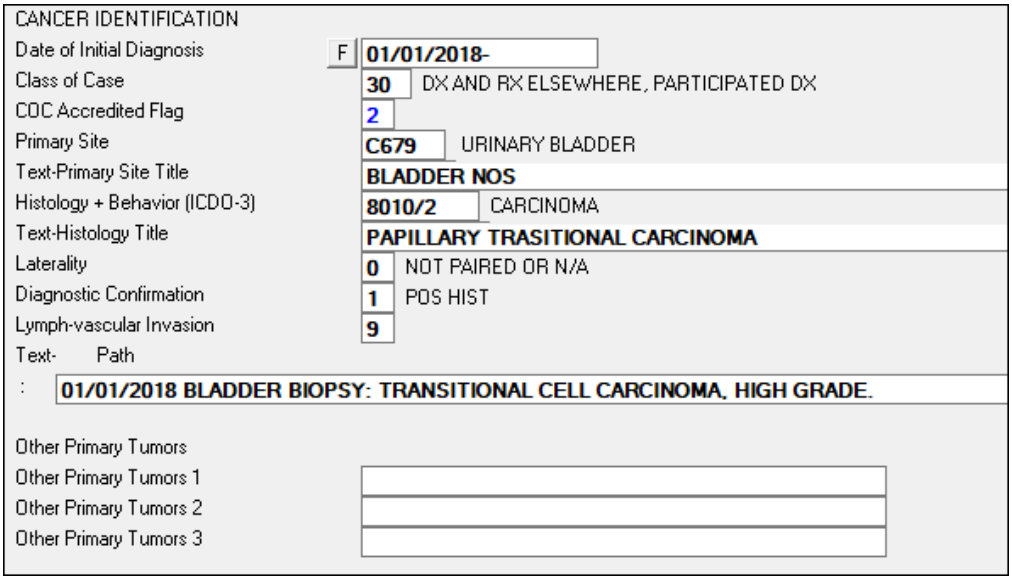
Addr Current City/Town:
Record the patient's current city of residence.

Addr Current State:
Use the help button to search for the state that the patient currently lives in.

Addr Current Postal (Zip) Code:
Record the extended 9-digit zip code or the short 5-digit zip code of the patient's current residence.

Cancer Identification

Page 4



*Date of Initial Diagnosis

Record the date the cancer was first diagnosed, whether clinically (physician's documentation, x-ray, CT scan) or pathologically (biopsy, surgery). Refer to the list of 'ambiguous terms' in Section 1, page 10 for language that represents a diagnosis of cancer. (Refer to prompt box for date format).

*Class of Case

Refer to the class of case table in section 1 and select the class of case that reflects the facility's role in the management of the cancer. A decision to not treat is still considered treatment. A drop-down menu is available in the software however the descriptions are shortened compared to this manual.

*CoC Accredited Flag

Automatically calculated and entered into RMCDS based on the institutional settings in Parameters. CoC Accredited Flag is assigned at the point and time of data abstraction to label an abstract being prepared for an analytic cancer case at a facility accredited by the Commission on Cancer (CoC). Code 0 is for an abstract prepared at a facility WITHOUT CoC accreditation of its cancer program.

*Primary Site

For solid tumors, use the help button or use the ICD-O-3.1 book (purple book) to search for the *primary site code*. Code the site in which the primary tumor originated, even if it extends into an adjacent 'sub-site'. Code the primary site, not the site of metastasis. If primary site is not stated, code to unknown primary site (C809).

For hematopoietic and lymphoid neoplasms, refer to the online hematopoietic database. This includes lymphomas, leukemias and blood cancers.

*Text- Primary Site Title

Document the primary tumor site, including sub-site and laterality. Do not leave blank. The text should support the code used for primary site.

Example 1: *Right lower lobe of lung.* (Laterality: Right; Sub-site: lower lobe; Tumor Site: lung.) ***Example 2:*** *Skin, left forearm.* (Tumor Site: Skin; Laterality & Sub-site: left forearm.)

*Histology + Behavior

This field is a two-part code.

Histologic Type: For solid tumors, use the Solid Tumor Rules in conjunction with the ICD-O-3.2 Spreadsheet to search for the histology code. *The ICD-O-3.2 histology lists have been updated however a published manual has been delayed due to the COVID-19 epidemic.* When the correct histology has been determined you may enter the code directly or use the search icon. If a report only has a diagnosis of "cancer" or "malignancy," code to 8000, malignant neoplasm. If a diagnosis is reported as "carcinoma," code to 8010.

For hematopoietic and lymphoid neoplasms, refer to the online hematopoietic database.

Behavior Code: Select the behavior of the primary tumor. Tumor behavior is used by pathologists to describe whether the tumor is benign (0), borderline (1), in situ (2) or malignant (3). This code will be placed after the '/ 'in the Histologic Type + Behavior Code field.

- Benign and borderline behavior codes are used for intracranial and central nervous system primary sites only.
- In the absence of pathologic examination, code behavior as invasive (3).
- In situ behavior (2) can only be identified by pathologic examination.

*Histology text

Record the histology (morphology) of the tumor, including grade and behavior. The text should support the histology and grade coded in histology + behavior. Grade should match the grade documented in pathology text and coded in the four grade data items.

Example: Invasive adenocarcinoma, CGD 2, PGD 3, PTCGD BLANK, PTPGD BLANK (CGD=clinical grade, PGD- pathologic grade, PTCGD=post therapy clinical grade, PTPGD=post therapy pathologic grade)

*Laterality:

Refer to the prompt box and select the laterality of the primary tumor. Review the list of paired sites in Section 1 to determine which primary sites require tumor laterality coded. For tumors which are not listed as a paired organ, code '0' (organ is not a paired site).

*Diagnostic Confirmation

Refer to the prompt box and select the appropriate method of diagnostic confirmation. (See Section 1, pages 15-16 for instructions for coding diagnostic confirmation).

*Lymphovascular Invasion

The primary source of information about lymphovascular invasion is the pathology report. Code the absence or presence of lymphovascular invasion as stated in the pathology report. Refer to the prompt box and select the appropriate code. If there is no pathology report, code this field to 9. Use code 8 for the following sites: lymphoma, leukemia, hematopoietic and reticuloendothelial disorders, myelodysplastic syndromes, and myeloproliferative disorders. Refer to the SEER manual for details.

*Text-DX Proc Path

Record information from the pathology report(s). Include date and type of procedure, tumor site, tumor size, histologic type, behavior type, grade, involvement of resected margins, number of nodes removed,

number of nodes positive, lymph-vascular invasion and any related pertinent comments or addendums made by the pathologist.

Example: 9/5/16 RLL lung resection: Adenocarcinoma, Grade 2, tumor size 2.5cm. 00/03 LNs. Margins clear. Negative LVI.

Other Primary Tumors 1-3:
Record information relating to prior reportable cancers the patient has had that are documented in the medical record.

Example: 2015 Left Breast Cancer

Stage Of Disease At Diagnosis

Page 4

***Directly Assigned SS2018:**
The Summary Stage 2018 v2.1 manual should be used to assign directly assigned SS2018 beginning with cases diagnosed 01/01/2018 and later. You may also use the Registrar Staging Assistant but please keep in mind that the general rules are not in the assistant. Refer to the summary stage manual for the general rules.

- SEER*RSA 2.1 for cases diagnosed 01/01/2022 and after
- SEER*RSA 2.0 for cases diagnosed 01/01/2021 and after.

Refer to the table below as a reference for selecting the appropriate code

Code	Label
0	In situ
1	Localized only
2	Regional by direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension AND lymph node involvement
7	Distant site(s)/node(s) involved
8	Benign/borderline*
9	Unknown if extension or metastasis. (unstaged, unknown, or unspecified). Death Certification only

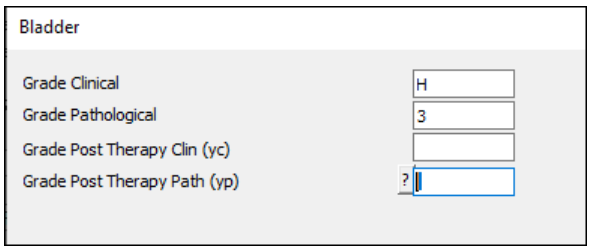
*Applicable for the following SS2018 chapters: Brain, CNS Other, Intracranial Gland

Site-Specific Data Items (SSDI)

The Site-Specific Data Item (SSDI) button will display at the bottom of every page once the Primary Site Histology and diagnosis date have been coded. Click the SSDI button to display the Grade Data Items and the SSDIs. The OCCR only requires 15 SSDIs across all primary site schemas. Please reference the SSDI required list in section 1.

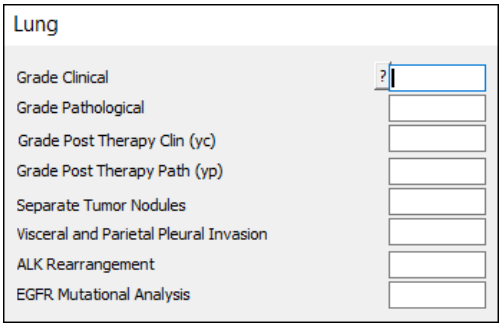
Note: All SSDIs will be shown in RMCDS. However, you are only required to report the 15 on the list. Some sites will also require a schema discriminator to be coded as well.

A. If a primary site/ histology combination does not require SSDIs, only the Grade Data Items will display.



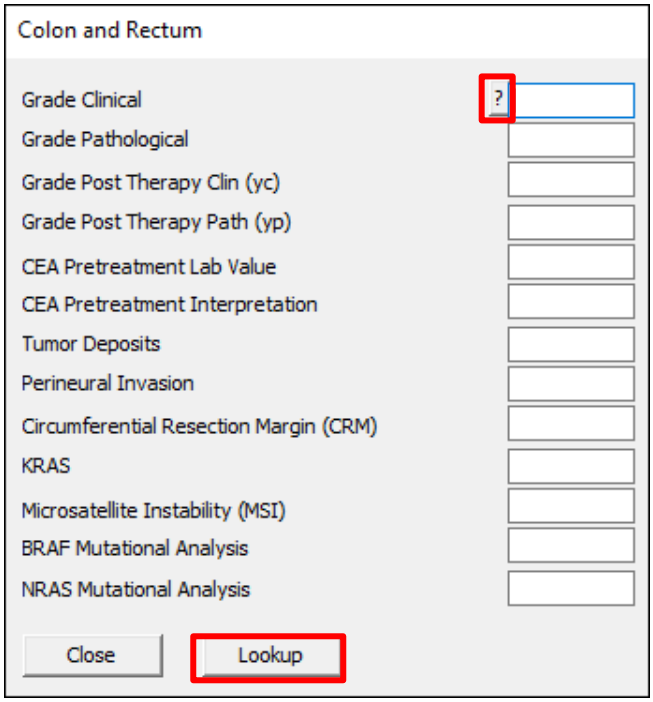
B. If a primary site/histology combination does require SSDIs, they will display after the Grade Data Items. DIFFERENT PRIMARY SITE/HISTOLOGY COMBINATIONS WILL HAVE THEIR OWN INDIVIDUAL SSDIs.

Example:
Lung adenocarcinoma has four SSDIs – *Separate Tumor Nodules* and *Visceral and Parietal Pleural Invasion, ALK rearrangement, EGFR Analysis.* Please refer to the required SSDI table for OCCR required items.

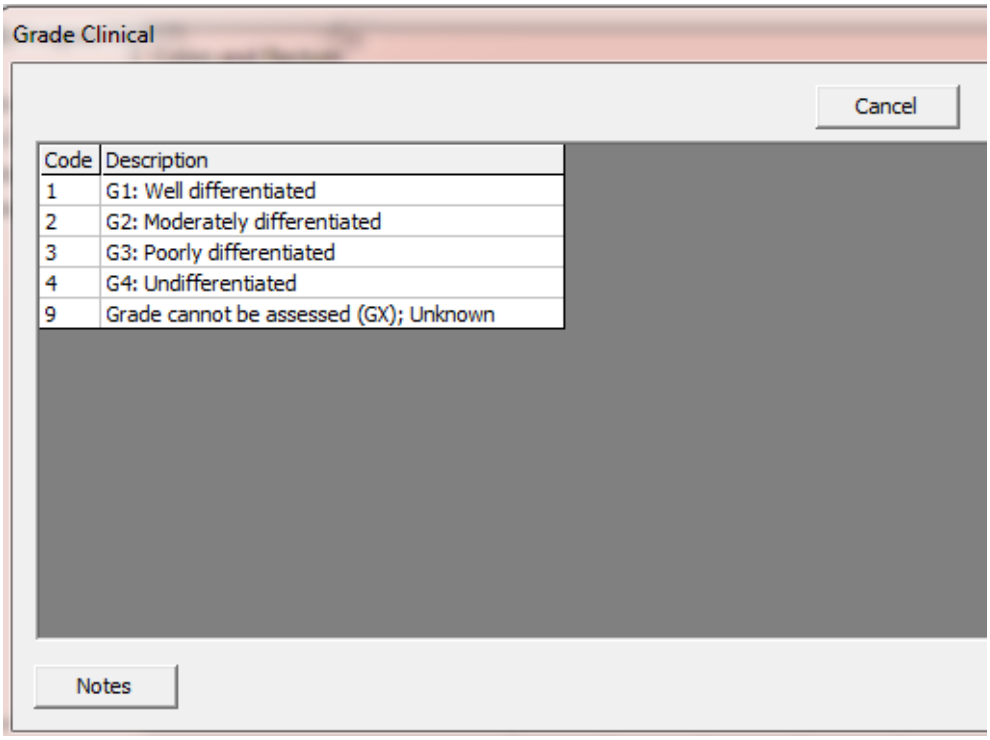


Site-Specific Data Items (SSDI) Grade

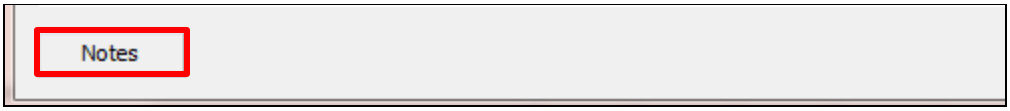
For both Grade Data Items and SSDIs, there is a look-up available. Select a data item text box and then click the either the question mark button or look-up button. A list of available choices for that data item will display.



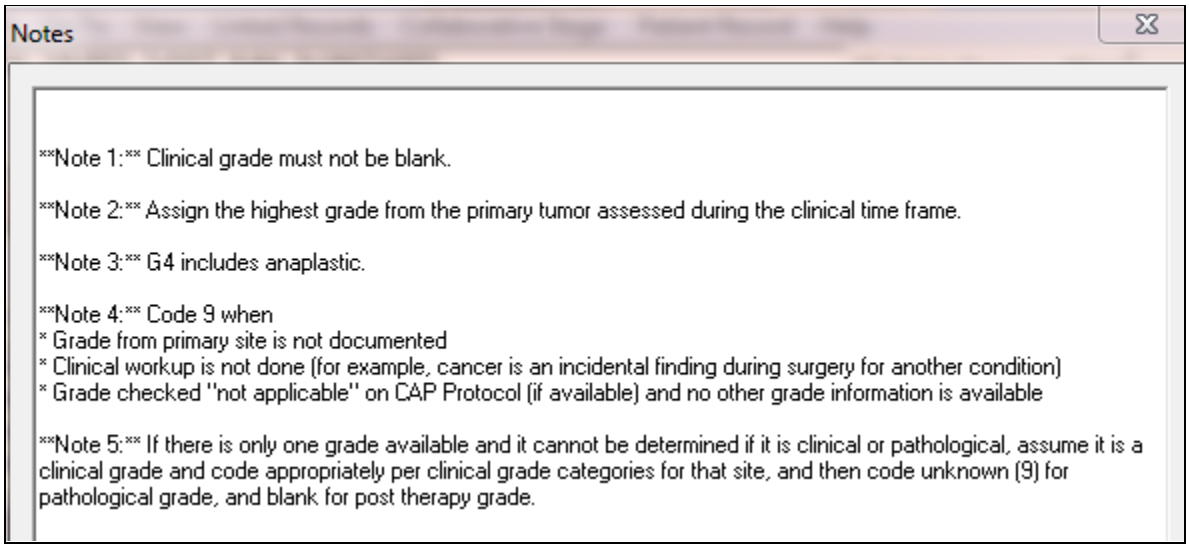
For example, the look-up for Grade Clinical for Colon and Rectum displays the following choices:



In addition, notes relating to how to code the data item can be viewed by clicking the Notes button.



For Grade Clinical for Colon and Rectum, the following notes are displayed:



Required SSDIs must be coded in order to clear edits.

Prognostic Factors

Page 5

*Tumor Size Summary

Record the largest dimension or diameter of the primary tumor in millimeters in a 3-digit field. 1 centimeter (cm) is equal to 10 millimeters (mm). To convert centimeters to millimeters, multiply by 10. Use the search icon and select an appropriate tumor size if no exact measurement is stated.

Example: Tumor is described as 3.5 cm. 3.5 cm x 10 = 35 mm. Record Tumor Size as 035.

*Regional Nodes Positive:

Record the exact number of lymph nodes positive. If you do not know the exact number, Use the help button and select the appropriate code to record the number of regional lymph nodes examined by the pathologist and found to contain metastases. Distant nodes should not be recorded in this field.

- If there was only a positive aspiration of a lymph node, use code 95 for both pos and examined.

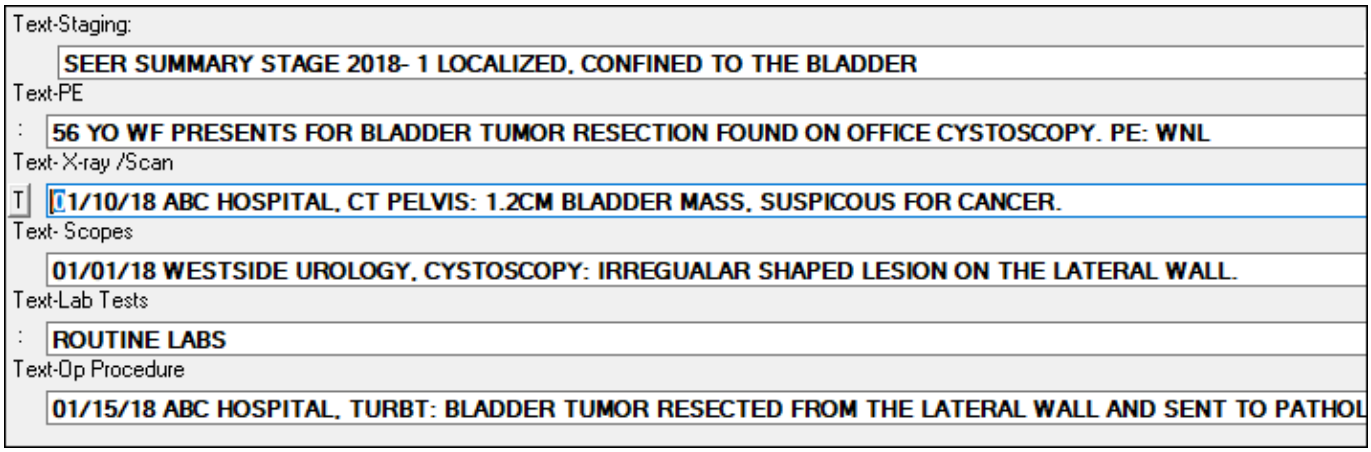
*Regional Nodes Examined:

Record the exact number of lymph nodes examined. If you do not know the exact number, use the help button and select the appropriate code to record the total number of regional lymph nodes that were removed and examined by the pathologist. Distant nodes should not be recorded in this field.

Text-Diagnosis

Page 5

***See Instructions in Section 1, page 19 for OCCR Standardized Text Format**



*Text- Staging:

Document Summary Stage 2018 and elements that justify the coded summary stage.
OCCR no longer requires assigning the TNM stage. However, documentation of the clinical and pathologic TNM stage as documented in the medical record is requested. Include any pertinent information not already mentioned in the abstract that contributes to staging.

SS2018 Colon Example: SEER Summary Stage 2018- 4 Reg by Dir Ext to pericolic fat + Reg to LNs, Pericolic

***Text-PE:**

Document the patient's history of the tumor and the clinical description of the tumor from their history and physical. Document any risk factors. Include gender, age, race and ethnicity. If *Physical Exam* is unknown or not applicable, record "No PE". Do not leave blank. You should always be able to record at least the patient's age, race (if collected) and sex and a note about the physical exam.

How to document in text field: *54 year old white male with a dark brown area on the left forearm approximately 1 cm. History of smoking, 2 packs a day for 20 years. No personal history of cancer.*

***Text-X-ray/Scan:**

Record all imaging examinations which provide information on tumor characteristics. Include the date tests were done, location of X-ray/Scan, type of X-ray/Scan and a brief description of the pertinent positive or negative findings.

Example: 11/21/18 XYZ Hosp, CT Chest: 2.5 cm lesion within the RML of lung with hilar and mediastinal adenopathy

***Text-Scopes:**

Record all endoscopic examinations. Include procedure, tumor location and pertinent positive or negative clinical findings.

Example: 8/4/18 XYZ Hosp, Colonoscopy to cecum: Apple core lesion in the descending colon 60cm from the anal verge extending to 63cm, biopsy taken. 2 polyps in the transverse colon at 94 and 110 cm removed with snare polypectomy.

***Text-Lab Tests:**

Record all pertinent information from lab examinations other than cytology or histology. Include dates and names of any pertinent lab tests performed along with values, interpretation of the result and the normal range prom the processing lab.

Example: 9/15/18 CEA 800, high, range <2.5 non-smoker, <5.0 smoker
PSA 10, high, range <0.0-4.0.

***Text-Op Procedure:**

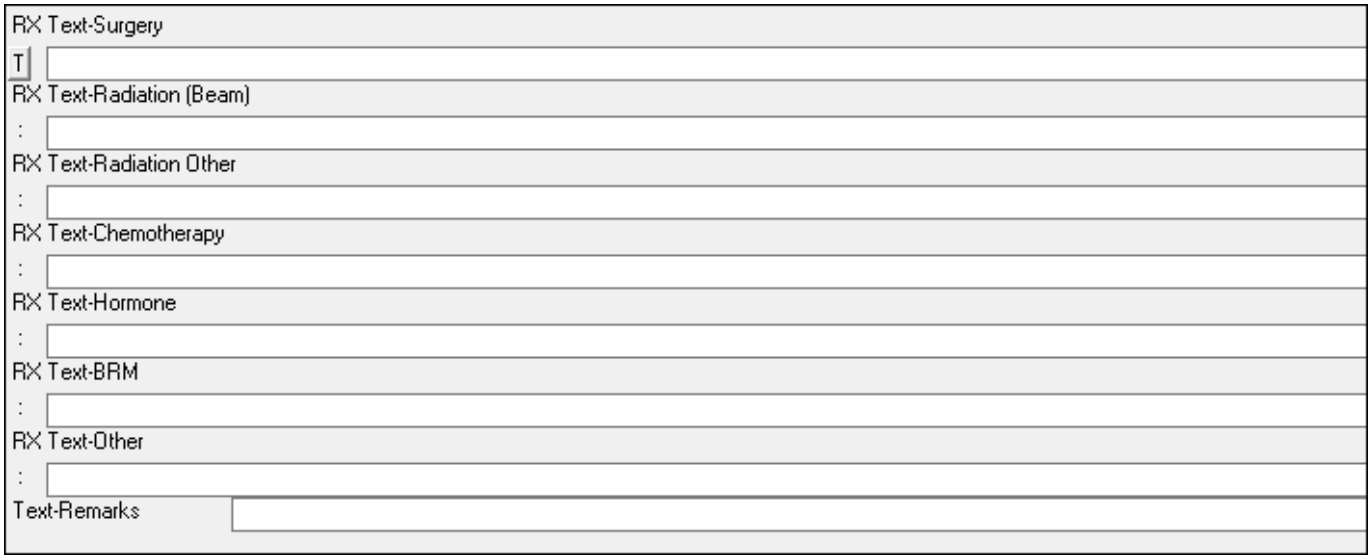
Record all diagnostic procedures which provided information for diagnosis. This includes biopsy procedures and surgical procedures. Include the date, name location of the procedure and pertinent findings from the procedure. If *Operative Procedure* is unknown or not applicable, record 'NONE' in the text field. Do not leave blank.

Example: 8/6/18 XYZ Hosp, USG Rt Breast needle bx: successful needle biopsy at 10:00.
09/10/18 XYZ Hosp, Rt Breast Wire Loc Lumpectomy + SLN Bx: elliptical incision made around the wire and tissue excised. 1 hot node located in the Rt axilla and excised.

Text – Treatment

Page 6

***See Instructions in Section 1, page 19 for OCCR Standardized Text Format**



***RX Text-Surgery:**
Record information from the operative report. Include date and location of surgery, name of procedure performed, and any surgical findings noted.

> ***Example:*** *2/12/18 XYZ hosp: Right hemicolectomy: 7 cm mass in right colon. No liver mets. No enlarged lymph nodes.*

***RX Text-Radiation (Beam):**
Record any treatment of tumor with beam radiation. Include beginning date, end date, type of beam radiation and area radiated.

> ***Example:*** *Hosp XYZ: 1/10/18 – 2/27/18 IMRT to breast*

***RX Text-Radiation Other:**
Record any treatment of tumor with radiation other than beam. This includes brachytherapy and systemic radiation therapy. Include the date, type of radiation and area radiated.

> ***Example:*** *4/2/2018 XYZ hosp: iodine 131 or 2/1/18 XYZ hosp: radioactive seed implant to breast*

***RX Text-Chemotherapy:**
Record any chemotherapy treatment given. Include the start date, name of drugs administered, and location.

Example: *2/2/2018 XYZ hosp: Carboplatin x 6 cycles*

***RX Text - Hormone:**
Record any hormonal treatment given. Include start date, name of drugs administered and location.

Example: *10/20/18 Dr. Jones office: Lupron*

***RX Text- BRM (Immunotherapy):**
Record any treatment with biologic response modifiers or immunotherapy. Include the start date, name of drugs administered and location.

Example: *6/4/18 ABC Cancer Center: Herceptin*

***RX Text - Other:**
Record any information regarding treatment that cannot be defined as surgery, radiation or systemic therapy. This includes experimental treatments.

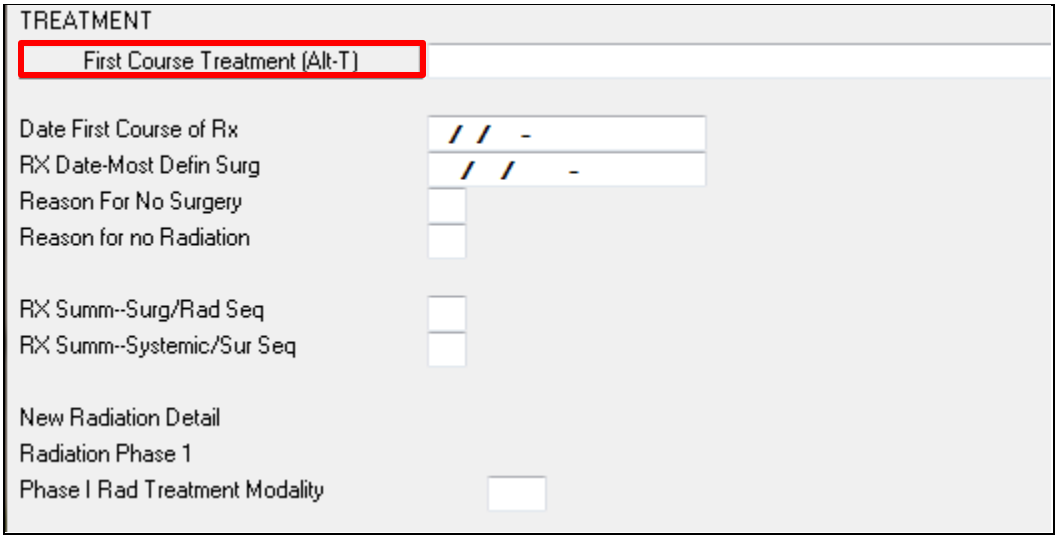
Example: *4/1/18 Clinical Trial, NOS*
3/26/18 Pt chose no treatment, went to hospice

***Text- Remarks:**
Document any relevant information that does not belong in another text section.

First Course Treatment Box

Page 7

First Course Treatment Box - To view the First Course Treatment box, select the **'First Course Treatment (Alt-T)'** button adjacent to left of the first text box. Holding down 'Alt ' and the letter 'T' button on the keyboard will also work.



Date Flags - If the treatment is coded, there must be a date recorded for that treatment. If there is no date available, use the appropriate flag button to provide a reason for the missing date. Use all the available information to estimate a date. A blank date should be a last resort.

DATE FLAGS

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown whether any therapy administered).

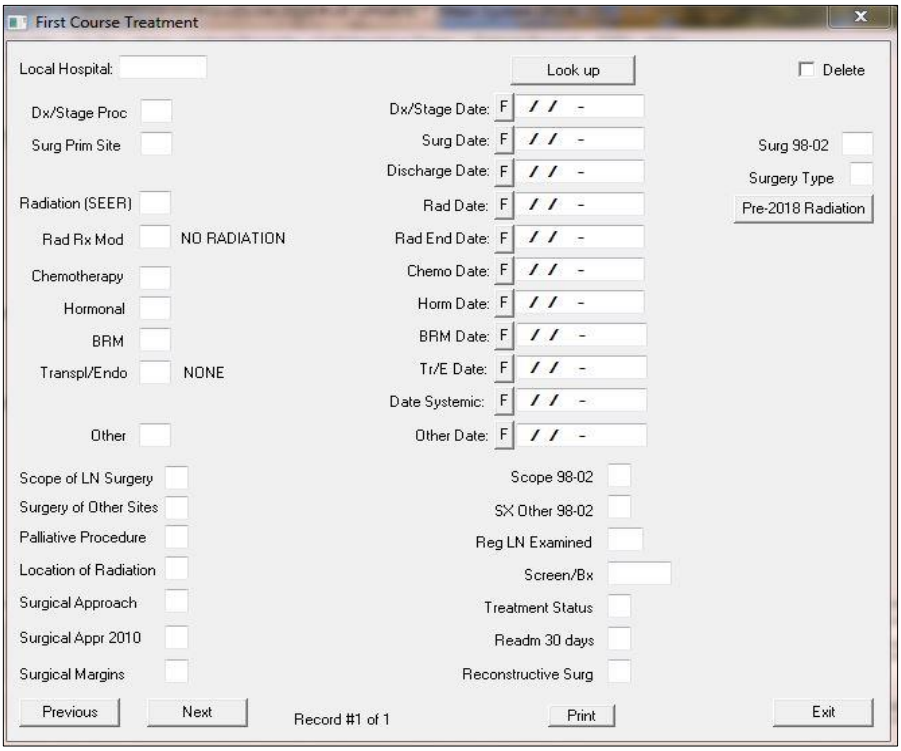
11 No proper value is applicable in this context (e.g., no therapy administered or autopsy only case).

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., therapy given but date unknown).

15 Information is not available at this time, but it is expected that it will be available later (e.g., therapy is planned as part of the first course of therapy but had not been started at the time of the most recent follow-up).

Document all applicable treatment with corresponding date in the appropriate date field. The following instructions will cover required fields that cannot be left blank.

Code Look Up - Coding options for each field can be viewed by placing your cursor in the field and selecting the 'Look up' button located to the upper right.



Local Hospital:
Each facility is given an ID number. Place your facility ID number here or use the 'Look up' button to search. All diagnosis and treatment at your facility is entered on treatment screen 1. All diagnosis and treatment performed elsewhere is entered on treatment screen 2 using local hospital 999.

***Dx/Stage Procedure:**
Required if biopsy is performed
Select the appropriate diagnostic procedure, usually biopsy of primary site or biopsy of other site.

***Surgery Prim Site:**
Select the appropriate surgical code. If multiple surgeries were performed, code the most invasive surgery. If surgery is coded, both Surg Date and Discharge Date fields must have a date or a flag. A complete list of site specific surgical codes and notes can be found in Appendix B of the STORE Manual.

***Scope of Reg LN Surgery:**
Select the highest appropriate code regarding the removal, biopsy, or aspiration of regional lymph nodes in an effort to diagnose or stage the disease. Some primaries and histologies will always require this field to be coded as 9. Please refer to page 248 of your STORE manual for these sites and histologies.

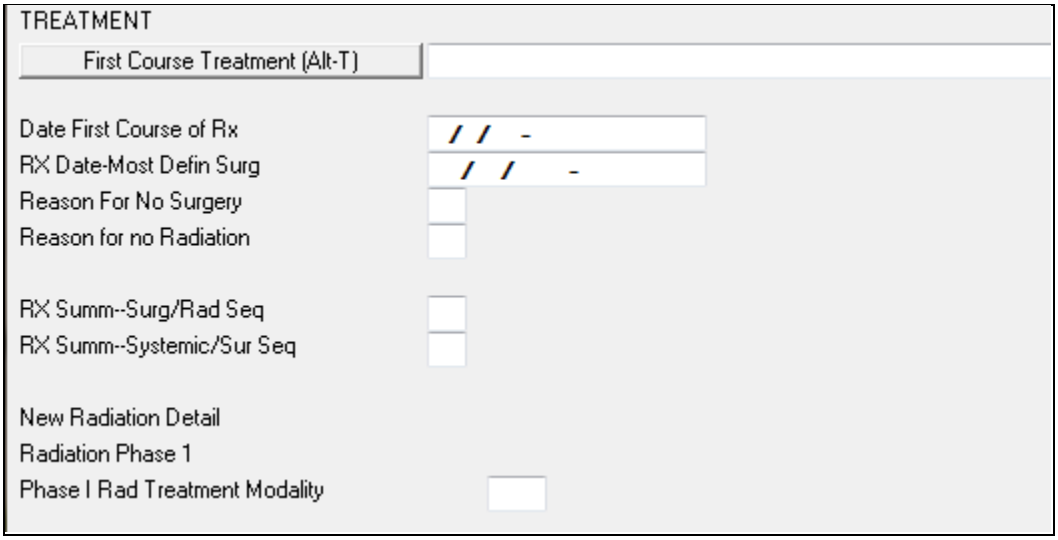
***Surgery of Other Sites:**
Select the appropriate code regarding surgery performed to other regional sites or other metastatic sites.

***Treatment Status:**

Select the appropriate code to summarize the type of treatment, if any, the patient received.

Treatment

Page 7



Date First Course of Rx:
Record the date that the patient first received treatment, or date surgical procedure was performed in an effort to remove cancer. This includes dates decisions were made to not treat. If no date is available, use the flag button to give a reason. Use all available information to estimate the date. A blank date should be a last resort.

RX Date-Most Defin Surg:
Record the date of the most definitive surgical procedure of the primary site performed as part of the first course of treatment. If no date is available, use the flag button to give a reason. Use all available information to estimate the date. A blank date should be a last resort.

Reason for No Surgery

Select the blank field and refer to the prompt box at the top of the page or use the to select the reason for no surgery or if surgery was done.

Reason for No Radiation:

Select the blank field and refer to the prompt box at the top of the page or use the to select the reason for no radiation or if radiation was given.

RX Summ-Surg/Rad Seq:

Select the blank field and refer to the prompt box at the top of the page or use the . Select the timing sequence that surgery was given in relation to radiation treatment.

RX Summ-Systemic/Surg Sequence:

Select the blank field and refer to the prompt box at the top of the page or use the . Select the timing sequence that the patient was systemic in relation to surgery.

New Radiation Detail
Radiation Phase I

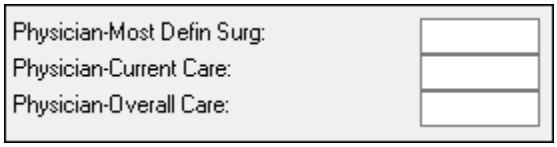
Phase I Rad Treatment Modality

Select the appropriate phase I radiation treatment modality if applicable. If no radiation therapy was administered, record '00'.

Physician Information

Page 7

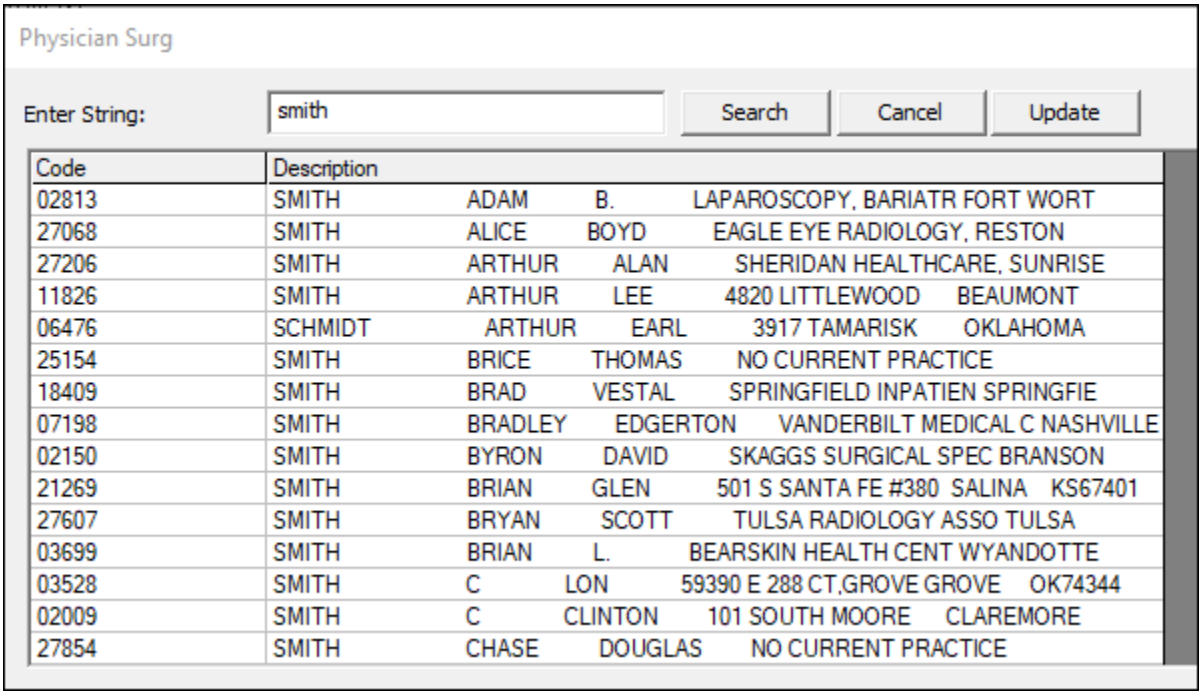
Physician information is not required; however, if the information is available please add the physician in the appropriate fields. Physician information can be searched for by selecting the help button adjacent to the field.



***Physician – Most Def Surg:** Physician who performed most definitive surgery
***Physician – Current Care:** Physician overseeing patient care for this cancer. Example: Oncologist
***Physician – Overall Care:** Primary care physician (PCP)

To Search for a Physician:

1. Click on the button to view the physician lookup window
2. Type in the last name of the physician and then select 'Find'
3. Select physician by double clicking the number to the left of the physician name

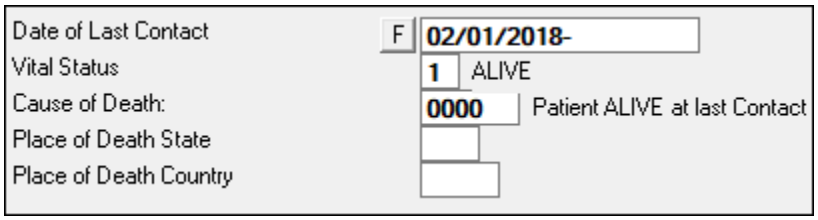


NOTE: If a physician is not listed in the Physician Lookup table, you should add the physician by using the update button. Use the physician lookup at the Oklahoma Board of Medical Licensure to find the physicians license number. If the physician is out of state, you may add it or document the name in Text--Remarks.

Patient Outcomes

Page 8

Patient outcomes fields provide information on when the patient was last seen, vital status, death information if applicable.



Date Last Contact or Death:

Record the date of last contact with the patient or record the date of death.

Vital Status:

Refer to the prompt box above and select the vital status of the patient. If the patient has multiple tumors, vital status should be the same for all tumors.

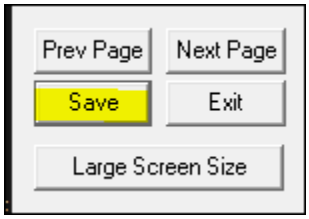
Place of Death State:
Record Place of Death State, if applicable, by selecting the help button and searching for the correct geocode for the state the patient passed away in.

Place of Death Country:
Record Place of Death Country, if applicable, by selecting the help button and searching for the correct abbreviation for the country the patient passed away in.

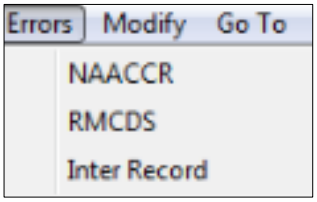
Save Abstract and Run Data Edits

After completing the abstract you will need to run edits to ensure accuracy.

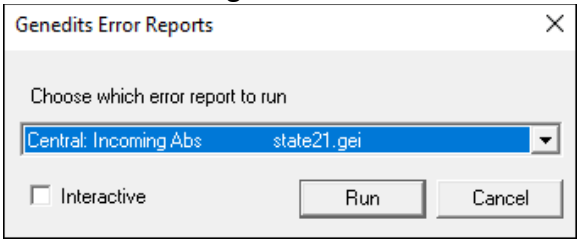
1. Save the abstract by clicking the, 'Save' button located on the bottom left corner.



2. Select 'Errors' from the menu at the top of the abstract.
    a. From the Errors menu select click 'NAACCR'.

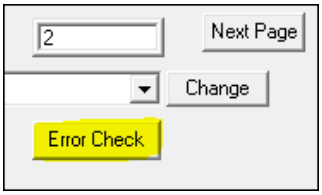


    b. A box labeled Genedits Error Reports will open. From the dropdown menu select, 'Central: Incoming Abs'.

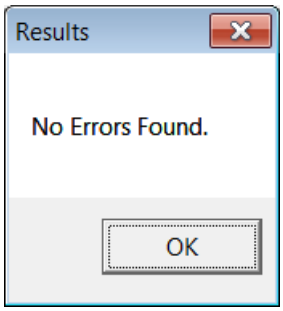


    c. If you choose, you may run the error check in interactive mode. This will allow you to see the errors and make corrections directly in the abstract. Check the box if desired.
    d. Click Run

3. Alternatively you may use the 'quick' Error check button located on the bottom left of the abstract window. This must be set up for use by each user in Parameters> Personal tab.



Scenario #1: *No Errors Found:*

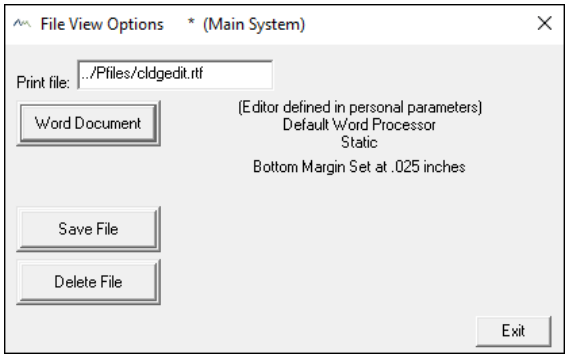


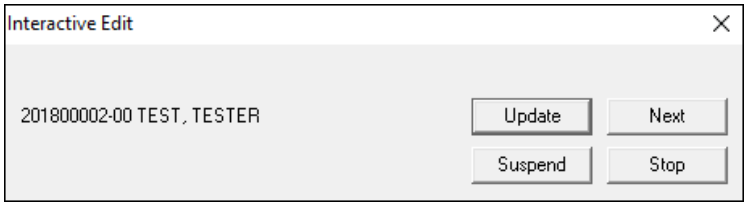
The abstract is without error and a results box stating, 'No Errors Found' appears. Click 'OK'.

The case is complete. You may now close the abstract.

Scenario #2: *Abstract Error:*

If the abstract has errors, depending on if you run interactive edits, either the option to print the error report or an interactive edit window will appear.



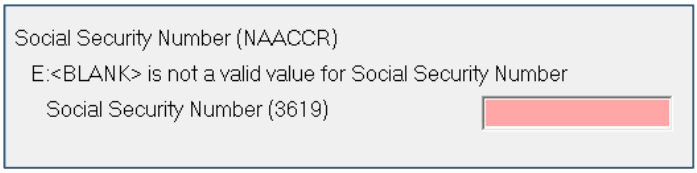


To view the edits in a Word Document:

1. Select 'Word Document' and Microsoft word document with the edit results will open.
2. Correct any errors and re-run the error check.
3. Continue this process until all errors have been cleared.
4. If necessary, use the NAACCR edits detail report for help resolving errors.

To view the edits in Interactive Edits:

1. Select 'Update'. Any corrections that need to be done will appear.
2. It will show you the field name, the edit, and a brief description of the error.



3. Correct the error and re-run edits.
4. Continue this process until all errors have been cleared.
5. If necessary, use the NAACCR edits detail report for help resolving errors.

Note: Sometimes an abstract will have multiple fields to correct. An error in one field may cause several fields to appear in pink. Always look next to the 'E:____' to identify the error message.

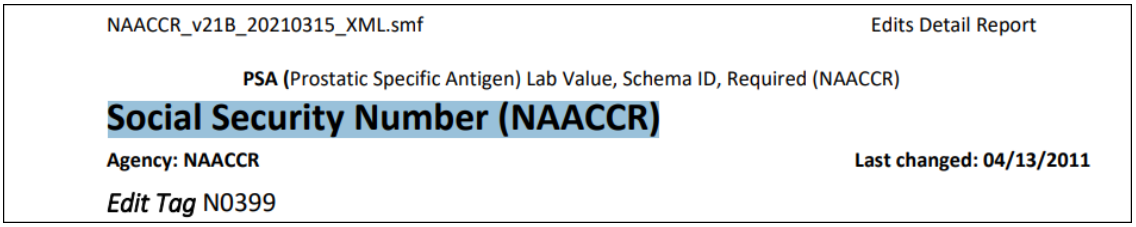
Correcting Edit Errors

If you are unsure what the error means, follow the steps below:

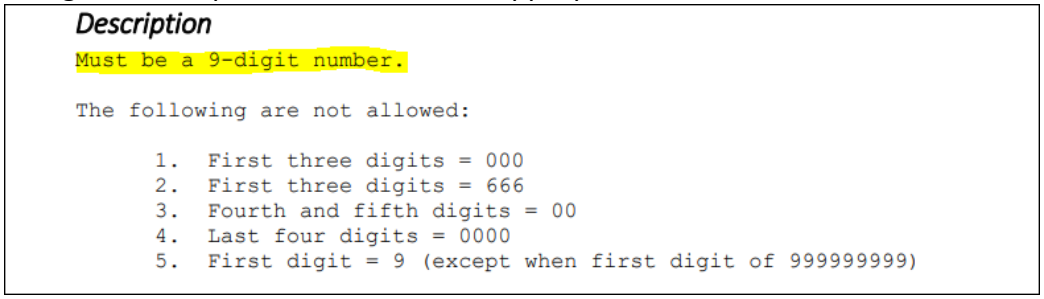
1. Using your web browser, go to the NAACCR Edits Detail Report which can be found here: https://www.naaccr.org/wp-content/uploads/2022/03/Edit-Detail-Report-v22B.pdf

2. Search for the error in the document by pressing 'Ctrl + F' on your keyboard and typing in the error. Press the enter key on your keyboard.

3. The find function will search the document for the error. If the first result is not your error, click the down arrow or continue to press the enter button to move to the next result



4. Review the Detail Report
5. Using the description rules, make the appropriate corrections.



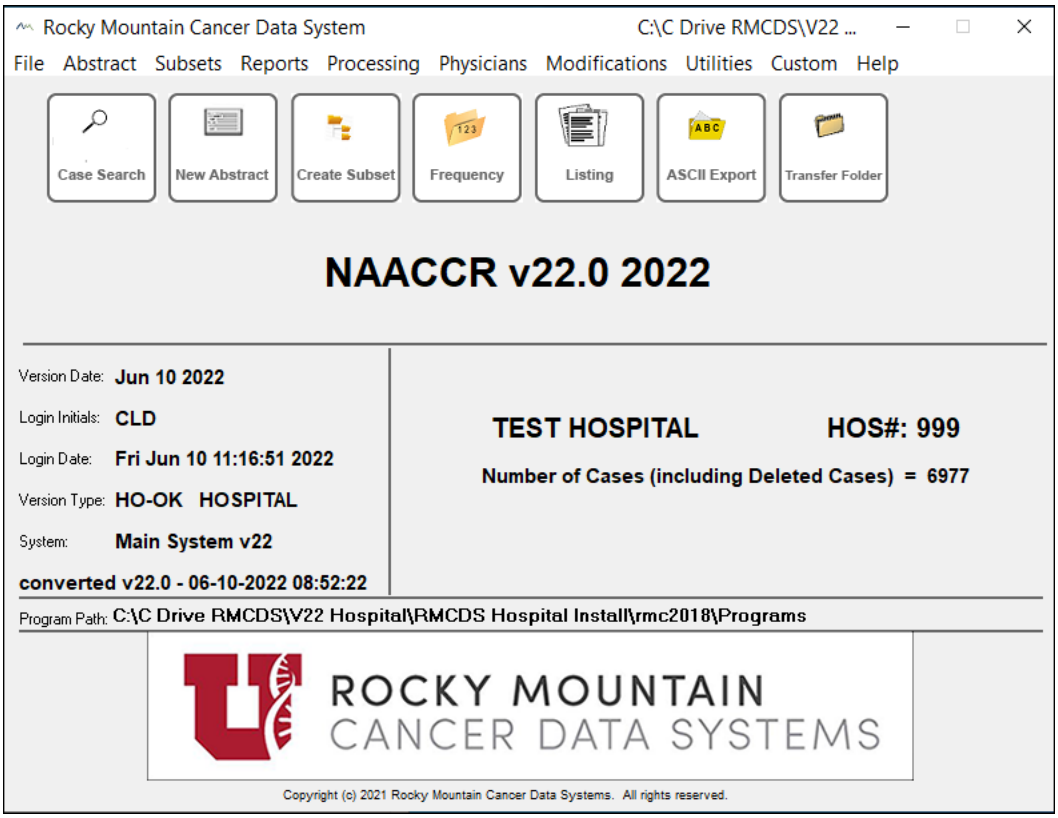
6. Save the abstract and re-run the edits.
7. Repeat process of correction until all edits are clear.

All edit errors must be resolved before the abstract can be considered complete and ready to be submitted. If you are unable to resolve the edit error, contact your facility consultant at the Oklahoma Central Cancer Registry.

Section 3:

RMCDS Software Instructions

Main Screen



NAACCR v: Current NAACCR version of the RMCDS system. NAACCR conversion is a separate update that should not be confused with the RMCDS software updates. This conversion is done annually according to the year of cases being abstracted and submitted. For example, 2022 cases should be abstracted and submitted in NAACCR v22.0. Conversions must be done in sequential order. Instructions to update will be sent out by the OCCR when available.

Version Date: Date last RMCDS software update was done. (Software update recommended monthly)

Login Initials: Initials of user logged in to RMCDS.

Login Date: Current Date and login time

Version Type: Version based on facility using RMCDS software. Hospital version includes every type of facility that reports to the Oklahoma Central Cancer Registry.

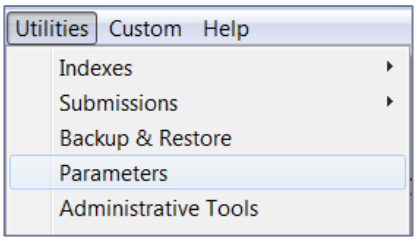
System: Current system or subsystem logged into.

Converted: Date of last NAACCR conversion.

Program Path: The program path is the directory on your local computer or network where RMCDS is located. The software must be mapped correctly to a letter drive in order to insure all components will function. Program Path can vary depending on the structure at your facility. If you do not know the path to RMCDS on your computer, look at line above the RMCDS logo on the main screen.

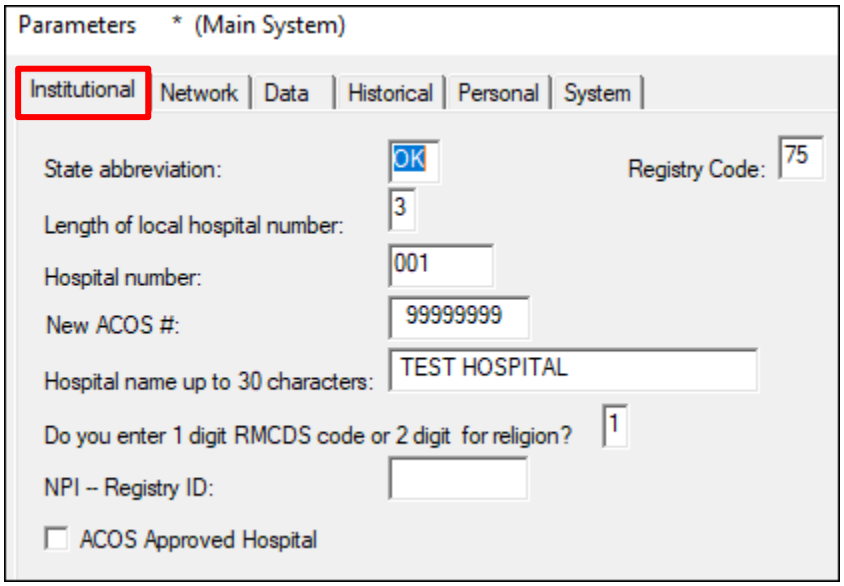
Setting Parameters

To enter the parameter program go to 'Utilities' on the Main Menu and choose 'Parameters'



Parameters will need to be completed upon initial installation and as new users are assigned login rights to RMCDS.

Institutional Parameters



Upon initial installation, RMCDS will not have your facility information. See below description for adding facility-specific information to your database.

State Abbreviation: The two letter state abbreviation of 'OK' should be in the state abbreviation field.

Registry Code: Oklahoma's NAACCR Registry number of 75.

Length of local hospital number: The next box will tell the programs how many digits you are using for your local hospital number. This should be set to 3.

Hospital Number: Enter the three digit number that was assigned to your facility by the OCCR.

New ACOS#: If you know your ACOS# (not common) you can enter it here. Otherwise, just enter all zeros followed by your facility id number (10 characters only).

Hospital name: Enter your facility name (up to 30 characters).

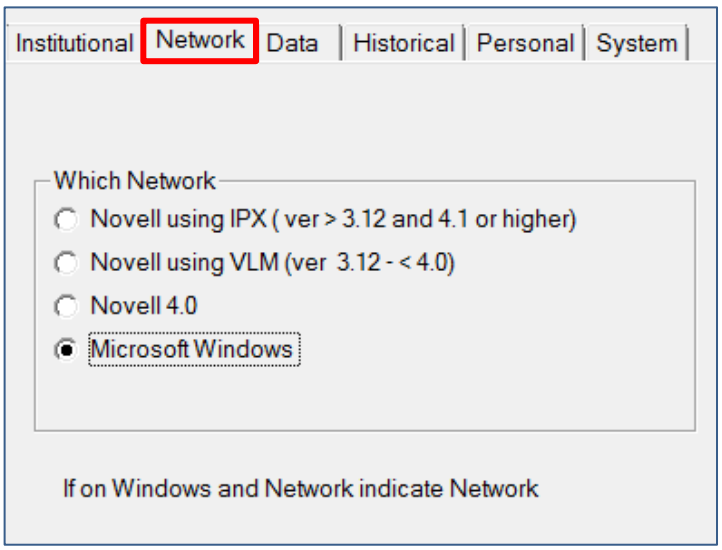
Religion: If you are collecting religion you may also choose to enter either the 1-digit RMCDS codes or a 2-digit code. *Note: religion is not a data item in the customized screen set 18. However, it is available in screen set 90 All Fields.*

NPI – Registry ID: If you know your NPI # you can enter it here. However, it is not required.

ACOS Approved Hospital: If your hospital is accredited by the American College of Surgeons Commission on Cancer (ACOS CoC) place a check mark in this box, otherwise no checkmark is needed. The CoC Accredited Flag will automatically enter in the abstract based on how this item is marked.

Network Parameters

Which Network: This is normally defaulted to "Microsoft Windows". If you are on both a network and Windows, you should indicate the network.

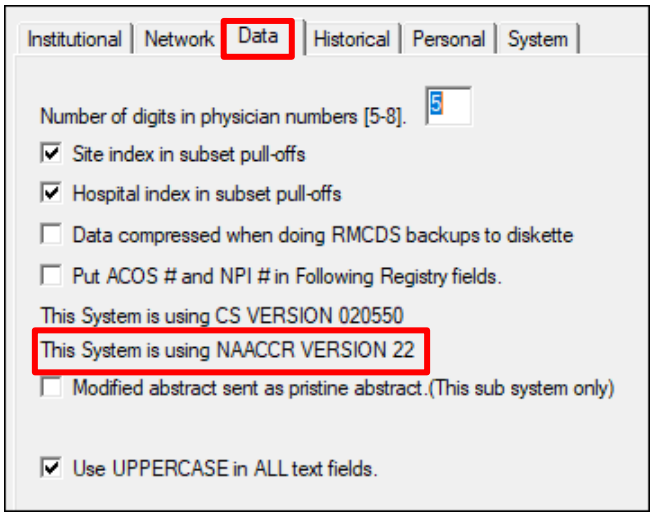


Data Parameters

These fields should be defaulted to the specifications displayed here. If not, please Select and/or Deselect so the first, second and last fields are marked with a checkmark.

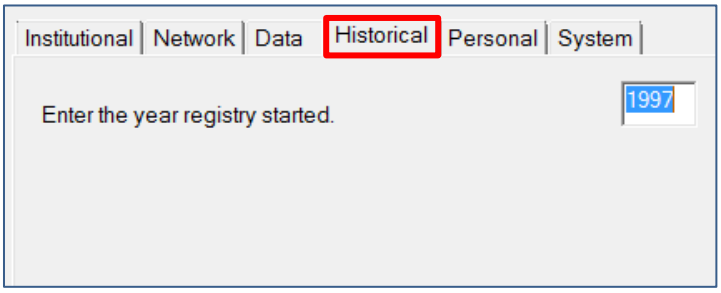
You can also verify your current NAACCR Version on this tab where it states

"This System is using NAACCR VERSION 22"



Historical Parameters

Enter the year that the facility began collecting cancer data.



Personal Parameters

Password: Click Yes to change your password for logging in to RMCDS.

Default screen set: Set both fields to *"18 OK Hospital"* if the facility is state report only. If the hospital is ACOS CoC approved use *"90 ALL FIELDS + CUSTOM FIELDS"*

Minimum and Maximum screen #: These can be left at the default '00' and '99' respectively.

Sys Switch prompt: Select this box if you have more than one system and you would like to be prompted to log in to each subsystem upon switching.

Text Editor: Leave as 'Default Word Processor'

Margin: Leave at 0.25"

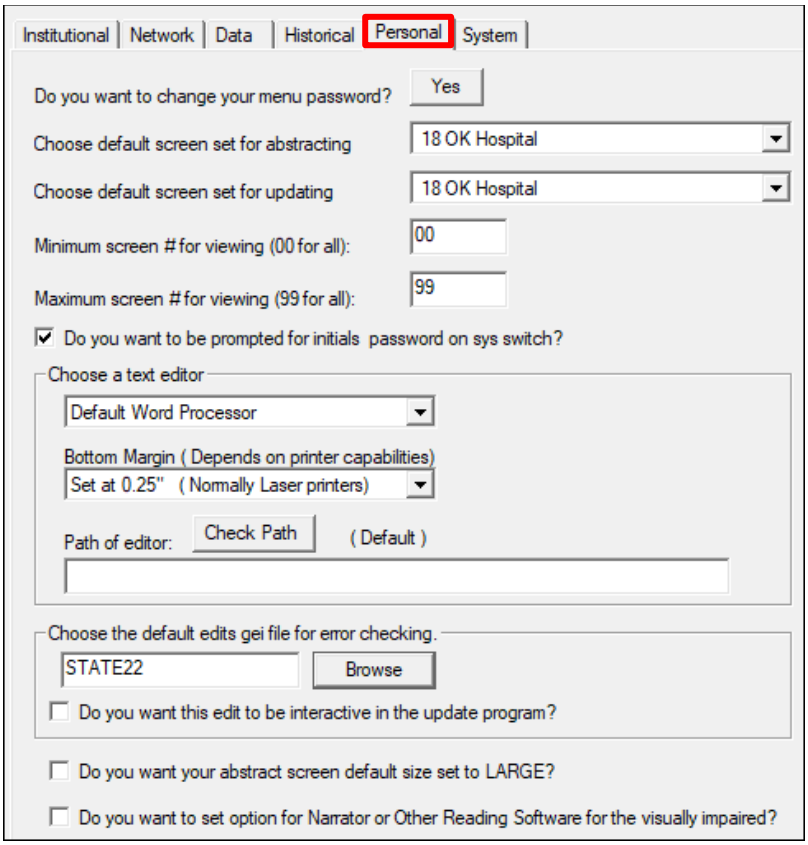
Path: To make sure your path is correct, click on 'Check Path'. You should receive a message that states "doesn't need path set up"

Quick Error Check Button Setup
Default edits: Click the Browse button and select STATE22.gei for state report only facilities.

Interactive edit: Check the box if you would like the errors to be displayed interactively within RMCDS. Do not check if you would like the report in MS Word.

Set Screen to Large: Check the box if you would like the abstracting screen defaulted to always open as the large view.

Set Visually Impaired Options: check the box to set option for narrator or other reading software for the visually impaired.

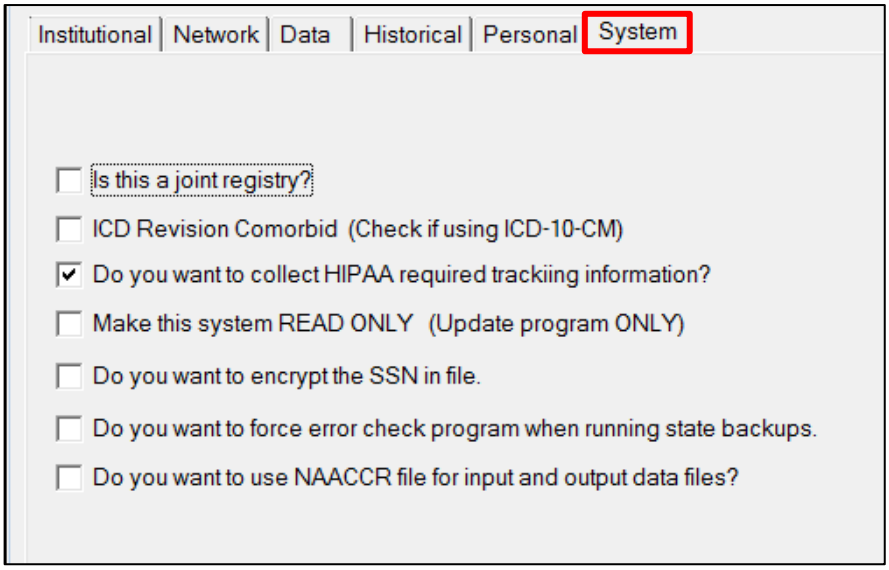


System Parameters

Joint Registry and ICD Revision: Used by ACOS CoC Accredited Hospitals only.

HIPAA Tracking: Turn this on to track data requests for HIPAA compliance.

Leave the remainder of the items unchecked.

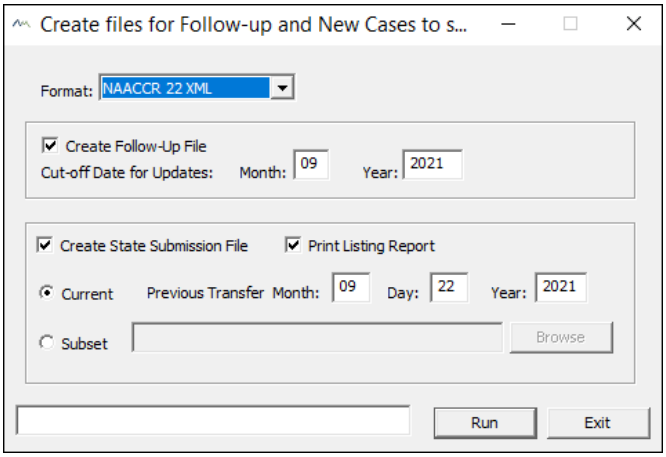


When all desired settings are updated, click OK to close the Parameters program.

Creating RMCDS State Submission

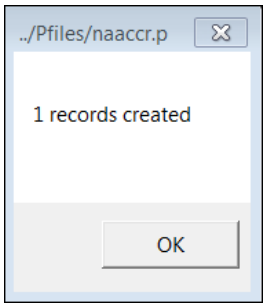
How to create a state submission file**:**

1. Open the Rocky Mountain system for which you want to create a submission file.
2. Click on **Utilities> Submissions** and then select **State**

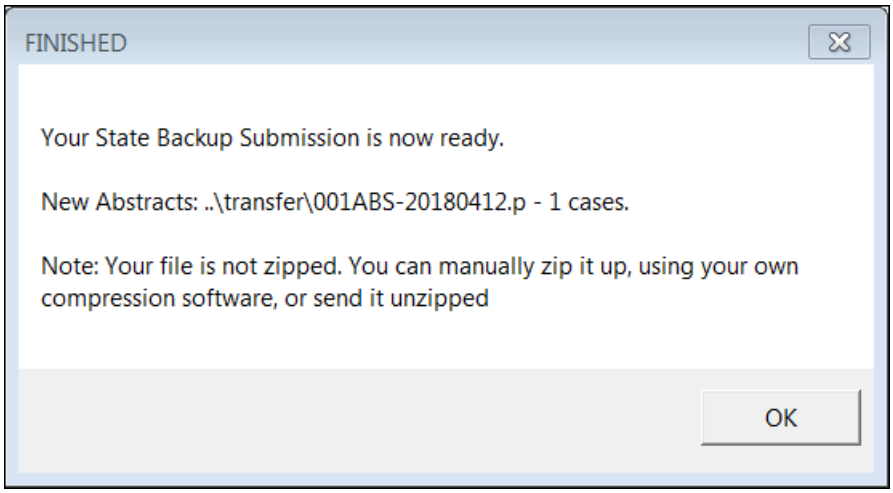


3. Make sure the format is defaulted to the most current NAACCR version.
4. UNCHECK 'Create Follow-Up file' box.
5. Previous Transfer date will be defaulted to the date of the last state submission was created.
6. Click **Run**.

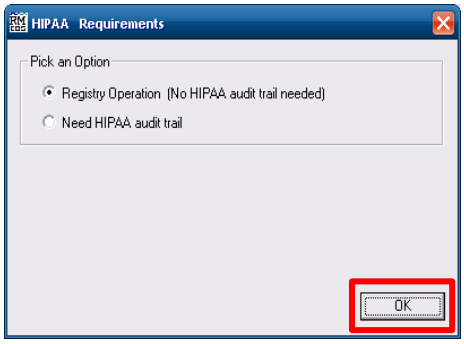
7. A message showing how many records were created will display. Click **OK.**



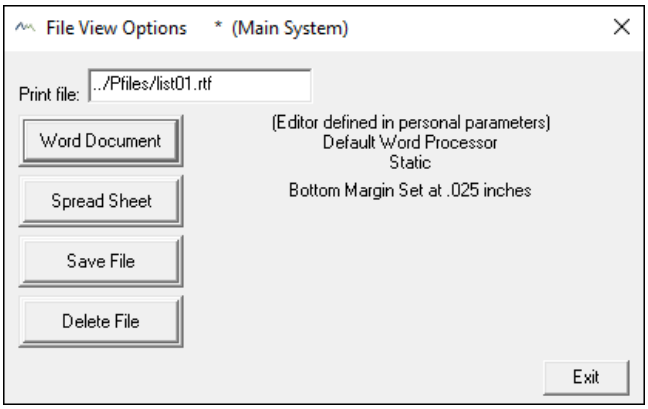
8. FINISHED:
   A window notifying you that your file is now ready appears. This window also tells you where your file is saved, what it is named and how many cases it contains. In this example the file is in the rmc2018/transfer folder, the file is called 001ABS-20180412.p and it has 1 case in it.



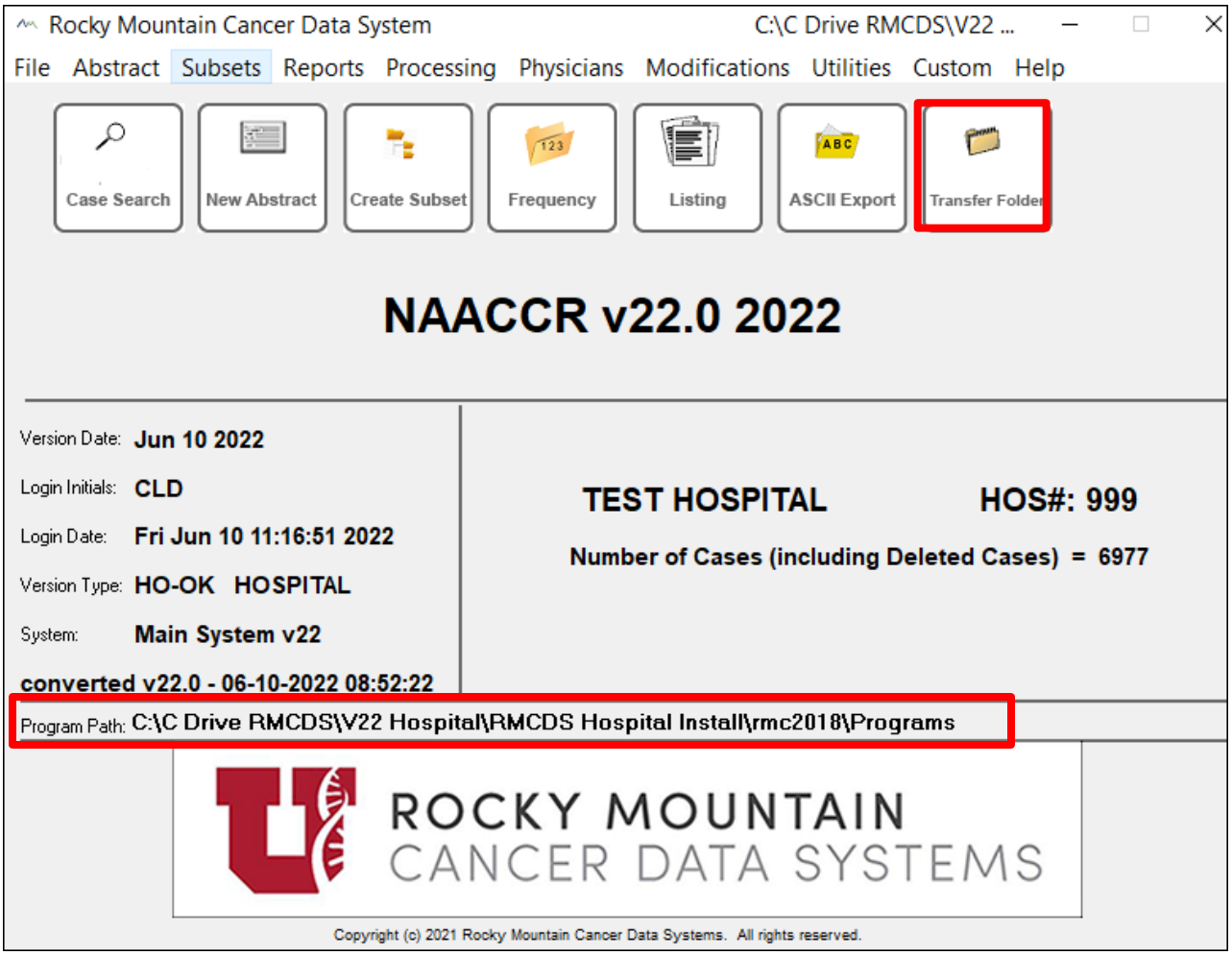
9. HIPAA Requirements
10. Select Registry Operation
11. Click **OK**.



12. View File Options:
    Click 'Word Document' to open the file in Word. Click 'Spreadsheet' to open the file in Excel. The list can be printed or saved electronically for your records. After you print or save your document, click Exit.
    Exit out of any remaining pop-up windows to return to the main screen.



13. Make note of the Program Path seen on the main Rocky Mountain screen. This will be the default location for your submission files. You can also access your submission files by choosing the Transfer Folder from the Quick Launch Buttons on the main screen.



14. You may now refer to the Web Plus Upload Instructions on the following page to submit the file to the state registry.

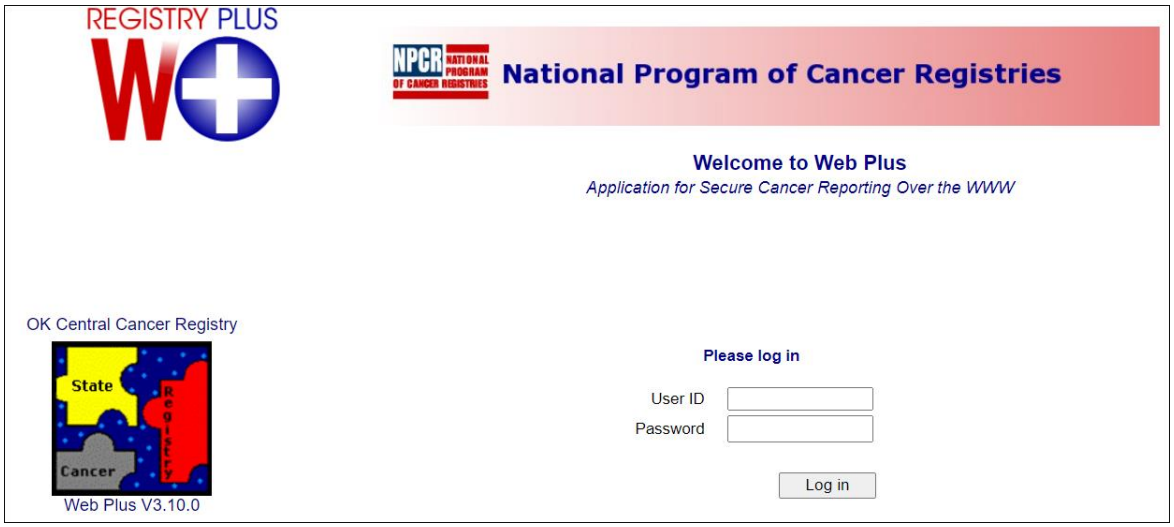
Web Plus Upload Instructions

How to upload an RMCDS submission file to Web Plus:

1. Open your internet browser and navigate to the following web address: https://occrweb.health.ok.gov

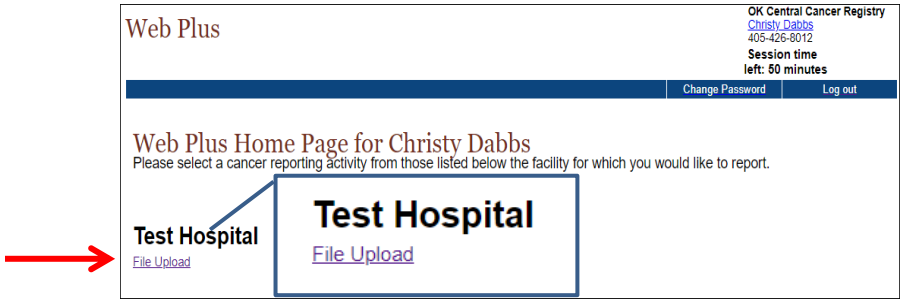
2. Type the User ID and password into the appropriate fields**. The OCCR provides the username, and the user creates their own unique password. If you do not have a user ID, please contact OCCR so that one may be assigned to you. Click **Log in**.

   Password & Challenge Questions
   If you have forgotten your password or challenge question answers, email christyd@health.ok.gov for a password or challenge question reset. The OCCR does not know your password or challenge question answers. New security measures require users to change their password every 90 days. The user will automatically be prompted to change the password when it has expired.

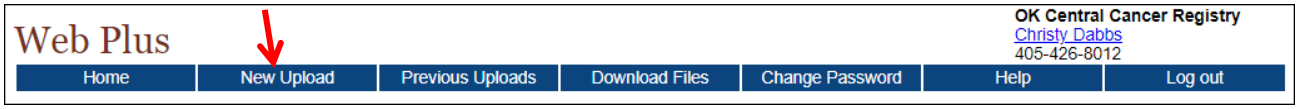


**First time users: The first time you log into Web Plus you will be prompted to change your password. Proceed to step 3 after you change your password. You will also be prompted to set up three challenge questions.

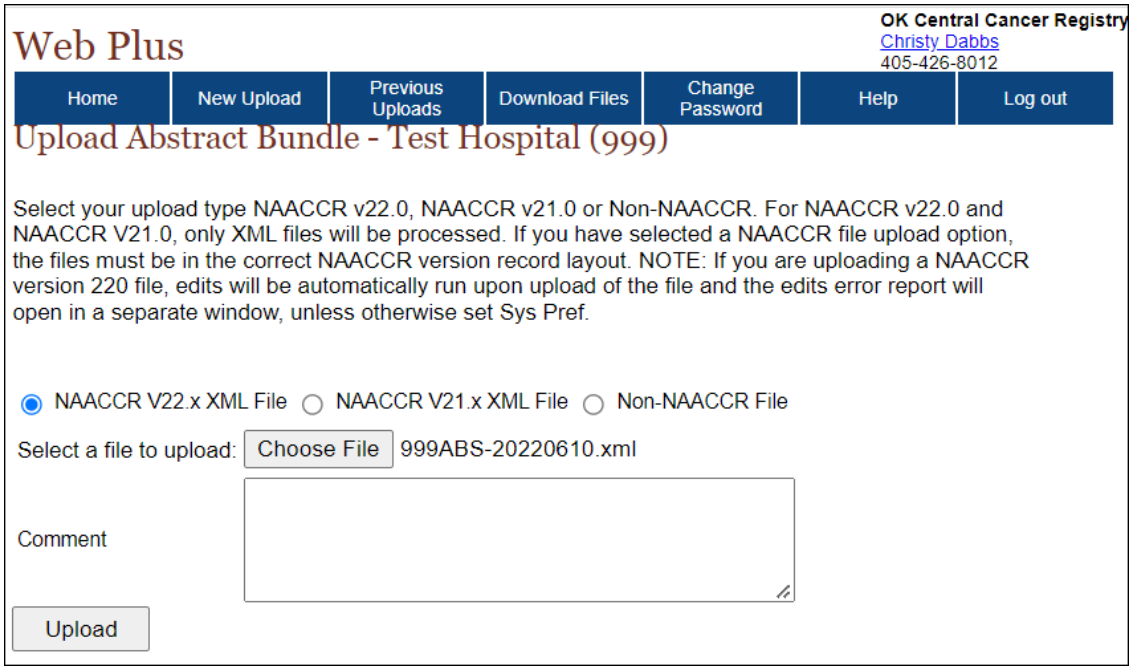
3. Click **File Upload**.



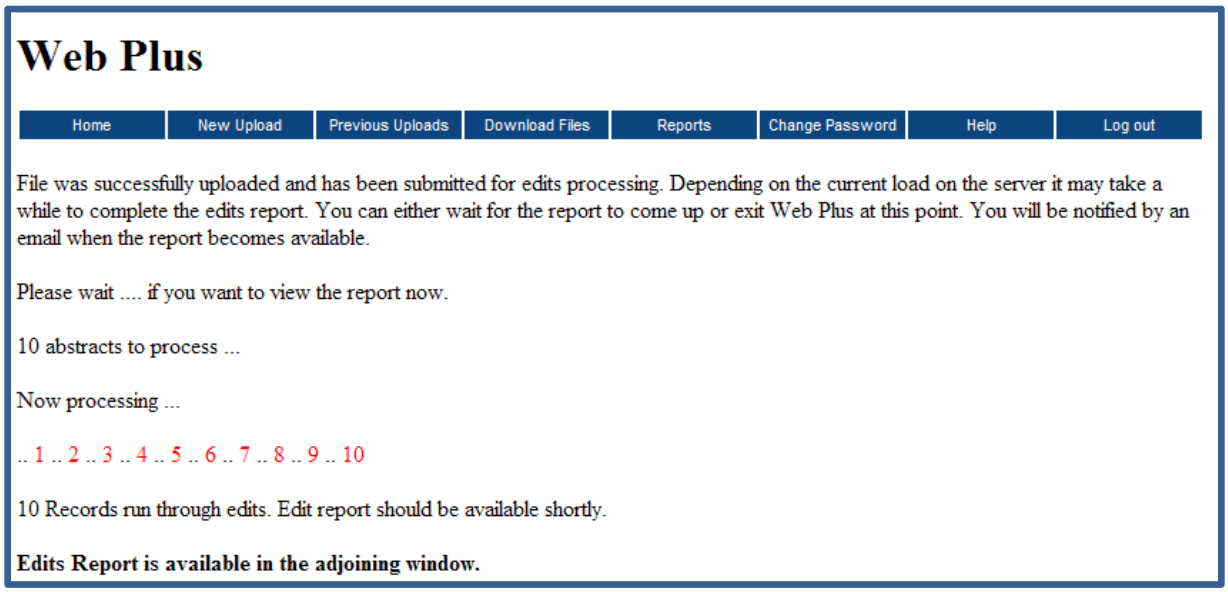
4. Click **New Upload**



5. Select the **NAACCR V22.x XML File** upload type

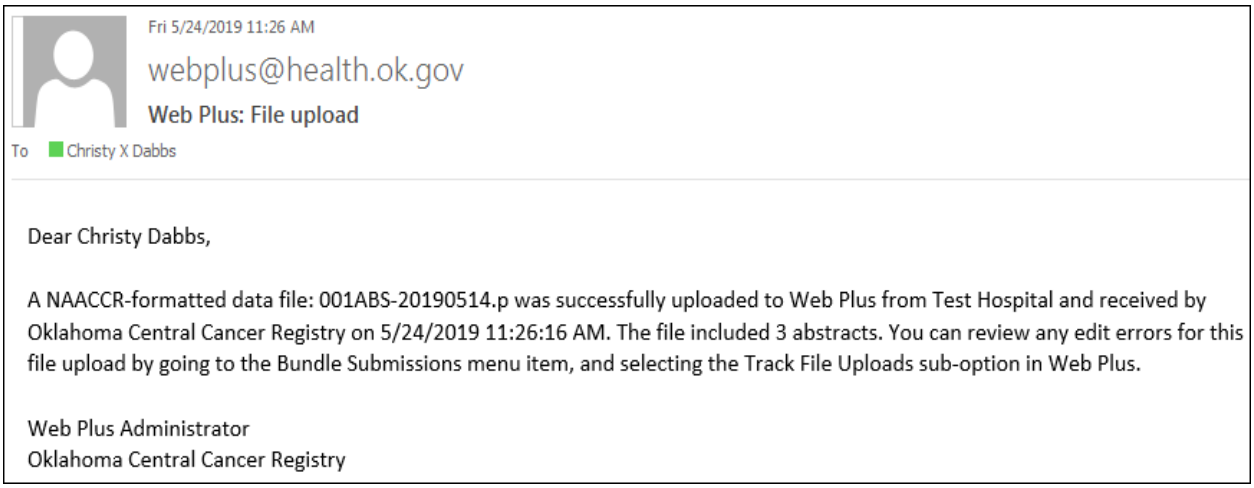


6. Select the '**Choose File**' button and navigate to the file to be uploaded.
   For RMCDS this will be the path located on the main screen (see step 13.)
7. Double click the file to upload
   a. In this example the file is 999ABS-20220610.xml
8. Enter any information about the file being uploaded in the comments box you would like the Central Registry to be aware of.
9. Click the '**Upload**' button.
10. A confirmation window confirms the file was successfully uploaded and how many cases are processed. You will receive a pop up window with your EDIT Report. You will also receive an email stating that the edit report is ready.



11. You will receive two emails from webplus@health.ok.gov. Please make sure this address is in your whitelist or safe senders list. One email will confirm your successful upload and the other will state whether or not your bundle was accepted or rejected. If rejected, you will need to view the Edits Report.

Sample Email



Web Plus - Reviewing Edits Report

You will receive an email stating that the edit report is ready for review.

1. Click on **'Previous Uploads'** option from the File Upload menu.
2. Click on **'View Edit Report'** link to view the edit report of the uploaded file.
3. Make all error corrections in your RMCDS database.
4. Create a new state submission file using the Creating RMCDS Submission File instructions. *Be sure to change the previous transfer date to the date of the last **successful** upload.*

5. Resubmit the file using the Web Plus Upload Instructions.

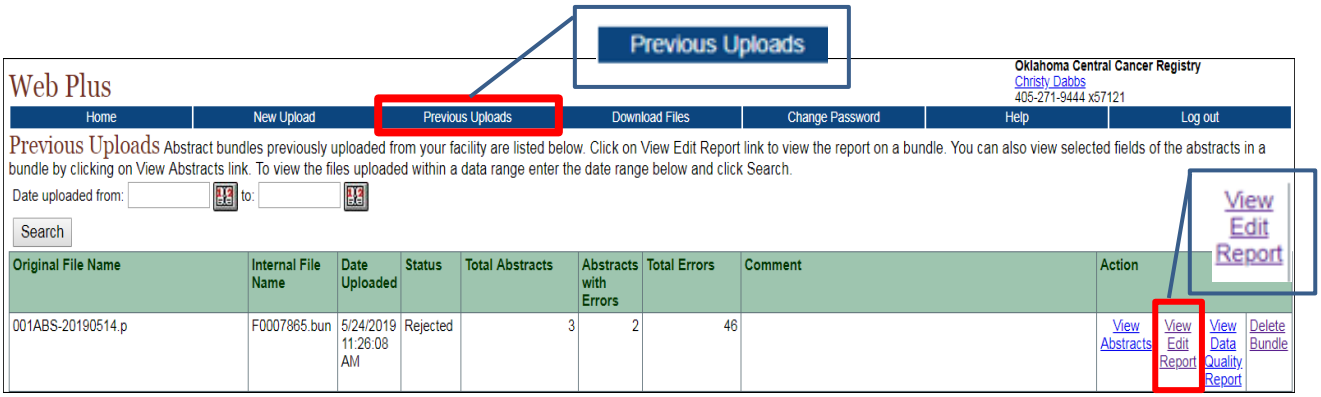
Sample Email

Dear Christy Dabbs,

Edit report of the abstracts bundle, 001ABS-20190514.p submitted on 5/24/2019 11:26:08 AM, is ready. Please log on to Web Plus and select "Previous Uploads" option from the menu. All your previous uploads will be listed on this page. Click on "View Edit Report" link to view the report of this bundle. The report will open in a separate window.

Since more than 0% of the abstracts in the bundle have errors your bundle has been rejected.Please look at the error report and correct all the errors and resubmit the bundle. If you think the errors in the report are invalid please contact us.

Thank you,
Web Plus System Administrator
Oklahoma Central Cancer Registry



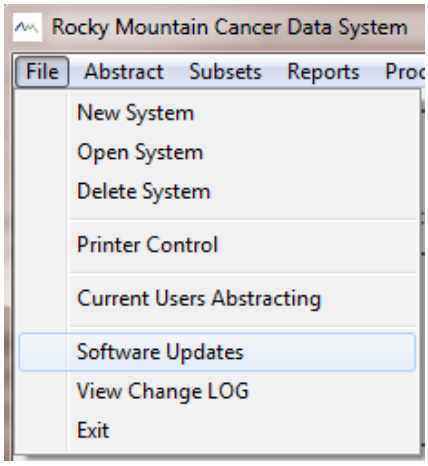
If you have any questions, please contact the Oklahoma Central Cancer Registry.

RMCDS Update

Prior to running the software update, make note of the version date on the main screen. You will compare this to the version date after the update is complete.

To use the Automatic Update you must have an active connection to the internet. Many facilities have firewalls set up to prevent access to certain sites on the internet. If your facility has a firewall it may prevent you from successfully updating utilizing this method. If you are unsuccessful in using the automatic update, contact your IT department to determine if your facility has a firewall. If you are behind a firewall, the IT department may be able to punch a hole through for you to access the RMCDS FTP site. The address they will need for this is ftp://rmcdsxxx@rmcds1.med.utah.edu **(xxx is your three digit hospital number assigned to the facility by the OCCR).** You can cancel the automatic update any time when the 'Cancel' button is available. If you cancel, you will have to re-enter your login to reopen RMCDS.

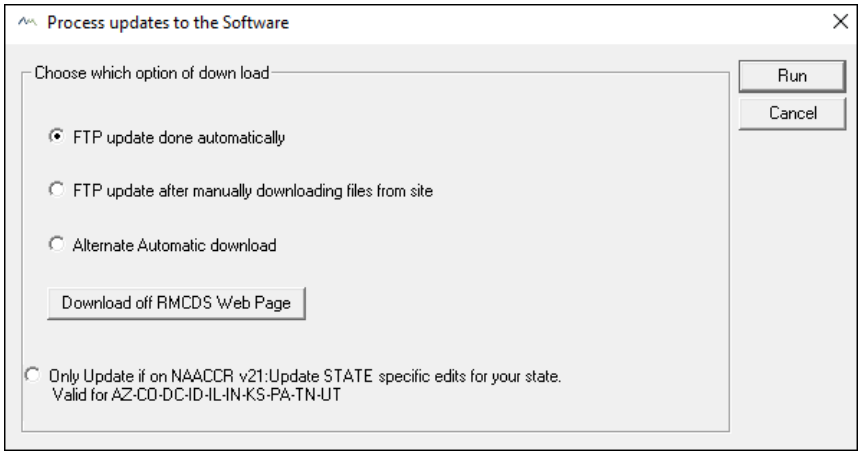
1. To run the automatic update, from the Main Menu click on ‘File’ and choose ‘Software Updates’.



2. This will open a new window called ‘Process updates to the software’. The Main Menu will close.

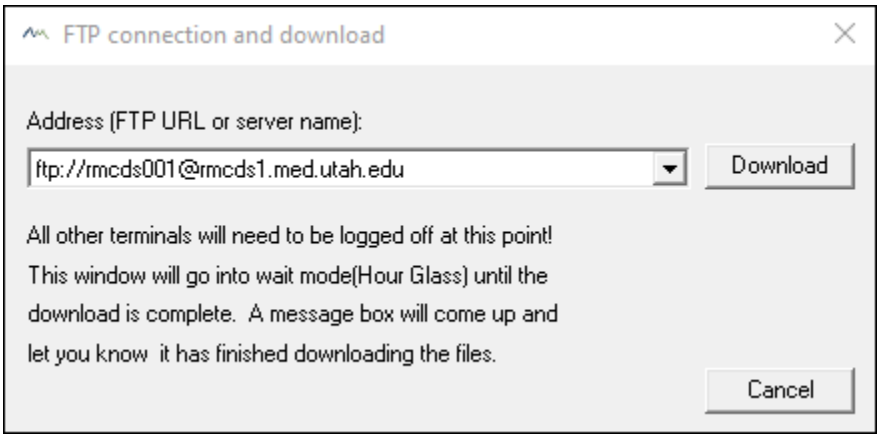
3. There are four options for running the software update.
   - FTP update done automatically (preferred method)
   - FTP Update done after manually downloading files from site (do not use)
   - Alternate Automatic Download Use this option If you have an issue with a firewall.
   - Download off RMCDS Web Page. Do not use this method unless you have requested access to update using this method.

   Note: Oklahoma does not have a state specific edit metafile. You may ignore the last option for updating STATE specific edits.

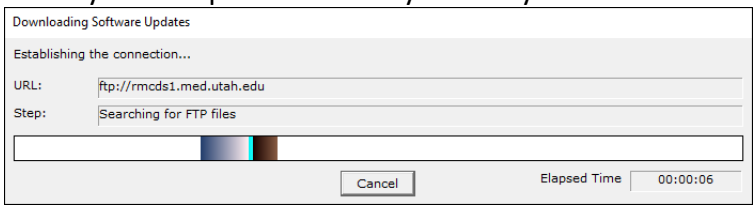


4. Click the Run button and a new window will open.

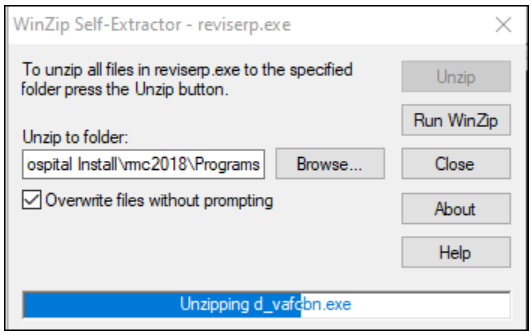
The facility FTP address will be listed in the box. The number following RMCDS is your 3-digit facility number assigned by the OCCR. **If the RMCDS software is installed on a network, make sure that all other terminals are logged off of RMCDS before you continue.**

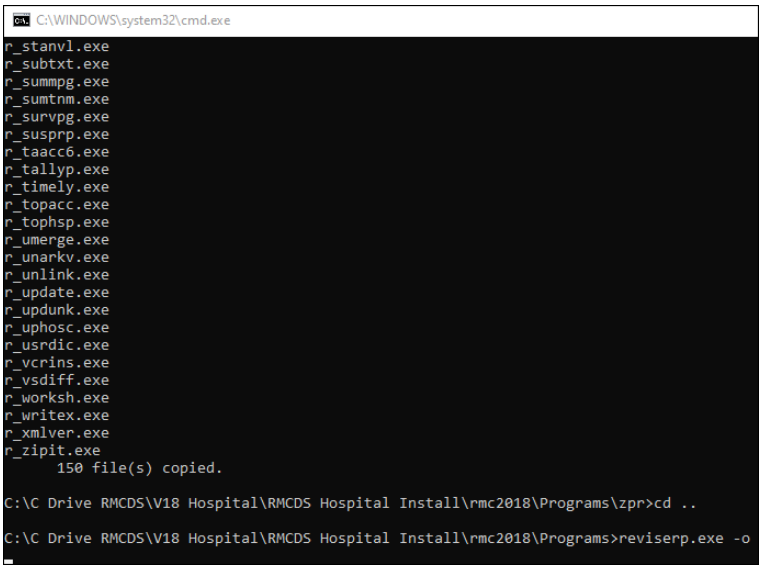


5. Click on the 'Download' button. A status window will appear until the files have successfully been copied onto your computer. This may take anywhere from 5 to 15 minutes.



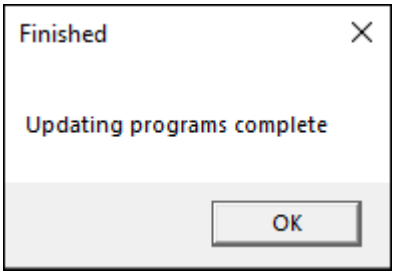
If the alternate method is used, screens will pop up while the programs are updated. File names will scroll as this happens.



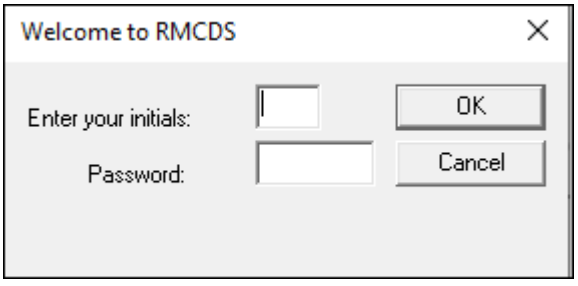


6. When the update is complete, a message window will appear.

   Click 'OK' to close the update program.



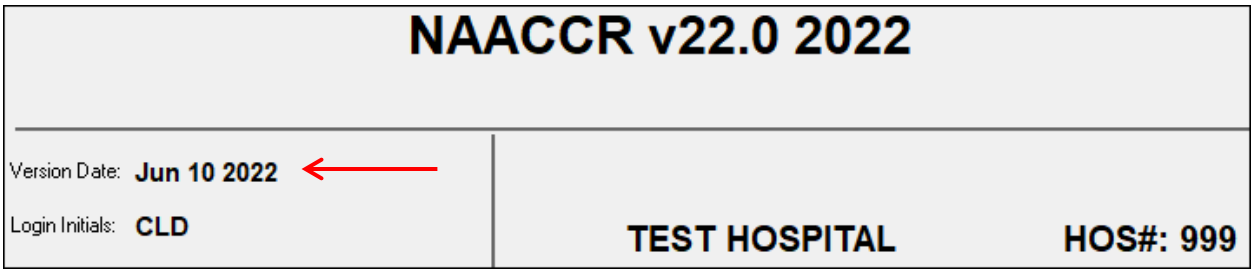
   The login screen appears prompting you to enter your initials and password to open RMCDS.



7. Please note the Version date on the main screen. The date is now updated and should be no more than a few days prior to the current date. This date corresponds to the last date RMCDS posted an update file to the FTP site.

   If this date remains as the version date prior to the update, then the update was not successful and must be run again. If the date is current, then all of your RMCDS programs have been

updated. **We recommend that you update RMCDS at least once a month to stay current.** Updates are free of charge and available 24 hours a day.



If you have any questions, please contact the Oklahoma Central Cancer Registry**.**

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