

Edit Name: Addr at DX--City (NAACCR)

Agency: NAACCR

Last Changed: 04/05/2007

Fields: Addr at DX--City [Std# 70]

Description:

Item may not be blank. Must be alpha, left-justified, and blank-filled. Mixed case is allowed, but uppercase is preferred by USPS. Embedded spaces are allowed, but no more than one consecutive embedded space is allowed. Special characters are not allowed.

Although dashes and numbers are generally not allowed, there are a few official USPS exceptions. The following city names will pass:

BLAIRSDEN-GRAEGLE
BLRSDN-GREAGL
57TH AVE
MCBH K-BAY
VLG OF 4 SSNS
BATESBURG-LEESVILLE
BATSBRG-LEVIL

Edit Name: Addr at DX--No/Street (NAACCR)

Agency: NAACCR

Last Changed: 04/05/2007

Fields: Addr at DX--No & Street [Std# 2330]

Description:

Item may not be blank. Must be alphanumeric, left-justified, and blank-filled. Mixed case is allowed. Embedded spaces are allowed. Special characters are limited to periods, slashes, hyphens, and pound signs.

Edit Name: Addr at DX--Postal Code (NAACCR)

Agency: NAACCR

Last Changed: 04/05/2007

Fields: Addr at DX--Postal Code [Std# 100]

Description:

Item may not be blank. Must be alphanumeric, left-justified, and blank-filled. Mixed case is allowed. Embedded spaces are not allowed. Special characters are not allowed.

Edit Name: Addr at DX--Postal Code, Addr at DX--State (COC)

Agency: COC

Last Changed: 04/27/2007

Fields: Addr at DX--Postal Code [Std# 100]

Addr at DX--State [Std# 80]

Description:

This edit is skipped if any of the fields are blank.

This edit is skipped if Addr at DX--State is AA (APO/FPO for Armed Services the Americas), AE (APO/FPO for Armed Services Europe), or AP (APO/FPO for Armed Services Pacific).

If Addr at DX--State is CD (Resident of Canada, NOS, and province, territory, commonwealth or possession is unknown), or US (Resident of United States, NOS, and state, territory, commonwealth or possession is unknown), or ZZ (Residence unknown):

Addr at DX--Postal Code must be 99999 or 999999999 (Resident

Addr at DX--Postal Code, Addr at DX--State (COC) (continued)

of U.S., U.S. possessions or territories, or Canada and postal code is unknown; residence unknown).

If Addr at DX--Postal Code is 88888 or 888888888 (Resident of country outside U.S., U.S. possessions or territories, or Canada and postal code is unknown):

Patient's residence at diagnosis must be outside the U.S. or its possessions or Canada (Addr at DX--State must be XX or YY).

If Addr at DX--Postal Code is 99999 or 999999999 (Resident of U.S., U.S. possessions or territories, or Canada and postal code is unknown; residence unknown):

Patient's residence at diagnosis must be in the U.S. or its possessions or in Canada, or residence must be unknown (Addr at DX--State must not be XX or YY.)

If the patient's residence at diagnosis is in the U.S. or its possessions (Addr at DX--State is one of the 2-letter abbreviations in the state table in the FORDS), then Addr at DX--Postal Code must be either 5 digits or 9 digits. The first 5 digits must be greater than 00009.

If the patient's residence at diagnosis is in Canada (Addr at DX--State is one of the 2-letter abbreviations in the state table in the FORDS, then Addr at DX--Postal Code must be 6 characters long and of the form letter-number-letter-number-letter-number, where all of the letters are upper case.

Edit Name: Addr at DX--State (NAACCR)

Agency: NAACCR

Last Changed: 04/27/2007

Fields: Addr at DX--State [Std# 80]

Description:

Field must contain valid US postal code for state or Canadian province.

Special Codes:

- CD Resident of Canada, NOS, and province, territory, commonwealth or possession is unknown
- US Resident of United States, NOS, and state, territory, commonwealth or possession is unknown
- XX Resident of country other than United States (including its territories, commonwealths, or possessions) or Canada, and country known
- YY Resident of country other than United States (including its territories, commonwealths, or possessions) or Canada, and country unknown
- ZZ Residence unknown

Edit Name: Addr at DX--State, Postal Code Range (NAACCR)

Agency: NAACCR

Last Changed: 05/14/2007

Fields: Addr at DX--State [Std# 80]

Addr at DX--Postal Code [Std# 100]

Description:

Please note: this edit produces a warning, rather than an error. Use care when applying this edit, since state border areas may be an issue.

Addr at DX--State, Postal Code Range (NAACCR) (continued)

This edit is skipped if:

1. Any of the fields are blank
2. Addr at DX--State is equal to any of the following:
 - AA APO/FPO for Armed Services the Americas
 - AE APO/FPO for Armed Services Europe
 - AP APO/FPO for Armed Services Pacific
 - CD Resident of Canada, NOS, and province, territory, commonwealth or possession is unknown
 - US Resident of United States, NOS, and state, territory, commonwealth or possession is unknown
 - XX Resident of country other than United States (including its territories, commonwealths, or possessions) or Canada, and country known
 - YY Resident of country other than United States (including its territories, commonwealths, or possessions) or Canada, and country unknown
 - ZZ Residence unknown
3. Addr at DX--State indicates a Canadian province (AB,BC,MB,NB,NL,NT,NS,NU,ON,PE,QC,SK,YT)
4. Addr at DX--Postal Code is equal to 99999 or 999999999 (Resident of U.S., U.S. possessions or territories, or Canada and postal code is unknown; residence unknown)

This edit generates a warning if Addr at DX--Postal Code falls outside the range allowed for Addr at DX--State.

The state/postal code ranges are:

State	Postal Code Range
AK	99500-99959
AL	35000-36999
AR	71600-72999
AS	96799
AZ	85000-86599
CA	90000-96199
CO	80000-81699
CT	06000-06389, 06391-06999
DC	20000-20099, 20200-20599
DE	19700-19999
FL	32000-34999
FM	96941-96944
GA	30000-31999, 39800-39897
GU	96910-96932
HI	96700-96798, 96800-96899
IA	50000-52899
ID	83200-83413, 83415-83899
IL	60000-62999
IN	46000-47999
KS	66000-67999
KY	40000-42799
LA	70000-71499
MA	01000-02799
MD	20600-21999
MH	96960, 96970
MO	63000-65899
ME	03900-04999
MI	48000-49999
MN	55000-56799
MP	69650-69652

Addr at DX--State, Postal Code Range (NAACCR) (continued)

MS	38600-39799
MT	59000-59999
NC	27000-28999
ND	58000-58899
NE	68000-69399
NH	03000-03899
NJ	07000-08999
NM	87000-88499
NV	89000-89899
NY	10000-14999, 06390
OH	43000-45899
OK	73000-73300, 73302-73343, 73345-74999
OR	97000-97999
PA	15000-19699
PR	00600-00799, 00900-00999
PW	96940
RI	02800-02999
SC	29000-29999
SD	57000-57799
TN	37000-38599
TX	75000-79999, 88500-88599
UT	84000-84799
VA	20100-20199, 22000-24699
VI	00800-00899
VT	05000-05500, 05502-05543, 05545-05999
WA	98000-99499
WI	53000-54999
WV	24700-26899
WY	82000-83199

Edit Name: Addr at DX--Supplement1 (COC)

Agency: COC

Last Changed: 09/16/2002

Fields: Addr at DX--Supplement1 [Std# 2335]

Description:

Item may be blank. Must be alphanumeric, left-justified, and blank-filled. Mixed case is allowed. Embedded spaces are allowed. Special characters are limited to periods, slashes, hyphens, and pound signs.

Edit Name: Age at Diagnosis (SEER AGEDX)

Agency: SEER

Last Changed: 03/04/2003

Fields: Age at Diagnosis [Std# 230]

Description:

This field became a required (rather than optional) data item for COC as of 1/1/2003 and is required for all diagnosis years. Consequently this edit is now used by COC, as well as SEER, and will be added to the COC edit set.

Must be a valid value for Age at Diagnosis (000...120, 999).

Edit Name: Age, Birth Date, Date of Diagnosis (NAACCR IF13)

Agency: NAACCR

Last Changed: 04/28/2007

Fields: Age at Diagnosis [Std# 230]

Age, Birth Date, Date of Diagnosis (NAACCR IF13) (continued)

Date of Diagnosis [Std# 390]

Birth Date [Std# 240]

Description:

If the Age at Diagnosis is coded as unknown (999), then the Year of Birth must be coded as unknown (9999).

If either month of birth or month of diagnosis is unknown (99), then a working age is computed as year of diagnosis - year of birth. Otherwise the working age is computed as the actual age: $((\text{year of diagnosis} * 12 + \text{month of diagnosis}) - (\text{year of birth} * 12 + \text{month of birth}))/12$.

If the month of diagnosis or month of birth is unknown, or if the months of diagnosis and birth are known and equal and the day of diagnosis or day of birth is unknown, then Age at Diagnosis must equal the working age or the working age - 1.

If the months of diagnosis and birth are known and equal, and the day of diagnosis is earlier than the day of birth, then 1 is subtracted from the working age, and Age at Diagnosis must equal the new working age.

For all other cases, Age at Diagnosis must equal the working age.

Edit Name: Age, Primary Site, Morph ICDO3--Adult (SEER)

Agency: SEER

Last Changed: 04/27/2007

Fields: Over-ride Age/Site/Morph [Std# 1990]

Age at Diagnosis [Std# 230]

Primary Site [Std# 400]

Morph--Type&Behav ICD-O-3 [Std# 521]

Date of Diagnosis [Std# 390]

Description:

This edit and the edit Age, Primary Site, Morphology ICDO3--Pediatric (NPCR) replace the edit Age, Primary Site, Morphology ICDO3 (SEER IF15) for cases diagnosed on or after 01/01/2001. There is no overlap in the two edits. The edit Age, Primary Site, Morphology ICDO3--Pediatric (NPCR) is for ages 000 - 014 and this edit (Age, Primary Site, Morphology ICDO3--Adult (SEER)) is for ages 015 and older. The field Over-ride Age/Site/Morph is shared by both edits and contains a "1" when the case has been reviewed and accepted as is.

This edit is skipped if Morph--Type&Behav ICD-O-3 is blank or year of Date of Diagnosis is less than 2001.

The edit is also skipped if Age at Diagnosis is less than 15.

If the Over-ride Age/Site/Morph contains a '1' (review completed and case accepted as coded), no further checking is done.

For each specified age group in the following table, the Primary Site/Morphology combinations require review.

014 < Age < 020

Esophagus C150-C159	Any morphology
Small intestine C170-C179	Any morphology
Colon C180-C189	Any other than carcinoid 8240-8245

Age, Primary Site, Morph ICD03--Adult (SEER) (continued)

Rectosigmoid C199	Any morphology
Rectum C209	Any morphology
Anus, anal canal C210-C218	Any morphology
Gallbladder C239	Any morphology
Other biliary tract C240-C249	Any morphology
Pancreas C250-C259	Any morphology
Trachea C339	Any other than carcinoid 8240-8245
Lung and bronchus C340-C349	Any other than carcinoid 8240-8245
Pleura C384	Any morphology
Breast C500-C509	Any morphology
Uterus, NOS C559	Any morphology
Cervix uteri C530-C539	Any Histologic Type ICD-O-3 with Behavior ICD-O-3 of 3 (malignant)
Corpus uteri C540-C549	Any morphology
014 < Age < 030	
Any site	Multiple Myeloma 9732
	Chronic myeloid leukemia
	9863,9875,9876,9945
	Chronic lymphocytic leukemia 9823
Penis C609	Any morphology
014 < Age < 045	
Prostate C619	Adenocarcinoma, NOS 8140
Age > 014	
Eye C690-C699	Retinoblastoma 9510-9514
Any site	Wilms tumor 8960
Age > 045	
Placenta C589	Choriocarcinoma 9100

Additional Information:

Some cancers occur almost exclusively in certain age groups. For example, retinoblastoma is a tumor of young children, while prostate cancer occurs in older men. This edit checks that selected cancers are reported only for patients of specific ages at diagnosis. The expected ages are listed for each edited site/morphology combination in the "Description" field of the edit documentation.

First check that the primary site and histologic type are coded correctly and that the age, date of birth, and date of diagnosis are correct. These two dates are not actually used in the edit; however, they may have been used to calculate the age at diagnosis, which is used in this edit. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may also be required.

If upon review, all items are correct as coded, an over-ride flag may be set so that the case will not be considered in error when the edit is run again. Enter a 1 in the field Over-ride Age/Site/Morph to indicate that the coding is correct.

EXAMPLE

AGE	35
PRIMARY SITE	PROSTATE, C61.9
MORPHOLOGY -TYPE AND BEHAVIOR	8140/3, ADENOCARCINOMA

Age, Primary Site, Morph ICDO3--Adult (SEER) (continued)

DATE OF DIAGNOSIS 2/13/95
DATE OF BIRTH 1/10/60

The edit identifies prostate cancers occurring before age 45. On review, the birth date in this case is in error and should be 1/10/06. Enter the correct birth date. The age will recalculate to 89, and the case will no longer be in error.

Edit Name: Age, Primary Site, Morph ICDO3--Pediatric (NPCR)

Agency: NPCR

Last Changed: 04/27/2007

Fields: Over-ride Age/Site/Morph [Std# 1990]
Age at Diagnosis [Std# 230]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Date of Diagnosis [Std# 390]

Description:

This edit and the edit Age, Primary Site, Morphology ICDO3--Adult (SEER) replace the edit Age, Primary Site, Morphology ICDO3 (SEER IF15) for cases diagnosed on or after 01/01/2001. There is no overlap in the two edits. This edit (Age, Primary Site, Morphology ICDO3--Pediatric (NPCR)) is for ages 000 - 014 and the edit Age, Primary Site, Morphology ICDO3--Adult (SEER) is for ages 015 and older. The field Over-ride Age/Site/Morph is shared by both edits and contains a "1" when the case has been reviewed and accepted as is.

This edit is based on the International Classification of Childhood Cancer (ICCC) CHILD-CHECK program edit of "Unlikely Combinations of Age and Tumour Type" as specified on page 11 of IARC Technical Report No. 29. It also includes SEER edits for ages 000 - 014 that were formerly part of the edit Age, Primary Site, Morphology ICDO3 (SEER IF15).

This edit is skipped if Histologic Type ICD-O-3 is blank or year of Date of Diagnosis is less than 2001.

This edit is skipped if Age at Diagnosis is greater than 14.

If the Over-ride Age/Site/Morph contains a '1' (review completed and case accepted as coded), no further checking is done.

For each specified group in the following list, the Age/Primary Site/Morphology combinations require review.

Unlikely Combinations of Age and Tumor Type

ICCC Diagnostic Group: IIa Hodgkin Lymphoma

Histologic Type ICD-O-3: 9650-9667
Primary Site: Any
Age at Diagnosis: 000 - 002

ICCC Diagnostic Group: IVa Neuroblastoma and ganglioneuroblastoma

Histologic Type ICD-O-3: 9490, 9500

Age, Primary Site, Morph ICD03--Pediatric (NPCR) (continued)

Primary Site: Any
Age at Diagnosis: 010 - 014

ICCC Diagnostic Group: V Retinoblastoma

Histologic Type ICD-O-3: 9510-9514
Primary Site: Any
Age at Diagnosis: 006 - 014

ICCC Diagnostic Group: VIa Wilms tumor, rhabdoid, and clear cell sarcoma

Histologic Type ICD-O-3: 8960, 8964
Primary Site: Any

Histologic Type ICD-O-3: 8963
Primary Site: C649, C809

Age at Diagnosis: 009 - 014

ICCC Diagnostic Group: VIb Renal carcinoma

Histologic Type ICD-O-3: 8010-8041, 8050-8075, 8082,
8120-8122, 8130-8141, 8143, 8155, 8190-8201, 8210,
8211, 8221-8231, 8240, 8241, 8244-8246, 8260-8263,
8290, 8310, 8320, 8323, 8401, 8430, 8440, 8480-8490,
8504, 8510, 8550, 8560-8573
Primary Site: C649

Histologic Type ICD-O-3: 8312
Primary Site: Any

Age at Diagnosis: 000 - 008

ICCC Diagnostic Group: VIIa Hepatoblastoma

Histologic Type ICD-O-3: 8970
Primary Site: Any
Age at Diagnosis: 006 - 014

ICCC Diagnostic Group: VIIb Hepatic carcinoma

Histologic Type ICD-O-3: 8010-8041, 8050-8075, 8082, 8120-8122,
8140, 8141, 8143, 8155, 8190-8201, 8210, 8211, 8230, 8231, 8240,
8241, 8244-8246, 8260-8263, 8310, 8320, 8323, 8401, 8430, 8440,
8480-8490, 8504, 8510, 8550, 8560-8573
Primary Site: C220, C221

Histologic Type ICD-O-3: 8160-8180
Primary Site: Any

Age at Diagnosis: 000 - 008

ICCC Diagnostic Group: VIIIa Osteosarcoma

Histologic Type ICD-O-3: 9180-9200
Primary Site: Any
Age at Diagnosis: 000 - 005

Age, Primary Site, Morph ICD03--Pediatric (NPCR) (continued)

ICCC Diagnostic Group: VIIIb Chondrosarcoma

Histologic Type ICD-O-3: 9220-9230
Primary Site: Any

Histologic Type ICD-O-3: 9231, 9240
Primary Site: C400-C419

Age at Diagnosis: 000 - 005

ICCC Diagnostic Group: VIIIc Ewing sarcoma

Histologic Type ICD-O-3: 9260
Primary Site: C400-C419, C809

Histologic Type ICD-O-3: 9363, 9364
Primary Site: C400-C419

Age at Diagnosis: 000 - 003

ICCC Diagnostic Group: Xb Non-gonadal germ cell

Histologic Type ICD-O-3: 9060-9102
Primary Site: C000-C559, C570-C619, C630-C699, C739-C750,
C754-C809

Age at Diagnosis: 008 - 014

ICCC Diagnostic Group: Xd Gonadal carcinoma

Histologic Type ICD-O-3: 8010-8041, 8050-8075, 8082, 8120-8122,
8130-8141, 8143, 8155, 8190-8201, 8210, 8211, 8221-8241,
8244-8246, 8260-8263, 8290, 8310, 8320, 8323, 8430, 8440,
8480-8490, 8504, 8510, 8550, 8560-8573
Primary Site: C569, C620-C629

Histologic Type ICD-O-3: 8380, 8381, 8441-8473
Primary Site: Any

Age at Diagnosis: 000 - 004

ICCC Diagnostic Group: XIb Thyroid carcinoma

Histologic Type ICD-O-3: 8010-8041, 8050-8075, 8082, 8120-8122,
8130-8141, 8155, 8190, 8200, 8201, 8211, 8230, 8231, 8244-8246,
8260-8263, 8290, 8310, 8320, 8323, 8430, 8440, 8480, 8481,
8500-8573
Primary Site: C739

Histologic Type ICD-O-3: 8330-8350
Primary Site: Any

Age at Diagnosis: 000 - 005

ICCC Diagnostic Group: XIc Nasopharyngeal carcinoma

Histologic Type ICD-O-3: 8010-8041, 8050-8075, 8082, 8120-8122,
8130-8141, 8155, 8190, 8200, 8201, 8211, 8230, 8231, 8244-8246,
8260-8263, 8290, 8310, 8320, 8323, 8430, 8440, 8480, 8481, 8504,

Age, Primary Site, Morph ICD03--Pediatric (NPCR) (continued)

8510, 8550, 8560-8573
Primary Site: C110-C119
Age at Diagnosis: 000 - 005

ICCC Diagnostic Group: XIe Skin carcinoma

Histologic Type ICD-O-3: 8010-8041, 8050-8075, 8082, 8090-8110,
8140,8143, 8147, 8190, 8200, 8240, 8246, 8247, 8260, 8310, 8320,
8323, 8390-8420, 8430, 8480, 8542, 8560, 8570-8573, 8940
Primary Site: C440-C449
Age at Diagnosis: 000 - 004

ICCC Diagnostic Group: XIIf NOS carcinoma

Histologic Type ICD-O-3: 8010-8082, 8120-8155, 8190-8263, 8290,
8310, 8314-8323, 8430-8440, 8480-8580, 8940, 8941
Primary Site: C000-C109, C129-C218, C239-C399, C480-C488,
C500-C559, C570-C619, C630-C639, C659-C729, C750-C809
Age at Diagnosis: 000 - 004

ICCC Diagnostic Group: XIIa Mesothelial neoplasms (M905)

Histologic Type ICD-O-3: 9050-9053
Primary Site: Any
Age at Diagnosis: 000 - 014

Additional SEER Groups:

Cervix Uteri

Histologic Type ICD-O-3: Any
Behavior Code ICD-O-3: 2
Primary Site: C530-C539
Age at Diagnosis: 000 - 014

Placenta: choriocarcinoma

Histologic Type ICD-O-3: 9100
Primary Site: C589
Age at Diagnosis: 000 - 014

Esophagus, Small Intestine, Rectosigmoid, Rectum, Anus, Anal Canal,
Gallbladder, Other Biliary Tract, Pancreas, Pleura, Breast,
Uterus, NOS, Corpus Uteri, Penis

Histologic Type ICD-O-3: Any
Primary Site: C150-C159, C170-C179, C199, C209, C210-C218, C239,
C240-C249, C250-C259, C384, C500-C509, C559, C540-C549, C609
Age at Diagnosis: 000 - 014

Colon, Trachea, Lung and Bronchus

Histologic Type ICD-O-3: Any other than carcinoid (8240-8245)
Primary Site: C180-C189, C339, C340-C349
Age at Diagnosis: 000 - 014

Cervix Uteri

Age, Primary Site, Morph ICDO3--Pediatric (NPCR) (continued)

Histologic Type ICD-O-3: Any with Behavior ICD-O-3 of 3
 Primary Site: C530-C539
 Age at Diagnosis: 000 - 014

Prostate: adenocarcinoma

Histologic Type ICD-O-3: 8140
 Primary Site: C619
 Age at Diagnosis: 000 - 014

Multiple Myeloma

Histologic Type ICD-O-3: 9732
 Primary Site: Any
 Age at Diagnosis: 000 - 014

Chronic Myeloid Leukemia

Histologic Type ICD-O-3: 9863, 9875, 9876, 9945
 Primary Site: Any
 Age at Diagnosis: 000 - 014

Chronic Lymphocytic Leukemia

Histologic Type ICD-O-3: 9823
 Primary Site: Any
 Age at Diagnosis: 000 - 014

Edit Name: Age, Primary Site, Morphology ICDO3 (SEER IF15)

Agency: SEER

Last Changed: 04/27/2007

Fields: Over-ride Age/Site/Morph [Std# 1990]
 Age at Diagnosis [Std# 230]
 Primary Site [Std# 400]
 Morph--Type&Behav ICD-O-3 [Std# 521]
 Date of Diagnosis [Std# 390]

Description:

This edit is skipped if year of Date of Diagnosis is greater than 2000. For cases diagnosed on or after 1/1/2001, this edit has been replaced by the edits Age, Primary Site, Morph ICDO3--Pediatric (NPCR) and Age, Primary Site, Morph ICDO3--Adult (SEER).

This edit is skipped if Morph--Type&Behav ICD-O-3 is blank.

If the Over-ride Age/Site/Morph contains a '1' (review completed and case accepted as coded), no further checking is done.

For each specified age group in the following table, the Primary Site/Morphology combinations require review.

Age at Diagnosis < 015	
Cervix uteri C530-C539	Any histology with in situ behavior 2
Placenta C589	Choriocarcinoma 9100

Age at Diagnosis < 020

Age, Primary Site, Morphology ICDO3 (SEER IF15) (continued)

Esophagus C150-C159	Any morphology
Small intestine C170-C179	Any morphology
Colon C180-C189	Any other than carcinoid 8240-8245
Rectosigmoid C199	Any morphology
Rectum C209	Any morphology
Anus, anal canal C210-C218	Any morphology
Gallbladder C239	Any morphology
Other biliary tract C240-C249	Any morphology
Pancreas C250-C259	Any morphology
Trachea C339	Any other than carcinoid 8240-8245
Lung and bronchus C340-C349	Any other than carcinoid 8240-8245
Pleura C384	Any morphology
Breast C500-C509	Any morphology
Uterus, NOS C559	Any morphology
Cervix uteri C530-C539	Any histology with malignant behav 3
Corpus uteri C540-C549	Any morphology
Age at Diagnosis < 030	
Any site	Multiple myeloma 9732
Any site	Chronic myeloid leukemia 9863, 9875, 9876, 9945
Any site	Chronic lymphocytic leukemia 9823
Penis C609	Any morphology
Age at Diagnosis < 045	
Prostate C619	Adenocarcinoma, NOS 8140
Age at Diagnosis > 005	
Eye C690-C699	Retinoblastoma 9510-9514
Age > 014	
Any site	Wilms tumor 8960
Age at Diagnosis > 045	
Placenta C589	Choriocarcinoma 9100

Additional Information

Some cancers occur almost exclusively in certain age groups. For example, retinoblastoma is a tumor of young children, while prostate cancer occurs in older men. This edit checks that selected cancers are reported only for patients of specific ages at diagnosis. The expected ages are listed for each edited site/morphology combination in the "Description" field of the edit documentation.

First check that the primary site and histologic type are coded correctly and that the age, date of birth, and date of diagnosis are correct. These two dates are not actually used in the edit; however, they may have been used to calculate the age at diagnosis, which is used in this edit. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may also be required.

If upon review, all items are correct as coded, an over-ride flag may be set so that the case will not be considered in error when the edit is run again. Enter a 1 in the field Over-ride Age/Site/Morph to indicate that the coding is correct.

EXAMPLE

Age, Primary Site, Morphology ICDO3 (SEER IF15) (continued)

AGE	35
PRIMARY SITE	PROSTATE, C61.9
MORPHOLOGY -TYPE AND BEHAVIOR	8140/3, ADENOCARCINOMA
DATE OF DIAGNOSIS	2/13/95
DATE OF BIRTH	1/10/60

The edit identifies prostate cancers occurring before age 45. On review, the birth date in this case is in error and should be 1/10/06. Enter the correct birth date. The age will recalculate to 89, and the case will no longer be in error.

Edit Name: Ambiguous Terminology DX, Date of DX (SEER IF157)

Agency: SEER

Last Changed: 09/25/2006

Fields: Date of Diagnosis [Std# 390]
Ambiguous Terminology DX [Std# 442]

Description:

If year of Date of Diagnosis is greater than 2006 and not equal to 9999, then Ambiguous Terminology DX cannot be blank.

If year of Date of Diagnosis is less than 2007, then Ambiguous Terminology DX must be blank.

Edit Name: Autopsy Only, RX (NPCR)

Agency: NPCR

Last Changed: 05/24/2007

Fields: Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
RX Summ--Surg Prim Site [Std# 1290]
RX Summ--Scope Reg LN Sur [Std# 1292]
RX Summ--Surg Oth Reg/Dis [Std# 1294]
Reason for No Surgery [Std# 1340]
RX Summ--BRM [Std# 1410]
RX Summ--Chemo [Std# 1390]
RX Summ--Hormone [Std# 1400]
RX Summ--Other [Std# 1420]
RX Summ--Transplnt/Endocr [Std# 3250]
Rad--Regional RX Modality [Std# 1570]
RX Summ--Surg/Rad Seq [Std# 1380]
RX Summ--Systemic/Sur Seq [Std# 1639]

Description:

This edit is skipped if year of Date of Diagnosis is less than 2006 or equal to 9999.

If Type of Reporting Source is 6 (autopsy only):

1. RX Summ--Surg Prim Site must = 00 or 98
2. RX Summ--Scope Reg LN Sur

Autopsy Only, RX (NPCR) (continued)

- A. For primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (C700-C729), unknown site (C809), lymphoma and hematopoietic (9590-9989)
 - RX Summ--Scope Reg LN Sur must = 0 or 9
- B. For all other sites/histologies
 - RX Summ--Scope Reg LN Sur must = 0
3. RX Summ--Surg Oth Reg/Dis
 - A. For primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (C700-C729), unknown site (C809), lymphoma and hematopoietic (9590-9989)
 - RX Summ--Surg Oth Reg/Dis must = 0 or 9
 - B. For all other sites/histologies
 - RX Summ--Surg Oth Reg/Dis must = 0
4. Reason for No Surgery must = 9
5. RX Summ--BRM must = 00
6. RX Summ--Chemo must = 00
7. RX Summ--Hormone must = 00
8. RX Summ--Other must = 0
9. RX Summ--Transplnt/Endocr = 00
10. Rad--Regional RX Modality must = 00
11. RX Summ--Surg/Rad Seq must = 0
12. RX Summ--Systemic/Sur Seq must = 0

Edit Name: Behavior ICDO3, Site, Histology ICDO3 (NAACCR)

Agency: NAACCR

Last Changed: 04/27/2007

Fields: Date of Diagnosis [Std# 390]
Behavior Code ICD-O-3 [Std# 523]
Histologic Type ICD-O-3 [Std# 522]
Primary Site [Std# 400]

Description:

This edit is skipped if Behavior Code ICD-O-3 is empty or greater than 1.

Behavior Code ICD-O-3 is allowed to be 0 (benign) or 1 (borderline) only under the following conditions:

1. Behavior Code ICD-O-3 may be 0 or 1 if Year of Date of Diagnosis is greater than 2003 and not equal 9999 and Primary Site equals C700-C729 or C751-C753 (brain tumor sites).
2. Behavior Code ICD-O-3 may be 1 if year of Date of Diagnosis is less than 2001 and Histologic Type ICD-O-3 equals one of the following: 8442, 8451, 8462, 8472, 8473. (Please note that 9421 is not included because the standard setting organizations have agreed to collect it with a behavior of 3 rather than 1.) These codes may have been entered as malignant in ICD-O-2, but converted to borderline in ICD-O-3.

Edit Name: Behavior ICDO3, Summary Stage 1977 (NAACCR)

Agency: NAACCR

Last Changed: 11/29/2005

Fields: Behavior Code ICD-O-3 [Std# 523]
SEER Summary Stage 1977 [Std# 760]
Type of Reporting Source [Std# 500]

Behavior ICDO3, Summary Stage 1977 (NAACCR) (continued)

Description:

The purpose of this edit is to accommodate cases that have been converted from ICD-O-2 to ICD-O-3.

This edit is skipped if SEER Summary Stage 1977 is blank or if case is death certificate only (Type of Reporting Source = 7).

If Behavior Code ICD-O-3 = 2 (in situ), then SEER Summary Stage 1977 must be 0.

If Behavior Code ICD-O-3 = 3 (malignant), then SEER Summary Stage 1977 must be greater than 0.

Edit Name: Behavior ICDO3, Summary Stage 2000 (NAACCR)**Agency:** NAACCR**Last Changed:** 12/15/2005**Fields:** Behavior Code ICD-O-3 [Std# 523]
SEER Summary Stage 2000 [Std# 759]
Type of Reporting Source [Std# 500]**Description:**

This edit is skipped if SEER Summary Stage 2000 is blank or if case is death certificate only (Type of Reporting Source = 7).

If Behavior Code ICD-O-3 = 2 (in situ), then SEER Summary Stage 2000 must be 0.

If Behavior Code ICD-O-3 = 3 (malignant), then SEER Summary Stage 2000 must be greater than 0.

Edit Name: Birth Date (NAACCR DATEEDIT)**Agency:** NAACCR**Last Changed:** 04/27/2007**Fields:** Birth Date [Std# 240]**Description:**

Birth Date must contain a valid date or 99999999.

The edit does the following:

1. This edit first checks that the date is a valid date using the following generic date checking criteria:
 - a) All parts of a date must be zero-filled; blanks and non-digits are not allowed.
 - b) Allowable values for month, day, and year are verified. Checks are performed first for error conditions, then missing conditions, then unknown conditions; within this order, first year is checked, then month, then day. Checking is halted when the first non-valid condition is reached.

ERROR conditions:

YEAR--lowest allowed value is current (system)
year - 150; highest allowed year is current (system)
year.
MONTH--allowed values are 0-12 and 99.
DAY--allowed values are 0-31 and 99. Upper bounds for known values are checked for each individual month, and a value of 29 for February is allowed only in leap

Birth Date (NAACCR DATEEDIT) (continued)

years.

MISSING conditions: missing values (0) are not allowed for year, month, or day.

UNKNOWN conditions: unknown values are allowed for year, month, and day, but see individual date edit descriptions for checks of validity between unknown components of year.

2. Checks specific to Birth Date are then performed:

- a) If the year is unknown (9999), month and day must be unknown (99 and 99, respectively).
- b) If the month is unknown (99), the day must be unknown (99).
- c) Year of birth must be less than or equal to the current year.
- d) If the year of birth is equal to the current year and month is known, the month must be less than or equal to the current month.
- e) If the birth year and month are equal to the current year and month and the day is known, the day must be less than or equal to the current day.

Additional Information:

This is a validity check, but it's not simple. Valid day codes are 01-31 and 99. The edit is smart enough to know which months have no 31st's and which years have February 29th's. Valid month codes are 01-12 and 99. Valid year codes are 9999 and any year between 150 years ago and today.

The edit only allows sensible use of the unknown codes. If the year is unknown, then the entire date must be unknown. If the year is known but the month is unknown, then the day must also be unknown.

The edit checks year first, then month, and then day; and it stops checking as soon as it finds something wrong. For example, if the year is OK but both the day and month are badly coded (77771999, for example), the edit will validate the year, then detect the bad month code, and then stop -- it will not bother to check the day, so you will only get an error message complaining about the bad month code. This does not mean that the edit thinks that a day of 77 is valid -- it just did not bother to check the day code because it found the month problem first.

No part of the field may be blank (empty). No letters, symbols or spaces are accepted. If the month or day is coded 00, then the month or day is considered to be "missing" entirely.

This edit produces a variety of error messages, depending on the type of error detected when it stopped.

Invalid parts of the date are checked for first (year, then month, then day),

Birth Date (NAACCR DATEEDIT) (continued)

and "missing" parts of the date are checked for after this (year, then month, then day). For example, if the year is valid but the month is 00 and the day is 33 (00331999), the edit will detect the invalid day code first and complain about that; having stopped there, the edit will not get around to detecting the "missing" month code.

Edit Name: Birth Date, Date of Diagnosis (NAACCR IF47)

Agency: NAACCR

Last Changed: 04/11/2007

Fields: Birth Date [Std# 240]
Date of Diagnosis [Std# 390]

Description:

Birth Date must not be later than Date of Diagnosis. If either year is coded 9999 (unknown), the edit is skipped. If either month is coded 99 (unknown), then only the years are compared. If either day is coded 99 (unknown), then only the years and months are compared.

Edit Name: Birthplace (COC)

Agency: COC

Last Changed: 03/04/2003

Fields: Birthplace [Std# 250]

Description:

This field is allowed to be blank because the item was not required until 2003. Another edit (Birthplace, Date of Diagnosis (COC)) verifies that this item is not blank if the year of Date of Diagnosis is greater than 2002 and not equal 9999. Registries should include both edits in their edit set.

Must be a valid Birthplace code. See SEER Program Manual, Appendix B, for numeric and alphabetic lists of places and codes. May be blank.

Edit Name: Birthplace, Date of Diagnosis (SEER IF52)

Agency: SEER

Last Changed: 04/15/2007

Fields: Sequence Number--Central [Std# 380]
Date of Diagnosis [Std# 390]
Birthplace [Std# 250]

Description:

If Sequence Number--Central = 00, for Diagnosis Year 1973-87, the Place of Birth must not be:

682 China (People's Republic of China)
683 Hong Kong
684 Taiwan (Formosa) (Republic of China)
685 Tibet
686 Macao (Macao)

If Sequence Number--Central = 00, for Diagnosis year 1973-91, the Place of Birth must not be:

499 Europe, NOS
600 Asia, NOS

Edit Name: Bladder, RX Summ--Surg Prim Site, BRM (COC)

Agency: COC

Last Changed: 04/11/2007

Fields: Primary Site [Std# 400]
RX Summ--Surg Prim Site [Std# 1290]
RX Summ--BRM [Std# 1410]

Description:

This edit is skipped if either RX Summ--Surg Prim Site or RX Summ--BRM is empty.

If Primary Site = C670-C679 (bladder) and RX Summ--Surg Prim Site = 16, then RX Summ--BRM must = 01.

Edit Name: Cancer Status (COC)

Agency: COC

Last Changed: 03/29/1997

Fields: Cancer Status [Std# 1770]

Description:

Must be a valid Cancer Status code (1,2,9).

Edit Name: Cause of Death (SEER COD)

Agency: SEER

Last Changed: 04/11/2007

Fields: Cause of Death [Std# 1910]

Description:

This edit checks that Cause of Death contains either a 4-digit number, an upper case letter followed by 3 digits, or an upper case letter followed by 2 digits and a blank. Actual valid codes have varied with the edition of ICD in use. To check that only valid codes have been entered, use the edit "ICD Revision Number, Cause of Death (SEER IF37)", which checks for valid codes based on the ICD revision number that is used.

Must be a valid Underlying Cause of Death code:

0000 Patient alive at last contact
7777 State death certificate not available
7797 State death certificate available but underlying cause of death is not coded

All other cases: ICDA-8, ICD-9, or ICD-10 underlying cause of death code. ICDA-8 & ICD-9 codes consist of 4 digits while ICD-10 consists of an upper case letter followed by 3 digits.

Edit Name: Cervix In Situ ICDO3 (SEER IF88)

Agency: SEER

Last Changed: 04/03/2003

Fields: Sequence Number--Central [Std# 380]
Primary Site [Std# 400]
Behavior Code ICD-O-3 [Std# 523]
Histologic Type ICD-O-3 [Std# 522]
Date of Diagnosis [Std# 390]

Description:

This edit is skipped if Behavior Code ICD-O-3 is empty.

If year of Date of Diagnosis is greater than 1995 and less than 2003 AND Primary

Cervix In Situ ICDO3 (SEER IF88) (continued)

Site is C530-C539 (cervix) AND Histologic Type ICD-O-3 is less than 9590 AND Behavior Code ICD-O-3 is 2 (in situ), then Sequence Number--Central must equal 98.

If Sequence Number--Central is 98, then Date of Diagnosis must be greater than 1995 and less than 2003 AND Primary Site must = C530-C539 (cervix) and AND Histologic Type ICD-O-3 must be less than 9590 AND Behavior Code ICD-O-3 must be 2 (insitu).

Edit Name: Class of Case (COC)

Agency: COC

Last Changed: 04/15/2007

Fields: Class of Case [Std# 610]

Description:

This field must contain a valid value for Class of Case (0-9).

Edit Name: County at DX (NAACCR)

Agency: NAACCR

Last Changed: 05/17/2007

Fields: County at DX [Std# 90]

Description:

County at DX must be three-digit number.

Edit Name: County at DX, Addr at DX--State (NAACCR)

Agency: NAACCR

Last Changed: 04/11/2007

Fields: County at DX [Std# 90]

Addr at DX--State [Std# 80]

Description:

This edit is skipped if any of the fields are blank.

This edit is skipped if Addr at DX--State equals CD (Resident of Canada, NOS, and province, territory, commonwealth or possession is unknown), US (Resident of United States, NOS, and state, territory, commonwealth or possession is unknown), XX (Country Known, Not US, Not Canada), YY (Country Unknown, Not US, Not Canada), or ZZ (Residence unknown).

This edit is skipped if Addr at DX--State indicates a Canadian province (AB,BC,MB,NB,NL,NT,NS,NU,ON,PE,QC,SK,YT).

This edit is skipped if Addr at DX--State is AA (APO/FPO for Armed Services the Americas), AE (APO/FPO for Armed Services Europe), or AP (APO/FPO for Armed Services Pacific).

This edit verifies that the County at DX code is valid for the Addr at DX--State.

Edit Name: CS Extension (CS)

Agency: CS

Last Changed: 09/28/2003

Fields: CS Extension [Std# 2810]

Description:

Must be a valid two-digit number (00-99) or blank.

Edit Name: CS Extension, Bladder Schema (CS)

Agency: CS

Last Changed: 04/27/2007

Fields: Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Extension [Std# 2810]

Description:

This edit is skipped if CS Extension is empty.

If Primary Site = C670-C679 (bladder):

1. If Histologic Type ICD-O-3 = 8120 (transitional cell carcinoma), then CS Extension cannot = 01 (papillary transitional cell carcinoma, stated to be non-invasive) or 03 (papillary transitional cell carcinoma, with inferred description of non-invasive).
2. If Histologic Type ICD-O-3 = 8130 (papillary transitional cell carcinoma), then CS Extension cannot = 06 (transitional cell carcinoma in situ).

Edit Name: CS Extension, CS Lymph Nodes, CS Mets at DX (CS)

Agency: CS

Last Changed: 04/29/2007

Fields: Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Extension [Std# 2810]
CS Lymph Nodes [Std# 2830]
CS Mets at DX [Std# 2850]

Description:

This edit is skipped if CS Extension, CS Lymph Nodes, or CS Mets at DX is blank.

This edit is skipped for the following CS schemas which are histologically based:

Kaposi Sarcoma (Histologic Type ICD-O-3 = 9140)
Lymphoma (Histologic Type ICD-O-3 = 9590-9699, 9702-9729)
Hematopoietic (Histologic Type ICD-O-3 = 9731-9989)

If CS Extension = 95 (no evidence of primary tumor), then CS Lymph Nodes and CS Mets at DX cannot both = 00 (none).

If Primary Site = Breast (C500-509):

If CS Extension = 00 (in situ), then CS Lymph Nodes must = 00 (none; no regional lymph node involvement, or ITCs detected by immunohistochemistry or molecular methods ONLY) or 05 (none; no regional lymph nodes but with (ITCs) detected on routine H and E stains) and CS Mets at DX must = 00 (none).

For all other sites:

If CS Extension = 00, then both CS Lymph Nodes and CS Mets at DX must = 00 (none).

Edit Name: CS Extension, CS Tumor Size, Site, Hist ICDO3 (CS)

Agency: CS

Last Changed: 03/16/2004

Fields: Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Extension [Std# 2810]
CS Tumor Size [Std# 2800]

CS Extension, CS Tumor Size, Site, Hist ICDO3 (CS) (continued)

Description:

This edit is skipped if CS Extension or CS Tumor Size is empty.

If Histologic Type ICD-O-3 is not = 9140 (Kaposi Sarcoma):

If CS Extension = 95, then CS Tumor Size must = 000.

If Primary Site is not = C420-C424, C760-C765, C767-C768, C770-C775, C778-C779, C809 ("Other and Ill-Defined Sites, Unknown Primary Site" schema):

If CS Tumor Size = 000, then CS Extension must = 95.

Edit Name: CS Extension, Hematopoietic (CS)**Agency:** CS**Last Changed:** 03/26/2007**Fields:** Histologic Type ICD-O-3 [Std# 522]
CS Extension [Std# 2810]
Type of Reporting Source [Std# 500]**Description:**

This edit is skipped if CS Extension is empty or if the case is death certificate only (Type of Reporting Source = 7).

This edit is skipped if Histologic Type ICD-O-3 is not = 9731-9989 (Hematopoietic schema).

The CS Extension values of 10 (localized disease) and 99 (unknown) are allowed only for Histologic Type ICD-O-3 codes 9731, 9734, 9740, 9750, 9755-9758, and 9930 in the Hematopoietic schema. This is because these particular histologies may be coded to either 10 (localized) or 80 (systemic) and it is possible that it might be unknown (99) whether the disease is localized or systemic. (Except for death certificate only cases, all other hematopoietic histologies must be coded to 80. This is edited by the CS algorithm program.)

Edit Name: CS Extension, Primary Site, Behavior ICDO3 (CS)**Agency:** CS**Last Changed:** 05/21/2007**Fields:** Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Extension [Std# 2810]
Type of Reporting Source [Std# 500]**Description:**

The purpose of this edit is to verify that the values coded in Behavior Code ICD-O-3 and CS Extension are consistent.

This edit is skipped if CS Extension is empty or if the case is death certificate only (Type of Reporting Source = 7).

This edit is also skipped for the following histologies:

Kaposi Sarcoma (Histologic Type ICD-O-3 = 9140)

Lymphoma (Histologic Type ICD-O-3 = 9590-9699, 9702-9729)

Hematopoietic (Histologic Type ICD-O-3 = 9731-9989)

This edit is also skipped for borderline ovarian cases (Primary Site = C569, Histologic Type ICD-O-3 = 8442, 8451, 8462, 8472, or 8473, and Behavior Code ICD-

CS Extension, Primary Site, Behavior ICDO3 (CS) (continued)

O-3 = 1).

For all CS schemas:

If CS Extension = 00, then Behavior Code ICD-O-3 must = 2
(in situ).

If Primary Site = C180-C189 (Colon schema) or C199 or C209 (Rectum schema):
If CS Extension = 05, then Behavior Code ICD-O-3 must = 2.
If Histologic Type ICD-O-3 = 8210, 8261, or 8263 ('carcinoma in a
polyp' codes), then if Behavior Code ICD-O-3 = 2, CS Extension
must = 05.

If Primary Site = C500-C509 (Breast schema):
If Behavior Code ICD-O-3 = 2, then CS Extension must = 00, 05,
or 07.

If Primary Site = C700-C729 (Brain schema and Other CNS schema):
If CS Extension = 05, then Behavior Code ICD-O-3 must = 0 (benign)
or 1 (borderline).
If Behavior Code ICD-O-3 = 0 or 1, then CS Extension must = 05.

If Primary Site = C379, C740-741, C749, C750-C755, and C758-C759 (Thymus,
Adrenal (Suprarenal) Gland, and Other Endocrine Glands schema):
If CS Extension = 05, then Primary Site must = C751, C752, or C753
and Behavior Code ICD-O-3 must = 0 or 1.
If Behavior Code ICD-O-3 = 0 or 1, then CS Extension must = 05.

If Primary Site = C659 or C669 (Renal Pelvis and Ureter schema) or
C681, C688, or C689 (Other Urinary schema):
If Behavior Code ICD-O-3 = 2, then CS Extension must = 00 or 05.
If CS Extension = 00 or 05, then Behavior Code ICD-O-3 must = 2.

If Primary Site = C680 (Urethra) :
If Behavior Code ICD-O-3 = 2, then CS Extension must = 00, 01, 02,
or 05.
If CS Extension = 00, 01, 02, or 05, then Behavior Code ICD-O-3
must = 2.

If Primary Site = C670-C679 (Bladder schema):
If Behavior Code ICD-O-3 = 2, then CS Extension must = 01, 03,
06, or 10.
If CS Extension = 01, 03, or 06, then Behavior Code ICD-O-3
must = 2.

If none of the above conditions are true:
If CS Extension is greater than or equal to 10, then Behavior
Code ICD-O-3 must = 3 (invasive).

Edit Name: CS Extension, Primary Site, Histol ICDO3 (NAACCR)

Agency: NAACCR

Last Changed: 04/21/2007

Fields: CS Extension [Std# 2810]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Description:

This edit was adapted from a C/NET edit and is part of a set of supplemental

CS Extension, Primary Site, Histol ICDO3 (NAACCR) (continued)

Collaborative Staging edits that were developed to provide additional error catching beyond that already included in the error handling portion of the CS algorithm routine.

This edit does not check for obsolete codes. Obsolete codes for CS Extension are edited by "Obsolete Codes - CS Extension (SEER IF146)" and "Obsolete Codes - CS Extension (NAACCR)".

Groups (by number) are

- 01 LipUpper
- 02 LipLower
- 03 OthLip
- 04 BaseTongue
- 05 AntTongue
- 06 GumUpper
- 07 GumLower
- 08 OthGum
- 09 FOM
- 10 HardPalate
- 11 SoftPalate
- 12 OthMouth
- 13 BuccalMucosa
- 14 ParotidGland
- 15 SubmandibularGland
- 16 OthSalivary
- 17 Oropharynx
- 18 AntEpiglottis
- 19 Nasopharynx
- 20 Hypopharynx
- 21 OthPharynx
- 22 Esophagus
- 23 Stomach
- 24 SmallIntestine
- 25 Colon
- 26 Rectum
- 27 Anus
- 28 Liver
- 29 Gallbladder
- 30 ExtraHepaticDucts
- 31 Ampulla
- 32 OthBiliary
- 33 PancreasHead
- 34 PancreasBodyTail
- 35 OthPancreas
- 36 OthDigestive
- 37 NasalCavity
- 38 MiddleEar
- 39 MaxillarySinus
- 40 EthmoidSinus
- 41 OthSinus
- 42 GlotticLarynx
- 43 SupraLarynx
- 44 SubLarynx
- 45 OthLarynx
- 46 Trachea
- 47 Lung
- 48 HeartMediastinum

CS Extension, Primary Site, Histol ICDO3 (NAACCR) (continued)

49 Pleura
50 OthRespiratory
51 Bone
52 Skin
53 SkinEyelid
54 Melanoma
55 MF
56 SoftTissue
57 Peritoneum
58 Breast
59 Vulva
60 Vagina
61 Cervix
62 Corpus
63 Ovary
64 FallopianTube
65 OthAdnexa
66 OthFemaleGen
67 Placenta
68 Penis
69 Prostate
70 Testis
71 OthMaleGen
72 Scrotum
73 Kidney
74 RenalPelvis
75 Bladder
76 Urethra
77 OthUrinary
78 Conjunctiva
79 MelanomaConjunctiva
80 OthEye
81 MelanomaIrisCiliary
82 MelanomaChoroid
83 MelanomaOthEye
84 LacrimalGland
85 Orbit
86 Retinoblastoma
87 Brain
88 OthCNS
89 Thyroid
90 OthEndocrine
91 KS
92 Lymphoma
93 HemeRetic
94 OthIllDef

Edit Name: CS Extension, Renal Pelvis/Ureter Schema (CS)

Agency: CS

Last Changed: 01/05/2004

Fields: Primary Site [Std# 400]
CS Extension [Std# 2810]

Description:

This edit is skipped if CS Extension is empty.

Renal Pelvis (C659) and Ureter (C669) belong to the same schema, but Renal

CS Extension, Renal Pelvis/Ureter Schema (CS) (continued)

Pelvis can have a CS Extension of 60 while Ureter cannot. All other CS Extension values are the same for both sites and edited by the CS algorithm program.

Edit Name: CS Extension, SSF 1, Thyroid Schema (CS)

Agency: CS

Last Changed: 04/13/2005

Fields: Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Extension [Std# 2810]
CS Site-Specific Factor 1 [Std# 2880]

Description:

This edit is skipped if CS Extension or CS Site-Specific Factor 1 is empty.

This edit is skipped for the following CS schemas which are histologically based:

Kaposi Sarcoma (Histologic Type ICD-O-3 = 9140)
Lymphoma (Histologic Type ICD-O-3 = 9590-9699, 9702-9729)
Hematopoietic (Histologic Type ICD-O-3 = 9731-9989)

If Primary Site = C739 (Thyroid schema):

If CS Extension = 10, then CS Site-Specific Factor 1 must = 001.
If CS Extension = 20, then CS Site-Specific Factor 1 must = 002.

Edit Name: CS Items, Date of DX (NPCR)

Agency: CS

Last Changed: 04/27/2007

Fields: Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Extension [Std# 2810]
CS Lymph Nodes [Std# 2830]
CS Mets at DX [Std# 2850]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor 3 [Std# 2900]

Description:

If year of Date of Diagnosis is greater than 2003 and not equal 9999, then the following CS data items cannot be blank:

CS Extension
CS Lymph Nodes
CS Mets at DX

The remaining logic is skipped for the following CS schemas which are histologically based:

Kaposi Sarcoma (Histologic Type ICD-O-3 = 9140)
Lymphoma (Histologic Type ICD-O-3 = 9590-9699, 9702-9729)
Hematopoietic (Histologic Type ICD-O-3 = 9731-9989)

If Primary Site = C619 (Prostate schema):

CS Site-Specific Factor 3 cannot be blank

CS Items, Date of DX (NPCR) (continued)

If Primary Site = C384 (Pleura schema):
CS Site-Specific Factor 1 cannot be blank

Edit Name: CS Items, Death Certificate Only (CS)
Agency: CS **Last Changed:** 04/15/2007
Fields: Type of Reporting Source [Std# 500]
Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Tumor Size [Std# 2800]
CS Extension [Std# 2810]
CS Tumor Size/Ext Eval [Std# 2820]
CS Lymph Nodes [Std# 2830]
Regional Nodes Examined [Std# 830]
Regional Nodes Positive [Std# 820]
CS Reg Nodes Eval [Std# 2840]
CS Mets at DX [Std# 2850]
CS Mets Eval [Std# 2860]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor 2 [Std# 2890]
CS Site-Specific Factor 3 [Std# 2900]
CS Site-Specific Factor 4 [Std# 2910]
CS Site-Specific Factor 5 [Std# 2920]
CS Site-Specific Factor 6 [Std# 2930]

Description:

This edit is skipped if:

1. Year of Date of Diagnosis is less than 2004 or equal to 9999
2. Type of Reporting Source is not = 7 (Death Certificate Only)

The purpose of this edit is to verify that the CS data items, when entered, are correctly coded for Death Certificate Only cases (Type of Reporting Source = 7).

The valid codes for each schema can be found in the table, "Table of Unknown and Not Applicable Values for Collaborative Staging Data Items, by Schema Name", available on the CS web page (cancerstaging.org/cstage/software.html).

Edit Name: CS Items, DX Pre-2004 (CS)
Agency: CS **Last Changed:** 12/11/2003
Fields: Date of Diagnosis [Std# 390]
CS Tumor Size [Std# 2800]
CS Extension [Std# 2810]
CS Tumor Size/Ext Eval [Std# 2820]
CS Lymph Nodes [Std# 2830]
CS Reg Nodes Eval [Std# 2840]
CS Mets at DX [Std# 2850]
CS Mets Eval [Std# 2860]
CS Site-Specific Factor 1 [Std# 2880]

CS Items, DX Pre-2004 (CS) (continued)

CS Site-Specific Factor 2 [Std# 2890]
CS Site-Specific Factor 3 [Std# 2900]
CS Site-Specific Factor 4 [Std# 2910]
CS Site-Specific Factor 5 [Std# 2920]
CS Site-Specific Factor 6 [Std# 2930]

Description:

If year of Date of Diagnosis is less than 2004, then the following CS data items must be blank:

CS Tumor Size
CS Extension
CS Tumor Size/Ext Eval
CS Lymph Nodes
CS Reg Nodes Eval
CS Mets at DX
CS Mets Eval
CS Site-Specific Factor 1
CS Site-Specific Factor 2
CS Site-Specific Factor 3
CS Site-Specific Factor 4
CS Site-Specific Factor 5
CS Site-Specific Factor 6

Edit Name: CS Items, Type Reporting Source (NPCR)

Agency: CS

Last Changed: 04/11/2007

Fields: Date of Diagnosis [Std# 390]
Type of Reporting Source [Std# 500]
CS Extension [Std# 2810]
CS Lymph Nodes [Std# 2830]
CS Mets at DX [Std# 2850]
CS Site-Specific Factor 1 [Std# 2880]
CS Site-Specific Factor 3 [Std# 2900]

Description:

This edit is skipped if year of Date of Diagnosis is less than 2004 or equal to 9999.

If Type of Reporting Source = 7 (Death Certificate Only):

CS Extension must = 88 or 99
CS Lymph Nodes must = 88 or 99
CS Mets at DX must = 88 or 99
CS Site-Specific Factor 1 must = 096, 888, or 999; may be empty
CS Site-Specific Factor 3 must = 096, 099, 888, or 999; may be empty

Edit Name: CS Lymph Nodes (CS)

Agency: CS

Last Changed: 09/28/2003

Fields: CS Lymph Nodes [Std# 2830]

Description:

Must be a valid two-digit number (00-99) or blank.

Edit Name: CS Lymph Nodes, Nodes Pos, SSF3, Breast Schema(CS)

CS Lymph Nodes, Nodes Pos, SSF3, Breast Schema(CS) (continued)

Agency: CS **Last Changed:** 04/27/2007

Fields: Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Lymph Nodes [Std# 2830]
Regional Nodes Positive [Std# 820]
CS Site-Specific Factor 3 [Std# 2900]

Description:

This edit is skipped if CS Lymph Nodes or CS Site-Specific Factor 3 is empty.

This edit is skipped for the following histologies:

Kaposi Sarcoma (Histologic Type ICD-O-3 = 9140)
Lymphoma (Histologic Type ICD-O-3 = 9590-9699, 9702-9729)
Hematopoietic (Histologic Type ICD-O-3 = 9731-9989)

If Primary Site = C500-C509 (Breast schema):

If CS Lymph Nodes = 05 (none, no regional lymph nodes but with ITCs detected on routine H and E stains), then Regional Nodes Positive must = 00 (all nodes examined negative) and CS Site-Specific Factor 3 must = 000 (all ipsilateral nodes examined negative).

Edit Name: CS Lymph Nodes, Primary Site, Histol ICDO3 (NAACCR)

Agency: NAACCR **Last Changed:** 04/21/2007

Fields: CS Lymph Nodes [Std# 2830]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Description:

This edit was adapted from a C/NET edit and is part of a set of supplemental Collaborative Staging edits that were developed to provide additional error catching beyond that already included in the error handling portion of the CS algorithm routine.

This edit validates CS Lymph Nodes by primary site and histology.

There is an exception for the group 90 schema "OthEndocrine" (C379, C740-741, C749, C750-C755, and C758-C759). If Primary Site = C751, C752, or C753, CS Lymph Nodes must be coded 99.

This edit does not check for obsolete codes. Obsolete codes for CS Lymph Nodes are edited by "Obsolete Codes - CS Lymph Nodes (SEER IF147)" and "Obsolete Codes - CS Lymph Nodes (NAACCR)".

Groups (by number) are

01 LipUpper
02 LipLower
03 OthLip
04 BaseTongue
05 AntTongue
06 GumUpper
07 GumLower
08 OthGum
09 FOM
10 HardPalate

CS Lymph Nodes, Primary Site, Histol ICDO3 (NAACCR (continued))

11 SoftPalate
12 OthMouth
13 BuccalMucosa
14 ParotidGland
15 SubmandibularGland
16 OthSalivary
17 Oropharynx
18 AntEpiglottis
19 Nasopharynx
20 Hypopharynx
21 OthPharynx
22 Esophagus
23 Stomach
24 SmallIntestine
25 Colon
26 Rectum
27 Anus
28 Liver
29 Gallbladder
30 ExtraHepaticDucts
31 Ampulla
32 OthBiliary
33 PancreasHead
34 PancreasBodyTail
35 OthPancreas
36 OthDigestive
37 NasalCavity
38 MiddleEar
39 MaxillarySinus
40 EthmoidSinus
41 OthSinus
42 GlotticLarynx
43 SupraLarynx
44 SubLarynx
45 OthLarynx
46 Trachea
47 Lung
48 HeartMediastinum
49 Pleura
50 OthRespiratory
51 Bone
52 Skin
53 SkinEyelid
54 Melanoma
55 MF
56 SoftTissue
57 Peritoneum
58 Breast
59 Vulva
60 Vagina
61 Cervix
62 Corpus
63 Ovary
64 FallopianTube
65 OthAdnexa
66 OthFemaleGen
67 Placenta
68 Penis

CS Lymph Nodes, Primary Site, Histol ICDO3 (NAACCR (continued))

69 Prostate
70 Testis
71 OthMaleGen
72 Scrotum
73 Kidney
74 RenalPelvis
75 Bladder
76 Urethra
77 OthUrinary
78 Conjunctiva
79 MelanomaConjunctiva
80 OthEye
81 MelanomaIrisCiliary
82 MelanomaChoroid
83 MelanomaOthEye
84 LacrimalGland
85 Orbit
86 Retinoblastoma
87 Brain
88 OthCNS
89 Thyroid
90 OthEndocrine
91 KS
92 Lymphoma
93 HemeRetic
94 OthIllDef

Edit Name: CS Lymph Nodes, Regional Nodes Positive (CS)

Agency: CS

Last Changed: 03/21/2005

Fields: Regional Nodes Positive [Std# 820]
CS Lymph Nodes [Std# 2830]

Description:

This edit is skipped if either CS Lymph Nodes or Regional Nodes Positive is empty.

If Regional Nodes Positive = 01-97, then CS Lymph Nodes cannot = 00.

Edit Name: CS Lymph Nodes, SSF 1, Head/Neck Schemas (CS)

Agency: CS

Last Changed: 04/27/2007

Fields: Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Lymph Nodes [Std# 2830]
CS Site-Specific Factor 1 [Std# 2880]

Description:

This edit is skipped if CS Lymph Nodes is empty.

This edit is skipped for the following CS schemas which are histologically based:

Kaposi Sarcoma (Histologic Type ICD-O-3 = 9140)
Lymphoma (Histologic Type ICD-O-3 = 9590-9699, 9702-9729)
Hematopoietic (Histologic Type ICD-O-3 = 9731-9989)

CS Lymph Nodes, SSF 1, Head/Neck Schemas (CS) (continued)

If Primary Site = C000-C148 or C300-C329 (Head and Neck site schemas):

If CS Lymph Nodes not = 00 or 99, then CS Site-Specific Factor 1 must not = 000.

Edit Name: CS Lymph Nodes, SSF 3,4,5, Breast Schema (CS)

Agency: CS

Last Changed: 04/15/2007

Fields: Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Lymph Nodes [Std# 2830]
CS Site-Specific Factor 3 [Std# 2900]
CS Site-Specific Factor 4 [Std# 2910]
CS Site-Specific Factor 5 [Std# 2920]

Description:

This edit is skipped if CS Lymph Nodes is empty.

This edit is skipped for the following CS schemas which are histologically based:

Kaposi Sarcoma (Histologic Type ICD-O-3 = 9140)
Lymphoma (Histologic Type ICD-O-3 = 9590-9699, 9702-9729)
Hematopoietic (Histologic Type ICD-O-3 = 9731-9989)

If Primary Site = C500-C509 (Breast schema):

If CS Lymph Nodes = 00, then both CS Site-Specific Factor 4 and CS Site-Specific Factor 5 must not = 888.

If CS Lymph Nodes not = 00, then both CS Site-Specific Factor 4 and CS Site-Specific Factor 5, if not blank, must = 888.

If CS Site-Specific Factor 3 = 001-097, then CS Lymph Nodes must not = 00, 74, or 77.

Edit Name: CS Mets at DX (CS)

Agency: CS

Last Changed: 09/28/2003

Fields: CS Mets at DX [Std# 2850]

Description:

Must be a valid two-digit number (00-99) or blank.

Edit Name: CS Mets at DX, Primary Site, Histol ICDO3 (NAACCR)

Agency: NAACCR

Last Changed: 04/21/2007

Fields: CS Mets at DX [Std# 2850]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Description:

This edit was adapted from a C/NET edit and is part of a set of supplemental Collaborative Staging edits that were developed to provide additional error catching beyond that already included in the error handling portion of the CS algorithm routine.

CS Mets at DX, Primary Site, Histol ICDO3 (NAACCR) (continued)

This edit does not check for obsolete codes. Obsolete codes for CS Extension are edited by "Obsolete Codes - CS Mets at DX (SEER IF148)" and "Obsolete Codes - CS Mets at DX (NAACCR)".

Groups (by number) are

- 01 LipUpper
- 02 LipLower
- 03 OthLip
- 04 BaseTongue
- 05 AntTongue
- 06 GumUpper
- 07 GumLower
- 08 OthGum
- 09 FOM
- 10 HardPalate
- 11 SoftPalate
- 12 OthMouth
- 13 BuccalMucosa
- 14 ParotidGland
- 15 SubmandibularGland
- 16 OthSalivary
- 17 Oropharynx
- 18 AntEpiglottis
- 19 Nasopharynx
- 20 Hypopharynx
- 21 OthPharynx
- 22 Esophagus
- 23 Stomach
- 24 SmallIntestine
- 25 Colon
- 26 Rectum
- 27 Anus
- 28 Liver
- 29 Gallbladder
- 30 ExtraHepaticDucts
- 31 Ampulla
- 32 OthBiliary
- 33 PancreasHead
- 34 PancreasBodyTail
- 35 OthPancreas
- 36 OthDigestive
- 37 NasalCavity
- 38 MiddleEar
- 39 MaxillarySinus
- 40 EthmoidSinus
- 41 OthSinus
- 42 GlotticLarynx
- 43 SupraLarynx
- 44 SubLarynx
- 45 OthLarynx
- 46 Trachea
- 47 Lung
- 48 HeartMediastinum
- 49 Pleura
- 50 OthRespiratory
- 51 Bone

CS Mets at DX, Primary Site, Histol ICDO3 (NAACCR) (continued)

52 Skin
53 SkinEyelid
54 Melanoma
55 MF
56 SoftTissue
57 Peritoneum
58 Breast
59 Vulva
60 Vagina
61 Cervix
62 Corpus
63 Ovary
64 FallopianTube
65 OthAdnexa
66 OthFemaleGen
67 Placenta
68 Penis
69 Prostate
70 Testis
71 OthMaleGen
72 Scrotum
73 Kidney
74 RenalPelvis
75 Bladder
76 Urethra
77 OthUrinary
78 Conjunctiva
79 MelanomaConjunctiva
80 OthEye
81 MelanomaIrisCiliary
82 MelanomaChoroid
83 MelanomaOthEye
84 LacrimalGland
85 Orbit
86 Retinoblastoma
87 Brain
88 OthCNS
89 Thyroid
90 OthEndocrine
91 KS
92 Lymphoma
93 HemeRetic
94 OthIllDef

Edit Name: CS Reg Nodes Ex, Pos, Site, Hist ICDO3, Report(CS)

Agency: CS

Last Changed: 05/17/2007

Fields: Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
Regional Nodes Examined [Std# 830]
Regional Nodes Positive [Std# 820]
Type of Reporting Source [Std# 500]

Description:

This edit is also skipped if Regional Nodes Examined or Regional Nodes Positive is blank.

CS Reg Nodes Ex, Pos, Site, Hist ICDO3, Report(CS) (continued)

If Death Certificate only case (Type of Reporting Source = '7') the Regional Nodes Positive and Regional Nodes Examined must both be coded 99.

For the following sites and histologies (ICD-O-3), Regional Nodes Positive and Regional Nodes Examined must both be coded '99'.

1. Hematopoietic: 9731-9734, 9740-9758, 9760-9989
2. Lymphomas: 9590-9699, 9702-9729
3. Brain (except for histology 9140 (Kaposi sarcoma)):
C700, C710-C719
4. Other CNS (except for histology 9140 (Kaposi sarcoma)):
C701, C709, C720-C725, C728, C729
5. Other and ill-defined (except for histology 9140 (Kaposi sarcoma)):
C420-C429, C760-C765, C767, C768, C770-C779, C809
6. Placenta (C589) and Intracranial Other Endocrine (C751, C752, C753)

For all cases, the following is checked:

1. If Regional Nodes Examined = 00 , Regional Nodes Positive must = 98.
2. If Regional Nodes Examined = 01 - 90, Regional Nodes Positive must = 97 or 99, or be less than or equal to Regional Nodes Examined.
3. If Regional Nodes Examined = 96, 97, or 98, Regional Nodes Positive must = 00 - 90, 97, or 99.
4. If Regional Nodes Examined = 99, then Regional Nodes Positive must = 99.
5. If Regional Nodes Examined = 95, Regional Nodes Positive must = 00, 95, or 99.

Edit Name: CS Site-Specific Factor 1 (CS)

Agency: CS

Last Changed: 09/28/2003

Fields: CS Site-Specific Factor 1 [Std# 2880]

Description:

Must be a valid three-digit number (000-999) or blank.

Edit Name: CS Site-Specific Factor 2 (CS)

Agency: CS

Last Changed: 09/28/2003

Fields: CS Site-Specific Factor 2 [Std# 2890]

Description:

Must be a valid three-digit number (000-999) or blank.

Edit Name: CS Site-Specific Factor 3 (CS)
Agency: CS **Last Changed:** 09/28/2003
Fields: CS Site-Specific Factor 3 [Std# 2900]
Description:
Must be a valid three-digit number (000-999) or blank.

Edit Name: CS Site-Specific Factor 4 (CS)
Agency: CS **Last Changed:** 09/28/2003
Fields: CS Site-Specific Factor 4 [Std# 2910]
Description:
Must be a valid three-digit number (000-999) or blank.

Edit Name: CS Site-Specific Factor 5 (CS)
Agency: CS **Last Changed:** 09/28/2003
Fields: CS Site-Specific Factor 5 [Std# 2920]
Description:
Must be a valid three-digit number (000-999) or blank.

Edit Name: CS Site-Specific Factor 6 (CS)
Agency: CS **Last Changed:** 09/28/2003
Fields: CS Site-Specific Factor 6 [Std# 2930]
Description:
Must be a valid three-digit number (000-999) or blank.

Edit Name: CS SSF 1, OthCNS/OthEndocrine Schemas (CS)
Agency: CS **Last Changed:** 04/01/2004
Fields: Primary Site [Std# 400]
CS Site-Specific Factor 1 [Std# 2880]
Description:

This edit is skipped if CS Site-Specific Factor 1 is empty.

The schema Other Part of Central Nervous System includes C701, C709, C720-C725, C728, and C729. However, CS Site-Specific Factor 1 values of 010, 020, 030, and 040 are allowed only for C701 and C709. All other CS Site-Specific Factor values are the same for all sites in this schema and edited by the CS algorithm program.

Also, the schema Thymus, Adrenal (Suprarenal) Gland, and Other Endocrine Glands includes C379, C740-741, C749, C750-C755, and C758-C759. However, CS Site-Specific Factor 1 values of 010, 020, 030, and 040 are allowed only for C751, C752, and C753. All other CS Site-Specific Factor values are the same for all sites in this schema and edited by the CS algorithm program.

Edit Name: CS SSF 1, Primary Site, Histol ICDO3 (NAACCR)
Agency: NAACCR **Last Changed:** 03/30/2005
Fields: CS Site-Specific Factor 1 [Std# 2880]

CS SSF 1, Primary Site, Histol ICDO3 (NAACCR) (continued)

Primary Site [Std# 400]
 Histologic Type ICD-O-3 [Std# 522]
 Date of Diagnosis [Std# 390]

Description:

This edit was adapted from a C/NET edit and is part of a set of supplemental Collaborative Staging edits that were developed to provide additional error catching beyond that already included in the error handling portion of the CS algorithm routine.

This edit validates CS Site-Specific Factor 1 by primary site and histology. It also checks for obsolete CS Site-Specific Factor 1 codes using year of Date of Diagnosis. Obsolete codes should be re-coded per Collaborative Stage guidelines. If year of Date of Diagnosis is greater than 2004 and not equal 9999, then the following obsolete codes are not allowed:

Schema	CS Site-Specific Factor 1	Obsolete as of CS Version
Melanoma (8720-8790) Skin (C440-C449, C510-C512, C518-C519, C600-C602, C608-C609, C632)	990	01.01.00
Melanoma (8720-8790) Conjunctiva (C690)	990	01.02.00
Melanoma (8720-8790) Choroid (C693)	990	01.02.00
Melanoma (8720-8790) Iris & Ciliary Body (C694)	990	01.02.00

Edit Name: CS SSF 2, Primary Site, Histol ICDO3 (NAACCR)

Agency: NAACCR

Last Changed: 02/07/2005

Fields: CS Site-Specific Factor 2 [Std# 2890]
 Primary Site [Std# 400]
 Histologic Type ICD-O-3 [Std# 522]

Description:

This edit was adapted from a C/NET edit and is part of a set of supplemental Collaborative Staging edits that were developed to provide additional error catching beyond that already included in the error handling portion of the CS algorithm routine.

This edit validates CS Site-Specific Factor 2 by site and histology.

Edit Name: CS SSF 3, Breast Schema (CS)

Agency: CS

Last Changed: 04/27/2007

Fields: Primary Site [Std# 400]
 Histologic Type ICD-O-3 [Std# 522]
 Regional Nodes Examined [Std# 830]

CS SSF 3, Breast Schema (CS) (continued)

CS Site-Specific Factor 3 [Std# 2900]

Description:

This edit is skipped if CS Site-Specific Factor 3 is empty.

This edit is also skipped for the following histologies:

Kaposi Sarcoma (Histologic Type ICD-O-3 = 9140)
 Lymphoma (Histologic Type ICD-O-3 = 9590-9699, 9702-9729)
 Hematopoietic (Histologic Type ICD-O-3 = 9731-9989)

If Primary Site = Breast (C500-509):

If Regional Nodes Examined = 00 (no nodes examined), then
 CS Site-Specific 3 must = 098 (axillary LNs = none examined)

Edit Name: CS SSF 3, Primary Site, Histol ICDO3 (NAACCR)

Agency: NAACCR

Last Changed: 03/30/2005

Fields: CS Site-Specific Factor 3 [Std# 2900]
 Primary Site [Std# 400]
 Histologic Type ICD-O-3 [Std# 522]
 Date of Diagnosis [Std# 390]

Description:

This edit was adapted from a C/NET edit and is part of a set of supplemental Collaborative Staging edits that were developed to provide additional error catching beyond that already included in the error handling portion of the CS algorithm routine.

This edit validates CS Site-Specific Factor 3 by primary site and histology. It also checks for obsolete CS Site-Specific Factor 3 codes using year of Date of Diagnosis. Obsolete codes should be re-coded per Collaborative Stage guidelines. If year of Date of Diagnosis is greater than 2004 and not equal 9999, then the following obsolete codes are not allowed:

Schema	CS Site-Specific Factor 3	Obsolete as of CS Version
Prostate (C619)	031	01.02.00
	033	01.02.00
	034	01.02.00

Edit Name: CS SSF 3, RX Summ--Surg, Prostate Schema (CS)

Agency: CS

Last Changed: 04/27/2007

Fields: Primary Site [Std# 400]
 Histologic Type ICD-O-3 [Std# 522]
 RX Summ--Surg Prim Site [Std# 1290]
 CS Site-Specific Factor 3 [Std# 2900]
 Type of Reporting Source [Std# 500]

Description:

This edit is skipped if case is autopsy only (Type of Reporting Source = 6).

For cases using the CS Prostate schema, if no prostatectomy is coded in the

CS SSF 3, RX Summ--Surg, Prostate Schema (CS) (continued)

surgery field, CS Site-Specific Factor 3 must also show no prostatectomy.

If CS Site-Specific Factor 3 is not blank:

If Primary Site = C619 (Prostate) and Histologic Type ICD-O-3 is not = 9140(Kaposi Sarcoma), 9590-9699 (Lymphoma), 9702-9729 (Lymphoma), 9731-9989 (Hematopoietic):

If there was no prostatectomy (RX Summ--Surg Prim Site not = 30, 50, 70, 80, or 90), then CS Site-Specific Factor 3 must = 096, 097, or 098.

Edit Name: CS SSF 4, Primary Site, Histol ICDO3 (NAACCR)

Agency: NAACCR

Last Changed: 05/24/2007

Fields: CS Site-Specific Factor 4 [Std# 2910]
 Primary Site [Std# 400]
 Histologic Type ICD-O-3 [Std# 522]
 Date of Diagnosis [Std# 390]

Description:

This edit was adapted from a C/NET edit and is part of a set of supplemental Collaborative Staging edits that were developed to provide additional error catching beyond that already included in the error handling portion of the CS algorithm routine.

This edit validates CS Site-Specific Factor 4 by primary site and histology. It also checks for obsolete CS Site-Specific Factor 4 codes using year of Date of Diagnosis. Obsolete codes should be re-coded per Collaborative Stage guidelines. If year of Date of Diagnosis is greater than 2004 and not equal 9999, then the following obsolete codes are not allowed:

Schema	CS Site-Specific Factor 4	Obsolete as of CS Version
Prostate (C619)	000	01.02.00
	010	01.02.00
	020	01.02.00
	030	01.02.00
	080	01.02.00
	999	01.02.00

Edit Name: CS SSF 4, RX Summ--Surg, Testis Schema (CS)

Agency: CS

Last Changed: 04/27/2007

Fields: Primary Site [Std# 400]
 Histologic Type ICD-O-3 [Std# 522]
 RX Summ--Surg Prim Site [Std# 1290]
 CS Site-Specific Factor 4 [Std# 2910]
 Type of Reporting Source [Std# 500]

Description:

This edit is skipped if case is a death certificate only (Type of Reporting Source = 7).

CS SSF 4, RX Summ--Surg, Testis Schema (CS) (continued)

For cases using the CS Testis schema, if there is no radical orchiectomy coded in the surgery field, CS Site-Specific Factor 4 must also show no radical orchiectomy done, and vice versa.

If CS Site-Specific Factor 4 is not blank:

If Primary Site = C620-C629 (Testis) and Histologic Type ICD-O-3 is not = 9140 (Kaposi Sarcoma), 9590-9699 (Lymphoma), 9702-9729 (Lymphoma), 9731-9989

(Hematopoietic):

If RX Summ--Surg Prim Site = 80 (orchiectomy, NOS), 90 (Surgery, NOS), or 99 (unknown if surgery performed), then CS Site-Specific Factor 4 must = 000 (radical orchiectomy not performed) or 999 (unknown if radical orchiectomy performed).

Otherwise if there was no radical orchiectomy (RX Summ--Surg Prim Site not = 40), then CS Site-Specific Factor 4 must = 000.

If CS Site-Specific Factor 4 = 000, then RX Summ--Surg Prim Site must not = 40.

Edit Name: CS SSF 5, Primary Site, Histol ICDO3 (NAACCR)

Agency: NAACCR

Last Changed: 02/07/2005

Fields: CS Site-Specific Factor 5 [Std# 2920]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Description:

This edit was adapted from a C/NET edit and is part of a set of supplemental Collaborative Staging edits that were developed to provide additional error catching beyond that already included in the error handling portion of the CS algorithm routine.

This edit validates CS Site-Specific Factor 5 by site and histology.

Edit Name: CS SSF 5, SSF 6, Grade, Prostate Schema (CS)

Agency: CS

Last Changed: 04/27/2007

Fields: Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Site-Specific Factor 5 [Std# 2920]
CS Site-Specific Factor 6 [Std# 2930]
Grade [Std# 440]

Description:

For cases using the CS Prostate schema, if a Gleason's score and/or patterns are coded in CS Site-Specific Factor 5 and/or CS Site-Specific Factor 6, then Grade must not be coded 9 (unknown).

If CS Site-Specific Factor 5 or CS Site-Specific Factor 6 is not blank:

If Primary Site = C619 (Prostate) and Histologic Type ICD-O-3 is not = 9140 (Kaposi Sarcoma), 9590-9699 (Lymphoma), 9702-9729 (

CS SSF 5, SSF 6, Grade, Prostate Schema (CS) (continued)

Lymphoma), 9731-9989 (Hematopoietic):

If CS Site-Specific Factor 5 = (011-015, 021-025, 031-035, 041-045, or 051-055) or CS Site-Specific Factor 6 = 002-010, then Grade must not = 9.

Edit Name: CS SSF 6, Breast Schema (CS)

Agency: CS

Last Changed: 04/27/2007

Fields: Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]
CS Site-Specific Factor 6 [Std# 2930]

Description:

This edit is skipped if CS Site-Specific Factor 6 is empty.

This edit is also skipped for the following histologies:

Kaposi Sarcoma (Histologic Type ICD-O-3 = 9140)
Lymphoma (Histologic Type ICD-O-3 = 9590-9699, 9702-9729)
Hematopoietic (Histologic Type ICD-O-3 = 9731-9989)

If Primary Site = Breast (C500-509):

If Behavior Code ICD-O-3 = 2 (in situ), then CS Site-Specific Factor 6 must = 010 (entire tumor reported as in situ (no invasive component reported)) and vice versa.

Edit Name: CS SSF 6, Primary Site, Histol ICDO3 (NAACCR)

Agency: NAACCR

Last Changed: 02/07/2005

Fields: CS Site-Specific Factor 6 [Std# 2930]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Description:

This edit was adapted from a C/NET edit and is part of a set of supplemental Collaborative Staging edits that were developed to provide additional error catching beyond that already included in the error handling portion of the CS algorithm routine.

This edit validates CS Site-Specific Factor 6 by site and histology.

Edit Name: CS Tumor Size (CS)

Agency: CS

Last Changed: 09/28/2003

Fields: CS Tumor Size [Std# 2800]

Description:

Must be a valid three-digit number (000-999) or blank.

Edit Name: CS Tumor Size, Primary Site, Histol ICDO3 (NAACCR)

CS Tumor Size, Primary Site, Histol ICDO3 (NAACCR) (continued)

Agency: NAACCR **Last Changed:** 04/16/2007

Fields: CS Tumor Size [Std# 2800]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Description:

If Kaposi's Sarcoma, Lymphoma, or HemeRetic, CS Tumor Size must be 888.

If site = {C150-C169, C180-C209}, CS Tumor Size may be {000-995,998-999}.

If site = {C340-C349, C500-C509}, CS Tumor Size may be {000-999}.

Otherwise, CS Tumor Size may be {000-995,999}.

Edit Name: CS Tumor Size, Site, Histol ICDO3 (CS)

Agency: CS **Last Changed:** 05/26/2004

Fields: CS Tumor Size [Std# 2800]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Description:

This edit is skipped if CS Tumor Size is empty.

This edit is skipped for the following CS schemas which are histologically based:

Kaposi Sarcoma (Histologic Type ICD-O-3 = 9140)

Lymphoma (Histologic Type ICD-O-3 = 9590-9699, 9702-9729)

Hematopoietic (Histologic Type ICD-O-3 = 9731-9989)

If Primary Site = Colon (C180-C189), Rectosigmoid (C199) or Rectum (C209):

If CS Tumor Size = 998, then Histologic Type ICD-O-3 must = 8220 or 8221.

If Primary Site = Unknown Primary Site (C809), then CS Tumor Size must = 999.

Edit Name: CS Tumor Size, SSF 1, Malign Melanoma Schemas (CS)

Agency: CS **Last Changed:** 04/27/2007

Fields: Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
CS Tumor Size [Std# 2800]
CS Site-Specific Factor 1 [Std# 2880]

Description:

This edit is skipped if CS Tumor Size or CS Site-Specific Factor 1 is empty.

This edit applies all Malignant Melanoma schemas except Other Eye (C691, C692, C695, C698, C699).

If Histologic Type ICD-O-3 = 8720-8790 (Malignant Melanoma) and the Primary Site = any of the following:

C440-C449, C510-C512, C518-C519, C600-C602, C608-C609, C632 (skin, vulva, penis, scrotum), C690 (conjunctiva), C693 (choroid), C694 (iris & ciliary body)

CS Tumor Size, SSF 1, Malign Melanoma Schemas (CS) (continued)

If CS Tumor Size = 000 then, CS Site-Specific Factor 1
must = 000 and vice versa.

Edit Name: CS Version 1st (CS)

Agency: CS

Last Changed: 04/11/2007

Fields: CS Version 1st [Std# 2935]

Description:

Must be a six-digit number or blank. If not blank, the first four digits must = 0100, 0101, 0102, 0103, or the full number must = 000937 (a trial version).

Edit Name: CS Version 1st, CS Version Latest (CS)

Agency: CS

Last Changed: 02/18/2005

Fields: CS Version 1st [Std# 2935]

CS Version Latest [Std# 2936]

Description:

This edit is skipped if either field is blank.

CS Version Latest must be greater than or equal to CS Version 1st.

Edit Name: CS Version Latest (SEER)

Agency: SEER

Last Changed: 04/11/2007

Fields: CS Version Latest [Std# 2936]

Description:

Must be a six-digit number or blank. If not blank, the first four digits must = 0102 or 0103.

Edit Name: Date of 1st Crs RX--COC (NPCR)

Agency: NPCR

Last Changed: 04/27/2007

Fields: Date of 1st Crs RX--COC [Std# 1270]

Description:

This edit is skipped if Date of 1st Crs RX--COC is blank.

1. This edit first checks that the date is a valid date using the following generic date checking criteria:

- a) All parts of a date must be zero-filled; blanks and non-digits are not allowed.
- b) Allowable values for month, day, and year are verified. Checks are performed first for error conditions, then unknown conditions; within this order, first year is checked, then month, then day. Checking is halted when the first non-valid condition is reached.

ERROR conditions:

YEAR--lowest allowed value is current (system)
year - 150; highest allowed year is current (system)

Date of 1st Crs RX--COC (NPCR) (continued)

year + 5.
 MONTH--allowed values are 0-12 and 99.
 DAY--allowed values are 0-31 and 99. Upper bounds for known values are checked for each individual month, and a value of 29 for February is allowed only in leap years or for unknown or missing years (9999 or 0000).

UNKNOWN conditions: unknown values are allowed for year, month, and day, but see individual date edit descriptions for checks of validity between unknown components of year.

2. Checks specific to Date of 1st Crs RX--COC are then performed:
 - a) If the year is 0000, month and day must also equal 00. (A date of all zeroes means there was no treatment.) A partial date of zeroes will fail as a MISSING condition.
 - b) If the year is unknown (9999), month and day must be unknown (99 and 99, respectively).
 - c) If the month is unknown (99), the day must be unknown (99).
 - d) Year must be less than or equal to the current year.
 - e) If the year is equal to the current year and month is known, the month must be less than or equal to the current month.
 - f) If year and month are equal to the current year and month and the day is known, the day must be less than or equal to the current day.

Edit Name: Date of 1st Crs RX--COC, Date Init RX--SEER (NPCR)

Agency: NPCR

Last Changed: 08/08/2005

Fields: Date of 1st Crs RX--COC [Std# 1270]
 Date of Initial RX--SEER [Std# 1260]

Description:

Date of 1st Crs RX--COC and Date of Initial RX--SEER cannot both be blank.

Edit Name: Date of 1st Crs RX--COC, Date Last Contact (COC)

Agency: COC

Last Changed: 03/04/2003

Fields: Date of Last Contact [Std# 1750]
 Date of 1st Crs RX--COC [Std# 1270]

Description:

This edit is skipped if Date of 1st Crs RX--COC or Date of Last Contact is blank.

Date of Last Contact (also referred to as Date of Last Follow-Up or of Death) must not precede Date of 1st Crs RX--COC. If Date of 1st Crs RX--COC = 00000000 the edit is skipped. If either year is unknown (9999) the edit is skipped. If

Date of 1st Crs RX--COC, Date Last Contact (COC) (continued)

either month is unknown (99), then only the years are compared. If either day is unknown (99), then only the years and months are compared.

Edit Name: Date of 1st Crs RX--COC, Date of DX (COC)
Agency: COC **Last Changed:** 03/04/2003
Fields: Date of 1st Crs RX--COC [Std# 1270]
Date of Diagnosis [Std# 390]

Description:

This edit is skipped if Date of 1st Crs RX--COC or Date of Diagnosis is blank.

Date of 1st Crs RX--COC must not precede Date of Diagnosis. If Date of 1st Crs RX--COC = 00000000 the edit is skipped. If either year is unknown (9999) the edit is skipped. If either month is unknown (99), then only the years are compared. If either day is unknown (99), then only the years and months are compared.

Edit Name: Date of Init RX--SEER, Date Last Cont(NAACCR IF35)
Agency: NAACCR **Last Changed:** 04/12/2007
Fields: Date of Last Contact [Std# 1750]
Date of Initial RX--SEER [Std# 1260]

Description:

This edit is skipped if any of the single fields for Date of Initial RX--SEER or Date of Last Contact have failed.

Date of Last Contact (also referred to as Date of Last Follow-Up or of Death) must not precede Date of Initial RX--SEER. If Date of Initial RX--SEER = 00000000 the edit is skipped. If either year is unknown (9999) the edit is skipped. If either month is unknown (99), then only the years are compared. If either day is unknown (99), then only the years and months are compared.

Edit Name: Date of Init RX--SEER, Date of DX (NAACCR IF18)
Agency: NAACCR **Last Changed:** 04/12/2007
Fields: Date of Initial RX--SEER [Std# 1260]
Date of Diagnosis [Std# 390]

Description:

This edit is skipped if any of the single fields for Date of Initial RX--SEER or Date of Diagnosis have failed.

Date of Initial RX--SEER must not precede Date of Diagnosis. If Date of Initial RX--SEER = 00000000 the edit is skipped. If either year is unknown (9999) the edit is skipped. If either month is unknown (99), then only the years are compared. If either day is unknown (99), then only the years and months are compared.

Edit Name: Date of Initial RX--SEER (NPCR)
Agency: NPCR **Last Changed:** 04/27/2007
Fields: Date of Initial RX--SEER [Std# 1260]

Date of Initial RX--SEER (NPCR) (continued)

Description:

This edit is skipped if Date of Initial RX--SEER is blank.

1. This edit first checks that the date is a valid date using the following generic date checking criteria:

- a) All parts of a date must be zero-filled; blanks and non-digits are not allowed.
- b) Allowable values for month, day, and year are verified. Checks are performed first for error conditions, then unknown conditions; within this order, first year is checked, then month, then day. Checking is halted when the first non-valid condition is reached.

ERROR conditions:

YEAR--lowest allowed value is current (system)

year - 150; highest allowed year is current (system)

year + 5.

MONTH--allowed values are 0-12 and 99.

DAY--allowed values are 0-31 and 99. Upper bounds for known values are checked for each individual month, and a value of 29 for February is allowed only in leap years or for unknown or missing years (9999 or 0000).

UNKNOWN conditions: unknown values are allowed for year, month, and day, but see individual date edit descriptions for checks of validity between unknown components of year.

2. Checks specific to Date of Initial RX--SEER are then performed:
 - a) If the year is 0000, month and day must also equal 00. (A date of all zeroes means there was no treatment.) A partial date of zeroes will fail as a MISSING condition.
 - b) If the year is unknown (9999), month and day must be unknown (99 and 99, respectively).
 - c) If the month is unknown (99), the day must be unknown (99).
 - d) Year must be less than or equal to the current year.
 - e) If the year is equal to the current year and month is known, the month must be less than or equal to the current month.
 - f) If year and month are equal to the current year and month and the day is known, the day must be less than or equal to the current day.

Edit Name: Date of Last Contact (NAACCR DATEEDIT)

Agency: NAACCR

Last Changed: 04/27/2007

Fields: Date of Last Contact [Std# 1750]

Date of Last Contact (NAACCR DATEEDIT) (continued)

Description:

The edit does the following:

1. This edit first checks that the date is a valid date using the following generic date checking criteria:
 - a) All parts of a date must be zero-filled; blanks and non-digits are not allowed.
 - b) Allowable values for month, day, and year are verified. Checks are performed first for error conditions, then missing conditions, then unknown conditions; within this order, first year is checked, then month, then day. Checking is halted when the first non-valid condition is reached.

ERROR conditions:

YEAR--lowest allowed value is current (system)

year - 150; highest allowed year is current (system)

year + 5.

MONTH--allowed values are 0-12 and 99.

DAY--allowed values are 0-31 and 99. Upper bounds for known values are checked for each individual month, and a value of 29 for February is allowed only in leap years or for unknown or missing years (9999 or 0000).

MISSING conditions: missing values (0) are not allowed for year, month, or day.

UNKNOWN conditions: unknown values are allowed for year, month, and day, but see individual date edit descriptions for checks of validity between unknown components of year.

2. Checks specific to Date of Last Contact are then performed:
 - a) If the year is unknown (9999), month and day must be unknown (99 and 99, respectively).
 - b) If the month is unknown (99), the day must be unknown (99).
 - c) Year of last contact must be less than or equal to the current year.
 - d) If the year of last contact is equal to the current year and month is known, the month must be less than or equal to the current month.
 - e) If the year and month of last contact are equal to the current year and month and the day is known, the day must be less than or equal to the current day.

Edit Name: Date of Last Contact, Cause of Death (SEER IF12)

Agency: SEER

Last Changed: 04/12/2007

Fields: Cause of Death [Std# 1910]
Date of Last Contact [Std# 1750]
Vital Status [Std# 1760]

Date of Last Contact, Cause of Death (SEER IF12) (continued)

ICD Revision Number [Std# 1920]

Description:

The ICD-9 Cause of Death codes for AIDS (0420-0449) may be used only after 1986.

If the ICD Code Used for Cause of Death is '9' (Ninth revision), the Vital Status is dead (4) and Year of Follow-up > 1986, then the Underlying Cause of Death may be in the range 0420-0449 (AIDS related causes).

Edit Name: Date of Last Contact, Date of Diag. (NAACCR IF19)

Agency: NAACCR

Last Changed: 04/11/2007

Fields: Date of Diagnosis [Std# 390]

Date of Last Contact [Std# 1750]

Description:

Date of Last Contact must not precede Date of Diagnosis. If either year is unknown (9999), the edit is skipped. If either month is unknown (99), then only the years are compared.

If either day is unknown (99), then only the years and months are compared.

Edit Name: Date of Multiple Tumors, Date of DX (SEER IF165)

Agency: SEER

Last Changed: 05/22/2006

Fields: Date of Diagnosis [Std# 390]

Date of Multiple Tumors [Std# 445]

Description:

If year of Date of Diagnosis is greater than 2006 and not equal to 9999, then Date of Multiple Tumors cannot be blank.

If year of Date of Diagnosis is less than 2007, then Date of Multiple Tumors must be blank.

Edit Name: DC State File Number, Vital Status (NAACCR)

Agency: NAACCR

Last Changed: 03/29/1997

Fields: DC State File Number [Std# 2380]

Vital Status [Std# 1760]

Description:

If Vital Status = 1 (alive), then DC State File Number must be blank.

Edit Name: Death Certificate Only, RX (NPCR)

Agency: NPCR

Last Changed: 05/14/2007

Fields: Date of Diagnosis [Std# 390]

Type of Reporting Source [Std# 500]

RX Summ--Surg Prim Site [Std# 1290]

RX Summ--Scope Reg LN Sur [Std# 1292]

RX Summ--Surg Oth Reg/Dis [Std# 1294]

Reason for No Surgery [Std# 1340]

RX Summ--BRM [Std# 1410]

RX Summ--Chemo [Std# 1390]

Death Certificate Only, RX (NPCR) (continued)

RX Summ--Hormone [Std# 1400]
 RX Summ--Other [Std# 1420]
 RX Summ--Transplnt/Endocr [Std# 3250]
 Rad--Regional RX Modality [Std# 1570]
 RX Summ--Surg/Rad Seq [Std# 1380]
 RX Summ--Systemic/Sur Seq [Std# 1639]

Description:

This edit is skipped if year of Date of Diagnosis is less than 2006 or equal to 9999.

If Type of Reporting Source is 7 (death certificate only):

1. RX Summ--Surg Prim Site must = 98 or 99
2. RX Summ--Scope Reg LN Sur must = 9
3. RX Summ--Surg Oth Reg/Dis must = 9
4. Reason for No Surgery must = 9
5. RX Summ--BRM must = 99
6. RX Summ--Chemo must = 99
7. RX Summ--Hormone must = 99
8. RX Summ--Other must = 9
9. RX Summ--Transplnt/Endocr = 99
10. Rad--Regional RX Modality must = 99
11. RX Summ--Surg/Rad Seq must = 0
12. RX Summ--Systemic/Sur Seq must = 0

Edit Name: Derived AJCC M (CS)

Agency: CS

Last Changed: 04/27/2007

Fields: Derived AJCC M [Std# 2980]

Description:

Must be a valid two-digit Storage Code for Derived AJCC M. May be blank.

The following Storage Codes are valid:
 00, 10-13, 19, 88, 99

This table shows the corresponding Display String for each Storage Code:

Storage Code	Display String	Comments
99	MX	MX
00	M0	M0
10	M1	M1
11	M1a	M1a
12	M1b	M1b
13	M1c	M1c
19	M1NOS	M1 NOS
88	NA	Not applicable

Edit Name: Derived AJCC N (CS)

Agency: CS

Last Changed: 04/27/2007

Fields: Derived AJCC N [Std# 2960]

Description:

Must be a valid two-digit Storage Code for Derived AJCC N. May be blank.

Derived AJCC N (CS) (continued)

The following Storage Codes are valid:

00-04, 09-13, 18-23, 29, 30-33, 39, 88, 99

This table shows the corresponding Display String for each Storage Code:

Storage Code	Display String	Comments
99	NX	NX
00	N0	N0
09	N0NOS	N0 NOS
01	N0(i?)	N0(i?)
02	N0(i+)	N0(i+)
03	N0(mol?)	N0(mol?)
04	N0(mol+)	N0(mol+)
10	N1	N1
19	N1NOS	N1 NOS
11	N1a	N1a
12	N1b	N1b
13	N1c	N1c
18	N1mi	N1mi
20	N2	N2
29	N2NOS	N2 NOS
21	N2a	N2a
22	N2b	N2b
23	N2c	N2c
30	N3	N3
39	N3NOS	N3 NOS
31	N3a	N3a
32	N3b	N3b
33	N3c	N3c
88	NA	Not applicable

Edit Name: Derived AJCC Stage Group (CS)

Agency: CS

Last Changed: 04/27/2007

Fields: Derived AJCC Stage Group [Std# 3000]

Description:

Must be a valid two-digit Storage Sode for Derived AJCC Stage Group. May be blank.

The following Storage Codes are valid:

00-02, 10-24, 30-43, 50-63, 70-74, 88, 90, 99

This table shows the corresponding Display String for each Storage Code:

Storage Code	Display String	Comments
00	0	Stage 0
01	0a	Stage 0a
020	is	Stage 0is
10	I	Stage I
11	INOS	Stage I NOS
12	IA	Stage IA
13	IA1	Stage IA1
14	IA2	Stage IA2
15	IB	Stage IB
16	IB1	Stage IB1

Derived AJCC Stage Group (CS) (continued)

17	IB2	Stage IB2
18	IC	Stage IC
19	IS	Stage IS
23	ISA	Stage ISA (lymphoma only)
24	ISB	Stage ISB (lymphoma only)
20	IEA	Stage IEA (lymphoma only)
21	IEB	Stage IEB (lymphoma only)
22	IE	Stage IE (lymphoma only)
30	II	Stage II
31	IINOS	Stage II NOS
32	IIA	Stage IIA
33	IIB	Stage IIB
34	IIC	Stage IIC
35	IIEA	Stage IIEA (lymphoma only)
36	IIEB	Stage IIEB (lymphoma only)
37	IIE	Stage IIE (lymphoma only)
38	IISA	Stage IISA (lymphoma only)
39	IISB	Stage IISB (lymphoma only)
40	IIS	Stage IIS (lymphoma only)
41	IIESA	Stage IIESA (lymphoma only)
42	IIESB	Stage IIESB (lymphoma only)
43	IIES	Stage IIES (lymphoma only)
50	III	Stage III
51	IIINOS	Stage III NOS
52	IIIA	Stage IIIA
53	IIIB	Stage IIIB
54	IIIC	Stage IIIC
55	IIIEA	Stage IIIEA (lymphoma only)
56	IIIEB	Stage IIIEB (lymphoma only)
57	IIIE	Stage IIIE (lymphoma only)
58	IIISA	Stage IIISA (lymphoma only)
59	IIISB	Stage IIISB (lymphoma only)
60	IIIS	Stage IIIS (lymphoma only)
61	IIIESA	Stage IIIESA (lymphoma only)
62	IIIESB	Stage IIIESB (lymphoma only)
63	IIIES	Stage IIIES (lymphoma only)
70	IV	Stage IV
71	IVNOS	Stage IV NOS
72	IVA	Stage IVA
73	IVB	Stage IVB
74	IVC	Stage IVC
88	NA	Not applicable
90	OCCULT	Stage Occult
99	UNK	Stage Unknown

Edit Name: Derived AJCC T (CS)

Agency: CS

Last Changed: 04/27/2007

Fields: Derived AJCC T [Std# 2940]

Description:

Must be a valid two-digit Storage Code for Derived AJCC T. May be blank.

The following Storage Codes are valid:

00, 01, 05-07, 10-23, 29-33, 39-44, 49, 88, 99

This table shows the corresponding Display String for each Storage Code:

Derived AJCC T (CS) (continued)

Storage Code	Display String	Comments
99	TX	TX
00	T0	T0
01	Ta	Ta
05	Tis	Tis
06	Tispu	Tispu (Urethra only)
07	Tispd	Tispd (Urethra only)
10	T1	T1
11	T1mic	T1mic
19	T1NOS	T1 NOS
12	T1a	T1a
13	T1a1	T1a1
14	T1a2	T1a2
15	T1b	T1b
16	T1b1	T1b1
17	T1b2	T1b2
18	T1c	T1c
20	T2	T2
29	T2NOS	T2 NOS
21	T2a	T2a
22	T2b	T2b
23	T2c	T2c
30	T3	T3
39	T3NOS	T3 NOS
31	T3a	T3a
32	T3b	T3b
33	T3c	T3c
40	T4	T4
49	T4NOS	T4 NOS
41	T4a	T4a
42	T4b	T4b
43	T4c	T4c
44	T4d	T4d
88	NA	Not applicable

Edit Name: Derived AJCC--Flag (CS)**Agency:** CS**Last Changed:** 09/29/2003**Fields:** Derived AJCC--Flag [Std# 3030]**Description:**

Must be a valid value for Derived AJCC--Flag (1,2). May be blank.

Edit Name: Derived AJCC--Flag, Derived AJCC (COC)**Agency:** CS**Last Changed:** 12/11/2003**Fields:** Derived AJCC--Flag [Std# 3030]
Derived AJCC T [Std# 2940]
Derived AJCC T Descriptor [Std# 2950]
Derived AJCC N [Std# 2960]
Derived AJCC N Descriptor [Std# 2970]
Derived AJCC M [Std# 2980]
Derived AJCC M Descriptor [Std# 2990]
Derived AJCC Stage Group [Std# 3000]

Derived AJCC--Flag, Derived AJCC (COC) (continued)

Description:

This edit checks the AJCC--Flag against the derived data items as required by COC.

If Derived AJCC--Flag is blank, then the following fields must be blank:

- Derived AJCC T
- Derived AJCC T Descriptor
- Derived AJCC N
- Derived AJCC N Descriptor
- Derived AJCC M
- Derived AJCC M Descriptor
- Derived AJCC Stage Group

If Derived AJCC--Flag is not blank, then the following fields must not be blank:

- Derived AJCC T
- Derived AJCC T Descriptor
- Derived AJCC N
- Derived AJCC N Descriptor
- Derived AJCC M
- Derived AJCC M Descriptor
- Derived AJCC Stage Group

Edit Name: Derived Items, Date of DX (NPCR)

Agency: CS

Last Changed: 04/11/2007

Fields: Date of Diagnosis [Std# 390]
Derived SS2000 [Std# 3020]
CS Version 1st [Std# 2935]
CS Version Latest [Std# 2936]

Description:

If year of Date of Diagnosis is greater than 2003 and not equal 9999, then the following CS data items cannot be blank:

- Derived SS2000
- CS Version 1st
- CS Version Latest

Edit Name: Derived Items, DX Pre-2004 (CS)

Agency: CS

Last Changed: 12/11/2003

Fields: Date of Diagnosis [Std# 390]
Derived AJCC T [Std# 2940]
Derived AJCC T Descriptor [Std# 2950]
Derived AJCC N [Std# 2960]
Derived AJCC N Descriptor [Std# 2970]
Derived AJCC M [Std# 2980]
Derived AJCC M Descriptor [Std# 2990]
Derived AJCC Stage Group [Std# 3000]
Derived SS1977 [Std# 3010]
Derived SS2000 [Std# 3020]
CS Version 1st [Std# 2935]
CS Version Latest [Std# 2936]

Derived Items, DX Pre-2004 (CS) (continued)

Description:

If year of Date of Diagnosis is less than 2004, then the following CS derived and version data items must be blank:

Derived AJCC T
 Derived AJCC T Descriptor
 Derived AJCC N
 Derived AJCC N Descriptor
 Derived AJCC M
 Derived AJCC M Descriptor
 Derived AJCC Stage Group
 Derived SS1977
 Derived SS2000
 CS Version 1st
 CS Version Latest

Edit Name: Derived SS1977 (CS)

Agency: CS

Last Changed: 04/27/2007

Fields: Derived SS1977 [Std# 3010]

Description:

Must be a valid one-digit Storage Code for Derived SS1977. May be blank.

The following Storage Codes are valid:
 0-5, 7-9

This table shows the corresponding Display String for each Storage Code:

Storage Code	Display String	Comments
0	IS	In situ
1	L	Localized
2	RE	Regional, direct extension
3	RN	Regional, lymph nodes only
4	RE+RN	Regional, extension and nodes
5	RNOS	Regional, NOS
7	D	Distant
8	NA	Not applicable
9	U	Unknown/Unstaged

Edit Name: Derived SS1977--Flag (CS)

Agency: CS

Last Changed: 09/29/2003

Fields: Derived SS1977--Flag [Std# 3040]

Description:

Must be a valid value for Derived SS1977--Flag (1,2). May be blank.

Edit Name: Derived SS1977--Flag, Derived SS1977 (CS)

Agency: CS

Last Changed: 09/29/2003

Fields: Derived SS1977--Flag [Std# 3040]
 Derived SS1977 [Std# 3010]

Description:

If Derived SS1977--Flag is blank, then Derived SS1977 must be blank.

Derived SS1977--Flag, Derived SS1977 (CS) (continued)

If Derived SS1977--Flag is not blank, then Derived SS1977 must not be blank.

Edit Name: Derived SS2000 (CS)

Agency: CS

Last Changed: 04/27/2007

Fields: Derived SS2000 [Std# 3020]

Description:

Must be a valid one-digit Storage Code for Derived SS2000. May be blank.

The following Storage Codes are valid:

0-5, 7-9

This table shows the corresponding Display String for each Storage Code:

Storage Code	Display String	Comments
0	IS	In situ
1	L	Localized
2	RE	Regional, direct extension
3	RN	Regional, lymph nodes only
4	RE+RN	Regional, extension and nodes
5	RNOS	Regional, NOS
7	D	Distant
8	NA	Not applicable
9	U	Unknown/Unstaged

Edit Name: Derived SS2000--Flag (CS)

Agency: CS

Last Changed: 09/29/2003

Fields: Derived SS2000--Flag [Std# 3050]

Description:

Must be a valid value for Derived SS2000--Flag (1,2). May be blank.

Edit Name: Derived SS2000--Flag, Derived SS2000 (CS)

Agency: CS

Last Changed: 09/29/2003

Fields: Derived SS2000--Flag [Std# 3050]

Derived SS2000 [Std# 3020]

Description:

If Derived SS2000--Flag is blank, then Derived SS2000 must be blank.

If Derived SS2000--Flag is not blank, then Derived SS2000 must not be blank.

Edit Name: Diagnostic Confirmation (SEER DXCONF)

Agency: SEER

Last Changed: 09/29/1995

Fields: Diagnostic Confirmation [Std# 490]

Description:

Must be a valid Diagnostic Confirmation code (1,2,4-9).

Diagnostic Confirmation, Behavior ICDO2(SEER IF31) (continued)

Edit Name: Diagnostic Confirmation, Behavior ICDO2(SEER IF31)

Agency: SEER

Last Changed: 04/12/2007

Fields: Over-ride Histology [Std# 2040]
Diagnostic Confirmation [Std# 490]
Behavior (92-00) ICD-O-2 [Std# 430]

Description:

This edit is skipped if Behavior (92-00) ICD-O-2 is blank. If a case has been previously reviewed and accepted as coded (Over-ride-Histology = 2 or 3), no further checking is done.

For in situ cases (Behavior (92-00) ICD-O-2 = 2), Diagnostic Confirmation must specify microscopic confirmation (1, 2 or 4).

Additional Information:

The distinction between in situ and invasive is very important to a registry, since prognosis is so different, and in situ cases are usually excluded from incidence rate calculations. Since the determination that a neoplasm has not invaded surrounding tissue, i.e., is in situ, is made via the microscope, cases coded in situ in behavior should have a microscopic confirmation code. However, very rarely, a physician will designate a case noninvasive or in situ without microscopic evidence.

Check that Behavior Code and Diagnostic Confirmation have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may also be required.

If upon review all items are correct as coded, an over-ride flag may be set so that the case will not be considered in error when the edit is run again. Set the Over-ride--Histology field to 2 (or 3, if the flag is also being set for the Morphology -Type/Behavior (SEER MORPH) edit).

Edit Name: Diagnostic Confirmation, Behavior ICDO3(SEER IF31)

Agency: SEER

Last Changed: 04/12/2007

Fields: Over-ride Histology [Std# 2040]
Diagnostic Confirmation [Std# 490]
Behavior Code ICD-O-3 [Std# 523]

Description:

This edit is skipped if Behavior Code ICD-O-3 is blank. If a case has been previously reviewed and accepted as coded (Over-ride-Histology = 2 or 3), no further checking is done.

For in situ cases (Behavior Code ICD-O-3 = 2), Diagnostic Confirmation must specify microscopic confirmation (1, 2 or 4).

Additional Information:

The distinction between in situ and invasive is very important to a registry, since prognosis is so different, and in situ cases are usually excluded from incidence rate calculations. Since the determination that a neoplasm has not invaded surrounding tissue, i.e., is in situ, is made via the microscope, cases

Diagnostic Confirmation, Behavior ICDO3(SEER IF31) (continued)

coded in situ in behavior should have a microscopic confirmation code. However, very rarely, a physician will designate a case noninvasive or in situ without microscopic evidence.

Check that Behavior Code and Diagnostic Confirmation have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may also be required.

If upon review all items are correct as coded, an over-ride flag may be set so that the case will not be considered in error when the edit is run again. Set the Over-ride--Histology field to 2 (or 3, if the flag is also being set for the Morphology -Type/Behavior (SEER MORPH) edit).

Edit Name: Diagnostic Confirmation, Date of Diag (SEER IF55)

Agency: SEER

Last Changed: 04/12/2007

Fields: Date of Diagnosis [Std# 390]
Diagnostic Confirmation [Std# 490]

Description:

1. For Diagnosis Year 1973-87, Diagnostic Confirmation may be 1, 2, 4, 6-9.
2. For Diagnosis Year 1988+, Diagnostic Confirmation may be 1, 2, 4-9.

Edit Name: Diagnostic Confirmation, Histology ICDO2(SEER IF48)

Agency: SEER

Last Changed: 04/27/2007

Fields: Over-ride Leuk, Lymphoma [Std# 2070]
Diagnostic Confirmation [Std# 490]
Histology (92-00) ICD-O-2 [Std# 420]

Description:

This edit is skipped if Histology (92-00) ICD-O-2 is blank.

If a case has been previously reviewed and accepted as coded (Over-ride Leuk, Lymphoma = 1), no further checking is done.

If Histology (92-00) ICD-O-2 = 9590 - 9717 (lymphoma) then Diagnostic Confirmation cannot be 6 (direct visualization) or 8 (clinical). If Histology (92-00) ICD-O-2 = 9720 - 9941 (leukemia and other) then Diagnostic Confirmation cannot be 6 (direct visualization).

Additional Information:

Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma that have diagnostic confirmation 6 (direct visualization) or 8 (clinical), and any leukemia with a diagnostic confirmation of 6 (direct visualization).

Check that the Histologic Type and Diagnostic Confirmation are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in Diagnostic Confirmation) for leukemias. Correction of errors may require inspection of the abstracted text,

Diagnostic Confirmation, Histology ICDO2(SEER IF48 (continued))

either online or as recorded on a paper abstract.

If upon review, all items are correct as coded, an over-ride flag may be set so that the case will not be considered in error when the edit is run again. Enter a 1 in the field Over-ride Leuk,Lymphoma to indicate that the coding is correct.

EXAMPLE

HISTOLOGIC TYPE 9821/3
DIAGNOSTIC CONFIRMATION 6 (DIRECT VISUALIZATION)

On review, this leukemia diagnosis was based on a hematologic study, CBC.
Correct the Diagnostic Confirmation code to 1 (Positive Histology).

Edit Name: Diagnostic Confirmation, Histology ICDO3(SEER IF48)

Agency: SEER

Last Changed: 04/27/2007

Fields: Over-ride Leuk, Lymphoma [Std# 2070]
Diagnostic Confirmation [Std# 490]
Histologic Type ICD-O-3 [Std# 522]

Description:

This edit is skipped if Histologic Type ICD-O-3 is blank.

If a case has been previously reviewed and accepted as coded (Over-ride Leuk, Lymphoma = 1), no further checking is done.

If Histologic Type ICD-O-3 = 9590 - 9729 (lymphoma) then Diagnostic Confirmation cannot be 6 (direct visualization) or 8 (clinical). If Histologic Type ICD-O-3 = 9731 - 9948 (leukemia and other) then Diagnostic Confirmation cannot be 6 (direct visualization).

Additional Information:

Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma that have diagnostic confirmation 6 (direct visualization) or 8 (clinical), and any leukemia with a diagnostic confirmation of 6 (direct visualization).

Check that the Histologic Type and Diagnostic Confirmation are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in Diagnostic Confirmation) for leukemias. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract.

If upon review, all items are correct as coded, an over-ride flag may be set so that the case will not be considered in error when the edit is run again. Enter a 1 in the field Over-ride Leuk,Lymphoma to indicate that the coding is correct.

EXAMPLE

HISTOLOGIC TYPE 9835/3
DIAGNOSTIC CONFIRMATION 6 (DIRECT VISUALIZATION)

On review, this leukemia diagnosis was based on a hematologic study, CBC.
Correct the Diagnostic Confirmation code to 1 (Positive Histology).

Edit Name: Edit Over-rides (NAACCR)

Agency: NAACCR

Last Changed: 04/12/2007

Fields: Over-ride Site/Type [Std# 2030]
Over-ride Histology [Std# 2040]
Over-ride Age/Site/Morph [Std# 1990]
Over-ride SeqNo/DxConf [Std# 2000]
Over-ride Site/Lat/SeqNo [Std# 2010]
Over-ride Surg/DxConf [Std# 2020]
Over-ride Report Source [Std# 2050]
Over-ride Ill-define Site [Std# 2060]
Over-ride Leuk, Lymphoma [Std# 2070]
Over-ride Site/Behavior [Std# 2071]
Over-ride Site/EOD/DX Dt [Std# 2072]
Over-ride Site/Lat/EOD [Std# 2073]
Over-ride Site/Lat/Morph [Std# 2074]
Over-ride SS/NodesPos [Std# 1981]
Over-ride SS/TNM-N [Std# 1982]
Over-ride SS/TNM-M [Std# 1983]
Over-ride SS/DisMet1 [Std# 1984]
Over-ride Acsn/Class/Seq [Std# 1985]
Over-ride HospSeq/DxConf [Std# 1986]
Over-ride COC-Site/Type [Std# 1987]
Over-ride HospSeq/Site [Std# 1988]
Over-ride Site/TNM-StgGrp [Std# 1989]

Description:

Edit over-rides should all be blank or 1, with the exception of Over-ride Histology, which can be 1-3 or blank.

Edit Name: Edit Over-rides (SEER REVIEWFL)

Agency: SEER

Last Changed: 08/19/1998

Fields: Over-ride Site/Type [Std# 2030]
Over-ride Histology [Std# 2040]
Over-ride Age/Site/Morph [Std# 1990]
Over-ride SeqNo/DxConf [Std# 2000]
Over-ride Site/Lat/SeqNo [Std# 2010]
Over-ride Surg/DxConf [Std# 2020]
Over-ride Report Source [Std# 2050]
Over-ride Ill-define Site [Std# 2060]
Over-ride Leuk, Lymphoma [Std# 2070]
Over-ride Site/Behavior [Std# 2071]
Over-ride Site/EOD/DX Dt [Std# 2072]
Over-ride Site/Lat/EOD [Std# 2073]
Over-ride Site/Lat/Morph [Std# 2074]

Description:

Edit over-rides should all be blank or 1, with the exception of Over-ride Histology, which can be 1-3 or blank.

Edit Name: EOD--Extension (SEER)

EOD--Extension (SEER) (continued)

Agency: SEER **Last Changed:** 07/13/2004

Fields: EOD--Extension [Std# 790]

Description:

EOD--Extension must be a two-digit number. May be blank.

Edit Name: EOD--Extension Prost Path (SEER)

Agency: SEER **Last Changed:** 03/24/2003

Fields: EOD--Extension Prost Path [Std# 800]

Description:

Must be a valid EOD--Extension Prost Path code (00-99 or blank).

Edit Name: EOD--Lymph Node Involv (SEER)

Agency: SEER **Last Changed:** 07/13/2004

Fields: EOD--Lymph Node Involv [Std# 810]

Description:

EOD--Lymph Node Involv must be a one-digit number. May be blank.

Edit Name: Grade (COC)

Agency: COC **Last Changed:** 07/24/1999

Fields: Grade [Std# 440]

Description:

Must be a valid code for Grade (1-9).

Edit Name: Institution Referred From (COC)

Agency: COC **Last Changed:** 03/10/2003

Fields: Institution Referred From [Std# 2410]

Description:

This field is allowed to be blank because the item was not required until 2003. Another edit (Institution Referred From, Date of Diagnosis) verifies that this item is not blank if the year of Date of Diagnosis is greater than 2002 and not equal 9999. Registries should include both edits in their edit set.

Must be numeric, right-justified, zero-filled, or all blanks.

Edit Name: Institution Referred To (COC)

Agency: COC **Last Changed:** 03/10/2003

Fields: Institution Referred To [Std# 2420]

Description:

This field is allowed to be blank because the item was not required until 2003. Another edit (Institution Referred To, Date of Diagnosis) verifies that this item is not blank if the year of Date of Diagnosis is greater than 2002 and not equal 9999. Registries should include both edits in their edit set.

Must be numeric, right-justified, zero-filled, or all blanks.

Edit Name: Laterality (SEER LATERAL)

Agency: SEER

Last Changed: 03/12/2003

Fields: Laterality [Std# 410]

Description:

Must be a valid Laterality code (0-4, 9).

Edit Name: Laterality, Primary Site (NAACCR IF24)

Agency: NAACCR

Last Changed: 04/28/2007

Fields: Laterality [Std# 410]

Primary Site [Std# 400]

Date of Diagnosis [Std# 390]

Description:

The following paired organ sites must have a code other than zero for Laterality:

C079	Parotid gland
C080	Submandibular gland
C081	Sublingual gland
C090	Tonsillar fossa
C091	Tonsillar pillar
C098-C099	Tonsil, NOS
C301	Middle ear
C310	Maxillary sinus
C312	Frontal sinus
C341-C349	Lung
C384	Pleura
C400	Long bones of upper limb, scapula and associated joints
C401	Short bones of upper limb and associated joints
C402	Long bones of lower limb and associated joints
C403	Short bones of lower limb and associated joint
C441	Skin of eyelid
C442	Skin of external ear
C443	Skin of other and unspecified parts of face (midline code `9')
C445	Skin of trunk (midline code `9')
C446	Skin of upper limb and shoulder
C447	Skin of lower limb and hip
C471	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C472	Peripheral nerves and autonomic nervous system of lower limb and hip
C491	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C492	Connective, subcutaneous, and other soft tissues of lower limb and hip
C500-C509	Breast
C569	Ovary
C570	Fallopian tube
C620-C629	Testis
C630	Epididymis
C631	Spermatic cord
C649	Kidney, NOS
C659	Renal pelvis
C669	Ureter
C690-C699	Eye
C740-C749	Adrenal gland

Laterality, Primary Site (NAACCR IF24) (continued)

C754 Carotid body

If the year of Date of Diagnosis is greater than 2003 and not equal 9999, then the following CNS Primary Sites must have a code other than zero for laterality:

C700 Cerebral meninges, NOS
 C710 Cerebrum
 C711 Frontal lobe
 C712 Temporal lobe
 C713 Parietal lobe
 C714 Occipital lobe
 C722 Olfactory nerve
 C723 Optic nerve
 C724 Acoustic nerve
 C725 Cranial nerve, NOS

Edit Name: Laterality, Primary Site, Morph ICDO3 (SEER IF42)

Agency: SEER

Last Changed: 04/28/2007

Fields: Laterality [Std# 410]
 Primary Site [Std# 400]
 Histologic Type ICD-O-3 [Std# 522]
 Behavior Code ICD-O-3 [Std# 523]
 Date of Diagnosis [Std# 390]
 Over-ride Site/Lat/Morph [Std# 2074]

Description:

This edit is skipped if Histologic Type ICD-O-3 is empty.

If diagnosis year less than 1988 and Histologic Type ICD-O-3 >= 9590, no further editing is performed.

If diagnosis year greater than 1987 and Histologic Type ICD-O-3 = 9140, 9700, 9701, 9590-9980, no further editing is performed.

If the Over-ride Site/Lat/Morph field contains a '1'(review complete), no further editing is performed.

If the Primary Site is a paired organ (see lists below) and the Behavior Code ICD-O-3 is in situ (`2'), then Laterality must be `1', `2' or `3', meaning right: origin of primary; left: origin of primary; or only one side involved, right or left origin unspecified.

For all diagnosis years the following are considered paired organ sites for purposes of this edit:

C079 Parotid gland
 C080 Submandibular gland
 C091 Tonsillar pillar
 C098-C099 Tonsil, NOS
 C301 Middle ear
 C310 Maxillary sinus
 C312 Frontal sinus
 C341-C349 Lung
 C384 Pleura
 C500-C509 Breast
 C569 Ovary

Laterality, Primary Site, Morph ICDO3 (SEER IF42) (continued)

C570 Fallopian tube
 C620-C629 Testis
 C630 Epididymis
 C631 Spermatic cord
 C649 Kidney, NOS
 C659 Renal pelvis
 C669 Ureter
 C690-C699 Eye
 C740-C749 Adrenal gland
 C754 Carotid body

For cases diagnosed after 1978 the following are also considered paired organ sites for purposes of this edit:

C081 Sublingual gland
 C090 Tonsillar fossa
 C400 Long bones of upper limb, scapula and associated joints
 C401 Short bones of upper limb and associated joints
 C402 Long bones of lower limb and associated joints
 C403 Short bones of lower limb and associated joints
 C441 Skin of eyelid
 C442 Skin of external ear
 C446 Skin of upper limb and shoulder
 C447 Skin of lower limb and hip
 C471 Peripheral nerves and autonomic nervous system of upper limb and shoulder
 C472 Peripheral nerves and autonomic nervous system of lower limb and hip
 C491 Connective, subcutaneous, and other soft tissues of upper limb and shoulder
 C492 Connective, subcutaneous, and other soft tissues of lower limb and hip

Edit Name: Lymphoma ICDO3, Site, Summ Stg 1977 (NAACCR)

Agency: NAACCR

Last Changed: 04/28/2007

Fields: Primary Site [Std# 400]
 Histologic Type ICD-O-3 [Std# 522]
 SEER Summary Stage 1977 [Std# 760]

Description:

The purpose of this edit is to accommodate cases that have been converted from ICD-O-2 to ICD-O-3.

This edit is skipped if SEER Summary Stage 1977 is blank.

If case is a lymphoma (Histologic Type ICD-O-3) = 9590-9699, 9702-9729):

1. If Primary Site = C770-C779 (lymph nodes), then SEER Summary Stage 1977 cannot equal 3 or 4.

2. If Primary Site = C778, then SEER Summary Stage 1977 cannot equal 1 (localized).

Edit Name: Marital Status at DX (SEER MARITAL)

Agency: SEER

Last Changed: 02/11/1997

Marital Status at DX (SEER MARITAL) (continued)

Fields: Marital Status at DX [Std# 150]

Description:

Must be a valid Marital Status at DX code (1-5,9).

Edit Name: Morph Coding Sys--Current (NAACCR)

Agency: NAACCR

Last Changed: 03/02/2001

Fields: Morph Coding Sys--Current [Std# 470]

Description:

Must be 2-6 (ICD-O-2) or 7 (ICD-O-3).

Edit Name: Mult Tum Rpt As One Prim, Date of DX (SEER IF155)

Agency: SEER

Last Changed: 01/11/2007

Fields: Date of Diagnosis [Std# 390]

Mult Tum Rpt as One Prim [Std# 444]

Description:

If year of Date of Diagnosis is greater than 2006 and not equal to 9999, then Mult Tum Rpt As One Prim cannot be blank.

If year of Date of Diagnosis is less than 2007, then Mult Tum Rpt As One Prim must be blank.

Edit Name: Multiplicity Cntr, Date of Mult Tum (SEER IF163)

Agency: SEER

Last Changed: 04/22/2007

Fields: Multiplicity Counter [Std# 446]

Date of Multiple Tumors [Std# 445]

Description:

This edit is skipped if either Multiplicity Counter or Date of Multiple Tumors is blank.

If Multiplicity Counter = 01 (one tumor only), then Date of Multiple Tumors must = 00000000 (single tumor); if Date of Multiple Tumors = 00000000, then Multiplicity Counter must = 01.

If Multiplicity Counter = 88 (information on multiple tumors not collected/not applicable for this site), then Date of Multiple Tumors must = 88888888 (information on multiple tumors not collected/not applicable for this site); if Date of Multiple Tumors = 88888888, then Multiplicity Counter must = 88.

Edit Name: Name--Alias (SEER)

Agency: SEER

Last Changed: 12/12/2005

Fields: Name--Alias [Std# 2280]

Description:

Note: This edit is not supported by the COC as of 1/1/2003; however, SEER has agreed to support this data item and edit.

Name--Alias may be blank. If entered, must be alpha, left-justified, and blank-filled. Mixed case, embedded spaces, hyphens, and apostrophes are also allowed. No other special characters are allowed.

Edit Name: Name--First (NAACCR)
Agency: NAACCR **Last Changed:** 04/12/2007
Fields: Name--First [Std# 2240]
Description:
Name--First may not be blank. Must be alpha, left-justified, and blank-filled. Mixed case is allowed. Embedded spaces are not allowed. Special characters are not allowed.

Edit Name: Name--Last (NAACCR)
Agency: NAACCR **Last Changed:** 04/12/2007
Fields: Name--Last [Std# 2230]
Description:
Name--Last may not be blank. Must be alpha, left-justified, and blank-filled. Mixed case is allowed. Embedded spaces are not allowed. Embedded hyphen is allowed. No other special characters are allowed.

Edit Name: Name--Maiden (NAACCR)
Agency: NAACCR **Last Changed:** 04/12/2007
Fields: Name--Maiden [Std# 2390]
Description:
Name--Maiden may be blank. If entered, must be alpha, left-justified, and blank-filled. Mixed case is allowed. Embedded spaces are not allowed. Embedded hyphen is allowed. No other special characters are allowed.

Edit Name: Name--Middle (NAACCR)
Agency: NAACCR **Last Changed:** 04/12/2007
Fields: Name--Middle [Std# 2250]
Description:
Name--Middle may be blank. If entered, must be alpha, left-justified, and blank-filled. Mixed case is allowed. Embedded spaces are not allowed. Special characters are not allowed.

Edit Name: Non-Reportable Skin ICDO3 (SEER IF117)
Agency: SEER **Last Changed:** 09/06/2004
Fields: Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Description:
This edit is skipped if Histologic Type ICD-O-3 is blank.

If Primary Site = C440-C449 (skin) and Histologic Type ICD-O-3 = 8000-8110, then an error is generated.

These cases are non reportable to SEER.

Edit Name: NPI--Following Registry (NAACCR)
Agency: NAACCR **Last Changed:** 04/20/2007
Fields: NPI--Following Registry [Std# 2445]

NPI--Following Registry (NAACCR) (continued)

Description:

NPI--Following Registry must be a 10-digit number or blank. 0000000000 and 9999999999 are not allowed.

The NPI consists of nine numeric digits followed by a one numeric check digit. A check digit validation is performed using the Luhn Algorithm. The algorithm proceeds in three steps. First, every second digit, beginning with the next-to-rightmost and proceeding to the left, is doubled. If that result is greater than nine, its digits are summed (which is equivalent, for any number in the range 10 through 18, of subtracting 9 from it). Thus a 2 becomes 4 and a 7 becomes 5 (7 X 2 = 14, 14 becomes 1 + 4 = 5). Second, all the digits are summed. (Note: 24 is added to the sum, to account for the ISO prefix for USA (80840) when stored as part of an ID card. The prefix must be accounted for, so the NPI check will be the same with or without the prefix.) Third, the result is divided by 10. If the remainder is zero, the original number is valid.

Edit Name: NPI--Inst Referred From (NAACCR)

Agency: NAACCR

Last Changed: 04/20/2007

Fields: NPI--Inst Referred From [Std# 2415]

Description:

NPI--Inst Referred From must be a 10-digit number or blank. 0000000000 and 9999999999 are not allowed.

The NPI consists of nine numeric digits followed by a one numeric check digit. A check digit validation is performed using the Luhn Algorithm. The algorithm proceeds in three steps. First, every second digit, beginning with the next-to-rightmost and proceeding to the left, is doubled. If that result is greater than nine, its digits are summed (which is equivalent, for any number in the range 10 through 18, of subtracting 9 from it). Thus a 2 becomes 4 and a 7 becomes 5 (7 X 2 = 14, 14 becomes 1 + 4 = 5). Second, all the digits are summed. (Note: 24 is added to the sum, to account for the ISO prefix for USA (80840) when stored as part of an ID card. The prefix must be accounted for, so the NPI check will be the same with or without the prefix.) Third, the result is divided by 10. If the remainder is zero, the original number is valid.

Edit Name: NPI--Inst Referred To (NAACCR)

Agency: NAACCR

Last Changed: 04/20/2007

Fields: NPI--Inst Referred To [Std# 2425]

Description:

NPI--Inst Referred To must be a 10-digit number or blank. 0000000000 and 9999999999 are not allowed.

The NPI consists of nine numeric digits followed by a one numeric check digit. A check digit validation is performed using the Luhn Algorithm. The algorithm proceeds in three steps. First, every second digit, beginning with the next-to-rightmost and proceeding to the left, is doubled. If that result is greater than nine, its digits are summed (which is equivalent, for any number in the range 10 through 18, of subtracting 9 from it). Thus a 2 becomes 4 and a 7 becomes 5 (7 X 2 = 14, 14 becomes 1 + 4 = 5). Second, all the digits are summed. (Note: 24 is added to the sum, to account for the ISO prefix for USA (80840) when stored as part of an ID card. The prefix must be accounted for, so the NPI check will be the same with or without the prefix.) Third, the result is divided by 10. If the remainder is zero, the original number is valid.

NPI--Physician 3 (NAACCR) (continued)

Edit Name: NPI--Physician 3 (NAACCR)

Agency: NAACCR

Last Changed: 04/20/2007

Fields: NPI--Physician 3 [Std# 2495]

Description:

NPI--Physician 3 must be a 10-digit number or blank. 0000000000 and 9999999999 are not allowed.

The NPI consists of nine numeric digits followed by a one numeric check digit. A check digit validation is performed using the Luhn Algorithm. The algorithm proceeds in three steps. First, every second digit, beginning with the next-to-rightmost and proceeding to the left, is doubled. If that result is greater than nine, its digits are summed (which is equivalent, for any number in the range 10 through 18, of subtracting 9 from it). Thus a 2 becomes 4 and a 7 becomes 5 (7 X 2 = 14, 14 becomes 1 + 4 = 5). Second, all the digits are summed. (Note: 24 is added to the sum, to account for the ISO prefix for USA (80840) when stored as part of an ID card. The prefix must be accounted for, so the NPI check will be the same with or without the prefix.) Third, the result is divided by 10. If the remainder is zero, the original number is valid.

Edit Name: NPI--Physician 4 (NAACCR)

Agency: NAACCR

Last Changed: 04/20/2007

Fields: NPI--Physician 4 [Std# 2505]

Description:

NPI--Physician 4 must be a 10-digit number or blank. 0000000000 and 9999999999 are not allowed.

The NPI consists of nine numeric digits followed by a one numeric check digit. A check digit validation is performed using the Luhn Algorithm. The algorithm proceeds in three steps. First, every second digit, beginning with the next-to-rightmost and proceeding to the left, is doubled. If that result is greater than nine, its digits are summed (which is equivalent, for any number in the range 10 through 18, of subtracting 9 from it). Thus a 2 becomes 4 and a 7 becomes 5 (7 X 2 = 14, 14 becomes 1 + 4 = 5). Second, all the digits are summed. (Note: 24 is added to the sum, to account for the ISO prefix for USA (80840) when stored as part of an ID card. The prefix must be accounted for, so the NPI check will be the same with or without the prefix.) Third, the result is divided by 10. If the remainder is zero, the original number is valid.

Edit Name: NPI--Physician--Follow-Up (NAACCR)

Agency: NAACCR

Last Changed: 04/20/2007

Fields: NPI--Physician--Follow-Up [Std# 2475]

Description:

NPI--Physician Follow_up must be a 10-digit number or blank. 0000000000 and 9999999999 are not allowed.

The NPI consists of nine numeric digits followed by a one numeric check digit. A check digit validation is performed using the Luhn Algorithm. The algorithm proceeds in three steps. First, every second digit, beginning with the next-to-rightmost and proceeding to the left, is doubled. If that result is greater than nine, its digits are summed (which is equivalent, for any number in the range 10 through 18, of subtracting 9 from it). Thus a 2 becomes 4 and a 7 becomes 5 (7 X 2 = 14, 14 becomes 1 + 4 = 5). Second, all the digits are summed. (Note: 24 is added to the sum, to account for the ISO prefix for USA (80840) when stored as

NPI--Physician--Follow-Up (NAACCR) (continued)

part of an ID card. The prefix must be accounted for, so the NPI check will be the same with or without the prefix.) Third, the result is divided by 10. If the remainder is zero, the original number is valid.

Edit Name: NPI--Physician--Managing (NAACCR)

Agency: NAACCR

Last Changed: 04/20/2007

Fields: NPI--Physician--Managing [Std# 2465]

Description:

NPI--Physician--Managing must be a 10-digit number or blank. 0000000000 and 9999999999 are not allowed.

The NPI consists of nine numeric digits followed by a one numeric check digit. A check digit validation is performed using the Luhn Algorithm. The algorithm proceeds in three steps. First, every second digit, beginning with the next-to-rightmost and proceeding to the left, is doubled. If that result is greater than nine, its digits are summed (which is equivalent, for any number in the range 10 through 18, of subtracting 9 from it). Thus a 2 becomes 4 and a 7 becomes 5 ($7 \times 2 = 14$, 14 becomes $1 + 4 = 5$). Second, all the digits are summed. (Note: 24 is added to the sum, to account for the ISO prefix for USA (80840) when stored as part of an ID card. The prefix must be accounted for, so the NPI check will be the same with or without the prefix.) Third, the result is divided by 10. If the remainder is zero, the original number is valid.

Edit Name: NPI--Physician--Prim Surg (NAACCR)

Agency: NAACCR

Last Changed: 04/20/2007

Fields: NPI--Physician--Prim Surg [Std# 2485]

Description:

NPI--Physician--Prim Surg must be a 10-digit number or blank. 0000000000 and 9999999999 are not allowed.

The NPI consists of nine numeric digits followed by a one numeric check digit. A check digit validation is performed using the Luhn Algorithm. The algorithm proceeds in three steps. First, every second digit, beginning with the next-to-rightmost and proceeding to the left, is doubled. If that result is greater than nine, its digits are summed (which is equivalent, for any number in the range 10 through 18, of subtracting 9 from it). Thus a 2 becomes 4 and a 7 becomes 5 ($7 \times 2 = 14$, 14 becomes $1 + 4 = 5$). Second, all the digits are summed. (Note: 24 is added to the sum, to account for the ISO prefix for USA (80840) when stored as part of an ID card. The prefix must be accounted for, so the NPI check will be the same with or without the prefix.) Third, the result is divided by 10. If the remainder is zero, the original number is valid.

Edit Name: Obsolete Codes - CS Extension (SEER IF146)

Agency: SEER

Last Changed: 04/28/2007

Fields: CS Extension [Std# 2810]

Primary Site [Std# 400]

Histologic Type ICD-O-3 [Std# 522]

Date of Diagnosis [Std# 390]

Description:

This edit checks for all obsolete CS Extension codes. Obsolete codes should be

Obsolete Codes - CS Extension (SEER IF146) (continued)

re-coded per Collaborative Stage guidelines. The following codes are obsolete if year of Date of Diagnosis is greater than 2004 and not equal 9999.

Schema	CS Extension Codes	Obsolete as of CS Version
Breast (C500-C509)	72	01.01.00
Prostate (C619)	31	01.02.00
	33	01.02.00
	34	01.02.00
Renal Pelvis (C659, C669)	62	01.02.00

Edit Name: Obsolete Codes - CS Lymph Nodes (SEER IF147)

Agency: SEER

Last Changed: 04/28/2007

Fields: CS Lymph Nodes [Std# 2830]
 Primary Site [Std# 400]
 Histologic Type ICD-O-3 [Std# 522]
 Date of Diagnosis [Std# 390]

Description:

This edit checks for all obsolete CS Lymph Nodes codes. Obsolete codes should be re-coded per Collaborative Stage guidelines. The following codes are obsolete if year of Date of Diagnosis is greater than 2004 and not equal 9999.

Schema	CS Lymph Nodes	Obsolete as of CS Version
Thyroid (C739)	10	01.02.00
	11	01.02.00
	20	01.02.00
	21	01.02.00
	30	01.02.00
	31	01.02.00

Edit Name: Obsolete Codes - CS Mets at DX (SEER IF148)

Agency: SEER

Last Changed: 04/28/2007

Fields: CS Mets at DX [Std# 2850]
 Primary Site [Std# 400]
 Histologic Type ICD-O-3 [Std# 522]
 Date of Diagnosis [Std# 390]

Description:

This edit checks for all obsolete CS Mets at DX codes. Obsolete codes should be re-coded per Collaborative Stage guidelines. The following codes are obsolete if year of Date of Diagnosis is greater than 2004 and not equal 9999.

Schema	CS Mets at DX	Obsolete as of CS Version
Thyroid (C739)	10	01.02.00
	11	01.02.00
	50	01.02.00

Edit Name: Obsolete Codes - CS SSF 1 (SEER IF149)**Agency:** SEER**Last Changed:** 04/28/2007

Fields: CS Site-Specific Factor 1 [Std# 2880]
 Primary Site [Std# 400]
 Histologic Type ICD-O-3 [Std# 522]
 Date of Diagnosis [Std# 390]

Description:

This edit checks for all obsolete CS Site-Specific Factor 1 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines. The following codes are obsolete if year of Date of Diagnosis is greater than 2004 and not equal 9999.

Schema	CS Site-Specific Factor 1	Obsolete as of CS Version
Melanoma (8720-8790) Skin (C440-C449, C510-C512, C518-C519, C600-C602, C608-C609, C632)	990	01.01.00
Melanoma (8720-8790) Conjuntiva (C690)	990	01.02.00
Melanoma (8720-8790) Choroid (C693)	990	01.02.00
Melanoma (8720-8790) Iris & Ciliary Body (C694)	990	01.02.00

Edit Name: Obsolete Codes - CS SSF 3 (SEER IF150)**Agency:** SEER**Last Changed:** 04/28/2007

Fields: CS Site-Specific Factor 3 [Std# 2900]
 Primary Site [Std# 400]
 Histologic Type ICD-O-3 [Std# 522]
 Date of Diagnosis [Std# 390]

Description:

This edit checks for all obsolete CS Site-Specific Factor 3 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines. The following codes are obsolete if year of Date of Diagnosis is greater than 2004 and not equal 9999.

Schema	CS Site-Specific Factor 3	Obsolete as of CS Version
Prostate (C619)	031	01.02.00
	033	01.02.00
	034	01.02.00

Edit Name: Obsolete Codes - CS SSF 4 (SEER IF151)

Obsolete Codes - CS SSF 4 (SEER IF151) (continued)

Agency: SEER **Last Changed:** 04/28/2007

Fields: CS Site-Specific Factor 4 [Std# 2910]
 Primary Site [Std# 400]
 Histologic Type ICD-O-3 [Std# 522]
 Date of Diagnosis [Std# 390]

Description:

This edit checks for all obsolete CS Site-Specific Factor 4 codes. Obsolete codes should be re-coded per Collaborative Stage guidelines. The following codes are obsolete if year of Date of Diagnosis is greater than 2003 and not equal 9999.

Schema	CS Site-Specific Factor 3	Obsolete as of CS Version
Prostate (C619)	000	01.02.00
	010	01.02.00
	020	01.02.00
	030	01.02.00
	080	01.02.00
	999	01.02.00

Edit Name: Physician 3 (COC)

Agency: COC **Last Changed:** 03/29/1997

Fields: Physician 3 [Std# 2490]

Description:

Field must contain alphanumeric and be left-justified. May be blank.

Edit Name: Physician 4 (COC)

Agency: COC **Last Changed:** 03/29/1997

Fields: Physician 4 [Std# 2500]

Description:

Field must contain alphanumeric and be left-justified. May be blank.

Edit Name: Physician--Follow-Up (COC)

Agency: COC **Last Changed:** 02/13/2004

Fields: Physician--Follow-Up [Std# 2470]

Description:

Item may be blank. If entered, must be alphanumeric, left-justified, and blank-filled. Mixed case is allowed. Embedded spaces are allowed. Special characters are not allowed.

Edit Name: Physician--Primary Surg (COC)

Agency: COC **Last Changed:** 02/13/2004

Fields: Physician--Primary Surg [Std# 2480]

Description:

Item may be blank. If entered, must be alphanumeric, left-justified, and blank-filled. Mixed case is allowed. Embedded spaces are allowed. Special characters

Physician--Primary Surg (COC) (continued)

are not allowed.

Edit Name: PIN III ICDO3, Date of Diagnosis (SEER IF110)

Agency: SEER

Last Changed: 08/03/2005

Fields: Date of Diagnosis [Std# 390]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Behavior Code ICD-O-3 [Std# 523]

Description:

If the year of Date of Diagnosis is greater than 2000 and not = 9999 and Primary Site = C619 (Prostate) and Histologic Type ICD-O-3 = 8148 and Behavior Code ICD-O-3 = 2 (PIN III), an error is generated.

This edit should be used only by registries that do not collect and/or do not want to submit PIN III cases for diagnosis years beginning with 2001.

Edit Name: Place of Death (NAACCR)

Agency: NAACCR

Last Changed: 03/12/2003

Fields: Place of Death [Std# 1940]

Description:

Must be a valid Place of Death code. See Appendix B of SEER Program Code Manual 1992 for numeric and alphabetic lists of places and codes.

Edit Name: Place of Death, Vital Status (NAACCR)

Agency: NAACCR

Last Changed: 03/29/1997

Fields: Place of Death [Std# 1940]
Vital Status [Std# 1760]

Description:

If Place of Death = 997 (patient is alive), Vital Status must = 1 (alive). If Place of Death not = 997, Vital Status must = 0.

Edit Name: Primary Payer at DX (NPCR)

Agency: NPCR

Last Changed: 04/28/2007

Fields: Primary Payer at DX [Std# 630]

Description:

Must be a valid code for Primary Payer at DX (01,02,10,20,21,31,35,60-68,99) or blank.

Edit Name: Primary Site (SEER SITE)

Agency: SEER

Last Changed: 05/14/2001

Fields: Primary Site [Std# 400]

Description:

Must be one of the topography codes defined by the International Classification of Diseases for Oncology, Second Edition or Third Edition. (The decimal point

Primary Site (SEER SITE) (continued)

is dropped and the `C' is required.)

Edit Name: Primary Site, Behavior Code ICDO3 (SEER IF39)

Agency: SEER

Last Changed: 04/28/2007

Fields: Primary Site [Std# 400]
 Behavior Code ICD-O-3 [Std# 523]
 Over-ride Site/Behavior [Std# 2071]

Description:

This edit is skipped if Behavior Code ICD-O-3 is empty.

The following primary sites with a behavior of in situ (Behavior Code ICD-O-3 = 2) require review. If the Over-ride Site/Behavior field contains a '1', no further checking is done.

C269	Gastrointestinal tract, NOS
C399	Ill-defined sites within respiratory system
C559	Uterus, NOS
C579	Female genital tract, NOS
C639	Male genital organs, NOS
C689	Urinary system, NOS
C729	Nervous system, NOS
C759	Endocrine gland, NOS
C760-C768	Ill-defined sites
C809	Unknown primary site

Additional Information:

Since the designation of in situ is very specific and almost always requires microscopic confirmation, it is assumed that specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being in situ is reliable. Therefore this edit does not allow an in situ behavior code to be used with specified organ system and ill-defined site codes.

Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may be necessary. Check the information available about primary site and histologic type carefully. If a specific in situ diagnosis is provided, try to obtain a more specific primary site. A primary site within an organ system may sometimes be assumed based on the diagnostic procedure or treatment given or on the histologic type. If no more specific site can be determined, it is probably preferable to code a behavior code of 3.

EXAMPLE

PRIMARY SITE CODE	C55.9, UTERUS NOS
BEHAVIOR CODE	2

The abstract reads, "Uterine D&C with squamous cell carcinoma in situ". The category "Uterus, NOS" is to be used when it cannot be determined whether a cancer arose in the cervix or corpus uteri. Based on the histologic type and diagnostic procedure, the most likely site in this case is cervix uteri rather than corpus. Change the primary site code to C53.9, Cervix uteri.

Edit Name: Primary Site, Histology, Behav ICDO3 (NAACCR)

Agency: NAACCR

Last Changed: 04/28/2007

Fields: Histologic Type ICD-O-3 [Std# 522]

Behavior Code ICD-O-3 [Std# 523]

Primary Site [Std# 400]

Description:

This edit is skipped if Histologic Type ICD-O-3 is empty.

The following primary sites and/or histologies (ICD-O-3) should not have a behavior of in situ (Behavior Code ICD-O-3 = 2):

C380-C383, C388

Heart, mediastinum

C384 Pleura

C390, C398-C399

Other and ill-defined respiratory sites and intrathoracic organs

C400-C403, C408-C409, C410-C414, C418-C419

Bones, joints, and articular cartilage

C440-C449, C510-C512, C518-C519, C600-C601, C608-C609, C632 (M9700-9701)

Mycosis Fungoides and Sezary's Disease of skin, vulva, penis, scrotum

C470-C476, C478-C479, C490-C496, C498-C499

Peripheral nerves and autonomic nervous system; connective, subcutaneous, and other soft tissues

C480-C482, C488

Retroperitoneum and peritoneum

C701, C709, C720-725, C728-C729

Other parts of central nervous system

(M-9140) Kaposi's Sarcoma of all sites

C692(M-9510-9514)

Retinoblastoma

(M-9590-9699, 9702-9729)

Hodgkin and Non-Hodgkin Lymphoma of all sites

(M-9731-9989)

Hematopoietic, reticuloendothelial, immunoproliferative, and myeloproliferative neoplasms

C420-C424, C760-C765, C767-C768, C770-C775, C778-C779, C809

Other and ill-defined sites, unknown primary site

Edit Name: Primary Site, Laterality (SEER IF82)

Agency: SEER

Last Changed: 03/31/2003

Fields: Primary Site [Std# 400]

Laterality [Std# 410]

Primary Site, Laterality (SEER IF82) (continued)

Description:

If Primary Site C342 (lung, middle lobe), Laterality cannot equal 2 (left).

Edit Name: Primary Site, Morphology-Imposs ICDO3 (SEER IF38)

Agency: SEER

Last Changed: 05/03/2007

Fields: Primary Site [Std# 400]

Histologic Type ICD-O-3 [Std# 522]

Description:

This edit is skipped if Histologic Type ICD-O-3 is empty.

The site/histology combinations on the following list are considered to be impossible:

C480-C488 (Retroperitoneum & peritoneum)
8720-8790 (Melanomas)

C300 (Nasal cavity)
9250-9342 (Osteosarcomas--Giant cell, Ewing's, odontogenic)

C301 (Middle ear)
9250-9342 (Osteosarcomas--Giant cell, Ewing's, odontogenic)

C310-C319 (Accessory sinuses)
9250-9342 (Osteosarcomas--Giant cell, Ewing's, odontogenic)

C381-C388 (Pleura and mediastinum)
8010-8245,8247-8671,8940-8941 (Carcinomas)
8720-8790 (Melanomas)

C470-C479 (Peripheral nerves)
8010-8671,8940-8941 (Carcinomas)
8720-8790 (Melanomas)

C490-C499 (Connective tissue)
8720-8790 (Melanomas)

C700-C709 (Meninges)
8010-8671,8940-8941 (Carcinomas)

C710-C719 (Brain)
8010-8671,8940-8941 (Carcinomas)

C720-C29 (Other central nervous system)
8010-8671,8940-8941 (Carcinomas)

C400-C419 (Bone)
8010-8060,8075-8671,8940-8941 (Carcinomas, except squamous cell)
8720-8790 (Melanomas)

C760-C768 (Ill-defined sites)
8720-8790 (Melanomas)
8800-8811,8813-8830,8840-8921,9040-9044 (Sarcomas, except periosteal fibrosarcoma)
8990-8991 (dermatofibrosarcoma)
8940-8941 (Mesenchymoma)
9120-9170 (Mixed tumor, salivary gland type)

Primary Site, Morphology-Imposs ICDO3 (SEER IF38) (continued)

9240-9252 (Blood vessel tumor, Mesenchymal chondrosarcoma,
and giant cell tumors)
9540-9560 (Nerve sheath tumor)
9580-9582 (Granular cell tumor and alveolar soft part sarcoma)

Additional Information:

Combinations of site and type are designated as impossible by this edit because the combination is biologically impossible, i.e., the particular form of cancer does not arise in the specified site, or because standard cancer registry conventions have been established to code certain combinations in certain ways.

In reviewing these errors, it is important to understand the biology of the disease and the clinical picture and history of the individual case before deciding on a correct code. It will often be useful to check medical references or to discuss specific problem cases with the registry's medical advisors. The suggestions below are a starting point for analyzing an error, but are not a substitute for a medical decision.

Correction of these errors will usually require inspection of the abstracted text, either online or as recorded on a paper abstract. Reference to the original medical record may also be required.

GENERAL

First review the case for the following:

1. Is the histologic type correctly coded? If not, correct the histologic type code. Note that the code for "Cancer" and "Malignancy" (8000/3) is NOT interchangeable with the code for "Carcinoma, NOS" (8010/3), which refers only to a malignancy of epithelial origin.
2. Is the primary site coded correctly? Check whether the site coded as the primary site could be instead the site of metastatic spread or the site where a biopsy was performed. If so, check for a more appropriate primary site.

SPECIFIC GUIDELINES

(The numbered categories refer to rows in the table of impossible combinations presented under "Description" in the documentation.)

1. Retroperitoneum/Peritoneum and Melanomas: If melanoma is identified in peritoneal or retroperitoneal tissue, it is almost certainly metastatic to that site. Try to identify the primary site of the melanoma. If no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44.__, as the appropriate primary site.
2. Nasal Cavity/Middle Ear/Accessory Sinuses and Osteosarcomas: Osteosarcomas arise in bone, and the specified site code in ICD-O-3 is C40.__ or C41.__. Osteosarcomas arising in the areas of the nose, middle ear, and sinuses should be assumed to have arisen in the bones of the skull and their primary site coded C41.0.
3. Pleura/Mediastinum and Carcinomas or Melanomas: If a carcinoma or melanoma is identified in the pleura or mediastinum, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma or melanoma. For

Primary Site, Morphology-Imposs ICDO3 (SEER IF38) (continued)

a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44.__, as the appropriate primary site.

4. Peripheral Nerves and Carcinomas or Melanomas: If a carcinoma or melanoma is identified in peripheral nerves, it is almost certainly metastatic to that site.

Try to identify the primary site of the carcinoma or melanoma. For a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44.__, as the appropriate primary site.

5. Connective Tissue and Melanomas: If a melanoma is identified in connective tissue, it is almost certainly metastatic to that site. Try to identify the primary site of melanoma. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44.__, as the appropriate primary site.

6. Meninges/Brain/Other CNS and Carcinomas: If a carcinoma is identified in the brain, meninges, or other central nervous system, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma. Check that the tumor is indeed a carcinoma and not "Cancer" or "Malignancy" which would be coded 8000/3. If it is a carcinoma and no primary can be determined, code "Unknown primary site", C80.9.

7. Bone and Carcinomas or Melanomas: If a carcinoma or melanoma is identified in the bone, it is almost certainly metastatic to that site. Try to identify the primary site of the carcinoma or melanoma. For a carcinoma, if no primary can be determined, code unknown primary site, C80.9. For a melanoma, if no primary can be determined, the standard convention in cancer registries is to code the primary site as skin, NOS, C44.9, which puts the case in the most likely site group for analysis. Most histologic type codes for melanomas in ICD-O-3 list skin, C44.__, as the appropriate primary site.

8. Ill-defined Sites and Various Histologies: Some histologic types are by convention more appropriately coded to a code representing the tissue in which such tumors arise rather than the ill-defined region of the body, which contains multiple tissues.

Edit Name: Primary Site, Morphology-Type ICDO3 (SEER IF25)

Agency: SEER

Last Changed: 06/20/2007

Fields: Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
Over-ride Site/Type [Std# 2030]

Description:

This edit is skipped if Histologic Type ICD-O-3 is blank.

If the case has already been reviewed and accepted as coded (Over-ride Site/Type = 1) no further editing is done.

Primary Site, Morphology-Type ICDO3 (SEER IF25) (continued)

If Primary Site is not in the range C000-C999, or if Histologic Type ICD-0-3 is not in the range 8000-9999, the message "Catastrophic Error in ICD-0-3 code" is returned and no further editing is done.

The SEER Site/Histology Validation List (see SEER web site) designates all four-digit histologies (specified as in situ or malignant in ICD-0) that do not require review for each site. Any site/histology combination not in the Site/Histology Validation List will be accepted only if the case has been reviewed, accepted as coded, and Over-ride--Site/Type = 1. All other combinations will generate the message "Incompatible site and morphology". Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the validation list.

Within the edit logic, the SEER Site/Histology Validation List is represented by three binary tables.

The Site/Histology Validation List contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never may not be included. Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct. The over-ride flag should not be set to 1 if the primary site or histologic type are changed to a combination that will pass the edit. However, if upon review the site/type combination is found to be accurate and in conformance with coding rules, it may be left as coded and the Over-ride--Site/Type flag coded to 1.

Additional Information:

This edit forces review of atypical site-type combinations. Combinations not requiring review are presented, by primary site, in the "SEER Site/Histology Validation List". This edit does not imply that there are errors but rather that the combination of site and histology are so unusual that they should be checked to ensure that they correctly reflect what is in the medical record. Resolution of discrepancies may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may be necessary.

Review of these cases requires investigating whether a) the combination is biologically implausible, or b) there are cancer registry coding conventions that would dictate different codes for the diagnosis. The following resources can be checked:

- Current oncology and pathology textbooks
- Current medical journal articles, e.g., via MEDLINE
- Pathologist advisors to the registry

If upon review it is decided that the case is appropriately coded, set the Over-ride--Site/Type flag to 1 so that the case will not be flagged for review when the edit is run again.

Edit Name: Race 1 (SEER RACE)

Agency: SEER

Last Changed: 03/10/2003

Fields: Race 1 [Std# 160]

Race 1 (SEER RACE) (continued)

Description:

Must be a valid Race 1 code (01-14,20-22,25-28,30-32,96-99).

Edit Name: Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR)**Agency:** NAACCR**Last Changed:** 04/12/2007**Fields:** Race 1 [Std# 160]
Race 2 [Std# 161]
Race 3 [Std# 162]
Race 4 [Std# 163]
Race 5 [Std# 164]**Description:**

Race 1, Race 2, Race 3, Race 4, and Race 5 are compared as follows:

If any race codes (for Race 2, 3, 4, and 5) = spaces, all subsequent race codes must = spaces.

If more than the Race 1 code is entered, if any race = 99 (unknown), all race codes (Race 1, 2, 3, 4, and 5) must = 99.

If more than the Race 1 code is entered, if any race codes (for Race 2, 3, 4, and 5) = 88 (no further race documented), then all subsequent race codes must also = 88.

A particular race code (other than spaces, 88, or 99) must not occur more than once.

Edit Name: Race 2 (NAACCR)**Agency:** NAACCR**Last Changed:** 03/10/2003**Fields:** Race 2 [Std# 161]**Description:**

This edit allows the field to be blank because the item was not required by the COC until 2000. Another edit (Race 2, Date of DX) verifies that this item is not blank if the year of Date of Diagnosis is greater than 1999 and not equal 9999. Registries should include both edits in their edit set.

Must be a valid Race 2 code (01-14,20-22,25-28,30-32,88,96-99) or blank.

Edit Name: Race 2, Date of DX (SEER IF89)**Agency:** SEER**Last Changed:** 04/08/2003**Fields:** Date of Diagnosis [Std# 390]
Race 2 [Std# 161]**Description:**

If year of Date of Diagnosis is 9999 (unknown), this edit is skipped.

If year of Date of Diagnosis is greater than 1999, Race 2 must not be blank.

Edit Name: Race 3 (NAACCR)**Agency:** NAACCR**Last Changed:** 03/10/2003**Fields:** Race 3 [Std# 162]

Race 3 (NAACCR) (continued)

Description:

This edit allows the field to be blank because the item was not required by the COC until 2000. Another edit (Race 3, Date of DX) verifies that this item is not blank if the year of Date of Diagnosis is greater than 1999 and not equal 9999. Registries should include both edits in their edit set.

Must be a valid Race 3 code (01-14,20-22,25-28,30-32,88,96-99) or blank.

Edit Name: Race 3, Date of DX (SEER IF90)**Agency:** SEER**Last Changed:** 04/08/2003**Fields:** Date of Diagnosis [Std# 390]
Race 3 [Std# 162]**Description:**

If year of Date of Diagnosis is 9999 (unknown), this edit is skipped.
If year of Date of Diagnosis is greater than 1999, Race 3 must not be blank.

Edit Name: Race 4 (NAACCR)**Agency:** NAACCR**Last Changed:** 03/10/2003**Fields:** Race 4 [Std# 163]**Description:**

This edit allows the field to be blank because the item was not required by the COC until 2000. Another edit (Race 4, Date of DX) verifies that this item is not blank if the year of Date of Diagnosis is greater than 1999 and not equal 9999. Registries should include both edits in their edit set.

Must be a valid Race 4 code (01-14,20-22,25-28,30-32,88,96-99) or blank.

Edit Name: Race 4, Date of DX (SEER IF91)**Agency:** SEER**Last Changed:** 04/08/2003**Fields:** Date of Diagnosis [Std# 390]
Race 4 [Std# 163]**Description:**

If year of Date of Diagnosis is 9999 (unknown), this edit is skipped.
If year of Date of Diagnosis is greater than 1999, Race 4 must not be blank.

Edit Name: Race 5 (NAACCR)**Agency:** NAACCR**Last Changed:** 03/10/2003**Fields:** Race 5 [Std# 164]**Description:**

This edit allows the field to be blank because the item was not required by the COC until 2000. Another edit (Race 5, Date of DX) verifies that this item is not blank if the year of Date of Diagnosis is greater than 1999 and not equal 9999. Registries should include both edits in their edit set.

Must be a valid Race 5 code (01-14,20-22,25-28,30-32,88,96-99) or blank.

Edit Name: Race 5, Date of DX (SEER IF92)

Race 5, Date of DX (SEER IF92) (continued)

Agency: SEER **Last Changed:** 04/08/2003

Fields: Date of Diagnosis [Std# 390]
Race 5 [Std# 164]

Description:

If year of Date of Diagnosis is 9999 (unknown), this edit is skipped.
If year of Date of Diagnosis is greater than 1999, Race 5 must not be blank.

Edit Name: Rad--Regional RX Modality (NPCR)

Agency: NPCR **Last Changed:** 04/12/2007

Fields: Rad--Regional RX Modality [Std# 1570]

Description:

Must be a valid code for Rad--Regional RX Modality (00, 20-32, 40-43, 50-55, 60-62, 80, 85, 98, 99). Must be a two-digit number. May be blank.

Edit Name: Rad--Regional RX Modality, Date of Diagnosis(NPCR)

Agency: NPCR **Last Changed:** 05/17/2007

Fields: Date of Diagnosis [Std# 390]
Rad--Regional RX Modality [Std# 1570]

Description:

If year of Date of Diagnosis is greater than 2005 and not equal to 9999, then Rad--Regional RX Modality cannot be blank.

Edit Name: Reason for No Surgery (NPCR)

Agency: NPCR **Last Changed:** 04/12/2007

Fields: Reason for No Surgery [Std# 1340]

Description:

Must be a valid Reason for No Surgery code (0-2,5-9) or blank.

Edit Name: Reason for No Surgery, Date of DX (NPCR)

Agency: NPCR **Last Changed:** 11/22/2005

Fields: Date of Diagnosis [Std# 390]
Reason for No Surgery [Std# 1340]

Description:

If year of Date of Diagnosis is greater than 2005 and not equal to 9999, then Reason for No Surgery cannot be blank.

Edit Name: RX Coding System--Current (NAACCR)

Agency: NAACCR **Last Changed:** 04/12/2007

Fields: RX Coding System--Current [Std# 1460]

Description:

Must be a valid RX Coding System--Current code (00-06, 99).

Edit Name: RX Summ--BRM (NPCR)

Agency: NPCR **Last Changed:** 04/12/2007

RX Summ--BRM (NPCR) (continued)

Fields: RX Summ--BRM [Std# 1410]

Description:

Must be a valid RX Summ--BRM code (00, 01, 82, 85-88, 99) or blank.

Edit Name: RX Summ--BRM, Date of DX (NPCR)

Agency: NPCR

Last Changed: 11/22/2005

Fields: Date of Diagnosis [Std# 390]
RX Summ--BRM [Std# 1410]

Description:

If year of Date of Diagnosis is greater than 2005 and not equal to 9999, then RX Summ--BRM cannot be blank.

Edit Name: RX Summ--Chemo (NPCR)

Agency: NPCR

Last Changed: 04/12/2007

Fields: RX Summ--Chemo [Std# 1390]

Description:

Must be a valid RX Summ--Chemo code (00-03,82,85-88,99) or blank.

Edit Name: RX Summ--Chemo, Date of DX (NPCR)

Agency: NPCR

Last Changed: 11/22/2005

Fields: Date of Diagnosis [Std# 390]
RX Summ--Chemo [Std# 1390]

Description:

If year of Date of Diagnosis is greater than 2005 and not equal to 9999, then RX Summ--Chemo cannot be blank.

Edit Name: RX Summ--Hormone (NPCR)

Agency: NPCR

Last Changed: 04/12/2007

Fields: RX Summ--Hormone [Std# 1400]

Description:

Must be a valid RX Summ--Hormone code (00, 01, 82, 85-88, 99) or blank.

Edit Name: RX Summ--Hormone, Date of DX (NPCR)

Agency: NPCR

Last Changed: 11/22/2005

Fields: Date of Diagnosis [Std# 390]
RX Summ--Hormone [Std# 1400]

Description:

If year of Date of Diagnosis is greater than 2005 and not equal to 9999, then RX Summ--Hormone cannot be blank.

Edit Name: RX Summ--Other (NPCR)

Agency: NPCR

Last Changed: 04/12/2007

Fields: RX Summ--Other [Std# 1420]

RX Summ--Other (NPCR) (continued)

Description:

Must be a valid RX Summ--Other code (0-3, 6-9) or blank.

Edit Name: RX Summ--Other, Date of DX (NPCR)

Agency: NPCR

Last Changed: 11/22/2005

Fields: Date of Diagnosis [Std# 390]

RX Summ--Other [Std# 1420]

Description:

If year of Date of Diagnosis is greater than 2005 and not equal to 9999, then RX Summ--Other cannot be blank.

Edit Name: RX Summ--Scope Reg LN Sur (SEER SCOPE)

Agency: SEER

Last Changed: 04/12/2007

Fields: RX Summ--Scope Reg LN Sur [Std# 1292]

Description:

Must be a valid RX Summ--Scope Reg LN Sur (0-7,9) or blank.

Edit Name: RX Summ--Scope Reg LN Sur, Date of DX (NPCR)

Agency: NPCR

Last Changed: 04/12/2007

Fields: Date of Diagnosis [Std# 390]

RX Summ--Scope Reg LN Sur [Std# 1292]

Description:

If year of Date of Diagnosis is greater than 2002 and not equal 9999, then RX Summ--Scope Reg LN Sur cannot be blank.

Edit Name: RX Summ--Scope Reg LN Sur, Site, ICDO3 (SEER IF109)

Agency: SEER

Last Changed: 04/30/2007

Fields: RX Summ--Scope Reg LN Sur [Std# 1292]

Primary Site [Std# 400]

Histologic Type ICD-O-3 [Std# 522]

Description:

This edit is skipped if RX Summ--Scope Reg LN Sur is empty.

RX Summ--Scope Reg LN Sur must = 9 for the following:

1. Primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (Primary Site = C700-C729)
2. Hodgkin and non-hodgkin lymphoma with a lymph node primary site: Histologic Type ICD-O-3 = 9590-9729 AND Primary Site = C770-C779, then RX Summ--Scope Reg LN Sur must = 9.
3. Unknown and ill-defined sites (C760-C768, C809) must also = 9.
4. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease:

RX Summ--Scope Reg LN Sur, Site, ICDO3 (SEER IF109 (continued))

For all sites, if Histologic Type ICD-O-3 = 9750, 9760-9764,
9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989

If Primary Site = C420, C421, C423, or C424

Edit Name: RX Summ--Surg Oth Reg/Dis (SEER SURGOTH)

Agency: SEER

Last Changed: 04/12/2007

Fields: RX Summ--Surg Oth Reg/Dis [Std# 1294]

Description:

Must be a valid RX Summ--Surg Oth Reg/Dis (0-5, 9) or blank.

Edit Name: RX Summ--Surg Oth Reg/Dis, Date of DX (NPCR)

Agency: NPCR

Last Changed: 04/12/2007

Fields: Date of Diagnosis [Std# 390]

RX Summ--Surg Oth Reg/Dis [Std# 1294]

Description:

If year of Date of Diagnosis is greater than 2002 and not equal 9999, then RX Summ--Surg Oth Reg/Dis cannot be blank.

Edit Name: RX Summ--Surg Prim Site (SEER SURGPRIM)

Agency: SEER

Last Changed: 04/12/2007

Fields: RX Summ--Surg Prim Site [Std# 1290]

Description:

Must be a numeric value (00, 10-90, 98, 99) or blank.

Edit Name: RX Summ--Surg Prim Site, Date of DX (NPCR)

Agency: NPCR

Last Changed: 04/12/2007

Fields: Date of Diagnosis [Std# 390]

RX Summ--Surg Prim Site [Std# 1290]

Description:

If year of Date of Diagnosis is greater than 2002 and not equal 9999, then RX Summ--Surg Prim Site cannot be blank.

Edit Name: RX Summ--Surg Prim Site, Diag Conf (SEER IF76)

Agency: SEER

Last Changed: 04/12/2007

Fields: RX Summ--Surg Prim Site [Std# 1290]

Diagnostic Confirmation [Std# 490]

Over-ride Surg/DxConf [Std# 2020]

Description:

This edit is skipped if RX Summ--Surg Prim Site is blank.

If the case was previously reviewed and accepted as coded (Over-ride Surg/Dx Conf = 1) no further checking is performed.

RX Summ--Surg Prim Site, Diag Conf (SEER IF76) (continued)

For anyone with RX Summ--Surg Prim Site = 20-90 the diagnosis should be histologically confirmed (Diagnostic Confirmation 1,2,4).

Additional Information:

If the patient had a surgical procedure, most likely there was a microscopic examination of the cancer. This edit forces review of cases with a surgical procedure coded in the RX Summ--Surg Prim Site field but not a microscopic confirmation code in Diagnostic Confirmation. Verify the surgery and diagnostic confirmation codes, and correct any errors. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may be necessary.

Sometimes there are valid reasons why no microscopic confirmation is achieved with surgery, for example, the tissue removed may be inadequate for evaluation. If upon review, the items are correct as coded, an over-ride flag may be set so that the case will not be considered in error when the edit is run again. Enter a 1 in the field Over-ride Surg/DxConf to indicate that the coding is correct.

Edit Name: RX Summ--Surg Prim Site, Primary Site, ICDO3 (COC)

Agency: COC

Last Changed: 04/12/2007

Fields: RX Summ--Surg Prim Site [Std# 1290]
Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]

Description:

This edit is skipped if either Histologic Type ICD-O-3 or RX Summ--Surg Prim Site is empty.

The valid RX Summ--Surg Prim Site codes for each Primary Site are specified in Appendix B of the FORDS Manual-2003.

Exceptions are as follows:

For all sites, if Histologic Type ICD-O-3 = 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989, then RX Summ--Surg Prim Site must = 98.

If Primary Site = C420, C421, C423, or C424, then RX Summ--Surg Prim Site must = 98.

If Primary Site group is All Other Sites (group 30 in the table used for this edit) and RX Summ--Surg Prim Site = 41 (enucleation for eye surgery only), then Primary Site must = C690-C699.

Unknown and ill-defined sites (C760-C768, C809) must also = 98.

Edit Name: RX Summ--Surg/Rad Seq (NPCR)

Agency: NPCR

Last Changed: 04/12/2007

Fields: RX Summ--Surg/Rad Seq [Std# 1380]

Description:

Must be a valid RX Summ--Surg/Rad Seq code (0,2-6,9) or blank.

RX Summ--Surg/Rad Seq, Date of DX (NPCR) (continued)

Edit Name: RX Summ--Surg/Rad Seq, Date of DX (NPCR)

Agency: NPCR

Last Changed: 11/22/2005

Fields: Date of Diagnosis [Std# 390]

RX Summ--Surg/Rad Seq [Std# 1380]

Description:

If year of Date of Diagnosis is greater than 2005 and not equal to 9999, then RX Summ--Surg/Rad Seq cannot be blank.

Edit Name: RX Summ--Systemic/Sur Seq (COC)

Agency: COC

Last Changed: 05/14/2007

Fields: RX Summ--Systemic/Sur Seq [Std# 1639]

Description:

This field is allowed to be blank because the item is not required until 2006. Another edit (RX Summ--Systemic/Sur Seq, Date of DX) verifies that this item is not blank if the year of Date of Diagnosis is greater than 2005 and not equal to 9999.

Must be a valid RX Summ--Systemic/Sur Seq code (0, 2-6, 9) or blank.

Edit Name: RX Summ--Systemic/Sur Seq, Date of DX (COC)

Agency: COC

Last Changed: 05/14/2007

Fields: Date of Diagnosis [Std# 390]

RX Summ--Systemic/Sur Seq [Std# 1639]

Description:

If year of Date of Diagnosis is greater than 2005 and not equal to 9999, then RX Summ--Systemic/Sur Seq cannot be blank.

Edit Name: RX Summ--Transplnt/Endocr (NPCR)

Agency: NPCR

Last Changed: 04/12/2007

Fields: RX Summ--Transplnt/Endocr [Std# 3250]

Description:

This field must contain 00, 10-12, 20, 30, 40, 82, 85-88, 99 or blank.

Edit Name: RX Summ--Transplnt/Endocr, Date of DX (NPCR)

Agency: NPCR

Last Changed: 11/29/2005

Fields: Date of Diagnosis [Std# 390]

RX Summ--Transplnt/Endocr [Std# 3250]

Description:

If year of Date of Diagnosis is greater than 2005 and not equal to 9999, then RX Summ--Transplnt/Endocr cannot be blank.

Edit Name: Seq Num--Central, Prim Site, Morph ICDO3(SEER IF22)

Agency: SEER

Last Changed: 04/30/2007

Fields: Sequence Number--Central [Std# 380]

Over-ride Ill-define Site [Std# 2060]

Seq Num--Central, Prim Site, Morph ICDO3(SEER IF22 (continued)

Primary Site [Std# 400]

Histologic Type ICD-O-3 [Std# 522]

Description:

This edit is skipped if Histologic Type ICD-O-3 is empty.

If Sequence Number--Central is in the range of 60-88 (state registry-required/cancer committee-required) or 98 (cervix carcinoma in situ), this edit is skipped.

Multiple primaries require review for a person for whom the site or histology is ill-defined or unspecified.

If the case has been reviewed and accepted as coded (Over-ride Ill-define site = 1), no further editing is performed.

If Sequence Number--Central indicates the person has had more than one primary (>00), then any case with one of the following Primary Site/Histologic Type combinations requires review:

1. C760-C768 (Ill-defined sites) or C809 (unknown primary) and Histologic Type ICD-O-3 < 9590
2. C770-C779 (lymph nodes) and Histologic Type ICD-O-3 not in range 9590-9729
3. C420-C424 and Histologic Type ICD-O-3 not in range 9590-9989
4. Any site code and Histologic Type ICD-O-3 9740-9758.

Additional Information:

This edit forces review of multiple primary cancers when one of the primaries is coded to a site-morphology combination that could indicate a metastatic site rather than a primary site.

GENERAL

It is important to verify that the suspect case is indeed a separate primary from any others that may have been reported for the patient. Correction of errors may require inspection of the abstracted text, either online or as recorded on a paper abstract. Review of the original medical record may be necessary. If the suspect case is accurate as coded, and the number of primaries is correct, set the Over-ride Ill-define site flag to 1 so that the case will not be considered in error when the edit is run again. It is not necessary to set the over-ride flag on the patient's other primary cancers.

If it turns out that the suspect cancer is considered a manifestation of one of the patient's other cancers, delete the former case, resequence remaining cases, and correct the coding on the latter case as necessary.

SPECIFIC GUIDELINES

1. Ill-defined sites (C76.0 - C76.8) or unknown primary (C80.9) and histology code less than 9590: Look for evidence that the unknown or ill-defined primary is a secondary site (extension or metastasis) from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian carcinoma known to the registry, and should not be entered as a second primary.

Seq Num--Central, Prim Site, Morph ICDO3(SEER IF22 (continued))

2. Lymph nodes (C77.0-C77.9) and histology code not in the range 9590-9729: Primary malignancies of lymph nodes are almost exclusively the lymphomas coded in the range 9590-9729. A carcinoma, sarcoma, leukemia, or other diagnosis outside that range in a lymph node is most likely a metastatic (secondary) lesion. Check whether the lymph node lesion could be a manifestation of one of the patient's other cancers. If the lesion in the lymph node is considered a separate primary, try to ascertain a more appropriate primary site than lymph nodes.

3. Hematopoietic and reticuloendothelial systems (C42.0-C42.4) and histology not in the range 9590-9989: Primary cancers of the blood, bone marrow, spleen, etc. are almost exclusively lymphomas, leukemias, and related conditions coded in the range 9590-9989. A carcinoma, sarcoma, or other diagnosis outside that range in one of these sites is most likely a metastatic (secondary) lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers. If the lesion is considered a separate primary, try to ascertain a more appropriate primary site other than those in the C42 group.

4. Other lymphoreticular neoplasms and mast cell tumors of any site (histologies 9740-9758): Verify that these diagnoses are coded correctly and are indeed separate primaries from the other reported ones.

EXAMPLE

	SITE	HISTOLOGIC TYPE
SEQ. NUM. 01	RECTUM, C20.9	ADENOCA, 8140/3
SEQ. NUM. 02	PRIMARY UNK., C80.9	ADENOCA, 8140/3

The edit identifies the primary unknown case above (number 02) as case requiring review. When the patient's chart is reviewed again, it is determined that the diagnosis was based on a liver biopsy showing metastatic adenocarcinoma, and the patient has known liver metastases from his rectal CA. Delete case number 02, and change the sequence number of the rectal cancer to 00. Check carefully for any demographic, diagnostic, staging, treatment, or follow-up information recorded on the primary unknown abstract that should be added to the rectal cancer case.

Edit Name: Sex (SEER Sex)

Agency: SEER

Last Changed: 01/06/1995

Fields: Sex [Std# 220]

Description:

Must have a valid Sex code (1-4,9).

Edit Name: Sex, Primary Site (SEER IF17)

Agency: SEER

Last Changed: 08/23/2005

Fields: Sex [Std# 220]

Primary Site [Std# 400]

Description:

Primary Site codes C510-C589 (female genital organs) are invalid for males (Sex = 1). Primary Site codes in the range C600-C639 (male genital organs) are invalid for females (Sex = 2).

Edit Name: Site Coding Sys--Current (NAACCR)
Agency: NAACCR **Last Changed:** 01/08/2001
Fields: Site Coding Sys--Current [Std# 450]
Description:
Must be 4 (ICD-O-2) or 5 (ICD-O-3).

Edit Name: Social Security Number (NAACCR)
Agency: NAACCR **Last Changed:** 04/30/2007
Fields: Social Security Number [Std# 2320]
Description:
Must be a 9-digit number.

The following are not allowed:

1. First three digits = 000
2. First three digits = 666
3. Fourth and fifth digits = 00
4. Last four digits = 0000
5. First digit = 8
6. First digit = 9 (except when first digit of 999999999)

Edit Name: Spanish/Hispanic Origin (SEER SPANORIG)
Agency: SEER **Last Changed:** 09/20/2004
Fields: Spanish/Hispanic Origin [Std# 190]
Description:
Must be a valid Spanish/Hispanic Origin code (0-9).

Edit Name: Summ Stg 1977, Site, Hist ICDO2, Rpt Srce (NAACCR)
Agency: NAACCR **Last Changed:** 08/03/2005
Fields: Primary Site [Std# 400]
Histology (92-00) ICD-O-2 [Std# 420]
SEER Summary Stage 1977 [Std# 760]
Type of Reporting Source [Std# 500]
Behavior (92-00) ICD-O-2 [Std# 430]
Description:
This edit is skipped if any of the fields are blank; it is also skipped if Behavior (92-00) ICD-O-2 = 0 (benign) or 1 (borderline).

If case is death certificate only (Type of Reporting Source = 7) then SEER Summary Stage 1977 must equal 9.

This edit allows a SEER Summary Stage 1977 code of 0-5, 7, 9 for all Primary Sites and Histology (92-00) ICD-O-2 codes with the following exceptions:

If Histology (92-00) ICD-O-2 is in the range of 8800-9055, 9110-9134, 9141-9507, or 9520-9581, then SEER Summary Stage 1977 must not = 0.

If Primary Site = C50_ (breast) and Histology (92-00) ICD-O-2 = 8530 (inflammatory carcinoma), then SEER Summary Stage 1977 must not = 0, 1, 3, or 5.

Summ Stg 1977, Site, Hist ICDO2, Rpt Srce (NAACCR) (continued)

Otherwise, allowable codes are:

Hodgkin and Non-Hodgkin Lymphoma of All Sites
(M-9590-9698, 9702-9717)

Allowable values: 1, 5, 7, 9 with the following exception:

If Primary Site = C778, then SEER Summary Stage 1977 must not = 1

Hematopoietic and Myeloproliferative Neoplasms
(M-9720-9989)

Allowable values for 9731, 9740, 9764, 9930:
1, 7, 9

Allowable values for all others: 7

Heart, Mediastinum
C380-C383, C388

Allowable values: 1-5, 7, 9

Pleura
C384

Allowable values: 1-5, 7, 9

Other and Ill-Defined Respiratory Sites and Intrathoracic Organs
C390, C398-C399

Allowable values: 1-5, 7, 9

Bones, Joints, and Articular Cartilage
C400-C403, C408-C409, C410-C414, C418-C419

Allowable values: 1-5, 7, 9

Mycosis Fungoides and Sezary Disease of Skin, Vulva, Penis, Scrotum
C440-C449, C510-C512, C518-C519, C600-C601, C608-C609, C632
(M-9700-9701)

Allowable values: 1-5, 7, 9

Peripheral Nerves and Autonomic Nervous System; Connective, Subcutaneous, and
Other Soft Tissues

C470-C476, C478-C479, C490-C496, C498-C499

Allowable values: 1-5, 7, 9

Retroperitoneum and Peritoneum
C480-C482, C488

Allowable values: 1-5, 7, 9

Retinoblastoma
C692, C699

(M-9510-9514)

Allowable values: 1-5, 7, 9

Brain and Cerebral Meninges
C700, C710-C719

Allowable values: 1, 5, 7, 9

Other Parts of Central Nervous System
C701, C709, C720-C725, C728-C729

Allowable values: 1, 5, 7, 9

Pituitary Gland, Craniopharyngeal Duct, Pineal Gland

Summ Stg 1977, Site, Hist ICDO2, Rpt Srce (NAACCR) (continued)

C751-C753

Allowable values: 0-2, 5, 7, 9

Other and Ill-Defined Sites, Unknown Primary Site

C760-C765, C767-C768, C809

C42 and C77 excluding 9590-9698, 9702-9717, 9720-9989

Allowable values: 9

Edit Name: Summary Stage 1977 (NAACCR)

Agency: NAACCR

Last Changed: 08/03/2005

Fields: SEER Summary Stage 1977 [Std# 760]

Description:

This field is allowed to be blank because the item was not required after 2000. Another edit (Summary Stage, Date of Diagnosis) verifies that this item is not blank if the year of Date of Diagnosis is less than 2001. Central registries should include both edits in their edit set.

Must be a valid SEER Summary Stage 1977 code (0-5, 7-9) or blank.

Edit Name: Summary Stage 1977, Date of Diagnosis (NAACCR)

Agency: NAACCR

Last Changed: 08/03/2005

Fields: Date of Diagnosis [Std# 390]

SEER Summary Stage 1977 [Std# 760]

Description:

If year of Date of Diagnosis is less than 2001, then SEER Summary Stage 1977 cannot be blank.

Edit Name: Summary Stage 1977, Type of Report Source (NAACCR)

Agency: NAACCR

Last Changed: 08/03/2005

Fields: Type of Reporting Source [Std# 500]

SEER Summary Stage 1977 [Std# 760]

Description:

This edit is skipped if SEER Summary Stage 1977 is blank.

If case is death certificate only (Type of Reporting Source = 7) then SEER Summary Stage 1977 must equal 9.

Edit Name: Summary Stage 2000 (NAACCR)

Agency: NAACCR

Last Changed: 08/20/2003

Fields: SEER Summary Stage 2000 [Std# 759]

Description:

This field is allowed to be blank because the item was not required until 2001. Another edit (Summary Stage 2000, Date of Diagnosis) verifies that this item is not blank if the year of Date of Diagnosis is greater than 2000 and less than 2004. Central registries should include both edits in their edit set.

Must be a valid SEER Summary Stage 2000 code (0-5, 7-9) or blank.

Edit Name: Summary Stage 2000, Date of Diagnosis (NAACCR)

Agency: NAACCR

Last Changed: 12/12/2003

Fields: Date of Diagnosis [Std# 390]
SEER Summary Stage 2000 [Std# 759]

Description:

If year of Date of Diagnosis is greater than 2000 and less than 2004, then SEER Summary Stage 2000 cannot be blank.

Edit Name: Surgery, Rad, Surg/Rad Seq (COC)

Agency: COC

Last Changed: 01/20/2005

Fields: RX Summ--Surg Prim Site [Std# 1290]
RX Summ--Scope Reg LN Sur [Std# 1292]
RX Summ--Surg Oth Reg/Dis [Std# 1294]
Rad--Regional RX Modality [Std# 1570]
RX Summ--Surg/Rad Seq [Std# 1380]

Description:

This edit is skipped if any of the fields are blank.

If surgery was performed (RX Summ--Surg Prim Site = 10-90 or RX Summ--Scope Reg LN Sur = 1-8 or RX Summ--Surg Oth Reg/Dis = 1-8), and if radiation was given (Rad--Regional RX Modality = 20-98) then RX Summ--Surg/Rad Seq must specify sequence (codes 2-9).

If surgery was not performed (RX Summ--Surg Prim Site = 00 and RX Summ--Scope Reg LN Sur = 0 and RX Summ--Surg Oth Reg/Dis = 0), or no radiation (Rad--Regional RX Modality = 00), then RX Summ--Surg/Rad Seq must specify no (0).

If surgery was not performed (RX Summ--Surg Prim Site = 98 (coded for hematopoietic, ill-defined and unknown sites) and RX Summ--Scope Reg LN Sur = 9 and RX Summ--Surg Oth Reg/Dis = 0), or no radiation (Rad--Regional RX Modality = 00), then RX Summ--Surg/Rad Seq must specify no (0).

Edit Name: Type of Rep Srce(DC),Seq Num--Cent,ICDO3(SEER IF04)

Agency: SEER

Last Changed: 04/12/2007

Fields: Over-ride Report Source [Std# 2050]
Type of Reporting Source [Std# 500]
Sequence Number--Central [Std# 380]
Histologic Type ICD-O-3 [Std# 522]

Description:

This edit is skipped if Histologic Type ICD-O-3 is empty.

If the case has been previously reviewed and accepted as coded (Over-ride Report Source = 1), no further editing is done.

If the Type of Reporting Source specifies a death certificate only case (7) and the histology is not a lymphoma, leukemia, immunoproliferative or myeloproliferative disease (Histologic Type ICD-O-3 is < 9590), then the Sequence Number--Central must specify one primary only (00 or 60).

Additional Information:

Type of Rep Srce(DC),Seq Num--Cent,ICD03(SEER IF04 (continued)

Cancer diagnoses on death certificates are notoriously inaccurate. Secondary sites are sometimes listed as primary sites, such as "Liver cancer" when there are metastases to the liver. Depending on who the informant or certifier of death is, the diagnosis and intervals can be incorrect. The registry may well have more accurate information about the course of the patient's disease than the death certificate. This edit forces review of multiple primary cancers when one of the primaries is coded as a death-certificate-only case (DCO) (except for DCO cases of leukemia, lymphoma, and related diseases with morphology codes > 9590).

Scrutinize the entire death certificate and all patient abstracts (and the original medical records if necessary) for any evidence that the cancer mentioned on the death certificate is a manifestation of a cancer diagnosed before death. Review the clinical history, treatment, follow-up, and any autopsy results that are available. If the patient died in a hospital, it may be necessary to review the medical record of the final admission. It may also be helpful to contact the patient's clinician or a nursing home to clarify the number of primary cancers. If the DCO case cannot be ruled out, and the number of primaries is correct, set the Over-ride Report Source flag to 1 so that the case will not appear in future edits as an error. It is not necessary to set the over-ride flag on the patient's other primary cancers.

If it turns out that the DCO case should be considered a manifestation of one of the patient's other cancers, delete the DCO case, resequence remaining cases, and correct the coding on the remaining case(s) as necessary. It may also turn out that the cancer reported on the death certificate is a separate independent primary that was diagnosed before death. In that case, changing the Type of Reporting Source from DCO to another code will eliminate the error.

Edit Name: Type of Report Srce(DC/AO), COD (SEER IF09)

Agency: SEER

Last Changed: 08/23/2005

Fields: Type of Reporting Source [Std# 500]
Cause of Death [Std# 1910]

Description:

For autopsy only and death certificate only cases (Type of Reporting Source = 6 or 7), Underlying Cause of Death must not = 0000 (alive).

For death certificate only cases (Type of Reporting Source = 7), Underlying Cause of Death must not = 7777 (death certificate not available).

Edit Name: Type of Report Srce(DC/AO), Date of Dx (SEER IF02)

Agency: SEER

Last Changed: 08/23/2005

Fields: Type of Reporting Source [Std# 500]
Date of Diagnosis [Std# 390]
Date of Last Contact [Std# 1750]

Description:

If the Type of Reporting Source specifies an autopsy only case (6) or a death certificate only case (7), the Date of Last Contact must equal the Date of Diagnosis.

Edit Name: Type of Report Srce(DC/AO), Diag Conf (SEER IF05)

Type of Report Srce(DC/AO), Diag Conf (SEER IF05) (continued)

Agency: SEER **Last Changed:** 08/23/2005

Fields: Diagnostic Confirmation [Std# 490]
Type of Reporting Source [Std# 500]

Description:

1. If the Type of Reporting Source specifies an autopsy only case (6), the Diagnostic Confirmation must be positive histology (1) or direct visualization without microscopic confirmation (6).
2. If the Type of Reporting Source specifies a death certificate only case (7), the Diagnostic Confirmation must be unknown whether or not microscopically confirmed (9).

Edit Name: Type of Report Srce(DC/AO), Vit Stat (COC)

Agency: COC **Last Changed:** 07/24/1999

Fields: Type of Reporting Source [Std# 500]
Vital Status [Std# 1760]

Description:

This edit is skipped if any of the single field edits for Type of Reporting Source or Vital Status have failed.

If the Type of Reporting Source specifies a death certificate only case (7) or an autopsy only case (6), the Vital Status of the patient must specify dead (0).

Edit Name: Type of Reporting Source (SEER RPRTSRC)

Agency: SEER **Last Changed:** 07/13/2005

Fields: Type of Reporting Source [Std# 500]

Description:

Must be a valid Type of Reporting Source code (1-8).

Edit Name: Unknown Site, Hist ICDO3, Summ Stg 1977 (NAACCR)

Agency: NAACCR **Last Changed:** 11/29/2005

Fields: Primary Site [Std# 400]
Histologic Type ICD-O-3 [Std# 522]
SEER Summary Stage 1977 [Std# 760]

Description:

The purpose of this edit is to accommodate cases that have been converted from ICD-O-2 to ICD-O-3.

This edit is skipped if SEER Summary Stage 1977 is blank.

This edit is skipped for the following histologies (Histologic Type ICD-O-3):

- Kaposi sarcoma (9140)
- Lymphomas (9590-9699,9702-9729)
- Hematopoietic and myeloproliferative neoplasms(9731-9989)

This edit verifies that an unknown Primary Site (C809) has a SEER Summary Stage 1977 of 9.

Edit Name: Unknown Site, Laterality (SEER IF138)

Unknown Site, Laterality (SEER IF138) (continued)

Agency: SEER

Last Changed: 07/14/2005

Fields: Primary Site [Std# 400]

Laterality [Std# 410]

Description:

This edit verifies that an unknown Primary Site (C809) has a Laterality of 0.

Edit Name: Vital Status (COC)

Agency: COC

Last Changed: 04/12/2007

Fields: Vital Status [Std# 1760]

Description:

Must be a valid Vital Status code (0,1).

Edit Name: Vital Status, Cause of Death (COC)

Agency: NONE

Last Changed: 04/12/2007

Fields: Vital Status [Std# 1760]

Cause of Death [Std# 1910]

Description:

This edit is skipped if either field is blank.

If Vital Status is 1 (alive), then Underlying Cause of Death must = 0000 (alive); if Vital Status = 0 (dead), then Underlying Cause of Death must not = 0000 (alive).
