Standards for Cancer Registries, Volume I

Data Exchange Standards and Record Descriptions

Version 16
November 2015

Edited by
Lori A. Havener, CTR

Sponsoring Organizations
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Edited by:
Lori A. Havener, CTR

For further information, contact:
NAACCR, Inc.
Phone: (217) 698-0800
http://www.naaccr.org

Comments and suggestions on this and other NAACCR standards documents are welcome. Please send your comments to the editor or to any member of the NAACCR Board of Directors.

The other volumes in the series, Standards for Cancer Registries, are:

Volume II, *Data Standards and Data Dictionary*. Intended for hospital and central cancer registries, programmers, and analysts, this provides detailed specifications and codes for each data item in the data exchange record layout.

Volume III, *Standards for Completeness, Quality, Analysis, and Management of Data*. Intended for central registries, this provides detailed standards for many aspects of the operation of a population-based cancer registry.

Volume IV, *Standard Data Edits.* This standard document currently is only made available electronically as a program code and a database. It documents standard computerized edits for data corresponding to the data standards Volume II.

Volume V, *Pathology Laboratory Electronic Reporting*. Recommends message or format standards for electronic transmission of reports (pathology, cytology and hematology) from pathology laboratories to central cancer registries.

Copies of the standards documents can be viewed or downloaded from NAACCR's website at http://www.naaccr.org.

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The NAACCR Board of Directors has approved the adoption of these standards.

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President:
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Cancer Care Nova Scotia
Surveillance and Epidemiology Unit
Telephone: (902) 473-6084
E-mail: cwiggins@salud.unm.edu

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Telephone: (603) 653-6620
E-mail: bruce.l.riddle@dartmouth.edu

Executive Director *ex officio*:
Betsy A. Kohler, MPH, CTR
NAACCR
Telephone: (217) 698-0800
E-mail: bkohler@naaccr.org

Sponsoring Member Organization Representative:
Lori Swain — 2014-16
National Cancer Registrars Association
Telephone: (703) 299-6640
E-mail: lswain@ncra-usa.org

Members at Large:
Francis P. Boscoe, PhD — 2014-16
New York State Cancer Registry
Telephone: (518) 474-2255
E-mail: frank.boscoe@health.ny.gov

Eric B. Durbin, Dr.PH, MS — 2013-17
Kentucky Cancer Registry
Telephone: (859) 218-3179
E-mail: ericd@kcr.uky.edu

Christopher Johnson — 2014-16
Cancer Data Registry of Idaho
Telephone: (208) 489-1380
E-mail: cjohnson@teamiha.org

Deirdre Rogers, MS, CTR — 2015-17
Mississippi Cancer Registry
Telephone: (601) 815-5479
E-mail: dbrogers@umc.edu

Winny Roshala, BA, CTR — 2013-17
Cancer Registry of Greater California
Telephone: (916) 779-0313
E-mail: wroshala@crgc-cancer.org

Kim Vriends, BHA, CHIM — 2012-16
Prince Edward Island Cancer Registry
Telephone: (902) 894-2167
E-mail: kavriends@gov.pe.ca

Standardization and Registry Development Steering Committee
2015 - 2016

Antoinette Stroup, PhD (co-chair)
New Jersey State Cancer Registry
Telephone: (609) 633-0500
E-mail: Antoinette.stroup@doh.state.nj.us

Randi Rycroft, MSPH, CTR (co-chair)
Colorado Central Cancer Registry
Telephone: (303) 692-2542
E-mail: randi.rycroft@state.co.us

Lori A. Havener, CTR
NAACCR
Telephone: (217) 698-0800
E-mail: lhavener@naaccr.org

Eric B. Durbin, Dr.PH, MS
Kentucky Cancer Registry
Telephone: (859) 219-0773
E-mail: ericd@kcr.uky.edu

Jim Hofferkamp, CTR
NAACCR
Telephone: (217) 698-0800
E-mail: jhofferkamp@naaccr.org

Sandy Jones
Centers for Disease Control and Prevention
National Program of Cancer Registries
Telephone: (770) 488-5689
E-mail: sthames@cdc.gov

Amy Kahn, MS, CTR
New York State Cancer Registry
Telephone: (518) 474-2255
E-mail: ark02@health.ny.gov

Mary Jane King, MPH, CTR
Ontario Cancer Registry
Telephone: (416) 217-1242
E-mail: maryjane.king@cancercare.on.ca

Carol Kosary
National Cancer Institute
SEER Program, SRP, DCCPS
Telephone: (301) 402-5212
E-mail: ck26s@nih.gov

Gary M. Levin, BA, CTR
Florida Cancer Data System
University of Miami
Telephone: (305) 243-4073
E-mail: glevin@med.miami.edu

Rich Pinder
Los Angeles Cancer Surveillance Program
Telephone: (323) 442-1640
E-mail: rpinder@usc.edu

Winny Roshala, BA, CTR
Cancer Registry of Greater California
Telephone: (916) 779-0313
E-mail: wroshala@crgc-cancer.org

David Stinchcomb, PhD
Westat
Telephone: (301) 610-5571
E-mail: DavidStinchcomb@westat.com

STANDARD SETTING ORGANIZATIONS

American Joint Committee on Cancer (AJCC)
633 N. Saint Clair Street
Chicago, IL 60611
Telephone: (312) 202-5290
Fax: (312) 202-5205
E-mail: ajcc@facs.org
Website: www.cancerstaging.org

Canadian Council of Cancer Registries
c/o Statistics Canada
Health Statistics Section
Health Statistics Division
Main Building, Room 220, Section F
120 Parkdale Ave.
Ottawa, ON K1A 0T6
Telephone: (613) 951-1630
Fax: (613) 951-0792

Centers for Disease Control and Prevention (CDC)
National Program of Cancer Registries (NPCR)
Division of Cancer Prevention and Control
National Center for Chronic Disease
Prevention and Health Promotion
MS-K53
4770 Bufford Highway, NE
Atlanta, GA 30341-3724
Telephone: (770) 488-4783
Fax: (770) 488-4759
Website: www.cdc.gov/nccdphp/dcpc/npcr

Commission on Cancer (CoC)
633 N. Saint Clair Street
Chicago, IL 60611-3211
Telephone: (312) 202-5085
E-mail: coc@facs.org
Website: www.facs.org

National Cancer Institute SEER Program (NCI SEER)
Cancer Surveillance Research Program
Division of Cancer Control and Population Sciences
6116 Executive Boulevard, Suite 504
MSC 8316
Bethesda, MD 20892-8316
Telephone: (301) 496-8510
Fax: (301) 496-9949
E-mail: cancer.gov_staff@mail.nih.gov
Website: www.seer.cancer.gov

National Cancer Registrars Association (NCRA)
1340 Braddock Place #203
Alexandria, VA 22314
Telephone: (703) 299-6640
Fax: (703) 299-6620
E-mail: info@ncra-usa.org
Website: www.ncra-usa.org

North American Association of Central Cancer Registries, Inc. (NAACCR)
2121 W. White Oaks Drive
Springfield, IL 62704
Telephone: (217) 698-0800
Fax: (217) 698-0188
E-mail: info@naaccr.org
Website: www.naaccr.org

1. INTRODUCTION

1.1 Version 16 of the Record Layout

The North American Association of Central Cancer Registries, Inc. (NAACCR) Standards for Cancer Registries, Volume I, *Data Exchange Standards and Record Descriptions, Version 16* (January 1, 2016 implementation) includes several new data items and revisions to the record layout. New data items include the geocoded county fields as well as new data items for the transition from collaborative stage (CS) to TNM. The Electronic Health Record (EHR) Reporting and Volume II Harmonization Task Force submitted changes to harmonize Volume II to better accommodate EHR reporting, most of these were wording modifications (e.g., change "hospital" to "reporting facility"), these changes do not impact Standards Volume I. Refer to the Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary*, Version 16 for detailed information.

2. PURPOSE AND USE OF DATA EXCHANGE LAYOUTS

The NAACCR data exchange record layouts were designed to facilitate electronic transmission of cancer registry data among registries for multiple purposes. The layouts can be used to provide standardized data from reporting sources to central registries; to share tumor reports on residents of other states/provinces from one central registry to another; or to report data from diverse facilities or states/provinces contributing to a combined study. The NAACCR data set is comprised of all data items recommended for use by the major cancer registry standard-setting organizations. For some types of data, more than one coding system is provided in the layout. For example, information on stage of the tumor at diagnosis is represented by many items comprising TNM, SEER EOD, Summary Stage, and Collaborative Stage. Any single registry is unlikely to collect all of the items in the layouts. It is hoped that all items collected by an individual registry can be accommodated in the NAACCR layouts and thus shared in a common data format with other registries.

The layouts were intended to provide a common language for cancer registry systems. It was not NAACCR's intent to require that systems would use the NAACCR data item names and layouts internally. However, it has proven convenient for some systems to do so. The standard has been widely accepted both for data exchange and local use.

2.1. RECORD LAYOUT DESIGN DECISIONS

The simplest method for encompassing the Incidence, Confidential and Full Case Abstract record types was chosen: each longer record type builds on the next shorter record type by adding fields. The incidence-only records use only the first section of the overall layout, while the case abstract records use the full layout. Thus shorter, efficient records can be used for the smaller data set without requiring separate formats.

In selecting data items, it was decided to include more rather than less. All data items that currently are standardized by NAACCR, SEER, or the Commission on Cancer have been included. Additional items were added that are currently used by several systems and which probably could become standardized. Other fields were added to help coordinate the data exchange. Data items that were used in the past are usually maintained in the record so that historically collected information can still be exchanged.

2.1.1. Data Exchange Records

2.1.1.1. Incidence Record (record type I)

These records include all the coded fields for each case, including demographic, tumor, staging, treatment, and follow-up fields. The primary use of the incidence record is to transmit data for multi-registry research projects or surveillance. See Appendix C for the Incidence Record layout (columns 1-3339).

2.1.1.2. Confidential Record (record type C)

These records include all the data items in the incidence record, plus items such as patient name and Social Security Number that identify the case. Also included are quasi-confidential data items such as referring hospital or primary physician, items which some agencies are required to keep confidential**.**
This record type can be used to exchange cases between registries, whether central-based or hospital-based. See Appendix C for the Confidential Record layout (columns 1-5564).

2.1.1.3. Full Case Abstract (record type A)

These records contain all fields noted above, plus the supportive text required for the transmission of full case abstracts. The full case abstract allows the receiving registry to perform a higher degree of quality control with each case report. See Appendix C for the Full Case Abstract Record layout (columns 1-22824).

2.1.1.4. Pathology Laboratory Record (record type L)

The Pathology Laboratory record is designed for electronic transmission of reports from pathology laboratories to central registries. Health Level 7 (HL7) or a character delimited flat file is recommended as the data format for transmitting pathology laboratory reports. A standard pathology laboratory dataset, data dictionary, and HL7 transmission format and flat file were developed to enhance the completeness, timeliness, consistency, and efficiency with which tumor data are transmitted by pathology laboratories and received and processed by central cancer registries (see Standards for Cancer Registries, Volume V).

2.1.1.5. Update/Correction (record type U) and Modified Records (record type M)

Two record layout types, an update/correction record and a modified record, provide data layouts to transmit changes or revisions to data that have already been sent to a receiving registry.

The Update/ Correction, record type U, which has its own record version data items (see section 2.3.1), is a short format record that can be used to transmit individual, field specific corrections to data already submitted. The record length is 1543 bytes. This record type is for use by those registries and software providers that do not already have a well-functioning corrections system, or who wish to use a standardized format. In this volume, version 16 of the update/correction record is documented. Version 16 of the "U" record can be used only to update data that are already coded according to the standards documented in version 16 of the NAACCR data exchange record types I, C, and A. See Appendix D for the Update/Correction Record layout.

The Modified Record, record type M, is the same length (22824 characters) and contains the same fields, in the same locations, as the Full Case Abstract, record type A. A Modified Record represents an alternative way for submitting changed information to a receiving registry, on tumor records that have already been submitted. It is designed for transmitting an entire tumor record in which one or more modifications, updates, or corrections have been made since the last time the tumor record was submitted to the receiving registry. Like record type 'U', the 'M' record may be used to transmit corrections or follow-up.

Like the "U" record, a version 16 "M" record can be used only to update data already coded according to the standards documented in version 16 of the NAACCR data exchange record. This is because the definitions, data length, and code meanings for certain variables changed between version 16 and previous versions.

2.1.1.6. Canadian Data

The NAACCR data standards thus far adopted do not cover all Canadian data. Changes have been made to accommodate postal codes, standard abbreviations for provinces, and other fields. As Canadian standards are adopted by NAACCR, future versions will incorporate these additional standards into the layout.

2.2. SUMMARY OF NAACCR DATA EXCHANGE RECORD TYPES

Record Type is a generated field that identifies which of the six NAACCR data exchange record types is being used in a file of data exchange records. Since Record Type R (Analysis/Research Record) is not used it has been removed from Standards Volume I Version 12.1. Data dictionary descriptions for record types I, C, A, and M (data item numbers 10 – 7600) can be found in the NAACCR Standards for Cancer

Registries Volume II: *Data Standards and Data Dictionary*. The record layout for these record types can be found in Appendix C of this document.

RECORD TYPE I: INCIDENCE RECORD (coded data without direct personal identifiers)

Contents:	Demographic, Tumor and Staging, Treatment, and Follow-up (Optional)
Use:	Combined studies
Length:	3339 characters

RECORD TYPE C: CONFIDENTIAL RECORD (incidence record plus personal identifiers)

Contents:	Demographic, Tumor and Staging, Treatment, Follow-up, and Pathology, plus Patient Identifiers and Physicians
Use:	Case sharing between central registries
Length:	5564 characters

RECORD TYPE A: FULL CASE ABSTRACT (confidential record plus text; used for reporting to central registry)

Contents:	Demographic, Tumor and Staging, Treatment, Follow-up, and Pathology, Patient Identifiers & Physicians, plus Text
Use:	Sending abstracts between registries
Length:	22824 characters

RECORD TYPE L: PATHOLOGY LABORATORY

Contents:	Demographic, Tumor, and partial Staging (content varies dependent on availability at pathology laboratories and agreement between pathology laboratory and central registry)
Use:	Electronic transmission of tumor reports from pathology laboratories to central registries
Length:	No standard length

RECORD TYPE U: UPDATE/CORRECTION RECORD (short format record used to submit changes to data already submitted)

Contents:	Sender ID Section, Record ID Section, Correction Section
Use:	Transmitting changes for previously submitted cases
Length:	1543 characters

RECORD TYPE M: RECORD MODIFIED SINCE PREVIOUS SUBMISSION TO CENTRAL REGISTRY (identical in format to the A record type; used to submit changes to data already submitted)

Contents:	Demographic, Tumor and Staging, Treatment, and Follow-up, Patient Identifiers and Physicians, plus Text
Use:	Transmitting changes for previously submitted cases
Length:	22824 characters

2.3. RECORD TYPES FOR SUBMISSION OF CORRECTED, UPDATED, OR MODIFIED DATA

Two record types, an update/correction record and a modified record, provide data layouts to transmit changes or revisions to records that have already been sent to a receiving registry. Two methods exist because of parallel development that occurred in the registry community. Both methods work. Some central registries require changes to be submitted using the "U" record type; other central registries require changes to be submitted using the "M" record type.

2.3.1. Record Type "U" Update/Correction Record

2.3.1.1. Data Dictionary Descriptions

Each item in the Update/Correction record is described briefly. The standard item number in square brackets follows the item name. For data items with numbers 1-7600, see NAACCR Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary* for more information.

2.3.1.2. Sender ID Section of Update/Correction Record

The Sender ID section includes data items that identify the registry that is sending the update or correction to another registry. This section also includes the items that identify the records as NAACCR correction records.

Record Type [10]
Each update/correction record must have a 'U' in this field.

Update/Correction Record Version [9000]
1 = Version 1, first approved version, September 1997
2 = Version 2, February 1998
7 = Version 7, June 2000
A = Version 10, June 2003
B = Version 11, January 2006 (layout same as A; content, however may be different)
120 = Version 12, January 2010
121 = Version 12.1, January 2011
122 = Version 12.2, January 2012
130 = Version 13, January 2013
140 = Version 14, January 2014
150 = Version 15, January 2015
160 = Version 16, January 2016

Vendor Name [2170]
Name and version number of the cancer registry software used to create the update/correction record. Entered by the software.

Registry Type [30]
Registry Type of the data source generating the update/correction record; combined with Registry ID, identifies a unique cancer registry or data source.

Registry ID [40]
Registry ID of the data source generating the update/correction record; combined with Registry Type, identifies a unique cancer registry or data source.

Patient System ID Hosp [21]

Unique number assigned to each person in its database by the source (sending) registry identified in the fields Registry Type + Registry ID (e.g., a hospital cancer registry). The Patient System ID + Tumor Record Number together identify a unique case in the sending registry's database. If the sending registry is a central registry rather than a hospital, then use the Patient ID Number field [20] from the central registry.

Tumor Record Number [60]
Unique number assigned to each tumor in its database for a specific patient by the source (sending) registry identified in the fields Registry Type + Registry ID (e.g., a hospital cancer registry). The Patient ID Number + Tumor Record Number together identify a unique case in the sending registry's database.

2.3.1.3. Record ID Section of Update/Correction Record

This section includes items that identify the patient and tumor that were previously reported. The items are used by the receiving registry to link the update/correction record with the previously submitted tumor report. Many identifying items are included to increase the probability of successful linkage.

Patient ID Number—Receiver [9010]
Unique number assigned by the receiving registry to each person in its database. This usually corresponds to NAACCR field [20] in the central registry. The Patient ID Number—Receiver + Tumor Record Number—Receiver together identify a unique case in the receiving registry database. This number may be unknown to the sender. If unknown, leave blank.

Tumor Record Number—Receiver [9011]
Unique number assigned by the receiving registry to each tumor in its database for a specific patient. The Patient ID Number—Receiver + Tumor Record Number—Receiver together identify a unique case in the receiving registry's database. This number may be unknown to the sender. If unknown, leave blank**.**

Name—Last [2230], Name—First [2240], Name—Middle [2250], Social Security Number [2320], Sex [220], Date of Birth [240], Date of Birth Flag [241], Date of Diagnosis [390], Date of Diagnosis Flag [391], Primary Site [400], Laterality [410], Histology (92-00) ICD-O-2 [420], Histologic Type ICD-O-3 [522], Behavior (92-00) ICD-O-2 [430], Behavior Code ICD-O-3 [523]
Consolidated value for each item as reflected in the sending registry's database. There should be one value for each item for each patient or tumor. If the value of any of these items is being changed in the update/correction record, the ORIGINAL unchanged value should be included in the Record ID segment of the update/correction record.

Medical Record Number [2300], Military Record No Suffix [2310], Reporting Hospital [540], Accession Number—Hosp [550], Sequence Number—Hospital [560]
Entries of these fields can vary with the nature of the sending and receiving registries. When the sending registry is a single reporting facility, or is a central registry that has only one value for each of these items in its database, include those values in these fields. When the sending registry is a central registry and has multiple values for each field, the item(s) may be left blank. Whenever these items are filled in, the values must be those that correspond to the facility that is coded in Reporting Hospital [540].

2.3.1.4. Correction Section of the Update/Correction Record

This section identifies the data item that is being changed and the new value. It also includes date and time stamps and an area for text comments.

Date of This Change [9005]
System-generated date written in the standard format for all dates in the NAACCR layouts.

Time of This Change [9006]
System-generated, HHMMSS format, using a 24-hour clock.

CRC CHECKSUM [2081]
Cyclic Redundancy Code (CRC) CHECKSUM for the NAACCR record in which it resides. A unique value is calculated for each unique record in a NAACCR file. The value is calculated by applying a CRC algorithm to all data fields of the NAACCR record (excluding the CRC CHECKSUM field). Following a transmission, the CRC CHECKSUM can be recalculated and compared with the transmitted CHECKSUM. Identical values indicate an error-free transmission; differing values indicate an error in transmission.

Those using this field at this time must provide recipients of the data with the algorithm used to create the data transmission file. Otherwise the item should be left blank.

A NAACCR group prepared recommendations for a CRC algorithm to be used with NAACCR-formatted data transmissions. Their report is on the NAACCR website (www.naaccr.org), under the Standards and Registry Operations page.

Correction Comments [9020]
Free text explaining reason or source of correction, entered either manually or by the software. The comments should justify the change to the receiving registry so that they can evaluate the validity of the new information compared with what they already have.

Examples of manually entered comments:
1) Autopsy: small cell CA RUL lung, mets to L lung, lymph nodes, and brain
2) Pt remarried 6/5/97; new husband is Hispanic, pt is not
3) Slide review AFIP 6/5/09 final DX neuroblastoma
4) Name spelling changed per patient signature on 3 admissions
5) Per MD follow up letter, pt initially dx'd while resident of New Jersey

Examples of software-entered comments:
1) ICD-O-2 to ICD-O-3 conversion rerun
2) Correct Japanese cases miscoded Chinese
3) Convert MD codes to state license numbers
4) Address corrections per geocoding vendor

Changed Item [9030]
The NAACCR item number of the data item to be changed. For example, if reporting a change in the sex field, the value 220 (the NAACCR item number for sex) would be placed in this field.

Changed Item New Value [9040]
The new value for the changed data item referred to in NAACCR item number 9030. For example, if the sex of the patient were being changed from 9, for unknown, to 1, for male, the value 1 would be entered in this field.

2.3.1.5. Answers to Frequently Asked Questions about the Update/Correction Record

2.3.1.5.1. What is an update/correction record?

An update/correction record is a record for transmitting changed data on a case already transmitted. It conveys the changed data along with all items necessary to link the update/correction to the original full record. The update/correction record may be used to transmit corrections or follow-up, i.e., any change to any item, including abstracting text.

2.3.1.5.2. When should an update/correction record be generated by my software?

Update/Correction records should be system-generated whenever a change is made to a data item on a case that has already been transmitted, or written to a transmit file. (The Date Case Transmitted/Date Case Report Exported field can be used to identify tumor records that have already been transmitted). The vendor software should write out the new, corrected values, in addition to writing out the Sender ID Section and Record ID Section data items. The pre-change values must be used in the Sender ID Section and Record ID Section whenever a correction is made to one of these fields. The current date and time are written out on the update/correction record, and the Date Case Last Changed field in the case database is updated as well.

Central registries may negotiate with software vendors/data sources to provide corrections only on a subset of all possible items. For example, a central registry may not wish to receive corrections to items it does not store in its database. At this time there is no standard set of items for which corrections are to be required. Systems should have the potential to allow correction of any field.

2.3.1.5.3. When should update/correction records be transmitted?

There is no standard frequency for transmitting files of accumulated update/correction records. Frequency will vary with caseload and frequency of transmission of new cases. The most common approach is to send accumulated update/correction records each time a transmittal of new cases is generated. It might also be useful to allow ad hoc submissions of update/correction records for those times when numerous corrections are made at once.

2.3.1.5.4. Who should receive update/corrections records?

Update/Correction records should be sent to any agency to which the original case was sent, unless prior arrangements have been made to not receive corrections.

2.3.1.5.5. Does my registry software need to capture corrections to all data elements?

It is probably best for the sending (hospital) system to have the capability to generate corrections to all data elements, though in any particular installation, the capability might not be used for all elements. It is probably also best for the receiving (central) system to be able to accommodate corrections to any data element, though, again, in a particular application, not all capabilities may be implemented. The central system should have the ability to ignore and skip over corrections to any fields they have no interest in.

2.3.1.5.6. How do I accommodate sending update/corrections to multiple requesters?

We suggest that you use the same methods you use to handle multiple case transmits. The software would not need to select which fields to send each party, since receiving parties will have the ability to ignore data they are not requesting.

2.3.1.5.7. What is the purpose of the patient identifiers in the update/correction record?
The Record ID Section of the record contains all fields that might be needed to correctly link the update/correction record to the original case. Experience has shown that all identifier fields may change in value, and Registry ID may be incorrectly keyed; either of these could cause an update/correction to be applied to the wrong record. Allowing the match to be over-determined by comparing multiple fields reduces this possibility.

2.3.1.5.8. If several corrections are made to a record at one time, generating an equal number of update/correction records, should the Sender ID Section and Record ID Section of the update/correction records be the same for each update/correction record?
Yes, all update/correction records for a *specific patient-tumor-facility with identical date and time stamps* should have identical Sender ID and Record ID Sections. Later corrections to the same record, with later date or time stamps, could have different Sender ID and Record ID Sections. At the central registry, correction transactions should be applied in order by facility, by date, by time.

2.3.1.5.9. How about corrections made to the same record during two different work sessions (i.e., changes made one day and subsequent changes to the same record made on the next day)? Should the Record ID Section of the update/correction records be the same?
Same answer as number 2.3.1.5.8. Since they have different time stamps, they can have different Record ID values.

2.3.1.5.10. How will a system recognize and update/correction records?
NAACCR-format update/correction records will be identified by a **'U'** in the first position in Record Type [10].

2.3.1.5.11. Is additional programming needed to incorporate update/correction records into the central registry?
At a minimum, programming will be required to link and then print or display the update/correction record with the original record so that someone can make corrections to the database manually. More elaborate programming is desirable, so that some or all of the update/correction transactions can be applied automatically.

2.3.1.5.12. What is required for internal processing?
See answer to number 2.3.1.5.11.

2.3.1.5.13. What are the advantages of a uniform update/correction record to a central registry?
A standardized update/correction record format means that the central registry will only have to process one type of update/correction record. Communications with vendors are simplified.

2.3.1.5.14. How will a vendor of central registry software assist in incorporating corrections into the central system?
This may vary. The vendor needs to provide basic capabilities for receiving, linking, and displaying the contents of update/correction records. The vendor may also need to apply consolidation/reconciliation procedures that exist in ordinary records processing to the update/correction records.

2.3.1.5.15. How can update/correction records be edited? Can the EDITS program be used to edit incoming records?
The EDITS program cannot be used against the update/correction format per se. However, the update/correction record format could be converted to a NAACCR standard record layout, with most fields blank, and then item edits could be run against the reformatted records.

2.3.1.5.16. What about corrections to state-specific items?
NAACCR will consider reserving a block of item numbers for use by states/requestors to identify their user fields. Details will be forthcoming.

2.3.1.5.17. Will central registries that already have a different functioning system for receiving update/correction records be required to change to this new system?
No. As always, compliance with NAACCR standards is voluntary. The new update/correction record is provided as a service to registries that do not now have a functioning method or that wish to standardize to this approach.

This format for updating records is recommended as a standard for central cancer registries that have not already implemented an effective system for updating records with information from multiple sources. The format is designed to provide a standard for central registries that receive data from a variety of different computer software programs. Central registries, which do not receive data from software supported by multiple vendors, may be able to take advantage of alternative approaches.

2.3.2. Record Type 'M' Modified Record

2.3.2.1. Data Dictionary Descriptions and Record Layout
Changes to previously submitted data records could also be submitted using the "M" record type. The Uniform Data Standards and Information & Technology Committees first approved this record type in 2002. As explained below, the "M" record is identical in format to the "A" record type. Thus, the data dictionary descriptions are found in NAACCR Standards for Cancer Registries Volume II. The record layout table is also found in Appendix C of this document.

2.3.2.2. Questions & Answers about the "M" record

2.3.2.2.1. What is the "M" (modified) record?
An "M" (modified) record represents an alternative way for submitting changed information to a receiving registry, on tumor records that have already been submitted. The "M" record is identical in format to NAACCR record type "A", the case abstract record. "A" and "M" refer to possible values of Record Type [10], found in column 1 of the NAACCR exchange record. The "M" record is designed for transmitting an entire tumor record in which one or more modifications / updates / corrections have been made since the last time the tumor record was submitted to the receiving registry. Like record type "U" (the update/change record), the "M" record may be used to transmit corrections or follow-up, i.e., any change to any item, including abstracting text.

2.3.2.2.2. When should an "M" record be generated by my software?
It depends upon the central registry to which you report. Some central registries require that updates be submitted in the "U" record format; other central registries require the "M" format. If a central registry requires "M" records, then "M" records should be system-generated whenever a transmit file is created (see also 2.3.2.2.3). Tumor records that have not been reported to the central registry should be written in the "A" format, and tumor records that have already been transmitted but that have had an update to any field, should be written in the "M" format. (The Date Case Report Exported field [2110] can be used to identify tumor records, which have already been transmitted, and a comparison of item #2110 to the Date Case Last Changed field [2100] can be used to identify records that have been modified since the last time they were exported. Also, it is assumed that the Date Case Report Exported field will be updated when an "M" record is generated.) Note that the only difference between an "A" record and an "M" record is the code found in the Record Type field [10]. Some central registries will require that a submission file contain only "A" or only "M" records; other central registries may allow both "A" and "M" records to be

within the same file. At this time there is no standard set of items for which "M" records are to be required. Systems should have the potential to note a change/correction/update to any field.

2.3.2.2.3. When should "M" records be transmitted?
There is no standard frequency for transmitting files of accumulated, modified records. Frequency will vary with caseload and frequency of transmission of new reports. The most common approach is to send accumulated modified records each time a transmittal of new reports is generated. It might also be useful to allow ad hoc submissions of "M" records for those times when numerous corrections are made at once.

2.3.2.2.4. Who should receive "M" records?
"M" records should be sent to any agency to which the original tumor record was sent, unless prior arrangements have been made to not receive corrections.

2.3.2.2.5. Does my registry software need to capture corrections to all data elements?
It is simplest for the sending (hospital) system to update the "Date Case Last Changed" field whenever any modification is made to the record. The central registry's software system should have the ability to ignore changes to any fields in which they have no interest. If a central registry requiring the "M" record wants to limit the number of modified records received, it should specify which data items should trigger an "M" record upon update.

2.3.2.2.6. How do I accommodate sending update/corrections to multiple requesters?
We suggest that you use the same methods you use to handle multiple case transmits. The software would not need to select which fields to send each party, since receiving parties will have the ability to ignore data they are not requesting. If you submit data to some registries that require "U" records and some that require "M" records, then "U" records should be generated according to the guidelines provided in NAACCR Standards Volume 1.

2.3.2.2.7. If several corrections are made to a record between two data submissions, how should the transmitting software handle this?
The submitting software should only include the version of the record that is current at the time the transmittal file is generated.

2.3.2.2.8. How will a system recognize modified records?
NAACCR-format modified records will be identified by an "M" in column 1 Record Type [10].

2.3.2.2.9. How are comments about the reason for the update(s) provided in the "M" record?
No narrative field specific to changes exists within the "M" record, since it is identical in format to the "A" record. When any coded data item is changed, its associated text field(s) may also need to be modified. If a registry does not use data item Text—Remarks [2680] for other purposes, it could use that field to provide some documentation of the reason(s) the record was updated.

2.3.2.2.10. Is additional programming needed to incorporate "M" records into the central registry?
Yes. At a minimum, programming will be required to link the incoming records with the source records previously received from the submitting facility, to compare the record pairs data item-by-data item, and then print or display the update/correction record with the original record so that someone can make corrections to the database manually. More elaborate programming is desirable, so that some or all of the changes can be applied automatically, as well as to flag "M" records for which no previously submitted record is found in the database.

2.3.2.2.11. What is required for internal processing?
The central registry should maintain and be able to update the source records submitted by each facility. See also answer in 2.3.2.2.10.

2.3.2.2.12. Why use the "M" record when we already have the "U" record?
Several central registries were already using the "A" record format for updates before the "U" record was developed. These central registries and some of the vendors reporting to them did not see an advantage in changing their data processing programs. The addition of the code "M" to the NAACCR Record Type field allows a consistent way to identify the "A" records that actually contain changed information on a previously submitted record.

2.3.2.2.13. How will a vendor of central registry software assist in incorporating corrections into the central system?
This may vary. The vendor needs to provide basic capabilities for receiving, linking, and displaying the contents of modified records. The vendor may also need to apply consolidation/ reconciliation procedures that exist in ordinary records processing to the modified records. See also answer in 2.3.2.2.10.

2.3.2.2.14. How can "M" records be edit-checked?
The EDITS program can be used against the "M" record because its format is identical to the "A" record. The version 10 metafile, and forward, has the ability to recognize and process "M" records.

2.3.2.2.15. Can the "M" record be used to report corrections to state-specific items?
Yes. Because the "M" record is identical in format to an "A" record, changes to state-specific data items will be included without any additional programming, assuming that any change to the hospital's registry record triggers the generation of an "M" record. The central registry has the challenge of programming a method to process the incoming "M" records in an efficient way.

2.3.2.2.16. Will central registries that already have a different functioning system for receiving update/correction records be required to change to this new system?
No. As always, compliance with NAACCR standards is voluntary. The new "M" record is provided as a service to several registries that have been requiring that updates be submitted in the "A" format, with a code in the Record Type field indicating that the record is an update of a previous submission. Adding the "M" value allows vendors and central registries to agree on which code indicates a full case abstract that contains new or modified information in a previously submitted record.

3. CODING STANDARDS

Detailed coding instructions for many data items in the data exchange record are implied by the "Source of Standard" located in NAACCR Standards for Cancer Registries Volume II, *Data Standards and Data Dictionary*. The following list includes the current reference manuals:

- *AJCC Cancer Staging Manual (TNM)*
- *Canadian Cancer Registry Data Dictionary*
- *COC Facility Oncology Registry Data Standards (FORDS)*
- *Collaborative Stage Data Collection System*
- *NAACCR Standards for Cancer Registries Volume I: Data Exchange Standards and Record Description*
- *NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary*
- *SEER Program Code Manual*
- *SEER Summary Stage 2000*
- *WHO ICD-O Third Edition*

Because coding standards have changed over time, it is important to be aware of the coding standards that apply to any given record. The following variables indicate which coding standard was used when the information was originally abstracted, as well as the coding standard that currently applies to the data item. In some instances, there are also variables indicating how the current code in a field was obtained: coded directly from the data source or translated with or without review from codes assigned under another set of coding rules. The sender of the record should specify this information for each record, using the following fields (for definitions see NAACCR Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary)*:

- COC Coding Sys-Current [2140]
- COC Coding Sys-Original [2150]
- Coding System for EOD [870]
- CS Version Derived [2936]
- CS Version Input Current [2937]
- CS Version Original [2953]
- ICD-O-2 Conversion Flag [1980]
- ICD-O-3 Conversion Flag [2116]
- Morph Coding Sys-Current [470]
- Morph Coding Sys-Originl [480]
- Race Coding Sys-Current [170]
- Race Coding Sys-Original [180]
- RX Coding System-Current [1460]
- SEER Coding Sys-Current [2120]
- SEER Coding Sys-Original [2130]
- Site Coding Sys-Current [450]
- Site Coding Sys-Original [460]
- TNM Edition Number [1060]

3.1. DATE FORMAT

The date format (YYYYMMDD) specifically addresses the NAACCR standard data transmission format; not how the data should be stored in an individual registry's database. Only valid portions of the date should be transmitted. Below are the common formats to handle the situation where only certain components of date are known.

YYYYMMDD – when complete date is known and valid.
YYYYMM – when year and month are known and valid, and day is unknown.
YYYY – when year is known and valid, and month and day are unknown.

The field is fixed-length and left-justified. Any missing component should be replaced by spaces. If there are no known date components, the fixed-length variable will be completely blank.

Standard edits check that no dates are later than today's date.

Prior to Version 12 many NAACCR date fields were used to convey non-date information (e.g., the use of 0s in the field RX Date--Surgery [1200] to indicate "no surgery"). For each date item for which an "unknown" or "not applicable" value is appropriate, an auxiliary data item is used, to serve as a flag or indicator (e.g., Date Conclusive DX Flag [448] or RX Summ--Treatment Status [1285]). This item would be blank if a valid date is transmitted in its associated date item. The only date fields that would not have this flag are system-generated dates (e.g., Date Case Completed [2090]), for which "unknown" would never be a legitimate value.

If a registry departs from these standards in any fields when submitting or sharing data, they must send accompanying documentation of the codes used along with the data being submitted.

3.2. REQUIRED FIELDS FOR DATA EXCHANGE

Some fields must always be completed on each data record. These are considered the absolute minimum required to identify the data record, specify the coding system used, and allow for basic incidence counts (e.g., Date of Birth or Age at Diagnosis must be present). Additional fields are usually required to carry out meaningful data exchange (see Appendix C) such as:

- Stage (using any of the stage coding systems)
- Date of Last Contact and Vital Status
- Summary treatment fields

3.3. NAACCR NAMING AND NUMBERING CONVENTIONS

Item names are a maximum of 25 characters. Standardized abbreviations are used when necessary. Standardized punctuation and spacing are also used. Related fields are sometimes named with an identical stem and changing suffix. For example, names of all modalities of treatment in the first course of therapy have the identical stem "RX Summ", for Treatment Summary, followed by an indicator of the type of treatment, for example, "Chemo". Item names, while relatively stable, can change and have changed with different versions of the layout. Item numbers, in contrast, are unchanged during the life of the data item. Item numbers have been retired when items have been deleted from the layout, but item numbers will never be reused for a different item. Ranges of item numbers have been assigned to different uses, as follows:

Range	**Use**
00001 - 04999	Data items in new case layouts, record types I, C, A, or M
05000 - 06999	Data items in Analysis/Research record only (These data items are not within the purview of NAACCR, and NAACCR will not use the data item numbers in this range.)
07000 - 08999	Pathology Laboratory record
09000 - 09099	Data items in Update/Correction record only
09100 - 09499	Future use
09500 - 09999	Data items for Local use
10000 - 10499	System variables for Local use

20000 - 20999	Data items for International use (These data items are not within the purview of NAACCR, and NAACCR will not use the data item numbers in this range.)
99000 - 99999	Data items for Patient Care Evaluation studies. ACoS or others may assign these. A large range is allotted because many new items may be assigned each year for individual studies.

APPENDIX A. Abbreviations and Symbols Used

ACoS	American College of Surgeons
ACS	American Cancer Society
AJCC	American Joint Committee on Cancer
CCCR	Canadian Council of Cancer Registries
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
CoC	Commission on Cancer (of the American College of Surgeons)
CTR	Certified Tumor Registrar
DAM	*Data Acquisition Manual* (manual of ACoS)
EOD	Extent of Disease
FIPS	Federal Information Processing Standards
FORDS	*Facility Oncology Registry Data Standards* (manual of ACoS)
FTRO	*Fundamental Tumor Registry Operations Program* (of the American College of Surgeons)
HIM	Health Information Management
HL7	Health Level 7
IACR	International Association of Cancer Registries
IARC	International Agency for Research on Cancer
ICD	International Classification of Diseases
ICD-O	*International Classification of Diseases for Oncology*
ICD-O-1	*International Classification of Diseases for Oncology*, First edition
ICD-O-2	*International Classification of Diseases for Oncology*, Second edition
ICD-O-3	*International Classification of Diseases for Oncology*, Third edition
NAACCR	North American Association of Central Cancer Registries, Inc.
NCDB	National Cancer Data Base
NCI	National Cancer Institute
NCRA	National Cancer Registrars Association
N.d.	No date (bibliographic term: no ascertainable date of publication)
NOS	Not Otherwise Specified
N.p.	No place (bibliographic term: no ascertainable place of publication)
NPCR	National Program of Cancer Registries
NPI	National Provider Identifier
ROADS	*Registry Operations and Data Standards* (manual of ACoS)
SEER	Surveillance, Epidemiology, and End Results Program (of the National Cancer Institute)
TNM	Tumor, Nodes, and Metastasis: staging system of AJCC and UICC
UDS	Uniform Data Standards Work Group (of NAACCR)
UICC	Union Internationale Contre le Cancer (in English, International Union Against Cancer)
WHO	World Health Organization

APPENDIX B. Historical Reference of All Introductions To Previous Versions of Volume I

The following sections repeat actual verbiage from previous introductions to Volume I. These have been preserved for historical reference of changes to Volume I.

Version 15
There are minimal changes to the North American Association of Central Cancer Registries, Inc. (NAACCR) Standards for Cancer Registries, Volume I, *Data Exchange Standards and Record Descriptions, Version 15.* The NAACCR Version 15 data exchange record layout is effective for cases diagnosed on or after January 1, 2015.

This edition of Standards Volume I, Version 15 includes revisions to the standard setters' requirements and the addition of seven new survival data items which are designed to facilitate a common approach to survival analysis by NAACCR registries. Other changes to note in Standards Volume II include the addition of new codes for Sex [220] and RX Date Other Flag [1251]. These changes are reported in detail in the companion volume, Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary*, Version 15.

Version 14
There are minimal changes to the North American Association of Central Cancer Registries, Inc. (NAACCR) Standards for Cancer Registries, Volume I, *Data Exchange Standards and Record Descriptions, Version 14.* The NAACCR Version 14 data exchange record layout is effective for cases diagnosed on or after January 1, 2014.

This edition of Standards Volume I, Version 14 includes several revisions to the standard setters' requirements. Other changes to Standards Volume II include adding 'blank' as an allowable value for Place of Death Country [1944] and Place of Death State [1942]; updating the Rationale in the NPI fields; and, adding a Note to the Chemo and BRM fields regarding the change in classification for some targeted therapies, such as Herceptin.

Version 13
There are several changes to the North American Association of Central Cancer Registries, Inc. (NAACCR) Standards for Cancer Registries, Volume I, *Data Exchange Standards and Record Descriptions, Version 13.* The NAACCR Version 13 data exchange record layout is effective for cases diagnosed on or after January 1, 2013.

This edition of Standards Volume I, Version 13 includes several new data items and changes to existing data items. New data items include: Census Code 2010, NPCR Specific field, Census Tract Poverty Indicator, Place of Death (State and Country), Secondary Diagnosis for ICD-10-CM (1-10) and fields to collect country information. Some of the changes include renaming many of the data item names so they would alphabetically follow corresponding data items (e.g., date and date flag data items); Unusual Follow-up Method length was changed to 2 characters; and, the retirement of First Course Calc Method [1500].

Version 12.2
There are minimal changes to the North American Association of Central Cancer Registries, Inc. (NAACCR) Standards for Cancer Registries, Volume I, *Data Exchange Standards and Record Descriptions, Version 12.2.* This edition includes clarification of descriptions, rationales and coding

instructions, and the retirement of FIN Coding System [35]. The NAACCR Version 12.2 data exchange record layout is effective for cases diagnosed on or after January 1, 2012.

The implementation of CS PostRX and CS PreRX input and derived data items has been deferred indefinitely.

Version 12.1
This edition of the Standards for Cancer Registries, Volume I, *Data Exchange Standards and Record Descriptions* includes new data items, addition of new codes to existing data items, and clarification of descriptions, rationales and coding instructions. New data items include: Census Tract 2010 [135], Census TR Certainty 2010 [367], Census Block Group 2010 [363], and Over-ride CS 1-20 [3750 - 3769]. There are two fields with new codes Multiplicity Counter [446] and Marital Status at DX [150]. Version 12.1 of the NAACCR (all abbreviations are listed in Appendix A) data exchange record layout reflects the needed changes for the reporting of tumors diagnosed from January 1, 2011 onward.

The CS PostRX and CS PreRX input and derived data items have been delayed for 2012 implementation.

Version 12
Version 12 of the NAACCR (all abbreviations are listed in Appendix A) data exchange record layout reflects the needed changes for the reporting of tumors diagnosed from January 1, 2010 onward. To begin the process of bringing standard registry items into a form more consistent with widely-accepted data transmission formats many new data items and changes to existing data items were recommended by the NAACCR Interoperability Ad Hoc Committee. For example, the date format has changed to CCYYMMDD and the non-date values (i.e., 00000000, 88888888 and 99999999) are incorporated into new status fields and date field flags using the HL7 flavors of null. Some of the new data items and changes to existing data items came from the work and coordinated efforts between the taskforces that developed the AJCC Cancer Staging Manual 7th Edition and the Collaborative Staging System Version 2.00.00. Text fields were expanded and many doubled in size.

Due to the many new data items, changes to existing data items and the expansion of text fields, the record layout has increased to 22,824 characters. Record type I (Incidence Record) is 3339 characters, record type C (Confidential Record) is 5564 characters and Record type A (Full Case Abstract) is 22824 characters.

Since Record Type R (Analysis/Research Record) is not used; it has been removed from Standards Volume I Version 12.

Version 11.3
Version 11.3 of the NAACCR (all abbreviations are listed in Appendix A) data exchange record layout reflects the needed changes for the reporting of tumors diagnosed from January 1, 2009 onward. New data items, Race—NAPIIA [193] and Date of Death—Canada [1755], as well as revisions to existing data items reflect changes introduced for the needs of the various standard setting organizations. These changes are reported in detail in the companion volume, Standards for Cancer Registries, Volume II: *Data Standards and Data Dictionary*, Thirteenth Edition, Version 11.3.

Introductions from prior versions of Volume I have been retained as a historical reference in Appendix B.

Version 11.2
Version 11.2 of the NAACCR (all abbreviations are listed in Appendix A) data exchange record layout reflects the needed changes for the reporting of tumors diagnosed from January 1, 2008 onward. New data items as well as revisions to existing data items reflect changes introduced for the needs of the various

standard setting organizations. These changes are reported in detail in the companion volume, Standards for Cancer Registries, Volume II: *Data Standards and Data Dictionary*, Twelfth Edition, Version 11.2.

NAACCR and the Canadian Council of Cancer Registries (CCCR) have been working in a collaborative effort to resolve discrepancies among standards. Through this collaborative effort the CCCR requirements and recommendations for collection of data items are included in Standards for Cancer Registries, Volume II: *Data Standards and Data Dictionary*, Twelfth Edition, Version 11.2, Chapter VIII, Required Status Table as well as Appendix C of this document.

Version 11.1
Version 11.1 of the NAACCR (all abbreviations are listed in Appendix A) data exchange record layout reflects the needed changes for the reporting of tumors diagnosed from January 1, 2007 onward. New data items reflect changes introduced for the needs of the various standard setting organizations. These changes are reported in detail in the companion volume, Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary*, Eleventh Edition, Record Layout Version 11.1.

Version 11
Version 11.0 of the NAACCR (all abbreviations are listed in Appendix A) data exchange record layout reflects the needed changes for the reporting of tumors diagnosed from January 1, 2006 onward. New data items reflect changes introduced for the needs of the various standard setting organizations. These changes are reported in detail in the companion volume, Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary*, Tenth Edition, Record Layout Version 11.

The electronic pathology lab reporting recommendations, previously Chapter VI in NAACCR Standards for Cancer Registries Volume II, has had major revisions. The E-path Transmission Work Group developed an HL7 implementation guide for the reporting of pathology laboratory results to cancer registries. As a result of work on the HL7 implementation guide, a new NAACCR Standards Volume (Volume V) document will contain information on electronic reporting of pathology specimen data from pathology laboratories to cancer registries and is expected to be published in 2005.

Version 10.1
Version 10.1 of the NAACCR (All abbreviations are listed in Appendix A) data exchange record layout reflects the needed changes for the reporting of tumors diagnosed from January 1, 2004 onward. New data items reflect changes introduced with FORDS and AJCC Sixth Edition. Other changes are reflective of the needs of the various standard setting organizations and these changes are reported in detail in the companion volume, Standards for Cancer Registries Volume II: *Data Standards and Data Dictionary*. The following changes were made to this volume: format of the document; addition of Record Type M, Modified Record; addition of the Coding Standards section; change of the data numbering range to include data items for International use; Appendix E, Data Descriptor Table for Record Types R and U; and, editorial revisions. Track change lines were not used within this document due to the extent of the changes.

With this latest version of the standards, the Research/Analysis Record (Type R) will be retired due to nonuse by the NAACCR community. It is the feeling of the IT Committee that the recoded data items that are a part of the Type R record may be generated by recode algorithms that are part of the SEER*Stat and SEER*Prep systems. For informational and historical purposes, we will continue to list these recoded data items as part of Volume I of the NAACCR standards.

The electronic pathology lab reporting recommendations, previously Chapter 6 in NAACCR Standards for Cancer Registries Volume II, are currently undergoing a major revision. The E-Path Transmission Work Group is developing an HL7 implementation guide for the reporting of pathology laboratory results

to cancer registries and plans to have the new guide available in the fall of 2004. Upon completion, the HL7 implementation guide will be incorporated into the NAACCR Standards for Cancer Registries Volume I.

Version 9

Version 9 of the NAACCR data exchange record layout reflected the needed changes for the reporting of cancer cases diagnosed from January 1, 2001 onward. New data items reflected changes to some histologic codes as a result of the introduction of the *International Classification of Diseases for Oncology, Third Edition.* Also new was a field for SEER Summary Stage 2000 data as were a number of new override flags. Other changes were reflective of the needs of the various standards setting organizations and those changes were reported in detail in the companion volume, *Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifth Edition.*

Version 8

Version 8 of the NAACCR data exchange record layout completed the changes required to accommodate the major revision of cancer registry treatment coding that began in 1996. The 1996 revision that resulted in version 5 was the most extensive revision since the standard was first established. A new layout had been required to accommodate the publication of the Commission on Cancer's ROADS Manual. The Information and Technology Committee (formerly called the Data Exchange Committee) chose to take the opportunity at that time to reorganize the record format and lengthen it to 5,966 bytes, inserting room for expansion in each content area to accommodate changes to the layout for the next several years.

With the publication of the 1998 ROADS Supplement, the third edition of the SEER Program Code Manual, and the fifth edition of AJCC's TNM manual, additional changes in the NAACCR data exchange layout were required, resulting in version 6. Version 6 was first published in the revised NAACCR Standards, Volume II, Data Standards and Data Dictionary, dated March 20, 1998.

Version 7

Beginning with the release of version 6, the NAACCR Board of Directors agreed that the NAACCR layout would change once a year only. All approved revisions occurring during the year were to be released in April for implementation in January of the following year. Thus, changes scheduled to take effect in January 1999 were released in April 1998 as version 7 of the record layout. This was published as a small supplementary revision of the Volume II standards, since it included data dictionary entries for the few changed items as well as the revised layout.

Version 6

This volume was intended to be a companion to *Volume II: Data Standards and Data Dictionary* released in March 1998. This volume also introduced two new record types and layouts; type U an Update/Correction record, and type R an Analysis/Research record. We hope that both new record types served to enhance the data processing and analytic capabilities of our member registries.

Version 5

This was the first major change in the NAACCR layout. The American College of Surgeons had added more than 50 new fields for 1996. It was the Data Exchange Committee's mission to include all registry data items for which data standards exist. There was not enough room in the existing expansion areas in the 1995 record, so the committee decided to revise the entire format. The goals were to make sure fields were grouped by their appropriate category, and to add new empty expansion areas so that the overall layout would not require expansion for the next few years.

The new record layout increased in length from 850 to 1525 for non-confidential records, and from 5300 to 5966 for full abstracts. In addition to the 55 new CoC items, the NAACCR Uniform Data Standards

Committee and Data Exchange Committee added eight items, and NPCR revised its recommendations on some items. The State- and Site-specific studies field areas were combined into a single State/Requestor area, and expanded to a total of 500 characters.

Version 4

The changes between version 3.0 and 4.0 comprised the minimum set of changes needed to allow the NAACCR standard record layout to meet two immediate needs for 1995 cases: 1) Accommodating the data changes approved by the NAACCR UDS effective with 1995 cases. 2) Incorporating all missing items from the SEER record layout, so that standardized SEER edits in the EDITS software could be performed against the NAACCR record layout.

NO existing data items were moved or changed in length. New items were added in previously unused spaces.

A major revision of this layout and the corresponding data dictionary (Volume II of the series) was anticipated later in 1995 to accommodate primarily changes necessitated by the revised data set recommendations of the American College of Surgeons.

Version 3

There were three reasons that caused a revision in the standard record format. First, the NAACCR Data Exchange Committee in its April 1993 meeting decided to add one field (smoking history) and make two other fields required (County at Diagnosis and Diagnostic Confirmation). Secondly, the Uniform Data Standards Committee decided in November to add a data item for Name-Derived Ethnicity. Thirdly, some minor changes in item names and references were made to bring this document into agreement with the newly written Standards for Cancer registries, Volume II.

APPENDIX C. NAACCR Case Record Layout, Version 16 For Implementation 1/1/2016 Record Types I, C, A, and M

The following table represents Version 16 of the NAACCR record layout for 2016 implementation.

NOTE: NPCR is currently discussing data item requirements and will notify its partners when the requirements are finalized.

Note: The target audience for the "Exchange Elements" columns is comprised primarily of the various designers of registry software, at the hospital, central registry, and national levels. In these two columns we mark fields that are either required by key national organizations for cancer reporting or are of special importance in the unambiguous communication of reports and the proper linking of records. We make a clear distinction between items required for facilities reporting to central registries (labeled hosp -> central), and those items that central registries should use when sending cases to other central registries (labeled central -> central). Some central and national registries have additional required data fields. For these, vendors should contact the registry directly.

T - used when the data is vital to a complete exchange record. If data item is unknown, it should have the proper code for unknown assigned. The set of data items designated as 'T' is designed to include variables that every registry collects; thus every record must have a valid code for the field. (Note that the instructions in Chapter IX of Volume II, to blank-fill columns for data items not collected by a registry do not apply here.) T* - means the vendor should convey the data if collected and present. If it is normally not collected, leave blank. If collected but missing, use the code for unknown or not applicable. The receiving end may, of course, ignore these items if they so choose. TH - means only certain historical cases may require these fields.

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
10	Record Type	1	1	1	R	.	R	.	R	R	R	T	T	NAACCR
30	Registry Type	2	2	1	.	.	.	.	.	.	.	.	T	NAACCR
37	Reserved 00	3	16	14										
50	NAACCR Record Version	17	19	3	R	.	R	R	R	.	.	T	T	NAACCR
45	NPI--Registry ID	20	29	10	.	.	.	R*	.	.	.	.	.	CMS
40	Registry ID	30	39	10	R	.	.	R	R	R	R	T	T	NAACCR
60	Tumor Record Number	40	41	2	.	.	.	S	S	R*	R*	T	T	NAACCR
20	Patient ID Number	42	49	8	R	.	.	R	R	R*	R*	.	T	Reporting Registry
21	Patient System ID-Hosp	50	57	8	.	.	.	.	.	.	.	T	.	NAACCR
370	Reserved 01	58	94	37										
70	Addr at DX--City	95	144	50	R	R	R	R	.	R*	R*	T	T	CoC
80	Addr at DX--State	145	146	2	R	R	R	R	R	.	.	T	T	CoC
100	Addr at DX--Postal Code	147	155	9	R	R	R	R	.	R*	R*	T	T	CoC
90	County at DX	156	158	3	R	R	R	R	R	.	.	T	T	FIPS/SEER
110	Census Tract 1970/80/90	159	164	6	RH*	.	.	RH	RH	.	.	.	T*	SEER
368	Census Block Grp 1970-90	165	165	1	.	.	.	S	.	.	.	.	.	Census
120	Census Cod Sys 1970/80/90	166	166	1	RH*	.	.	RH	RH	.	.	.	T*	SEER
364	Census Tr Cert 1970/80/90	167	167	1	RH*	.	.	RH	RH	.	.	.	.	SEER
130	Census Tract 2000	168	173	6	RH	.	.	RH	RH	.	.	.	T*	NAACCR
362	Census Block Group 2000	174	174	1	.	.	.	S	.	.	.	.	.	Census
365	Census Tr Certainty 2000	175	175	1	RH	.	.	RH	RH	.	.	.	.	NAACCR
150	Marital Status at DX	176	176	1	.	.	.	R	R	.	.	.	.	SEER
160	Race 1	177	178	2	R	R	R	R	R	.	.	T	T	SEER/CoC
161	Race 2	179	180	2	R	R	R	R	R	.	.	T	T	SEER/CoC
162	Race 3	181	182	2	R	R	R	R	R	.	.	T	T	SEER/CoC
163	Race 4	183	184	2	R	R	R	R	R	.	.	T	T	SEER/CoC
164	Race 5	185	186	2	R	R	R	R	R	.	.	T	T	SEER/CoC
170	Race Coding Sys--Current	187	187	1	.	R	R	.	.	.	.	T	T	NAACCR
180	Race Coding Sys--Original	188	188	1	.	R	R	.	.	.	.	T	T	NAACCR
190	Spanish/Hispanic Origin	189	189	1	R	R	R	R	R	.	.	T	T	SEER/CoC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
200	Computed Ethnicity	190	190	1	R	.	.	D	R	.	.	.	.	SEER
210	Computed Ethnicity Source	191	191	1	R	.	.	R	R	.	.	.	.	SEER
220	Sex	192	192	1	R	R	R	R	R	R*	R*	T	T	SEER/CoC
230	Age at Diagnosis	193	195	3	R	R	R	R	R	D	D	.	.	SEER/CoC
240	Date of Birth	196	203	8	R	R	R	R	R	R*	R*	T	T	SEER/CoC
241	Date of Birth Flag	204	205	2	R	R	R	R	R	R*	R*	T	T	NAACCR
250	Birthplace	206	208	3	RH*	.	.	.	.	R*	R*	T*	T	SEER/CoC
270	Census Occ Code 1970-2000	209	211	3	R*	.	.	.	.	.	.	.	.	Census/NPCR
280	Census Ind Code 1970-2000	212	214	3	R*	.	.	.	.	.	.	.	.	Census/NPCR
290	Occupation Source	215	215	1	R*	.	.	.	.	.	.	.	.	NPCR
300	Industry Source	216	216	1	R*	.	.	.	.	.	.	.	.	NPCR
310	Text--Usual Occupation	217	316	100	R*	.	.	.	.	.	.	T*	T*	NPCR
320	Text--Usual Industry	317	416	100	R*	.	.	.	.	.	.	T*	T*	NPCR
330	Census Occ/Ind Sys 70-00	417	417	1	R*	.	.	.	.	.	.	.	.	NPCR
191	NHIA Derived Hisp Origin	418	418	1	D	.	.	D	R	.	.	.	.	NAACCR
193	Race--NAPIIA(derived API)	419	420	2	R	.	.	D	R	.	.	.	.	NAACCR
192	IHS Link	421	421	1	R*	.	.	.	R	.	.	.	.	NPCR
366	GIS Coordinate Quality	422	423	2	R*	.	.	S	.	.	.	.	.	NAACCR
3300	RuralUrban Continuum 1993	424	425	2	D	.	.	.	.	.	.	.	.	NAACCR
3310	RuralUrban Continuum 2003	426	427	2	D	.	.	.	.	.	.	.	.	NAACCR
135	Census Tract 2010	428	433	6	R	.	.	R	R	.	.	.	.	NAACCR
363	Census Block Group 2010	434	434	1	.	.	.	R	.	.	.	.	.	Census
367	Census Tr Certainty 2010	435	435	1	R	.	.	R	R	.	.	.	.	NAACCR
102	Addr at DX--Country	436	438	3	.	R	R	R	.	.	.	.		NAACCR
1832	Addr Current--Country	439	441	3	.	R	.	R	.	.	.	.	.	NAACCR
252	Birthplace--State	442	443	2	R*	R	R	R	R	D	D	.	.	NAACCR
254	Birthplace--Country	444	446	3	R*	R	R	R	R	D	D	.	.	NAACCR
1847	FollowUp Contact--Country	447	449	3	.	.	.	.	.	.	.	.	.	NAACCR
1942	Place of Death--State	450	451	2	R	.	.	R*	R*	D	D	.	.	NAACCR
1944	Place of Death--Country	452	454	3	R*	.	.	R*	R*	D	D	.	.	NAACCR

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
272	Census Ind Code 2010 CDC	455	458	4	R*	.	.	.	.	.	.	.	.	Census/NPCR
282	Census Occ Code 2010 CDC	459	462	4	R*	.	.	.	.	.	.	.	.	Census/NPCR
145	Census Tr Poverty Indictr	463	463	1	R	.	.	D	R	.	.	.	.	NAACCR
94	County at DX Geocode1990	464	466	3	D	.	.	D	R	.	.	.	.	NAACCR
95	County at DX Geocode2000	467	469	3	D	.	.	D	R	.	.	.	.	NAACCR
96	County at DX Geocode2010	470	472	3	D	.	.	D	R	.	.	.	.	NAACCR
97	County at DX Geocode2020	473	475	3	.	.	.	D	R	.	.	.	.	NAACCR
3312	RuralUrban Continuum 2013	476	477	2	D	.	.	D	R	.	.	.	.	NAACCR
530	Reserved 02	478	527	50										
380	Sequence Number--Central	528	529	2	R	.	.	R	R	D	D	.	T	SEER
390	Date of Diagnosis	530	537	8	R	R	R	R	R	R	R*	T	T	SEER/CoC
391	Date of Diagnosis Flag	538	539	2	R	.	.	R	R	.	.	T	T	NAACCR
400	Primary Site	540	543	4	R	R	R	R	R	R	R	T	T	SEER/CoC
410	Laterality	544	544	1	R	R	R	R	R	R*	R*	T	T	SEER/CoC
419	Morph--Type&Behav ICD-O-2	545	549	5	.	.	.	.	.	.	.	.	.	
420	Histology (92-00) ICD-O-2	545	548	4	RH	RH	RH	RH	RH	RH	RH	TH	TH	SEER/CoC
430	Behavior (92-00) ICD-O-2	549	549	1	RH	RH	RH	RH	RH	RH	RH	TH	TH	SEER/CoC
521	Morph--Type&Behav ICD-O-3	550	554	5	.	.	.	.	.	.	.	.	.	
522	Histologic Type ICD-O-3	550	553	4	R	R	R	R	R	R	R	T	T	SEER/CoC
523	Behavior Code ICD-O-3	554	554	1	R	R	R	R	R	R	R	T	T	SEER/CoC
440	Grade	555	555	1	R	R	R	R	R	R*	R*	T	T	SEER/CoC
441	Grade Path Value	556	556	1	RH*	RH	RH	RH	RH	.	.	T*	T*	AJCC
449	Grade Path System	557	557	1	RH*	RH	RH	RH	RH	.	.	T*	T*	AJCC
450	Site Coding Sys--Current	558	558	1	R	R	R	.	.	.	.	T	T	NAACCR
460	Site Coding Sys--Original	559	559	1	.	R	R	.	.	R*	R*	T	T	NAACCR
470	Morph Coding Sys--Current	560	560	1	R	R	R	.	.		.	T	T	NAACCR
480	Morph Coding Sys--Originl	561	561	1	.	R	R	.	.	R*	R*	T	T	NAACCR
490	Diagnostic Confirmation	562	562	1	R	R	R	R	R	R	R	T	T	SEER/CoC
500	Type of Reporting Source	563	563	1	R	.	.	R	R	.	.	T	T	SEER
501	Casefinding Source	564	565	2	R*	.	.	.	.	.	.	T*	T*	NAACCR

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
442	Ambiguous Terminology DX	566	566	1	.	RH	RH	RH	RH	.	.	.	.	SEER
443	Date Conclusive DX	567	574	8	.	RH	RH	RH	RH	.	.	.	.	SEER
448	Date Conclusive DX Flag	575	576	2	.	RH	RH	RH	RH	.	.	.	.	NAACCR
444	Mult Tum Rpt as One Prim	577	578	2	.	RH	RH	RH	RH	.	.	.	.	SEER
445	Date of Mult Tumors	579	586	8	.	RH	RH	RH	RH	.	.	.	.	SEER
439	Date of Mult Tumors Flag	587	588	2	.	RH	RH	RH	RH	.	.	.	.	NAACCR
446	Multiplicity Counter	589	590	2	.	RH	RH	RH	RH	.	.	.	.	SEER
680	Reserved 03	591	690	100										
545	NPI--Reporting Facility	691	700	10	R*	R	R	R*	.	.	.	.	.	CMS
540	Reporting Facility	701	710	10	R	R	R	R	.	.	.	T	.	CoC
3105	NPI--Archive FIN	711	720	10	.	R	R	.	.	.	.	.	.	CMS
3100	Archive FIN	721	730	10	.	R	R	.	.	.	.	.	.	CoC
550	Accession Number--Hosp	731	739	9	.	R	R	R	.	.	.	T*	.	CoC
560	Sequence Number--Hospital	740	741	2	.	R	R	R	.	.	.	T	.	CoC
570	Abstracted By	742	744	3	.	R	R	R	.	.	.	.	.	CoC
580	Date of 1st Contact	745	752	8	R	R	R	.	.	.	.	T	.	CoC
581	Date of 1st Contact Flag	753	754	2	R	R	R	.	.	.	.	T	.	NAACCR
590	Date of Inpt Adm	755	762	8	.	.	.	.	.	.	.	.	.	NAACCR
591	Date of Inpt Adm Flag	763	764	2	.	.	.	.	.	.	.	.	.	NAACCR
600	Date of Inpt Disch	765	772	8	.	.	.	.	.	.	.	.	.	NAACCR
601	Date of Inpt Disch Flag	773	774	2	.	.	.	.	.	.	.	.	.	NAACCR
605	Inpatient Status	775	775	1	.	.	.	.	.	.	.	.	.	NAACCR
610	Class of Case	776	777	2	R	R	R	RC	.	.	.	T	.	CoC
630	Primary Payer at DX	778	779	2	R*	R	R	R	R	.	.	.	.	CoC
2400	Reserved 15	780	780	1										
668	RX Hosp--Surg App 2010	781	781	1	.	R	R	.	.	.	.	T*	.	CoC
670	RX Hosp--Surg Prim Site	782	783	2	.	R	R	R	.	.	.	T*	.	CoC
672	RX Hosp--Scope Reg LN Sur	784	784	1	.	R	R	R	.	.	.	T*	.	CoC
674	RX Hosp--Surg Oth Reg/Dis	785	785	1	.	R	R	R	.	.	.	T*	.	CoC
676	RX Hosp--Reg LN Removed	786	787	2	.	RH	RH	.	.	.	.	T*	.	CoC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
2450	Reserved 16	788	788	1										
690	RX Hosp--Radiation	789	789	1	.	.	.	RH	.	.	.	TH*	.	SEER
700	RX Hosp--Chemo	790	791	2	.	R	R	R	.	.	.	T*	.	CoC
710	RX Hosp--Hormone	792	793	2	.	R	R	R	.	.	.	T*	.	CoC
720	RX Hosp--BRM	794	795	2	.	R	R	R	.	.	.	T*	.	CoC
730	RX Hosp--Other	796	796	1	.	R	R	R	.	.	.	T*	.	CoC
740	RX Hosp--DX/Stg Proc	797	798	2	.	R	R	.	.	.	.	.	.	CoC
3280	RX Hosp--Palliative Proc	799	799	1	.	R	R	.	.	.	.	T*	.	CoC
746	RX Hosp--Surg Site 98-02	800	801	2	.	RH	RH	RH	.	.	.	TH*	.	CoC
747	RX Hosp--Scope Reg 98-02	802	802	1	.	RH	RH	RH	.	.	.	TH*	.	CoC
748	RX Hosp--Surg Oth 98-02	803	803	1	.	RH	RH	RH	.	.	.	TH*	.	CoC
750	Reserved 04	804	833	30										
930	TNM Path Staged By	834	835	2	.	R	R	R	R	.	.	T*	T*	CoC
990	TNM Clin Staged By	836	837	2	.	R	R	R	R	.	.	T*	T*	CoC
1112	Mets at DX-Bone	838	838	1	.	R	R	R	R	.	.	.	.	SEER
1113	Mets at DX-Brain	839	839	1	.	R	R	R	R	.	.	.	.	SEER
1114	Mets at Dx-Distant LN	840	840	1	.	R	R	R	R	.	.	.	.	SEER
1115	Mets at DX-Liver	841	841	1	.	R	R	R	R	.	.	.	.	SEER
1116	Mets at DX-Lung	842	842	1	.	R	R	R	R	.	.	.	.	SEER
1117	Mets at DX-Other	843	843	1	.	R	R	R	R	.	.	.	.	SEER
752	Tumor Size Clinical	844	846	3	.	.	.	R	R	.	.	.	.	SEER
754	Tumor Size Pathologic	847	849	3	.	.	.	R	R	.	.	.	.	SEER
756	Tumor Size Summary	850	852	3	R	R	R	S	S	.	.	.	.	NPCR/CoC
3605	Derived SEER Path Stg Grp	853	857	5	.	.	.	D	R	.	.	.	.	SEER
3610	Derived SEER Clin Stg Grp	858	862	5	.	.	.	D	R	.	.	.	.	SEER
3614	Derived SEER Cmb Stg Grp	863	867	5	.	.	.	D	R	.	.	.	.	SEER
3616	Derived SEER Combined T	868	872	5	.	.	.	D	R	.	.	.	.	SEER
3618	Derived SEER Combined N	873	877	5	.	.	.	D	R	.	.	.	.	SEER
3620	Derived SEER Combined M	878	882	5	.	.	.	D	R	.	.	.	.	SEER
3622	Derived SEER Cmb T Src	883	883	1	.	.	.	D	R	.	.	.	.	SEER

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
3624	Derived SEER Cmb N Src	884	884	1	.	.	.	D	R	.	.	.	.	SEER
3626	Derived SEER Cmb M Src	885	885	1	.	.	.	D	R	.	.	.	.	SEER
772	SEER Primary Tumor	886	888	3	.	.	.	.	.	.	.	.	.	SEER
774	SEER Regional Nodes	889	891	3	.	.	.	.	.	.	.	.	.	SEER
776	SEER Mets	892	893	2	.	.	.	.	.	.	.	.	.	SEER
762	Derived SS2017	894	894	1	.	.	.	.	.	.	.	.	.	SEER
764	Directly Assigned SS2017	895	895	1	.	.	.	.	.	.	.	.	.	SEER
3650	NPCR Derived Clin Stg Grp	896	899	4	R	.	.	.	.	.	.	.	.	NPCR
3655	NPCR Derived Path Stg Grp	900	903	4	R	.	.	.	.	.	.	.	.	NPCR
759	SEER Summary Stage 2000	904	904	1	R	R	R	R+	R+	.	.	TH*	TH*	SEER
760	SEER Summary Stage 1977	905	905	1	RH	RH	RH	.	S	.	.	TH*	TH*	SEER
779	Extent of Disease 10-Dig	906	917	12	.	.	.	.	.	.	.	.	.	
780	EOD--Tumor Size	906	908	3	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER/CoC
790	EOD--Extension	909	910	2	.	.	.	RH	RH	.	.	TH*	TH*	SEER
800	EOD--Extension Prost Path	911	912	2	.	.	.	RH	RH	.	.	TH*	TH*	SEER
810	EOD--Lymph Node Involv	913	913	1	.	.	.	RH	RH	.	.	TH*	TH*	SEER
820	Regional Nodes Positive	914	915	2	R	R	R	R	R	R*	R*	T*	T*	SEER/CoC
830	Regional Nodes Examined	916	917	2	R	R	R	R	R	R*	R*	T*	T*	SEER/CoC
840	EOD--Old 13 Digit	918	930	13	.	.	.	RH	RH	.	.	.	.	SEER
850	EOD--Old 2 Digit	931	932	2	.	.	.	RH	RH	.	.	.	.	SEER
860	EOD--Old 4 Digit	933	936	4	.	.	.	RH	RH	.	.	.	.	SEER
870	Coding System for EOD	937	937	1	.	.	.	RH	RH	.	.	.	TH*	SEER
1060	TNM Edition Number	938	939	2	R	R	R	R	R	.	.	T*	T*	CoC
880	TNM Path T	940	943	4	R	R	R	R	R	.	.	T*	T*	AJCC
890	TNM Path N	944	947	4	R	R	R	R	R	.	.	T*	T*	AJCC
900	TNM Path M	948	951	4	R	R	R	R	R	.	.	T*	T*	AJCC
910	TNM Path Stage Group	952	955	4	R	R	R	S	S	.	.	T*	T*	AJCC
920	TNM Path Descriptor	956	956	1	R	R	R	R	R	.	.	T*	T*	CoC
2162	Reserved 19	957	957	1										
940	TNM Clin T	958	961	4	R	R	R	R	R	.	.	T*	T*	AJCC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
950	TNM Clin N	962	965	4	R	R	R	R	R	.	.	T*	T*	AJCC
960	TNM Clin M	966	969	4	R	R	R	R	R	.	.	T*	T*	AJCC
970	TNM Clin Stage Group	970	973	4	R	R	R	S	S	.	.	T*	T*	AJCC
980	TNM Clin Descriptor	974	974	1	R	R	R	R	R	.	.	T*	T*	CoC
2163	Reserved 20	975	975	1										
1120	Pediatric Stage	976	977	2	.	.	.	.	.	.	.	.	.	CoC
1130	Pediatric Staging System	978	979	2	.	.	.	.	.	.	.	.	.	CoC
1140	Pediatric Staged By	980	980	1	.	.	.	.	.	.	.	.	.	CoC
1150	Tumor Marker 1	981	981	1	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER
1160	Tumor Marker 2	982	982	1	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER
1170	Tumor Marker 3	983	983	1	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER
1182	Lymph-vascular Invasion	984	984	1	RH*	R	R	RS	RS	R*	R*	T*	T*	AJCC
2800	CS Tumor Size	985	987	3	RH	RH	RH	S	S	R*	R*	T	T	AJCC
2810	CS Extension	988	990	3	RH	RH	RH	S	S	R*	R*	T	T	AJCC
2820	CS Tumor Size/Ext Eval	991	991	1	RH	RH	RH	S	S	R*	R*	T*	T*	AJCC
2830	CS Lymph Nodes	992	994	3	RH	RH	RH	S	S	R*	R*	T	T	AJCC
2840	CS Lymph Nodes Eval	995	995	1	RH*	RH	RH	S	S	R*	R*	T*	T*	AJCC
2850	CS Mets at DX	996	997	2	RH	RH	RH	S	S	R*	R*	T	T	AJCC
2860	CS Mets Eval	998	998	1	RH*	RH	RH	S	S	R*	R*	T*	T*	AJCC
2851	CS Mets at Dx-Bone	999	999	1	.	RH	RH	RH	RH	R*	R*	T*	T*	AJCC
2852	CS Mets at Dx-Brain	1000	1000	1	.	RH	RH	RH	RH	R*	R*	T*	T*	AJCC
2853	CS Mets at Dx-Liver	1001	1001	1	.	RH	RH	RH	RH	R*	R*	T*	T*	AJCC
2854	CS Mets at Dx-Lung	1002	1002	1	.	RH	RH	RH	RH	R*	R*	T*	T*	AJCC
2880	CS Site-Specific Factor 1	1003	1005	3	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2890	CS Site-Specific Factor 2	1006	1008	3	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2900	CS Site-Specific Factor 3	1009	1011	3	RH	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2910	CS Site-Specific Factor 4	1012	1014	3	RH	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2920	CS Site-Specific Factor 5	1015	1017	3	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2930	CS Site-Specific Factor 6	1018	1020	3	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2861	CS Site-Specific Factor 7	1021	1023	3	RH	RS	RS	RS	RS	RS	RS	T*	T*	AJCC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
2862	CS Site-Specific Factor 8	1024	1026	3	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2863	CS Site-Specific Factor 9	1027	1029	3	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2864	CS Site-Specific Factor10	1030	1032	3	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2865	CS Site-Specific Factor11	1033	1035	3	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2866	CS Site-Specific Factor12	1036	1038	3	RH	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2867	CS Site-Specific Factor13	1039	1041	3	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2868	CS Site-Specific Factor14	1042	1044	3	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2869	CS Site-Specific Factor15	1045	1047	3	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2870	CS Site-Specific Factor16	1048	1050	3	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2871	CS Site-Specific Factor17	1051	1053	3	RH	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2872	CS Site-Specific Factor18	1054	1056	3	.	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2873	CS Site-Specific Factor19	1057	1059	3	.	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2874	CS Site-Specific Factor20	1060	1062	3	.	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2875	CS Site-Specific Factor21	1063	1065	3	.	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2876	CS Site-Specific Factor22	1066	1068	3	.	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2877	CS Site-Specific Factor23	1069	1071	3	.	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2878	CS Site-Specific Factor24	1072	1074	3	.	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2879	CS Site-Specific Factor25	1075	1077	3	RS	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
2730	CS PreRx Tumor Size	1078	1080	3	.	.	.	.	.	.	.	.	.	AJCC
2735	CS PreRx Extension	1081	1083	3	.	.	.	.	.	.	.	.	.	AJCC
2740	CS PreRx Tum Sz/Ext Eval	1084	1084	1	.	.	.	.	.	.	.	.	.	AJCC
2750	CS PreRx Lymph Nodes	1085	1087	3	.	.	.	.	.	.	.	.	.	AJCC
2755	CS PreRx Reg Nodes Eval	1088	1088	1	.	.	.	.	.	.	.	.	.	AJCC
2760	CS PreRx Mets at DX	1089	1090	2	.	.	.	.	.	.	.	.	.	AJCC
2765	CS PreRx Mets Eval	1091	1091	1	.	.	.	.	.	.	.	.	.	AJCC
2770	CS PostRx Tumor Size	1092	1094	3	.	.	.	.	.	.	.	.	.	AJCC
2775	CS PostRx Extension	1095	1097	3	.	.	.	.	.	.	.	.	.	AJCC
2780	CS PostRx Lymph Nodes	1098	1100	3	.	.	.	.	.	.	.	.	.	AJCC
2785	CS PostRx Mets at DX	1101	1102	2	.	.	.	.	.	.	.	.	.	AJCC
2940	Derived AJCC-6 T	1103	1104	2	.	DH	DH	D*	S	D	D	T*	T*	AJCC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
2950	Derived AJCC-6 T Descript	1105	1105	1	.	DH	DH	D*	S	D	D	T*	T*	AJCC
2960	Derived AJCC-6 N	1106	1107	2	.	DH	DH	D*	S	D	D	T*	T*	AJCC
2970	Derived AJCC-6 N Descript	1108	1108	1	.	DH	DH	D*	S	D	D	T*	T*	AJCC
2980	Derived AJCC-6 M	1109	1110	2	.	DH	DH	D*	S	D	D	T*	T*	AJCC
2990	Derived AJCC-6 M Descript	1111	1111	1	.	DH	DH	D*	S	D	D	T*	T*	AJCC
3000	Derived AJCC-6 Stage Grp	1112	1113	2	.	DH	DH	D*	S	D	D	T*	T*	AJCC
3400	Derived AJCC-7 T	1114	1116	3	RH*	DH	DH	D*	S	D	D	T*	T*	AJCC
3402	Derived AJCC-7 T Descript	1117	1117	1	RH*	DH	DH	D*	S	D	D	T*	T*	AJCC
3410	Derived AJCC-7 N	1118	1120	3	RH*	DH	DH	D*	S	D	D	T*	T*	AJCC
3412	Derived AJCC-7 N Descript	1121	1121	1	RH*	DH	DH	D*	S	D	D	T*	T*	AJCC
3420	Derived AJCC-7 M	1122	1124	3	RH*	DH	DH	D*	S	D	D	T*	T*	AJCC
3422	Derived AJCC-7 M Descript	1125	1125	1	RH*	DH	DH	D*	S	D	D	T*	T*	AJCC
3430	Derived AJCC-7 Stage Grp	1126	1128	3	RH*	DH	DH	D*	S	D	D	T*	T*	AJCC
3440	Derived PreRx-7 T	1129	1131	3	.	.	.	.	.	.	.	.	.	AJCC
3442	Derived PreRx-7 T Descrip	1132	1132	1	.	.	.	.	.	.	.	.	.	AJCC
3450	Derived PreRx-7 N	1133	1135	3	.	.	.	.	.	.	.	.	.	AJCC
3452	Derived PreRx-7 N Descrip	1136	1136	1	.	.	.	.	.	.	.	.	.	AJCC
3460	Derived PreRx-7 M	1137	1139	3	.	.	.	.	.	.	.	.	.	AJCC
3462	Derived PreRx-7 M Descrip	1140	1140	1	.	.	.	.	.	.	.	.	.	AJCC
3470	Derived PreRx-7 Stage Grp	1141	1143	3	.	.	.	.	.	.	.	.	.	AJCC
3480	Derived PostRx-7 T	1144	1146	3	.	.	.	.	.	.	.	.	.	AJCC
3482	Derived PostRx-7 N	1147	1149	3	.	.	.	.	.	.	.	.	.	AJCC
3490	Derived PostRx-7 M	1150	1151	2	.	.	.	.	.	.	.	.	.	AJCC
3492	Derived PostRx-7 Stge Grp	1152	1154	3	.	.	.	.	.	.	.	.	.	AJCC
3010	Derived SS1977	1155	1155	1	.	DH	DH	D*	S	D	D	T*	T*	AJCC
3020	Derived SS2000	1156	1156	1	RH	DH	DH	D+	R+	D	D	T*	T*	AJCC
3600	Derived Neoadjuv Rx Flag	1157	1157	1	.	.	.	.	.	.	.	T*	T*	AJCC
3030	Derived AJCC--Flag	1158	1158	1	.	DH	DH	D*	S	.	.	T*	T*	AJCC
3040	Derived SS1977--Flag	1159	1159	1	.	DH	DH	D*	S	.	.	T*	T*	AJCC
3050	Derived SS2000--Flag	1160	1160	1	RH	DH	DH	D*	S	.	.	T*	T*	AJCC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
2937	CS Version Input Current	1161	1166	6	R	R	R	S	S	R*	R*	T*	T*	AJCC
2935	CS Version Input Original	1167	1172	6	R	R	R	S	S	R*	R*	.	.	AJCC
2936	CS Version Derived	1173	1178	6	RH	DH	DH	D*	S	D	D	.	.	AJCC
3700	SEER Site-Specific Fact 1	1179	1179	1	.	.	.	.	.	.	.	.	.	SEER
3702	SEER Site-Specific Fact 2	1180	1180	1	.	.	.	.	.	.	.	.	.	SEER
3704	SEER Site-Specific Fact 3	1181	1181	1	.	.	.	.	.	.	.	.	.	SEER
3706	SEER Site-Specific Fact 4	1182	1182	1	.	.	.	.	.	.	.	.	.	SEER
3708	SEER Site-Specific Fact 5	1183	1183	1	.	.	.	.	.	.	.	.	.	SEER
3710	SEER Site-Specific Fact 6	1184	1184	1	.	.	.	.	.	.	.	.	.	SEER
3165	ICD Revision Comorbid	1185	1185	1	.	.	.	.	.	.	.	T*	.	CoC
3110	Comorbid/Complication 1	1186	1190	5	.	R	R	.	.	.	.	T*	.	CoC
3120	Comorbid/Complication 2	1191	1195	5	.	R	R	.	.	.	.	T*	.	CoC
3130	Comorbid/Complication 3	1196	1200	5	.	R	R	.	.	.	.	T*	.	CoC
3140	Comorbid/Complication 4	1201	1205	5	.	R	R	.	.	.	.	T*	.	CoC
3150	Comorbid/Complication 5	1206	1210	5	.	R	R	.	.	.	.	T*	.	CoC
3160	Comorbid/Complication 6	1211	1215	5	.	R	R	.	.	.	.	T*	.	CoC
3161	Comorbid/Complication 7	1216	1220	5	.	R	R	.	.	.	.	T*	.	CoC
3162	Comorbid/Complication 8	1221	1225	5	.	R	R	.	.	.	.	T*	.	CoC
3163	Comorbid/Complication 9	1226	1230	5	.	R	R	.	.	.	.	T*	.	CoC
3164	Comorbid/Complication 10	1231	1235	5	.	R	R	.	.	.	.	T*	.	CoC
3780	Secondary Diagnosis 1	1236	1242	7	.	R	R	.	.	.	.	T*	.	CoC
3782	Secondary Diagnosis 2	1243	1249	7	.	R	R	.	.	.	.	T*	.	CoC
3784	Secondary Diagnosis 3	1250	1256	7	.	R	R	.	.	.	.	T*	.	CoC
3786	Secondary Diagnosis 4	1257	1263	7	.	R	R	.	.	.	.	T*	.	CoC
3788	Secondary Diagnosis 5	1264	1270	7	.	R	R	.	.	.	.	T*	.	CoC
3790	Secondary Diagnosis 6	1271	1277	7	.	R	R	.	.	.	.	T*	.	CoC
3792	Secondary Diagnosis 7	1278	1284	7	.	R	R	.	.	.	.	T*	.	CoC
3794	Secondary Diagnosis 8	1285	1291	7	.	R	R	.	.	.	.	T*	.	CoC
3796	Secondary Diagnosis 9	1292	1298	7	.	R	R	.	.	.	.	T*	.	CoC
3798	Secondary Diagnosis 10	1299	1305	7	.	R	R	.	.	.	.	T*	.	CoC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
3720	NPCR Specific Field	1306	1380	75	R	.	.	.	.	.	.	.	.	NPCR
1180	Reserved 05	1381	1435	55										
1260	Date Initial RX SEER	1436	1443	8	R#	.	.	R	R	.	.	T*	T*	SEER
1261	Date Initial RX SEER Flag	1444	1445	2	R#	.	.	R	R	.	.	T*	T*	NAACCR
1270	Date 1st Crs RX CoC	1446	1453	8	R#	R	R	.	.	.	.	T*	T*	CoC
1271	Date 1st Crs RX CoC Flag	1454	1455	2	R#	R	R	.	.	.	.	T*	T*	NAACCR
1200	RX Date Surgery	1456	1463	8	R	R	R	RC	RC	.	.	T*	T*	CoC
1201	RX Date Surgery Flag	1464	1465	2	R	R	R	RC	RC	.	.	T*	T*	NAACCR
3170	RX Date Mst Defn Srg	1466	1473	8	R	R	R	.	.	.	.	T*	.	CoC
3171	RX Date Mst Defn Srg Flag	1474	1475	2	R	R	R	.	.	.	.	T*	.	NAACCR
3180	RX Date Surg Disch	1476	1483	8	.	R	R	.	.	.	.	.	.	CoC
3181	RX Date Surg Disch Flag	1484	1485	2	.	R	R	.	.	.	.	.	.	NAACCR
1210	RX Date Radiation	1486	1493	8	R	R	R	RC	RC	.	.	T*	T*	CoC
1211	RX Date Radiation Flag	1494	1495	2	R	R	R	RC	RC	.	.	T*	T*	NAACCR
3220	RX Date Rad Ended	1496	1503	8	.	R	R	.	.	.	.	.	.	CoC
3221	RX Date Rad Ended Flag	1504	1505	2	.	R	R	.	.	.	.	.	.	NAACCR
3230	RX Date Systemic	1506	1513	8	.	R	R	RC	RC	.	.	T*	T*	CoC
3231	RX Date Systemic Flag	1514	1515	2	.	R	R	RC	RC	.	.	T*	T*	NAACCR
1220	RX Date Chemo	1516	1523	8	R	R	R	RC	RC	.	.	T*	T*	CoC
1221	RX Date Chemo Flag	1524	1525	2	R	R	R	RC	RC	.	.	T*	T*	NAACCR
1230	RX Date Hormone	1526	1533	8	R	R	R	RC	RC	.	.	T*	T*	CoC
1231	RX Date Hormone Flag	1534	1535	2	R	R	R	RC	RC	.	.	T*	T*	NAACCR
1240	RX Date BRM	1536	1543	8	R	R	R	RC	RC	.	.	T*	T*	CoC
1241	RX Date BRM Flag	1544	1545	2	R	R	R	RC	RC	.	.	T*	T*	NAACCR
1250	RX Date Other	1546	1553	8	R	R	R	RC	RC	.	.	T*	T*	CoC
1251	RX Date Other Flag	1554	1555	2	R	R	R	RC	RC	.	.	T*	T*	NAACCR
1280	RX Date DX/Stg Proc	1556	1563	8	.	R	R	.	.	.	.	.	.	CoC
1281	RX Date DX/Stg Proc Flag	1564	1565	2	.	R	R	.	.	.	.	.	.	NAACCR
1285	RX Summ--Treatment Status	1566	1566	1	R#	R	R	R	R	.	.	T*	T*	SEER/CoC
1290	RX Summ--Surg Prim Site	1567	1568	2	R	R	R	R	R	.	.	T	T*	SEER/CoC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
1292	RX Summ--Scope Reg LN Sur	1569	1569	1	R	R	R	R	R	.	.	T	T*	SEER/CoC
1294	RX Summ--Surg Oth Reg/Dis	1570	1570	1	R	R	R	R	R	.	.	T	T*	SEER/CoC
1296	RX Summ--Reg LN Examined	1571	1572	2	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER/CoC
1310	RX Summ--Surgical Approch	1573	1573	1	.	RH	RH	.	.	.	.	.	.	CoC
1320	RX Summ--Surgical Margins	1574	1574	1	.	R	R	R*	R*	.	.	.	.	CoC
1330	RX Summ--Reconstruct 1st	1575	1575	1	.	RH	RH	RH	RH	.	.	.	.	SEER
1340	Reason for No Surgery	1576	1576	1	R	R	R	R	R	.	.	T	T*	SEER/CoC
1350	RX Summ--DX/Stg Proc	1577	1578	2	.	R	R	.	.	.	.	.	.	CoC
3270	RX Summ--Palliative Proc	1579	1579	1	.	R	R	.	.	.	.	T*	.	CoC
1360	RX Summ--Radiation	1580	1580	1	RH	.	.	R	R	.	.	TH*	TH*	SEER
1370	RX Summ--Rad to CNS	1581	1581	1	.	.	.	RH	RH	.	.	.	.	SEER/CoC
1380	RX Summ--Surg/Rad Seq	1582	1582	1	R	R	R	R	R	.	.	T	T*	SEER/CoC
3250	RX Summ--Transplnt/Endocr	1583	1584	2	R	R	R	R	R	.	.	T*	T*	CoC
1390	RX Summ--Chemo	1585	1586	2	R	R	R	R	R	.	.	T*	T*	SEER/CoC
1400	RX Summ--Hormone	1587	1588	2	R	R	R	R	R	.	.	T*	T*	SEER/CoC
1410	RX Summ--BRM	1589	1590	2	R	R	R	R	R	.	.	T*	T*	SEER/CoC
1420	RX Summ--Other	1591	1591	1	R	R	R	R	R	.	.	T*	T*	SEER/CoC
1430	Reason for No Radiation	1592	1592	1	R	R	R	.	.	.	.	.	.	CoC
1460	RX Coding System--Current	1593	1594	2	R	R	R	.	RH	.	.	T*	T*	NAACCR
2161	Reserved 18	1595	1595	1										
1510	Rad--Regional Dose: cGy	1596	1600	5	.	R	R	.	.	.	.	T	.	CoC
1520	Rad--No of Treatment Vol	1601	1603	3	.	R	R	.	.	.	.	T	.	CoC
1540	Rad--Treatment Volume	1604	1605	2	.	R	R	.	.	.	.	T	.	CoC
1550	Rad--Location of RX	1606	1606	1	.	R	R	.	.	.	.	T	.	CoC
1570	Rad--Regional RX Modality	1607	1608	2	R	R	R	RC	.	.	.	T	T*	CoC
3200	Rad--Boost RX Modality	1609	1610	2	.	R	R	RC	.	.	.	T*	T*	CoC
3210	Rad--Boost Dose cGy	1611	1615	5	.	R	R	.	.	.	.	.	.	CoC
1639	RX Summ--Systemic/Sur Seq	1616	1616	1	R	R	R	R	R	.	.	T	T	CoC
1640	RX Summ--Surgery Type	1617	1618	2	.	.	.	RH	RH	.	.	.	.	SEER
3190	Readm Same Hosp 30 Days	1619	1619	1	.	R	R	.	.	.	.	.	.	CoC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
1646	RX Summ--Surg Site 98-02	1620	1621	2	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER/CoC
1647	RX Summ--Scope Reg 98-02	1622	1622	1	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER/CoC
1648	RX Summ--Surg Oth 98-02	1623	1623	1	.	RH	RH	RH	RH	.	.	TH*	TH*	SEER/CoC
1190	Reserved 06	1624	1723	100										
1660	Subsq RX 2nd Course Date	1724	1731	8	.	.	.	.	.	.	.	.	.	CoC
1661	Subsq RX 2ndCrs Date Flag	1732	1733	2	.	.	.	.	.	.	.	.	.	NAACCR
1670	Subsq RX 2nd Course Codes	1734	1744	11	.	.	.	.	.	.	.	.	.	
1671	Subsq RX 2nd Course Surg	1734	1735	2	.	.	.	.	.	.	.	.	.	CoC
1677	Subsq RX 2nd--Scope LN SU	1736	1736	1	.	.	.	.	.	.	.	.	.	CoC
1678	Subsq RX 2nd--Surg Oth	1737	1737	1	.	.	.	.	.	.	.	.	.	CoC
1679	Subsq RX 2nd--Reg LN Rem	1738	1739	2	.	.	.	.	.	.	.	.	.	CoC
1672	Subsq RX 2nd Course Rad	1740	1740	1	.	.	.	.	.	.	.	.	.	CoC
1673	Subsq RX 2nd Course Chemo	1741	1741	1	.	.	.	.	.	.	.	.	.	CoC
1674	Subsq RX 2nd Course Horm	1742	1742	1	.	.	.	.	.	.	.	.	.	CoC
1675	Subsq RX 2nd Course BRM	1743	1743	1	.	.	.	.	.	.	.	.	.	CoC
1676	Subsq RX 2nd Course Oth	1744	1744	1	.	.	.	.	.	.	.	.	.	CoC
1680	Subsq RX 3rd Course Date	1745	1752	8	.	.	.	.	.	.	.	.	.	CoC
1681	Subsq RX 3rdCrs Date Flag	1753	1754	2	.	.	.	.	.	.	.	.	.	NAACCR
1690	Subsq RX 3rd Course Codes	1755	1765	11	.	.	.	.	.	.	.	.	.	
1691	Subsq RX 3rd Course Surg	1755	1756	2	.	.	.	.	.	.	.	.	.	CoC
1697	Subsq RX 3rd--Scope LN Su	1757	1757	1	.	.	.	.	.	.	.	.	.	CoC
1698	Subsq RX 3rd--Surg Oth	1758	1758	1	.	.	.	.	.	.	.	.	.	CoC
1699	Subsq RX 3rd--Reg LN Rem	1759	1760	2	.	.	.	.	.	.	.	.	.	CoC
1692	Subsq RX 3rd Course Rad	1761	1761	1	.	.	.	.	.	.	.	.	.	CoC
1693	Subsq RX 3rd Course Chemo	1762	1762	1	.	.	.	.	.	.	.	.	.	CoC
1694	Subsq RX 3rd Course Horm	1763	1763	1	.	.	.	.	.	.	.	.	.	CoC
1695	Subsq RX 3rd Course BRM	1764	1764	1	.	.	.	.	.	.	.	.	.	CoC
1696	Subsq RX 3rd Course Oth	1765	1765	1	.	.	.	.	.	.	.	.	.	CoC
1700	Subsq RX 4th Course Date	1766	1773	8	.	.	.	.	.	.	.	.	.	CoC
1701	Subsq RX 4thCrs Date Flag	1774	1775	2	.	.	.	.	.	.	.	.	.	NAACCR

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
1710	Subsq RX 4th Course Codes	1776	1786	11	.	.	.	.	.	.	.	.	.	
1711	Subsq RX 4th Course Surg	1776	1777	2	.	.	.	.	.	.	.	.	.	CoC
1717	Subsq RX 4th--Scope LN Su	1778	1778	1	.	.	.	.	.	.	.	.	.	CoC
1718	Subsq RX 4th--Surg Oth	1779	1779	1	.	.	.	.	.	.	.	.	.	CoC
1719	Subsq RX 4th--Reg LN Rem	1780	1781	2	.	.	.	.	.	.	.	.	.	CoC
1712	Subsq RX 4th Course Rad	1782	1782	1	.	.	.	.	.	.	.	.	.	CoC
1713	Subsq RX 4th Course Chemo	1783	1783	1	.	.	.	.	.	.	.	.	.	CoC
1714	Subsq RX 4th Course Horm	1784	1784	1	.	.	.	.	.	.	.	.	.	CoC
1715	Subsq RX 4th Course BRM	1785	1785	1	.	.	.	.	.	.	.	.	.	CoC
1716	Subsq RX 4th Course Oth	1786	1786	1	.	.	.	.	.	.	.	.	.	CoC
1741	Subsq RX--Reconstruct Del	1787	1787	1	.	.	.	.	.	.	.	.	.	CoC
1300	Reserved 07	1788	1887	100										
1981	Over-ride SS/NodesPos	1888	1888	1	.	.	.	R	R	.	.	T*	T*	NAACCR
1982	Over-ride SS/TNM-N	1889	1889	1	.	.	.	R	R	.	.	T*	T*	NAACCR
1983	Over-ride SS/TNM-M	1890	1890	1	.	.	.	R	R	.	.	T*	T*	NAACCR
1985	Over-ride Acsn/Class/Seq	1891	1891	1	.	R	R	.	.	.	.	T*	T*	CoC
1986	Over-ride HospSeq/DxConf	1892	1892	1	.	R	R	.	.	.	.	T*	T*	CoC
1987	Over-ride CoC-Site/Type	1893	1893	1	.	R	R	.	.	.	.	T*	T*	CoC
1988	Over-ride HospSeq/Site	1894	1894	1	.	R	R	.	.	.	.	T*	T*	CoC
1989	Over-ride Site/TNM-StgGrp	1895	1895	1	R	R	R	.	.	.	.	T*	T*	CoC
1990	Over-ride Age/Site/Morph	1896	1896	1	R	R	R	R	R	.	.	T*	T*	SEER
2000	Over-ride SeqNo/DxConf	1897	1897	1	R	.	.	R	R	.	.	T*	T*	SEER
2010	Over-ride Site/Lat/SeqNo	1898	1898	1	R	.	.	R	R	.	.	T*	T*	SEER
2020	Over-ride Surg/DxConf	1899	1899	1	R	R	R	R	R	.	.	T*	T*	SEER
2030	Over-ride Site/Type	1900	1900	1	R	R	R	R	R	.	.	T*	T*	SEER
2040	Over-ride Histology	1901	1901	1	R	R	R	R	R	.	.	T*	T*	SEER
2050	Over-ride Report Source	1902	1902	1	R	.	.	R	R	.	.	T*	T*	SEER
2060	Over-ride Ill-define Site	1903	1903	1	R	.	.	R	R	.	.	T*	T*	SEER
2070	Over-ride Leuk Lymphoma	1904	1904	1	R	R	R	R	R	.	.	T*	T*	SEER
2071	Over-ride Site/Behavior	1905	1905	1	R	R	R	R	R	.	.	T*	T*	SEER

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
2072	Over-ride Site/EOD/DX Dt	1906	1906	1	.	.	.	R	R	.	.	T*	T*	SEER
2073	Over-ride Site/Lat/EOD	1907	1907	1	.	.	.	R	R	.	.	T*	T*	SEER
2074	Over-ride Site/Lat/Morph	1908	1908	1	R	R	R	R	R	.	.	T*	T*	SEER
1960	Site (73-91) ICD-O-1	1909	1912	4	.	.	.	RH	RH	.	.	.	.	SEER
1970	Morph (73-91) ICD-O-1	1913	1918	6	.	.	.	.	.	.	.	.	.	
1971	Histology (73-91) ICD-O-1	1913	1916	4	.	.	.	RH	RH	.	.	.	.	SEER
1972	Behavior (73-91) ICD-O-1	1917	1917	1	.	.	.	RH	RH	.	.	.	.	SEER
1973	Grade (73-91) ICD-O-1	1918	1918	1	.	.	.	RH	RH	.	.	.	.	SEER
1980	ICD-O-2 Conversion Flag	1919	1919	1	.	RH	RH	R	R	.	.	T*	T*	SEER
2081	CRC CHECKSUM	1920	1929	10	.	.	.	S	S	.	.	.	.	NAACCR
2120	SEER Coding Sys--Current	1930	1930	1	.	.	.	.	R	.	.	T*	T*	NAACCR
2130	SEER Coding Sys--Original	1931	1931	1	.	.	.	.	R	.	.	T*	T*	NAACCR
2140	CoC Coding Sys--Current	1932	1933	2	.	R	R	.	.	.	.	T*	T*	CoC
2150	CoC Coding Sys--Original	1934	1935	2	.	R	R	.	.	.	.	T*	T*	CoC
2170	Vendor Name	1936	1945	10	.	R	R	.	.	.	.	T	T	NAACCR
2180	SEER Type of Follow-Up	1946	1946	1	.	.	.	R	R	.	.	.	.	SEER
2190	SEER Record Number	1947	1948	2	.	.	.	.	R	.	.	.	.	SEER
2200	Diagnostic Proc 73-87	1949	1950	2	.	.	.	RH	RH	.	.	.	.	SEER
2085	Date Case Initiated	1951	1958	8	.	.	.	.	.	.	.	.	.	NAACCR
2090	Date Case Completed	1959	1966	8	.	.	.	.	.	.	.	.	.	NAACCR
2092	Date Case Completed--CoC	1967	1974	8	.	D	D	.	.	.	.	.	.	CoC
2100	Date Case Last Changed	1975	1982	8	.	D	D	.	.	.	.	.	.	NAACCR
2110	Date Case Report Exported	1983	1990	8	R	.	.	.	.	.	.	T	.	NPCR
2111	Date Case Report Received	1991	1998	8	R	.	.	.	.	.	.	.	.	NPCR
2112	Date Case Report Loaded	1999	2006	8	R	.	.	.	.	.	.	.	.	NPCR
2113	Date Tumor Record Availbl	2007	2014	8	R	.	.	.	.	.	.	.	.	NPCR
2116	ICD-O-3 Conversion Flag	2015	2015	1	R	.	.	R	R	.	.	T	T	SEER/CoC
3750	Over-ride CS 1	2016	2016	1	.	RH	RH	R	R	.	.	.	.	AJCC
3751	Over-ride CS 2	2017	2017	1	.	RH	RH	R	R	.	.	.	.	AJCC
3752	Over-ride CS 3	2018	2018	1	.	RH	RH	R	R	.	.	.	.	AJCC

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
3753	Over-ride CS 4	2019	2019	1	.	RH	RH	R	R	.	.	.	.	AJCC
3754	Over-ride CS 5	2020	2020	1	.	RH	RH	R	R	.	.	.	.	AJCC
3755	Over-ride CS 6	2021	2021	1	.	RH	RH	R	R	.	.	.	.	AJCC
3756	Over-ride CS 7	2022	2022	1	.	RH	RH	R	R	.	.	.	.	AJCC
3757	Over-ride CS 8	2023	2023	1	.	RH	RH	R	R	.	.	.	.	AJCC
3758	Over-ride CS 9	2024	2024	1	.	RH	RH	R	R	.	.	.	.	AJCC
3759	Over-ride CS 10	2025	2025	1	.	RH	RH	R	R	.	.	.	.	AJCC
3760	Over-ride CS 11	2026	2026	1	.	RH	RH	R	R	.	.	.	.	AJCC
3761	Over-ride CS 12	2027	2027	1	.	RH	RH	R	R	.	.	.	.	AJCC
3762	Over-ride CS 13	2028	2028	1	.	RH	RH	R	R	.	.	.	.	AJCC
3763	Over-ride CS 14	2029	2029	1	.	RH	RH	R	R	.	.	.	.	AJCC
3764	Over-ride CS 15	2030	2030	1	.	RH	RH	R	R	.	.	.	.	AJCC
3765	Over-ride CS 16	2031	2031	1	.	RH	RH	R	R	.	.	.	.	AJCC
3766	Over-ride CS 17	2032	2032	1	.	RH	RH	R	R	.	.	.	.	AJCC
3767	Over-ride CS 18	2033	2033	1	.	RH	RH	R	R	.	.	.	.	AJCC
3768	Over-ride CS 19	2034	2034	1	.	RH	RH	R	R	.	.	.	.	AJCC
3769	Over-ride CS 20	2035	2035	1	RH	RH	RH	R	R	.	.	.	.	AJCC/NPCR
1650	Reserved 08	2036	2115	80										
1750	Date of Last Contact	2116	2123	8	R	R	R	R	R	.	.	T	T	SEER/CoC
1751	Date of Last Contact Flag	2124	2125	2	R	R	R	R	R	.	.	T	T	NAACCR
1760	Vital Status	2126	2126	1	R	R	R	R	R	D	D	T	T	SEER/CoC
1770	Cancer Status	2127	2127	1	.	R	R	.	.	.	.	.	.	CoC
1780	Quality of Survival	2128	2128	1	.	.	.	.	.	.	.	.	.	CoC
1790	Follow-Up Source	2129	2129	1	R*	R	.	.	.	.	.	T*	.	CoC
1800	Next Follow-Up Source	2130	2130	1	.	R	.	.	.	.	.	.	.	CoC
1810	Addr Current--City	2131	2180	50	.	R	.	R	.	.	.	T*	.	CoC
1820	Addr Current--State	2181	2182	2	.	R	.	R	.	.	.	T*	.	CoC
1830	Addr Current--Postal Code	2183	2191	9	.	R	.	R	.	.	.	T*	.	CoC
1840	County--Current	2192	2194	3	.	.	.	.	.	.	.	.	.	NAACCR
2700	Reserved 17	2195	2195	1										

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
1860	Recurrence Date--1st	2196	2203	8	.	R	R	RC	.	.	.	T*	.	CoC
1861	Recurrence Date--1st Flag	2204	2205	2	.	R	R	RC	.	.	.	T*	.	NAACCR
1880	Recurrence Type--1st	2206	2207	2	.	R	R	RC	.	.	.	T*	.	CoC
1842	Follow-Up Contact--City	2208	2257	50	.	.	.	.	.	.	.	T*	.	SEER
1844	Follow-Up Contact--State	2258	2259	2	.	.	.	.	.	.	.	T*	.	SEER
1846	Follow-Up Contact--Postal	2260	2268	9	.	.	.	.	.	.	.	T*	.	SEER
1910	Cause of Death	2269	2272	4	R	.	.	R	R	R*	R*	.	T	SEER
1920	ICD Revision Number	2273	2273	1	R	.	.	R	R	.	.	.	T	SEER
1930	Autopsy	2274	2274	1	.	.	.	.	.	.	.	.	.	NAACCR
1940	Place of Death	2275	2277	3	RH	.	.	.	.	R*	R*	T*	T*	NPCR
1791	Follow-up Source Central	2278	2279	2	R	.	.	.	.	.	.	.	T*	NAACCR
1755	Date of Death--Canada	2280	2287	8	.	.	.	.	.	R*	R*	.	.	CCCR
1756	Date of Death--CanadaFlag	2288	2289	2	.	.	.	.	.	R*	R*	.	.	NAACCR
1850	Unusual Follow-Up Method	2290	2291	2	.	.	.	.	.	.	.	.	.	NAACCR
1782	Surv-Date Active Followup	2292	2299	8	.	.	.	D	R	.	.	.	.	NAACCR
1783	Surv-Flag Active Followup	2300	2300	1	.	.	.	D	R	.	.	.	.	NAACCR
1784	Surv-Mos Active Followup	2301	2304	4	.	.	.	D	R	.	.	.	.	NAACCR
1785	Surv-Date Presumed Alive	2305	2312	8	.	.	.	D	R	.	.	.	.	NAACCR
1786	Surv-Flag Presumed Alive	2313	2313	1	.	.	.	D	R	.	.	.	.	NAACCR
1787	Surv-Mos Presumed Alive	2314	2317	4	.	.	.	D	R	.	.	.	.	NAACCR
1788	Surv-Date DX Recode	2318	2325	8	.	.	.	D	R	.	.	.	.	NAACCR
1740	Reserved 09	2326	2339	14										
2220	State/Requestor Items	2340	3339	1000	.	.	.	.	.	.	.	.	.	Varies
2230	Name--Last	3340	3379	40	R	R	.	R	.	R*	R*	T	T	CoC
2240	Name--First	3380	3419	40	R	R	.	R	.	R*	R*	T	T	CoC
2250	Name--Middle	3420	3459	40	R	R	.	R	.	R*	R*	T*	T*	CoC
2260	Name--Prefix	3460	3462	3	.	.	.	.	.	.	.	.	.	NAACCR
2270	Name--Suffix	3463	3465	3	.	.	.	R	.	.	.	T*	T*	NAACCR
2280	Name--Alias	3466	3505	40	R	.	.	R	.	.	.	T*	T*	NAACCR
2390	Name--Maiden	3506	3545	40	R	.	.	R	.	R*	R*	T*	T*	NAACCR

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
2290	Name--Spouse/Parent	3546	3605	60	.	.	.	.	.	.	.	.	.	NAACCR
2300	Medical Record Number	3606	3616	11	R	R	.	R	.	.	.	T	.	CoC
2310	Military Record No Suffix	3617	3618	2	.	.	.	.	.	.	.	.	.	CoC
2320	Social Security Number	3619	3627	9	R	R	.	R	.	.	.	T	T	CoC
2330	Addr at DX--No & Street	3628	3687	60	R	R	.	R	.	.	.	T	T	CoC
2335	Addr at DX--Supplementl	3688	3747	60	R	R*	.	R	.	.	.	T*	T*	CoC
2350	Addr Current--No & Street	3748	3807	60	.	R	.	R	.	.	.	T*	T*	CoC
2355	Addr Current--Supplementl	3808	3867	60	.	R*	.	R*	.	.	.	T*	.	CoC
2360	Telephone	3868	3877	10	.	R	.	R	.	.	.	T*	T*	CoC
2380	DC State File Number	3878	3883	6	R	.	.	R*	.	.	.	.	T*	State
2394	Follow-Up Contact--Name	3884	3943	60	.	.	.	.	.	.	.	.	.	SEER
2392	Follow-Up Contact--No&St	3944	4003	60	.	.	.	.	.	.	.	.	.	SEER
2393	Follow-Up Contact--Suppl	4004	4063	60	.	.	.	.	.	.	.	.	.	SEER
2352	Latitude	4064	4073	10	R*	.	.	S	.	.	.	.	.	NAACCR
2354	Longitude	4074	4084	11	R*	.	.	S	.	.	.	.	.	NAACCR
1835	Reserved 10	4085	4284	200										
2445	NPI--Following Registry	4285	4294	10	.	.	.	RH*	.	.	.	.	.	CMS
2440	Following Registry	4295	4304	10	.	.	.	RH	.	.	.	.	.	CoC
2415	NPI--Inst Referred From	4305	4314	10	.	R	.	.	.	.	.	.	.	CMS
2410	Institution Referred From	4315	4324	10	.	.	.	.	.	.	.	T*	.	CoC
2425	NPI--Inst Referred To	4325	4334	10	.	R	.	.	.	.	.	.	.	CMS
2420	Institution Referred To	4335	4344	10	.	.	.	.	.	.	.	T*	.	CoC
1900	Reserved 11	4345	4394	50										
2465	NPI--Physician--Managing	4395	4404	10	.	R	.	.	.	.	.	.	.	CMS
2460	Physician--Managing	4405	4412	8	.	.	.	.	.	.	.	.	.	NAACCR
2475	NPI--Physician--Follow-Up	4413	4422	10	.	R	.	R*	.	.	.	.	.	CMS
2470	Physician--Follow-Up	4423	4430	8	.	.	.	R	.	.	.	T*	T*	CoC
2485	NPI--Physician--Primary Surg	4431	4440	10	.	R	R	.	.	.	.	.	.	CMS
2480	Physician--Primary Surg	4441	4448	8	.	.	.	.	.	.	.	.	.	CoC
2495	NPI--Physician 3	4449	4458	10	.	R	R	.	.	.	.	.	.	CMS

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
2490	Physician 3	4459	4466	8	.	.	.	.	.	.	.	.	.	CoC
2505	NPI--Physician 4	4467	4476	10	.	R	R	.	.	.	.	.	.	CMS
2500	Physician 4	4477	4484	8	.	.	.	.	.	.	.	.	.	CoC
2510	Reserved 12	4485	4534	50										
7010	Path Reporting Fac ID 1	4535	4559	25	.	.	.	.	.	.	.	.	.	HL7
7090	Path Report Number 1	4560	4579	20	.	.	.	.	.	.	.	.	.	HL7
7320	Path Date Spec Collect 1	4580	4593	14	.	.	.	.	.	.	.	.	.	HL7
7480	Path Report Type 1	4594	4595	2	.	.	.	.	.	.	.	.	.	HL7
7190	Path Ordering Fac No 1	4596	4620	25	.	.	.	.	.	.	.	.	.	HL7
7100	Path Order Phys Lic No 1	4621	4640	20	.	.	.	.	.	.	.	.	.	HL7
7011	Path Reporting Fac ID 2	4641	4665	25	.	.	.	.	.	.	.	.	.	HL7
7091	Path Report Number 2	4666	4685	20	.	.	.	.	.	.	.	.	.	HL7
7321	Path Date Spec Collect 2	4686	4699	14	.	.	.	.	.	.	.	.	.	HL7
7481	Path Report Type 2	4700	4701	2	.	.	.	.	.	.	.	.	.	HL7
7191	Path Ordering Fac No 2	4702	4726	25	.	.	.	.	.	.	.	.	.	HL7
7101	Path Order Phys Lic No 2	4727	4746	20	.	.	.	.	.	.	.	.	.	HL7
7012	Path Reporting Fac ID 3	4747	4771	25	.	.	.	.	.	.	.	.	.	HL7
7092	Path Report Number 3	4772	4791	20	.	.	.	.	.	.	.	.	.	HL7
7322	Path Date Spec Collect 3	4792	4805	14	.	.	.	.	.	.	.	.	.	HL7
7482	Path Report Type 3	4806	4807	2	.	.	.	.	.	.	.	.	.	HL7
7192	Path Ordering Fac No 3	4808	4832	25	.	.	.	.	.	.	.	.	.	HL7
7102	Path Order Phys Lic No 3	4833	4852	20	.	.	.	.	.	.	.	.	.	HL7
7013	Path Reporting Fac ID 4	4853	4877	25	.	.	.	.	.	.	.	.	.	HL7
7093	Path Report Number 4	4878	4897	20	.	.	.	.	.	.	.	.	.	HL7
7323	Path Date Spec Collect 4	4898	4911	14	.	.	.	.	.	.	.	.	.	HL7
7483	Path Report Type 4	4912	4913	2	.	.	.	.	.	.	.	.	.	HL7
7193	Path Ordering Fac No 4	4914	4938	25	.	.	.	.	.	.	.	.	.	HL7
7103	Path Order Phys Lic No 4	4939	4958	20	.	.	.	.	.	.	.	.	.	HL7
7014	Path Reporting Fac ID 5	4959	4983	25	.	.	.	.	.	.	.	.	.	HL7
7094	Path Report Number 5	4984	5003	20	.	.	.	.	.	.	.	.	.	HL7

Item #	Data Item Name	Begin	End	Length	NPCR Collect	CoC Collect	CoC Transmit	SEER Collect	SEER Transmit	CCCR Collect	CCCR Transmit	Hosp-> Central	Central-> Central	Source of Standard
7324	Path Date Spec Collect 5	5004	5017	14	.	.	.	.	.	.	.	.	.	HL7
7484	Path Report Type 5	5018	5019	2	.	.	.	.	.	.	.	.	.	HL7
7194	Path Ordering Fac No 5	5020	5044	25	.	.	.	.	.	.	.	.	.	HL7
7104	Path Order Phys Lic No 5	5045	5064	20	.	.	.	.	.	.	.	.	.	HL7
2080	Reserved 13	5065	5564	500										
2520	Text--DX Proc--PE	5565	6564	1000	R^	.	.	R	.	.	.	T*	T*	NPCR
2530	Text--DX Proc--X-ray/Scan	6565	7564	1000	R^	.	.	R	.	.	.	T*	T*	NPCR
2540	Text--DX Proc--Scopes	7565	8564	1000	R^	.	.	R	.	.	.	T*	T*	NPCR
2550	Text--DX Proc--Lab Tests	8565	9564	1000	R^	.	.	R	.	.	.	T*	T*	NPCR
2560	Text--DX Proc--Op	9565	10564	1000	R^	.	.	R	.	.	.	T*	T*	NPCR
2570	Text--DX Proc--Path	10565	11564	1000	R^	.	.	R	.	.	.	T*	T*	NPCR
2580	Text--Primary Site Title	11565	11664	100	R^	.	.	R	.	.	.	T*	T*	NPCR
2590	Text--Histology Title	11665	11764	100	R^	.	.	R	.	.	.	T*	T*	NPCR
2600	Text--Staging	11765	12764	1000	R^	.	.	R	.	.	.	T*	T*	NPCR
2610	RX Text--Surgery	12765	13764	1000	R^	.	.	R	.	.	.	T*	T*	NPCR
2620	RX Text--Radiation (Beam)	13765	14764	1000	R^	.	.	R	.	.	.	T*	T*	NPCR
2630	RX Text--Radiation Other	14765	15764	1000	R^	.	.	R	.	.	.	T*	T*	NPCR
2640	RX Text--Chemo	15765	16764	1000	R^	.	.	R	.	.	.	T*	T*	NPCR
2650	RX Text--Hormone	16765	17764	1000	R^	.	.	R	.	.	.	T*	T*	NPCR
2660	RX Text--BRM	17765	18764	1000	R^	.	.	R	.	.	.	T*	T*	NPCR
2670	RX Text--Other	18765	19764	1000	R^	.	.	R	.	.	.	T*	T*	NPCR
2680	Text--Remarks	19765	20764	1000	.	.	.	R	.	.	.	T*	T*	NPCR
2690	Text--Place of Diagnosis	20765	20824	60	.	.	.	.	.	.	.	.	.	NPCR
2210	Reserved 14	20825	22824	2000										

Codes for Recommendations: R = Required. RH = Historically collected and currently transmitted. RC = Collected by SEER from COC-accredited hospitals. RN = Collect according to NPCR stage transition schedule. RS = Required, site specific. R$ = Requirements differ by year. S = Supplementary/recommended. D = Derived. DH = Historically derived and currently transmitted. + = Central registries may collect either SEER Summary Stage 2000 or Collaborative Stage. • = No recommendation. * = When available. # = Central registries may code available data using either the SEER or COC data item and associated rules. ^ = These text requirements may be met with one or several text block fields. TH = only certain historical cases may require these fields. TH* = Only certain historical cases may require these fields; transmit data if available for any case in exchange record. T = Data is vital to complete exchange record. T* = Transmit data if available for any case in exchange record.

APPENDIX D. NAACCR Update/Correction Record, Version 16 Record Type U

						* Required for		
Item #	**Item Name**	**Length**	**Begin**		**End**	**Central**	**Hospital**	**Notes**
	Sender ID Section							
10	Record Type	1	1		1	R	R	U = Correction
9000	Update/Correction Record Version	3	2		4	R	R	160 = Version 16
2170	Vendor Name	10	5		14	R	R	Vendor of correction record
30	Registry Type	1	15		15	R		Sending registry
40	Registry ID	10	16		25	R	R	Sending registry
21	Patient System ID-Hosp	8	26		33	R		Sending registry
60	Tumor Record Number	2	34		35	R	R	Sending registry
9002	Reserved for expansion	20	36		55			
	Record ID Section							
9010	Patient ID Number--Receiver	8	56		63			Receiving registry
9011	Tumor Record Number--Receiver	2	64		65			Receiving registry
2230	Name--Last	40	66		105			
2240	Name--First	40	106		145			
2250	Name--Middle	40	146		185			
2300	Medical Record Number	11	186		196		R	
2310	Military Record No Suffix	2	197		198			
2320	Social Security Number	9	199		207			
220	Sex	1	208		208			
240	Date of Birth	8	209		216			
241	Date of Birth Flag	2	217		218			
540	Reporting Hospital	10	219		228		R	
545	NPI—Reporting Facility	10	229		238			
550	Accession Number--Hosp	9	239		247		R	CCYY12345
390	Date of Diagnosis	8	248		255			
391	Date of Diagnosis Flag	2	256		257			

						* Required for		
Item #	**Item Name**	**Length**	**Begin**		**End**	**Central**	**Hospital**	**Notes**
560	Sequence Number--Hospital	2	258		259		R	
400	Primary Site	4	260		263			
410	Laterality	1	264		264			
420	Histology (92-00) ICD-O-2	4	265		268			
430	Behavior (92-00) ICD-O-2	1	269		269			
522	Histologic Type ICD-O-3	4	270		273			
523	Behavior Code ICD-O-3	1	274		274			
9050	Reserved for Expansion	40	275		314			
	Correction Section							
9005	Date of This Change	8	315		322	R	R	
9006	Time of This Change	6	323		328	R	R	
2081	CRC CHECKSUM	10	329		338			
9020	Correction Comments	200	339		538			
9030	Changed Item NAACCR Number	5	539		543	R	R	
9040	Changed Item New Value	1000	544		1543	R	R	Left-justify

APPENDIX E. NAACCR Data Descriptor Table for Record Type U

Item #	Item Name	Format	Allowable Values	Length	Source of Standard
10	Record Type		I, C, A, U, M, L	1	NAACCR
20	Patient ID Number	Right justified, zero filled		8	Reporting Registry
21	Patient System ID-Hosp	Right justified, zero filled		8	NAACCR
30	Registry Type		1-3	1	NAACCR
40	Registry ID	Right justified, zero filled	10-digit number. Reference to EDITS table REGID.DBF in Vol. II, Appendix B	10	NAACCR
60	Tumor Record Number	Right justified, zero filled	01-99	2	NAACCR
220	Sex		1-6, 9	1	SEER/CoC
240	Date of Birth	YYYYMMDD	Valid date	8	SEER/CoC
241	Date of Birth Flag			2	NAACCR
390	Date of Diagnosis	YYYYMMDD	Valid date	8	SEER/CoC
391	Date of Diagnosis Flag			2	NAACCR
400	Primary Site	C followed by 3 digits, no special characters, no embedded blanks	Reference ICD-O-3 for valid entries	4	SEER/CoC
410	Laterality		0-5, 9	1	SEER/CoC
420	Histology (92-00) ICD-O-2		Reference to ICD-O-2	4	SEER/CoC
430	Behavior (92-00) ICD-O-2		0-3; Reference to ICD-O-2	1	SEER/CoC
522	Histologic Type ICD-O-3		Reference to ICD-O-3	4	SEER/CoC
523	Behavior Code ICD-O-3		0-3; Reference to ICD-O-3	1	SEER/CoC
540	Reporting Hospital	Right justified, zero filled	10-digit number	10	CoC
545	NPI—Reporting Facility		10-digit NPI code (9-digit NPI integer plus 1 check digit), blank	10	CMS
550	Accession Number--Hosp		9-digit number	9	CoC
560	Sequence Number--Hospital	Right justified, zero filled	00-59, 60-87, 88, 99	2	CoC
2081	CRC CHECKSUM		Calculated or blank	10	NAACCR
2170	Vendor Name	Embedded spaces allowed		10	NAACCR
2230	Name--Last	Mixed case, no embedded spaces, left justified, blank filled. Embedded hyphen allowed, but no other special characters		40	CoC
2240	Name--First	Mixed case, no embedded spaces, no special characters, left justified, blank filled		40	CoC
2250	Name--Middle	Mixed case, no embedded spaces, no special characters, left justified, blank filled		40	CoC
2300	Medical Record Number	Leading spaces, right justified		11	CoC
2310	Military Record No Suffix	Right justified, zero filled	01-20, 30-69, 98, 99, or blank	2	CoC
2320	Social Security Number	9 digits, no dashes	Any 9-digit number except 000000000	9	CoC
9000	Update/Correction Record Version		1, 2, 7, A, B, 120, 121, 122, 130, 140, 150, 160	3	
9002	Reserved for expansion			20	
9005	Date of this Change	YYYYMMDD		8	
9006	Time of this Change	HHMMSS		6	
9010	Patient ID Number-Receiver		Blank	8	
9011	Tumor Record Number-Receiver		Blank	2	
9020	Correction comments			200	
9030	Changed Item NAACCR Number			5	
9040	Changed Item New Value			1000	
9050	Reserved for expansion			40	

*Record Types I, C, A, and M (data items #10 –7600) see NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary; Chapter IX Data Descriptor Table.