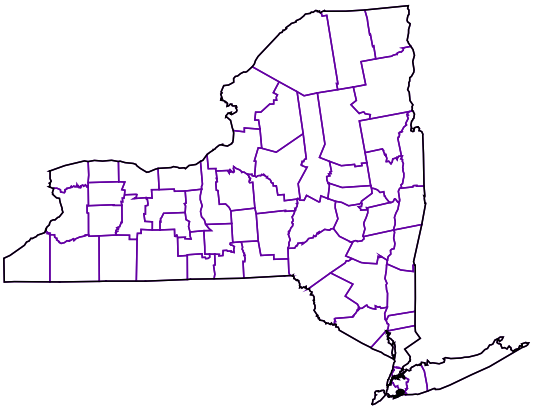

The New York State Cancer Registry

Facility Reporting Manual

2024 - Edition

The New York State Department of Health

STATE OF NEW YORK
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DEPARTMENT OF HEALTH
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The NYSCR Reporting Manual

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New York State Cancer Registry Reporting Manual

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ACKNOWLEDGEMENT

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New York State Cancer Registry Reporting Manual

Part One – Overview

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1.1 WHAT IS THE NEW YORK STATE CANCER REGISTRY?

The New York State Cancer Registry (NYSCR) collects and processes information on cancer cases in New York State. In addition, the NYSCR produces reports on cancer incidence and mortality statewide and in each county, by gender and anatomic site (i.e., breast, lung, colon, prostate, etc.). Because of its comprehensive database of information on cancer cases in New York, the NYSCR serves as an important resource for residents, health care professionals and researchers.

One of the oldest cancer registries in the country, the NYSCR has been collecting information on patients with cancer for more than 75 years. The first state law requiring the reporting of cancer cases diagnosed in New York State, excluding New York City, was passed in 1940. In 1972, the law was amended to include the reporting of information on cancer patients diagnosed in New York City. Evaluation of reporting patterns over time indicates that 1976 is the first year that is considered complete enough to use for the analysis of statewide cancer trends.

In 1995, the NYSCR began receiving additional funding from the Centers for Disease Control and Prevention (CDC) under the federal Cancer Registries Amendment Act. These funds enabled the Registry to make many improvements in the collection and processing of data. Since then, the Registry has increased the number of data elements collected on each cancer patient, consistent with the standards of the National Program of Cancer Registries (NPCR). In September 1996, all Registry data from 1979 to that time were converted into a new database for processing and storage.

In 2018 the NYSCR was selected to become a National Cancer Institute-funded Surveillance, Epidemiology, and End Results (SEER) Registry. SEER's data are extensively used by researchers, clinicians, public health entities and others. As a part of the SEER Program the information collected by the NYSCR will be included in this comprehensive program's database and thus available for such important research. Moreover, New York's data will also be included in SEER's incidence, mortality, and survival publications.

1.2 WHY REPORT TO THE NYSCR?

The NYSCR is a population-based cancer incidence registry responsible for the collection of demographic, diagnostic and treatment information on all patients diagnosed with and/or treated for cancer at hospitals, laboratories, and other health care facilities throughout New York State. Submission of data is mandated under section 2401 (Appendix A) of the NYS Public Health Law.

According to the Public Health Law, the person in charge of every reporting facility shall immediately, but not later than one hundred eighty days, give notice of every case of cancer or malignant disease coming under the care of the institution to the NYS Department of Health Cancer Registry. For a complete listing of reportable conditions refer to **Part 3: Reportable Conditions** of this manual.

NOTE: Registrars are encouraged to obtain the most accurate and complete information for each case. Therefore, in most instances, the NYS Cancer Registry **will not accept** any

cases through electronic submission if they are received **less than** one hundred twenty days (four months) after the diagnosis date.

The NYSCR collects a wide variety of information that can be used for research and public health planning and evaluation. The first objective of the Registry is to monitor cancer levels to detect potential public health risks. The Registry also responds to concerns of New Yorkers who perceive that their community may have an elevated level of cancer. Because Registry data are population-based, they can be used to monitor cancer incidence patterns in New York State. Data collected by the Registry are used:

- to determine cancer rates and trends;
- to prepare health policy and planning;
- for research in epidemiological studies (including case-control studies);
- for evaluation of cancer control interventions;
- to identify and target high-risk populations; and
- to respond to public concerns regarding perceived excesses of cancer in population-based settings.

The NYSCR also plays an important role in research to identify the causes of cancer. Researchers have used data collected by the Registry to identify cancer patients who could be interviewed about possible exposures they had prior to being diagnosed with cancer. These responses can be compared to interview responses of people without cancer to determine whether they had different exposures. One study of this kind, conducted with Registry data, found a possible association between alcohol consumption and breast cancer. Researchers can also use Registry data to determine whether groups of people with specific exposures, for example, those working in certain occupations, are more likely to develop cancer than people who do not have these exposures.

1.3 WHO REPORTS?

In accordance with the NYS Public Health Law every physician, dentist and other health care provider shall give notice immediately, but no later than one hundred eighty days, of every case of cancer or other malignant disease coming under his or her care, to the NYS Department of Health Cancer Registry. This includes all:

- Hospitals
- Diagnostic and Treatment Centers;
- Radiation Treatment Centers;
- Ambulatory Surgery Centers;
- Medical Practices
- Nursing Homes;
- Clinics;
- Laboratories; and

A complete copy of section 2401 of the NYS Public Health Law is available in Appendix A.

1.4 RECIPROCAL AGREEMENTS

In order that cancer-reporting in New York State be as complete as possible, the NYSCR has established formal agreements with several states, including all neighboring states, to exchange information regarding cancer patients.

1.5 WHAT INFORMATION IS COLLECTED ABOUT PATIENTS WITH CANCER?

When the NYSCR initially began collecting data, only minimal information about the patient and tumor was collected. Over time, the volume of cancer reports has increased, along with the amount of data collected for each report. Essentially, data collected by the Registry can be divided into two major categories: information pertaining to the disease process and information about the patient. Regarding the disease process, the Registry collects data on the:

- anatomic site of the tumor;
- cell type/histology of the cancer
- stage at diagnosis; and
- type of treatment rendered.

If a patient is diagnosed with more than one type of cancer, this same information is collected for each unique tumor.

The Registry also collects specific socio-demographic information on every patient diagnosed with cancer, consisting of, but not limited to:

- age;
- sex;
- ethnicity;
- race;
- residence; and
- place of birth.

Information regarding the date and cause of death of individuals diagnosed with cancer is also stored on the Registry's database.

The Registry includes reports of all malignant cancers, except selected skin cancers. Malignant cancers include those with both invasive and in situ behavior. In situ cancers are very early cancers, while invasive cancers have more potential to spread or metastasize to other parts of the body. The Registry also collects data on brain and nervous system tumors classified as benign or which have an uncertain behavior. Benign tumors are growths that do not have the potential to metastasize beyond the tissue where they originated. (See **Part 3: Reportable Conditions** of this manual for a detailed list of reportable conditions and terminology.)

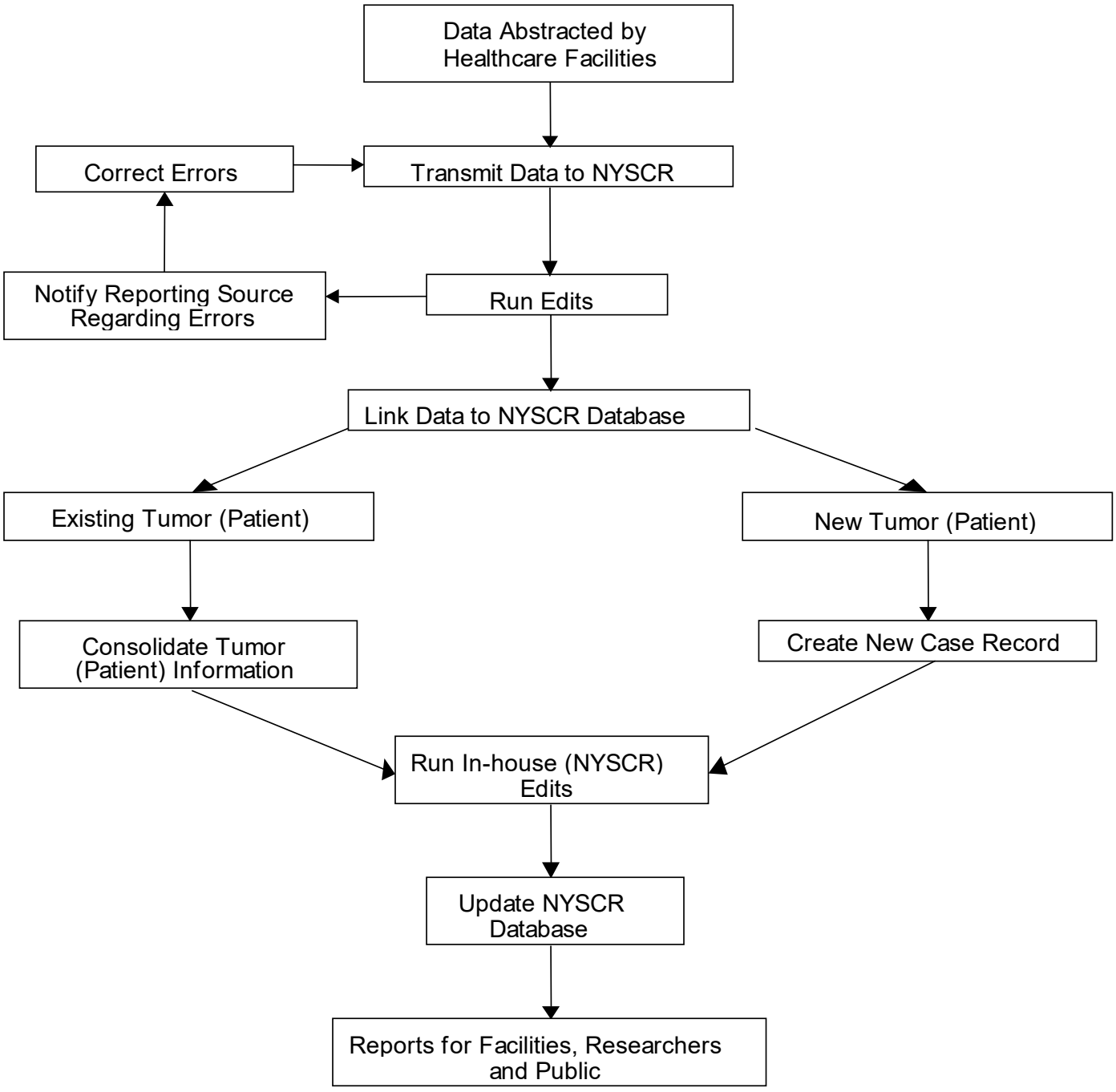
1.6 HOW ARE THE CANCER CASE REPORTS SENT AND PROCESSED?

The NYS Department of Health (DOH) and the NYSCR utilize the Health Commerce System (HCS), a secure Intranet site, for all data-reporting. The Registry offers, to interested facilities, a software application called SEER*Abs at no charge for electronic reporting purposes. In addition to the enhanced *Windows* format, SEER*Abs contains the most recent North American Association of Central Cancer Registries (NAACCR) file format.

Facilities are required to electronically transmit cancer cases to the NYSCR via the HCS at least once a month. If the facility has nothing to report for a particular month, the person(s) responsible for submitting cancer data must contact his/her Field Representative and inform them of that fact in writing.

Once received at the Registry, cancer reports are processed utilizing a combination of automated and manual protocols before they can be used for data analysis. One of the primary strengths of the NYSCR is multiple-source reporting for diagnosed cases. Approximately three reports are received for each primary tumor diagnosed. All incoming reports are electronically matched against records on file for patients diagnosed during the past 30+ years in New York State. About six percent of all cancers are second primaries (new cancers occurring among those patients who have been previously diagnosed with cancer). For some sites, such as oral cavity and pharynx, the number of multiple primaries in an individual may be quite high. Registry staff must review all tumor reports that match to reports already on the database to determine whether the new report represents a new primary cancer, or one that was previously reported. The diagram on the following page illustrates the various steps of NYSCR data processing.

1.6.1 Flow of data from reporting facilities through the NYSCR



In a process known as “geocoding”, address information is used to assign a census tract and, in New York City, health districts. Much of the geocoding process is automated; however, approximately 15 percent of New York State addresses must be manually geocoded by NYSCR staff. There are several kinds of addresses that cannot be coded by the computer. These include addresses with incomplete information on the record, mailing addresses not identified by street name (e.g., P.O. Boxes, rural routes, apartment buildings) and addresses located on newly created streets or those that run between several towns or counties.

The field services staff monitor the number of cases submitted by each facility and the total number of cancer cases for a given diagnosis year. Although facilities are required to submit cases within six months of diagnosis or first contact with the patient, some case reports are not received until after a year or more has passed. The Registry continuously works to improve the timeliness of facility reporting. When most of the data for a given year are received and processed, then death information processing begins.

1.7 WHAT IS DEATH INFORMATION PROCESSING?

When the NYS DOH receives death certificates, an underlying cause of death is assigned based on the entire list of primary and secondary diagnoses. Any mention of cancer on the death certificate is also recorded regardless of whether the person died as a direct result of the cancer. All records of people who die from cancer or with a co-morbidity of cancer are cross-referenced with the NYSCR database. If no match is identified, or if the cancer site on the death certificate differs from that recorded in the NYSCR database, follow-back is initiated by contacting the facility where the death occurred and requesting any additional information they may have. This is an important process, as year of diagnosis, stage at diagnosis, histology and many other important pieces of information are not included on a death certificate. Of all tumors recorded at the Registry, approximately 3 percent are reported from death certificates for which no additional information is available. This is typically attributed to deaths which in a non-hospital setting or out of state. In some cases, the deceased had been diagnosed and treated for cancer at a facility other than the one in which he or she passed away and further information cannot be found. These cases are called “death certificate only cases,” (DCOs). Further information is provided in **Part 6: Death Certificate Only and Death Clearance Lists**.

1.8 FILE RETENTION

There is no statute governing how long cancer case files must be kept by reporting facilities: however, retention for at least five years is strongly recommended by the NYSCR. As with most cancer data software, SEER*Abs contains a backup function and backup is strongly recommended following any data entry. SEER*Abs users can direct questions regarding file backup to their Field Representative, while commercial software users should contact their software vendor or someone from their facility’s information technology services for assistance.

1.9 ARE THERE OTHER MEASURES OF QUALITY APPLIED TO THE CANCER REGISTRY?

Three indicators commonly measure the quality of cancer reporting:

- The percentage of cases reported by DCO;
- The percentage of cases confirmed microscopically; and
- The percentage of cases with non-specific diagnoses.

The number of DCO cases gives an indication of the completeness of cancer registration. The number of microscopically confirmed cases and the number with non-specific diagnoses indicate the accuracy of diagnostic information. These measures are related to the overall quality of data and indicate potential for improved reporting from individual facilities. A high percent of cases without microscopic confirmation or with non-specific diagnoses indicates that either (1) there was inadequate medical record abstracting and reporting, or (2) the diagnostic work-ups at the facility may not have been as complete as they could have been. The latter sometimes occurs following a clinical diagnosis of cancer in those patients whose work-ups may be compromised due to various co-morbid conditions.

Measures of data quality vary considerably among cancer sites. They are affected by many factors including available methods of screening and early detection, survival associated with a particular site/histology and age group primarily affected.

In addition to these measures of completeness and diagnostic quality, other factors affect the analysis and interpretation of cancer registry data. While almost all cancer cases reported to the Registry have information about gender, age and county of residence, additional data important for research or program planning may be less complete, such as race, ethnicity, and stage at diagnosis.

1.10 UNDER WHAT CIRCUMSTANCES IS INFORMATION CORRECTED OR CHANGED?

The change/correction procedure ensures that the most accurate information is available to users of NYSCR data by enabling reporting facilities to provide updated or corrected information to the NYSCR after the original case has been transmitted.

Example: At the time a case is reported to the NYSCR, the primary site is unknown (C809). On a subsequent admission several months later, the primary site is documented as upper lobe of the left lung (C341). An update should be submitted to revise the primary site, laterality and any other information that may now be available. Central Registry staff will update this information on the patient's consolidated abstract in the NYSCR database.

Example: A case is received at the NYSCR that states the patient's primary site is a cervical lymph node (C770) and the histology is adenocarcinoma (8140). Because a lymph node is a secondary (metastatic) site of an adenocarcinoma, the facility is contacted to request further review of the patient's medical record to determine the correct primary site of this malignancy.

Example: A case is reported to the Registry before radiation treatment is started and/or completed. Update and resubmit the abstract to the NYSCR with updated radiation treatment information.

A representative of the NYSCR may contact a reporting facility when questionable and/or inconsistent information is received. In addition to correcting information in the facility's database, corrected information must be relayed to a NYSCR representative as soon as possible. Registrars are encouraged to obtain the most accurate and complete information for each case.

1.10.1 What to Change

Change required data items when incorrect or unknown information was initially reported, and more specific/accurate information is subsequently available.

Examples:

- Update diagnostic information (e.g., diagnosis date, primary site, histology) if initially submitted information is found to be incorrect.
- Change staging information as indicated in specific staging manuals (i.e., SEER Summary Stage, AJCC TNM Stage) if additional information becomes available.
- Update 1st Course of Treatment information if initially submitted with incorrect codes or unknown values and more accurate information becomes available.
- Change service type information, as well as other applicable fields, if a patient subsequently presents to the facility following submission as a "lab only" case.
- Submit any applicable changes to the patient's name (e.g., incorrect spelling on original abstract, name change due to marital status).

Do Not submit changes to update address changes or admission/discharge dates when the patient is re-admitted.

NOTE: Provide text in the "Remarks" field regarding any change(s), to assist NYSCR staff identify the most accurate information.

1.10.2 When to Submit Changes

When possible, changes and/or corrections should be made within ten (10) days of the original submission date.

1.10.3 Quality Control

Reporting facilities should have quality control measures in place to make sure cancer data reported to the NYSCR are complete, accurate and timely. Please refer to **Part 8 - Quality Assessment.**

1.11 ARE THERE NATIONAL CANCER DATA OR DATA FROM OTHER STATES TO COMPARE WITH NEW YORK?

The U.S. Congress passed the Cancer Registries Amendment Act in 1992, which authorized creation of the NPCR by the CDC. The NYSCR has received support from the NPCR since 1996, which has enabled the NYSCR to achieve 'gold' status for the quality and completeness of its cancer data. Through ongoing collaboration with the SEER program, the NPCR provides nationwide, regional, and state-based cancer incidence and mortality data published in the United States Cancer Statistics and in the

CDC WONDER web-based query system. The United States Cancer Statistics currently covers 99% of the United States population.

The NYSCR is a member of the North American Association of Central Cancer Registries (NAACCR), which sets data standards and best practices for population-based registries. Thanks to the initiation of federal funding for cancer registries, the NAACCR membership now includes central registries in all fifty states, the District of Columbia, Puerto Rico, Guam, and the Canadian provinces. NAACCR compiles and publishes Cancer in North America and associated data products.

When the NYSCR updated its database in 1996, it adopted the SEER and NAACCR standards for coding data. One major change in the collection and coding of multiple primary tumors was important for the interpretation of cancer incidence statistics. For cancer cases diagnosed prior to 1996, the NYSCR used the International Agency for Research on Cancer (IARC) rule for counting primary tumors, which allows only one primary per site per person per lifetime. Thus, the Cancer Registry would count only one breast cancer or one lung cancer per person. SEER coding rules allow for multiple primary cancers in an anatomic site, based on histology, length of time between tumors and the pathologist's determination as to whether a second cancer represents a second primary or a recurrence. According to data from the SEER program, approximately 5% of breast cancers, for example, are second primary cancers among women previously diagnosed with breast cancer. Because all data for cancers diagnosed prior to 1996 were coded using IARC rules, New York data for some sites of cancer are not directly comparable to SEER or NAACCR data. The extent of the effect for each cancer site is dependent upon site-specific probability of multiple primaries. Beginning with cases diagnosed in 1996, New York State's data are comparable to both SEER and NAACCR data. SEER data, currently represent approximately 35% of the U.S. population.

1.12 WHAT IS THE DIFFERENCE BETWEEN THE NYSCR AND THE HOSPITAL DISCHARGE FILES (SPARCS)?

The Statewide Planning and Research Cooperative System (SPARCS) maintains a database of all hospital discharges occurring in New York State. This is a valuable source of information regarding treatment, cost, and patterns of care as they relate to cancer. Cancer patients may be admitted to the hospital numerous times over the course of their treatment and recovery. Often, a cancer patient is seen at several different healthcare facilities over the course of several years. The NYSCR counts the number of primary tumors, not the number of hospital admissions. Reports from different healthcare facilities and different years are matched to the database so that an accurate count of the number of primary tumors can be made. This is not possible with the SPARCS data, since discharge files do not contain important clinical information required to determine whether a cancer diagnosis represents is a new primary tumor or recurrence of a previously reported primary tumor. Many data elements critical to studying cancer – such as stage at diagnosis, histology, behavior, and laterality – are not available in the discharge files.

1.13 WHAT DOES THE NYSCR DO TO PROTECT PRIVACY?

All information reported to the NYSCR is considered confidential. Strict policies and procedures are in place to protect every patient's privacy. Access to NYSCR offices is

restricted. All employees are trained in handling confidential information. Specific policies govern the release of data to outside investigators. All research studies involving data with patient identifiers must be reviewed and approved by the NYS DOH Institutional Review Board (IRB), which protects every patient's right to privacy. Data release policies also govern the release of de-identified, individual-level data involving small geographic areas. Statistics for areas smaller than the county level are only released when there are enough cases in the area to guard against revealing confidential information about an individual. When there are fewer than six cases of a particular type of cancer in small area, (e.g., four cases of bladder cancer), then the exact number of cases is not revealed. Rather, the table which displays the number of cases for the small area will indicate "fewer than six cases".

1.14 WHAT KINDS OF DATA DOES THE NYSCR RELEASE?

The NYSCR publishes Cancer Incidence and Mortality in New York State annually. This report provides statewide figures for the number of cancer cases, cancer deaths and the age-adjusted rates by county, primary site, gender, race, and year of diagnosis for the most recent five-year period, as well as the proportion of cases diagnosed at an early stage. Five years of data are combined, since the number of cases and rates for single years may vary considerably, particularly for most of the counties outside metropolitan areas and cities. Cancer Incidence and Mortality in New York State also provides data for New York State, New York City and New York State excluding New York City. Periodically, special reports are released. These include more detailed data than are available in the annual publication. For additional information on special reports produced by the NYSCR, visit the NYSCR website.

Researchers often request data to evaluate a public health intervention or to test a hypothesis. Staff in the analytic unit of the NYSCR respond to special requests for cancer data.

New York State Cancer Registry Reporting Manual

Part Two – Confidentiality

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2.1 DEFINITION

Confidential is defined by Webster's Dictionary as: private, secret; entrusted with confidence; containing information whose unauthorized disclosure could be prejudicial.

2.2 LEGAL AND ETHICAL ASPECTS

2.2.1 Why Safeguard Confidentiality?

Cancer data are highly confidential and one of the most important responsibilities of cancer registry professionals is to safeguard the privacy of cancer patient information. Improper disclosure of protected health information could result in emotional, psychological, and financial harm to both patients and their families. The standard of confidentiality maintained by cancer registries is similar to that of the doctor-patient relationship and it extends indefinitely – even after the patient is deceased.

2.2.2 The Public Health Law

New York State Public Health Law provides the NYSCR with the legislative authority to collect confidential cancer information. As previously noted in Section 1 of this manual, section 2401 states:

Every physician, dentist and other health care provider shall give notice immediately but not later than one hundred eighty days of every case of cancer or other malignant disease coming under his or her care, to the department, except as otherwise provided.

The NYS DOH has also instituted stringent regulations to ensure maximum confidentiality of records received. New York Codes, Rules and Regulations (NYCRR) protect the confidentiality of all cancer case information received by the NYSCR. Title 101.31 of the NYCRR states:

The identity of any person contained in a report of cancer made pursuant to the provisions of Section 2401 of the Public Health Law, or cancer data collected for other specific research studies, shall not be disclosed except to governmental or government-sponsored research projects for the purpose of scientific studies and research when the State Commissioner of Health determines that substantial knowledge may be gained by such disclosure leading toward the reduction of morbidity and mortality. The recipient shall limit the use of such information to the specific study or research purpose for which such disclosure is made, shall not further disclose such information, and shall satisfy the State Commissioner of Health that the confidentiality of the patient's identity will be maintained.

Additionally, Department regulation Subpart 50-1 through 50-4 governs the storage, access and disposal of patient information and requires the development of unit specific protocols to ensure confidentiality of personal health related information.

2.2.3 The Health Insurance Portability and Accountability Act (HIPAA)

Federal regulations [see 45 C.F.R. s164.512] authorize disclosure without patient consent in certain circumstances, including the following:

Disclosure is permitted to a public health authority authorized by law to access information to prevent/control disease, injury, disability (e.g., disease reporting, vital statistics reporting, public health surveillance, public health investigations, public health interventions and partner notification).

Under the HIPAA a 'Public Health Authority' refers to "an agency or authority of the United States, a State or territory, a political subdivision of a State or territory, an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate." [1] "...Such agencies are authorized by law to collect or receive such information for the purposes of preventing or controlling disease, injury, vital events such as birth or death and the conduct of public health surveillance, public health investigations and public health interventions." [2] *Central Cancer Registries* are considered public health authorities because their duties are mandated by state laws.

[1] C.F.R. 164.501
[2] C.F.R. 164.512

Cancer reporting and surveillance are required by New York State law. Public health reporting under the authority of New York State law is specifically exempted from HIPAA preemption, per 45 C.F.R. § 160.203(c). Access to patient medical records relating to the diagnosis and treatment of cancer by the NYSCR has been determined to be the minimum necessary for protected health information for the stated purpose in compliance with 45 C.F.R. s164.502. It is not necessary to complete a Business Associate Agreement before providing the NYSCR with the requested personally identifiable information. The requested information is required to conduct public health surveillance and will remain confidential. See Appendix B for more information regarding HIPAA.

2.3 POLICIES AND PROCEDURES

Anyone, whose position requires access to cancer data, whether at the NYSCR or a reporting facility, is responsible for ensuring confidentiality is continually maintained. Reporting facilities are urged to consider implementing the following policies and procedures if they are not already in place.

2.3.1 Confidentiality Pledge/Agreement

It is strongly recommended that anyone with access to confidential patient information first sign a **Confidentiality Pledge/Agreement**. This pledge/agreement should clearly state the expectations of the facility regarding the signatory's handling of confidential information as well as potential penalties for violating terms of the agreement. Additionally, this requirement should extend beyond employees of the facility to any consultants, contractors, auditors, etc. A sample confidentiality statement is available at the end of this section (Part 2).

2.4 DATA SECURITY

Every measure must be taken to ensure that confidentiality of all medical records is protected. This includes Electronic Medical Records (EMRs). Anyone requiring access to confidential patient information should be required to sign a confidentiality pledge before authorization is approved.

The following additional guidelines are offered to Health Information Management personnel to maintain security of confidential patient information whether stored on paper or electronically.

2.4.1 Paper records

Central storage sites containing confidential patient files must be always secured. A chain of custody should be maintained on every record removed from the central storage site, citing the name and department of the individual removing the record, along with the date and time of removal and return.

Individuals who sign out records must ensure that those records remain secure while in their possession.

2.4.2 Electronic records

If not already in place, strict security procedures must be instituted, preventing any unauthorized access to EMRs. Confidential medical information, which is abstracted and entered onto an EMR, must be done so only by authorized personnel. Each authorized user should be assigned a personal access identification and password. This ID and password must never be shared with others. Access to confidential medical data should be limited to those individuals and/or agencies with a legitimate use for such data. As previously mentioned, NYS Public Health Law provides for the transmission of confidential cancer data to the NYSCR.

Upon termination of employment for any reason, facilities must remove any ID/password from their system, which may provide access for the former employee to confidential patient data.

2.5 PROCEDURES FOR RELEASE OF CONFIDENTIAL CANCER PATIENT INFORMATION

Telephone: If a caller is not immediately known, the identity of the caller must be confirmed before any information is released.

Facsimile: When transmitting confidential information via fax, the following guidelines should be implemented to ensure that the information is received by an authorized party only:

1. Transmit data only to a fax machine/number that is located within a secure area, offering limited access.
2. Verify that the appropriate individual is present before transmitting confidential data.
3. Accompany each fax transmission with a cover sheet, which includes a notice of confidentiality.

   Example: *The documents accompanying this facsimile contain confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual(s) or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any unauthorized party and is required to destroy the information after its stated purpose has been fulfilled, unless otherwise required by law.*

   If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this facsimile in error, please notify the sender immediately to arrange for return of these documents.

4. Verify that the intended recipient has received the faxed information.

Electronic Mail: Common e-mail should never be used to transmit confidential patient information. If someone wishes to send confidential data electronically, s/he should use the Secure File Transfer Utility (SFT) on the NYS DOH Health Commerce System (HCS). An HCS account is necessary to access and transmit information via the SFT. This system allows for secure transmission of files up to 2 GB. Assistance using the SFT is available from your Field Representative.

Regular Mail: All confidential patient information sent to the NYSCR via postal mail, or other couriers, must be prominently marked “confidential”. Use of registered or express mail is recommended. This allows the sender to track the package, as well as confirm receipt. Use of reinforced envelopes/packaging is also strongly recommended.

2.6 SAMPLE CONFIDENTIALITY PLEDGE

I understand and accept the responsibility of maintaining the confidentiality of all data and information collected and processed by _____*(Facility Name)*_____.

I also understand my role in ensuring the right to privacy of persons and institutions cooperating with the cancer registry data collection activities.

I understand that _____*(Facility Name)*_____ has policies that protect the patient's right to consideration of privacy regarding his or her medical and personal information.

I understand that I must not reveal any confidential information to anyone except those individuals authorized to receive such information, such as another staff member or the original reporting source.

I also understand that failure to adhere to this policy may result in disciplinary action up to and including dismissal.

I have read and understand the _____*(Facility Name)*_____ confidentiality policy and procedures and pledge to act in accordance with these policies and procedures.

Name (Please print): _____

Signature: _____ Date: _____

Witness Name (Please print): _____

Signature: _____ Date: _____

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Part Three - Reportable Conditions and Terminology

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3.1 INTRODUCTION

In general, the following types of cases ARE reportable:

- Each form of in situ (behavior code 2) cancer, EXCEPT for the following:
  - All types of carcinoma in situ of the cervix uteri (including adenocarcinoma in situ)
  - CIN III (cervical intraepithelial neoplasia, grade three)
  - All types of carcinoma in situ of the prostate
  - PIN III (prostatic intraepithelial neoplasia, grade three)
  - In situ lymphomas
- Each form of malignant (behavior code 3) cancer, EXCEPT skin of non-mucoepidermoid sites (C440-C449) with any of the following histologies:
  - Malignant neoplasm (8000-8005)
  - Epithelial carcinoma (8010-8046)
  - Papillary and squamous cell carcinoma (8050-8084)
  - Squamous intraepithelial neoplasia III (SIN III) (8077) of skin sites coded to C44_
  - Basal cell carcinoma (8090-8110)
- All Primary Central Nervous System tumors, regardless of behavior, with the following ICD-O topography codes:
  - Meninges, C70_
  - Brain, C71_
  - Spinal cord, cranial nerves, and other parts of CNS, C72_
  - Pituitary gland, craniopharyngeal duct and pineal glands, C751 – C753
- Borderline ovarian tumors
  - Serous cystadenoma, borderline malignancy 8442/1
  - Serous tumor of low malignant potential 8442/1
  - Atypical proliferating serous tumor 8442/1
  - Papillary cystadenoma, borderline malignancy 8451/1
  - Serous papillary cystic tumorof borderline malignancy 8462/1
  - Papillary serous cystadenoma, borderline malignancy 8462/1
  - Papillary serous tumor of low malignant potential 8462/1
  - Atypical proliferative papillary serous tumor 8462/1
  - Serous surface papillary tumor of borderline malignancy 8463/1
  - Atypical proliferative mucinous tumor 8472/1
  - Mucinous cystic tumor of borderline malignancy 8472/1
  - Mucinous cystadenoma, borderline malignancy 8472/1
  - Mucinous tumor, NOS, of low malignant potential 8472/1
  - Pseudomucinous cystadenoma, borderline malignancy 8472/1
  - Papillary mucinous cystadenoma, borderline malignancy 8473/1
  - Papillary pseudomucinous cystadenoma, borderline 8473/1
  - Papillary mucinous tumor of low malignant potential 8473/1
  - Seromucinous borderline tumor of the ovary 8474/1
  - malignancy

3.2 RULES FOR REPORTING

3.2.1 Active Cancer

Any person diagnosed with active cancer, EXCEPT basal and squamous cell cancers of skin, after January 1950 must be reported to the NYSCR. Active cancer is defined as requiring therapy or management of the cancer or recurrence of the cancer. If a patient is diagnosed with or treated for metastatic cancer at your facility, report the PRIMARY SITE the first time the patient is seen at your facility for that cancer.

If ANY type of cancer-related service or management is provided for the patient at your facility, the case **IS** reportable.

> **Example:** A patient is diagnosed at another facility but seen at your facility for planned breast reconstruction, which is part of the first course of treatment.
>
> **Example:** A patient is diagnosed at another facility with melanoma and is seen at your facility for wide excision. This is reportable even if the pathology results from the wide excision are negative.

Patients seen at your facility for a reason completely unrelated to an active case of cancer are NOT reportable.

> **Example:** A patient is treated for a broken leg. The patient also has a secondary diagnosis of breast cancer. The patient is not treated for breast cancer while at your facility.

Autopsy/death certificate cases are exceptions. See section 3.2.1.4 for more information.

Active cancer includes:

3.2.1.1 Consult-Only Cases

Report consultation only services provided by your facility to establish or confirm a diagnosis of or a treatment plan for active cancer.

> **Examples of reportable consult-only cases:**
> - A biopsy is done elsewhere, and the specimen (including electronically transmitted microscopic images) is sent to your facility. The patient never enters your facility; however, your facility's pathologist diagnoses a reportable cancer in a pathology report. These cases are referred to as "Lab Only Cases." This category also includes specimens sent to your facility, which test positive for malignancy using immunohistochemistry testing and lab test (ex. ER/PR testing, HER2/neu testing). If the patient returns to your facility for treatment the case must be updated with the correct service type and any additional demographic/treatment information and resubmitted.
> - An outpatient CT scan of the chest reads, "probable carcinoma of the right lung." The clinical impression is confirmed at your facility and is reported back to the referring facility or physician.

- A patient comes to your facility for a second opinion, where staff physicians order diagnostic tests that support the original diagnosis and treatment plan. The patient returns to the referring institution for treatment.
- The patient does not have treatment at the hospital, but the MD presented the patient with treatment options. The patient does not return (service type "16").

Note: Consult-only services for a patient whose primary residence is NOT in the United States are NOT reportable to the NYSCR.

3.2.1.2 Transient Care

Report cancer cases when patients receive transient care at your facility to avoid interrupting a course of therapy started elsewhere.

Examples of reportable transient care:

- A patient from out of state is visiting relatives in the area. The oncology department at your facility administers the scheduled chemotherapy.
- Due to equipment failure, an institution refers a patient to your facility for radiation therapy. Your facility administers treatment until the equipment is repaired.

3.2.1.3 Palliative / Terminal Care

Report cases for patients with active cancer, admitted to your facility for the purpose of receiving supportive care, palliative care, pain management and/or hospice services.

3.2.1.4 Autopsy/Death Certificate Only Cases

This refers to an incidental finding of cancer at autopsy where there was no suspicion of cancer before the autopsy. To avoid Death Certificate Only (DCO) follow-back cases later, facilities should establish a mechanism to review death certificates for the presence of cancer diagnoses. See Part 6 for more information on DCO cases.

3.2.1.5 Clinical Cases

Report clinical cases. Clinical cases are non-histologically confirmed cancer diagnoses, based exclusively on the physician's clinical interpretation. The medical history and physical examination section of a medical record often ends with the physician's impression of the diagnosis, but the impression MUST be substantiated by the discharge summary or other supporting documentation. Do NOT report "rule out" only cases. See Section 3.5.1 for a list of ambiguous terms that constitute a reportable cancer diagnosis.

3.2.1.6 Neoplasms of the Central Nervous System (CNS) (See 3.3)

Report All PRIMARY central nervous system tumors and/or neoplasms with any of the following ICD-O topography codes:

- Meninges, C70_
- Brain, C71_
- Spinal cord, cranial nerves, and other parts of CNS, C72_
- Pituitary and pineal glands, C71 – C753
- Nerve roots for the following sites: C470, C473, C475, C476

3.2.1.7 Leukemia in Remission

Leukemia in remission is reportable if the patient receives treatment while at your facility. Cases in which the disease is *no longer active* should only be reported if the patient is still receiving cancer-directed therapy.

> **Example:** A patient diagnosed six months ago with acute myelocytic leukemia is now in remission and on a maintenance dose of chemotherapy. The patient was admitted for evaluation of neutropenia following the last course of chemotherapy. If this is the first admission to your facility, this patient should be reported because cancer-directed treatment (e.g., chemotherapy) is being administered.

3.2.1.8 Mucoepidermoid Sites

Mucoepidermoid sites include the vulva (i.e., labia, vaginal opening, clitoris, and clitoral hood), vagina, penis, scrotum and portions of the lip and anus.

3.2.1.8.1 Reportable Lip Cases

The codes for the mucoepidermoid portions of the lip are C000-C009. These include the inner mucosal surface of the lip, the vermilion surface of the lip (i.e., the pinkish colored area where lipstick is applied) and the vermilion border of the lip. Report all malignancies involving these sites.

Basal cell carcinomas do NOT arise in the mucoepidermoid portion of the lip and anus. They can only arise in the skin of these two sites and are therefore NOT REPORTABLE.

3.2.1.8.2 Reportable Anal Cases

C210 is the code that includes the mucoepidermoid portion of the anus called the anoderm. The anoderm is the lining of the anal canal immediately inferior to the dentate line and extending for about 1.5 cm to the anal verge. It is devoid of hair and sebaceous and sweat glands; therefore, it is NOT true skin. Report all malignancies involving this site.

Basal cell carcinomas do NOT arise in the mucoepidermoid portion of the lip and anus. They can only arise in the skin of these two sites and are therefore NOT REPORTABLE.

3.2.1.8.3 Reportable Basal Cell Carcinomas

Basal cell carcinomas ARE reportable when they arise in the:

Vulva	(C51_)
Vagina	(C529)
Penis	(C60_)
Scrotum	(C632)

Basal cell carcinomas do NOT arise in the mucoepidermoid portion of the lip and anus. They can only arise in the skin of these two sites and are therefore NOT REPORTABLE.

3.2.1.8.4 Reportable Squamous Cell Carcinomas

Squamous cell carcinomas ARE reportable when they arise in the mucoepidermoid sites of the:

Vulva	(C51_)
Vagina	(C529)
Penis	(C60_)
Scrotum	(C632)
Lip	(C00_)
Anus	(C210)

3.2.2 First-Seen Rule

Submit a report on every patient first diagnosed or treated at your facility. If first seen with a cancer recurrence or metastatic disease, report the information from the INITIAL diagnosis of the PRIMARY site (i.e., not metastatic site[s]). Report a patient again ONLY if the patient is diagnosed with another primary cancer. Create a new abstract for every new primary of each patient.

3.2.3 Infusion Ports/Sleeve Placements/Fiducial Markers

Report patients who come to your facility for insertion of an infusion port (e.g., mediport, infusaport, port-a-cath, or chemotherapy port), when the record states the device will be used to provide central access for chemotherapy for a reportable cancer at a treating facility. These cases are reportable even if the patient is to receive their subsequent chemotherapy at another facility.

Service Type for these cases should be coded as “18 Port/Cath” and Class of Case as “31: Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care.”

Fiducial markers are not considered treatment. These are placed for treatment planning purposes and to assist with daily treatment. Keep in mind that when brachytherapy is used for the treatment of prostate cancer, the radioactive seeds used across the board are Iodine-125. If I-125 seed implants are used, they are considered boost treatment and should be coded accordingly.

3.2.4 MammoSite Radiation Therapy

Report patients who come to your facility for the insertion of a MammoSite balloon catheter. The MammoSite Radiation Therapy System utilizes a specialized balloon catheter to deliver brachytherapy directly to the site of a lumpectomy, following a diagnosis of malignancy. These cases are reportable even if the patient is to receive their subsequent radiation therapy at another facility. It is understood that the patient’s medical record may contain minimal information related to her/his diagnosis.

3.2.5 Behavior Code

Patients diagnosed with a behavior code of 2 (in situ) or 3 (malignant) as defined in the International Classification of Disease for Oncology, Third Edition (ICD-O-3) and subsequent

updates, including all applicable ICD-O-3.2 Updates must be reported, except as otherwise noted.

3.2.5.1 Behavior Code 2 (In Situ) Terms That Are Reportable

Synonymous terms for behavior code 2 (in situ) that ARE reportable to the NYSCR (except for basal and squamous cell carcinomas of the SKIN) include:

- AIN II, II-III and III (anal intraepithelial neoplasia) (C210-C211)
- Clark level 1 for melanoma (limited to epithelium)
- Confined to epithelium
- DIN III (ductal intraepithelial neoplasia)
- Early or evolving melanoma in situ, or any other early or evolving melanoma (As of 01/01/2021)
- High grade biliary intraepithelial neoplasia (BilN III) of the gallbladder (C239)
- High grade dysplasia, Esophagus, Stomach, and Small Intestine only (C150-C179)
- High grade squamous intraepithelial lesion (HSIL) (II, II-III and III)
- Intraductal
- Intraepidermal, NOS
- Intraepithelial, NOS
- Involvement up to but not including the basement membrane
- Lentigo maligna (C44_) AKA, Hutchinson melanotic freckle, NOS (C44_)
- LIN III (Laryngeal Intraepithelial Neoplasia, grade III) (C32_)
- Lobular carcinoma in situ (LCIS) of breast
- Lobular neoplasia grade III (LIN III) (C50_)
- Non-infiltrating
- Non-invasive
- No stromal invasion
- PanIN III (Pancreatic Intraepithelial Neoplasia, grade III) (C25_)
- PeIN III (Penile intraepithelial neoplasia, grade III) (C60_)
- SIN III (Squamous Intraepithelial Neoplasia, grade III)
    - Squamous dysplasia, high grade, Esophagus, Stomach, and Small Intestine only (C150-C179)
- Squamous intraepithelial neoplasia/neoplasm, grade II (Excluding Cervix)
- VaIN II, II-III and III (vaginal intraepithelial neoplasia, grade II, II-III and III)
- VIN II, II-III and III (vulvar intraepithelial neoplasia, grade II, II-III and III)

3.2.5.2 Behavior Code 2 (In Situ) Terms That Are Not Reportable

Synonymous terms for behavior code 2 (in situ) that are NOT reportable to the NYSCR include:

- Bowen disease of SKIN
- CIN III (cervical intraepithelial neoplasia, grade III)
- PIN III (prostatic intraepithelial neoplasia, grade III)
- High Grade Dysplasia, Colon only (C180-C189)

3.2.6 Key Words and Conditions

Reportable conditions are defined in terms of key words and other specified conditions. The most comprehensive source for determining reportability is the International Classification of Diseases for Oncology, Third Edition (ICD-O-3), and all applicable ICD-O-3.2 Updates,

published by the World Health Organization (WHO). The ICD-O presents definitive information related to site, morphology, behavior, synonyms, codes, and rules. Section 3.8 of this manual contains a list of MOST of the terms that are reportable to the NYSCR.

3.2.7 Terms That May Not Sound Malignant but ARE Reportable

The following is a non-inclusive list of terms that may not sound malignant but ARE reportable to the NYSCR.

Acute myelofibrosis
Acute panmyelosis
Acute progressive histiocytosis X
Adamantinoma
Agnogenic myeloid metaplasia
Alpha heavy chain disease
Anal intraepithelial neoplasia (AIN II, II-III and III)
Askin tumor
Astrocytoma
Atypical carcinoid
Blastoma
Carcinoma in situ (except for cervix)
CASTLE
Dysgerminoma
Ependymoma
Ewing tumor (bone)
Franklin disease
Gamma heavy chain diseaseGlioma
Heavy chain disease
Hepatoma
High grade squamous intraepithelial lesion (HSIL) (II, II-III and III)
Hodgkin disease
Hypereosinophilic syndrome
Hypernephroma
Immunoproliferative small intestinal disease
Intratubular germ cell neoplasia
Kaposi sarcoma
Klatskin tumor
Krukenberg tumor
Letterer-Siwe disease
Leukemia
Leukemic reticuloendotheliosis
Linitis plastica
Lymphoma
Malignant (except malignant hypertension)
Mature teratoma of the testes
Melanoma
Meningioma
Merkel cell tumor (skin)
Mesothelioma
Mixed mesodermal tumor
Multiple myeloma
Mycosis fungoides
Myelofibrosis, acute
Neoplasm, malignant
Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia
Oligodendroglioma
Paget disease (breast)
Paget disease, extramammary (except Paget disease of bone)
Pagetoid reticulosis
PanIN (Pancreatic Intraepithelial Neoplasia grade III)
Peripheral neuroectodermal tumor
Phyllodes tumor, malignant (breast)
Pinealoma
Plasmacytoma
Primitive neuroectodermal tumor
Sarcoma
Seminoma
SETTLE
Sezary disease
Therapy related myelodysplastic syndrome
Thymoma (nearly all thymomas are reportable as of 01/01/2021)
Vaginal intraepithelial neoplasia (VaIN II. II-III and III)
Vulvar intraepithelial neoplasia (VIN II, II-lll and III)
Waldenstrom macroglobulinemia

3.3 REPORTABLE BENIGN, BORDERLINE AND MALIGNANT INTRACRANIAL AND CENTRAL NERVOUS SYSTEM TUMORS

3.3.1 Anatomic Sites

Report the following anatomic sites for PRIMARY intracranial and central nervous system (CNS) tumors and/or neoplasms, REGARDLESS of behavior.

Abducens nerve
Accessory nerve, NOS
Acoustic nerve
Anterior cranial fossa
Arachnoid, NOS
Basal ganglia
Basis pedunculi
Brain, NOS
Brain stem
Cauda equina
Central nervous system
Central white matter
Cerebellopontine angle
Cerebellum, NOS
Cerebral cortex
Cerebral hemisphere
Cerebral meninges
Cerebral peduncle
Cerebral ventricle
Cerebral white matter
Cerebrum
Cervical cord
Choroid plexus, NOS
Choroid plexus of fourth ventricle
Choroid plexus of lateral ventricle
Choroid plexus of third ventricle
Conus medullaris
Corpus callosum
Corpus striatum
Cranial dura mater
Cranial fossa, NOS
Cranial meninges
Cranial nerve, NOS
Cranial pia mater
Craniopharyngeal duct
Dura, NOS
Dura mater, NOS
Ependymal
Epidural
Extradural
Facial nerve
Falx cerebelli
Falx cerebri
Falx, NOS
Filum terminale
Fourth ventricle, NOS
Frontal lobe
Frontal pole
Globus pallidus
Glossopharyngeal nerve
Hippocampus
Hypoglossal nerve
Hypophysis
Hypothalamus
Infratentorial brain, NOS
Insula
Internal capsule
Intracranial arachnoid
Intracranial meninges
Intracranial site
Island of Reil
Lateral ventricle, NOS
Lumbar cord
Medulla oblongata
Meninges, NOS
Midbrain
Middle cranial fossa
Nervous system, NOS
Occipital lobe
Occipital pole
Oculomotor nerve
Olfactory nerve
Olive
Operculum
Optic chiasm
Optic nerve
Optic tract
Other parts of brain
Overlapping lesion of brain
Overlapping lesion of brain and central nervous system
Pallium
Parasellar
Parietal lobe
Pia mater, NOS
Pineal gland

Pituitary fossa
Pituitary gland
Pituitary, NOS
Pons
Posterior cranial fossa
Putamen
Pyramid
Rathke pouch
Rhinencephalon
Sacral cord
Sella turcica
Spinal accessory nerve
Spinal arachnoid
Spinal cord
Spinal dura mater
Spinal meninges
Spinal nerve root
Spinal pia mater
Suprasellar
Supratentorial brain, NOS
Tapetum
Temporal lobe
Tentorium cerebelli
Tentorium, NOS
Thalamus
Third ventricle, NOS
Thoracic cord
Trigeminal nerve
Trochlear nerve
Uncus
Vagus nerve
Ventricle, NOS
Vermis of cerebellum

3.3.2 Histology/Morphology Terms

Report the following histology/morphology terms for PRIMARY intracranial and central nervous system (CNS) tumors/neoplasms, REGARDLESS of BEHAVIOR.

Acoustic neuroma
Acidophil adenoma
Adenoma, NOS
Angioblastic meningioma
Angioblastoma
Angiocentric immunoproliferative Lesion
Angiocentric glioma
Angiolipoma, NOS
Angiomatous meningioma
Atypical choroid plexus papilloma
Atypical fibrous histiocytoma
Atypical fibroxanthoma
Atypical meningioma
Basophil adenoma
Capillary Hemangioma
Cavernous Hemangioma
Central neurocytoma
Cerebellar neurocytoma
Cerebellar liponeurocytoma
Chordoid glioma of third ventricle
Choroid plexus papilloma, NOS
Chromophobe adenoma
Craniopharyngioma
Dermoid cyst, NOS
Desmoplastic infantile astrocytoma and ganglioglioma
Diffuse astrocytoma, IDH mutant
Diffuse meningiomatosis
Dysembryoplastic neuroepithelial tumor
Dysplastic gangliocytoma of cerebellum (D=Lhemitte-Duclos)
Endotheliomatous meningioma
Ependymoma
Epithelioid hemangioendothelioma, NOS
Extra-adrenal paraganglioma, NOS
Extraventricular neurocytoma
Fibroblastic meningioma
Fibroma, NOS
Fibrous histiocytoma, NOS
Fibrous meningioma
Fibroxanthoma, NOS
Follicular Adenoma
Gangliocytoma
Ganglioglioma
Ganglioneuroma
Glioneuroma
Granular cell tumor, NOS
Hemangioblastic meningioma
Hemangioblastoma
Hemangioma
Hemangioendothelioma, benign
Hemangiopericytic meningioma
Hemangiopericytoma, benign
Hemangiopericytoma, NOS
Hurthle cell adenoma

Hurthle cell tumor
Lipoma
Lymphoproliferative disease, NOS
Melanocytic Schwannoma
Meningioma, NOS
Meningiomatosis, NOS
Meningotheliomatous meningioma
Mesenchymoma, benign
Mesenchymoma, NOS
Microfollicular adenoma
Mixed acidophil-basophil adenoma
Mixed cell adenoma
Mixed meningioma
Monomorphic adenoma
Mucoid cell adenoma
Multinodular and vascolating neuronal tumor (MVNT)
Multiple meningiomas
Multiple neurofibromatosis
Myxopapillary ependymoma
Neoplasm, benign
Neoplasm, uncertain whether benign or malignant
Neurilemmoma, NOS
Neurinoma
Neuroastrocytoma
Neurocytoma
Neurofibroma, NOS
Neurofibromatosis, NOS
Neurothekeoma
Neuroma, NOS
Oligodendroglioma IDH mutant and 1p/19q-codeleted
Oncocytic adenoma
Oncocytoma
Oxyphilic adenoma
Papillary adenoma, NOS
Papillary ependymoma
Papillary glioneuronal tumor
Papillary meningioma
Paraganglioma, NOS
Perineuroma
Pigmented Schwannoma
Pilocytic/juvenile astrocytoma
Pinealoma
Pineoblastoma
Pineocytoma
Pituicytoma
Pleomorphic xanthroastrocytoma
Plexiform neurofibroma
Plexiform neuroma
Prolactinoma
Psammomatous meningioma
Rathke pouch tumor
Recklinghausen disease (except of Bone)
Rhabdomyoma, NOS
Rosette-forming glioneuronal tumor
Schwannoma, NOS
Solitary fibrous tumor
Soft tissue tumor, benign
Spindle cell oncocytoma
Subependymal astrocytoma
Subependymal giant cell astrocytoma
Subependymal glioma
Subependymoma
Syncytial meningioma
Teratoma, NOS
Teratoma, benign
Transitional meningioma
Tumor, benign
Tumor cells, benign
Tumor cells, uncertain whether benign or malignant
Tumorlet(s)
Tumor, uncertain whether benign or malignant
Von Recklinghausen disease (except of Bone)
Xanthofibroma

3.4 WHAT IS NOT REPORTABLE TO THE NYSCR

3.4.1 History of

Do NOT report patients with a history of malignancy who are clinically free of disease.

If a patient with a history of breast cancer receives Tamoxifen therapy, report the case only if the breast cancer was the reason for admission (i.e., principal diagnosis).

Exception: When a history of malignancy case appears on a DCO list, follow it back to the NYSCR. The reason a case appears on a DCO list is because the patient and/or tumor associated with that patient was not reported at the time of the original diagnosis. It is likely that the facility reconciling the DCO case will have limited documentation about the tumor and that numerous data fields will be coded as "unknown". For more information on DCO cases, see Part 6.

3.4.2 Recurrence

A recurrent diagnosis is the SAME cancer arising in or from the SAME primary site where it appeared earlier and when it is NOT considered by the physician to be a new primary cancer. Do report a recurrent diagnosis if this is the first time seen at your facility. Report information related to the INITIAL diagnosis and ORIGINAL primary site for a case that is first seen at your facility with a recurrent cancer or metastatic disease. Do NOT report a recurrent diagnosis if you have previously reported the primary cancer.

3.4.3 Readmitted Patients

Do NOT report readmitted patients if you have previously reported that primary. If a patient is readmitted to your facility and new or additional metastatic sites are diagnosed and/or treated, the case is NOT reportable provided your facility previously has reported the ORIGINAL primary cancer. Review records of readmitted patients to determine if a NEW primary has been diagnosed. Report each new primary separately.

3.4.4 Basal and Squamous Cell Cancer of Skin

Basal and squamous cell cancer originating in SKIN (i.e., non-mucoepidermoid sites), is NOT reportable, regardless of stage at diagnosis.

3.4.5 "Evolving" Melanoma

Evolving melanoma and evolving melanoma in situ are not reportable **when diagnosed prior to January 1, 2021**. As of January 1, 2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable.

3.4.6 High Grade/Severe Dysplasia

High grade dysplasia (HGD) is reportable for some sites. HGD is **reportable** for sites in the Esophagus, Stomach, and Small Intestine. HGD is **not reportable** in the Colon.

3.5 GUIDELINES FOR INTERPRETATION OF EQUIVOCAL DIAGNOSTIC TERMINOLOGY

3.5.1 Ambiguous Terminology that Constitute a Diagnosis

Terms listed below ARE reportable. These terms are NOT to be used when determining multiple primaries. The Solid Tumor Rules manual contains a separate list of ambiguous terms:

Apparent(ly)	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect(ed)
Consistent with	Suspicious (for)
Favor(s)	Typical (of)
Malignant appearing	

Exception: If a CYTOLOGY is identified only with one or more of the above ambiguous terms, do not interpret this as a diagnosis of cancer. Report the case only if the cytology findings are supported by a positive biopsy or a physician's clinical impression of cancer confirms the cytology findings. The date of diagnosis is the date of the suspicious cytology. This is a change to previous instructions. The date of a suspicious cytology may be used as the date of diagnosis when a definitive diagnosis follows the suspicious cytology.

Report cases that use the words on the list or an equivalent word such as "favored" rather than "favor(s)." Do not substitute synonyms such as "supposed" for presumed or "equal" for comparable. Do not substitute "likely" for "most likely."

When a RADIOLOGY report mentions a "suspicious mass", BUT there is no other documentation or mention of the mass in the medical record, do NOT report this case. The report is useful however, for casefinding, indicating the need to search for additional information to support the observation on the imaging report.

3.5.2 Ambiguous Terms That Do Not Constitute A Diagnosis

Terms listed below are NOT considered diagnostic of cancer without additional information. If a phrase such as "strongly suggestive," "highly worrisome," or "very possible" is used, disregard the modifying phrase (i.e., "strongly," "highly," "very"), and refer to the primary term (i.e., "suggestive," "worrisome," "possible") to determine involvement.

Cannot be ruled out	Questionable
Equivocal	Rule-out
Possible	Suggests
Potentially malignant	Worrisome

3.6 RULES FOR DETERMINING MULTIPLE PRIMARIES AND HISTOLOGIES FOR SOLID TUMORS

The NYSCR follows SEER Solid Tumor Rules (STRs) for determining multiple primaries and histologies for all solid tumors, except lymphomas. The current structure was revised with cases diagnosed January 1, 2021. Specific rules are outlined for Head and Neck, Colon (incl. Rectosigmoid and Rectum), Lung, Cutaneous Melanoma, Breast, Kidney, Urinary Sites (i.e., Renal Pelvis, Ureter and Bladder), Non-malignant CNS, and Malignant CNS, peripheral Nerves and Other Sites. The STRs manual is available on the SEER website.

3.7 RULES FOR DETERMINING MULTIPLE PRIMARIES FOR HEMATOPOIETIC AND LYMPHOID NEOPLASMS

The NYSCR also follows SEER rules for determining multiple primaries for hematopoietic and lymphoid neoplasms. The current structure was implemented with cases diagnosed January 1, 2010. The rules set consists of both an online electronic database and manual, available via the SEER Hematopoietic Project website. While the manual can be downloaded in a .pdf format, the database is not available offline.

3.8 CASEFINDING LISTS FOR ICD-9-CM CODES

Use the following list as a guide for identifying cases that MAY be reportable to the NYSCR. Thoroughly review all available medical information to determine reportability.

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
042	AIDS (review cases for AIDS-related malignancies)
140.0 - 208.92	Malignant neoplasms
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
209.00 – 209.36	Malignant carcinoid/neuroendocrine tumors and Markel cell carcinoma
209.70-209.79	Secondary neuroendocrine tumors
210.0 - 229.9	Benign neoplasms
230.0 - 234.9	Carcinoma in situ
235.0 - 238.9	Neoplasms of uncertain behavior
237.73	Third Type-Schwannomatosis
237.79	Neurofibromatosis, other
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)
238.6	Extramedullary plasmacytoma (9734/3)
238.71	Essential thrombocythemia (9962/3)
238.72	Refractory cytopenia with multilineage dysplasia (9985/3)
238.71	Refractory anemia (9980/3)
238.72	Refractory anemia with ringed sideroblasts (9982/3)
238.73	High grade myelodysplastic syndrome lesions
238.72	Refractory anemia with excess blasts (9983/3)
238.72	Refractory anemia with excess blasts in transformation (9984/3)
238.74	Myelodysplastic syndrome with 5q- syndrome (9987/3)
238.75	Therapy-related myelodysplastic syndrome (9987/3)
238.76	Myelosclerosis with myeloid metaplasia (9961/3)

ICD-9-CM Codes	Diagnosis (in preferred ICD-O-3 terminology)
238.77	Post-transplant lymphoproliferative disorder (9987/3)
238.79	Chronic myeloproliferative disease (9960/3)
239.0 - 239.9	Neoplasms of unspecified behavior
259.2	Carcinoid Syndrome
273.2	Gamma heavy chain disease; Franklin disease
273.3	Waldenstrom macroglobulinemia
273.9	Unspecified disorder of immune mechanism (screen for potential 273.3 miscodes)
288.3	Hypereosinophilic syndrome (9964/3)
289.6	Familial Polycythemia (per SEER, synonym for Polycythemia vera (9950/3))
289.83	Acute myelofibrosis (9931/3)
748.1	Astrocytoma, astroglioma, astroblastoma of nose
789.51	Malignant Ascites
V07.39	Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
V10.0 - V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries and/or subsequent treatment)
V50.41	Prophylactic organ removal, breast
V50.42	Prophylactic organ removal, ovary
V50.49	Prophylactic organ removal, other
V58.0	Admission for radiotherapy
V58.11	Admission for chemotherapy
V58.12	Admission for immunotherapy for neoplastic condition
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow-up
V67.2	Chemotherapy follow-up
V71.1	Observation for suspected malignant neoplasm
V76.0 - V76.9	Special screening for malignant neoplasm

Refer to ICD-O-3 for inclusive listing of morphology terms.

3.9 CASEFINDING LIST FOR ICD-10-CM CODES

Use the following list as a guide for identifying cases that MAY be reportable to the NYSCR. Thoroughly review all available medical information to determine reportability.

ICD-10-CM Codes	Description
B20	Human immunodeficiency virus [HIV] disease with other diseases Note: Excludes HIV with malignancy (B21), see reportable list
B97.33, B97.34, B97.35	Human T-cell lymphotropic virus, (type I [HTLV-1], type II [HTLV-II], type 2 [HIV 2]) as the cause of diseases classified elsewhere
B97.7	Papillomavirus as the cause of diseases classified elsewhere
C00._- C43._, C4A._, C45._ - C48._, C49._ - C96._	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies *NEW for FY2018:* *C96.20 Malignant mast cell neoplasm, unspecified* *C96.21 Aggressive systemic mastocytosis* *C96.22 Mast cell sarcoma* *C96.29 Other malignant cell neoplasm*
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.01, C44.02	Basal/squamous cell carcinoma of skin of lip
C44.10_, C44.19_	Unspecified/other malignant neoplasm of skin of eyelid
C44.13_	Sebaceous cell carcinoma of skin of eyelid, including canthus Note: Effective 10/1/2018
C44.20_, C44.29_	Unspecified/other malignant neoplasm skin of ear and external auricular canal
C44.21_, C44.22_	Basal/squamous cell carcinoma of skin of ear and external auricular canal
C44.30_, C44.39_	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.31_, C44.32_	Basal/squamous cell carcinoma of skin of other and unspecified parts of face
C44.40, C44.49	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50_, C44.59_	Unspecified/other malignant neoplasm of skin of trunk
C44.60_, C44.69_	Unspecified/other malignant neoplasm of skin of upper limb, including shoulder
C44.70_, C44.79_	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin

ICD-10-CM Codes	Description
C49.A	Gastrointestinal Stromal Tumors Note: As of 1/1/2021 forward. Gastrointestinal Stromal Tumor, NOS (GIST, NOS) is considered malignant (/3), unless stated to be benign.
D00._ – D09._	In-situ neoplasms (*Note: Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable*).
D3A._	Benign carcinoid tumors
D10._ – D31._, D33._ D34, D35.0, D35.1, D35.5_ D35.9, D36._	Benign neoplasms (see “must collect” list for reportable benign neoplasms) Note: Screen for incorrectly coded malignancies or reportable by agreement tumors
D18.01	Lymphangioma, any site (*Note: Includes Lymphangiomas of Brain, Other parts of nervous system and endocrine glands, which are reportable*)
D18.02	Hemangioma of intracranial structures and any site
D32._	Benign neoplasm of meninges (cerebral, spinal, and unspecified)
D33._	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D37._ – D41._	Neoplasms of uncertain or unknown behavior (see “must collect” list for reportable neoplasms of uncertain or unknown behavior) Note: Screen for incorrectly coded malignancies or reportable by agreement tumors
D42._, D43._	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.0 – D44.2, D44.6 – D44.9	Neoplasm of uncertain or unknown behavior of other endocrine glands Note: Screen for incorrectly coded malignancies or reportable by agreement tumors
D44.3 – D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3) *ICD-10-CM Coding instruction note: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)*
D46._	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D47.0	Histiocytic and mast cell tumors of uncertain behavior
D47.02	Systemic mastocytosis
D47.01	Cutaneous mastocytosis (9740/1) Note: Effective 10/1/2017

ICD-10-CM Codes	Description
D47.09	Other mast cell neoplasms of uncertain behavior Note: Effective 10/1/2017
D47.1	Chronic myeloproliferative disease (9963/3)
D47.2	Monoclonal gammopathy Note: Screen for incorrectly coded Waldenstrom macroglobulinemia
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) *Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia*
D47.4	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis Myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.Z_	Neoplasm of uncertain behavior of lymphoid, hematopoietic, and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3)
D47.Z2	Castleman disease
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic, and related tissue, unspecified (9970/1, 9931/3)
D48._	Neoplasm of uncertain behavior of other and unspecified sites
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands, and other CNS
D49.0 – D49.9	Neoplasm of unspecified behavior (except for D49.6 and D49.7)
D61.1	Drug-induced aplastic anemia (also known as *"aplastic anemia due to antineoplastic chemotherapy"*) *ICD-10-CM Coding instruction note: Use additional code for adverse effect, if applicable, to identify drug*
D61.18_	Pancytopenia
D61.810	Antineoplastic chemotherapy induced pancytopenia
D61.82	Myelophthisis *ICD-10-CM Coding instruction: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)*
D63.0	Anemia in neoplastic disease *ICD-10-CM Coding instruction: Code first neoplasm (C00-C49)*
D64.81	Anemia due to antineoplastic chemotherapy
D69.49, D69.59, D69.6	Other thrombocytopenia Note: Screen for incorrectly coded thrombocythemia
D70.1	Agranulocytosis secondary to cancer chemotherapy *ICD-10-CM Coding instruction: Code also underlying neoplasm*

ICD-10-CM Codes	Description
D72.1	Eosinophilia (*Note: Code for eosinophilia (9964/3). Not every case of eosinophilia is a malignancy. Reportable Diagnosis is "Hypereosinophilic syndrome."*)
D72.110	Idiopathic hypereosinophilic syndrome [HES]
D72.111	Lymphocytic variant hypereosinophilic syndrome [LHES]
D72.118	Other hypereosinophilic syndrome
D72.119	Hypereosinophilic syndrome [HES], unspecified
D75.81	Myelofibrosis (note: this is not primary myelofibrosis [9961/3] *ICD-10-CM Coding instruction note: Code first the underlying disorder, such as: malignant neoplasm of breast (C50_)*
D76._	Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue
D89.0, D89.1	Other disorders involving the immune mechanism, not elsewhere classified *Note: Review for miscodes*
D89.4	Mast cell activation syndrome and related disorders Note: Review for miscodes
E08	Diabetes mellitus due to underlying condition *ICD-10-CM Coding instruction note: Code first the underlying condition, such as: malignant neoplasm (C00-C96)*
E31.2_	Multiple endocrine neoplasia [MEN] syndromes *ICD-10-CM Coding instruction: Code also any associated malignancies and other conditions associated with the syndromes*
E34.0	Carcinoid syndrome *ICD-10-CM Coding instruction: May be used as an additional code to identify functional activity associated with a carcinoid tumor*
E83.52	Hypercalcemia
E88.09	Other disorders of plasma-protein metabolism, not elsewhere classified
E88.3	Tumor lysis syndrome (following antineoplastic chemotherapy)
G13.0	Paraneoplastic neuromyopathy and neuropathy *ICD-10-CM Coding instruction note: Code first underlying neoplasm (C00-D49)*
G13.1	Other systemic atrophy primarily affecting central nervous system in neoplastic disease *ICD-10-CM Coding instruction note: Code first underlying neoplasm (C00-D49)*
G32.8	Other specified degenerative disorders of nervous system in diseases classified elsewhere *ICD-10-CM Coding instruction note: Code first underlying disease, such as: cerebral degeneration (due to) neoplasm (C00-D49)*

ICD-10-CM Codes	Description
G53	Cranial nerve disorders in diseases classified elsewhere Note: Code first underlying neoplasm (C00-D49)
G55	Nerve root and plexus compressions in diseases classified elsewhere *ICD-10-CM Coding instruction note: Code also underlying disease, such as neoplasm (C00-D49)*
G63	Polyneuropathy in diseases classified elsewhere *ICD-10-CM Coding instruction note: Code first underlying disease, such as: neoplasm (C00-D49)*
G73.1	Lambert-Eaton syndrome in neoplastic disease *ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)*
G89.3	Neoplasm related pain (acute)(chronic)
G99.2	Myelopathy in diseases classified elsewhere *ICD-10-CM Coding instruction: Code first underlying disease, such as: neoplasm (C00-D49)*
H47.42	Disorders of optic chiasm in (due to) neoplasm *ICD-10-CM Coding instruction: Code also underlying condition*
H47.52_	Disorders of visual pathways in (due to) neoplasm *ICD-10-CM Coding instruction: Code also underlying condition*
H47.63_	Disorders of visual cortex in (due to) neoplasm *ICD-10-CM Coding instruction: Code also underlying condition*
J34.81	Nasal mucositis (ulcerative)
J91.0	Malignant pleural effusion *ICD-10-CM Coding instruction: Code first underlying neoplasm*
J93.12	Secondary spontaneous pneumothorax *ICD-10-CM Coding instruction: Code first underlying condition, such as:* *Malignant neoplasm of bronchus and lung (C34_)* *Secondary malignant neoplasm of lung (C78.0_)*
K12.31	Oral mucositis (ulcerative) due to antineoplastic therapy
K12.33	Oral mucositis (ulcerative) due to radiation
K22.711	Barrett's esophagus with high grade dysplasia
K62.7	Radiation proctitis
K62.82	Dysplasia of anus (AIN I and AIN II)
K92.81	Gastrointestinal mucositis (ulcerated) (due to antineoplastic therapy)
M36.0	Dermato(poly)myositis in neoplastic disease *ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)*
M36.1	Arthropathy in neoplastic disease *ICD-10-CM Coding instruction: Code first underlying neoplasm, such as:* Leukemia (C91-C95), malignant histiocytosis (C96.A), multiple myeloma (C90.0)
M84.5_	Pathologic fracture in neoplastic disease *ICD-10-CM Coding instruction: Code also underlying neoplasm (C00-D49)*

ICD-10-CM Codes	Description
M90.6_	Osteitis deformans in neoplastic disease *ICD-10-CM Coding instruction: Code first the neoplasm (C40._, C41._)*
N42.3	Dysplasia of prostate (PIN I and PIN II)
N76.81	Mucositis (ulcerative) of vagina and vulva
N87._	Dysplasia of cervix uteri (CIN I and CIN II)
N89.0, N89.1, N89.3	Vaginal dysplasia (VIN I and VIN II)
N90.0, N90.1, N90.3	Vulvar dysplasia (VAIN I and VAIN II)
O01._	Hydatidiform mole Note: Benign tumor that can become malignant. If malignant, report as Choriocarcinoma (9100/3,) malignancy code in the C00- C97 range
O9A.1_	Malignant neoplasm complicating pregnancy, childbirth, and the puerperium (conditions in C00-C96) *ICD-10-CM Coding instruction: Use additional code to identify neoplasm*
Q85.0_	Neurofibromatosis (nonmalignant) (9540/1) *Note: Neurofibromatosis is not cancer. These tumors can be precursors to acoustic neuromas, which are reportable*
R18.0	Malignant ascites *ICD-10-CM Coding instruction: Code first malignancy, such as: Malignant neoplasm of ovary (C56_), secondary malignant neoplasm of retroperitoneum and peritoneum (C78.6)*
R53.0	Neoplastic (malignant) related fatigue *ICD-10-CM Coding instruction: Code first associated neoplasm*
R59._	Enlarged lymph nodes
R85.6_	Abnormal findings on cytological and histological examination of digestive organs *Note: see "must collect" list for R85.614*
R85.614	Cytologic evidence of malignancy on smear of anus
R87.61_, R87.62_	Abnormal findings on cytological/histological examination of female genital organs *Note: see "must collect" list for R87.614 and R87.624*
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina
R92._	Abnormal findings on diagnostic imaging of breast
R97._	Abnormal tumor markers
T38.6_	Poisoning by antigonadotropins, antiestrogens, antiandrogens, not elsewhere classified
T38.8_, T38.9_	Poisoning by hormones and their synthetic substitutes
T45.1_	Poisoning by adverse effect of and under dosing of antineoplastic and immunosuppressive drugs

ICD-10-CM Codes	Description
T45.8_, T45.9_	Poisoning by primary systemic and hematological agent, unspecified
T66	Unspecified effects of radiation
T80.1	Vascular complications following infusion, transfusion, and therapeutic injection
T80.2_	Infections following infusion, transfusion, and therapeutic injection
T80.810	Extravasation of vesicant antineoplastic chemotherapy
T80.818	Extravasation of other vesicant agent
T86.0	Complications of bone marrow transplant *ICD-10-CM Coding instruction: Use addition code to identify other transplant complications, such as: malignancy associated with organ transplant (C80.2) or post-transplant lymphoproliferative disorders (PTLD) (D47.Z1)*
Y63.2	Overdose of radiation given during therapy
Y84.2	Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm (medical surveillance following completed treatment) *ICD-10-CM Coding instruction: Use additional code to identify the personal history of malignant neoplasm (Z85._)*
Z12._	Encounter for screening for malignant neoplasms
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z15.0	Genetic susceptibility to malignant neoplasm *ICD-10-CM Coding instruction: Code first, if applicable, any current malignant neoplasm (C00-C75, C81-C96); Use additional code, if applicable, for any personal history of malignant neoplasm (Z85._)*
Z17.0, Z17.1	Estrogen receptor positive and negative status
Z40.0_	Encounter for prophylactic surgery for risk factors related to malignant neoplasms
Z42.1	Encounter for breast reconstruction following mastectomy
Z45.2	Encounter for Adjustment and Management of Vascular Access Device
Z48.3	Aftercare following surgery for neoplasm *ICD-10-CM Coding instruction: Use additional code to identify the neoplasm*
Z48.290	Encounter for aftercare following bone marrow transplant
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1_	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.5, Z51.89	Encounter for palliative care and other specified aftercare

ICD-10-CM Codes	Description
Z79.81	Long term (current) use of agents affecting estrogen receptors and estrogen levels *ICD-10-CM Coding instruction: Code first, if applicable, malignant neoplasm of breast (C50_), malignant neoplasm of prostate (C619)*
Z80._	Family history of primary malignant neoplasm
Z85._	Personal history of malignant neoplasm
Z86.0_, Z86.01_, Z86.03	Personal history of in situ and benign neoplasms and neoplasms of uncertain behavior
Z92.21, Z29.23, Z92.25. Z92.3	Personal history of antineoplastic chemotherapy, estrogen therapy, immunosuppression therapy or irradiation (radiation)
Z94.81, Z94.84	Bone marrow and stem cell transplant status

3.10 REPORTABLE TERMS LIST

The following list identifies MOST of the NYSCR's reportable terms. This list is not comprehensive. Refer to the footnotes at the bottom of each page for explanations of the various font types used in the list. The DEFINITIVE references are the 2024 Solid Tumor Rules, the Hematopoietic and Lymphoid Database and Manual and ICD-O, including the ICD-O-3.2 Updates through 2022. ***For newly reportable terms for 2023 and 2024, scroll to the end of this list, page 55.***

REPORTABLE LIST:

A

Acidophil adenocarcinoma
Acidophil adenoma
Acidophil-basophil carcinoma, mixed
Acidophil carcinoma
Acinar adenocarcinoma
Acinar adenocarcinoma, Sarcomatoid (C619)
Acinar carcinoma
Acinar cell carcinoma
Acinar cell cystadenocarcinoma
Acinic cell adenocarcinoma
Acoustic neuroma
Acquired cystic disease-associated renal cell carcinoma (C649)
Acral lentiginous melanoma, malignant
ACTH-producing tumor
Acute basophilic leukemia
Acute bilineal leukemia
Acute biphenotypic leukemia
Acute differentiated progressive histiocytosis
Acute erythremia [obs]
Acute erythremic myelosis [obs]
Acute erythroid leukemia
Acute granulocytic leukemia
Acute leukemia, NOS
Acute leukemia, Burkitt type [obs]
Acute lymphatic leukemia
Acute lymphoblastic leukemia, Burkitt type
Acute lymphoblastic leukemia, L2 type, NOS
Acute lymphoblastic leukemia, mature B-cell type
Acute lymphoblastic leukemia, NOS
Acute lymphoblastic leukemia, precursor-cell type
Acute lymphocytic leukemia
Acute lymphoblastic leukemia-lymphoma, NOS
Acute lymphoid leukemia
Acute megakaryoblastic leukemia
Acute mixed lineage leukemia
Acute monoblastic leukemia
Acute monocytic leukemia
Acute myeloblastic leukemia
Acute myeloblastic leukemia
Acute myelocytic leukemia
Acute myelocytic leukemia with maturation
Acute myelofibrosis
Acute myelogenous leukemia
Acute myeloid leukemia
Acute myeloid leukemia with abnormal marrow eosinophils (includes all variants)
Acute myeloid leukemia with BCR-ABL1
Acute myeloid leukemia with biallelic mutations of CEBPA
Acute myeloid leukemia with maturation
Acute myeloid leukemia with multilineage dysplasia
Acute myeloid leukemia with mutated NPM1
Acute myeloid leukemia with mutated RUNX1
Acute myeloid leukemia

Refer to ICD-O-3 for inclusive listing of morphology terms.

Asterisk (*): *Non-reportable if primary site is skin of non-mucoepidermoid anatomic site (ICD-O-3: C44_)
Bold: Indicates benign/borderline/uncertain tumors that are reportable if they occur intracranially or in the CNS
Underlined: Indicates a change in behavior OR a new ICD-O term, reportable with diagnoses made 1/1/2021 forward
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BOLD SMALL CAPS: Indicates a new term reportable with diagnoses made 1/1/2022 forward

(megakaryoblastic) with t(1;22)(p13;q13); RBM15-MKL1
Acute myeloid leukemia without maturation
Acute myeloid leukemia, 11q23 abnormalities
Acute myeloid leukemia, AML1 (CBF-alpha) / ETO
Acute myeloid leukemia, CBF-beta/MYH11
Acute myeloid leukemia, inv(16)(p13;q22)
Acute myeloid leukemia with inv(3)(q21q26.2) or t(3;3)(q21;q26.2); RPN1EVI1
Acute myeloid leukemia, M6 type
Acute myeloid leukemia, minimal differentiation
Acute myeloid leukemia, MLL
Acute myeloid leukemia, NOS (FAB or WHO type, not specified)
Acute myeloid leukemia, PML/RAR-alpha
Acute myeloid leukemia, t(15;17)(q22;q11-12)
Acute myeloid leukemia, t(16;16)(p13;q11)
Acute myeloid leukemia, t (8;21) (q22;q22)
Acute myeloid leukemia with BCR-ABL1
Acute myeloid leukemia with biallelic mutations of CEBPA
Acute myeloid leukemia with mutated NPM1
Acute myeloid leukemia with mutated RUNX1
Acute myeloid leukemia with prior myelodysplastic syndrome
Acute myeloid leukemia with t(6;9)(p23;q34) DEK-NUP214
Acute myeloid leukemia without prior myelodysplastic syndrome
Acute myelomonocytic leukemia
Acute myelomonocytic leukemia with abnormal eosinophils
Acute myelosclerosis
Acute non-lymphocytic leukemia
Acute panmyelosis
Acute panmyelosis with myelofibrosis (C421)
Acute progressive histiocytosis X
Acute promyelocytic leukemia
Acute promyelocytic leukemia, PML/RAR-alpha
Acute promyelocytic leukemia, t(15;17)(q22;q11-12)
Adamantinoma, NOS
Adamantinoma of long bones
Adenoacanthoma
Adenocarcinoid tumor
Adenocarcinoma and epidermoid carcinoma mixed
Adenocarcinoma and squamous cell carcinoma, mixed
Adenocarcinoma combined with other types of carcinoma
ADENOCARCINOMA, HPV-ASSOCIATED C530-C531, C538-C539)
Adenocarcinoma in a polyp, NOS
Adenocarcinoma in a polypoid adenoma
Adenocarcinoma in adenomatous polyp
Adenocarcinoma in adenomatous polyposis coli
Adenocarcinoma in multiple adenomatous polyps
ADENOCARCINOMA, HPV-INDEPENDENT, CLEAR CELL TYPE (C539)
ADENOCARCINOMA, HPV-INDEPENDENT, GASTRIC TYPE (C530-C531, C538-C539)
ADENOCARCINOMA, HPV-INDEPENDENT, MESONEPHRIC TYPE
ADENOCARCINOMA, HPV-INDEPENDENT, NOS C530-C531, C538-C539)
Adenocarcinoma in situ in a polyp, NOS
Adenocarcinoma in situ in adenomatous polyp
Adenocarcinoma in situ in polypoid adenoma
Adenocarcinoma in situ in tubular adenoma
Adenocarcinoma in situ in tubulovillous adenoma

Refer to ICD-O-3 for inclusive listing of morphology terms.

Asterisk (*): *Non-reportable if primary site is skin of non-mucoepidermoid anatomic site (ICD-O-3: C44_)
Bold: Indicates benign/borderline/uncertain tumors that are reportable if they occur intracranially or in the CNS
Underlined: Indicates a change in behavior OR a new ICD-O term, reportable with diagnoses made 1/1/2021 forward
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Adenocarcinoma in situ in villous adenoma
Adenocarcinoma in situ, NOS
Adenocarcinoma in tubular adenoma
Adenocarcinoma in tubulovillous adenoma
Adenocarcinoma in villous adenoma
Adenocarcinoma of anal ducts (C211)
Adenocarcinoma of anal glands (C211)
Adenocarcinoma of rete ovarii (C569)
Adenocarcinoma with apocrine metaplasia
Adenocarcinoma with cartilaginous and osseous metaplasia
Adenocarcinoma with cartilaginous metaplasia
Adenocarcinoma with mixed subtypes
Adenocarcinoma with neuroendocrine differentiation
Adenocarcinoma with osseous metaplasia
Adenocarcinoma with spindle cell metaplasia
Adenocarcinoma with squamous metaplasia
Adenocarcinoma, cylindroid
Adenocarcinoma, diffuse type
Adenocarcinoma, endocervical type
Adenocarcinoma, intestinal type
Adenocarcinoma, NOS
Adenocarcinoma, pancreatobiliary-type (C241)
Adenocystic carcinoma
Adenoid basal carcinoma (C53_)
Adenoid cystic carcinoma
Adenoid squamous cell carcinoma*
Adenoma, NOS
ADENOMATOUS POLYP, HIGH GRADE DYSPLASIA (C160 – C166, C168-C169, C170-C173, C178-C179)
Adenomyoepithelioma with carcinoma (C50_)
Adenosarcoma
Adenosquamous carcinoma
Adnexal carcinoma
Adnexal adenocarcinoma (C44_)
Adrenal cortical adenocarcinoma
Adrenal cortical carcinoma
Adrenal cortical tumor, malignant
Adrenal medullary paraganglioma, NOS (C741)
Adult T-cell leukemia
Adult T-cell leukemia/lymphoma
Adult T-cell leukemia/lymphoma (HTLV-1 positive) Includes all variants
Adult T-cell lymphoma
Adult T-cell lymphoma/leukemia
Aggressive digital papillary adenoma C44_)
Aggressive NK-cell leukemia
Agnogenic myeloid metaplasia
AIDS-associated Kaposi sarcoma
AIN II (C211)
AIN II-III (C211)
AIN III (C211)
Aleukemic granulocytic leukemia [obs]
Aleukemic leukemia, NOS [obs]
Aleukemic lymphatic leukemia [obs]
Aleukemic lymphocytic leukemia [obs]
Aleukemic lymphoid leukemia [obs]
Aleukemic monocytic leukemia [obs]
Aleukemic myelogenous leukemia [obs]
Aleukemic myeloid leukemia [obs]
ALK positive large B-cell lymphoma
Alpha cell tumor, malignant
Alpha heavy chain disease
Alveolar adenocarcinoma
Alveolar carcinoma
Alveolar cell carcinoma
Alveolar rhabdomyosarcoma
Alveolar soft part sarcoma
Amelanotic melanoma
Ameloblastic carcinoma
Ameloblastic fibrodentinosarcoma
Ameloblastic fibro-odontosarcoma
Ameloblastic odontosarcoma
Ameloblastic sarcoma
Ameloblastoma, fibrosarcoma
Ameloblastoma, malignant
AML M6
Anal intraepithelial neoplasia (AIN),

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grade II
Anal intraepithelial neoplasia (AIN), grade II-III
Anal intraepithelial neoplasia (AIN), grade III
Anaplastic astrocytoma, IDH-mutant (C71_)
Anaplastic astrocytoma, IDH-wildtype (C71_)
Anaplastic large B-cell lymphoma
Anaplastic large cell lymphoma ALK-negative
Anaplastic large cell lymphoma, CD30+
Anaplastic large cell lymphoma, NOS
Anaplastic large cell lymphoma, T cell and Null cell type
Anaplastic oligoastrocytoma (C71_)
Anaplastic oligodendroglioma, IDH-mutant and 1p/19q-codeleted (C71_)
Anaplastic pleomorphic xanthroastrocytoma (C71_)
Androblastoma, malignant
Angioblastic meningioma
Angioblastoma
Angiocentric glioma
Angiocentric immunoproliferative **lesion**
Angiocentric T-cell lymphoma [obs]
Angioendotheliomatosis
Angioimmunoblastic lymphoma
Angioimmunoblastic T-cell lymphoma
Angiolipoma, NOS
Angiomatous meningioma
Angiomyosarcoma
Angiosarcoma
Angiotropic lymphoma
Aortic body paraganglioma (C755)
Aortic body tumor (C755)
Aorticopulmonary paraganglioma (C755)
Apocrine adenocarcinoma
Argentaffinoma, malignant
Arrhenoblastoma, NOS
Askin tumor
Astroblastoma
Astrocytic glioma
Astrocytoma
Astrocytoma, anaplastic
Astrocytoma, low grade (C71_)
Astroglioma
Atypical carcinoid
Atypical carcinoid tumor
Atypical choroid plexus papilloma
Atypical chronic myeloid leukemia, BCR/ABL1 negative
Atypical chronic myeloid leukemia, Philadelphia chromosome (Ph1) negative
Atypical fibrous histiocytoma
Atypical fibroxanthoma
Atypical medullary carcinoma (C50_)
Atypical meningioma
Atypical proliferative mucinous **tumor**
Atypical proliferative papillary **serous tumor**
Atypical proliferating serous **tumor**
Atypical teratoid/rhabdoid tumor
Atypical teratoid/rhabdoid tumor (C71_)

B

B-ALL [obs]
Balloon cell melanoma
BALT Lymphoma
Basal cell adenocarcinoma
Basal cell carcinoma*
Basal cell carcinoma, fibroepithelial*
Basal cell carcinoma, morphoeic*
BASAL CELL CARCINOMA WITH ADNEXAL DIFFERENTIATION (C44_)
Basal cell epithelioma*
Basaloid carcinoma
Basaloid squamous cell carcinoma
Basal-squamous cell carcinoma, mixed*
Basophil adenocarcinoma
Basophil adenoma
Basophil carcinoma
Basophilic leukemia
Basosquamous carcinoma*
B-cell chronic lymphocytic leukemia/small lymphocytic

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lymphoma
B-cell lymphoma, NOS

B-lymphoblastic leukemia/lymphoma with t(12;21)(p13;q22; TEL-AML1 (ETV6-RUNX1)
B-lymphoblastic leukemia/lymphoma with t(9;22)(q34;q11.2); BCR-ABL1
B-lymphoblastic leukemia/lymphoma with t(v;11q23); MLL rearranged
B-lymphoblastic leukemia/lymphoma, NOS
B-lymphoblastic leukemia/lymphoma with hyperdiploidy
B-lymphoblastic leukemia/lymphoma with hypodiploidy (hypodiploid ALL)
B-lymphoblastic leukemia/lymphoma with t(1;19)(q23;p13.3); E2A PBX1 (TCF3 PBX1)
B-lymphoblastic leukemia/lymphoma with t(5;14)(q31;q32); IL3-IGH
B-lymphoblastic leukemia/lymphoma, not otherwise specified
B-lymphocytic leukemia/lymphoma, BCR-ABL1-like
BEDNAR TUMOR
Bellini duct carcinoma (C649)
Beta cell adenoma (C254)
Beta cell tumor, malignant
Bethesda category (classification) VI (C739)
Bile duct adenocarcinoma
Bile duct carcinoma
Bile duct cystadenocarcinoma
Biliary intraepithelial neoplasia III (8148/2)
Biliary intraepithelial neoplasia, high grade (8148/2)
Biphenotypic sinonasal sarcoma
Blast cell leukemia
Blastoma, NOS*
Blue nevus, malignant
Bosniak 4
Botryoid sarcoma
Brenner tumor, malignant
Breast implant-associated anaplastic large cell lymphoma (C50_)
Bronchial adenoma, carcinoid
Bronchial adenoma, cylindroid

Bronchial-associated lymphoid tissue lymphoma
Bronchiolar adenocarcinoma
Bronchiolar carcinoma
Bronchiolo-alveolar adenocarcinoma
Bronchiolo-alveolar carcinoma
Bronchiolo-alveolar carcinoma, Clara cell (C34_)
Bronchiolo-alveolar carcinoma, Clara cell and goblet cell type (C34_)
Bronchiolo-alveolar carcinoma, goblet cell type (C34_)
Bronchiolo-alveolar carcinoma, indeterminate type (C34_)
Bronchiolo-alveolar carcinoma, mixed mucinous and non-mucinous (C34_)
Bronchiolo-alveolar carcinoma, mucinous (C34_)
Bronchiolo-alveolar carcinoma, non-mucinous (C34_)
Bronchiolo-alveolar carcinoma, type II pneumocyte (C34_)
Bronchiolo-alveolar carcinoma, type II pneumocyte and goblet cell type (C34_)
Burkitt cell leukemia
Burkitt-like lymphoma
Burkitt lymphoma, NOS
Burkitt tumor

C

C cell carcinoma
C cell carcinoma (C739)
C-ALL
Cancer*
Capillary hemangioma
Carcinofibroma
Carcinoid, NOS (including appendix, effective with 2015 diagnoses)
Carcinoid tumor, argentaffin, malignant
Carcinoid tumor, NOS (including appendix, effective with 2015 diagnoses)

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Carcinoma in a polyp, NOS
Carcinoma in adenomatous polyp

Carcinoma in pleomorphic adenoma
Carcinoma in situ in a polyp, NOS
Carcinoma in situ in adenomatous polyp
Carcinoma in situ, NOS*
Carcinoma showing thymus-like differentiation
Carcinoma showing thymus-like element
Carcinoma simplex
Carcinoma with apocrine metaplasia
Carcinoma with chondroid differentiation (C50_)
Carcinoma with neuroendocrine Differentiation
Carcinoma with osseous differentiation (C50_)
Carcinoma with osteoclast-like giant Cells
Carcinoma with other types mesenchymal differentiation (C50_)
Carcinoma with productive fibrosis
Carcinoma, anaplastic*
Carcinoma, diffuse type
Carcinoma, intestinal type
Carcinoma, NOS*
Carcinoma, undifferentiated*
Carcinosarcoma, embryonal
Carcinosarcoma, NOS
Carotid body paraganglioma (C754)
Carotid body tumor (754)
CASTLE
Cavernous angioma
Cavernous hemangioma
CD30+ lymphoproliferative disorder
Cell adenocarcinoma, mixed
Cellular ependymoma (C71_)
Central neuroblastoma (C71_)
Central neurocytoma
Central osteosarcoma (C40_, C41_)
Central primitive neuroectodermal tumor, NOS (C71_)
Cerebellar liponeurocytoma
Cerebellar sarcoma, NOS
Ceruminous adenocarcinoma
Ceruminous carcinoma
Chemodectoma
Chloroma
Cholangiocarcinoma
Cholangiocarcinoma and hepatocellular carcinoma, combined
Chondroblastic osteosarcoma
Chondroblastoma, malignant
Chondroid chordoma
CHONDROSARCOMA GRADE I
Chondrosarcoma grade II/III (grade 2/3)
Chondrosarcoma, NOS
Chordoid glioma of third ventricle
Chordoma
Choriocarcinoma combined with embryonal carcinoma
Choriocarcinoma combined with other germ cell elements
Choriocarcinoma combined with teratoma
Choriocarcinoma, NOS
Chorioepithelioma
Choroid plexus carcinoma (C715)
Choroid plexus papilloma, anaplastic
Choroid plexus papilloma, malignant
Choroid plexus papilloma, NOS
Chromaffin paraganglioma (C741)
Chromophobe adenocarcinoma
Chromophobe adenoma
Chromophobe carcinoma
Chromophobe cell renal carcinoma (C649)
Chronic eosinophilic leukemia
Chronic erythremia [obs]
Chronic granulocytic leukemia
Chronic granulocytic leukemia, BCR/ABL
Chronic granulocytic leukemia, Philadelphia chromosome (Ph1) positive
Chronic granulocytic leukemia, T (9;22)(q34;q11)
Chronic idiopathic myelofibrosis
Chronic leukemia, NOS [obs]
Chronic lymphatic leukemia
Chronic lymphocytic leukemia

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Chronic lymphocytic leukemia, B-cell type (includes all variants of BCLL)
Chronic lymphoid leukemia
Chronic monocytic leukemia [obs]
Chronic myelocytic leukemia
Chronic myelomonocytic leukemia, NOS
Chronic myelogenous leukemia
Chronic myelogenous leukemia, BCR/ABL1positive
Chronic myelogenous leukemia, Philadelphia chromosome (Ph1) positive
Chronic myelogenous leukemia, t(9;22)(q34;q11)
Chronic myeloid leukemia
Chronic myelomonocytic leukemia
Chronic myelomonocytic leukemia in transformation [obs]
Chronic myelomonocytic leukemia, NOS
Chronic myelomonocytic leukemia, Type I
Chronic myelomonocytic leukemia, Type II
Chronic myeloproliferative disease, NOS
Chronic myeloproliferative disorder
Chronic neutrophilic leukemia
CIC-REARRANGED SARCOMA
Circumscribed arachnoidal cerebellar sarcoma
Classical Hodgkin lymphoma, lymphocyte depletion, diffuse fibrosis
Classical Hodgkin lymphoma, lymphocyte depletion, NOS
Classical Hodgkin lymphoma, lymphocyte depletion, reticular
Classical Hodgkin lymphoma, lymphocyte-rich
Classical Hodgkin lymphoma, mixed cellularity, NOS
Classical Hodgkin lymphoma, nodular sclerosis, cellular phase
Classical Hodgkin lymphoma, nodular sclerosis, grade 1
Classical Hodgkin lymphoma, nodular sclerosis, grade 2
Classical Hodgkin lymphoma, nodular sclerosis, NOS
Classic epithelioid sarcoma
Classic indolent Kaposi sarcoma
Clear cell adenocarcinofibroma (C569)
Clear cell adenocarcinoma, mesonephroid
Clear cell adenocarcinoma, NOS
Clear cell carcinoma
Clear cell chondrosarcoma (C40_, C41_)
Clear cell cystadenocarcinofibroma (C569)
Clear cell ependymoma (C71_)
Clear cell (glycogen-rich) urothelial carcinoma
Clear cell neuroendocrine tumor, non-functioning pancreatic
Clear cell sarcoma
Clear cell sarcoma of kidney
Clear cell sarcoma of tendons and aponeuroses
Cloacogenic carcinoma
CNS embryonal tumor with rhabdoid features (C71_)
Collecting duct carcinoma (C649)
Colloid adenocarcinoma
Colloid carcinoma
Combined carcinoid and adenocarcinoma
Combined hepatocellular carcinoma and Cholangiocarcinoma
Combined large cell neuroendocrine carcinoma
Combined small cell carcinoma
Combined small cell-adenocarcinoma
Combined small cell-squamous cell carcinoma
Comedocarcinoma, noninfiltrating
Comedocarcinoma, NOS
Common ALL
Common precursor B ALL
Composite carcinoid
Composite Hodgkin and non-Hodgkin lymphoma
Composite paraganglioma

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Composite pheochromocytoma (C741)
Condylomatous carcinoma
Congenital fibrosarcoma
Congenital spindle cell rhabdomyosarcoma with VGLL2/NCOA2/CITED2 rearrangements
Conventional central osteosarcoma (C40_, C41_)
Cortical T ALL
CPNET (C71_)
Craniopharyngioma
Cribriform carcinoma
Cribriform comedo-type carcinoma (C18_, C199, C209)
Cutaneous lymphoma
Cutaneous T-cell lymphoma, NOS (C44_)
Cylindrical cell carcinoma (C300, C31_)
Cylindroma, NOS (except of skin)
Cystadenocarcinoma, NOS
Cyst-associated renal cell carcinoma (C649)
Cystic astrocytoma
Cystic hypersecretory carcinoma (C50_)
Cystic neuroendocrine tumor, non-functioning pancreatic
Cystosarcoma phyllodes, malignant

D

DCIS, comedo type (C50_)
DCIS of high nuclear grade
DCIS of intermediate nuclear grade
DCIS of low nuclear grade
DCIS, NOS (C50_)
DCIS, papillary (C50_)
Dedifferentiated carcinoma
Dedifferentiated chondrosarcoma (C40_, C41_)
Dedifferentiated chordoma
Dedifferentiated liposarcoma
Dendritic cell sarcoma, NOS
DERMATOFIBROSARCOMA, NOS
DERMATOFIBROSARCOMA PROTUBERANS, NOS

Dermatofibrosarcoma protuberans with myoid differentiation
Dermoid cyst of Brain
Dermoid cyst with malignant transformation
Dermoid cyst with secondary tumor
Dermoid cyst, NOS
Desmoplastic infantile astrocytoma and ganglioglioma
Desmoplastic medulloblastoma
Desmoplastic melanoma, amelanotic (C44_)
Desmoplastic melanoma, malignant
Desmoplastic mesothelioma
Desmoplastic nodular medulloblastoma (C716)
Desmoplastic small round cell tumor
Di Guglielmo disease [obs]
Differentiated intraepithelial neoplasia
Differentiated penile intraepithelial neoplasia (PeIN) (C60_)
Differentiated vulvar intraepithelial neoplasia (VIN) (C51_)
Diffuse astrocytoma (C71_)
Diffuse astrocytoma, IDH-mutant (C71_)
Diffuse astrocytoma, IDH-wildtype (C71_)
Diffuse astrocytoma, low grade (C71_)
Diffuse leptomeningeal glioneuronal tumor (C71_)
Diffuse midline glioma, H3 K27M-mutant (C71_)
Diffuse meningiomatosis
Digital papillary adenocarcinoma (C44_)
Diktyoma
Diktyoma, malignant (C69_)
DIN III (ductal intraepithelial neoplasia III) (C50_)
Duct adenocarcinoma
Duct carcinoma
Duct carcinoma, desmoplastic type
Duct cell carcinoma
Ductal carcinoma

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Ductal carcinoma in situ, comedo type (C50_)

Ductal carcinoma in situ, cribriform type (C50_)
Ductal carcinoma in situ, micropapillary (C50_)
Ductal carcinoma in situ, NOS (C50_)
Ductal carcinoma in situ, papillary (C50_)
Ductal carcinoma in situ, solid type (C50_)
Ductal carcinoma, cribriform type (C50_)
Ductal intraepithelial neoplasia III (DIN III) (C50_)
Dysembryoplastic neuroepithelial tumor
Dysgerminoma
Dysplastic gangliocytoma of cerebellum (D=Lhemitte-Duclos)

E

Early/Evolving invasive melanoma (C44_)
Early/Evolving melanoma in situ (C44_)
EC-cell carcinoid
Eccrine adenocarcinoma (C44_)
Eccrine papillary adenocarcinoma (C44_)
Eccrine poroma, malignant
ECL cell carcinoid, malignant
Ectomesenchymoma
Embryoma
Embryonal adenocarcinoma
Embryonal carcinoma
Embryonal carcinoma and teratoma, mixed
Embryonal carcinoma, infantile
Embryonal carcinoma, polyembryonal type
Embryonal hepatoma
Embryonal rhabdomyosarcoma
Embryonal rhabdomyosarcoma, pleomorphic
Embryonal sarcoma
Embryonal teratoma
Embryonal tumor with multi-layered rosettes C19MC-altered (C71_)
Embryonal tumor with multi-layered rosettes, NOS (C71_)
Embryonal tumor with rhabdoid features (C710)
Encapsulated folicular variant of papillary thyroid carcinoma, NOS (EFVPTC, NOS) (C739)
Encapsulated papillary carcinoma (C50_)
Encapsulated papillary carcinoma with invasion (C50_)
Endocervical adenocarcinoma usual type (C53_)
Endocrine tumor, functioning, NOS
Endodermal sinus tumor
Endolymphatic stromal myosis
Endolymphatic stromal myosis (C541)
Endometrial sarcoma, NOS
Endometrial stromal sarcoma
Endometrial stromal sarcoma, high grade (C541)
Endometrial stromal sarcoma, low grade (C541)
Endometrial stromatosis (C541)
Endometrioid adenocarcinoma
Endometrioid adenocarcinoma, ciliated cell variant
Endometrioid adenocarcinoma, secretory variant (C569)
Endometrioid adenocarcinoma, villoglandular
Endometrioid adenofibroma, malignant
Endometrioid carcinoma
Endometrioid carcinoma with squamous differentiation
Endometrioid cystadenocarcinoma
Endometrioid cystadenofibroma, Malignant
Endometrioid intraepithelial neoplasia (C541)
Endotheliomatous meningioma
Enteric adenocarcinoma
Enterochromaffin cell carcinoid
Enterochromaffin-like cell tumor,

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malignant
Enteroglucagonoma, malignant

Enteropathy associated T-cell lymphoma
Enteropathy type intestinal T-cell lymphoma
Eosinophil adenocarcinoma
Eosinophil carcinoma
Eosinophilic leukemia
Ependymoblastoma
Ependymoma, anaplastic
Ependymoma, NOS
Ependymoma, RELA fusion-positive
Epidermoid carcinoma in situ with questionable stromal invasion*
Epidermoid carcinoma in situ, NOS*
Epidermoid carcinoma, keratinizing*
Epidermoid carcinoma, large cell, nonkeratinizing*
Epidermoid carcinoma, NOS*
Epidermoid carcinoma, small cell nonkeratinizing*
Epidermoid carcinoma, spindle cell*
Epithelial ependymoma
Epithelial tumor, malignant*
Epithelial-myoepithelial carcinoma
Epithelioid and spindle cell melanoma, mixed
Epithelioid cell melanoma
Epithelioid cell sarcoma
Epithelioid glioblastoma
Epithelioid hemangioendothelioma, malignant
Epithelioid hemangioendothelioma, NOS
Epithelioid leiomyosarcoma
Epithelioid malignant peripheral nerve sheath tumor
Epithelioid mesothelioma, NOS
Epithelioid MPNST
Epithelioid sarcoma
Epithelioid trophoblastic tumor
Epithelioma, malignant*
Epithelioma, NOS*
Erdhiem-Chester Disease
Erythremic myelosis, NOS
Erythroleukemia

Essential hemorrhagic thrombocythemia
Essential thrombocythemia
Essential thrombocytosis
Esthesioneuroblastoma
Esthesioneurocytoma
Esthesioneuroepithelioma
Ewing sarcoma
Ewing tumor
Extra-adrenal paraganglioma, NOS
Extramedullary plasmacytoma
Extraventricular neurocytoma

F

FAB L1
FAB L2
FAB L3 [obs]
FAB M0
FAB M1
FAB M2, AML1(CBF-alpha)/ETO
FAB M2, NOS
FAB M2, t(8;21)(q22;q22)
FAB M3 (includes all variants)
FAB M4
FAB M4Eo
FAB M5 (includes all variants)
FAB M6
FAB M7
Fascial fibrosarcoma
Fetal adenocarcinoma
Fibrillary astrocytoma
Fibroblastic liposarcoma
Fibroblastic meningioma
Fibroblastic osteosarcoma
Fibroblastic reticular cell tumor
Fibrochondrosarcoma
Fibroepithelial basal cell carcinoma, Pinkus type*
Fibroepithelioma of Pinkus type*
Fibroepithelioma, NOS*
Fibroliposarcoma
Fibroma, NOS
Fibromatosis-like metaplastic carcinoma

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(C50_)
Fibromyxosarcoma

Fibrosarcoma, NOS
Fibrosarcomatous dermatofibrosarcoma protuberans
Fibrous astrocytoma
Fibrous histiocytoma, malignant
Fibrous histiocytoma, NOS
Fibrous meningioma
Fibrous mesothelioma, malignant
Fibrous mesothelioma, NOS
Fibroxanthoma, malignant
Fibroxanthoma, NOS
Follicular adenocarcinoma, moderately differentiated
Follicular adenocarcinoma, NOS
Follicular adenocarcinoma, trabecular
Follicular adenocarcinoma, well differentiated
Follicular adenoma
FOLLICULAR CARCINOMA, ENCAPSULATED (C739)
Follicular carcinoma, minimally invasive (C739)
Follicular carcinoma, moderately differentiated
Follicular carcinoma, NOS
Follicular carcinoma, oxyphilic cell (C739)
Follicular carcinoma, trabecular
Follicular carcinoma, well differentiated
Follicular dendritic cell sarcoma
Follicular dendritic cell tumor
Follicular lymphoma, grade 1
Follicular lymphoma, grade 2
Follicular lymphoma, grade 3
Follicular lymphoma, NOS
Follicular thyroid carcinoma (FTC), encapsulated angioinvasive (C739)
FOLLICULAR TUMOR OF UNCERTAIN MALIGNANT POTENTIAL (C730)
Franklin disease

G

G cell tumor, malignant
Gamma heavy chain disease
Gangliocytoma
Ganglioglioma
Ganglioglioma, anaplastic
Ganglioneuroblastoma
Ganglioneuroma
GANT
Gastrin cell tumor, malignant
Gastrinoma
Gastrinoma, malignant
GASTROBLASTOMA (C160 – C169)
Gastrointestinal autonomic nerve tumor
Gastrointestinal pacemaker cell tumor
Gastrointestinal stromal sarcoma
Gastrointestinal stromal tumor, NOS
Gelatinous adenocarcinoma
Gelatinous carcinoma
Gemistocytic astrocytoma
Gemistocytoma
Generalized Langerhans cell histiocytosis
Germ cell tumor
Germ cell tumor, mixed
Germ cell tumor, nonseminomatous (C62_)
Germ cell tumors with associated hematological malignancy (C379)
Germinoma
Ghost cell odontogenic carcinoma
Giant cell and spindle cell carcinoma*
Giant cell carcinoma*
Giant cell glioblastoma
Giant cell sarcoma (except of Bone)
Giant cell sarcoma of bone
Giant cell tumor of bone, malignant
Giant cell tumor of tendon sheath, malignant (C49_)
GIST, NOS
Glassy cell carcinoma
Glioblastoma, IDH-mutant
Glioblastoma, IDH wildtype
Glioblastoma multiforme
Glioblastoma with sarcomatous

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component
Glioblastoma, NOS
Glioma, malignant
Glioma, mixed
Glioma, NOS (except Nasal glioma, not neoplastic)
Gliomatosis cerebri
Glioneuroma
Gliosarcoma
Glomangiosarcoma
Glomoid sarcoma
Glomus jugulare tumor, NOS (C755)
Glomus tumor, malignant
Glucogonoma
Glucogonoma, malignant
Glycogen-rich carcinoma
Goblet cell adenocarcinoma
Goblet cell carcinoid
Granular cell carcinoma
Granular cell myoblastoma, malignant
Granular cell tumor, malignant
Granular cell tumor, NOS
Granulocytic leukemia, NOS
Granulocytic sarcoma
Granulosa cell carcinoma
Granulosa cell tumor, adult type (C569)
Granulosa cell tumor, malignant
Granulosa cell tumor, sarcomatoid (C569)
Grawitz tumor

H

Hairy cell leukemia
Hairy cell leukemia variant
Heavy chain disease
Heavy chain disease, NOS
Hemangioblastic meningioma
Hemangioblastoma
Hemangioendothelial sarcoma
Hemangioendothelioma, benign
Hemangioendothelioma, malignant
Hemangioma, NOS
Hemangiopericytic meningioma
Hemangiopericytoma, benign
Hemangiopericytoma, malignant
Hemangiopericytoma, NOS
Hemangiosarcoma
Hepatoblastoma
Hepatocarcinoma
Hepatocellular and bile duct carcinoma, mixed
Hepatocellular carcinoma
Hepatocellular carcinoma, clear cell type (C220)
Hepatocellular carcinoma, fibrolamellar
Hepatocellular carcinoma, pleomorphic type (C220)
Hepatocellular carcinoma, sarcomatoid (C220)
Hepatocellular carcinoma, scirrhous (C220)
Hepatocellular carcinoma, spindle cell variant (C220)
Hepatocholangiocarcinoma
Hepatoid adenocarcinoma
Hepatoid carcinoma
Hepatoid yolk sac tumor
Hepatoma, malignant
Hepatoma, NOS
Hepatosplenic gamma-delta cell lymphoma
Hereditary leiomyomatosis & RCC-associated renal cell carcinoma (C649)
HGSIL of the anus and other mucoepidermoid sites II
HGSIL of the anus and other mucoepidermoid sites II-III
HGSIL of the anus and other mucoepidermoid sites III
Hidradenocarcinoma (C44_)
HIGH GRADE APPENDICEAL MUCINOUS NEOPLASM (HAMN) (C181)
High grade intraurothelial neoplasia
High grade neuroendocrine carcinoma
High grade serous carcinoma
High grade squamous intraepithelial lesion (HSIL) (II, II-III, III)
High grade surface osteosarcoma (C40_, C41_)
Histiocyte-rich large B-cell lymphoma

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Histiocytic medullary reticulosis [obs]
Histiocytic sarcoma

Hodgkin disease, lymphocyte predominance, diffuse [obs]
Hodgkin disease, lymphocyte predominance, NOS [obs]
Hodgkin disease, lymphocytic depletion, diffuse fibrosis
Hodgkin disease, lymphocytic depletion, NOS
Hodgkin disease, lymphocytic depletion, reticular
Hodgkin disease, lymphocytic-histiocytic predominance [obs]
Hodgkin disease, lymphocytic predominance, diffuse
Hodgkin disease, lymphocytic predominance, nodular
Hodgkin disease, lymphocytic predominance, NOS
Hodgkin disease, mixed cellularity, NOS
Hodgkin disease, nodular sclerosis, cellular phase
Hodgkin disease, nodular sclerosis, lymphocytic depletion
Hodgkin disease, nodular sclerosis, lymphocytic predominance
Hodgkin disease, nodular sclerosis, mixed cellularity
Hodgkin disease, nodular sclerosis, NOS
Hodgkin disease, nodular sclerosis, syncytial variant
Hodgkin disease, NOS
Hodgkin granuloma
Hodgkin lymphoma, mixed cellularity, NOS
Hodgkin lymphoma, lymphocyte depletion, NOS
Hodgkin lymphoma, lymphocytic depletion, diffuse fibrosis
Hodgkin lymphoma, lymphocyte depletion, reticular
Hodgkin lymphoma, lymphocyte-rich
Hodgkin lymphoma, nodular lymphocyte predominance
Hodgkin lymphoma, nodular sclerosis, cellular phase
Hodgkin lymphoma, nodular sclerosis, grade 1
Hodgkin lymphoma, nodular sclerosis, grade 2
Hodgkin lymphoma, nodular sclerosis, NOS
Hodgkin paragranuloma, nodular [obs]
Hodgkin paragranuloma, nodular
Hodgkin paragranuloma, NOS [obs]
Hodgkin sarcoma
Hurthle adenocarcinoma
Hurthle cell adenoma
Hurthle cell carcinoma
Hurthle cell tumor
Hutchinson melanotic freckle, NOS
HYDROA VACCINIFORME-LIKE LYMPHOPROLIFERATIVE DISORDER
Hypereosinophilic (idiopathic) syndrome
Hypernephroma

I

Idiopathic hemorrhagic thrombocythemia
Idiopathic thrombocythemia
Immature teratoma
IMMATURE TERATOMA OF THE LUNG (C34_)
IMMATURE TERATOMA OF THYMUS (C379)
IMMATURE TERATOMA OF THYROID (C739)
Immature teratoma, malignant
Immunoblastic sarcoma
Immunocytoma
Immunoproliferative disease, NOS
Immunoproliferative small intestinal disease
Infantile fibrosarcoma
Infiltrating and papillary adenocarcinoma
Infiltrating basal cell carcinoma, non-sclerosing (C44_)
Infiltrating basal cell carcinoma, NOS (C44_)
Infiltrating basal cell carcinoma, sclerosing (C44_)
Infiltrating duct adenocarcinoma

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Infiltrating duct and colloid carcinoma (C50_)

Infiltrating duct and cribriform carcinoma (C50_)
Infiltrating duct and lobular carcinoma
Infiltrating duct and lobular carcinoma in situ
Infiltrating duct and mucinous carcinoma (C50_)
Infiltrating duct and tubular carcinoma (C50_)
Infiltrating duct carcinoma
Infiltrating duct mixed with other types of carcinoma (C50_)
Infiltrating ductular carcinoma
Infiltrating lobular carcinoma
Infiltrating lobular carcinoma and ductal carcinoma in situ (C50_)
Infiltrating lobular mixed with other types of carcinoma (C50_)
Infiltrating papillary adenocarcinoma
Inflammatory adenocarcinoma
Inflammatory carcinoma
Inflammatory liposarcoma
Insular carcinoma (C739)
Insulinoma
Insulinoma, malignant
Interdigitating cell sarcoma
Interdigitating dendritic cell sarcoma
Interstitial cell tumor, malignant
Intestinal-type adenocarcinoma
INTESTINAL-TYPE ADENOMA, HIGH GRADE (C160-C166, C168-C169, C170-C173, C178, C179)
Intestinal T-cell lymphoma
Intimal sarcoma
Intracortical osteosarcoma (C40_, C41_)
Intracystic carcinoma, NOS
Intracystic papillary adenocarcinoma
Intracystic papillary neoplasm with associated invasive carcinoma
Intraductal adenocarcinoma, noninfiltrating, NOS
Intraductal and lobular carcinoma
Intraductal carcinoma and lobular carcinoma in situ
Intraductal carcinoma, clinging (C50_)
Intraductal carcinoma, noninfiltrating, NOS
Intraductal carcinoma, NOS
Intraductal carcinoma, solid type
Intraductal micropapillary carcinoma (C50_)
Intraductal oncocytic papillary neoplasm, NOS (C250-C254, C257-C259)
Intraductal oncocytic papillary neoplasm with associated invasive carcinoma (C250-C254, C257-C259)
Intraductal papillary adenocarcinoma with invasion
Intraductal papillary adenocarcinoma, NOS
Intraductal papillary carcinoma, NOS
Intraductal papillary mucinous carcinoma, invasive (C25_)
Intraductal papillary mucinous carcinoma, non-invasive (C25_)
Intraductal papillary mucinous neoplasm (IPMN) with an associated invasive carcinoma (C25_)
Intraductal papillary mucinous neoplasm with high-grade displasia (C25_)
Intraductal papilloma with ductal carcinoma in situ (C50_)
Intraductal papilloma with lobular carcinoma in situ (C50_)
Intraductal tubulopapillary neoplasm (C25_)
Intraepidermal carcinoma, NOS*
Intraepithelial carcinoma, NOS*
Intraepithelial squamous cell carcinoma*
Intraosseous carcinoma
Intraosseous low-grade osteosarcoma (C40_, C41_)
Intraosseous well differentiated osteosarcoma (C40_, C41_)
Intrapulmonary thymoma (C34_)
Intratubular germ cell neoplasia (C62_)
Intratubular malignant germ cells (C62_)

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Intravascular B-cell lymphoma
Intravascular bronchial alveolar tumor (C34_) [obs]
Intravascular large B-cell lymphoma (C499)
Invasive carcinoma of no special type (C50_)
Invasive carcinoma, NST (C50_)
Invasive encapsulated follicular variant of papillary thyroid carcinoma (invasive EFVPTC) (C739)
Invasive lobular carcinoma (C50_)
Invasive lobular carcinoma, alveolar type (C50_)
Invasive lobular carcinoma, solid type (C50_)
Invasive lobular carcinoma, tubulolobular variant (C50_)
Invasive mammary carcinoma (C50_)
Invasive micropapillary carcinoma (C50_)
Invasive mucinous adenocarcinoma (C34_)
Islet cell adenocarcinoma (C254)
Islet cell adenoma (C254)
Islet cell adenomatosis (C254)

Islet cell and exocrine adenocarcinoma, mixed
Islet cell carcinoma (254)
Islet cell tumor, NOS (C254)

J

Jugular paraganglioma C755)
Jugulotympanic paraganglioma (C755)
Juvenile astrocytoma (C71_)
Juvenile carcinoma of breast
Juvenile chronic myelomonocytic leukemia
Juvenile myelomonocytic leukemia
Juxtacortical chondrosarcoma
Juxtacortical osteosarcoma (C40_, C41_)

K

Kaposi sarcoma
Keratoacanthoma
Klatskin tumor
Krukenberg tumor
Kupffer cell sarcoma

L

Langerhans cell histiocytosis, disseminated
Langerhans cell histiocytosis, generalized
LANGERHANS CELL HISTIOCYTOSIS, MONOSTOTIC
LANGERHANS CELL HISTIOCYTOSIS, NOS
LANGERHANS CELL HISTIOCYTOSIS, POLYSTOTIC
Langerhans cell sarcoma
Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease
Large cell (Ki-1+) lymphoma
Large cell carcinoma with rhabdoid phenotype
Large cell carcinoma, NOS*
Large cell medulloblastoma (C716)
Large cell neuroendocrine carcinoma
Laryngeal paraganglioma
LCIS, NOS (C50_)
Leather bottle stomach (Linitis plastica, the gross description of gastric cancer known also as leather bottle stomach has a characteristic radiographic appearance)
Leiomyosarcoma, NOS
Lennert lymphoma
Lentigo maligna melanoma
Lepidic adenocarcinoma (C34_)
Lepidic predominant adenocarcinoma (C34_)
Lipid-rich urothelial carcinoma
Leptomeningeal sarcoma
Letterer-Siwe disease
Leukemia, NOS
Leukemic reticuloendotheliosis
Leydig cell tumor, malignant
Linitis plastica
Lipid-rich carcinoma
Lipid-rich urothelial carcinoma
Lipoma

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Lipoma-like liposarcoma
Liposarcoma, differentiated
Liposarcoma, mixed
Liposarcoma, NOS
Liposarcoma, well differentiated
LI-RADS 4
LI-RADS 5 (C220)
LI-RADS 5V (C220)
Liver cell carcinoma
Lobular adenocarcinoma
Lobular and ductal carcinoma
Lobular carcinoma in situ
Lobular carcinoma, NOS
Low grade adenosquamous carcinoma (C50_)
LOW GRADE APPENDICEAL MUCINOUS NEOPLASM (LAMN) (C181)
Low grade cribriform cystadenocarcinoma (LGCCC)
Low grade central osteosarcoma
Low grade fibromyxoid sarcoma
Low grade intramedullary osteosarcoma
Low grade myofibroblastic sarcoma
Low grade serous carcinoma
Lymphangioendothelial sarcoma
Lymphangioendothelioma, malignant
Lymphangiosarcoma
Lymphoblastic leukemia, NOS
Lymphoblastoma [obs]
Lymphocytic leukemia, NOS
Lymphoepithelial carcinoma*
Lymphoepithelioid lymphoma
Lymphoepithelioma*
Lymphoepithelioma-like carcinoma
Lymphoid leukemia, NOS
Lymphoma, NOS
Lymphomatoid granulomatosis, grade 3
Lymphomatoid papulosis (C44_)
Lymphoproliferative disease, NOS
Lymphosarcoma cell leukemia [obs]
Lymphosarcoma, diffuse [obs]
Lymphosarcoma, NOS [obs]

M

M6A
M6B
Macroglobulinemia, Waldenstrom
Malignancy*
Malignant chondroid syringoma (C44_)
Malignant cystic nephroma (C649)
Malignant eccrine spiradenoma (C44_)
Malignant fibrous histiocytoma (MFH) of bone
Malignant giant cell tumor of soft parts
Malignant histiocytosis
Malignant lymphoma, centroblastic, diffuse
Malignant lymphoma, centroblastic, follicular
Malignant lymphoma, centroblastic, NOS
Malignant lymphoma, centroblastic-centrocytic, diffuse [obs]
Malignant lymphoma, centroblastic-centrocytic, follicular
Malignant lymphoma, centrocytic [obs]
Malignant lymphoma, cleaved cell, NOS [obs]
Malignant lymphoma, convoluted cell [obs]
Malignant lymphoma, diffuse, NOS
Malignant lymphoma, follicle center, Follicular
Malignant lymphoma, follicle center, NOS
Malignant lymphoma, follicular, NOS
Malignant lymphoma, histiocytic, diffuse
Malignant lymphoma, histiocytic, nodular
Malignant lymphoma, histiocytic, NOS
Malignant lymphoma, Hodgkin
Malignant lymphoma, immunoblastic, NOS
Malignant lymphoma, large B-cell, diffuse, NOS
Malignant lymphoma, large B-cell, diffuse, centroblastic, NOS
Malignant lymphoma, large B-cell, diffuse, immunoblastic, NOS
Malignant lymphoma, large cell, cleaved and noncleaved

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Malignant lymphoma, large cell, cleaved, diffuse

Malignant lymphoma, large cell, cleaved, NOS
Malignant lymphoma, large cell, diffuse, NOS
Malignant lymphoma, large cell, follicular, NOS
Malignant lymphoma, large cell, immunoblastic
Malignant lymphoma, large cell, noncleaved, diffuse
Malignant lymphoma, large cell, noncleaved, follicular
Malignant lymphoma, large cell, noncleaved, NOS
Malignant lymphoma, large cell, NOS
Malignant lymphoma, large cleaved cell, Follicular
Malignant lymphoma, large cleaved cell, NOS
Malignant lymphoma, lymphoblastic
Malignant lymphoma, lymphocytic, diffuse, NOS
Malignant lymphoma, lymphocytic, intermediate differentiation, diffuse
Malignant lymphoma, lymphocytic, intermediate differentiation, nodular [obs]
Malignant lymphoma, lymphocytic, nodular, NOS
Malignant lymphoma, lymphocytic, NOS
Malignant lymphoma, lymphocytic, poorly differentiated, diffuse [obs]
Malignant lymphoma, lymphocytic, poorly differentiated, nodular [obs]
Malignant lymphoma, lymphocytic, well differentiated, diffuse
Malignant lymphoma, lymphocytic, well differentiated, nodular [obs]
Malignant lymphoma, lymphoplasmacytic
Malignant lymphoma, lymphoplasmacytoid
Malignant lymphoma, mixed cell type, follicular
Malignant lymphoma, mixed cell type, nodular
Malignant lymphoma, mixed lymphocytic-histiocytic nodular
Malignant lymphoma, mixed small cleaved and large cell, follicular
Malignant lymphoma, nodular, NOS
Malignant lymphoma, noncleaved, diffuse, NOS
Malignant lymphoma, noncleaved, follicular, NOS
Malignant lymphoma, noncleaved, NOS
Malignant lymphoma, non-Hodgkin, NOS
Malignant lymphoma, NOS
Malignant lymphoma, plasmacytoid
Malignant lymphoma, small B lymphocytic, NOS
Malignant lymphoma, small cell diffuse
Malignant lymphoma, small cell noncleaved, diffuse
Malignant lymphoma, small cell, diffuse, NOS
Malignant lymphoma, small cell, noncleaved, diffuse [obs]
Malignant lymphoma, small cell, NOS
Malignant lymphoma, small cleaved cell, diffuse
Malignant lymphoma, small cleaved cell, diffuse [obs]
Malignant lymphoma, small cleaved cell, follicular
Malignant lymphoma, small cleaved cell, NOS
Malignant lymphoma, small cleaved cell, NOS [obs]
Malignant lymphoma, small lymphocytic, diffuse
Malignant lymphoma, small lymphocytic, NOS
Malignant lymphoma, small noncleaved, Burkitt, diffuse
Malignant lymphoma, undifferentiated cell type,
Malignant lymphoma, undifferentiated

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cell type, NOS [obs]
Malignant lymphoma, undifferentiated, Burkitt type
Malignant lymphoma, undifferentiated cell, non-Burkitt [obs]
Malignant lymphomatous polyposis [obs]
Malignant mast cell tumor
Malignant mastocytoma
Malignant mastocytosis
Malignant melanoma in congenital melanocytic nevus (C44_)
Malignant melanoma in giant pigmented nevus
Malignant melanoma in junctional nevus
Malignant melanoma in precancerous melanosis
Malignant melanoma, NOS
Malignant melanoma, regressing
Malignant midline reticulosis [obs]
Malignant mucinous adenofibroma (C569)
Malignant mucinous cystadenofibroma (C569)
Malignant multilocular cystic nephroma (C649)
Malignant myelosclerosis [obs]
Malignant myoepithelioma
Malignant peripheral nerve sheath tumor
Malignant peripheral nerve sheath tumor with rhabdomyoblastic differentiation
Malignant perivascular epithelial cell tumor
Malignant reticulosis, NOS [obs]
Malignant rhabdoid tumor
Malignant Schwannoma with rhabdomyoblastic differentiation
Malignant serous adenofibroma (C569)
Malignant serous cystadenofibroma (C569)
Malignant tenosynovial giant cell tumor (C49_)
Malignant teratoma, anaplastic
Malignant teratoma, intermediate
Malignant teratoma, trophoblastic
Malignant teratoma, undifferentiated
Malignant tumor, clear cell type
Malignant tumor, fusiform cell type*
Malignant tumor, giant cell type*
Malignant tumor, small cell type*
Malignant tumor, spindle cell type*
MALT lymphoma
Mammary carcinoma, in situ (C50_)
Mantle cell lymphoma
Mantle zone lymphoma
Marginal zone B-cell lymphoma, NOS
Marginal zone lymphoma, NOS
Mast cell leukemia (C421)
Mast cell sarcoma
Mast cell tumor, NOS
Mastocytoma, malignant
Matrical carcinoma (C44_)*
Mature T ALL
Mature T-cell lymphoma, NOS
Mature teratoma of testis in adult
Mediastinal large B-cell lymphoma (C383)
Mediterranean lymphoma
Medullary adenocarcinoma
Medullary carcinoma with amyloid stroma (C739)
Medullary carcinoma with lymphoid stroma
Medullary carcinoma, NOS
Medullary osteosarcoma (C40_, C41_)
Medullary thyroid carcinoma (C739)
Medulloblastoma
Medulloblastoma, classic
Medulloblastoma, group 3 (C71_)
Medulloblastoma, group 4 (C71_)
Medulloblastoma, non-WNT/non-SHH (C71_)
Medulloblastoma, SHH-activated and TP53-mutant (C71_)
Medulloblastoma, SHH-activated and TP53-wildtype (C71_)
Medulloblastoma, WNT-activated (C71_)
Medulloepithelioma, NOS
Medullomyoblastoma
Megakaryocytic leukemia
Megakaryocytic myelosclerosis
Melanoma in situ

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Melanoma, malignant of soft parts
Melanoma, NOS
Melanotic medulloblastoma (C716)
Melanotic MPNST
Melanotic psammomatous MPNST
Melanotic Schwannoma
Meningeal melanoma (C71_)
Meningeal melanomatosis (C709)
Meningeal sarcoma
Meningeal sarcomatosis
Meningioma, anaplastic
Meningioma, malignant
Meningioma, NOS
Meningiomatosis, NOS
Meningothelial meningioma
Meningothelial sarcoma
Merkel cell carcinoma
Merkel cell tumor
Mesenchymal chondrosarcoma
Mesenchymal tumor, malignant
Mesenchymoma, benign
Mesenchymoma, malignant
Mesenchymoma, NOS
Mesodermal mixed tumor
Mesonephric adenocarcinoma
Mesonephric-like adenocarcinoma
Mesonephroma, malignant
Mesonephroma, NOS
Mesothelioma, biphasic, NOS
Mesothelioma, malignant
Metaplastic carcinoma of no special type (C50_)
Metaplastic carcinoma, NOS
Metaplastic carcinoma with chondroid differentiation (C50_)
Metaplastic carcinoma with osseous differentiation (C50_)
Metaplastic carcinoma with other types Mesenchymal differentiation (C50_)
Metaplastic thymoma (C379)
Metatypical carcinoma*
Microcystic adnexal carcinoma (C44_)
Microcystic urothelial carcinoma
Microfollicular adenoma
Microglioma (C71_) [obs]
Micropapillary adenocarcinoma (C34_)
Micropapillary carcinoma, NOS
Micropapillary serous borderline tumor Of testis (C621)
Micropapillary serous carcinoma (C569)
Middle ear paraganglioma (C755)
Midline carcinoma of children and young adults with NUT rearrangement
Minimally invasive adenocarcinoma, mucinous (C34_)
Minimally invasive adenocarcinoma, non-mucinous (C34_)
Minimally invasive adenocarcinoma, NOS (C34_)
MiT family translocation renal cell carcinoma (C649)
Mixed acidophil-basophil adenoma
Mixed acidophil-basophil carcinoma
Mixed acinar ductal carcinoma
Mixed acinar-endocrine carcinoma (C25_)
Mixed adenocarcinoma and epidermoid carcinoma
Mixed adenocarcinoma and squamous cell carcinoma
Mixed basal-squamous cell carcinoma*
Mixed carcinoid-adenocarcinoma
Mixed cell adenocarcinoma
Mixed cell adenoma
Mixed ductal-endocrine carcinoma (C25_)
Mixed embryonal carcinoma and teratoma
Mixed embryonal rhabdomyosarcoma and alveolar rhabdomyosarcoma
Mixed epithelioid and spindle cell melanoma
Mixed germ cell tumor
Mixed glioma
Mixed hepatocellular and bile duct carcinoma
Mixed invasive mucinous and non-mucinous adenocarcinoma (C34_)
Mixed islet cell and exocrine adenocarcinoma
Mixed liposarcoma

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Mixed medullary-follicular carcinoma (C739)

Mixed medullary-papillary carcinoma (C739)
Mixed meningioma
Mixed mesenchymal sarcoma
Mixed mesodermal tumor, NOS
Mixed Mullerian tumor
Mixed pancreatic endocrine and exocrine tumor, malignant (C25_)
Mixed phenotype acute leukemia with t(9;22)(q34;q11.2); BCR-ABL1
Mixed phenotype acute leukemia with t(v;11q23); MLL rearranged
Mixed phenotype acute leukemia, B/myeloid, NOS
Mixed phenotype acute leukemia, T/myeloid, NOS
Mixed pineal tumor (C753)
Mixed pineal tumor, transitional pineal tumor
Mixed pineocytoma-pineoblastoma (C753)
Mixed small cell carcinoma
Mixed teratoma and seminoma
Mixed tumor, malignant. NOS
Mixed type rhabdomyosarcoma
Monoblastic leukemia, NOS
Monocytic leukemia, NOS
Monocytoid B-cell lymphoma
Monomorphic adenoma
Monstrocellular sarcoma (C71_) [obs]
MPNST with glandular differentiation
MPNST with mesenchymal differentiation
MPNST with rhabdomyoblastic differentiation
MPNST, NOS
mu heavy chain disease
Mucinous adenocarcinofibroma (C569)
Mucinous adenocarcinoma
Mucinous adenocarcinoma, endocervical type
Mucinous carcinoid
Mucinous carcinoma
Mucinous carcinoma, gastric type (C53_)
Mucinous carcinoma, intestinal type (C53_)
Mucinous cystadenocarcinofibroma (C569)
Mucinous cystadenocarcinoma, non-invasive (C25_)
Mucinous cystadenocarcinoma, NOS
Mucinous cystadenoma, borderline malignancy
Mucinous cystic neoplasm (MCN) (non-invasive) of the pancreas with high-grade dysplasia
Mucinous cystic tumor of borderline malignancy
Mucinous cystic tumor with associated invasive carcinoma (C25_)
Mucinous tubular and spindle cell carcinoma (C649)
Mucinous tumor, NOS, of low malignant potential
Mucin-producing adenocarcinoma
Mucin-producing carcinoma
Mucin-secreting adenocarcinoma
Mucin-secreting carcinoma
Mucocarcinoid tumor
Mucoepidermoid carcinoma
Mucoid adenocarcinoma
Mucoid cell adenocarcinoma
Mucoid cell adenoma
Mucosal lentiginous melanoma
Mucosal-associated lymphoid tissue lymphoma
Mucous adenocarcinoma
Mucous carcinoma
Mullerian adenosarcoma
Mullerian mixed tumor
Multicentric basal cell carcinoma*
Multinodular and vascolating neuronal tumor (MVNT) (C712)
Multiple hemorrhagic sarcoma
Multiple meningiomas
Multiple myeloma
Multiple neurofibromatosis
Mycosis fungoides
Myelocytic leukemia, NOS

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Myelodysplastic syndrome, NOS
Myelodysplastic syndrome with 5q-syndrome
Myelodysplastic syndrome with 5q deletion (5q-) syndrome
Myelodysplastic syndrome with ring sideroblasts and multilineage dysplasia
Myelofibrosis as a result of myeloproliferative disease
Myelofibrosis with myeloid metaplasia
Myelogenous leukemia, NOS
Myeloid leukemia, NOS
Myeloid and lymphoid neoplasm with FGFR1 abnormalities
Myeloid and lymphoid neoplasms with PDGFRB rearrangement
Myeloid leukemia associated with Down Syndrome
Myeloid and lymphoid neoplasms with PDGFRB arrangement
Myeloid/lymphoid neoplasm with PCM1-JAK2
Myeloid sarcoma
Myeloid neoplasms with PDGFRB rearrangement
Myeloma, NOS
Myelomatosis
Myelomonocytic leukemia, NOS
Myeloproliferative disease, NOS
Myeloproliferative neoplasm, unclassifiable
Myelosclerosis with myeloid metaplasia
Myoepithelial carcinoma
Myosarcoma
Myxoid chondrosarcoma
Myxoid leiomyosarcoma
Myxoid liposarcoma
Myxoid pleomorphic liposarcoma
Myxoliposarcoma
Myxopapillary ependymoma
Myxopapillary ependymoma
Myxosarcoma

N

Neoplasm, benign
Neoplasm, malignant*
Neoplasm, uncertain whether benign or malignant
Nephroblastoma, NOS
Nephroma, NOS
Nesidioblastoma (C254)
Nested urothelial carcinoma
Neurilemmoma, malignant
Neurilemmoma, NOS
Neurilemosarcoma
Neurinoma
Neuroastrocytoma
Neuroblastoma, NOS
Neurocytoma
Neuroectodermal tumor, NOS
Neuroendocrine carcinoma
Neuroendocrine carcinoma, poorly differentiated (C50_)
Neuroendocrine tumor, well differentiated (C50_)
Neuroepithelioma, NOS
Neurofibroma, NOS
Neurofibrosarcoma
Neurogenic sarcoma
Neuroma, NOS
Neurosarcoma
Neurothekeoma
Neurotropic melanoma, malignant
NK/T-cell lymphoma, nasal, and nasal-type
Nodal marginal zone lymphoma
Nodular hidradenoma, malignant (C44_)
Nodular melanoma
Nonchromaffin paraganglioma, NOS
Nonencapsulated sclerosing adenocarcinoma
Nonencapsulated sclerosing carcinoma
Nonencapsulated sclerosing tumor
Non-Hodgkin lymphoma, NOS
Noninfiltrating intracystic carcinoma
Noninfiltrating intraductal papillary adenocarcinoma
Noninfiltrating intraductal papillary

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carcinoma nonkeratinizing*

NON-INVASIVE EFVPTC (C739)
NON-INVASIVE ENCAPSULATED FOLLICULAR VARIANT OF PAPILLARY THYROID CARCINOMA (NON-INVASIVE EFVPTC) (C739)
NON-INVASIVE FOLLICULAR THYROID NEOPLASM WITH PAPILLARY-LIKE NUCLEAR FEATURES (NIFTP) (C739)
NON-INVASIVE FTP (C739)
Non-invasive low grade serous carcinoma (C569)
Non-invasive mammary carcinoma (C50_)
Nonlipid reticuloendotheliosis [obs]
Nonlipid reticuloendotheliosis NOS
Non-lymphocytic leukemia, NOS
Non-small cell carcinoma (C34_)
NUT carcinoma
NUT midline

O

Oat cell carcinoma*
Odontogenic carcinoma
Odontogenic carcinosarcoma
Odontogenic fibrosarcoma
Odontogenic sarcoma
Odontogenic tumor, malignant
Olfactory neuroblastoma
Olfactory neurocytoma (C300)
Olfactory neuroepithelioma
Olfactory neurogenic tumor
Oligoastrocytoma, NOS
Oligodendroblastoma
Oligodendroglioma, anaplastic
Oligodendroglioma IDH mutant and 1p/19q-codeleted
Oligodendroglioma, NOS
Oncocytic adenocarcinoma
Oncocytic adenoma
Oncocytic carcinoma
Oncocytoma
Orchioblastoma
Ossifying fibromyxoid tumor, malignant (C49 _)
Osteoblastic sarcoma
Osteochondrosarcoma
Osteoclastoma, malignant
Osteofibrosarcoma
Osteogenic sarcoma, NOS
Osteosarcoma in Paget disease of bone
Osteosarcoma, NOS
Oxyphilic adenocarcinoma
Oxyphilic adenoma

P

Paget disease and infiltrating duct carcinoma of breast
Paget disease, extramammary (except Paget disease of bone)
Paget disease of bone in osteosarcoma
Paget disease, mammary
Pagetoid reticulosis
Pancoast tumor (a tumor in the apex of the chest with Horner syndrome)
Pancreatobiliary-type carcinoma (C241)
Pancreatoblastoma
PanIN III (Pancreatic Intraepithelial Neoplasia grade III)
Pancreatic endocrine tumor, nonfunctioning (254)
Pancreatic endocrine tumor, NOS (254)
Pancreatic neuroendocrine tumor
Pancreatic neuroendocrine tumor, nonfunctioning (254)
Papillary adenocarcinoma, follicular variant
Papillary adenocarcinoma, NOS
Papillary adenoma, NOS
Papillary and follicular adenocarcinoma
Papillary and follicular carcinoma
Papillary carcinoma in situ*
Papillary carcinoma of thyroid (C739)
Papillary carcinoma, columnar cell (C739)
Papillary carcinoma, diffuse sclerosing (C739)
Papillary carcinoma, encapsulated (C739)

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Papillary carcinoma, follicular variant
Papillary carcinoma, NOS*

Papillary carcinoma, oxyphilic cell (C739)
Papillary carcinoma, tall cell (C739)
Papillary cystadenocarcinoma, NOS
Papillary cystadenoma, borderline **malignancy**
Papillary ependymoma
Papillary ependymoma
Papillary epidermoid carcinoma*
Papillary glioneuronal tumor
Papillary meningioma
Papillary meningioma
Papillary microcarcinoma (C739)
Papillary mucinous cystadenocarcinoma (569)
Papillary mucinous cystadenoma, borderline malignancy
Papillary mucinous tumor of low malignant potential
PAPILLARY NEOPLASM, PANCREATOBILIARY TYPE, WITH HIGH GRADE INTRAEPITHELIAL NEOPLASIA C241
Papillary pseudomucinous Cystadenocarcinoma (C569)
Papillary pseudomucinous cystadenoma, borderline Malignancy
Papillary renal cell carcinoma (C649)
Papillary serous adenocarcinoma
Papillary serous cystadenocarcinoma
Papillary serous cystadenoma, borderline malignancy
Papillary serous tumor of low malignant potential
Papillary squamous cell carcinoma*
Papillary squamous cell carcinoma in situ
Papillary squamous cell carcinoma, non-invasive
Papillary transitional cell carcinoma
Papillary transitional cell carcinoma, non-invasive (C67_)
Papillary tumor of the pineal region
Papillary urothelial carcinoma (C67_)
Papillary urothelial carcinoma, non-invasive (C67_)
Papillocystic adenocarcinoma
Papillotubular adenocarcinoma
Parafollicular cell carcinoma (C739)
Paraganglioma (C755)
Paraganglioma, malignant
Parasympathetic paraganglioma (C75.5)
Parietal cell adenocarcinoma (C16_)
Parietal cell carcinoma (C16_)
Parosteal osteosarcoma (C40_, C41_)
PEComa, malignant
Penile intraepithelial neoplasia, Grade III (PeIN III)
Periductal stromal tumor, low grade (C50_)
Perineural MPNST
Perineurioma, malignant
Perineuroma
Periosteal chondrosarcoma (C40_, C41_)
Periosteal fibrosarcoma
Periosteal osteosarcoma
Periosteal osteosarcoma (C40_, C41_)
Periosteal sarcoma, NOS
Peripheral neuroectodermal tumor
Peripheral primitive neuroectodermal tumor, NOS
Peripheral T-cell lymphoma, AILD (Angioimmunoblastic Lymphadenopathy with Dysproteinemia)
Peripheral T-cell lymphoma, large cell
Peripheral T-cell lymphoma, pleomorphic medium and large cell
Peripheral T-cell lymphoma, pleomorphic medium and large cell
Peripheral T-cell lymphoma, pleomorphic small cell
Peripheral T-cell lymphoma, pleomorphic small cell
Perivascular epithelioid cell tumor, malignant
Pheochromoblastoma (C741)
Pheochromocytoma, NOS (C741)
Pheochromocytoma, malignant

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Phosphaturic mesenchymal tumor, malignant
Phyllodes tumor, malignant
Pigmented basal cell carcinoma*
PIGMENTED DERMATOFIBROSARCOMA PROTUBERANS (C44_)
Pigmented Schwannoma
Pilocytic astrocytoma (C71_)
Pilocytic/juvenile astrocytoma (C71_)
Piloid astrocytoma
Piloid astrocytoma (C71_)
Pilomatricoma, malignant (C44_)
Pilomatrixoma, malignant*
Pilomyxoid astrocytoma
Pineal parenchymal tumor of intermediate differentiation (C753)
Pinealoma
Pineoblastoma
Pineocytoma
Pinkus tumor
PI-RADS 4 (C619)
PI-RADS 5 C619)
Pituicytoma
Pituitary blastoma
Pituitary carcinoma, NOS (C751)
Plasma cell leukemia (C421)
Plasma cell myeloma
Plasma cell tumor
Plasmablastic lymphoma
Plasmacytic leukemia (C421)
Plasmacytic lymphoma
Plasmacytoma of bone (C40_, C41_)
Plasmacytoma, extramedullary (not occurring in bone)
Plasmacytoma, NOS
Pleomorphic carcinoma*
Pleomorphic cell sarcoma
Pleomorphic liposarcoma
Pleomorphic lobular carcinoma (C50_)
Pleomorphic lobular carcinoma in situ (C50_)
Pleomorphic rhabdomyosarcoma
Pleomorphic rhabdomyosarcoma, adult type
Pleomorphic xanthoastrocytoma
Pleuropulmonary blastoma
Plexiform Neurofibroma
Plexiform Neuroma
PNET, NOS
Pneumoblastoma
Polar spongioblastoma (C71_)
Polycythemia rubra vera
Polycythemia vera
Polyembryoma
Polygonal cell carcinoma*
POLYMORPHIC POST TRANSPLANT LYMPHOPROLIFERATIVE DISORDER (PTLD)
Polymorphic reticulosis [obs]
Polymorphous low grade adenocarcinoma
Polyvesicular vitelline tumor
Porocarcinoma (C44_)
Polymorphic post-transplant lymphoproliferative disorder
PPNET
Pre-B ALL
Precancerous melanosis
Precursor B-cell lymphoblastic leukemia
Precursor B-cell lymphoblastic lymphoma, NOS
Precursor cell lymphoblastic leukemia, NOS
Precursor cell lymphoblastic leukemia, not phenotyped
Precursor cell lymphoblastic lymphoma, NOS
Precursor T-cell lymphoblastic leukemia
Precursor T-cell lymphoblastic lymphoma, NOS
Preleukemia
Preleukemic syndrome
Pre-pre-B ALL
Pre-T ALL
Primary cutaneous anaplastic large cell lymphoma (C44_)
Primary cutaneous CD30+ large T-cell lymphoma (C44_)
PRIMARY CUTANEOUS CD30+ T CELL LYMPHOPROLIFERATIVE DISORDER (C44 _)

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PRIMARY CUTANEOUS CD4-POSITIVE SMALL/MEDIUM T-CELL LYMPHOMA (C44_)
Primary cutaneous follicle center lymphoma
Primary cutaneous gamma-delta T-cell lymphoma
Primary cutaneous neuroendocrine carcinoma (C44_)
Primary effusion lymphoma
Primary intraosseous carcinoma
Primary serous papillary carcinoma of peritoneum (C481)
Primitive neuroectodermal tumor
Primitive polar spongioblastoma (C71_) [obs]
Pro-B ALL
Prolactinoma
Proliferative polycythemia
Prolymphocytic leukemia
Prolymphocytic leukemia, B-cell type
Prolymphocytic leukemia, NOS
Prolymphocytic leukemia, T-cell type
Pro-T ALL
Protoplasmic astrocytoma
Psammomatous meningioma
Pseudoglandular squamous cell carcinoma*
Pseudomucinous adenocarcinoma
Pseudomucinous cystadenocarcinoma, NOS
Pseudomucinous cystadenoma, borderline malignancy
Pseudomyxoma peritonei
Pseudomyxoma peritonei with unknown primary site (C809)
Pseudosarcomatous carcinoma*
Pulmonary artery intimal sarcoma
Pulmonary blastoma
Pulmonary myxoid sarcoma with EWSR1-CREB1 translocation (C34_)

Q

Queyrat erythroplasia*

R

RAEB
RAEB I
RAEB II
RAEB-T
RARS
Rathke pouch tumor
Recklinghausen disease (except of Bone)
Refractory anemia
Refractory anemia, NOS
Refractory anemia with excess blasts
Refractory anemia with excess blasts in transformation
Refractory anemia with ringed sideroblasts
Refractory anemia with sideroblasts
Refractory anemia without sideroblasts
Refractory cytopenia with multilineage dysplasia
Refractory neutropenia
Refractory thrombocytopenia
Renal carcinoma, collecting duct type (C649)
Renal cell adenocarcinoma
Renal cell carcinoma
Renal cell carcinoma, chromophobe cell (C649)
Renal cell carcinoma, sarcomatoid (C649)
Renal cell carcinoma, spindle cell (C649)
Renal cell carcinoma, unclassified (C649)
Renal medullary carcinoma (C649)
Reserve cell carcinoma*
Reticulosarcoma, diffuse [obs]
Reticulosarcoma, NOS [obs]
Reticulum cell sarcoma, diffuse
Reticulum cell sarcoma, diffuse [obs]
Reticulum cell sarcoma, NOS [obs]
Retinoblastoma, differentiated
Retinoblastoma, diffuse (C692)
Retinoblastoma, NOS
Retinoblastoma, undifferentiated
Rhabdoid meningioma
Rhabdoid sarcoma

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Rhabdoid tumor, NOS
Rhabdomyoma, NOS

Rhabdomyosarcoma with ganglionic differentiation
Rhabdomyosarcoma, NOS
Rhabdosarcoma
Rodent ulcer*
Rosette-forming glioneuronal tumor
Round cell carcinoma*
Round cell liposarcoma
Round cell osteosarcoma (C40_, C41_)
Round cell sarcoma
ROUND CELL SARCOMA WITH EWSR1-NON-ETS FUSIONS

S

Salivary duct carcinoma
SALT lymphoma
Sarcoma botryoides
Sarcoma, NOS
SARCOMA WITH BCOR GENETIC ALTERATIONS
Sarcomatoid carcinoma*
Sarcomatoid mesothelioma
Schmincke tumor
Schneiderian carcinoma
Schwannoma, NOS
Scirrhous adenocarcinoma
Scirrhous carcinoma
Sclerosing epithelioid fibrosarcoma
Sclerosing hepatic carcinoma (C220)
Sclerosing liposarcoma
Sclerosing rhabdomyosarcoma
Sclerosing sweat duct carcinoma (C44_)
Sclerosing thymoma (C34_)
Sebaceous adenocarcinoma
Sebaceous carcinoma
Secretory carcinoma of breast
Seminoma with high mitotic index (C62_)
Seminoma, anaplastic
Seminoma, NOS
Seromucinous borderline tumor (C569)
Seromucinous carcinoma
Serotonin producing carcinoid
Serous adenocarcinofibroma (C569)
Serous adenocarcinoma, NOS
Serous carcinoma, NOS
Serous cystadenocarcinofibroma (C569)
Serous cystadenocarcinoma, NOS
Serous cystadenoma, borderline malignancy
Serous endometrial intraepithelial carcinoma
Serous papillary cystic tumor of borderline malignancy
Serous surface papillary carcinoma
Serous surface papillary tumor of borderline malignancy
Serous tubal intraepithelial carcinoma (C570)
Serous tumor, NOS, of low malignant potenential
Serrated adenocarcinoma
SERRATED DYSPLASIA, HIGH GRADE (C160 – C166, C168-C169, C170-C173, C178-C179 ONLY)
Sertoli cell carcinoma
Sertoli-Leydig cell tumor, poorly differentiated
Sertoli-Leydig cell tumor, poorly differentiated, with heterologous elements
Sertoli-Leydig cell tumor, sarcomatoid
SETTLE
Sezary disease
Sezary syndrome
Signet ring cell adenocarcinoma
Signet ring cell carcinoma
Skin appendage carcinoma
Skin-associated lymphoid tissue lymphoma
Small cell carcinoma, fusiform cell*
Small cell carcinoma, intermediate cell*
Small cell carcinoma, NOS*
Small cell carcinoma pulmonary type (C569)

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Small cell carcinoma, hypercalcemic type (C569)
Small cell neuroendocrine carcinoma
Small cell osteosarcoma
Small cell sarcoma
Small cell-large cell carcinoma*
Soft tissue sarcoma
Soft tissue tumor, benign
Soft tissue tumor, malignant
Solid adenocarcinoma with mucin formation
Solid carcinoma with mucin formation
Solid carcinoma, NOS
Solid papillary carcinoma in situ (C50_)
Solid papillary carcinoma with invasion (C50_)
Solid pseudopapillary carcinoma (C25_)
Solid pseudopapillary neoplasm of Pancreas
Solitary fibrous tumor/Hemangiopericytoma
Solitary fibrous tumor/hemangiopericytoma Grade 1 (CNS) (C71_)
Solitary fibrous tumor/hemangiopericytoma Grade 2 (CNS) (C71_)
Solitary fibrous tumor/hemangiopericytoma Grade 3 (CNS) (C71_)
Solitary myeloma
Solitary plasmacytoma
Somatostatin cell tumor, malignant
Somatostatinoma
Somatostatinoma, malignant
Spermatocytic seminoma
Spermatocytoma
Spindle cell carcinoma*
Spindle cell melanoma
Spindle cell melanoma, type A
Spindle cell melanoma, type B
Spindle cell oncocytoma
Spindle cell rhabdomyosarcoma
Spindle cell sarcoma
Spindle epithelial tumor with thymus-like differentiation
Spindle epithelial tumor with thymus-like element
Spindled mesothelioma
Splenic lymphoma with villous lymphocytes (C422)
Splenic marginal zone B-cell lymphoma (C422)
Splenic marginal zone lymphoma, NOS (C422)
Spongioblastoma multiforme
Spongioblastoma polare
Spongioblastoma, NOS
Spongioneuroblastoma
Squamotransitional cell carcinoma (C53_)
Squamous carcinoma*
Squamous cell carcinoma, HPV-associated
Squamous cell carcinoma, HPV-independent
Squamous cell carcinoma, HPV-negative
Squamous cell carcinoma, HPV-positive
Squamous cell carcinoma in situ with questionable stromal invasion*
Squamous cell carcinoma in situ, NOS*
Squamous cell carcinoma with horn formation*
Squamous cell carcinoma, acantholytic*
Squamous cell carcinoma, clear cell type*
Squamous cell carcinoma, keratinizing, NOS*
Squamous cell carcinoma, large cell, keratinizing*
Squamous cell carcinoma, large cell, nonkeratinizing*
Squamous cell carcinoma, microinvasive*
Squamous cell carcinoma, nonkeratinizing, NOS*
Squamous cell carcinoma, NOS*
Squamous cell carcinoma, sarcomatoid*
Squamous cell carcinoma, small cell*
Squamous cell carcinoma, spindle cell*
Squamous cell epithelioma*
Squamous dysplasia, high grade

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Squamous intraepithelial neoplasia/neoplasm, grade II (**Excluding Cervix**)
Squamous intraepithelial neoplasia, grade III, vulva, and vagina
Stem cell leukemia
Steroid cell tumor, malignant
Stromal endometriosis (C541)
Stromal myosis, NOS
Stromal myosis, NOS (C541)
Stromal sarcoma, NOS
Struma ovarii, malignant
Subacute granulocytic leukemia [obs]
Subacute leukemia, NOS [obs]
Subacute lymphatic leukemia [obs]
Subacute lymphocytic leukemia [obs]
Subacute lymphoid leukemia [obs]
Subacute monocytic leukemia [obs]
Subacute myelogenous leukemia [obs]
Subacute myeloid leukemia [obs]
Subcutaneous panniculitis-like T-cell lymphoma
Subependymal astrocytoma
Subependymal giant cell astrocytoma
Subependymal glioma
Subependymoma
Superficial spreading adenocarcinoma
Superficial spreading melanoma
Supratentorial PNET (C71_)
Sweat gland adenocarcinoma
Sweat gland carcinoma
Sweat gland tumor, malignant
Sympathicoblastoma
Syncytial meningioma
Synovial sarcoma, biphasic
Synovial sarcoma, epithelioid cell
Synovial sarcoma, monophasic fibrous
Synovial sarcoma, NOS
Synovial sarcoma, spindle cell
Synovioma, NOS
Synovioma, malignant
Syringomatous carcinoma (C44_)
Systemic EBV positive T-cell lymphoproliferative disease of childhood
Systemic tissue mast cell disease

T

T-cell lymphoma, NOS
T-cell /histiocyte-rich large B-cell lymphoma
T-cell rich large B-cell lymphoma
T/NK-cell lymphoma
Tanycytic ependymoma (C71_)
Tectal plate lipoma of brain
Telangiectatic osteosarcoma
Teratoblastoma, malignant
Teratocarcinoma
Teratoid medulloepithelioma
Teratoma with malignant transformation
Teratoma, benign
Teratoma, malignant, NOS
Teratoma, mature, of testis in adult
Teratoma, NOS
Terminal duct adenocarcinoma
Third type-schwannamatosis
Thecoma, malignant
Therapy-related acute myeloid leukemia, NOS
Therapy-related acute myeloid leukemia and myelodysplastic syndrome, NOS
Therapy-related acute myeloid leukemia, alkylating agent related
Therapy-related acute myeloid leukemia, epipodophyllotoxin-related
Therapy-related myelodysplastic syndrome, NOS
Therapy-related myelodysplastic syndrome, alkylating agent related
Therapy-related myelodysplastic syndrome, epidopophyllotoxin-related
Therapy-related myelodysplastic syndrome, NOS
Thymic carcinoma (C379)
Thymic carcinoma with adenoid cystic carcinoma-like features (C379)
Thymic large B-cell lymphoma (C379)
Thymoma, atypical (C379)
Thymoma, atypical, malignant (C379)
Thymoma, cortical, malignant (C379)
Thymoma, epithelial (C379)
Thymoma, epithelial, malignant (C379)

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Thymoma, lymphocyte-rich (C379)
Thymoma, lymphocyte-rich, malignant (C379)
Thymoma, lymphocytic (C379)
Thymoma, lymphocytic, malignant (C379)
Thymoma, malignant
Thymoma, medullary (C379)
Thymoma, medullary, malignant (C379)
Thymoma, mixed type (C379)
Thymoma, mixed type, malignant (C379)
Thymoma, NOS (C379)
Thymoma, organoid (C379)
Thymoma, organoid, malignant (C379)
Thymoma, predominantly cortical (C379)
Thymoma, predominantly cortical, malignant (C379)
Thymoma, spindle cell (C379)
Thymoma, spindle cell, malignant (C379)
Thymoma, type A (C379)
Thymoma, type A, malignant (C379)
Thymoma, type A, atypical variant (C379)
Thymoma, type AB (C379)
Thymoma, type AB, malignant (C379)
Thymoma, type B1 (C379)
Thymoma, type B1, malignant (C379)
Thymoma, type B2 (C379)
Thymoma, type B2, malignant (C379)
Thymoma, type B3 (C379)
Thymoma, type B3, malignant (C379)
Thymoma, type C (C379)
Tibial adamantinoma
Trabecular adenocarcinoma
T lymphoblastic leukemia/lymphoma
Trabecular carcinoma
Transitional carcinoma
Transitional cell carcinoma in situ
Transitional cell carcinoma, micropapillary (C67_)
Transitional cell carcinoma, NOS
Transitional cell carcinoma, sarcomatoid
Transitional cell carcinoma, spindle cell
Transitional meningioma
Transitional pineal tumor (C753)
Trichilemmal carcinoma (C44_)*
Trichilemmocarcinoma (C44_)*
Trophoblastic tumor, epithelioid
True histiocytic lymphoma [obs]
Tubular adenocarcinoma
Tubular carcinoma
Tubulocystic renal cell carcinoma (C649)
Tubulolobular carcinoma (C50_)
Tubulopapillary adenocarcinoma
Tumor cells, benign
Tumor cells, malignant*
Tumor cells, uncertain whether benign or malignant
Tumor malignant, NOS*
Tumorlet(s)
Typical carcinoid
T-zone lymphoma

U

Unclassified tumor, malignant*
Undifferentiated epithelioid sarcoma
Undifferentiated high-grade pleomorphic sarcoma
Undifferentiated high-grade pleomorphic sarcoma of bone (C40_)
Undifferentiated leukemia
Undifferentiated pleomorphic sarcoma
Undifferentiated round cell sarcoma
Undifferentiated sarcoma
Undifferentiated spindle cell sarcoma
Undifferentiated uterine sarcoma
Urachal carcinoma
Urothelial carcinoma
Urothelial carcinoma in situ
Urothelial carcinoma with divergent differentiation
Urothelial carcinoma with squamous differentiation
Urothelial carcinoma with trophoblastic Differentiation

V

Vagal paraganglioma
Vaginal intraepithelial neoplasia, grade II (C52_)
Vaginal intraepithelial neoplasia, grade

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II-III (C52_)
Vaginal intraepithelial neoplasia, grade III (C52_)
VaIN II
VaIN II-III
VaIN III
Verrucous carcinoma, NOS*
Verrucous epidermoid carcinoma*
Verrucous squamous cell carcinoma*
Villoglandular carcinoma (C53_)
Villous adenocarcinoma
VIN II
VIN II-III
VIN III
VIPoma
VIPoma, malignant
Von Recklinghausen disease (except of Bone)
Vulvar intraepithelial neoplasia, grade II
Vulvar intraepithelial neoplasia, grade II-III
Vulvar intraepithelial neoplasia, grade III

W

Waldenstrom macroglobulinemia
Warty carcinoma*
Water-clear cell adenocarcinoma
Well differentiated thymic carcinoma (C379)
Wilms tumor
Wolffian duct carcinoma

X

Xanthofibroma

Y

Yolk sac tumor

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2022 Reportability Update

ICD-O Code	***Term***
8010/2	High Grade Dysplasia, ***Esophagus, Stomach, Small Intestine only***

2023 Reportability Update

ICD-O Code	***Term***
9430/3	Astroblastoma, MN1-altered
9400/3	Astrocytoma, IDH-mutant, grade 2
9401/3	Astrocytoma, IDH-mutant, grade 3
9445/3	Astrocytoma, IDH-mutant, grade 4
8693/3	Cauda equina neuroendocrine tumor (cranial and paraspinal nerves)
9473/3	CNS embryonal tumor, NEC/NOS
9500/3	CNS tumor with BCCR internal tandem duplication
9500/3	CNS neuroblastoma, FOXR2-activated
9421/1	Diffuse astrocytoma, MYB- or MYBL1-altered
9385/3	Diffuse hemispheric glioma, H3 G34-mutant
9421/1	Diffuse low-grade glioma, MAPK pathway–altered†
9680/3	Diffuse large B-cell lymphoma associated with chronic inflammation of the pleura
9509/3	Diffuse leptomeningeal glioneuronal tumor
9385/3	Diffuse midline glioma, H3 K27-altered
9385/3	Diffuse pediatric-type glioma, H3-wildtype and IDH-wildtype
9050/3	Diffuse pleural mesothelioma (C38.4)
9170/3	Diffuse pulmonary lymphangiomatosis (C34._)
9680/3	Fibrin-associated diffuse B-cell lymphoma (C38.0)
9421/3	High-grade astrocytoma with piloid features (HGAP)8310/3 Hyalinizing clear cell carcinoma
9385/3	Infant-type hemispheric glioma
9749/1	Juvenile xanthogranuloma (C71.5)
9050/3	Localized pleural mesothelioma (C38.4)
8260/3	Low-grade papillary adenocarcinoma (C34._)
9174/3	Lymphangioleiomyomatosis
9540/3	Malignant melanotic nerve sheath tumor
9699/3	MALT lymphoma of the dura
9470/3	Medulloblastoma, histologically defined (C71.6)
9050/2	Mesothelioma in situ (C38.4)
8077/2	Moderate squamous dysplasia (C34._)
9509/0	Multinodular and vacuolating neuronal tumor
9509/1	Myxoid glioneuronal tumor
9450/3	Oligodendroglioma, IDH-mutant and 1p/19q-codeleted, grade 2
9451/3	Oligodendroglioma, IDH-mutant and 1p/19q-codeleted, grade 3
8272/3	Pituitary adenoma/pituitary neuroendocrine tumor (PitNET) (C75.1)
9413/0	Polymorphous low-grade neuroepithelial tumor of the young
9391/3	Posterior fossa ependymoma, NOS
9396/3	Posterior fossa group A (PFA) ependymoma

9396/3	Posterior fossa group B (PFB) ependymoma
9480/3	Primary intracranial sarcoma, DICER1-mutant
9749/3	Rosai-Dorfman disease
9391/3	Spinal ependymoma, NOS (C72.0)
9396/3	Spinal ependymoma, MYCN-amplified (C72.0)
9391/3	Supratentorial ependymoma, NOS
9396/3	Supratentorial ependymoma, YAP1 fusion-positive
9396/3	Supratentorial ependymoma, ZFTA fusion-positive
8044/3	Thoracic SMARCA4-deficient undifferentiated tumor (C34._)

2024 Reportability Update

ICD-O Code	***Term***
8147/3	Adenoid cystic (basal cell) carcinoma (C61.9)
8120/3	Conventional urothelial carcinoma
9085/3	Diffuse embryoma
8311/3	ELOC (formerly TCEB1)mutated RCC (C64.9)
8311/3	Eosinophilic solid and cystic RCC (C64.9)
8311/3	Fumarate hydratase-deficient RCC ALK-rearranged RCC (C64.9)
9070/2	Intratubular embryonal carcinoma
9061/2	Intratubular seminoma
9080/2	Intratubular teratoma
9061/2	Intratubular trophoblast
9071/2	Intratubular yolk-sac tumor
8120/3	Large nested urothelial carcinoma
8130/2	Low-grade papillary urothelial carcinoma with an inverted growth pattern
8960/1	Mixed congenital mesoblastic nephroma
9085/3	Mixed teratoma and yolk-sac tumor
8130/2	Non-invasive high-grade papillary urothelial carcinoma with an inverted growth
8130/2	Non-invasive papillary urothelial carcinoma, high-grade
8130/2	Non-invasive papillary urothelial carcinoma, low-grade
8860/0	Oncocytic angiomyolipoma
9104/3	Placental site trophoblastic tumor of testis
8122/3	Plasmacytoid urothelial carcinoma
8020/3	Poorly differentiated urothelial carcinoma
8140/3	Prostatic intraepithelial-like carcinoma (C61.9)
8070/3	Pure squamous carcinoma of urothelial tract
8510/3	Renal medullary carcinoma (C64.9)
9061/3	Seminoma with syncytiotrophoblastic cells
8510/3	SMARCB1-deficent dedifferentiated RCC of other specific subtypes (C64.9)
8510/3	SMARCB1-deficient medullary-like RCC (C64.9)
8510/3	SMARCB1-deficient undifferentiated RCC, NOS (C64.9)
9063/3	Spermatocytic tumor with sarcomatous differentiation
8085/3	Squamous cell carcinoma, HPV-associated
8086/3	Squamous cell carcinoma, HPV-independent
8311/3	T(6;11)RCC (C64.9)
9080/3	Teratoma, postpubertal-type
8311/3	TFEB-altered RCC (C64.9)

8311/3	TFEB-rearranged RCC (C64.9)
8120/3	Tubular and microcystic urothelial carcinoma
8311/3	Xp11 translocation RCC (C64.9)

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Part Four - Data Items and Descriptions

This section of the manual has been reduced to those data items that are NYSCR specific. For information on all other required data items, refer to the **Standards for Oncology and Registry Entry (STORE) Manual 2024** and/or the **SEER Program Coding and Staging Manual 2024**. For a complete list of NYSCR Required Fields, contact your Field Rep at (518) 474-0971.

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SOURCE TYPE

Reporting Status: Required
Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard
Facility Type	9521	2	NYSCR

Description
Code the source from the facility for the encounter being reported.

Codes
02 Hospital
03 US Hospital (VA, Military)
04 Laboratory – Independent – In State
05 Laboratory – Independent – Out of State
06 Clinic – Independent – In State
07 Clinic – Independent – Out of State
09 Radiation/Oncology Center
12 Freestanding Ambulatory Care Center
15 State, Territory, Country, Non-NY

SERVICE TYPE

Reporting Status: Required
Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard
Source Within Facility	9522	2	NYSCR

Description
Code for the service type for the encounter being reported.

Codes
01 Inpatient
03 Laboratory – within facility
04 Clinic – within facility
05 Autopsy Only
06 DCO/followback, unreported tumor
08 Hospice
11 Radiation treatment only
12 DCO/followback, unreported tumor, no cancer workup
14 DCO/followback, reported tumor, DCO site correct
15 State, Territory, Country; Non-NY
16 Consult Only, non-laboratory
17 Private medical practitioner, office visit
18 Port/Cath
19 DCO/followback, reported tumor, DCO site incorrect
20 Outpatient, non-surgical
21 Outpatient, surgical
23 Laboratory followback
24 ECC – Early Case Capture Childhood Submission

MANAGING PHYSICIAN FIRST NAME

Reporting Status: Required When Available
Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard
	9540	40	NYSCR

Description
The first name of the patient's managing physician.

Rationale
This information will be used as needed to follow up on cases with limited information.

MANAGING PHYSICIAN LAST NAME

Reporting Status: Required When Available
Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard
	9541	40	NYSCR

Description
The last name of the patient's managing physician.

Rationale
This information will be used as needed to follow up on cases with limited information.

MANAGING PHYSICIAN ADDRESS

Reporting Status: Required When Available
Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard
	9542	60	NYSCR

Description
The number and street address of the patient's managing physician.

Rationale
This information will be used as needed to follow up on cases with limited information.

MANAGING PHYSICIAN CITY

Reporting Status: Required When Available
Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard
	9543	50	NYSCR

Description
The name of the city used in the mailing address of the patient's managing physician.

Rationale
This information will be used as needed to follow up on cases with limited information.

MANAGING PHYSICIAN STATE

Reporting Status: Required When Available
Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard
	9544	2	NYSCR

Description
USPS abbreviation for the state used in the mailing address of the patient's managing physician.

Rationale
This information will be used as needed to follow up on cases with limited information.

MANAGING PHYSICIAN ZIP

Reporting Status: Required When Available
Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard
	9545	9	NYSCR

Description
Postal code used in the mailing address of the patient's managing physician.

Rationale
This information will be used as needed to follow up on cases with limited information.

MANAGING PHYSICIAN PHONE NUMBER

Reporting Status: Required When Available
Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard
	9546	10	NYSCR

Description
The phone number (including area code) of the patient's managing physician.

Rationale
This information will be used as needed to follow up on cases with limited information.

NYS TOBACCO HISTORY

Reporting Status: Required
Section: Special Use

Alternate Name	Item #	Length	Source of Standard
	9536	1	NYSCR

Description
Assign a code that best describes the patient's use of tobacco – current OR past. This field pertains specifically to tobacco use. Do not record any other smoking related history (e.g., e-cigarettes or "vaping" or marijuana use.

Codes
0 Never Used
1 Cigarette Smoker, Current
2 Cigar / Pipe Smoker, Current
3 Snuff / Chew / Smokeless, Current
4 Combination Use, Current
5 Previous Use
9 Unknown

PATH REPORT AVAILABLE

Reporting Status: Required (for Cases Diagnosed January 1, 2001 and Later)
Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard
	9525	1	NYSCR

Description
Indicates the availability of a pathology report.

Rationale
The field was added to enable the NYSCR to enforce the requirement of the field Text-DX Proc-Path (item #2570) when a pathology report is available to the abstractor. When this field is coded with a value of "1-Yes", then the Text-DX Proc-Path field (not a state-specific field) will also be required. The field of "Path Report Available?" is not required for Lab Only Consult cases because the field of Text-DX Proc-Path is a required field for all Laboratory Only Consults.

Codes
0 No
1 Yes

PARENT'S PHONE NUMBER

Reporting Status: Required When Available
Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard
	9547	10	NYSCR

Description
Phone number (including area code) of the patient's parent, legal guardian. Applies to all patients under 18 years of age.

PATIENT CONTROL NUMBER

Reporting Status: Required
Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard
	9524	20	NYSCR

Patient's admission number, account number, or laboratory identification number. This is usually a separate and unique number which differs from the medical record number.

Rationale
The "Patient Control Number" is a unique identifier assigned by your facility to the patient upon admission. The number is used by the facility identify a patient's particular period of hospitalization. It is useful in identifying a specific admission or transaction with the facility if additional information or clarification is needed at a future date.

Codes
If the patient control number is fewer than 20 characters, right-justify the characters and allow leading blanks.

PFI NUMBER

Reporting Status: **Required**
Section: State Requested Items

Alternate Name	Item #	Length	Source of Standard
Permanent Facility Identifier	9523	11	NYSCR

Description
A unique numerical identifier assigned to the physical location of the facility. Record your PFI number as assigned by the NYSCR.

Rationale
A method of identifying a facility by location. This identifier remains constant regardless of facility status changes or transfers of ownership.

Codes
Unique individual code as assigned by the NYSCR.

New York State Cancer Registry Reporting Manual

Part Five - Casefinding

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5.1 DEFINITION OF CASEFINDING

Casefinding is a systematic method of locating all eligible cases to be included in a cancer registry database. Although the hospital remains the primary source for most cases at the Central Registry, a number of non-hospital sources are critically important in accurately assessing cancer incidence. Comprehensive casefinding includes investigating all diagnostic and therapeutic services to look for active cancer cases. Casefinding identifies both new, previously unreported cancer cases, as well as those cases that have been identified elsewhere, and already entered into the registry.

5.2 CASEFINDING LIST FOR ICD-9-CM AND ICD-10-CM CODES

Refer to the casefinding lists included in sections 3.8 and 3.9 respectively.

5.3 CASEFINDING PROCEDURES

Registrars must rely on several sources of documentation to identify all cancer cases diagnosed and/or treated at a facility. More than one type of documentation is generally needed to capture all required information for each patient. Therefore, registrars must investigate every department or service area where a patient may be seen or treated within a facility, to identify eligible cases. Potential sources differ based on the facility type, size, services provided, etc. To ensure completeness, the task of casefinding should be limited to those familiar with the various reportable terms and conditions. Note that the American College of Surgeons (ACoS) and/or a particular facility's cancer committee may require the registrar(s) to abstract certain diagnoses that are not reportable to the NYSCR.

Effective communication skills are essential in the casefinding process. Registrars will likely interact with other facility staff while researching and compiling information on eligible cases. The NYSCR recommends that registrars explain the purpose of their visits to various departments along with any requests for information, underscoring how accurate, timely and complete cancer data collection plays a significant role in the health of all New Yorkers. Cooperation of ancillary departments involved in cancer care is critical to achieving maximum casefinding results.

The need for open communication regarding cancer reporting extends not only to the registrar's colleagues within their facility, but to the facility's assigned NYSCR field representative. The NYSCR Field Representative serves as a liaison between the NYSCR and the reporting facility. Registrars are encouraged to contact their field rep. with any questions and/or concerns that may present. The NYSCR is committed to maintaining open communication with reporting facilities and encourages questions and feedback. Working together, facility registrars and NYSCR field staff can usually resolve most issues quickly and completely.

5.3.1 Hospital Departments Involved in Casefinding

The list below identifies services/departments where eligible cancer cases may be identified. Not all facilities offer every service or contain every department listed. Registrars should review their facility's NYSDOH Operating Certificate for a complete list of all cancer related diagnostic and/or therapeutic services provided by the facility, both at their main campus, as well as at any satellite locations included on the Operating Certificate.

Each of the following services/departments is considered a potential source for eligible cancer cases:

- Laboratory Services (both on-site and contracted laboratory services):
  - Pathology (Including Autopsy Reports)
  - Cytology
  - Hematology
- Diagnostic Radiology
- Outpatient Services:
  - Clinics
  - Ambulatory Care Services
  - Outpatient Surgery
- Oncology-Related Services:
  - Chemotherapy
  - Radiation Therapy
- Emergency Department (ED/ER)
- Health Information Management / Medical Records (HIM)
- Staff Physician's Offices
- Long-Term Care Facility/Skilled Nursing Facility
- Hospice and Other Palliative Care Services

5.3.1.1 Laboratory: Pathology (including autopsy reports), Cytology and Hematology

The laboratory department is generally the primary casefinding source for eligible cases to be included in the registry database. Personnel who are thoroughly knowledgeable in cancer case reporting must review every pathology report (including all bone marrow biopsies and autopsy reports), cytology reports and hematology reports. This may be accomplished manually, through an electronic report based on related diagnostic codes and terms or a combination of both means, with a combination of both means being recommended.

At some larger institutions the pathology department may be comprised of distinct subspecialties such as dermatopathology, EENT pathology, GYN pathology and/or pediatric bone marrow pathology. All areas must be reviewed for reportable cancer diagnoses.

Experience demonstrates that trained registry personnel perform the most complete and accurate screening of pathology reports. If someone outside the registry reviews the pathology reports, a registrar should audit the findings periodically, to ensure complete and accurate casefinding. See Part 8: Quality Assessment for further information.

5.3.1.2 Diagnostic Radiology

Registrars should regularly review reports from diagnostic radiology for eligible cancer diagnoses. In addition to routine x-rays, casefinding sources should include all specialized diagnostic imaging conducted by the facility, such as MRI, CT and PET scans, mammography, fluoroscopy, ultrasound, and nuclear medicine.

5.3.1.3 Outpatient Services

Casefinding should include review of surgery and clinic visit logs. Billing records may also be helpful, as these contain both the diagnoses and applicable ICD codes. Inpatient and outpatient Disease Indices are often available separately.

5.3.1.4 Oncology-Related Services

In addition to diagnostic radiology radiation therapy, along with chemotherapy services should be viewed as casefinding sources. Radiation therapy and chemotherapy appointment logs/books should be reviewed routinely to identify eligible cases. Additionally, regular, thorough review of transcription reports related to patient consultations, treatment and follow-up visits may identify reportable cases.

5.3.1.5 Emergency Department (ED/ER)

ED records are a casefinding source. Review ED logs and death certificates to capture and report eligible cases of patients who expire in the ED or are declared dead on arrival (DOA).

5.3.1.6 Health Information Management / Medical Records (HIM)

Another significant source of cancer casefinding is the HIM/Medical Records Department, especially through the Disease Index. Usually run periodically, The Medical Record Disease Index (MRDI) is a listing (either electronic or as a hard copy) in numerical order by ICD code or medical record number. The MRDI should contain the patient's name, any reportable ICD diagnosis code(s), and medical record number. Additional information may include admission and/or discharge dates, physician's name and/or license/ID number, length of stay and ICD codes for co-morbid diagnoses and/or CPT procedure codes. When requesting a MRDI, the cancer registrar should specify the reportable ICD cancer codes to identify pertinent inpatient and outpatient visits.

The value of the MRDI as a casefinding source cannot be overstated. Not every reportable case has a positive histological diagnosis at each facility. Frequently in fact, a case is histologically diagnosed at one facility, or in a physician's office, and the patient is then seen at a different facility for treatment. These cases often can be identified through the MRDI.

Health Information Management/Medical Records Departments can also be a source of information associated with discharges, specifically discharges following a death (death log). Regular review of all hospital deaths reduces the likelihood of future DCO cases. See Part 6 – Death Certificate Only and Death Clearance Lists, for more information on DCOs.

5.3.1.7 Staff Physicians' Offices

A staff physician is any physician who is directly employed by the facility **or** any physician in private practice who has privileges to admit patients to and/or practice in that healthcare facility. When a facility employs a physician, the facility owns the medical records of patients seen by that physician. As a result, cancer registrars are responsible for reporting eligible cancer cases identified from these records.

5.3.1.8 Long-Term Care Facility / Skilled Nursing Facility

Long-term care facilities and/or skilled nursing facilities affiliated with a hospital are potential sources for casefinding. Routine review of these records should be performed to identify reportable cancer cases.

5.3.1.9 Hospice

If your facility maintains a hospice unit, monitor admissions for casefinding purposes. Report eligible cancer cases when a patient receives palliative and/or comfort care. To reduce the likelihood of future DCO cases, report active hospice cancer cases to the NYSCR whether patients were diagnosed and/or received any treatment at the facility.

5.4 QUALITY OF CASEFINDING / PERIODIC INTERNAL CASEFINDING AUDITS

The NYSCR strongly encourages all reporting facilities to conduct periodic internal casefinding checks, to ensure that every eligible cancer case is identified and reported. Registrars are encouraged to speak with their NYSCR field representative and to network with registrars from other facilities for ideas when developing their own system of internal review. Registrars should look for changes in services and/or staffing when significant fluctuations occur in the annual reporting caseload. Registrars are encouraged to address fluctuations in reporting totals with their NYSCR field representative as soon as they are noted. See Part 8 – Quality Assessment, for further information.

New York State Cancer Registry Reporting Manual

Part Six - Death Certificate Only and Death Clearance Lists

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6.1 INTRODUCTION

The following section contains specific information pertaining to Death Certificate Only (DCO) and Death Clearance Lists.

A DCO is an incidence of cancer that is reported to the NYSCR via the office of Vital Statistics or from the Statewide Planning and Research Cooperative System (SPARCS), following mention of cancer or other malignant disease on a Death Certificate, which in turn cannot be matched with any cases stored in the NYSCR database. SPARCS reports are limited to those records associated with cancer-related admissions, however, in some instances the type of cancer identified on a SPARCS record differs from that listed on the death certificate. Occasionally, previously reported cases may appear on a facility's DCO list. The circumstances which lead to this are discussed later in this section. DCO lists are transmitted to facilities on a yearly basis.

6.2 HOW A CASE BECOMES A DCO

The NYSCR receives a data file from Vital Statistics and SPARCS that contains information on every New York State death certificate with a diagnosis or co-morbidity attributed to cancer, as well as all cancer-related admissions for a given year. This file contains information related to the underlying cause of death, any contributing causes, the date of death, where death was declared and various bits of demographic information (e.g., name, social security number, address). A computerized program at the NYSCR attempts to match the information on the Vital Statistics and SPARCS file to those already in the Registry's database to determine whether a potentially reportable tumor, mentioned on a death certificate can be matched to a previously recorded tumor.

Potentially reportable cases which do not link automatically to a previously reported patient in the database are given to members of the Registry's Medical Coding Staff via an internal software program. The medical coders must then determine whether the Vital Statistics or SPARCS case matches any patient in the NYSCR database. If a match is established, the coder follows a special tumor matching protocol to determine whether the tumor reported on the death certificate matches a previously reported tumor for that patient. If a tumor on a death certificate cannot be matched to anyone in the Registry's database it becomes a DCO, and a follow-back is initiated with all applicable facilities (that in which the patient expired or was last treated).

Often the tumor reported on the Death Certificate reflects metastases from a previously reported tumor. Therefore, Death Certificate cases with common metastatic sites (lung, bone, etc.) are typically matched to previously reported tumors. Any death case matching a case on the registry database but containing a tumor that does not match a previously reported tumor, also becomes a DCO, with the appropriate follow-back procedures initiated.

6.3 DCO LISTS AS COMPLETENESS INDICATORS

DCO lists serve as a measure of the completeness of cancer reporting from individual facilities. The smaller the annual DCO list, the more complete the facility's cancer reporting is. In addition to the overall number of cases on a particular DCO list, facilities should also consider the percentage of DCO cases with regard to their overall cancer caseload. Registrars can request their annual average caseload from their respective field rep. Additionally, the code on the DCO list that indicates the cause of death may provide insight regarding weaknesses in existing casefinding procedures. For example, if the number of leukemia, lymphoma and multiple myeloma cases is high, the facility might not be identifying cases diagnosed /treated solely by hematologists.

6.4 METHODS FOR REDUCING DCO LISTS

A proactive approach to reducing the number of DCOs at a facility involves determining how and where death certificates are processed. The individual responsible for reporting to the NYSCR can then establish a mechanism to ensure that they obtain copies of all death certificates for review.

6.5 RECONCILIATION OF DCO LISTS

It is imperative that reporting facilities reconcile **all** DCOs in a timely manner. Facilities are required to submit all reportable DCO cases and provide information for any non-reportable and/or missing cases within four weeks of receiving their DCO list. To meet this requirement, the individual responsible for reconciling DCOs should request the medical records for these cases as soon as the list is received. The facility's field representative will contact the registrar if all cases are not received by the assigned date of completion.

Cases must be submitted electronically via the Health Commerce System. Specific abstracting instructions may vary from year to year, so it is important to read the instructions that accompany the DCO list carefully.

6.5.1 Reportable Cases

DCOs not previously reported that have been confirmed as reportable must be submitted via the facility's cancer reporting software. The NYSCR recognizes that information related to DCO cases might be limited due to a brief admission during the terminal phase of their illness, or in the case of a patients who expire in the facility's ED or are declared DOA. Information should be reported as it appears in the patient's medical record, even though it may differ from that found on the death certificate.

6.5.2 "History Only" Cases

According to regular reporting guidelines, "History Only" cases of cancer are not reportable. However, when a patient presents to your facility with a history of cancer, AND, as a result, the patient subsequently is included on your annual DCO list, that case is reportable to the NYSCR. It is understood that the facility may have limited documentation related to the cancer and that many of the data fields may be submitted as "unknown".

6.5.3 Non-Reportable Cases

If, after reviewing the medical record for a DCO case, it is determined that the patient did not have cancer or had been diagnosed with a non-reportable tumor, the registrar should inform his/her field representative. Cases deemed non-reportable will be deleted from the NYSCR database. To prevent a reportable case from being inappropriately deleted, supporting documentation showing the case is not reportable may be requested.

6.5.4 Previously Reported Cases

Registrars should contact their field representative if it is believed that a DCO case has been previously reported. The field representative can query the NYSCR's database to confirm whether a report was received from the facility for that patient. If a report is found on the database, the field representative determines whether the malignancy reported on the death certificate is reflective of the primary site that was originally reported. If a report cannot be found on the Registry's database, or if it is determined that the patient had been diagnosed with multiple primary tumors, the facility must report the case.

6.5.5 Patient Not in Database

If, after exhausting all available resources, a registrar cannot find any evidence that a patient on their DCO list was ever seen at their facility, the registrar should notify his/her field representative that the patient cannot be located within their facility's patient database. Resources that should be checked include, but are not limited to, emergency room logs, review of actual death certificates, cancer treatment areas and pathology/cytology labs.

6.5.6 Medical Record Cannot Be Located

Registrars should notify their NYSCR field representative about any DCO case that cannot be completed due to a lost or misfiled medical record. These cases will remain on the facility's outstanding DCO list until they are reconciled.

6.5.7 Digital Storage

If the medical record for a DCO case is being scanned for digital storage, the registrar should ascertain how long it could take for him/her to reconcile the case and notify their field representative.

6.6 DEATH CLEARANCE LISTS (DCLs)

The NYSCR, in conjunction with the NYSDOH Bureau of Vital Statistics, routinely prepares Death Clearance Lists (DCLs) to assist registrars with any patient follow-up activities conducted by their facility. Facilities with formal cancer registries that perform routine follow-up activities find the DCLs most useful. DCLs provide information on individuals who had a reportable condition mentioned on their death certificate or whose Cause of Death code was reflective of a reportable tumor. Facilities requesting DCLs receive lists that only contain information on those patients for which the facility previously submitted a reportable tumor to the NYSCR.

Electronic files are prepared for a given death year and upon request are sent to health facilities via the HCS. DCL files contain hospital-specific information regarding the death of individuals who were previously reported to the NYSCR by an institution (death clearance list) and cases reported by a facility that were subsequently seen somewhere else (non-death follow-up list). Instructions with information regarding the files are sent to the requesting facility by their assigned field representative, in a separate email.

New York State Cancer Registry Reporting Manual

Part Seven – Quality Assurance

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7.1 INTRODUCTION

Quality Assurance (QA) Measures and Continuous Quality Improvement (CQI) Procedures are used to achieve the highest quality cancer data. Good Quality Control (QC) Measures are necessary to assess registry data and identify areas of excellence, as well as opportunities for improvement.

These measures and controls allow registry professionals the benefit of a shared frame of reference, a common language, and a better understanding of the importance of QA Measures. By applying these techniques, cancer registries can improve the quality of their data, and create opportunities to improve communication within their facility and among those cancer data organizations with which they associate.

An effective cancer registry is staffed by individuals who have well-defined goals which are clearly documented. A registry can remain focused and maintain a sense of direction if staff has a clear understanding of the types of questions their registry can answer.

7.2 TERMINOLOGY

Quality Assurance (QA) – Webster's defines "quality" as a degree of excellence. Terms with similar meaning, include:

- Quality Control / Quality Assessment – Assures data are useful. The processes may also ensure data and other information meet a previously defined standard.
- Continuous Quality Improvement (CQI) – A mechanism that ensures ongoing QA activities in an effective and efficient manner. One CQI method is to assess quality concurrently (i.e., in real time) rather than after the fact (retrospectively).

Concurrent assessment of information can reduce the amount of work needed to provide quality data, enhance the knowledge of the registrar, and improve the usefulness of the database, since it occurs as data are collected. Errors are immediately identified and corrected.

7.3 IMPORTANCE OF QUALITY DATA

Cancer registrars are a critical resource in the war against cancer as they are on the front lines, collecting vital information. To be effective, this information must be complete, timely and accurate. In the cancer registry field, data are the building blocks of information, and they are measurable. Cancer registry professionals must always remain mindful that cancer data play an integral role in reducing the cancer burden on patients and society in general.

Registrars are familiar with numbers, reports, charts, and rates, but are often isolated from the patients who are affected by their work. Registry data, or information summaries based on the data, are used to assess risk, recommend therapies, and monitor patient outcomes. This information can also be used to educate cancer patients about the treatment decisions they face. Researchers use the data to increase public knowledge of the disease process. Public health officials use the data to monitor the burden of the diseases in populations – to plan, prioritize, implement, and evaluate cancer control interventions.

7.4 TIMELINESS

Timely data collection is important to both the hospital and Central Registry and comes with advantages and challenges. For example, in clinical trials; early patient and tumor identification assists in determining whether a patient is eligible for the trial. For the registrar however, this presents a challenge when determining stage and collecting treatment information, due to the lack of complete information at the time of abstracting. Different organizations have different timeliness standards. Most central registries have legislative mandates regarding the timing of data collection. NYS Public Health Law Section 2401 states: *Every physician, dentist and other health care provider shall give notice immediately but not later than one hundred eighty days of every case of cancer or other malignant disease coming under his or her care, to the department, except as otherwise provided*. (See Appendix A)

7.4.1 National Program of Cancer Registries (NPCR)

NPCR standards require that (1) within 12 months of the close of a diagnosis year, 90 percent of expected, unduplicated cases are available to be counted as incident cases and (2) within 24 months of the close of a diagnosis year, 95 percent of expected, unduplicated cases are available to be counted.

7.4.2 Surveillance Epidemiology and End Results (SEER)

SEER agreements with participating registries state that the registry must provide counts of new cases for a calendar year within 20 months of the end of a diagnosis year.

7.4.3 North American Association of Central Cancer Registries (NAACCR)

The NAACCR definition for timely reporting states that within 18 months of the close of a diagnosis year, the registry should contain 95 percent of expected cases.

7.4.4 American College of Surgeons (ACoS) Commission on Cancer (CoC)

CoC-approved programs are required to accession all eligible cases within six months of diagnosis or admission for treatment to the reporting facility. This is usually done retroactively since cancer is a disease for which treatment can be administered over many months. A patient may still be receiving first course of treatment and the medical record may be unavailable to the registry for review immediately upon discharge.

While these things may affect the reporting schedule, frequent data submission allows not only for a more even workload distribution, it also enhances data quality since errors may be caught and corrected early.

7.4.5 Monitoring Timely Reporting

There are several ways to monitor reporting for timeliness. Registrars can calculate the number of cases abstracted to-date for the current accession year as a percentage of the total number of cases expected for the current year. The expected number of cases can be determined by past reporting years, adjusted for changes in services delivered. This is then compared to the amount of time that has elapsed to-date in the current accession year, minus the allowable reporting time frame. For example, if the reporting time is six months, the number of cases abstracted by January 1st, should be 50 percent or more of the total number expected for the previous year. If so, the registry is within timeliness standards.

Another way to monitor timeliness is to have a computer generate the lag time. Lag time is the number of days between the discharge date or date of first contact (if there is no discharge date), and the date of submission to the central registry. If lag time is $\leq$ 180 days, the registry is within timeliness standards.

7.5 ACCURACY

Data must be accurate. The consistent use of national standard data definitions allows for reliable comparison among all data collection agencies and facilitates the compilation of aggregate data.

Central and hospital registries share a common mission, albeit occasionally different goals and/or strategies. Viewing each registry as a stand-alone entity, however, minimizes the effectiveness of cancer registration as a system, and can lead to a lack of cohesion and cooperation. Central and hospital registries each report to various entities, including groups outside the cancer registry community, such as state legislatures, hospital administrators and the public at-large. Over the last several years, cancer registration standard setters have worked more collaboratively to minimize differences in data collection. They recognize that conflict in data standards and goals hampers reliable comparison studies. In addition, differing data collection standards place an undue burden on registrars in reporting facilities by requiring duplicate as well as differing data collection requirements. Most of the differences between central and hospital databases can be resolved through improved collaboration. It therefore behooves central and hospital registries to pursue the path of cooperation and collaboration by looking to the common goal and adopting methods that benefit everyone and facilitate success.

Data accuracy is also dependent upon a clear understanding of the goals of the registry. Knowledgeable and experienced individuals must oversee the design, collection, and dissemination of information. In the hospital setting, discrepancies in staging and other core data items must be resolved by interaction among the hospital registrars, the medical staff, and the central registry. To resolve discrepancies, abstracts can be shared with attending physicians to provide opportunities for discussion. The sharing of abstracts with medical staff is especially important as advances in therapies often evolve faster than many registrar's ability to track them.

Open discussion among physicians and hospital and central registrars, provides excellent learning opportunities. Ongoing routine, as well as random, review of the data

by multiple participants can provide an excellent system of checks and balances. Many registrars do not have access to the professional development opportunities that a multi-staff department can provide. Building a network of professional resources to act as mentors or sounding boards can enhance knowledge and confidence.

Central registries provide an objective check of data by assessing the quality and consistency of coding as it relates to supporting documentation. Without access to the patient's medical record, the central registry must rely solely on the supporting text narrative provided by the hospital registrar. Poor documentation contributes to inaccurate coding. Detailed documentation can reduce misunderstandings with the interpretation of rules and provide the opportunity to correct inaccuracies in a timely and objective manner. Clear, concise text which supports all coded fields is an essential component of any cancer abstract.

7.5.1 Computerized Edits

Standardized edits are one of the most important QA tools a cancer registry has at its' disposal. Current cancer-reporting software, including SEER*Abs, provides computerized edit checks that are applied automatically to records as they are processed and submitted. The two (2) common types of computerized edits available in SEER*Abs, as well as commercial cancer-reporting software products, are:

- Range Edit Checks – which look for allowable values. If a value is outside the allowable range, the field cannot be populated (e.g., the acceptable range for ICD-O; C00_ - C80_).
- Inter-Field Edit Checks – which look at the relationship between variables within a single record to identify unlikely or improbable code combinations (e.g., a female with prostate cancer).

SEER*Abs also provides prompts, error messages, drop-down coding choice lists and online help (e.g., STORE Manual and SEER Program Coding and Staging Manual) to assist in making accurate coding choices.

7.5.2 Visual Edits

Although convenient, auto-coding should only be used in conjunction with a visual review of all text and codes. Computer-generated text should never be used when reporting information to the NYSCR. Text should always be entered into an abstract as it appears in the patient's medical record (i.e., in natural language). A visual review provides a check of the narrative text as it relates to the assigned codes and ensures that all information from the medical record is included in the abstract. The individuals involved in abstract review must be familiar with all data item requirements and coding instructions used by the NYSCR and be knowledgeable and well trained in abstracting cancer data from patient records.

7.5.3 Cancer File Submission Reports

As part of their QA procedures, reporting facilities should routinely review their NYSCR Cancer Case Submission Reports. These reports provide routine, detailed, and objective measures of the quality and consistency of coding. In addition to confirming receipt of batches by the NYSCR, the Cancer Case Submission Report provides a statistical breakdown of:

- the number of non-reportable tumors and early reported tumors;
- the number of records, including lab reports, within a batch that were rejected for errors and/or warnings; and
- the accepted number of records.

These variables – along with others such as percent of death certificate cases and percent of lab only cases – can be used to monitor patterns in reporting. The reporting facility should establish a procedure to retrieve, review and file all submission reports. All rejected cases and major errors identified on the submission report must be corrected and resubmitted to the NYSCR within 10 days of the original submission date. For more information on Submission Reports, see Part Eight of this manual (Electronic Reporting).

7.6 COMPLETENESS

Completeness can be assessed from two perspectives: completeness of individual abstracts and completeness of the registry's overall database. Complete data within an abstract is necessary to avoid misleading or misconstrued conclusions regarding stage, treatment regimens or other factors that could affect the care of future patients. Obtaining all data elements is challenging for registrars given that patient care is often provided at many different facilities. Often, the cancer registry is the only place within a facility where the complete picture of a patient's care is documented. Therefore, the cancer registry plays a crucial role in providing the facility with good QA information.

An important function in any registry's operation is to ensure the completeness of the database. Hospital-based registries must ensure that casefinding sources such as disease indices are updated whenever ICD codes change. Caseloads from previous year(s) should be compared, to determine fluctuations. If the caseload appears to be decreasing, the registrar should check to determine whether all appropriate cases are being captured and if any major events occurred that would justify a reduction in caseload. Examples of potential reductions in caseload could be the loss of an oncologist or the termination of certain cancer-related treatment services. In such instances the registrar could expect to see a decrease in the number of cancer cases.

A casefinding audit can be performed to assess a facility's completeness and determine if and where reportable cases are being missed. Obtaining complete treatment and follow-up information yearly from physician contacts can also assist in maintaining completeness.

At the central registry, DCOs are one method used to monitor case completeness, Inpatient facilities with incomplete casefinding may expect to see a higher DCO rate than similar facilities that are complete. For additional information regarding DCOs, refer to Part Six of this manual.

7.7 MEASURABILITY

For data collected by the NYSCR to be useful in research, public health planning and evaluation, it must be standardized, reliable and valid. Poorly documented, infrequently collected and/or non-standard data items are no less time-intensive to collect as are valid items. For example, quality of life and co-morbidity are topics of considerable interest. If all participants are not using the same measures, indicators, and definitions, the data are difficult to compare and difficult to interpret.

Use of this manual, as well as the SEER reporting manuals, and CoC's Standards for Oncology Registry Entry (STORE) manual as the basis of data collection ensures that data collection is consistent among all facilities, in turn making data comparison more relevant.

7.8 QUALITY ASSURANCE (QA) METHODS

There are many methods available to monitor compliance of standards at both hospital and central registries. The cancer registry professional should understand the concepts of Continuous Quality Improvement (CQI) and be able to appropriately implement QA procedures.

7.8.1 Facility Accreditation

Obtaining and maintaining various forms of accreditation through a formalized survey process is one method healthcare facilities can pursue to ensure that QA mechanisms are in place and adhered to.

For example, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) provides standards on quality of services and data collection to which the facility must demonstrate compliance. The American College of Surgeons (ACoS), Commission on Cancer (CoC) provides standards specifically designed for quality of cancer services and data collection to which accredited facilities must demonstrate compliance. By receiving approval through a nationally accrediting body, a reporting facility's cancer program is measured against a pre-defined standard of accountability, and quality of care. Communication is an essential component of applying for and maintaining various accreditation. Gaining accreditation is time consuming, costly, and requires cooperation and coordination of all those involved with the facility's cancer related services.

7.8.2 Central Registry Certification

Central registries are affected by various standard setting organizations. Therefore, it is incumbent upon central registries to stay abreast of the reporting requirements for organizations such as NPCR, SEER, NAACCR and the CoC. This awareness is vital to the NYSCR when considering modifications to reporting requirements, and to provide the best possible communication and service to reporting facilities throughout New York State. Ongoing communication must be maintained among all accrediting organizations and central registries. This issue has become extremely important over the last few

years as there have been national efforts to collect data fields in all states and regions that are consistent, timely and meet high standards of quality.

The NAACCR Registry Certification Committee has established a process by which NAACCR Full Member Registries may annually receive an objective evaluation and confidential feedback of their achievement in case ascertainment, case linkage, completeness of information abstracted on critical variables, data accuracy and timeliness of cancer case reporting. When population-based cancer registries achieve excellence in all areas, they are certified. Certification enables each registry the opportunity to receive an objective and confidential report that identifies areas of strength and weakness. Central registries are encouraged to share their findings with appropriate partners and staff.

If used appropriately, the certification process can help a registry prioritize procedures to maximize the quality of data outcomes, achieve excellence and, ultimately, NAACCR certification.

7.9 AUDITS

The types of audits conducted by the NYSCR include:

- Casefinding
- Re-abstracting

The purpose of an audit is to ensure that all reportable cases are abstracted, and that the information contained in each abstract is complete and accurate. The NYSCR conducts casefinding and re-abstracting audits at reporting facilities to assess reporting completeness and monitor data validity in abstracting.

7.9.1 Casefinding Audit

Casefinding audits are conducted to determine whether all cases eligible for reporting have been reported for an established time period.

7.9.1.1 Central Registry

The goal of a central registry is to record a minimum of 95 percent of all cases of cancer or malignant disease, occurring among individuals within a designated geographic area (incidence). This involves receiving reports from all potential sources (hospitals, outpatient services, physician offices and death certificates) within the designated geographic areas, as well as neighboring central registries and other central registries.

As previously stated, the NYSCR conducts regular, organized casefinding audits of reporting facilities. As part of a casefinding audit, field staff at the central registry review the MRDI, pathology reports, and all other applicable sources (e.g., oncology clinic logbook, radiation therapy logbook, outpatient clinics, etc.) for a specified period. Field staff make identify all reportable cancer cases within these sources, compare that list to the NYSCR's database, and make note of any cases that do not appear in the Registry's database.

Audits are conducted after the reporting deadline for the specified period has expired. All audit findings are clearly documented in writing to the applicable registrar(s), their supervisor, and any other appropriate facility staff, as well as to the director of the NYSCR.

7.9.1.2 Facilities

Complete casefinding by reporting facilities is not without its' challenges, as it requires identifying reportable diagnoses from multiple sources. Cooperation and clear lines of communication with all applicable departments within the reporting facility (e.g., pathology, cytology, diagnostic radiology, and radiation oncology departments), as well as any satellite clinics and/or outpatient surgery centers which fall under the facility's Operating Certificate, are essential to meet this goal. Requests for data that need to be forwarded to other departments can be accomplished more directly if registrars have good communication with the applicable department supervisors regarding the purpose and process of casefinding procedures.

Providing the validation and underlying principle for cooperation enhances the awareness, support, involvement and understanding necessary to capture all reportable cases. Because cancer patients are seen in multiple departments, it is necessary to look at all potential sources to accurately assess reporting completeness. Casefinding audits can identify areas where reportable cases are missed. Facilities should use this information as a tool to improve their routine casefinding procedures.

7.9.2 Re-abstracting Audits

Re-abstracting audits are intended to assess the quality of the data that are being reported to the NYSCR.

7.9.2.1 Central Registry

With this type of audit, NYSCR staff select a random sample of abstracts the facility has previously reported. The NYSCR then provides a written request for corresponding medical records of the selected abstracts to be photocopied or scanned and sent to the NYSCR. Once received, NYSCR field staff review the medical records and create a cancer case abstract. Information collected from the documents that were received as part of the audit is then compared with the original abstract provided by the facility to identify discrepancies. Detailed reports of the results are then shared with the reporting facility. These audits are successful only when there is clear communication between the NYSCR and facility staff regarding the criteria, methods, standards, and findings. Trends involving abstracting errors, as well as any other significant coding/staging errors are regularly incorporated into NYSCR training workshops, without identifying either the patients or reporting sources involved.

7.9.2.2 Hospital Registry

At the hospital/facility level, re-abstracting audits are a valuable measurement tool that can significantly contribute to data quality. For example, the cancer committee may choose to re-abstract 10 percent or more of the registry's cases for a particular site or histology to assess agreement with abstracting guidelines.

7.9.3 Site-specific Audits

Periodic site-specific audits (e.g., colon, breast, lung, hematopoietic) are a valuable QA tool for both facility and central registries, as they allow registrars staff to identify potential errors and correct them quickly.

7.9.4 Accession Register Audits

This type of audit is undertaken to verify that all abstracted cases entered into a facility's database have been successfully transmitted to the NYSCR.

7.9.5 MRDI Audits

MRDI audits consist of a review of a facility's Medical Record Disease Index to determine whether all reportable cancer encounters have been reported for a designated period. Potentially reportable cases are identified by ICD diagnosis codes.

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Part Eight – Electronic Reporting

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8.1 CREATING AN EXPORT FILE

The first step in preparing a file for submission to the NYSCR is the creation of an export file. Facilities using commercial software products should follow the instructions provided by their respective software vendor. Individual export files should be limited to a maximum of 500 abstracts each. Registrars should work with their software vendors to ensure that files do not contain more than 500 abstracts.

SEER*Abs users can export completed abstracts from SEER*Abs into an external file for submission to the central registry, through a direct database update.

8.2 SUBMITTING TO THE NYSCR VIA THE HEALTH COMMERCE SYSTEM (HCS)

All cancer abstracts are submitted to the NYSCR electronically via the HCS. Follow the steps below to transmit a file to the NYSCR.

1. Connect to the HCS.
2. Click **CR Facility Reporting**, found under the **My Applications** header, located to the left of the screen* (Figure 1).
3. Once on the Cancer Registry page, click **Browse** (Figure 2) and select the appropriate .xml or .txt file from the appropriate export folder (Figure 3).
4. Click **Open** (Figure 3) and the file name will appear in the **Upload File** box (Figure 4).
5. Click **Upload** (Figure 4).
6. Following completion of a successful file upload, the user should receive a message similar to that shown in Figure 5. Users should allow up to ½ hour for processing, after which the user will be able to view the file information in the same **CR Facility Reporting** application on the HCS website.

*If you do not have access to the **CR Facility Reporting** application, contact your HCS Coordinator and request s/he add the role of Facility Cancer Reporting Submitter to your HCS account. This role must be assigned separately through each facility a user submits cases for. If you have any questions, contact your NYSCR Field Services Representative at (518) 474-0971.

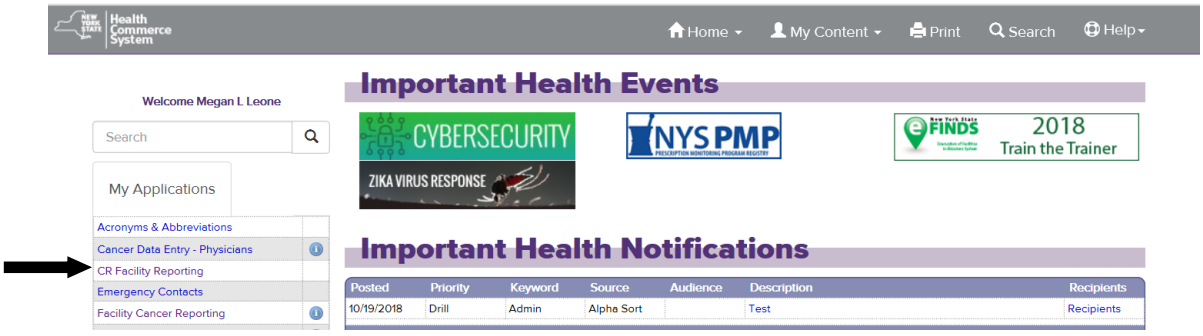

Figure 1

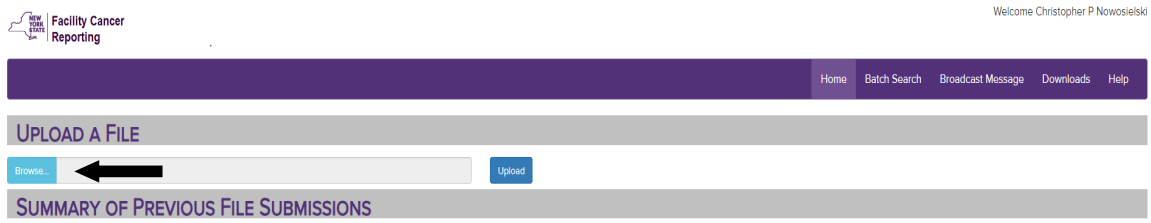

Figure 2

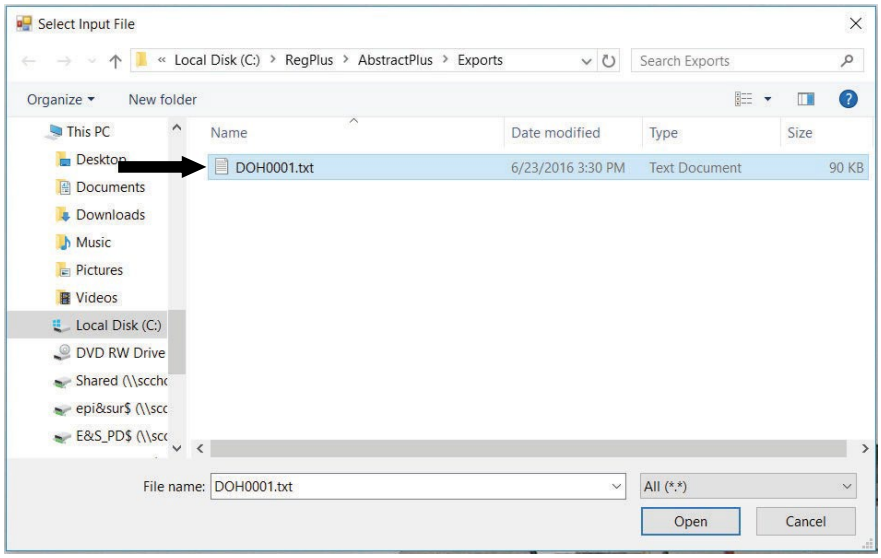

Figure 3

Figure 4

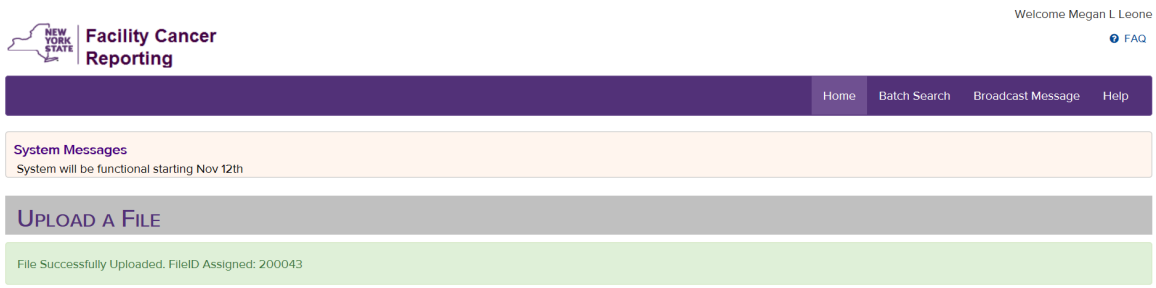

Figure 5

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New York State Cancer Registry Reporting Manual

Appendix A - NYS Public Health Law

Section 1. Short title.

This act shall be known and may be cited as the “Cancer Research Improvement
Act of 1997".

Section 2. Section 2401 of the public health law is amended to read as follows:

Article 24. Title 1.

§ 2401. Cancer; duty to report.

1. Every physician, dentist and other health care provider shall give notice immediately but not later than one hundred eighty days of every case of cancer or other malignant disease coming under his or her care, to the department, except as otherwise provided.

2. Whenever an examination of a tissue specimen in a laboratory discloses the existence of cancer or other malignant disease, the person in charge of such laboratory or the person making such examination shall immediately but not later than one hundred eighty days report the same together with all the facts in connection therewith to the department.

3. The person in charge of every cancer reporting facility shall immediately but not later than one hundred eighty days give notice of every case of cancer or malignant disease coming under the care of the institution to the department.

4. All abstracting work performed by a cancer reporting facility pursuant to the reporting provisions of this section shall be performed by a certified tumor registrar. Cancer reporting facilities may establish consortia to engage a certified tumor registrar to perform the reporting requirements of this section. A "certified tumor registrar" is an individual certified by a nationally recognized not-for-profit organization which certifies tumor registrars. The provisions of this subdivision shall not apply to any cancer reporting facility which renders services for one hundred or fewer cases of cancer and malignant disease per year as determined by the commissioner.

5. The department shall establish and update as necessary a manual designating which specific data elements shall be reported to the department pursuant to this section. The department shall make such manual available to every cancer reporting facility, physician, dentist, and other health care provider required to comply with the provisions of this section.

6. The department shall establish and update as necessary a data dictionary to standardize information interpretation of data elements reported by cancer reporting facilities and other health care providers. The department shall make such dictionary available to every cancer reporting facility, physician, dentist, and other health care provider required to comply with the provisions of this section.

7. The department shall, to the extent funds are made available, establish or contract for regional training programs to provide training to any cancer reporting facility, physician, dentist, or other health care provider required to comply with the provisions of this section. Such regional training programs shall provide training relating to the specific data elements which must be reported pursuant to this section, the data dictionary established pursuant to this section, and any other subjects which are intended to ensure quality, timely and complete compliance with this section.

8. The department shall, meet cancer registry goals established by a nationally recognized central cancer registry organization unless any such goal is contrary to any provision of law.

9. Where a cancer reporting facility fails to comply with the provisions of this section, the department may elect to perform registry services for such facility. Such cancer reporting facility shall reimburse the department for actual expenses incurred.

10. A physician, dentist, laboratory, cancer reporting facility or other health care provider which violates any provision of this section shall be subject to a civil penalty as provided in section twelve of this chapter.

11. The notices required by this section shall be upon forms supplied by the commissioner and shall contain such information as shall be required by the commissioner.

12. For the purpose of this section, a "cancer reporting facility" means a hospital as defined in article twenty-eight of this chapter, clinic or any organization certified pursuant to article forty-four of this chapter, or other similar public or private institution.

13. The commissioner shall have the power to promulgate any such rules and regulations as shall be necessary and proper to effectuate the purposes of this section.

§ 2401-a. Reporting.

1. Annual report. The commissioner shall, submit an annual report to the governor, the temporary president of the senate and the speaker of the assembly. The report shall include an evaluation of the cancer registry as it relates to timeliness, quality and completeness; an evaluation of the utility of the registry for scientific research; an evaluation of the access, timeliness and quality of reporting information to researchers and other similar individuals; an evaluation of the registry's data elements, including treatment, stage of disease, occupation and residence; an evaluation of the feasibility and utility of inclusion of occupational history and residence history; and an evaluation of integrating the registry with other data bases maintained by state agencies and departments, including the statewide planning and research cooperative system.

2. Quarterly report. The commissioner shall submit a quarterly report to the governor, the temporary president of the senate and the speaker of the assembly. The quarterly report shall include an evaluation of whether the registry is achieving cancer registry goals established by a nationally recognized central cancer registry organization, including numerical goals concerning timeliness, quality, and completeness.

3. Skin cancer reporting. The department shall annually submit a written report to the governor and the legislature on the incidence of skin cancer in the state of New York, by type and as a percentage of the overall number of reported cases of all types of cancer, as well as the associated causes of each type of skin cancer, if such causes are readily ascertainable. Such report shall be generated based on data gathered and reviewed pursuant to this title and shall provide information which is as current as practicable; provided, however, a retrospective of the past ten years of information collected pursuant to this title and predominant trends associated with such information, as concerns skin cancer and its associated causes, shall be a component of such report and each report submitted thereafter. At the discretion of the commissioner, such reports may provide additional information other than the information required by this subdivision. The first report created pursuant to this subdivision shall be submitted one year after the effective date of this subdivision. The reports generated pursuant to this subdivision shall be made available to the public on the department's website.

§ 2402. Cancer; reports confidential.

The reports of cancer cases made pursuant to the provisions of this article shall not be divulged or made public so as to disclose the identity of any person to whom they relate, by any person, except in so far as may be authorized in the sanitary code.

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New York State Cancer Registry Reporting Manual

Appendix B – HIPAA Information

This information sheet has been prepared to clarify and confirm the authority of NYSCR staff to access patient medical records relating to the diagnosis and treatment of cancer. Access to this information is sought under NYSDOH authority, pursuant to Public Health Law 2401, which provides that *"… every physician or other health care provider shall give notice immediately but not later than 180 days of every case of cancer or malignant disease coming under his or her care, to the Department of Health, except as otherwise provided."*

Such access has been determined by the NYSDOH/NYSCR to be the minimum necessary for protected health information for the state purpose in compliance with 45 C.F.R. s164.502. Please note that federal regulations permit reasonable reliance given attendant circumstances regarding requests for information made by public officials for stated purposes. [45 C.F.R. s164.514(d).]

The NYSDOH is a "public health authority", as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Federal regulations [see 45 C.F.R. s164.512] authorize disclosure without patient consent in a number of circumstances, including the following:

Disclosure is permitted to a public health authority authorized by law to access information to prevent/ control disease, injury, disability, e.g., disease reporting, vital statistics reporting, public health surveillance, public health investigations, public health interventions and partner notification.

Because the NYSDOH is a public health authority and because cancer reporting and surveillance are required by state law, it is not necessary to complete a business associate's agreement before providing the NYSCR with the requested personally identifiable information. The requested information is needed to conduct public health surveillance and will remain confidential.

If you have any questions with respect to the NYSCR's authority to access protected health information, please contact April Austin, Director, NYSCR, at 518-474-0971.

Frequently Asked Questions and Answers
About HIPAA and Cancer Reporting

The below FAQs and answers about HIPAA were excerpted and revised by New York State from a document prepared by the North American Association of Central Cancer Registries (NAACCR). If you have any specific questions about HIPAA and cancer reporting that are not addressed below, please contact your NYSCR representative.

1. What is a 'Public Health Authority' under HIPAA?

Under HIPAA, a 'Public Health Authority' refers to "an agency or authority of the United States, a State or territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate." [1] "...Such agencies are authorized by law to collect or receive such information for the purposes of preventing or controlling disease, injury, vital events such as birth or death and the conduct of public health surveillance, public health investigations and public health interventions." [2] *Central cancer registries* are considered public health authorities because their duties are mandated by state laws.

[1] C.F.R. 164.501
[2] C.F.R. 164.512

2. What is a 'Covered Entity' under HIPAA?

A **'**Covered Entity' is a health care plan, a healthcare clearinghouse, or a health care provider who transmits any health information in electronic form for financial and administrative transactions. A 'health care provider' is "a provider of medical or health services and any other person who furnishes, bills or is paid for health care in the normal course of business."[1]

[1] C.F.R. 160.103

3. How does HIPAA impact the data collection of non–reportable/benign diseases (i.e., benign brain, CIN III, Co-morbid conditions)?

HIPAA does not obstruct any state law that supports or mandates the reporting of such cases.

4. Are private practice physicians still required to report new cancer cases?

Yes, reporting is required when in compliance with state reporting regulations. The central cancer registry has a reportable list that identifies which cancers are reportable and all reportable cancers should be reported, as required by state law.

5. What, if any, are the consequences of not reporting new cancer case information to the New York State Cancer Registry?

Penalties for failing to comply with state reporting are specified in the state law. A fine may be levied up to $2,000 per violation and if violation is willful, imprisonment of up to one year is possible. PHL § 12 and 12-b.

6. Doesn't HIPAA nullify or preempt the state law for reporting cancer cases to central cancer registries?

No. Public health reporting under the authority of state law is specifically exempted from HIPAA preemption, per 45 C.F.R. § 160.203(c).