

NEVADA CANCER REPORTING MANUAL

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATE OF NEVADA



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ABOUT THE NEVADA CENTRAL CANCER REGISTRY

The Nevada Central Cancer Registry (NCCR) is a population-based registry that maintains data on all cancer patients within the state of Nevada. The Registry is housed under the Nevada Division of Public and Behavioral Health (DPBH) Office of Public Health Investigations and Epidemiology (OPHIE) and began collecting cancer incidence data in 1989. In 1995, NCCR began receiving funding from the National Program of Cancer Registries (NPCR) through the Centers for Disease Control and Prevention (CDC). The NCCR reference date is January 1, 1995.

The goal of NCCR is to gather comprehensive, timely, and accurate data on the incidences of cancer among Nevada residents.

The registry provides statistical data for use by epidemiologists, health researchers and others in the medical and allied health professions. Information from the registry is intended to identify cancer risk, evaluate cancer patient care, and characterize leading trends in cancer incidence, survival, and mortality among state residents.

NCCR provides the following services:

- Processes cases and conducts quality control audits on cases abstracted by health care facilities and providers of health care
- Receives and processes reports from pathology laboratories
- Executes Data Exchange Agreements with other states
- Provides training to cancer registrars in the state
- Provides statistical cancer data for researchers, prevention programs, medical professionals, and community partners

The Nevada Cancer Reporting Handbook serves as a supplement to the *2023 SEER Program Coding and Staging Manual* for consistent collection and coding of relevant cancer case information. This edition should be used for reportable cases diagnosed January 1, 2023, and forward. The contents of this manual are based on the guidelines for cancer reporting established by NPCR at the CDC and the North American Association of Central Cancer Registries (NAACCR).

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Requests for data for research studies, reports, or other relevant projects should be submitted to NCCR through data@dhhs.nv.gov.

Cancer Reporting Law

Public Law 102-515, the Cancer Registries Amendment Act, was enacted in 1992. Through this Congress established NPCR through the CDC. Through this act, NPCR was established to fund and support the operation of population-based, statewide cancer registries to collect cancer data.

NCCR is regulated by both Nevada Revised Statutes (NRS) 457.230-457.280 and Nevada Administrative Codes (NAC) 457.045-457.150. State regulations made cancer a reportable disease in Nevada effective in 1983.

The effort for the State to collect cancer data has been further strengthened through NAC 457.045-457.150 which provides the authority to require hospitals, pathology laboratories, free-standing cancer clinics, long-term care facilities, ambulatory surgery centers, and physicians to report cancer cases diagnosed and treated in Nevada. Compliance with cancer reporting will ensure complete, timely, and accurate surveillance data and enable the registry to produce meaningful cancer statistics for public use.

Quality Control

Accuracy and consistency are essential components of any hospital and central registry. The data must be accurate, complete, and timely. Visual editing is conducted at NCCR on a percentage of all reported cases. The NCCR conducts audits on quality control and completeness of data at randomly selected facilities. These audits are a useful tool to identify consistent reporting problems and supply meaningful training throughout the state on cancer data collection. The goal of the NCCR is to obtain complete reporting of all cancer cases in Nevada and to exceed the accuracy rate of 95 percent. The NCCR monitors completeness of reporting by reviewing frequency distribution reports for each facility.

It is the responsibility of the facility that is administering care to report cases to NCCR. If your hospital employs an external professional contract service for abstracting services to comply with NCCR reporting requirements, your facility is still fully responsible for all cancer reporting activities including but not limited to:

- Data quality
- Corrections
- Documentation

It is up to the facility to ensure that:

- All data quality expectations are met
- All deadlines are met
- All requirements are met

All activities are carried out to meet the facility responsibilities to the Nevada Department of Public and Behavior Health through NCCR.

NCCR is a state-mandated population-based statewide cancer surveillance system. Participation in NCCR is mandated under Nevada statute and is not a voluntary reporting system like the Commission on Cancer's National Cancer Database.

GENERAL PROCEDURES

Who Reports to NCCR

Hospitals

General, Critical Access and Specialty/Surgery Hospitals must report all required inpatient and outpatient cancer cases.

Non-Hospitals

Physicians in private or group practice must report all required cancer cases. This includes:

- Patients who are clinically diagnosed and receive no further work-up or treatment, or who have been referred to another physician
- Patients who are newly diagnosed in the physician's own laboratory or by sending a specimen from the office to an outside laboratory, whether hospital or independent
- Patients whose first course of treatment is initiated in the physician's office or clinic. This includes cancer treatment by surgery, radiation, chemotherapy, immunotherapy, or hormones

Dentists must report all required cancer cases that are diagnosed and/or treated in their practice, or who have been referred to another physician. This includes:

- Patients who are diagnosed or treated by a dentist who performs a biopsy and/or receives a pathology report of a reportable case.

Dermatologists must report all required cancer cases diagnosed and/or treated in their practice. This includes:

- Patients who are diagnosed or treated by a dermatologist who performs a biopsy and/or receives a pathology report of a reportable case.

Freestanding radiation or medical oncology clinics must report any patient initially diagnosed with a reportable cancer or when the physician initiates the first course of treatment (FCOT). This includes cancer treatment by surgery, radiation, chemotherapy, immunotherapy, or hormones. See [Appendix F](#) "Cancer Directed Treatment."

Surgery Centers – Freestanding surgery centers-includes plastic reconstructive, oral and maxillofacial surgery centers (independent centers not affiliated with any hospital) must report any patient undergoing a biopsy or other surgical procedure at the facility for a newly diagnosed reportable cancer. This includes cases also reported by either a hospital based or a private/independent medical laboratory.

Other Facilities - Facilities that provide cancer screening services, diagnostic services, or therapeutic cancer services must report confirmed cancer cases which are subject to reporting. This includes facilities that provide mammography or radiology services, palliative, prophylactic, or adjuvant therapy for reportable cases.

Long-term acute care hospitals, hospices and skilled nursing facilities must report the following types of diagnosed reportable cancer cases:

- Cases clinically diagnosed but not confirmed through biopsy, cytology, or other microscopic methods
- Cases for whom the first course of cancer treatment is initiated at the facility (treatment may include chemotherapy, immunotherapy, or hormone therapy), and
- Cases admitted with active cancer for the purpose of receiving supportive care, palliative care, pain management and/or hospice services.

Medical laboratories must report each specimen which shows evidence of cancer which are subject to reporting. This includes:

- Hospital-based laboratories
- Private laboratories, and
- Independent laboratories.

When to Report to NCCR

The timeframe for reporting cancer cases to NCCR, as defined in NAC 457.050.2b, is within 6 months from the date of first contact (patient’s first visit to the facility) following the cancer diagnosis. This includes all cases (analytic and non-analytic) diagnosed and/or treated for cancer, having a cancer related health visit while undergoing cancer treatment, or having any evidence of disease at the time of the encounter.

2023 Reporting Calendar

Patient encounter in:	Report no later than:
January 2023	July 2023
February 2023	August 2023
March 2023	September 2023
April 2023	October 2023
May 2023	November 2023
June 2023	December 2023
July 2023	January 2024
August 2023	February 2024
September 2023	March 2024
October 2023	April 2024
November 2023	May 2024
December 2023	*June 2024

*All cases from 2023 must be reported to NCCR on or before the June 30 Annual Reporting Deadline.

June 30 deadline is the annual call for data (CFD) milestone for cancer reporting in Nevada. All cases must be reported to NCCR on or before June 30, 2024, as required by Nevada law.

Facilities not in compliance with the six-month reporting rule will be notified of the delinquency and asked for corrective action to be made immediately, but no later upon 30 days of receipt of notification.

Any facility not in compliance may be asked to develop a remedial plan to bring the facility back into compliance with the Nevada Revised Statutes. At the discretion of the Program Manager and/or Chief Medical Officer, the plan must include at minimum, a detailed overview of the root cause for the underlying delays in reporting, and specific action steps that will outline how the facility will address the issues to improve reporting timelines. The action steps could include, but are not limited to resource allocation, training and

development, and process improvement measures. In summary, the facility at question will need to indicate how the facility plans to correct their non-reporting status and stay in compliance once the current reporting year has been completed, and compliance has been reached. At the discretion of the Cancer Registry Program Manager, the plan might include more or less detail and will be monitored and evaluated on a monthly basis.

How to Report to NCCR

Hospital staff will submit reportable cancer cases by either a commercial software vendor or NCCR's Web Plus platform.

CASEFINDING AND REPORTABILITY

Casefinding

Casefinding is a system for identifying every patient who was diagnosed and/or treated with a reportable diagnosis of cancer at your facility. Casefinding is usually a term applied to a hospital setting but can be used in physician practices as well. *All* reporters of cancer must have a process in place to ensure every possible case of cancer is reported. This includes both hospitals and non-hospitals. The casefinding process for a small physician office, for example, could be a task as simple as manual reviewing pathology reports.

Types of Casefinding

Active casefinding is performed by registry personnel who screen the source documents themselves and is usually performed in a hospital setting by a designated cancer reporter. The skillset for this task would include medical terminology, experience navigating through health records, knowledge of national and state reporting requirements, and a basic understanding of the cancer disease process. The State Cancer Registry recommends hiring a person with a Certified Tumor Registrar (CTR) credential. Investing in hiring or contracting a CTR would ensure that your facility identifies and submits all reportable cases with accurate and quality data. Active casefinding can be a little more costly at first, but the overall process is more thorough and accurate and saves time in the longer run.

Passive casefinding is when other departments notify the cancer registry of potentially reportable cases. Incomplete casefinding may occur because this process relies on other healthcare professionals that are not as familiar with reporting terminology rules. Best practices include a combination of both active and passive casefinding activities and is commonly used in most registries.

Casefinding Sources

Although 95% of reportable cancer cases are from pathology reports, review of only one type of source document cannot identify all cancer cases diagnosed or treated in a hospital. Source documents for casefinding may vary but in general hospital registry source documents can include, but are not limited to, the following:

- Other facilities and/or departments with potential sources for finding eligible cancer cases
 - Outpatient, clinic and ambulatory care services/surgery
 - Disease index
 - Daily facility and clinic discharges
 - Surgery and visit logs
 - Billing form copies (contain both diagnosis and ICD codes)
- Oncology related services
 - Radiation therapy logs
 - Nuclear medicine logs
 - Radiology logs, including logs of scans

- Radiation and chemotherapy appointment books/logs
- Staff physicians' offices
 - Disease index
- Long-term care facility/skilled nursing facility
 - Admission and discharge documents
- Hospice
 - Monitor admissions to facility hospice units for casefinding purposes. Collect eligible cases where:
 - Palliative or comfort care is provided
 - Active cancer cases whether patients have been diagnosed and/or have received treatment at the facility or not
 - Death certificates

Recognizing Cancer Terms

The following examples use general terms commonly found in pathology reports and medical reports.

- MRI brain: 12 mm area right frontal lobe likely representing indeterminate neoplasm (not reportable)
- Patient history: Patient has a nephrectomy some years ago for kidney tumor of unknown type (not reportable)
- Report of pelvic ultrasound: 7.4 hypoechoic pelvic mass (not reportable)
- Patient history: Patient reports a resection of a benign breast tumor several years ago, with no evidence of recurrence (not reportable)
- Pleural fluid cytology: Cells positive for metastatic malignancy (reportable)

Refer to the [Reportable Conditions](#) section of this manual for instructions on how to determine reportable terms.

Ambiguous Terminology Diagnostic of Cancer

The diagnosis of cancer is made when a recognized medical practitioner states that the patient has cancer. As part of the registry casefinding processes, all diagnostic reports should be reviewed to confirm whether a case is required to be reported. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included. Words or phrases that appear to be synonyms of these terms do not constitute a diagnosis such as “supposed” for “presumed” or “equal” for “comparable with”. “Likely” alone does not constitute a diagnosis however “most likely” does. Use only the exact words on the lists. See the STORE manual Ambiguous Terms at Diagnosis.

The first and foremost resource for the registrar for questionable cases is a physician who diagnosed and/or staged the tumor. If the physician is not available, the medical record and any other relevant reports, such as the pathology report, should be read carefully for the required information. The purpose of the ambiguous terminology listed below is to help registrars make consistent decisions with respect to reportability when no further information is available from any resource. When there is a clear statement of malignancy, the registrar should not refer to the list of ambiguous terms. Registrars should only rely on these terms when the situation is not clear, and the case cannot be discussed with the appropriate physician or pathologist.

Ambiguous terms can be found in pathology reports, radiology reports, or clinical reports. The following terms are reportable when used with a term like cancer, carcinoma, sarcoma, etc.

Terminology diagnostic of cancer

Apparently	Appears	Comparable with
Compatible with	Consistent with	Favors
Malignant appearing	Most likely	Presumed
Probable	Suspect(ed)	Suspicious (for)

Typical of

- Do not substitute synonyms such as “supposed” for presumed or “equal” for comparable.
- Do not substitute “likely” for most likely.
- Ignore modifiers or other adjectives the precede and ambiguous term (“mildly suspicious”)

Terminology *not* diagnostic of cancer

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

Non-Analytic Case Reporting

NCCR requires the collection and reporting of both analytic and non-analytic cases that meet reporting requirements. Your facility’s lack of involvement in initial diagnosis and/or treatment of a patients’ cancer make it non-analytic. A non-analytic case is reportable if a patient comes to your facility with evidence of cancer but was diagnosed and treated elsewhere. Nevada must have 100% cancer case reporting for accurate cancer incidence figures to be calculated.

Facilities with CoC-accredited cancer programs voluntarily abstract/report analytic cases to a clinical research database known as the National Cancer Database (NCDB). This voluntary reporting accounts to 70%-80% of hospitals in the United States – not 100% reporting. Hospital analytic cases are not the only part of the cancer registry database. Non-analytic cases are, indeed, equally important particularly when the patient has evidence of cancer, recurrence of cancer, or progression of cancer. Furthermore, non-analytic cases of recurrent/progressive cancers bring in more revenue from treatment than do your analytic cases. Reporting non-analytic cases also assists NCCR when finding a match during the death clearance process which helps reduce the number of “death clearance only cases” for the annual Call for Data submission; and assists in populating key demographic information (SSN, race, address, etc.) which are increasingly difficult for NCCR to acquire.

We’ve collected some non-analytic case scenarios to assist your decision-making process as you analyze whether a case needs to be abstracted and reported to NCCR. Consider the following:

- Has the case been previously submitted by your facility?
- Do you have any information to piece together a case?
- Did the patient come in with a history of some type of cancer and then have a procedure done or scan showing METS at your facility?

Examples of Reportable Non-Analytic Cases

The patient recently moved to Nevada from California and presents to your facility with severe abdominal pain; CT reveals liver METS; record indicates HX of breast cancer DX and TX in California; decision is made for hospice.

Rationale: This case should be reported because the patient will expire in Nevada and the only way we would catch this case is by death certificate. *Make sure to complete the address at diagnosis fields to reflect where the patient was diagnosed.

Chart reads “PT has HX of lung cancer S/P lobectomy in 2003; presents W/dizziness; CT shows brain METS; BX shows brain METS and METS lung cancer.”

Rationale: If this case has not previously been reported, it should be reported because there is enough information to estimate diagnosis date and treatment information.

Chart reads: “PT has HX of CLL DX 5 years ago and was TX W/CHEMO.”

Rationale: Abstract this case because date of diagnosis and treatment can be estimated.

Examples of Cases You Can Skip

- The patient comes in due to a motor vehicle accident and has a HX of CLL. There is no other information available about diagnosis date, treatment, etc.
- The patient is seen due to dehydration and there is a mention of a HX of cancer but insufficient information to construct a case.
- The patient comes in with a history of prostate cancer and is only seen for lab work.
- The patient is seen for a port-a-cath insertion only and there is no other information about the patient’s cancer.

We strongly suggest developing a process to track all skipped cases with the reason why the case was not abstracted. Tracking these cases on an Excel spreadsheet, for example, would assist your facility when NCCR conducts a case finding audit on your facility.

Reportable Conditions

Public Law 102-515 and its amendments identify reportable conditions for NPCR registries; therefore, Nevada refers to the histology and behavior codes of the *International Classification of Diseases for Oncology, 3rd Edition, 2nd Revision Morphology* (ICD-O-3.2) including approved updates and errata published by the WHO and approved by NAACCR for ICD-O-3.2. There is still no PDF version of ICD-O-3.2. Use the [ICD-O-3.2 tables](#) from IACR/WHO in addition to the [current Solid Tumor Rules](#) and [current SEER Hematopoietic Database](#) to determine whether a neoplasm is reportable to NCCR.

- All neoplasms with behavior code /2 (in situ) or /3 (malignant) with minor exceptions that include CIN III and PIN III or carcinoma in situ of the cervix or prostate.
- Benign and borderline primary intracranial and central nervous system (CNS) tumors with a behavior code of /0 or /1 in ICD-O-3 regardless of histologic type for these topography codes
 - Meninges
 - C70.0 Cerebral Meninges
 - C70.1 Spinal meninges
 - C70.9 Meninges, NOS
 - Brain
 - C71.0 Cerebrum
 - C71.1 Frontal lobe
 - C71.2 Temporal lobe
 - C71.3 Parietal lobe
 - C71.4 Occipital lobe
 - C71.5 Ventricle, NOS
 - C71.6 Cerebellum, NOS
 - C71.7 Brain stem
 - C71.8 Overlapping lesion of brain
 - C71.9 Brain, NOS
 - Spinal Cord, Cranial Nerves, and Other Parts of the Central Nervous System
 - C72.0 Spinal cord
 - C72.1 Cauda equina
 - C72.2 Olfactory nerve
 - C72.3 Optic nerve
 - C72.4 Acoustic nerve
 - C72.5 Cranial nerve, NOS
 - C72.8 Overlapping lesion of brain and central nervous system
 - C72.9 Nervous system, NOS
 - Other Endocrine Glands and Related Structures
 - C75.1 Pituitary gland
 - C75.2 Craniopharyngeal duct
 - C75.3 Pineal gland
- The following squamous intraepithelial neoplasias, grade III (8077/2) are reportable:
 - Anal intraepithelial neoplasia (AIN III) coded to C21
 - Vulvar intraepithelial neoplasia (VIN III) coded to C51
 - Vaginal intraepithelial neoplasia (VAIN III) coded to C52
- Analytic cases. Patients whose initial diagnosis was made at your facility and/or any part of the first course of treatment was delivered or prescribed at your facility. (Class of Case 00, 10, 11, 12, 13, 14, 20, 21, 22)

- Nonanalytic cases. Patients diagnosed elsewhere who had all first course treatment elsewhere who were seen at your facility for diagnosis of recurrent disease or for treatment of relapsed, persistent or progressive disease; cases diagnosed prior to the facility's Reference Date and diagnosis or treatment was given by the reporting facility; diagnosis was established by autopsy at reporting facility and was unsuspected prior to death (Class of Case 32, 35, 37 and 38). Record all available information regarding the original diagnosis and treatment.
- Malignant tumors of the skin such as adnexal carcinoma/adenocarcinoma (8390/3-8420/3), lymphoma, sarcoma, and Merkel cell carcinoma must be reported. Any carcinoma arising in a hemorrhoid is reportable, since hemorrhoids arise in mucosa, not in the skin.
- 2021 New Reportable Neoplasms/Reclassified Tumors
 - Early or evolving melanoma, in situ and invasive: As of 01/01/2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable.
 - All GIST tumors, except for those stated to be benign, are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2.
 - Nearly all thymomas are reportable as of 01/01/2021. The behavior code is /3 in ICD-O-3.2. The exceptions are:
 - Microscopic thymoma or thymoma, benign (8580/0)
 - Micronodular thymoma with lymphoid stroma (8580/1)
 - Ectopic hamartomatous thymoma (8587/0)
 - Pheochromocytoma and Medullary Paraganglioma of Adrenal Gland
- 2022 New Reportable Neoplasms/Reclassified Tumors
 - Low-grade appendiceal mucinous neoplasm (LAMN) is reportable.
 - High-grade appendiceal mucinous neoplasm (HAMN) is reportable.
 - Serrated dysplasia, high-grade (C160-C166, C168-C169, C170-C173, C178-C179)
 - Adenomatous polyp, high grade dysplasia (C160-C166, C168-C169, C170-C173, C178-C179)
 - Intestinal-type adenoma, high grade (C160-C166, C168-C169, C170-C173, C178-C179).
 - Chondrosarcoma, grade 1
 - 9 New Histology Codes with Associated New Histology Terms
 - 8455/3 - Intraductal oncocytic papillary neoplasm with associated invasive carcinoma (C250C254, C257-C259)
 - 8483/3 - Adenocarcinoma, HPV-associated C530-C531, C538-C539)
 - 8484/3 - Adenocarcinoma, HPV-independent, NOS C530-C531, C538-C539)
 - 8859/3 - Myxoid pleomorphic liposarcoma
 - 8976/3 - Gastroblastoma (C16.0 – C16.9)
 - 9111/3 - Mesonephric-like adenocarcinoma
 - 9366/3 - Round cell sarcoma with EWSR1-non-ETS fusions
 - 9367/3 - CIC-rearranged sarcoma
 - 9368/3 - Sarcoma with BCOR genetic alterations
- Pilocytic/juvenile astrocytoma (9421) will continue to be collected as a /3 even though the behavior code changed to /1 in the ICD-O-3.
- 8323/3 – Class of kidney has been reclassified as a ISUP Grade 1 (low grade neoplasm) which is not malignant. However, this cancer is still reportable in the United States using the 8323/3 malignant clear cell papillary renal cell carcinoma of kidney code.

- Carcinoid, NOS of the appendix is reportable. As of 01/01/2015, the ICD-O-3 behavior code changed from /1 to /3.
- Lobular carcinoma in situ (LCIS) of breast is reportable.
- Basal cell carcinoma in *genital sites* coded to labia, clitoris, vulva, vagina, prepuce, penis, and scrotum are reportable to NCCR.
- Squamous cell carcinoma in *genital sites* coded to labia, clitoris, vulva, vagina, prepuce, penis, and scrotum are reportable to NCCR.
- Pancreatic intraepithelial neoplasia (PanIN III) 8148/2 is reportable.
- Penile intraepithelial neoplasia G3, (PeIN) 8071/2 is reportable.

2023 New Reportable Neoplasms/Reclassified Tumors

ICD-O Code	Term	Remarks
9430/3	Astroblastoma, MN1-altered	New term
9400/3	Astrocytoma, IDH-mutant, grade 2	New term
9401/3	Astrocytoma, IDH-mutant, grade 3	New term
9445/3	Astrocytoma, IDH-mutant, grade 4	New term
8140/0	Bronchiolar adenoma/ciliated muconodular papillary tumor	New terms/Not reportable
8693/3	Cauda equina neuroendocrine tumor (cranial and paraspinal nerves)	New related term
9473/3	CNS embryonal tumor, NEC/NOS	New term
9500/3	CNS neuroblastoma, FOXR2-activated	New term
9500/3	CNS tumor with BCCR internal tandem duplication	New term
8821/1	Desmoid fibromatosis	New term/not reportable
9421/1	Diffuse astrocytoma, MYB- or MYBL1-altered	New preferred term for “pilocytic astrocytoma” Beginning with cases diagnosed 1/1/2023, pilocytic astrocytoma are coded 9421/1. Cases diagnosed prior to 1/1/2023 are coded 9421/3.
9385/3	Diffuse hemispheric glioma, H3 G34-mutant	New term
9680/3	Diffuse large B-cell lymphoma associated with chronic inflammation of the pleura (C38.4)	New term
9509/3	Diffuse leptomeningeal glioneuronal tumor	New code/new term/new behavior

ICD-O Code	Term	Remarks
9421/1	Diffuse low-grade glioma, MAPK pathway–altered†	Related term for “pilocytic astrocytoma” Beginning with cases diagnosed 1/1/2023, pilocytic astrocytoma are coded 9421/1. Cases diagnosed prior to 1/1/2023 are coded 9421/3.
9385/3	Diffuse midline glioma, H3 K27-altered	New term
9385/3	Diffuse pediatric-type glioma, H3-wildtype and IDH-wildtype	New term
9050/3	Diffuse pleural mesothelioma (C38.4)	New term
9170/3	Diffuse pulmonary lymphangiomatosis (C34._)	New term
9680/3	Fibrin-associated diffuse B-cell lymphoma (C38.0)	New term
9421/3	High-grade astrocytoma with piloid features (HGAP)	New code/new term. Beginning 1/1/2023, cases diagnosed as <i>high-grade astrocytoma with piloid features (HGAP)</i> are coded 9421/3. Beginning 1/1/2023, cases diagnosed as Pilocytic astrocytoma in the C71._ are to be coded 9421/1
8310/3	Hyalinizing clear cell carcinoma	New term
9385/3	Infant-type hemispheric glioma	New term
9749/1	Juvenile xanthogranuloma (C71.5)	New code/new term/new behavior
9050/3	Localized pleural mesothelioma (C38.4)	New term
8260/3	Low-grade papillary adenocarcinoma (C34._)	New term
9174/3	Lymphangiomyomatosis	Behavior code change from /1 to /3. Reportable for cases diagnosed 1/1/2023 forward.
9540/3	Malignant melanotic nerve sheath tumor	New term
9699/3	MALT lymphoma of the dura	New term
9470/3	Medulloblastoma, histologically defined (C71.6)	New term
9050/2	Mesothelioma in situ (C38.4)	New code/behavior. Reportable 1/1/2023
8077/2	Moderate squamous dysplasia (C34._)	New term. *Note: moderate and severe squamous dysplasia are

ICD-O Code	Term	Remarks
		incidental findings on bronchoscopy. Considered precursor to squamous carcinoma in situ (SCIS). Reportability has not yet been determined.
9509/0	Multinodular and vacuolating neuronal tumor	New code/new term/new behavior. Cases diagnoses prior to 1/1/2023 use code 9505/0. Cases diagnosed 1/1/2023 forward use code 9509/0.
9509/1	Myxoid glioneuronal tumor	New term
9450/3	Oligodendroglioma, IDH-mutant and 1p/19q-codeleted, grade 2	New term
9451/3	Oligodendroglioma, IDH-mutant and 1p/19q-codeleted, grade 3	New term
8820/0	Papillary fibroelastoma	New term/not reportable
8272/3	Pituitary adenoma/pituitary neuroendocrine tumor (PitNET) (C75.1)	New term. Per WHO, both terms may be used in the diagnosis or pituitary neuroendocrine tumor, or PitNET. All are coded 8272/3. Pituitary adenoma, NOS is coded 8272/0.
9413/0	Polymorphous low-grade neuroepithelial tumor of the young	New term
9391/3	Posterior fossa ependymoma, NOS	New term
9396/3	Posterior fossa group A (PFA) ependymoma	New term
9396/3	Posterior fossa group B (PFB) ependymoma	New term
9480/3	Primary intracranial sarcoma, DICER1-mutant	New term
9749/3	Rosai-Dorfman disease	New term
8077/2	Severe squamous dysplasia (C34..)	New term. Note: moderate and severe squamous dysplasia are incidental findings on bronchoscopy. Considered precursor to squamous carcinoma in situ (SCIS). Reportability has not yet been determined.
9396/3	Spinal ependymoma, MYCN-amplified (C72.0)	New term

ICD-O Code	Term	Remarks
9391/3	Spinal ependymoma, NOS (C72.0)	New term
9391/3	Supratentorial ependymoma, NOS	New term
9396/3	Supratentorial ependymoma, YAP1 fusion-positive	New term
9396/3	Supratentorial ependymoma, ZFTA fusion-positive	New term
8044/3	Thoracic SMARCA4-deficient undifferentiated tumor (C34._)	New term

Special Notes

- IMPORTANT FOR CASES Diagnosed 2023 FORWARD:
- Beginning 1/1/2023, all cases diagnosed with pilocytic astrocytoma/juvenile pilocytic astrocytoma and related terminology are to be reported with behavior /1. They will no longer be collected with malignant behavior (/3). ICD-O code 9421/3 will be valid for the diagnosis of high-grade astrocytoma with piloid features or HGAP only. Coding instructions are included in the remarks section for 9421/1 and 9421/3 in the 2023 ICD-O Update Tables 1 and 2.

Hematopoietic and Lymphoid Neoplasms

The [Hematopoietic and Lymphoid Neoplasm Coding Manual](#) provides the instructions and rules for determining the number of primaries, the primary site and histology, and the cell lineage or phenotype.

Do not use ICD-O-3 to code any histology 9590-9993. Use the [Hematopoietic and Lymphoid Neoplasm Database](#) as a tool to assist in screening for reportable cases and determining reportability requirements. The database also contains abstracting and coding information for all hematopoietic and lymphoid neoplasms. The Hematopoietic Database is the only complete source of information for lymphoid and myeloid neoplasms including but not limited to lymphoma, leukemia, plasma cell neoplasms, myelodysplastic syndromes, and myeloproliferative diseases.

<https://seer.cancer.gov/seertools/hemelymph>

*Use the Hematopoietic and Lymphoid Neoplasm Database only when instructed by the rules in the Hematopoietic Manual.

Non-Reportable Conditions

- Skin neoplasms (C44.0 – C44.9) that are NOT reportable
 - 8000-8005 malignant neoplasms, NOS of the skin
 - 8010-8046 epithelial carcinomas, NOS of the skin
 - 8050-8084 papillary and squamous cell carcinoma of the skin
 - 8090-8110 basal cell carcinoma of the skin
 - 8077/2 squamous intraepithelial neoplasia III (SIN III) of the skin
- BIRADS Category 4 and BIRADS Category 5 Diagnosis without biopsy is not reportable. A positive/suspicious mammogram date should be used as the date of diagnosis ONLY when the patient goes on to subsequently have a positive biopsy and/or resection that confirms the suspicious abnormality is in fact a malignancy.
- Colorectal tumors with the following morphologic description: serrated dysplasia, high grade; adenomatous polyp, high grade dysplasia; tubular adenoma, high grade; villous adenoma, high grade; tubule-villous adenoma, high grade.
- Microscopic thymoma or thymoma benign (8580/0), micronodular thymoma with lymphoid stroma (8580/1), and ectopic hamartomatous thymoma (8587/0).
- Patients who have a history of cancer, but diagnosis or treatment were not performed at your facility. (Class of case 33)
- Patients who receive transient care to avoid interruption of therapy started elsewhere. (Class of case 31)
- Patients seen only in consultation to confirm a diagnosis. (Class of case 30)
- Patients with adenocarcinoma in situ and carcinoma in situ of the cervix, cervical intraepithelial neoplasia (CIN) or prostatic intraepithelial neoplasia (PIN)
- Patients with a pre-cancerous condition or benign tumor (other than CNS sites stated above)
- Patients above who are not reportable for your facility, but who die at your facility with active cancer. Although these cases are not required, they may be reported to NCCR. Cases not reported at the time of death may appear later on a Death Certificate Only listing (list of patients who died at your facility with cancer but not listed in the NCCR database). These will require additional follow-back by the registry and research by the registrar. A minimal abstract prepared with documentation of any available information regarding date of diagnosis, primary site, histology, or treatment is very useful.

REQUIRED DATA ITEMS

This portion of the manual is intended to explain in detail each data item required by NCCR. It should be used as the primary information resource for any data item that must be coded and documented in accordance with Nevada cancer reporting law.

NCCR follows the data standards and requirements set forth by NPCR. For more information on what is required by the standard setters, see [v23: Required Status Table](#) at the NAACCR website.

Data item descriptions and instructions are included in the CoC Store Manual, the NAACCR Volume II Data Dictionary, and the SEER Coding and Staging Manual; all are essentially comparable in content, rules, instructions, and examples provided to ensure consistent coding across platforms.

The descriptions and instructions for the data items are organized into sections following the same order as they appear in Web Plus. The sections include:

- Hospital Specific
- Patient Information
- Demographic
- Cancer Information
- Text Fields
- Stage of Disease
- Site Specific Data Items (SSDIs)
- Diagnostic Biopsy Procedures
- First Course of Treatment
- Radiation Therapy
- Chemotherapy
- Hormone Therapy
- Immunotherapy
- Other Treatment
- Patient Outcomes

Hospital Specific

Abstracted By: (570)

An alphanumeric code assigned by the reporting facility that identifies the individual abstracting the case.

Reporting Facility: (540)

The Reporting Facility identification number or FIN is used to identify a reporting facility in the central registry database and is useful for monitoring data submission, ensuring the accuracy of data and identifying areas for special studies.

NPI Reporting Facility: (545)

The NPI (National Provider Identifier) code for the facility submitting the data in the record.

Date of 1st Contact: (580)

Date of first patient contact, inpatient or outpatient, for the diagnosis and/or treatment of the tumor. The date may represent an outpatient visit for biopsy, imaging exam or laboratory test. If the patient is diagnosed at the reporting facility, the date of diagnosis and the date of first contact will be the same. If the patient is diagnosed at an outside facility, the date of first contact is the date the treatment starts at the reporting facility.

Date Case Initiated: (2085)

Date the electronic abstract is initiated in the reporting facility's cancer registry database. Standard edits check that no dates are later than the current date or the date completed.

Accession Number: (550)

Provides a unique identifier for the patient consisting of the year in which the patient was first seen at the reporting facility and the consecutive order in which the patient was abstracted. The first four numbers specify the year, and the last five numbers are the numeric order in which the patient was entered into the registry database. Within a registry, all primaries for an individual must have the same accession number. The first four digits must be greater than or equal to 1944.

Format: The first four digits of the Accession Number specify the year in which the patient first had contact with the reporting facility in the format CCYY. The last five digits are the sequential/numeric order in which the registry entered the case into the database.

Each patient receives only one accession number from your facility for a lifetime, regardless of the facility "reference date," number of primary cancers reported, or alternate numbering assignment.

Class of Case: (610)

Use the drop down and select the class of case that reflects the facility's role in the management of the cancer. A decision to not treat is still considered treatment.

Primary Payer at DX: (630)

Use the drop-down and select the code that describes the primary payer or insurance carrier at the time of the initial diagnosis and/or treatment. If primary payer is unknown, select "99" for unknown. Do not leave blank.

Patient Information

Address fields: All address data items should conform to the U.S. Postal Service Postal Addressing Standards. The address should be fully spelled out with standard use of abbreviations and punctuation per USPS postal addressing standards. The current [USPS Pub. 28](#) may be found and downloaded [here](#).

Name - Last: (2230)

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

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

Name - First: (2240)

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

Name - Middle: (2250)

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

Name - Suffix: (2270)

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

Name – Birth Surname: (2232)

Record patient's last name (surname) at birth, regardless of gender or marital status. If birth surname is unknown or not applicable, leave blank. This is a new data item similar to Maiden Name but not the same. Beginning 01/01/2021 Name –Birth Surname replaces Name – Maiden. This data item may also be used to determine Hispanic origin.

Name - Alias: (2280)

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

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

Social Security No: (2320)

Record the patient's social security number without dashes. If social security number is unknown or the patient does not have one, code as 999999999. If a partial social security only is known, code as 999999999.

Medicare Beneficiary ID: (2315)

In April 2018 CMS began transitioning the use of the social security number for a Medicare recipient's identification card to a randomly generated Medicare Beneficiary Identifier.

Every person with Medicare has been assigned an MBI. The MBI is confidential like the SSN and should be protected as Personally Identifiable Information.

The identifier consists of 11 characters using numbers 1-9 and letters A to Z. Record the Medicare Beneficiary ID number if the patient is a Medicare recipient and you have access to the Medicare Beneficiary ID.

Medical Rec No: (2300)

Record the medical record number, usually assigned by the reporting facility's health information management (HIM) department. If the medical record is unknown, leave blank.

Addr at DX – No & Street (2330)

Record the physical address of the patient at the time of diagnosis. Only record a post office box if you cannot locate in the medical record the physical address where the patient resided at diagnosis.

Addr at DX – Supplemental: (2335)

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

Addr at DX – City (70)

Record the city of patient's physical address at the time of diagnosis.

State at Diagnosis: (80)

Use the drop-down and select the patient's state of residence at the time of diagnosis.

Zip Code at Diagnosis: (100)

Record the extended 9-digit code or the short 5-digit code for the patient's address at the time of diagnosis.

County at Diagnosis: (90)

Use the Federal Information Processing System (FIPS) code for the county where the patient was diagnosed. The FIPS code is a number used by State and Federal agencies that uniquely identify geographic areas.

Visit <https://tinyurl.com/FIPSCountyCode> for a table with all the cities in Nevada group by county.

County Name	FIPS Code	County Name	FIPS Code
Carson City	510	Lincoln County	017
Churchill County	001	Lyon County	019
Clark County	003	Mineral County	021
Douglas County	005	Nye County	023
Elko County	007	Pershing County	027
Esmeralda County	009	Storey County	029
Eureka County	011	Washoe County	031
Humboldt County	013	White Pine County	033
Lander County	015		

Demographics

The Patient Demographics section of the abstract includes the set of data items used to describe personal information about an individual patient. When grouped, these data can be used to study how cancer rates differ by geographic location, as well as what groups are at a higher risk of certain types of cancer. Much of the information in this section is confidential in nature and can be used to identify individual patients. Care must be taken at all times to assure patient confidentiality when reporting cases.

Date of Birth: (240)

Record the patient's date of birth. Leave the year, month and/or day blank when they cannot be estimated or are unknown. If the date of birth is unknown, but the age at diagnosis and date of diagnosis are known, calculate the year of birth by subtracting the patient's age at diagnosis from the year of diagnosis. Leave the month and day blank.

Sex: (220)

Use the drop-down and choose the appropriate code to record the sex of the patient.

Marital Status: (150)

Code for the patient's marital status at the time of diagnosis for the reportable tumor. If the patient has multiple tumors, marital status may be different for each tumor.

Code	Description
1	Single (never married)
2	Married (including common law)
3	Separated
4	Divorced
5	Widowed

6	Unmarried or Domestic Partner
9	Unknown

Tobacco Use Smoking Status (344)

Tobacco smoking history is usually documented as unstructured text from physician and nursing notes, or other available sections in the medical record. Use the drop-down and select the code that describes the code that best describes the patients' smoking status. Do not record the patient's past or current use of e-cigarette vaping devices.

Code	Description
0	Never smoker
1	Current same day smoker
2	Former smoker
3	Smoker, current status unknown
9	Unknown if ever smoked

Code 2: If there is evidence in the medical record that the patient quit recently (within 30 days prior to diagnosis), assign code 1, current smoker. The 30 days prior information, if available, is intended to differentiate patients who may have quit recently due to symptoms that lead to a cancer diagnosis.

Code 3: Smoker, current status unknown

Code 9: assign when the medical record only indicates "No"

Race Codes (160-164)

Use the drop-down and choose the appropriate code to record the patient's race. Race codes 1-5 must ALL be completed, even if race is unknown. If the patient is multiracial, record the minority race in Race 1 and the other race in Race 2. Code 88 = no additional races; code 99 = unknown.

Refer to the coding instructions in the [SEER Program Coding and Staging Manual](#) (page 68) to accurately code this data item.

Special Note for Nevada registrars:

Code Race 1 as 01 (White) when the race is described as White or Caucasian regardless of place of birth OR if there is a statement that the patient is Hispanic or Latino(a) and no further information is available. Race 2 through Race 5 should be coded to 99. Do not use **code 98 (Other)**.

Hispanic Ethnicity: (190)

Ethnic origin has a significant association with cancer rates and outcomes. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the "white" category of race data item (160). The following coding instructions are from the [SEER Program and Staging Manual](#) (page 73):

Code	Description
------	-------------

0	Non-Spanish/Non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS
7	Spanish surname only. The only evidence of the person's Hispanic origin is the surname or maiden (birth surname) and there is no evidence of that he/she is not Hispanic.
8	Dominican Republic (effective with diagnosis on or after 1/1/2005).
9	Unknown whether Spanish/Hispanic or not

Coding Instructions

1. Coding Spanish Surname or Origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.
2. Use all information to determine the Spanish/Hispanic origin including:
 - a. The ethnicity stated in the medical record
 - b. Hispanic origin stated on the death certificate
 - c. Birthplace
 - d. Information about life history and/or language spoken found in the abstracting process
 - e. A last name or maiden name (birth surname) found on a list of Hispanic/Spanish names
3. Assign code 6 when there is more than one ethnicity/origin (multiple codes), such as Mexican (code 1) and Dominican Republic (code 8). There is no hierarchy among the codes 1-5 or 8.
4. Assign code 7 when the only evidence of the patient's Hispanic origin is a surname or maiden name (birth surname) and there is no evidence that the patient is not Hispanic. Code 7 is ordinarily for central registry use only.
5. Portuguese, Brazilians, and Filipinos are not presumed to be Spanish or non-Spanish
 - a. Assign code 7 when the patient is Portuguese, Brazilian, or Filipino and their name appears on a Hispanic surname list
 - b. Assign code 0 when the patient is Portuguese, Brazilian, or Filipino and their name does NOT appear on a Hispanic surname list
6. Assign code 9
 - a. For death certificate only (DCO) cases when Spanish/Hispanic origin is unknown
 - b. When there is no written or verbal indication of Spanish origin, the patient declined to answer their Spanish origin, or the patient does not know their Spanish origin.

Example: The patient's race is white or black, they were born in the United States, their last name is not on a Spanish surname list, and there is no mention of Spanish origin in the patient record.

Birthplace State: (252)

Use the drop down and select the state in which the patient was born. If unknown, select “ZZ” for unknown.

Birthplace Country: (254)

Use the search icon and select or search for the country in which the patient was born. If unknown, select “ZZU” for unknown.

TEXT - Usual Occupation: (310)

****Required when available**** Record the longest held occupation of the patient if known. Do NOT record “retired.” If the patient was a homemaker and also worked outside the home during most of his/her adult life, record the usual occupation outside the home; if the patient was a homemaker and did not work outside the home for most of his/her adult life, record “homemaker.” If the patient was not a student or homemaker and had never worked, record “never worked” as the usual occupation. If not known enter UNKNOWN, if retired enter UNKNOWN. Example: Teacher

Use the [Cancer Registrar’s Guide to Collecting Industry and Occupation](#) for more instructions and information.

Text - Usual Industry: (320)

****Required when Available**** Record the industry of the longest held occupation. If not known enter UNKNOWN, if retired enter UNKNOWN. Example: Education.

Cancer Information

Sequence No: (560)

Indicates the sequence of all malignant and non-malignant reportable neoplasms over the lifetime of the patient. Sequence number 00 indicates that a patient has only one malignant neoplasm in a lifetime. If this same patient is diagnosed with a second malignant neoplasm, the sequence number for the first neoplasm is changed to 01, while the sequence number for the second neoplasm is coded 02.

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

A re-evaluation of all related sequence numbers is required whenever an additional neoplasm is identified.

Date of Diagnosis: (390)

Record the date the cancer was first diagnosed, whether clinically (physician’s documentation, x-ray, CT scan) or pathologically (biopsy, surgery).

Age at Diagnosis: (230)

Click the calculate button to compute/derive the age of the patient at diagnosis. Data items Date of Diagnosis and Date of Birth must be completed to derive the age at diagnosis.

Text: Place of Diagnosis: (2690)

Text area for manual documentation of the facility, physician office, city, state, or county where the diagnosis was made.

Text: Primary Site: (2580)

Primary Site – Text is the written description for the code entered in Primary Site. Do not use vendor-driven text auto-coding of primary site in this field. Enter free text. Include sub-site and laterality. Do not leave blank.

Example 1: Right lower lobe of lung

Example 2: Skin, left forearm

Primary Site: (400)

- Enter the topography code for the site of origin of the primary solid tumor from the *International Classification of Disease for Oncology (ICD-O-3)*. The terms site, primary site, and topography are used synonymously.
- You can still use the “purple book” to find the topography code for the primary site of origin. If the medical record does not contain the information, consult with the physician to identify the primary site.
- Follow the coding instructions in ICD-O-3 and in the most current version of the SEER Solid Tumor Rules to assign primary site for solid tumors.
- Try not to assign unknown/ill-defined site topography codes; they are general terms with vague anatomy. Unknown/ill-defined sites include: 069, 189, 260-269, 328-329, 390-399, 409, 419, 479, 499, 559, 579, 639, 760-769, and 809.
 - Assigning code C80.9 should be a rare occurrence. Hospital registrars should take the time to research these cases in order to avoid using C80.9. This would include scrubbing the medical record for any clues that could lead to a better code, or, if possible, presenting the case at cancer conference (tumor board) to obtain more definitive information about the tumor.
 - If it still not possible to determine primary site, abstract the case as an unknown primary and document as much information in the text fields from the pathology report, operative report, etc.
 - NCCR plans on following back to facilities with a list of abstracts that were coded to C80.9 (unknown primary, NOS). Every attempt should be made to determine the most appropriate code to avoid using C80.9.
 - When coding specific tissue with ill-defined sites use the alphabetic index in ICD-O-3 to assign the most specific code if only a general location is specified in the record.
 - Do not use topography codes in the C76 series for soft tissue neoplasms or neoplasms of unknown primary. Use the most specific soft/tissue primary site codes.
 - Use Code C76.0 for node positive head and neck cancer without evidence of a primary site.

Use the following table to assign primary site when the only information available is the histologic type of tumor and the patient has metastatic disease without an identifiable primary site.

Histologic Groups	Preferred Site Codes for Ill-Defined Primary Sites
Melanoma	C44.9 Skin, NOS
Sarcoma	C49.9 Connective & Subcutaneous Soft Tissue

Histologic Groups	Preferred Site Codes for Ill-Defined Primary Sites
Meningioma	C70.9 Meninges, NOS
Cholangiocarcinoma	C24.0 Bile Duct, NOS
Hepatocellular Carcinoma	C22.0 Liver
Retinoblastoma	C69.2 Retina
Lymphoma	C77.9 Lymph Nodes, NOS
Multiple Myeloma	C42.1 Bone Marrow
Leukemia/Hodgkins	C77.9
Kaposi Sarcoma	C44.9 Skin

Laterality: (410)

Use the drop down and select the laterality of the primary tumor. Review the list of paired organ sites in [Appendix C](#) to determine which primary sites require tumor laterality coded. For tumors which are not listed as a paired organ, select “0” (organ is not a paired site).

Text - Histology: (2590)

Document the histology (morphology) of the primary tumor site, including grade and behavior. Do not leave blank. Histology text is the written description of the code entered in Histologic type.

Histologic Type: (522)

For solid tumors, use the search icon or use the [ICD-O-3.2 Spreadsheet](#) to search for the histology code. The ICD-O-3.2 histology lists have been updated; however, a published manual has been delayed due to the COVID-19 pandemic. If a report only has a diagnosis of “cancer” or “malignancy,” code to 8000, malignant neoplasm. If a diagnosis is reported as “carcinoma,” code to 8010.

For hematopoietic and lymphoid neoplasms, use the following guide for histology coding:

- Acute myeloid leukemia (AML) – 9861
- Chronic myeloid leukemia (CML) – 9863
- Acute lymphoblastic leukemia (ALL) – 9811
- Chronic lymphocytic leukemia (CLL) – 9823
- Non-Hodgkin lymphoma – 9591
- Hodgkin’s Disease (lymphoma) – 9650
- Multiple myeloma (Plasma Cell Myeloma) – 9732
- Myelodysplastic syndrome – 9989

Behavior Code: (523)

Use the drop-down and select the behavior of the primary tumor. Tumor behavior is used by pathologists to describe whether the tumor is benign (0), borderline (1), in situ (2) or malignant (3). Benign and borderline behavior codes are used for intracranial and central nervous system primary sites only. In the absence of pathologic examination, code behavior as invasive (3). In situ behavior (2) can only be identified by pathologic examination.

ICD-O-3 Conversion Flag (2116)

Code specifying how the conversion of site and morphology codes from ICD-O-2 to ICD-O-3 was accomplished.

Grade: (440)

Code for the grade or degree of differentiation of the reportable tumor. For lymphomas and leukemias, field also is used to indicate T-, B-, Null-, or NK-cell origin.

Grade Clinical: (3843)

Defined as the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant). Record the grade of the primary tumor from the biopsy specimen. This data item cannot be blank. Note: Benign Brain, CNS and Other Intracranial gland: For benign tumors ONLY (behavior 0), code 1 can be automatically assigned for all histologies. This was confirmed by the College of American Pathology (CAP) Cancer Committee.

Grade Pathological: (3844)

Record the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. Record the highest grade documented from any microscopic specimen of the primary site whether from the clinical work-up or the surgical resection. If the patient has not yet had or there is no plan to have a surgical resection, use code 9. This data item cannot be blank.

Grade Post Therapy Path (yp): (3845)

Record the grade of a solid primary tumor that has been surgically resected following neoadjuvant therapy. Record the highest grade documented from the surgical treatment resection specimen of the primary site following neoadjuvant therapy. This data item may be blank.

Diagnostic Confirmation: (490)

Use the drop-down and select the appropriate method of diagnostic confirmation.

Type of Reporting Source: (500)

Codes the source used to abstract the majority of information on the tumor being reported. Use the drop-down and select the appropriate reporting source.

Text Fields

See [Appendix C](#) for more instructions and resources for text documentation.

Pathology--Text: (2570)

Document information from cytology and pathology reports. Include date of procedure, specimen number, name of procedure or site of biopsy, tumor type, grade, involvement of resected margins, number of nodes removed and any additional comments or addendums which confirm or change the initial diagnosis. If Pathology is unknown or not applicable, record 'NONE' in the text field. Do not leave blank.

How to document in text field: 9/5/18 (2023-00021): wide EXC skin LT forearm: BX site changes; no residual melanoma identified; MARG (-); no LNs examined

Physical Exam Text: (2520)

Document the patient's history of the tumor and the clinical description of the tumor from the history and physical. Document any risk factors. Include gender, age, race and ethnicity. If Physical Exam is unknown or not applicable, record "NONE". Do not leave blank. You should always be able to record at least the patient's age, race (if collected) and sex.

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

Remarks Text: (2680)

Document pertinent information not indicated in other text fields. Include marital status, race, ethnicity, smoking history, family and personal history of cancer, birthplace, occupation, industry, date of death, and justification of over-ride flags.

How to document in text field: married, white, non-Hispanic; Medicare managed care; former 1 PPD smoker x 20 years (quit 2010); no ETOH HX; no family HX or personal HX of cancer; patient record says “born in Los Angeles, CA”; worked as nurse in healthcare industry

X-ray/Scan-Text: (2530)

Document all imaging examinations which provide information on tumor characteristics. Include the date imaging examinations were done, name of the imaging examination and a brief description of the findings. Include information from the impression section and any other pertinent information, such as tumor size from the findings section of the report. If X-ray/Scan is unknown or not applicable, record ‘NONE’ in the text box. Do not leave blank.

Note: Do not record Bi-Rads for mammograms. This cannot be used to determine reportable status.

How to document in text field: 11/21/12 CT Chest: 2.5 cm lesion within the RML of lung, with hilar and mediastinal adenopathy. Largest lymph node, right hilum 2.2 cm.

Scopes--Text: (2540)

Document information from endoscopic examinations that provide information for staging and treatment. Examples of endoscopic examinations are colonoscopy, cystoscopy, nasopharyngoscopy, nasolaryngoscopy and mediastinoscopy. Include the date and name of endoscopy along with the abnormal findings and tumor size. Colon and esophagus should also include the scope starting and ending centimeters If the physician documents this in the report. If Scopes is unknown or not applicable, record ‘NONE’ in the text box. Do not leave blank.

How to document in text field: 4/2/18 Colonoscopy: Large fungating mass in the sigmoid colon beginning at 20 cm from the anal verge and extending to 24 cm, 4 cm in length, biopsied.

Operative Report Text: (2560)

Also called “findings” this text area is for manual documentation of all biopsy and surgical procedures that provide information for staging. Document dates, names of procedures, along with abnormal findings, and location of tumor. Document observations of the surgeon (what is seen/felt/palpated) when the patient is opened up/explored. Do not record what surgeon did (step by step procedure). Do not record path findings.

If Dx Procedures is unknown or not applicable, record ‘NONE’ in the text field. Do not leave blank. Record “technique only” if no findings are documented.

How to document in text field: 8/6/18 Punch biopsy of dark skin lesion on left forearm.

Stage of Disease

NCCR and NPCR require directly assigned Summary Stage 2018 and voluntary capture of AJCC TNM staging.

Staging Text: (2600) Please include description of:

1. Tumor size and extension, and how they were assessed
2. Lymph node involvement, and how involvement was assessed
3. Assessment for metastasis
4. Any other information pertaining to staging.

e.g., SS2018- 9 Unknown- biopsy only

e.g., SS2018- 1 localized - confined to the primary site after surgical resection and lymph node biopsy.

Summary Stage 2018 (3955)

Summary Stage groups cases into broad categories of in situ, local, regional, and distant. Summary Stage can be used to evaluate disease spread at diagnosis, treatment patterns and outcomes over time. Use the [Summary Stage 2018 Manual, Version 3.0 \(published October 2022\)](#) to help you determine the stage.

A new SS2018 chapter for Medulloblastoma has been added for cases diagnosed from January 1, 2023, and forward.

Regional Lymph Nodes Positive: (850)

Record the exact number of regional nodes examined by the pathologist and found to contain metastasis. If biopsy or aspiration of regional node is positive, code “95”. If no regional lymph nodes were examined by pathologist, code “98”. Use the search icon and select appropriate positive regional nodes value if no exact number is stated.

Example: Two regional nodes are positive as reported by the pathologist. Record Regional LN Positive as 02.

Regional Lymph Nodes Examined: (830)

Record the total number of regional lymph nodes that were removed and examined by the pathologist. If only biopsy or aspiration of regional node is performed, code “95”. If no regional lymph nodes were examined by pathologist, code “00”. Use the search icon and select appropriate examined regional nodes if no exact number is stated.

Example: Pathologist states that 15 regional lymph nodes were removed during resection of a colon cancer. Record Regional LN Examined as 15.

Tumor Size Summary: (756)

Record the largest dimension or diameter of the primary tumor in millimeters in this 3-digit field. 1 centimeter (cm) is equal to 10 millimeters (mm). To convert centimeters to millimeters, multiply by 10. Use the search icon and select an appropriate tumor size if an exact measurement is not stated. Do not add the size of pieces or chips together to create a whole; they may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size. If the only measurement describes pieces or chips, record tumor size as 999.

Example: Tumor is described as 3.5 cm. $3.5 \text{ cm} \times 10 = 35 \text{ mm}$. Record Tumor Size as 035.

LVI: (1182)

Indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist. LVI includes lymphatic invasion, vascular invasion, and lymphovascular invasion.

Site Specific Data Items (SSDI)

Site specific data items apply to specific primary sites, histologies and years of diagnosis. To display the relevant SSDIs for the case, you must first enter the Date of first contact, Sex, Date of diagnosis, Primary site, Histology and Behavior then click Save. Use the magnifying glass next to the data item for code choices and instructions for coding.

Note: Some site and histology combinations also require schema discriminators. These will be listed in the SSDI section. You will also be notified with a pop-up message letting you know a schema discriminator is required.

Schema Discriminator 1 & 2: (3926 and 3927)

Captures additional information needed to generate AJCC ID and Schema ID for some anatomic sites. Discriminators can be based on sub site, histology or other features which affect prognosis.

Only certain primary sites require the schema discriminators to be coded. If the primary site requires it, you will see it in the display (or edits).

Brain Molecular Markers: (3816)

Required for certain brain neoplasms. Multiple brain molecular markers have become standard pathology components necessary for diagnosis. This data item captures clinically important brain cancer subtypes identified by molecular markers that are not distinguishable by ICD-O-3 codes. Use the magnifying glass for applicable codes and instructions.

Breslow Tumor Thickness: (3817)

Required for melanoma. Breslow Tumor Thickness, the measurement of the thickness of a melanoma as defined by Dr. Alexander Breslow, is a prognostic factor for melanoma of the skin. This is not the tumor size. Use the magnifying glass for applicable codes and instructions.

LDH Lab Value: (3932)

Required for melanoma. LDH (Lactate Dehydrogenase) Lab Value, measured in serum, is a predictor of treatment response, progression-free survival and overall survival for patients with Stage IV melanoma of the skin. Use the magnifying glass for applicable codes and instructions.

Esophagus and EGJ Tumor Epicenter: (3829)

Required for Esophagus squamous tumors. Esophagus and Esophagogastric Junction (EGJ), Squamous Cell (including adenosquamous), Tumor Location refers to the position of the epicenter of the tumor in the esophagus. Use the magnifying glass for applicable codes and instructions.

Estrogen Receptor Summary: (3827)

Required for Breast. ER (Estrogen Receptor) Summary is a summary of results of the estrogen receptor (ER) assay. This is found on the pathology report or separate scanned report from pathology. Use the magnifying glass for applicable codes and instructions.

Progesterone Receptor Summary: (3915)

Required for Breast. PR (Progesterone Receptor) Summary is a summary of results from the progesterone receptor (PR) assay. This is found on the pathology report or separate scanned report from pathology. Use the magnifying glass for applicable codes and instructions.

HER2 Overall Summary: (3855)

Required for Breast. HER2 Overall Summary is a summary of results from HER2 testing. This is found on the pathology report or separate scanned report from pathology. Use the magnifying glass for applicable codes and instructions.

Fibrosis Score: (3835)

Required for liver. Fibrosis Score, the degree of fibrosis of the liver based on pathological examination, is a prognostic factor for liver cancer. Use the magnifying glass for applicable codes and instructions.

Gleason Patterns Clinical: (3838)

Required for prostate. Prostate cancers are graded using Gleason score or pattern. This data item represents the Gleason primary and secondary patterns from needle core biopsy or TURP. Use the magnifying glass for applicable codes and instructions.

Gleason Patterns Pathological: (3839)

Required for prostate. Prostate cancers are graded using Gleason score or pattern. This data item represents the Gleason primary and secondary patterns from prostatectomy or autopsy.

Gleason Score Clinical: (3840)

Required for prostate. This data item records the Gleason score based on adding the values for primary and secondary patterns in Needle Core Biopsy or TURP. Use the magnifying glass for applicable codes and instructions.

Gleason Score Pathological: (3841)

Required for prostate. Prostate cancers are graded using Gleason score or pattern. This data item represents the Gleason primary and secondary patterns from prostatectomy or autopsy. Use the magnifying glass for applicable codes and instructions.

Gleason Tertiary Pattern: (3842)

Required for prostate. Prostate cancers are graded using Gleason score or pattern. This data item represents the tertiary pattern value from prostatectomy or autopsy. Use the magnifying glass for applicable codes and instructions.

PSA (Prostatic Specific Antigen): (3920)

Required for prostate. PSA (Prostatic Specific Antigen) is a protein produced by cells of the prostate gland and is elevated in patients with prostate cancer. This data item pertains to PSA lab value. Use the magnifying glass for applicable codes and instructions.

Microsatellite Instability (MSI): (3890)

Required for Colon and Rectum. Microsatellite Instability (MSI) is a form of genetic instability manifested by changes in the length of repeated single- to six-nucleotide sequences (known as DNA microsatellite sequences). High MSI, found in about 15% of colorectal carcinomas, is an adverse prognostic factor and predicts poor response to 5-FU chemotherapy. High MSI is a hallmark of hereditary nonpolyposis colorectal carcinoma, also known as Lynch syndrome. Use the magnifying glass for applicable codes and instructions.

p16: (3956)

Required for Cervix. The p16 biomarker is over-expressed (produced) in response to HPV. It is therefore a surrogate marker for HPV disease. Use the magnifying glass for applicable codes and instructions.

Diagnostic Biopsy Procedure

Date Diagnostic Procedure: (1280)

Record the date of the biopsy of primary site or the biopsy of another site. If no diagnostic procedure was performed, leave blank.

Date DX Procedure Flag: (1281)

Flag explains why no appropriate value is in the field Date Diagnostic Procedure. Data item will be left blank if the Date Diagnostic Procedure is known. Use the drop down and select the appropriate value if date is not known.

Diagnostic Procedure: (1350)

Use the drop down and select the appropriate diagnostic procedure, usually biopsy of primary site or biopsy of another site. If no diagnostic procedure was performed, leave blank or code 00-No surgical diagnostic or staging procedure performed.

First Course of Treatment

It is important for registrars to differentiate between cancer-directed treatment and non-cancer directed, as well as what would be considered FCOT. See [Appendix F](#) to review those concepts.

RX Summ – Treatment Status: (1285)

This field will document active surveillance (watchful waiting) and eliminate searching each treatment modality to determine whether treatment was given.

Codes

- 0 No treatment given
- 1 Treatment given
- 2 Active surveillance (watchful waiting)
- 9 Unknown if treatment was given

Assign code 0 when the patient does not receive any treatment.

Assign code 1 when the patient received treatment collected in any of the following data items:

- Surgery of Primary Site
- Surgical Procedure of Other Site
- Radiation Treatment Modality (phase 1, 2, or 3)
- Chemotherapy
- Hormone Therapy
- Immunotherapy
- Hematologic Transplant and Endocrine Procedures
- Other Therapy

Date 1st CRS RX CoC: (1270)

Date of initiation of the first therapy for the cancer being reported, using the CoC definition of first course. The date of first treatment includes the date a decision was made not to treat the patient. See STORE for details. See Chapter V, Unresolved Issues for further discussion of the difference between SEER and CoC items.

Date--Surgery: (1200)

Record the date of the surgical procedure to the primary site. Date the first surgery of the type described under Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes was performed. If no surgery, leave, BLANK.

Date – Surgery Flag: (1201)

Flag explains why no appropriate value is in the field Date - Surgery. Data item will be left blank if the date is known. Use the drop-down and select the appropriate value if the date is not known.

Treatment Date Most Definitive Surgery: (3170)

Date of most definitive surgical resection of the primary site performed as part of the first course of treatment. When the patient has more than one surgical procedure, use the date of the most definitive surgery. e.g., Patient has surgery of the primary site, and the margins are positive. The patient has a re-excision and margins are now negative. The re-excision date is the most definitive.

Treatment Date Most Definitive Surgery Flag: (3171)

This flag explains why no appropriate value is in the field, Treatment Date Most Definitive Surgery.

Text - Surgery: (2610)

Document information from the operative report. Include date of surgery, name of procedure performed, and any pertinent surgical findings noted. If Surgery is unknown or not applicable, record 'NONE' in the text field. Do not leave blank.

How to document in text field: 2/12/18 Wide local excision of malignant melanoma, Rt chest, with 2cm margins.

RX SUMM - Surgery Primary Site 2023: (1291)

Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment. This includes treatment given at all facilities as part of the first course of treatment. If no surgery to the primary site was performed, record '00'.

RX SUMM – Scope of Regional LN (1292)

Describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at all facilities.

Codes (Refer to the most recent versions of STORE and the SEER Program Code Manual for instructions that should be applied to all surgically treated cases for all types of cancers.) The treatment of breast and skin cancers are where the distinction between sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes is most frequently encountered. For all other sites, non-sentinel regional node dissections are typical, and codes 2, 6 and 7 are infrequently used.

- 0 None
- 1 Biopsy or aspiration of regional lymph node, NOS
- 2 Sentinel lymph node biopsy
- 3 Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS
- 4 1 to 3 regional lymph nodes removed
- 5 4 or more regional lymph nodes removed
- 6 Sentinel node biopsy and code 3, 4, or 5 at same time or timing not noted
- 7 Sentinel node biopsy and code 3, 4, or 5 at different times
- 9 Unknown or not applicable

Surgery of Other Regional/Distant Site: (1294)

Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

Reason No Surgery: (1340)

Records the reason that no surgery was performed on the primary site.

Radiation Therapy

Text - Radiation (Beam) (2620)

Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation. Minimum required text: dates and treatment modality. If no radiation, document NONE.

Text - Radiation Other (2630)

Text area for manual documentation of information regarding treatment of the tumor being reported with radiation other than beam radiation. Minimum required text: dates and treatment modality. If no radiation, document NONE.

Date Radiation Started (1210)

Records the date on which radiation therapy began at any facility that is part of the first course of treatment.

Phase I Radiation Treatment Modality (1506)

Identifies the radiation modality administered during the first phase of radiation treatment delivered as part of the first course of treatment.

Chemotherapy

Text – Chemotherapy (2640)

Text area for manual documentation of information regarding chemotherapy treatment of the reported tumor. Document dates and names of drugs administered. If no chemotherapy, document NONE.

Chemotherapy (1390)

Codes for chemotherapy given as part of the first course of treatment or the reason chemotherapy was not given. Use SEER*Rx to determine drug categories and reportability. <https://seer.cancer.gov/seertools/seerrx/>

Date Chemotherapy (1220)

Date of initiation of chemotherapy that is part of the first course of treatment.

Hormone Therapy

Text - Hormone Therapy (2650)

Text area for information about hormonal treatment. Include dates and names of drugs administered.

Suggestions for text:

- Date treatment was started
- Where treatment was given, e.g., at this facility, at another facility
- Name of physician
- Type of hormone or antihormone, e.g., Tamoxifen
- Other treatment information, e.g., treatment cycle incomplete; unknown if hormones were given If no hormone therapy, enter: None

Example: 2/14/2023 Some Hospital Dr. John Smith: Lupron

Hormone Therapy (1400)

Records whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure. Use SEER*Rx to determine drug categories and reportability. <https://seer.cancer.gov/seertools/seerrx/>

Codes (Refer to the most recent version of STORE and the SEER Program Code Manual for additional instructions.)

00	None, hormone therapy was not part of the planned first course of therapy.
01	Hormone therapy administered as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (e.g., comorbid conditions, advanced age).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in the patient record. Death certificate-only cases.

Date Hormone Therapy (1230)

Date of initiation for hormone therapy that is part of the first course of treatment. If no hormone therapy, leave BLANK.

Immunotherapy

TEXT – Immunotherapy (2660)

Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy. Enter dates and names of drugs administered. If no immunotherapy, enter None.

Immunotherapy (1410)

Records whether immunotherapeutic (biologic response modifiers) agents were administered as first-course treatment at all facilities or the reason they were not given. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells. Use SEER*Rx to determine drug categories and reportability. <https://seer.cancer.gov/seertools/seerrx/>

00	None, immunotherapy was not part of the planned first course of therapy.
01	Immunotherapy administered as first course therapy.

82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (e.g., comorbid conditions, advanced age).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician but was not administered as part of first-course therapy. No reason was stated in the patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record; death certificate-only cases.

Date Immunotherapy (1240)

Date of initiation for immunotherapy (a.k.a. biological response modifier) that is part of the first course of treatment. If no Immunotherapy, leave BLANK.

Other Treatment

Identifies other treatment (TX) given at all facilities that cannot be defined as surgery, radiation, or systemic therapy. TX for reportable hematopoietic diseases can be supportive care, observation, or any TX that does not meet the usual definition in which TX modifies, controls, removes, or destroys proliferating cancer tissue. Such treatments include phlebotomy, transfusions, and aspirin. Use SEER*Rx to determine drug categories and reportability. <https://seer.cancer.gov/seertools/seerrx/>

Text - Other Treatment

Text area for manual documentation of information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown) and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field. If no other treatment administered, enter None.

Date Other Treatment

Date of initiation for other treatment that is part of the first course of treatment at any facility. If no other treatment, leave BLANK.

Follow-Up/Recurrence/Death

DateLastContact/Death: (1750)

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

DateLastContact/DeathFlag: (1861)

Code explains why no appropriate value is in the field DateLastContact/Death. Data item will be left blank if the date is known. Use the drop down and select "12" if the date is not known.

Vital Status: (1760)

Use the drop-down and select the vital status of the patient. If the patient has multiple tumors, vital status should be the same for all tumors.

Cause of Death: (1910)

Patient Alive = 0000; Patient Expired = 7777

ICD Revision Number: (1920)

Patient Alive = 0; Patient Expired = 1

Place of Death State: (1942)

Patient Alive = blank; Patient Expired = Abbreviation for state of expiration; See SEER Coding Manual Appendix B for Country and State codes:

https://seer.cancer.gov/manuals/2022/SPCSM_2022_Appendix_B.pdf

Place of Death Country: (1944)

Patient Alive = blank; Patient Expired = Abbreviation for country of death. See SEER Coding Manual Appendix B for Country and State codes:

https://seer.cancer.gov/manuals/2022/SPCSM_2022_Appendix_B.pdf

WEB PLUS TRAINING FOR FILE UPLOADERS AND FACILITY ABSTRACTORS

General

Web Plus is a web-based application that collects cancer data securely over the public Internet. The online abstracting capability within Web Plus will be used to electronically report cancer cases to NCCR. This software is provided free at no cost by the CDC and will be replacing any and all of the reporting forms previously used for cancer reporting in the state of Nevada. If you would like to learn more about Web Plus, visit the [Web Plus section of the CDC's website](#).

NCCR is committed to a paperless reporting approach and is progressively transitioning away from paper-based submissions. As part of this initiative, we actively discourage the use of less secure methods such as mail and fax for sending paper records.

What does Web Plus do?

- Eliminates the need to distribute and maintain software at physicians' offices and other low-volume reporting sources.
- Provides lookup-assisted data entry with an advanced search feature for data items with extensive lookups.
- Has a link for each data item to the NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary for information about the data item.
- Supports calculation of Age at Diagnosis and Schema determination.
- Runs edits every time an abstract is saved with remaining errors displayed for correction.
- Prevents cases from being submitted to NCCR until all errors have been resolved.
- Supports all data items in national standard data sets, including text.
- Provides reports at any time.

All records in Web Plus are saved in a database at NCCR, and cases entered by one facility or office are not visible to other facilities. Data are validated by the NPCR EDITS engine and is hosted on a secure web server that has a digital certificate installed. The communication between the client and the server is encrypted with Secure Socket Layer (SSL) technology. For more information, see Security Features in Web Plus and Maximizing Data Security in Web Plus sections at the CDC website.

Web Plus Users

Users	Description
Facility Abstractor	Works in a facility or doctor's office and handles patients' medical records and paperwork. When a patient is diagnosed with cancer, the Facility Abstractor reports the case to NCCR. The Facility Abstractor also completes and submits any follow-back abstracts that the central registry posted for their facility.

File Uploader	Uploads either files of abstracts in the appropriate NAACCR format that were not abstracted using Web Plus or non-NAACCR files in any format; views EDITS error reports and cleans or works with abstractors to clean errors on rejected abstracts prior to resubmitting; downloads files posted by the central registry, and view reports.
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Online Abstracting

The link that you click on the homepage to abstract online is associated with a specific abstract display type (data entry form), also known as “Source”, indicated by the name of the link. You can only abstract information for abstracts of the Source (or link) that you select. For example, if you will be reporting for Derm Office and select V18 Dermatology (a display type for online entry), you will not be able to open and work on the assigned follow-back abstracts. To work on abstracts of a different Source, click Home on the Web Plus menu, and click the link for the type of abstract you would like to work with.

File Upload will take you to a menu where you can then upload and download files.

Click the link of the abstract source of the facility for which you are abstracting. The Facility Abstractor menu will display:

Create a New Abstract







Click on New Abstract; the Data Entry page will open

There are two main sections; the box on the left contains the fields where case information is entered; and the box on the right has two tabs: Help and Edit Errors. In addition, there are two buttons to the right (Add/View Comment and Run Edits), a printer icon, and information on the time left in the session (inactivity causes the session time left to decrease).

Help Tab

The Help tab describes saving and editing an abstract and provides a description of the data entry Help icons. The Edit Errors tab lists errors that exist in an abstract after saving an abstract or opening an incomplete abstract. The editing feature helps complete the abstract, so it meets the central registry standards.

These are the Web Plus Help icons:

Icon	Description	Click the icon to . . .
	Special Lookups	open a listing of codes and terms to choose from. Find the term that best applies and click on the code to the left of the term. When a specific code is clicked, it is automatically filled into the abstract for the data item.
	Calculate Field Value	calculate a value for a field from values in other fields (for example, when date of birth and date of diagnosis are entered, age at diagnosis can be calculated)
	Context-sensitive Help	open Help page with the NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary for information about the data item. Note: Context-sensitive Help is no longer being updated for new data items.
	Print Preview	open page that shows the fields and the content you have entered in your abstract; this page allows you to print a copy of your abstract.

The fields you see on the left depend on the display type (data entry form) assigned to your facility by the Web Plus Administrator. The headings, such as Hospital Specific and Demographic, can vary. These are only headings; they do not signify a group of required fields. Your Web Plus Administrator uses them to organize the fields for clearer viewing and to help with data entry.

Saving

It is very important to Save regularly while abstracting. Web Plus does not automatically save an abstract. When you click Save, the Edit Errors tab will open on the right and a list of edit errors will appear in the window. You don't have to immediately fix the errors, as entering more information will clear many errors.

Also, when clicking save, you will be taken to the top of the abstract (even if that is not where you were last entering information).

Comments

Comments can be entered at any time while working on the abstract. When the abstract is released, the comments will be available to central registry staff. To enter a comment, click on Ad/View Comment.

Add/View Comment Run Edits Session time left: 200 minutes

Write a comment or view previous comments regarding this abstract

Edit Errors

There are edit errors and/or edit warnings for the abstract. Error or warning messages along with a list of fields and values checked by the edit are listed below each failed or warned edit. Click on a field below any error or warning message to move to it in the data entry area and make corrections. Click Save to save your corrections and rerun edits.

Note: All edit errors must be resolved in order to complete and release the abstract to the central registry. Although edit warnings are for your information and are not required to be corrected prior to completion of the abstract, if at all possible effort should be made to resolve any warnings prior to releasing the abstract to the central registry.

Total edit errors: 52

1. **Addr at DX--City (NAACCR) ...**
Error: Addr at DX--City must contain letters and spaces only, left-justified
i. City =
2. **Addr at DX--No/Street (NAACCR) ...**
Error: Addr at DX--No & Street is not valid
i. Number and Street Name of Patient Address at Dx =
3. **Addr at DX--Postal Code (NAACCR) ...**
Error: Addr at DX--Postal Code must contain alphanumeric and be left-justified
i. Zip Code =

The comment window will open.

Add comment for the central cancer registry

You can enter a comment here while you are working on an abstract. When you complete and release the abstract, the central registry can view the comment.

Save Close

Enter a comment and click Save. When there is information in the comment field, there will be an asterisk in the Add/View Comment button.

*Add/View Comment

Print Preview

The Print Preview feature (the printer icon in the upper right corner, next to the Run Edits button) allows you to view all the fields and the content entered in the abstract. You can also print the abstract.


Click Print Preview . A separate window will open that displays the abstract.

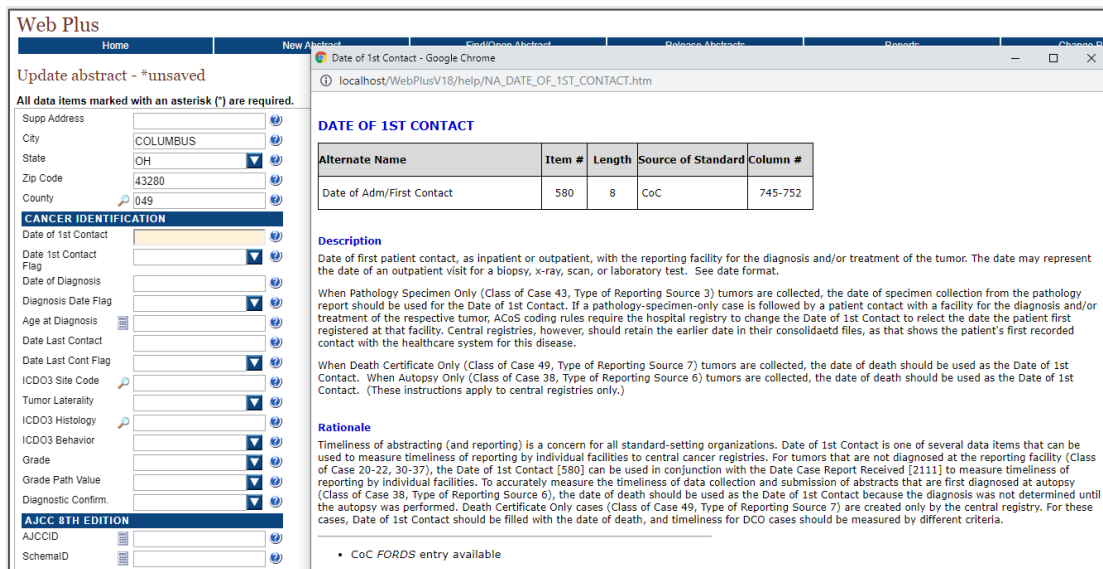
Entering Information

Some information will be prefilled – including the abstractor initials, the reporting facility number, and anything else the Web Plus administrator defaults.

When entering name and address, Web Plus will capitalize the text automatically.

To move to the next field, tab or use the mouse. Using the enter key will not work.

If you need more information about a field, click the Help icon  that is next to the field. A popup window will open with information. Close the window when done. For example, below is the information for Date of 1st Contact:



The screenshot shows the Web Plus interface with a help popup window open for the 'Date of 1st Contact' field. The popup window has a title bar 'Date of 1st Contact - Google Chrome' and a URL 'localhost/WebPlusV18/help/NA_DATE_OF_1ST_CONTACT.htm'. The main content of the popup is titled 'DATE OF 1ST CONTACT' and includes a table with the following data:

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Adm/First Contact	580	8	CoC	745-752

Below the table is a 'Description' section with the following text: 'Date of first patient contact, as inpatient or outpatient, with the reporting facility for the diagnosis and/or treatment of the tumor. The date may represent the date of an outpatient visit for a biopsy, x-ray, scan, or laboratory test. See date format. When Pathology Specimen Only (Class of Case 43, Type of Reporting Source 3) tumors are collected, the date of specimen collection from the pathology report should be used for the Date of 1st Contact. If a pathology-specimen-only case is followed by a patient contact with a facility for the diagnosis and/or treatment of the respective tumor, ACoS coding rules require the hospital registry to change the Date of 1st Contact to reflect the date the patient first registered at that facility. Central registries, however, should retain the earlier date in their consolidated files, as that shows the patient's first recorded contact with the healthcare system for this disease. When Death Certificate Only (Class of Case 49, Type of Reporting Source 7) tumors are collected, the date of death should be used as the Date of 1st Contact. When Autopsy Only (Class of Case 38, Type of Reporting Source 6) tumors are collected, the date of death should be used as the Date of 1st Contact. (These instructions apply to central registries only.)' A 'Rationale' section follows, explaining the importance of the Date of 1st Contact for timeliness of reporting. At the bottom, there is a note: '• CoC FORDS entry available'.

Clicking on the down arrow associated with a field will open the dropdown list; make a selection and the value will populate the field and the list will close. If the value is known, it can be directly entered without using the dropdown list, however it is important that the format is exactly as required (for example, sex is a numeric one-digit field with only the values seen below, visible when clicking on the down arrow in the Sex field).

PATIENT IDENTIFICATION	
Last Name	THOMAS
First Name	LILY
Middle Name	M
Maiden Name	
Alias	SUE
Social Security No.	111115435
Birth Date	19670523
Birth Date Flag	
Sex	
Race 1	
Hispanic Ethnicity	1 Male 2 Female 3 Other(intersex,disorder of sex development/DSD) 'Hermaphrodite'is obsolete) 4 Transsexual, NOS 5 Transsexual, natal male 6 Transsexual, natal female 9 Not Stated/Unknown
PATIENT ADDRESS	
Number and Street	
Supp Address	
City	
State	
Zip Code	
County	
CANCER IDENTIFIC	
Date of 1st Contact	

When tabbing to fields, a description will often appear to the right telling you what to do. In the example below, the cursor is in the Age at Diagnosis field. The instructions are to click on the calculator icon next to the field label in order to calculate Age at Diagnosis.

CANCER IDENTIFICATION	
Date of 1st Contact	20181005
Date 1st Contact Flag	
Date of Diagnosis	20190201
Diagnosis Date Flag	
Age at Diagnosis	
Date Last Contact	
Date Last Cont Flag	
ICD03 Site Code	
Tumor Laterality	
ICD03 Histology	

Age at Diagnosis
Click on the calculator icon to the left to calculate and enter age at diagnosis.

The calculator icon is available for certain fields; clicking it will fill the field in with an appropriate value.

Other fields offer special lookups (magnifying glass), which open searchable lists. For example, once a state has been entered, clicking on the magnifying glass next to county will bring up a list of county codes. This list is searchable by name or part of name only; you can also scroll down or click a page number at the top of the list to move further down in the list. When you find the appropriate code, click it and the code will populate the county field.

Hispanic Ethnicity	<input type="text"/>	<input type="button" value="v"/>	<input type="button" value="h"/>
PATIENT ADDRESS INFORMATION			
Number and Street	123 MAIN STREET	<input type="button" value="v"/>	<input type="button" value="h"/>
Supp Address	<input type="text"/>	<input type="button" value="v"/>	<input type="button" value="h"/>
City	COLUMBUS	<input type="button" value="v"/>	<input type="button" value="h"/>
State	OH	<input type="button" value="v"/>	<input type="button" value="h"/>
Zip Code	43001	<input type="button" value="v"/>	<input type="button" value="h"/>
County	<input type="text"/>	<input type="button" value="v"/>	<input type="button" value="h"/>
CANCER IDENTIFICATION			
Date of 1st Contact	<input type="text"/>	<input type="button" value="v"/>	<input type="button" value="h"/>
Date 1st Contact Flag	<input type="text"/>	<input type="button" value="v"/>	<input type="button" value="h"/>
Date of Diagnosis	<input type="text"/>	<input type="button" value="v"/>	<input type="button" value="h"/>
Diagnosis Date Flag	<input type="text"/>	<input type="button" value="v"/>	<input type="button" value="h"/>
Age at Diagnosis	<input type="text"/>	<input type="button" value="v"/>	<input type="button" value="h"/>
Date Last Contact	<input type="text"/>	<input type="button" value="v"/>	<input type="button" value="h"/>
Date Last Cont Flag	<input type="text"/>	<input type="button" value="v"/>	<input type="button" value="h"/>

Select county code

1 2 3 [Next](#)

Search

Code	Label
001	Adams County
003	Allen County
005	Ashland County
007	Ashtabula County
009	Athens County
011	Auglaize County
013	Belmont County
015	Brown County
017	Butler County

Text Fields

Text Fields are another type of data entry field. This is an area where you enter text to describe diagnostic information, such as information from a pathology report, treatment information, such as X-rays or surgery, and other types of information. The text fields displayed depend on those collected by your central registry.

Text fields can be used to confirm coded values, and to document supplemental information not contained within the coded values. You can also provide information that you are uncertain how to code so that a central abstractor/reviewer may code it properly in the data fields when the abstract is released to the central registry. The text is limited only by the maximum number of characters indicated for each field (for most text fields, 1,000 characters are allowed).

Text fields can be set up to display in two different ways. This is a setting in the user's account (Location of Text Data Items within Display Type), so can vary by user if needed. The Central Registry Administrator or Local Administrator can set this for a user.

One way is to display all text fields in the window on the right side of the screen. The Text Fields tab lies between the Edit Errors tab and the Help tab in this setup.

Enter new abstract [Print Preview](#)

All data items marked with an asterisk (*) are required.

PATIENT ADDRESS INFORMATION	
Number and Street	123 MAIN STREET
Supp Address	
City	COLUMBUS
State	OH
Zip Code	43001
County	049

CANCER IDENTIFICATION	
Date of 1st Contact	
Date 1st Contact Flag	
Date of Diagnosis	20180101
Diagnosis Date Flag	
Age at Diagnosis	
Date Last Contact	
Date Last Cont Flag	
ICDO3 Site Code	C341
Tumor Laterality	1
ICDO3 Histology	8140
ICDO3 Behavior	3
Grade	
Grade Path Value	
Diagnostic Confirm.	

AJCC 8TH EDITION	
AJCCID	36
SchemalD	00360

SSDI +

Edit Errors		Text Fields		Help	
Diagnosis		Treatment		Miscellaneous	
PE (Max: 1000 chars.)					
X-Ray / Scan (Max: 1000 chars.)					
Scopes (Max: 1000 chars.)					
Lab Tests (Max: 1000 chars.)					
OP (Max: 1000 chars.)					
Path (Max: 1000 chars.)					
Primary Site Title (Max: 100 chars.)					
Histology Title (Max: 100 chars.)					

Click to save the abstract and run data Edits. See the box to the right for Edits results each time the abstract is saved.

The other way is to display text fields within the fields on the left.

County	<input type="text" value="049"/>	
CANCER IDENTIFICATION		
Date of 1st Contact	<input type="text"/>	
Date 1st Contact Flag	<input type="text"/>	
Date of Diagnosis	<input type="text" value="20180101"/>	
Diagnosis Date Flag	<input type="text"/>	
Age at Diagnosis	<input type="text"/>	
Date Last Contact	<input type="text"/>	
Date Last Cont Flag	<input type="text"/>	
Primary Site Text	<input type="text"/>	
ICDO3 Site Code	<input type="text" value="C341"/>	
Tumor Laterality	<input type="text" value="1"/>	
Morphology Text	<input type="text"/>	
Pathology Text *	<input type="text"/>	
ICDO3 Histology	<input type="text" value="8140"/>	
ICDO3 Behavior	<input type="text" value="3"/>	
Grade	<input type="text"/>	
Grade Path Value	<input type="text"/>	
Diagnostic Confirm.	<input type="text"/>	
AJCC 8TH EDITION		
AJCCID	<input type="text" value="36"/>	
SchemalD	<input type="text" value="00360"/>	

Specific field information

Dates: All dates are to be entered in the YYYYMMDD (4-digit year, 2-digit month, 2-digit day) format.

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when no known date applies

A date flag field is filled out for each date field which is “unknown” or “not applicable” explaining why the corresponding date field is blank. The date field flag is left blank if a valid date is transmitted in its associated date item.

If social security is completely unknown, enter all 9s.

Zip code can be entered as 5 or 9 digits.

Critical fields will be labeled with an asterisk (*). These are fields that the central registry wants to ensure are completed. Upon saving an abstract, if a critical field is missing there will be a warning shown in the window with the edit errors. Whether or not an abstract can be released if a critical field is missing depends on a setting made by the central registry Administrator.

AJCC ID, Schema ID, SSDIs and Grade (2018+ diagnosis year)

Site-Specific Data Item (SSDI) functionality is used for cases diagnosed January 1, 2018, and forward. The SSDI Data Items will be disabled until the AJCC ID and Schema ID are calculated. The SSDI Section look like this when disabled.



This section will expand once the Schema ID and AJCC ID have been calculated. To calculate these fields, the following data items must first be entered: Date of Diagnosis, Primary Site, Histologic Type ICD-O-3, and the Behavior Code ICD-O-3. An example is below:

CANCER IDENTIFICATION		
Date of Diagnosis *	<input type="text" value="20180101"/>	
Diagnosis Date Flag	<input type="text" value=""/>	
Age at Diagnosis	<input type="text" value="034"/>	
ICDO3 Site Code *	<input type="text" value="C341"/>	
Tumor Laterality	<input type="text" value="1"/>	
ICDO3 Histology *	<input type="text" value="8140"/>	
ICDO3 Behavior	<input type="text" value="3"/>	

These data fields MUST be completed in order for the SSDI functionality to be enabled. If one of the following fields are not filled-in, a message will appear to alert you that the data field is missing when you save (for example, the message may say 'Invalid behavior was used' if that field is left blank, because blank is not valid).

Once the fields are entered, AJCC ID and Schema ID can be calculated either by clicking on the calculator buttons next to the fields, or by saving the abstract. After the calculation of the Schema ID/AJCC ID:

AJCCID	<input type="text" value="36"/>	
SchemaID	<input type="text" value="00360"/>	

The SSDI Section will be enabled once the AJCC ID and Schema ID are calculated and the abstract saved. The SSDIs that will display are specific to the primary site and other information. Below are the SSDIs that display for the example above, with lung as the primary site.

SSDI		
alkRearrangement	<input type="text"/>	
egfrMutationalAnalysis	<input type="text"/>	
SepNodules	<input type="text"/>	
Pleurallnv	<input type="text"/>	

Additional fields required for 2018 diagnosis year and later cases are Grade Clinical and Grade Pathological.

Enter new abstract Add/View Comment

All data items marked with an asterisk (*) are required.

Site	2	
Usual Occupation	<input type="text"/>	
Occupation Source	<input type="text"/>	
Usual Industry	<input type="text"/>	
Industry Source	<input type="text"/>	
CANCER IDENTIFICATION		
Date of Diagnosis	20180915	
Diagnosis Date Flag	<input type="text"/>	
Age at Diagnosis	042	
ICD03 Site Code	C500	
Tumor Laterality	1	
ICD03 Histology	8500	
ICD03 Behavior	3	
Grade	<input type="text"/>	
GradeClin	<input type="text"/>	
GradePath	<input type="text"/>	
GradePost	<input type="text"/>	
Diagnostic Confirm	1	
Reg Nodes Positive	00	
Reg Nodes Exam	03	
LVI	<input type="text"/>	
SchemaDisc1	<input type="text"/>	
SchemaDisc2	<input type="text"/>	
AJCCID	48.2	
SchemaID	00480	
STAGE OF DISEASE		
Summary Stage 2018	2	
Summary Stage 2000	<input type="text"/>	

Edit Errors | **Text Fields** | **Help**

-----EDIT RESULT-----

Editset Name: Central: Vs18 State Example - Incoming Abstracts

There are edit errors and/or edit warnings for the abstract. Error or warning messages along with a list of fields and values checked by the edit are listed below each failed or warned edit. Click on a field below any error or warning message to move to it in the data entry area and make corrections. Click Save to save your corrections and rerun edits.

Note: All edit errors must be resolved in order to complete and release the abstract to the central registry. Although edit warnings are for your information and are not required to be corrected prior to completion of the abstract, if at all possible effort should be made to resolve any warnings prior to releasing the abstract to the central registry.

Total edit errors: 2

- Grade Clin,Path,PostTX, Date of Diagnosis (NAACCR) ...
 - Error Grade Clinical must be reported for diagnosis date 2018+
 - i. GradeClin =
 - ii. GradePath =
 - iii. GradePost =
 - iv. Date of Diagnosis = 20180915
- Grade Clin,Path,PostTX, Date of Diagnosis (NAACCR) ...
 - Error Grade Pathological must be reported for diagnosis date 2018+
 - i. GradeClin =
 - ii. GradePath =
 - iii. GradePost =
 - iv. Date of Diagnosis = 20180915

Use the Schema ID Table as a guide for what SSDIs are required for 2018 cases by site from the Site-Specific Data Item (SSDI) Manual. Information is available here: <https://apps.naaccr.org/ssdi/list/>.

Note: The standard AJCC Cancer Surveillance API that Web Plus uses contains two versions worth of content, one representing version 8 and the other version 9.

In the Surveillance API, site, histology, and year of diagnosis are all required to point to the appropriate set of staging tables. The API returns the TNM Edition Number [NAACCR item 1060] as well as the AJCC ID [995] and Schema ID [3800]. This information, along with the options set in the Reference Tables database SSDI table, determines the appropriate SSDIs to display and, when Schema Discriminators are required, the values for the Grade fields.

Displays without Schema ID, AJCC ID and schema discriminators will not display applicable SSDIs (the SSDI section will not be enabled, although can still be expanded to show all SSDIs) and the values for the Grade fields may not be correct.

Find/Open Abstract

Once an abstract has been started and saved, you will be able to return later for further work. On the home page, click on the appropriate facility source.

The screenshot shows the 'Web Plus Home Page for Lily O'Connell'. At the top right, it says 'Any State Cancer Registry' with an email link 'WebPlusHelp@state.gov' and phone number '999-999-9999'. Below this is a 'Session time left: 20 minutes' indicator and buttons for 'Change Password' and 'Log out'. The main heading is 'Web Plus Home Page for Lily O'Connell' with a sub-heading 'Please select a cancer reporting activity from those listed below the facility for which you would like to report.' There are three sections: 'Derm Office' with links for 'V18 Dermatology', 'File Upload', 'Death Certificate Follow-back Requests (Outstanding:5_Released:3)', and 'Pathlab Follow-back Requests (Outstanding:5_Released:2)'; 'Training Hospital' with links for 'Abstract V180 Hospital' and 'File Upload'; and 'Urology Clinic' with links for 'V18 Urology' and 'File Upload'.

Click on Find/Open Abstract

The screenshot shows the 'Web Plus' navigation menu. At the top right, it says 'Any State Cancer Registry' with an email link 'WebPlusHelp@state.gov' and phone number '999-999-9999'. Below this is a horizontal menu with buttons for 'Home', 'New Abstract', 'Find/Open Abstract', 'Release Abstracts', 'Reports', 'Change Password', 'Help', and 'Log out'. A mouse cursor is pointing at the 'Find/Open Abstract' button.

The page to search for the abstract will open.

The screenshot shows the 'Find Abstract' search page. It has a heading 'Find Abstract' and instructions: 'To view a listing of all abstracts, click Find. To find an abstract for a specific patient, enter the patient's first or last name in the Name box or social security number in the Social Security box below, and click Find. Search on partial name and social security is supported. You can also search by abstract status and/or source by selecting from the drop-down lists provided.' Below the instructions are four input fields: 'Name', 'Social Security', 'Status' (a dropdown menu with 'All' selected), and 'Source' (a dropdown menu with 'All' selected). A 'Find' button is located below the input fields.

You can search on name, partial name, social security number, partial social security number, status (incomplete, complete, or released), and source.

Status values:

Incomplete abstracts are those which are missing data and/or still have edit errors to be addressed.

Complete abstracts are those that have all required data and edit errors addressed but have not yet been released.

It is possible that an abstract with a status value of 'complete' may not be complete when opened. This can occur if there have been changes to the display type the abstract was created in, or if the display type of the abstract was changed to a different one.

Once released abstracts have been sent to the Central Registry, they are no longer editable, but can still be viewed.

Source values: The values available in the Source dropdown will be those that have been assigned to the facility. You can view the list of abstracts of any of the facility's sources on the Find/Open abstract page (if you don't narrow the search on Source), but you will only be able to open, edit (if incomplete) or delete those associated with the Source you clicked on at the Home Page.

Find Abstract

To view a listing of all abstracts, click Find.

To find an abstract for a specific patient, enter the patient's first or last name in the Name box or social security number in the Social Security box below, and click Find. Search on partial name and social security is supported.

You can also search by abstract status and/or source by selecting from the drop-down lists provided.

Name Social Security Status Source

Total abstracts: 12. Locate the abstract of interest, and click on either the Open or Delete link in the Actions column of the table below.

Action	AbsRefID	Last Name	First Name	DxDate	Social Security	Birth Date	Primary Site	Laterality	Abstractor	Edit Errors	Status	Source	
Not Available	900	LAFLEUR	CLAUDE	02/02/2013	999999999	10/29/1956	C169	0	DOE		Incomplete	DCO Follow-back	
Open Delete Change Display Type	936	TESTING	PATIENT	04/04/2014		08/07/1954	C619	0	JD	36	Incomplete	Cancer Reporting Hosp	
Open Delete Change Display Type	949	NEVADA	DERM						JD	29	Incomplete	Cancer Reporting Hosp	
Open Delete Change Display Type	951	SMITH	JANE	01/02/2015	123456789	01/02/1950			rms	0	Incomplete	Cancer Reporting Hosp	
Open Delete Change Display Type	3309	SMITH	JOAN	01/01/2017	789456123	12/12/1950	C189	0	ns	7	Incomplete	Cancer Reporting Hosp	
Not Available	Change Display Type	3314	SCOTT	JANOTHAN	01/01/2012	999999999	01/01/1960	C474	1	JD	25	Incomplete	Abstract V180 Hospital
Not Available		3559	TATHAM	CASE	02/03/2018	123457899	05/04/1929	C619	0	JD	0	Released	Abstract V180 Hospital
Not Available	Change Display Type	4640	VERSION EIGHTEEN	TEST CASE	02/01/2018	123456789	06/05/1979	C619	0	JD	0	Complete	Abstract V180 Hospital
Not Available		5370	FMTEST001	FMTEST001 //2018	999999999	02/03/1950	C187	0	fm	0	Released	Abstract V180 Hospital	
Not Available		6375	TEST	CASE	02/03/2018	123457891	05/04/1929	C619	0	JD	0	Complete	DCO Follow-back
Not Available		6412	PATHTEST	FOUR	09/10/2018	111119090	03/14/1987	C160	0	lmt	1	Incomplete	Pathlab Follow-back
Not Available		6679	SMITH	STAN		123456789	01/01/1970		lmt	22	Incomplete	Pathlab Follow-back Initial	

The list of abstracts can be sorted in ascending order on any column.

Click on Open in the Action column of an incomplete abstract, and the data entry page will open and display previously entered information. The heading of the abstract, located above data entry fields, will be Update Abstract. In addition, upon opening the incomplete abstracts, edits will run automatically, and errors are displayed on the right.

Edit Errors

Each abstract is edited for data quality and completeness whenever you save or open it. The edits applied to the information depend on the edit set selected for your facility by your Web Plus Administrator at your central registry. An edit set that may be used in Web Plus, for example, is "Central: Vs21 State Example-Incoming Abstracts."

As an abstractor you must correct all identified errors to complete your abstract before you can release it to the central registry.

The edit errors pane lists edits in the abstract. The edit set runs each time the abstract is saved or re-opened.

The edit errors include the name of the edit, the description of the error, and a link to the field. Following the name of the edit is an ellipsis (...); click on the ellipses to view detailed information about the edit. For example, clicking on the ellipses after edit error 4 below brings up the text in with the green background, which is further information about the edit.

<p>4. Grade Clin,Path,PostTX, Date of Diagnosis (NAACCR) ... Error Grade Clinical must be reported for diagnosis date 2018+ i. GradeClin = ii. GradePath = iii. GradePost = iv. Date of Diagnosis = 2018</p> <p>5. Grade Clin,Path,PostTX, Date of Diagnosis (NAACCR) ... Error Grade Pathological must be reported for diagnosis date 2018+ i. GradeClin = ii. GradePath = iii. GradePost = iv. Date of Diagnosis = 20180915</p>	<p>This edit is skipped if date of diagnosis = blank (unknown) or invalid. 1. Grade Clinical, Grade Pathological, and Grade Post Therapy must be blank if diagnosis date pre-2018. 2. Grade Clinical must not be blank if diagnosis date 2018+. 3. Grade Pathological must not be blank if diagnosis date 2018+. 4. Grade Post Therapy may be blank if diagnosis date 2018+.</p>
---	--

To correct abstract edit errors, you can click on the link to the field associated with the edit error, which is displayed just below the error description. This will take you to that field, which will now be located at the top of the abstract display on the left.

For example, clicking on Class of Case below takes you to that field on the left, and now the abstract is displayed so that field is at the top.

Enter new abstract Add/View Comment

All data items marked with an asterisk (*) are required.

2018 RADIATION TREATMENT	
PhaseRTModality	
RadBoostDose	
RadBoostRvModal	
RadNumRxVol	
RadRegDose	
Radiation Type	
RadRxVol	

FIRST COURSE OF TREATMENT	
Treatment Status	1
First Rx Date	20180915
First Rx Date Flag	
Surgery Date	20180915
Surgery Date Flag	
RxDateMostDefSurg	20180915
RxDateDefSurgFlag	
Surgery Prim Site	43
Scope Reg LN Rx	2
Non-Cancer Surgery	0
DateSentinelLNbx	20180915
DateSentLNbxFlag	
Reason No Surgery	0
Radiation Date	

Total edit errors: 9

- Missing Critical Field: [Text-Primary Site Title](#)
- Class of Case (COC) ...
Error is not a valid value for Class of Case
i. [Class of Case =](#)
- Text-Primary Site Title (NAACCR) ...
Error Text-Primary Site Title must not be blank
i. [Primary Site Text =](#)
- Estrogen Receptor Summary, Schema ID, Required (NAACCR) ...
Error Estrogen Receptor Summary must not be blank for Schema ID: 00480 cases diagnosed 2018 and later
i. [ERSummary =](#)
ii. [SchemaID = 00480](#)
iii. [Date of Diagnosis = 20180915](#)
iv. [Type Report Source = 1](#)
- Grade Clin.Path,PostTX, Date of Diagnosis (NAACCR) ...
Error Grade Clinical must be reported for diagnosis date 2018+
i. [GradeClin =](#)
ii. [GradePath =](#)
iii. [GradePost =](#)
iv. [Date of Diagnosis = 20180915](#)
- Grade Clin.Path,PostTX, Date of Diagnosis (NAACCR) ...
Error Grade Pathological must be reported for diagnosis date 2018+
i. [GradeClin =](#)
ii. [GradePath =](#)
iii. [GradePost =](#)
iv. [Date of Diagnosis = 20180915](#)
- HER2 Overall Summary, Schema ID, Required (NAACCR) ...
Error HER2 Overall Summary must not be blank for Schema ID: 00480 cases diagnosed 2018 and later
i. [HER2OverallSumm =](#)
ii. [SchemaID = 00480](#)
iii. [Date of Diagnosis = 20180915](#)

Click to save the abstract and run data Edits. See the box to the right for Edits results each time the abstract is saved.

You can continue to click on fields and correct edit errors in that manner.

If there are any critical fields identified as missing, those will also need to be filled in. In the example below, clicking on the missing critical field Text – Primary Site Title brings up a message that the user must click on the Text Fields tab to view the field. This is because the display for the user in the example is set to show text fields on the right, separate from the abstract.

Enter new abstract Add/View Comment

All data items marked with an asterisk (*) are required.

2018 RADIATION TREATMENT	
PhaseRTModality	
RadBoostDose	
RadBoostRvModal	
RadNumRxVol	
RadRegDose	
Radiation Type	
RadRxVol	

FIRST COURSE OF TREATMENT	
Treatment Status	1
First Rx Date	20180915
First Rx Date Flag	
Surgery Date	20180915
Surgery Date Flag	
RxDateMostDefSurg	20180915
RxDateDefSurgFlag	
Surgery Prim Site	43
Scope Reg LN Rx	2
Non-Cancer Surgery	0
DateSentinelLNbx	20180915
DateSentLNbxFlag	
Reason No Surgery	0
Radiation Date	

Message from webpage

Please fill out the missing critical text fields (click the Text Fields tab to view text fields). All critical fields are marked with asterisks(*)

EDIT RESULT

Editset Name: Central: Vs18 State Example - Incoming Abstracts

- Missing Critical Field: [Text-Primary Site Title](#)
- Class of Case (COC) ...
Error is not a valid value for Class of Case
i. [Class of Case =](#)
- Text-Primary Site Title (NAACCR) ...
Error Text-Primary Site Title must not be blank
i. [Primary Site Text =](#)
- Estrogen Receptor Summary, Schema ID, Required (NAACCR) ...
Error Estrogen Receptor Summary must not be blank for Schema ID: 00480 cases diagnosed 2018 and later
i. [ERSummary =](#)
ii. [SchemaID = 00480](#)
iii. [Date of Diagnosis = 20180915](#)
iv. [Type Report Source = 1](#)
- Grade Clin.Path,PostTX, Date of Diagnosis (NAACCR) ...
Error Grade Clinical must be reported for diagnosis date 2018+

Click to save the abstract and run data Edits. See the box to the right for Edits results each time the abstract is saved.

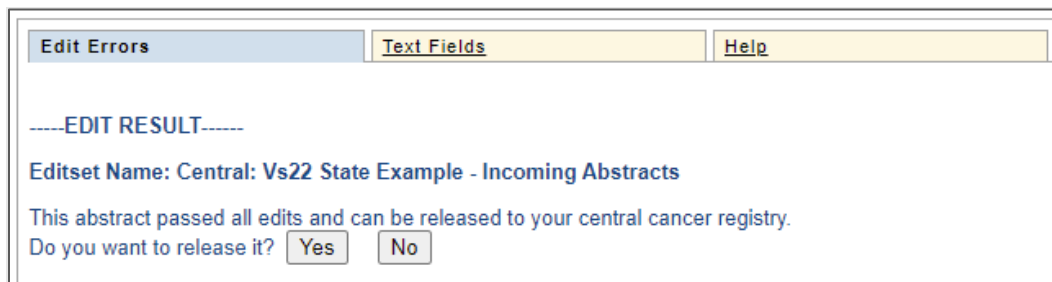
When all edit errors are resolved and critical fields completed, upon the next save of the abstract, Web Plus will inform you that the abstract is complete and ready for release to the central registry.

Edits Busy Message

Users may sometimes get the message “Edits busy, please try again later” upon saving an abstract. This message appears when two (or more) users are running edits at the same time. The system is not able to accommodate more than one user running edits at a time, so it lets users know it is busy. They can continue to work and will be able to run edits when the edits are available. This might be particularly noticeable when many users are entering cases at the same time, or when a large file is being uploaded (and edits are being run on it) while users are also entering cases.

Releasing Abstracts

The system has informed you that the abstract has passed all edits and can be released:



-----EDIT RESULT-----

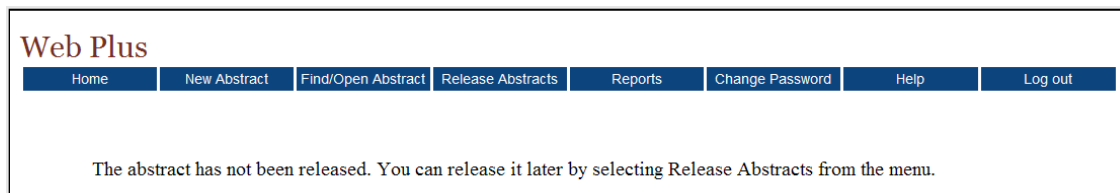
Editset Name: Central: Vs22 State Example - Incoming Abstracts

This abstract passed all edits and can be released to your central cancer registry.

Do you want to release it?

If you click Yes and release the abstract after completion, you will get a message that the abstract has been released to the Central Registry.

You may choose not to release the abstract at this point if you wish to complete more abstracts and release all at once, or if you or someone else will review the abstract before it is released. Click No and you will see the following message.

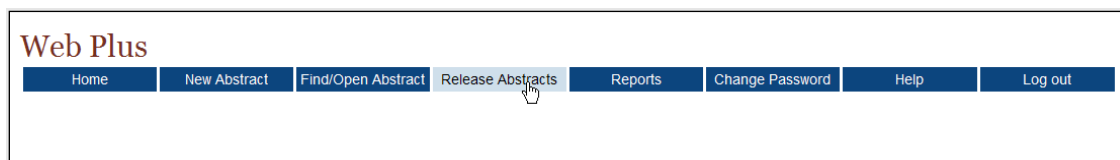


Web Plus

Home New Abstract Find/Open Abstract Release Abstracts Reports Change Password Help Log out

The abstract has not been released. You can release it later by selecting Release Abstracts from the menu.

You can go back to the abstract via Find/Open Abstract and open it and release it there. Or you can go to Release Abstracts.



Web Plus

Home New Abstract Find/Open Abstract Release Abstracts Reports Change Password Help Log out

Here, the system will display a list of all completed but not yet released abstracts.

Release Abstracts

Please select the abstracts that you would like to release to your central registry by checking the box in the Release column. Then click the Release Selected Abstracts button at the bottom of the page. Please note that only completed abstracts are available for release.

AbsRefID	Last Name	First Name	Abstractor	DxDate	Primary Site	Date Case Completed	Source	Select
6404	TATHAM	ZED	lmt	09/12/2019	C711	12/23/2019	LT Abstract 4 v180	<input type="checkbox"/>
6420	SMITH	FRED	lmt	04/21/2019	C619	02/19/2020	LT Abstract 4 v180	<input type="checkbox"/>

Select All Unselect All Release Selected Abstracts

Click the box in the Release column, or if there are several abstracts click the Select All button. Then click Release Selected Abstracts, and the system releases the selected abstracts to the central registry and changes the status of the abstracts to Released. Use the Find/Open page to view the released abstracts.

Deleting an Abstract

An abstract can be deleted from the Find/Open Abstract list if it has not yet been released.

Find the abstract:

Find Abstract

To view a listing of all abstracts, click Find.

To find an abstract for a specific patient, enter the patient's first or last name in the Name box or social security number in the Social Security box below, and click Find. Search on partial name and social security is supported.

You can also search by abstract status and/or source by selecting from the drop-down lists provided.

Name Social Security Status Source

Total abstracts: 12. Locate the abstract of interest, and click on either the Open or Delete link in the Actions column of the table below.

Action	AbsRefID	Last Name	First Name	DxDate	Social Security	Birth Date	Primary Site	Laterality	Abstractor	Edit Errors	Status	Source
Not Available	900	LAFLEUR	CLAUDE	02/02/2013	999999999	10/29/1956	C169	0	DOE		Incomplete	DCO Follow-back
Open Delete Change Display Type	936	TESTING	PATIENT	04/04/2014		08/07/1954	C619	0	JD	36	Incomplete	Cancer Reporting Hosp
Open Delete Change Display Type	949	NEVADA	DERM						JD	29	Incomplete	Cancer Reporting Hosp
Open Delete Change Display Type	951	SMITH	JANE	01/02/2015	123456789	01/02/1950			rms	0	Incomplete	Cancer Reporting Hosp
Open Delete Change Display Type	3309	SMITH	JOAN	01/01/2017	789456123	12/12/1950	C189	0	ns	7	Incomplete	Cancer Reporting Hosp
Not Available	3314	SCOTT	JANOTHAN	01/01/2012	999999999	01/01/1960	C474	1	JD	25	Incomplete	Abstract V180 Hospital
Not Available	3559	TATHAM	CASE	02/03/2018	123457899	05/04/1929	C619	0	JD	0	Released	Abstract V180 Hospital
Not Available	4640	VERSION EIGHTTEEN	TEST CASE	02/01/2018	123456789	06/05/1979	C619	0	JD	0	Complete	Abstract V180 Hospital
Not Available	5370	FMTEST001	FMTEST001	//2018	999999999	02/03/1950	C187	0	fm	0	Released	Abstract V180 Hospital
Not Available	6375	TEST	CASE	02/03/2018	123457891	05/04/1929	C619	0	JD	0	Complete	DCO Follow-back
Not Available	6412	PATHTEST	FOUR	09/10/2018	111119090	03/14/1987	C160	0	lmt	1	Incomplete	Pathlab Follow-back
Not Available	6679	SMITH	STAN		123456789	01/01/1970			lmt	22	Incomplete	Pathlab Follow-back Initial

To Delete an abstract, click Delete in the Action column. The Confirm Delete window will open.

Confirm Delete

Abstract Reference ID to delete

Once confirmed a message will appear that the abstract has been deleted.

Confirm Delete

Abstract Reference ID to delete

Abstract Reference ID (AbsRefID) =949 has been deleted. The list will be refreshed when you rerun the query.

A deleted abstract cannot be restored, as it is completely removed from the database.

Change an Abstract's Display Type

From the Find/Open Abstract page, the display type of a non-released, non-follow-back abstract can be changed. This may be done, for example, if the abstract was started in the wrong display type.

Find the abstract you want to change the display type for.

Find Abstract

To view a listing of all abstracts, click Find.

To find an abstract for a specific patient, enter the patient's first or last name in the Name box or social security number in the Social Security box below, and click Find. Search on partial name and social security is supported.

You can also search by abstract status and/or source by selecting from the drop-down lists provided.

Name Social Security Status Source

Total abstracts: 3. Locate the abstract of interest, and click on either the Open or Delete link in the Actions column of the table below.

Action	AbsRefID	Last Name	First Name	DxDate	Social Security	Birth Date	Primary Site	Laterality	Abstractor	Edit Errors	Status	Source
Open Delete Change Display Type	951	SMITH	JANE	01/02/2015	123456789	01/02/1950			rms	0	Incomplete	Cancer Reporting Hosp
Open Delete Change Display Type	3309	SMITH	JOAN	01/01/2017	789456123	12/12/1950	C189	0	ns	7	Incomplete	Cancer Reporting Hosp
Not Available	6679	SMITH	STAN		123456789	01/01/1970			imt	22	Incomplete	Pathlab Follow-back Initial

Click on Change Display Type. Pick the display type to assign the abstract to; options available are only those display types that have been assigned to the facility.

Action	AbsRefID	Last Name	First Name	DxDate	Social Security	Birth Date	Primary Site	Laterality	Abstractor	Edt Errors	Status	Source
Open Delete Change Display Type	951	SMITH	JANE								Incomplete	Cancer Reporting Hosp
Open Delete Change Display Type	3309	SMITH	JOAN								Incomplete	Cancer Reporting Hosp
Not Available	6679	SMITH	STAN								Incomplete	Pathlab Follow-back Initial

Change Display Type

Please select a display type to assign this abstract, Absrefid = 3309

- Cancer Reporting Hosp
- TNM Demonstration
- Abstract V180 Hospital

[OK](#)

You will get a message that the display type has been changed. Click OK and Find again.

Message from webpage ✕

Display type changed successfully. Please click Find again to view the change

[OK](#)

The abstract is seen as associated with the new display type. In this instance, to open and edit the abstract the user must select 'Abstract V180 Hospital' on the home page.

Find Abstract

To view a listing of all abstracts, click Find.

To find an abstract for a specific patient, enter the patient's first or last name in the Name box or social security number in the Social Security box below, and click Find. Search on partial name and social security is supported.

You can also search by abstract status and/or source by selecting from the drop-down lists provided.

Name Social Security Status Source

[Find](#)

Total abstracts: 3. Locate the abstract of interest, and click on either the Open or Delete link in the Actions column of the table below.

Action	AbsRefID	Last Name	First Name	DxDate	Social Security	Birth Date	Primary Site	Laterality	Abstractor	Edt Errors	Status	Source
Open Delete Change Display Type	951	SMITH	JANE	01/02/2015	123456789	01/02/1950			rms	0	Incomplete	Cancer Reporting Hosp
Not Available Change Display Type	3309	SMITH	JOAN	01/01/2017	789456123	12/12/1950	C189	0	ns	7	Incomplete	Abstract V180 Hospital
Not Available	6679	SMITH	STAN		123456789	01/01/1970			lmt	22	Incomplete	Pathlab Follow-back Initial

Follow-Back Abstracts

NCCR may receive information about a tumor for a patient who was diagnosed and/or treated at your facility from other reporting sources, such as death certificates or pathology laboratory reports. If the central registry obtains this information before you have reported the tumor to them, they may choose to use the information that they have received to generate a request for more information from you. They do this by creating a follow-back abstract, which they fill with what information they have, and post to Web Plus for you to add to and complete.

The Web Plus follow-back process includes the following steps:

The follow-back supervisor at your central cancer registry uploads files of partially filled abstracts generated with information from death certificate and pathology lab files into Web Plus, or manually begins the individual abstracts online.

Your central registry notifies you via e-mail to log into Web Plus and update the follow-back abstracts.

Once posted for you to complete, follow-back abstracts are processed via the regular Web Plus record flow; with the exception that, if the central registry allows, you can reject follow-back abstracts with a justifying comment back to the central registry, and then the Follow-back Supervisor or Monitor can either re-route the abstract to a new facility/physician, or delete the abstract from the follow-back process.

Once completed, you release the follow-back abstracts to your central registry.

Throughout the follow-back process, the Follow-back Supervisor and Follow-back Monitors will use Web Plus follow-back reports and tracking features and may communicate with you via e-mail as needed.

If your central registry has posted follow-back abstracts to Web Plus for you to complete, the system places a link to these abstracts on your homepage. The follow-back request links include running outstanding and released follow-back abstract totals that are updated as you complete and release or reject the follow-back abstracts.

You will see links to follow-back abstracts on your home page.

Web Plus Home Page for James Smith
Please select a cancer reporting activity from those listed below the facility for which you would like to report.

Derm Office
[Abstract V180 Hospital](#)
[LT Abstract 2 v180](#)
[File Upload](#)
[Death Certificate Follow-back Requests \(Outstanding:16, Released:0\)](#)
[Pathlab Follow-back Requests \(Outstanding:4, Released:0\)](#)

Dr. Smith All Cancer Office
[LT Abstract 4 v180](#)
[File Upload](#)
[Death Certificate Follow-back Requests \(Outstanding:7, Released:0\)](#)
[Pathlab Follow-back Requests \(Outstanding:5, Released:1\)](#)

Radiology Facility
[LT Abstract 3 v180](#)
[Ily_v18 copy](#)
[File Upload](#)
[Death Certificate Follow-back Requests \(Outstanding:3, Released:0\)](#)
[Pathlab Follow-back Requests \(Outstanding:2, Released:0\)](#)

Recall that the link that you click on your homepage is associated with a specific abstract Source, indicated by the name of the link. If your central registry has posted death certificate follow-back abstracts to Web Plus for you to complete, you will see a Death Certificate Follow-back Requests link. If your central registry has posted pathology laboratory follow-back abstracts to Web Plus for you to complete, you will see a Pathlab Follow-back Requests link. When you click on a follow-back link, a page will open with a list of follow-back abstracts that have been assigned to the facility.

You have received follow-back requests on the following patients. Please click on the Open link to open a record and update it.

Actions	AbsRefID	Last Name	First Name	DxDate	Social Security	Birth Date	Primary Site	Laterality	Abstractor	Edit Errors	Status
Open	6884	feb	five	09/11/2019	111119899	09/22/1966	C774	1	lmt	0	Incomplete
Open	6883	feb	four	09/12/2019	999999999	02/12/1933	C447	1	lmt	0	Incomplete
Open	6885	feb	six	07/12/2019	222333344	04/12/1991	C539	0	lmt	33	Incomplete
Open	6874	Fisher	FOUR	09/10/2018	111119090	03/14/1987	C160	0	lmt	0	Released
Open	6873	Fisher	THREE	11/23/2018	111114432	06/04/1978	C421	1	lmt		Incomplete
Open	6634	Smith	Green	08/12/2019	111114444	09/22/1954	C443	1	lmt	33	Incomplete

The list is sortable on column headers, in ascending order.

Click Open and a data entry screen for the abstract will open; there will be some fields already filled in, and edits will run.

Pathology Follow-back Abstract Add/View Comment

All data items marked with an asterisk (*) are required.

Reporting Facility	7777777771
Abstractor	lmt
PATIENT IDENTIFICATION	
Last Name	Smith
First Name	Green
Middle Name	
Maiden Name	
Alias	
Social Security No.	111114444
Birth Date	19540922
Birth Date Flag	
Birthplace State	
Birthplace Country	
Sex	1
Race 1	99
Race 2	
Race 3	
Race 4	
Race 5	
Hispanic Ethnicity	
Usual Occupation	
Usual Industry	

Edit Errors [Help](#)

There are edit errors in the abstract. Error messages along with the error fields are listed below. Click on a field below any error message to move to it in the data entry area. Click on Save to save the changes and rerun Edits.

Total edit errors: 33

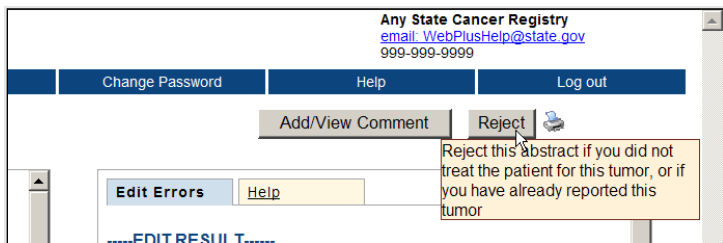
- 1 Missing Critical Field: [Pathology Text](#)
- 2 Missing Critical Field: [Physical Exam](#)
- 3 Missing Critical Field: [Staging Text](#)
- 4 [Addr at DX--No/Street \(NAACCR\) ...](#)
Error: Addr at DX--No & Street is not valid
i. Number and Street =
- 5 [Addr at DX--Postal Code \(NAACCR\) ...](#)
Error: Addr at DX--Postal Code must contain alphanumeric and be left-justified
i. Zip Code =
- 6 [Class of Case \(COC\) ...](#)
Error: is not a valid value for Class of Case
i. Class of Case =
- 7 [County at DX Reported \(NAACCR\) ...](#)
Error: County at DX Reported must be a three-digit number
i. County =
- 8 [Diagnostic Confirmation \(SEER DXCONF\) ...](#)
Error: Diagnostic Confirmation not valid
i. Diagnostic Confirm =
- 9 [Spanish/Hispanic Origin \(SEER SPANORIG\) ...](#)
Error: Spanish/Hispanic Origin not valid
i. Hispanic Ethnicity =
- 10 [Date of 1st Contact, Date Flag \(NAACCR\) ...](#)
Error: If date is blank, corresponding flag must = 12, indicating unknown date

Click to save the abstract and run data Edits. See the box to the right for Edits results each time the abstract is saved.

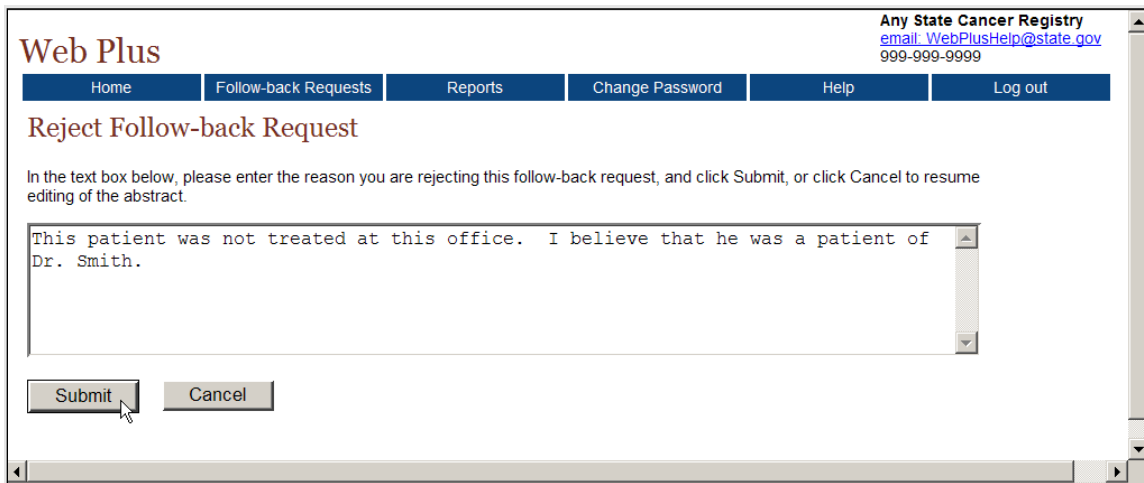
The data entry page for a follow-back abstract functions the same as for a regular abstract, in terms of data entry, the running of data quality edits and the cleaning of edit errors, completion, and release of abstracts. However, the central registry may have different reporting requirements for regular reports of tumors and follow-back abstracts. As a result, you may see different data fields, required fields, and edits for your follow-back abstracts than you do for your regular reporting.

One difference with follow-back abstract functionality is the ability to reject an abstract back to the central registry. This might be done if the central registry permits, and if you have not diagnosed, treated or seen the patient listed on the follow-back abstract. The central registry can reroute a follow-back abstract to a different facility.

Click Reject in the upper righthand corner of the abstract.



A page will open where a reason for rejecting the abstract is to be entered.



Enter the reason and click Submit. Web Plus will let you know the abstract has been rejected. The abstract will also be removed from the facility's list of follow-back abstracts.

The abstract has been rejected and a message sent to the central cancer registry.

Reports

There are several reports that facility abstractors can run.

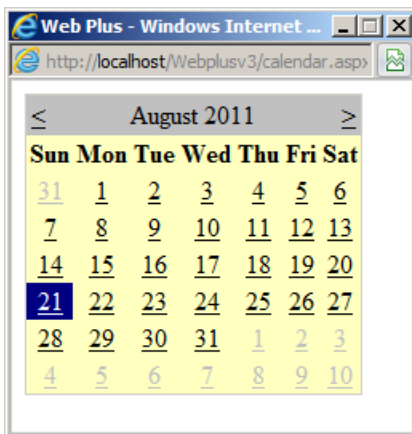


You can click on any report to run it. Note that most reports open in new browser tabs. Many reports contain confidential information, so it is important to close the browser tabs once done with the report.

Reports are modifiable on date range. On an opened report, click the Calendar Icon beside the From or To date field.



The Calendar window will open.



Navigate to find a date, click on it and the field will be populated. You can also type the date in the window by using the mm/dd/yyyy format, such as 09/01/2019 for September 1, 2019. The date calendar and format are the same for both the From and To date fields.

And reports can be printed (click on **Printable Report** or **Printable Form** in the upper right-hand corner of the report).

This report . . .	Lists . . .
Abstracts Submitted Sorted by Abstractor	All abstracts that a facility has released within a certain date range; the abstracts are sorted first by abstractor initials and then by patient name.
Abstracts Accessed Sorted by Patient Name	All abstracts from a facility have been accessed by users within a certain date range; sorted in order of patient name.
Descriptive Statistics on Released Abstracts	Descriptive statistics on abstracts released within a certain date range. Statistics are for fields such as demographics and site group.
Activity Report	The numbers of released and unreleased abstracts by month or year (depending on the length of the date range specified).
Facility Outstanding DCO Abstract Listing Report	A line listing of all death certificate follow-back abstracts assigned to your facility that have not yet been released to the central registry.
Facility Outstanding Pathology Abstract Listing Report	A line listing of all pathology laboratory follow-back abstracts assigned to your facility that have not yet been released to the central registry.
HIPPA Accounting of Disclosure report	A user-generated HIPPA-compliant report of information disclosure (via abstracts) to your central registry using Web Plus
Audit Reports	
System Logins	The dates and times of user logging in and out of Web Plus within a selected date range.
Abstract Updates	The dates and times that abstracts from your facility have been updated.
Abstract Searches	The abstractor and the date and time for all searches for abstracts at your facility.
Abstract Deletions	The dates and times that abstracts have been deleted at your facility.
Abstract Releases	Information about abstracts released from your facility including release time and date and abstractor.

Abstracts Submitted Sorted by Abstractor

Below is an example of the Abstracts Submitted Sorted by Abstractor report. The Abstractor initials are shown (not the abstractor's name).

11/8/2019 8:25:31 AM

Any State Cancer Registry Test Facility 1 Web Plus Cancer Abstract Submissions by Abstractor

Choose a date range: From: 10/08/2019 To: 11/08/2019 [Printable Report](#)

Abstractor: DOE

Patient Name	Social Security #	Medical Record #	Birth Date	Diagnosis Date	Primary Site	Laterality	Behavior	Grade	Date Created	Date Completed (Lag Time in Days)	Date Released (Lag Time in Days)
BOUDREAU, ANDRE	999999999	99988556123	11/14/1958	02/01/2013	C809	0	3	9	3/4/2015	10/30/2019 (1701 d)	10/30/2019 (1701 d)
GREEN, FRED	999999999	12345147	11/14/1961	11/22/2012	C619	0	3	3	3/4/2015	10/30/2019 (1701 d)	10/30/2019 (1701 d)

Abstractor: fm

Patient Name	Social Security #	Medical Record #	Birth Date	Diagnosis Date	Primary Site	Laterality	Behavior	Grade	Date Created	Date Completed (Lag Time in Days)	Date Released (Lag Time in Days)
TESTNEWEDITONE, TESTNEWEDITONE	999999999	04564654	02/03/1950	//2018	C187	0	3		4/22/2019	11/14/2018 (-159 d)	11/05/2019 (197 d)

Abstractor: me

Patient Name	Social Security #	Medical Record #	Birth Date	Diagnosis Date	Primary Site	Laterality	Behavior	Grade	Date Created	Date Completed (Lag Time in Days)	Date Released (Lag Time in Days)
TEST, CASE	999999999	00242442	02/05/1940	//2018	C619	0	3		10/19/2018	11/05/2019 (382 d)	11/05/2019 (382 d)
TEST, TNM	123456789		03/06/1950	//2016	C619	0	3	1	11/1/2018	05/03/2019 (183 d)	11/01/2019 (365 d)

Abstracts Accessed Sorted by Patient Name

Below is an example of the Abstracts Accessed Sorted by Patient Name report:

9/21/2011 12:56:08 PM

Any State Cancer Registry
Test Facility 1
Web Plus Cancer Abstracts Accesses

Choose a date range: From: 08/21/2011 To: 09/21/2011 [Printable Report](#)

Patient Name	Social Security #	Medical Record #	Birth Date	Diagnosis Date	Primary Site	Laterality	User ID	Date & Time Accessed
DOE, JANE	999999999		11/14/1938	12/08/2010	C443		1 JOHNDOE	9/7/2011 8:48:00 AM
DOE, JANE	999999999		11/14/1938	12/08/2010	C443		1 JOHNDOE	9/7/2011 8:58:00 AM
DOE, JANE	999999999		11/14/1938	12/08/2010	C443		1 JOHNDOE	9/7/2011 9:45:00 AM
DOE, JANE	999999999		11/14/1938	12/08/2010	C443		1 JOHNDOE	9/7/2011 10:18:00 AM
DOE, JOHN	999999999		11/14/1958	02/24/2010	C619	0	JOHNDOE	9/7/2011 2:11:00 PM
DOE, JOHN	999999999		11/14/1958	02/24/2010	C619	0	JOHNDOE	9/7/2011 2:12:00 PM
GODSKI, CHRISTIN	999999999		01/16/1948	//			JOHNDOE	9/12/2011 12:53:00 PM
JOHNSON, HAROLD	999999999		11/14/1921	02/01/2010	C809	0	JOHNDOE	9/7/2011 3:02:00 PM
JOHNSON, HAROLD	999999999		11/14/1921	02/01/2010	C809	0	JOHNDOE	9/7/2011 3:02:00 PM
JOHNSON, JOHN	999999999	12312312312	03/16/1961	02/23/2011	C619	0	JOHNDOE	9/12/2011 2:42:00 PM
JOHNSON, JOHN	999999999	12312312312	03/16/1961	02/23/2011	C619	0	JOHNDOE	9/12/2011 3:11:00 PM
JOHNSON, JOHN	999999999	12312312312	03/16/1961	02/23/2011	C619	0	JOHNDOE	9/12/2011 4:08:00 PM
JOHNSON, JOHN	999999999	12312312312	03/16/1961	02/23/2011	C619	0	JOHNDOE	9/12/2011 4:37:00 PM

Descriptive Statistics on Released Abstracts

The Descriptive Statistics on Released Abstracts report offers several modifiable options in addition to date range.

8/27/2019 8:51:05 AM Web Plus for Any State Cancer Registry Test Facility 1 Descriptive Statistics on Released Abstracts

[Printable Form](#)

Select a Date Range: From: To: Select all released

Select Level of Site Group Detail: ▼

Include Site Groups with no cases? Yes No Group by managing physician? Yes No

These are the report options:

Option	Description								
Date Range	Includes only those abstracts that were released within the specified date range								
Select All Released	When clicked, all abstracts released by the facility will be included, regardless of date released								
Select Level of Site Group Detail	Specifies what level of primary site grouping to use for the report; the default grouping is 18 categories <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th>Grouping Level</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>Aggregate</td> <td>18 categories</td> </tr> <tr> <td>Subaggregate</td> <td>60 categories</td> </tr> <tr> <td>Recode</td> <td>78 groups</td> </tr> </tbody> </table>	Grouping Level	Description	Aggregate	18 categories	Subaggregate	60 categories	Recode	78 groups
Grouping Level	Description								
Aggregate	18 categories								
Subaggregate	60 categories								
Recode	78 groups								
Include site groups with no cases	When Yes is clicked, the primary site distribution will show all site groups regardless of whether abstracts were released. When No is clicked, only those primary site groups containing released abstracts released will appear on the report.								

Option	Description
Group by managing physician	When Yes is clicked, the records in the report will be grouped into sections by managing physician, displaying the descriptive statistics for abstracts released by each managing physician.

The aggregate site groups are:

- Bones and Joints
- Brain and Other Nervous System
- Breast
- Digestive System
- Endocrine System
- Eye and Orbit
- Female Genital System
- Invalid
- Leukemia
- Lymphoma
- Male Genital System
- Miscellaneous
- Myeloma
- Oral Cavity and Pharynx
- Respiratory System
- Skin excluding Basal and Squamous
- Urinary System

This is an example of the Descriptive Statistics on Released Abstracts report:

1/10/2020 12:09:29 PM Web Plus for Any State Cancer Registry Test Facility 2 Descriptive Statistics on Released Abstracts [Printable Form](#)

Select a Date Range: From: To: Select all released

Select Level of Site Group Detail:

Include Site Groups with no cases? Yes No Group by managing physician? Yes No

County of Residence

County	Count of cases (%)
Out of State	2(100%)
Total	2(100%)

Zip Code of Residence

Zip Code	Count of cases (%)
11772	1(50%)
99999	1(50%)
Total	2(100%)

Race and Sex

Sex	Count of cases (%)			Total
	Black	White	Other	
Male	0(0%)	2(100%)	0(0%)	2(100%)
Female	0(0%)	0(0%)	0(0%)	0(0%)
Total	0(0%)	2(100%)	0(0%)	2(100%)

Age Group

Age Group	Male	Female	Total
0-9	0(0%)	0(0%)	0(0%)
10-19	0(0%)	0(0%)	0(0%)
20-29	0(0%)	0(0%)	0(0%)
30-39	0(0%)	0(0%)	0(0%)
40-49	0(0%)	0(0%)	0(0%)
50-59	0(0%)	0(0%)	0(0%)
60-69	1(50%)	0(0%)	1(50%)
70-79	0(0%)	0(0%)	0(0%)
80-89	1(50%)	0(0%)	1(50%)
90+	0(0%)	0(0%)	0(0%)
Total	2(100%)	0(0%)	2(100%)

Site Group

Site Group	Male	Female	Total
Digestive System	1(50%)	0(0%)	1(50%)
Male Genital System	1(50%)	0(0%)	1(50%)
Total	2(100%)	0(0%)	2(100%)

Treatment Group



Treatment Group	Count
RxSumSurgPSite	2(100%)
RxSumChemo	0(0%)
RxSumHorm	0(0%)
RxSumBRM	0(0%)
RxSumOth	2(100%)
RadRegModal	0(0%)
RxSumTransEndo	0(0%)

Activity Report

The Activity Report provides information on the abstracting activity at the facility in terms of number of released and unreleased abstracts.

If the date range selected is contained within one calendar year, the report will be by month.

Any State Cancer Registry Test Facility 1 Web Plus Cancer Abstracting Activity



Select a Date Range: From:  To:  [Printable Report](#)

Group by managing physician? Yes No

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Released	0	0	0	0	0	0	0	0	0	0	0	0	0
Unreleased	0	0	0	2	1	0	0	0	0	0	0	0	3
Total	0	0	0	2	1	0	0	0	0	0	0	0	3

If the date range spans calendar years, the report will be by year.

Any State Cancer Registry Test Facility 1 Web Plus Cancer Abstracting Activity

Select a Date Range: From:  To:  [Printable Report](#)

Group by managing physician? Yes No

Year	Released	Unreleased	Total
2017	1	23	24
2018	7	37	44
2019	3	23	26
2016	0	18	18

Facility Outstanding Follow-back Abstract Listing

The Facility Outstanding Follow-back Abstract Listing report includes a line listing of all follow-back abstracts assigned to your facility that you have not yet released. You can print this report for your records, or if you need to go somewhere away from your computer to look up patient records. If your facility has both DCO and Pathology Follow-back abstracts, separate reports will need to be run.

Web Plus for Any State Cancer Registry
Current Outstanding DCO Abstracts
as of Wednesday, September 21, 2011

[Printable Report](#)

Facility: Test Facility 1
Total Remaining DCO Abstracts: 6

Last Name	First Name	MI	AbsRefID	Sex	SSN	DTHCRT#	DOB	DOD	COD	Site	Status
PETERS	MADELON	E	19	2	999999999	000010	07/05/1912	03/23/2010	C349		Incomplete
RUCKNER	WALLACE	I	13	1	999999999	000004	03/08/1929	07/31/2010	C159		Incomplete
STORK	MABEL	E	17	2	999999999	000008	04/02/1928	11/26/2010	C800		Incomplete
TWICHELL	ROBERT	E	15	1	999999999	000006	02/11/1926	08/24/2010	C349		Incomplete
VALLE	THOMAS	A	10	1	999999999	000001	02/21/1927	05/25/2010	C619		Incomplete
VUTT	RUTH	T	12	2	999999999	000003	09/12/1915	08/20/2010	C509		Incomplete

HIPAA Accounting of Disclosure Report

When a physician or hospital submits information to a central cancer registry, an accounting of disclosures of protected health information is required. The Web Plus HIPAA Accounting of Disclosure Report is a HIPAA-compliant report that includes the date of the disclosure, the name and address of the central cancer registry (entity who received the protected health information), a brief description of the protected health information disclosed, and a brief statement of the purpose of the disclosure. The HIPAA Accounting of Disclosure Report can be generated for all released abstracts and abstracts released within a specified date range, as well as for individual released abstracts.

When you click on the HIPAA Accounting of Disclosure Report, a page will open that requires the selection of a date range.

Web Plus for Any State Cancer Registry Derm Office Disclosures of Public Health Information (PHI)
to Any State Cancer Registry

Select a Date Range and click Run: From: To:

[Printable Report](#)

After clicking Run, information on patients and description of PHI and reason for disclosure will be shown.

Web Plus for Any State Cancer RegistryDerm OfficeDisclosures of Public Health Information (PHI)
to Any State Cancer Registry

Select a Date Range and click
Run:

From: To:

[Printable Report](#)

Patient Name	Disclosure Date	Entity Receiving	Entity Address	Description of PHI	Reason for Disclosure of PHI
Adam_Farlean	11/12/2019	Any State Cancer Registry	Some street Some city, GA 00000	Electronic record of confidential cancer patient, tumor and treatment information	Public health reporting for the purpose of population-based activities related to improving health.
BRIGHT_STAR	9/10/2019	Any State Cancer Registry	Some street Some city, GA 00000	Electronic record of confidential cancer patient, tumor and treatment information	Public health reporting for the purpose of population-based activities related to improving health.
JONES_JANUARY	11/21/2019	Any State Cancer Registry	Some street Some city, GA 00000	Electronic record of confidential cancer patient, tumor and treatment information	Public health reporting for the purpose of population-based activities related to improving health.
SMITH_SUElab	11/12/2019	Any State Cancer Registry	Some street Some city, GA 00000	Electronic record of confidential cancer patient, tumor and treatment information	Public health reporting for the purpose of population-based activities related to improving health.
SMITH_SUE	9/16/2019	Any State Cancer Registry	Some street Some city, GA 00000	Electronic record of confidential cancer patient, tumor and treatment information	Public health reporting for the purpose of population-based activities related to improving health.

If you click on an individual patient name, the entire cancer case report for that patient will display.

Web Plus for Any State Cancer RegistryDerm OfficeDisclosures of Public Health Information (PHI)* to Any State Cancer Registry

Patient Name:BRIGHT, STAR LUCY
Disclosure Date:9/10/2019
Name and Address of Entity Receiving PHI:Any State Cancer Registry
 Some street
 Some city, GA 00000
Description of PHI:Electronic record of confidential patient, tumor and treatment information.
Reason for Disclosure of PHI:Public health reporting for the purpose of population-based activities related to improving health.
 *A copy of the Public Health Information abstracted from your health record and reported to your State Cancer Registry is attached.

Patient's name: BRIGHT, STAR LUCY
Abstractor: lmt
Last Name: BRIGHT
First Name: STAR
Middle Name: LUCY
Maiden Name:
Alias:
Social Security No.: 999999999
Number and Street: 246 N HIGH ST
Supp Address:
City: COLUMBUS
State: Ohio
Zip Code: 43215
County: 049
Race 1: American Indian, Aleutian, or Eskimo
Race 2: No further race documented
Race 3: No further race documented
Race 4: No further race documented
Race 5: No further race documented
Hispanic Ethnicity: Puerto Rican
Birth Date: 19/70/0512
Birth Date Flag:
Birthplace State:
Birthplace Country:
Sex: Female
Usual Occupation:

Audit Reports

The System Log-ins report shows user log ins, log outs, and invalid log in attempts at the facility.

Login Audit Report			
Choose a date range:	From:	08/21/2011	To: 09/21/2011
			<input type="button" value="Select"/>
Date Report Run: 9/21/2011 1:30:30 PM			
			Printable Report
Facility	UserID	Date-Time	Action
1111111111	JOHNDOE	9/6/2011 3:44:00 PM	Logged in
1111111111	JOHNDOE	9/6/2011 3:44:00 PM	Logged out
1111111111	JOHNDOE	9/7/2011 8:21:00 AM	Logged in
1111111111	JOHNDOE	9/7/2011 8:45:00 AM	Logged out
1111111111	JOHNDOE	9/7/2011 8:48:00 AM	Logged in

The Abstract Updates report shows the dates and times when users updated abstracts at the facility. If you click on the AbsRefId, you will see the specific updates made to the abstract.

Abstract Update Log

Choose a date range: From: To:

Date Report Run: 9/21/2011 1:31:52 PM [Printable Form](#)

AbsRefID	UserID	Facility	DateTime
4	JOHNDOE	1111111111	9/7/2011 8:32:00 AM
4	JOHNDOE	1111111111	9/7/2011 8:43:00 AM
4	JOHNDOE	1111111111	9/7/2011 8:44:00 AM
4	JOHNDOE	1111111111	9/7/2011 8:44:00 AM
4	JOHNDOE	1111111111	9/7/2011 8:55:00 AM

The remaining Audit Reports, Abstract Searches, Deletions, Exports and Releases, give results organized similarly to the Abstract Updates.

Uploading Files

Files are uploaded by the facility file uploader, who has a choice regarding the type of file to upload: either a file of abstracts in NAACCR format (current versions, V23, or prior version V21) or non-NAACCR files in any format. For files uploaded in the current NAACCR format, edit error and data quality reports are generated upon upload and are available for the file uploader to view at any time. Note that in Web Plus, abstract bundles are also referred to as file uploads.

Upon logging in, a facility user will see the facilities and options available.

Web Plus Any State Cancer Registry
email: WebPlusHelp@state.gov
999-999-9999
Session time left: 20 minutes

	Change Password	Log out
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Web Plus Home Page for Lily O'Connell
Please select a cancer reporting activity from those listed below the facility for which you would like to report.

Derm Office
[V18 Dermatology](#)
[File Upload](#)
[Death Certificate Follow-back Requests \(Outstanding:5, Released:3\)](#)
[Pathlab Follow-back Requests \(Outstanding:5, Released:2\)](#)

Training Hospital
[Abstract V180 Hospital](#)
[File Upload](#)

Urology Clinic
[V18 Urology](#)
[File Upload](#)

Select File Upload for the facility for which you will be uploading files. It is important to select the correct facility, as uploaded files will be associated with that facility. If a file is uploaded under the wrong facility, contact NCCR.

The menu items available to a file uploader are: New Upload, Previous Uploads, Download Files, Reports (although there are no reports currently available to the File Uploader), Change Password, Help/About and Log out.

Web Plus Any State Cancer Registry
email: WebPlusHelp@state.gov
999-999-9999

Home	New Upload	Previous Uploads	Download Files	Reports	Change Password	Help	Log out
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Choose one of the above options to proceed.

New Upload

Click the New Upload menu item.



The Upload Abstract Bundle page will open. This page displays the name of the facility and facility ID for which the file will be uploaded.

Upload Abstract Bundle - New Cancer Hospital
 (1234512345)

Select your upload type NAACCR v23.0, NAACCR v22.0 or Non-NAACCR. For NAACCR v23.0 and NAACCR V22.0, only XML files will be processed. If you have selected a NAACCR file upload option, the files must be in the correct NAACCR version record layout. NOTE: If you are uploading a NAACCR version 230 file, edits will be automatically run upon upload of the file and the edits error report will open in a separate window, unless otherwise set Sys Pref.

NAACCR V23.x XML File NAACCR V22.x XML File Non-NAACCR File

Select a file to upload: No file chosen

Comment

Select the type of file you are uploading, NAACCR current version, NAACCR previous version, or non-NAACCR file (any other format). Click Choose File to navigate to and select the file you will upload. A comment can be added if desired; it will be available to the central registry.

Upload Abstract Bundle - New Cancer Hospital
 (1234512345)

Select your upload type NAACCR v23.0, NAACCR v22.0 or Non-NAACCR. For NAACCR v23.0 and NAACCR V22.0, only XML files will be processed. If you have selected a NAACCR file upload option, the files must be in the correct NAACCR version record layout. NOTE: If you are uploading a NAACCR version 230 file, edits will be automatically run upon upload of the file and the edits error report will open in a separate window, unless otherwise set Sys Pref.

NAACCR V23.x XML File NAACCR V22.x XML File Non-NAACCR File

Select a file to upload: v23files_1.xml

Comment

Click Upload. The file will be securely uploaded to NCCR. If a NAACCR V21 file has been uploaded, edits and data completeness checks are run on the file (except if the central registry has set edits to defer; then no edits will be run on the file). Edit error and data quality reports are generated. In addition, Web Plus provides feedback during the upload process; it counts the number of abstracts as they are uploaded, and as it does so, the numbers are displayed in red or green depending on whether the current abstract being uploaded contains edit errors (red) or has no edit errors (green).

This is an example of an error free file:

Web Plus

Home	New Upload	Previous Uploads	Download Files	Change Password	Help	Log out
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File was successfully uploaded and has been submitted for edits processing. Depending on the current load on the server it may take a while to complete the edits report. You can either wait for the report to come up or exit Web Plus at this point. You will be notified by an email when the report becomes available.

Please wait if you want to view the report now.

100 abstracts to process ...

Now processing ...

.. 1 .. 2 .. 3 .. 4 .. 5 .. 6 .. 7 .. 8 .. 9 .. 10 .. 11 .. 12 .. 13 .. 14 .. 15 .. 16 .. 17 .. 18 .. 19 .. 20 .. 21 .. 22 .. 23 .. 24 .. 25 .. 26 .. 27 .. 28 .. 29 .. 30 .. 31 .. 32 .. 33 .. 34 .. 35 .. 36 .. 37 .. 38 .. 39 .. 40 .. 41 .. 42 .. 43 .. 44 .. 45 .. 46 .. 47 .. 48 .. 49 .. 50 .. 51 .. 52 .. 53 .. 54 .. 55 .. 56 .. 57 .. 58 .. 59 .. 60 .. 61 .. 62 .. 63 .. 64 .. 65 .. 66 .. 67 .. 68 .. 69 .. 70 .. 71 .. 72 .. 73 .. 74 .. 75 .. 76 .. 77 .. 78 .. 79 .. 80 .. 81 .. 82 .. 83 .. 84 .. 85 .. 86 .. 87 .. 88 .. 89 .. 90 .. 91 .. 92 .. 93 .. 94 .. 95 .. 96 .. 97 .. 98 .. 99 .. 100

100 Records run through edits. Edit report should be available shortly.

Edits Report is available in the adjoining window.

When the NAACCR file upload is complete, if edits were run, an Edit Error Report will open in a separate window. The edit report for this file indicates 0% errors.

**Any State Cancer Registry
EDIT Report**

Report From Bundle: 1234512345c_V21.xml
Internal File Name: F0000375.bun
Bundle Received From Hospital: 1234512345
Total Abstracts in the Bundle: 100

Edit Set Name: Central: Vs21 State Example - Incoming Abstracts
Total Errors in the Bundle: 0
Total Abstracts with Errors in the Bundle: 0 (0%)
Date Report Created: 2/10/2021

This is an example of an uploaded file where two abstracts have errors and the others are error free:

Web Plus

Home	New Upload	Previous Uploads	Download Files	Change Password	Help	Log out
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File was successfully uploaded and has been submitted for edits processing. Depending on the current load on the server it may take a while to complete the edits report. You can either wait for the report to come up or exit Web Plus at this point. You will be notified by an email when the report becomes available.

Please wait if you want to view the report now.

4 abstracts to process ...

Now processing ...

.. 1 .. 2 .. 3 .. 4

4 Records run through edits. Edit report should be available shortly.

Edits Report is available in the adjoining window.

The Edit Error Report provides details on the errors in the abstracts.

**Any State Cancer Registry
EDIT Report**

Report From Bundle: test file 2a
Internal File Name: F0000175.bun
Bundle Received From Hospital: 2222222222
Total Abstracts in the Bundle: 4

Edit Set Name: Central: Vs18 State Example - Incoming Abstracts
Total Errors in the Bundle: 5
Total Abstracts with Errors in the Bundle: 2 (50%)
Date Report Created: 1/14/2020

Record No in File: 2 **Total Errors:** 2
Patient's Name: SMITH, BREANA **Social Security:** 111119876
Errors:

1. Edit: Race 1, Race 2, Race 3, Race 4, Race 5 (SEER IF93)
 Type: E
 Message: If a race code = 88, all subsequent race codes must = 88
 Field(s): Race 1, Race 2, Race 3, Race 4, Race 5
 Value(s): 01, 88, 88, 88,
2. Edit: Race 5, Date of DX (SEER IF92)
 Type: E
 Message: If year of Date of Diagnosis is greater than 1999, then Race 5 must not be blank
 Field(s): Date of Diagnosis, Race 5
 Value(s): 20190301,

Record No in File: 3 **Total Errors:** 3
Patient's Name: JONES, JANUARY **Social Security:** 999999999
Errors:

1. Edit: Rad--Regional RX Modality, Date of Diagnosis (NPCR)
 Type: E
 Message: If DX year = 2018 or later, Rad--Regional RX Modality must be blank
 Field(s): Date of Diagnosis, Rad--Regional RX Modality, Primary Site, Histologic Type ICD-O-3
 Value(s): 20190523, 00, C446, 8720
2. Edit: Regional Nodes Examined, Date of Dx (SEER)
 Type: E
 Message: If year of Date of Diagnosis > 2003, then Regional Nodes Examined cannot be blank
 Field(s): Date of Diagnosis, Regional Nodes Examined
 Value(s): 20190523,
3. Edit: Regional Nodes Positive, Date of Dx (SEER)
 Type: E
 Message: If year of Date of Diagnosis > 2003, then Regional Nodes Positive cannot be blank
 Field(s): Date of Diagnosis, Regional Nodes Positive
 Value(s): 20190523,

The Edit Report is divided into two sections, and contains the following information:

Section	Value	Description
Report Header	Report From Bundle	Name and path of uploaded file
	Internal File Name	Name of file within the Web Plus application
	Bundle Received From Hospital	Name and Facility ID of facility for which file was uploaded

Section	Value	Description
	Total Abstracts in the Bundle	Total number of abstracts in the uploaded file
	Edit Set Name	Name of edit set run on uploaded file
	Total Errors in the Bundle	Total number of edit errors in the uploaded file, across abstracts
	Total Abstracts with Errors in the Bundle	Total number of abstracts containing edit errors
	Date Report Created	Date edits were run, and the error report created
Detailed Edit Report on Individual Abstracts	A list of failed edits for each abstract that contains edit errors, by abstract; The failed edit name, error type (error or warning), error message, fields checked by the edit and submitted values are listed for each edit error	

The Edit Error Report may be viewed, printed, or saved at the time of upload. A Data Quality Report (detailed information below) is also generated. This report lists number and percentages of missing/unknown values submitted in selected fields, number and percent of non-specific values for selected fields, and the diagnosis and discharge date distribution of the abstracts in the file. The Data Quality Report is helpful for monitoring the overall quality and timeliness of your facility's cancer reporting, and for identifying any potential reporting problem areas or areas in need of improvement. Both the edits error report and the data quality report are saved in the Web Plus system and are available for viewing at any time on the Previous Uploads, Track File Uploads page.

If you upload a file that has been previously uploaded, you will see a message that the file appears to have been previously uploaded and was not uploaded.

Upload Abstract Bundle - New Cancer Hospital
(1234512345)

Select your upload type NAACCR v23.0, NAACCR v22.0 or Non-NAACCR. For NAACCR v23.0 and NAACCR V22.0, only XML files will be processed. If you have selected a NAACCR file upload option, the files must be in the correct NAACCR version record layout. NOTE: If you are uploading a NAACCR version 230 file, edits will be automatically run upon upload of the file and the edits error report will open in a separate window, unless otherwise set Sys Pref.

NAACCR V23.x XML File NAACCR V22.x XML File Non-NAACCR File

Select a file to upload: No file chosen

Comment

Uploading file ... Please wait

This file appears to have been previously uploaded.
Your file was not uploaded.

The user uploading the file will also receive an email from the Web Plus system email address, as additional information (and, if the file is very large, the user may wish to log off Web Plus while it is being uploaded; the email will confirm that the file uploaded successfully). An email of an error-free file will look like this:

Dear Facility Tester,

Edit report of the abstracts bundle, wp333333331_18.dat submitted on 1/23/2020 1:09:42 PM, is ready. Please log on to Web Plus and select "Previous Uploads" option from the menu. All your previous uploads will be listed on this page. Click on "View Edit Report" link to view the report of this bundle. The report will open in a separate window.

The bundle does not have any edit errors and has been accepted.

Thank you,
Web Plus System Administrator
Any State Cancer Registry

An email of a file with errors will look like this:

Dear Facility Tester,

Edit report of the abstracts bundle, wp111111111_66.dat submitted on 1/23/2020 1:15:29 PM, is ready. Please log on to Web Plus and select "Previous Uploads" option from the menu. All your previous uploads will be listed on this page. Click on "View Edit Report" link to view the report of this bundle. The report will open in a separate window.

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

Thank you,
Web Plus System Administrator
Any State Cancer Registry

Previous Uploads / Track File Uploads

To track your facility's file uploads, go to Previous Uploads, then Track File Uploads.

Web Plus Any State Cancer Registry
email: WebPlusHelp@state.gov
800.600.0000

Home New Upload Previous Uploads Download Files Change Password Help Log out

[Track File Uploads](#)

Choose one of the above options to proceed.

A page with previous uploads, in descending date uploaded order, will open. By default, the last 30 days of previous uploads will be displayed. To view more uploaded files, search on the date uploaded either by using the calendar icon to locate the date or by entering in the date (the format is MM/DD/YYYY).

Web Plus Any State Cancer Registry
Registry Contact Name
555-555-5555

Home New Upload Previous Uploads Download Files Change Password Help Log out

Previous Uploads Abstract bundles previously uploaded from your facility are listed below. Click on View Edit Report link to view the report on a bundle. You can also view selected fields of the abstracts in a bundle by clicking on View Abstracts link. To view the files uploaded within a date range enter the date range below and click Search. If no date range specified then only the last 30 days will be displayed.

Date uploaded from: to:

Search

Original File Name	Internal File Name	Date Uploaded	Status	Total Abstracts	Abstracts with Errors	Total Errors	Comment	Action
Jan20211234512345.dat	F0000377.bun	2/10/2021 9:21:57 AM	Bundle Uploaded	39	N/A	N/A	This is our final V18 file.	View Abstracts Delete Bundle
WP Admin Tool 4_0_2_1.docx	F0000376.docx	2/10/2021 9:20:32 AM	Bundle Uploaded	N/A	N/A	N/A		Delete Bundle
1234512345c_V21.xml	F0000375.bun	2/10/2021 9:16:30 AM	No Errors	100	0	0		View Abstracts View Edit Report View Data Quality Report
1234512345b_V21.xml	F0000374.bun	2/10/2021 9:15:16 AM	Rejected	100	1	1		View Abstracts View Edit Report View Data Quality Report Delete Bundle
1234512345a_V21.xml	F0000373.bun	2/10/2021 9:01:04 AM	Rejected	100	1	1		View Abstracts View Edit Report View Data Quality Report Delete Bundle
Jan20211234512345_V21.xml	F0000372.bun	2/10/2021 8:52:27 AM	Rejected	39	39	125	This is the January 2021 submission file.	View Abstracts View Edit Report View Data Quality Report Delete Bundle
Web Plus.docx	F0000369.docx	2/4/2021 2:15:50 PM	Bundle Uploaded	N/A	N/A	N/A		Delete Bundle
northconcases.dat	F0000368.bun	2/4/2021 2:14:49 PM	Rejected	76	75	228		View Abstracts View Edit Report Delete Bundle
testfilemt1comb_V21.xml	F0000367.bun	2/4/2021 2:13:55 PM	Rejected	11	4	60		View Abstracts View Edit Report View Data Quality Report Delete Bundle

On this page you will see the name of the file, the internal name (given by Web Plus), date and time of upload, status of bundle, total number of abstracts, abstracts with errors and total errors (all if current version NAACCR file and if edits have been run), and a comment if one was included.

In the Action section, you can view limited information about the abstracts in a file, view the edit report and view the data quality report (all for current NAACCR version files), and delete a bundle (if permissible).

Non-NAACCR file uploads will have N/A for the abstract level information.

View Abstracts

The View Abstracts report shows limited fields from the abstracts: name, birth date, medical record number, accession number, and primary site. Abstracts can be viewed for both current NAACCR version (V21) and prior NAACCR version (V18) files.

View Abstracts in Bundle					
Abstract Bundle:	test file 2a, Bundle ID:F0000175.bun				
Total Abstracts:	4				
Abstracts with errors:	2				
Total errors in bundle:	5				
LastName	FirstName	BirthDate	MedRecNum	AccNumHosp	PSite
SMITH	SUE	08/02/1985			C447
SMITH	BREANA	09/12/1976			C500
JONES	JANUARY	12/10/1974			C446
SMITH	ANN	03/13/1967			C340

View Edit Report

As previously described, the edit report shows summary information about the file and number of edit errors, and then for each record with errors gives the patient name and social security number and lists those errors. This report can be used to assist with fixing edit errors before resubmitting the file.

Any State Cancer Registry EDIT Report	
Report From Bundle: Jan20211234512345_V21.xml Internal File Name: F0000372.bun Bundle Received From Hospital: 1234512345 Total Abstracts in the Bundle: 39	
Edit Set Name: Central: Vs21 State Example - Incoming Abstracts Total Errors in the Bundle: 125 Total Abstracts with Errors in the Bundle: 39 (100%) Date Report Created: 2/10/2021	
Record No in File: 1 Total Errors: 2 Patient's Name: SMITH, B Social Security: 999999999 Errors:	
1. Edit: RX Summ--Surg Prim Site, Schema ID, Primary Site (COC) Type: E Message: Conflict among RX Summ--Surg Prim Site: 22, Primary Site: C493, and Schema ID: 00421 Field(s): RX Summ--Surg Prim Site, Primary Site, Schema ID, Date of Diagnosis, Type of Reporting Source Histologic Type ICD-O-3 Value(s): 22, C493, 00421, 20190723, 1, 8800	
2. Edit: Text--Dx Proc--Path, Diagnostic Confirm (NAACCR) Type: E Message: If Diagnostic Confirmation is 1-4, Text--Dx Proc--Path cannot be blank Field(s): Diagnostic Confirmation, Text--Dx Proc--Path Value(s): 1,	
Record No in File: 2 Total Errors: 2 Patient's Name: SMITH, A Social Security: 111112345 Errors:	
1. Edit: CoC Accredited Flag, Date DX, Type Report Source (NAACCR) Type: E Message: CoC Accredited Flag must not be blank for cases diagnosed 2018 and later Field(s): CoC Accredited Flag, Type of Reporting Source, Date of Diagnosis Value(s): , 4, 20180501	
2. Edit: Text--Dx Proc--Path, Diagnostic Confirm (NAACCR) Type: E Message: If Diagnostic Confirmation is 1-4, Text--Dx Proc--Path cannot be blank Field(s): Diagnostic Confirmation, Text--Dx Proc--Path Value(s): 1,	

View Data Quality Report

The Data Quality Report is helpful for monitoring the overall quality and timeliness of a facility's cancer reporting, and for identifying any potential reporting problem areas or areas in need of improvement. For the purposes of the Data Quality Report, accepted abstracts

are separated into “Analytic” and Non-Analytic” categories, based on the class of case that was submitted on the abstract. Analytic cases are defined as cases that were first diagnosed and/or received all or part of their first course of treatment, or had treatment planned at your facility, and are reported with a class of case of 0-2. Non-analytic cases are those cases that were first diagnosed and received their entire first course of treatment at a facility other than your facility or that were diagnosed at autopsy and are reported with a class of case of 3-8. Accepted abstracts submitted with blank or unknown class of case are considered non-analytic.

As non-analytic cases of cancer generally contain less specific information and information of lesser quality than analytic reports, examining the quality of analytic reports separately from non-analytic reports will provide a more precise accounting of the overall data quality and completeness of the cases reported by your facility.

The Data Quality Report will only be available for files that are uploaded and have edits run in Web Plus. If a file is uploaded but edits are run using the Web Plus Admin Tool, the Data Quality Report will not be available.

Any State Cancer Registry Data Quality Indicators Report			
Report From Bundle: 1234512345c_v21.xml Internal File Name: F0000375 bun Bundle Received From Hospital: New Cancer Hospital (1234512345) Total Abstracts in the Bundle: 100 Date Report Created: 2/10/2021 Edit Set Name: Central: V21 State Example - Incoming Abstracts Total Abstracts with Errors in the Bundle: 0 (0%)			
Data Quality of Accepted Reports			
Missing/Unknown Values	Analytic* (N=100)	Non-Analytic (N=0)	National Standard
Sex [220]	0 (0%)	0 (0%)	<=2%
Age [230]	0 (0%)	0 (0%)	<=2%
County at Diagnosis [90]	1 (1%)	0 (0%)	<=2%
Race [160]	7 (7%)	0 (0%)	<=3%
Ethnicity [190]	5 (5%)	0 (0%)	
Zip code [100]	0 (0%)	0 (0%)	
Street Address (incl. PO Box) [2330]	0 (0%)	0 (0%)	
Month Of Diagnosis [390], pos 1-2]	0 (0%)	0 (0%)	
Laterality [410]	2 (2%)	0 (0%)	
Behavior [523]	0 (0%)	0 (0%)	
Grade [440]	100 (100%)	0 (0%)	
Derived SEER Sum Stg 2000 [3020]	100 (100%)	0 (0%)	
Diagnostic Confirmation [490]	1 (1%)	0(0%)	
Class of Case [610]	0 (0%)	0 (0%)	
Primary Site Title [2580]	0 (0%)	0 (0%)	
Histology Title [2590]	0 (0%)	0 (0%)	
Unspecific Values:			
Primary Site [400]: C809 or C76_	1 (1%)	0 (0%)	
Morphology [522]: 8000-8005, 8010 or 8800	3 (3%)	0 (0%)	
Diagnostic Confirmation [490]: 5-8	1 (1%)	0 (0%)	
Date Distribution of Accepted Reports			
Diagnosis Dates**			
< 2016	0 (0%)	0 (0%)	
2017	0 (0%)	0 (0%)	
2018	68 (68%)	0 (0%)	
2019	32 (32%)	0 (0%)	
2020	0 (0%)	0 (0%)	
2021	0 (0%)	0 (0%)	
Discharge Dates			
< 2016	0 (0%)	0 (0%)	
2017	0 (0%)	0 (0%)	
2018	0 (0%)	0 (0%)	
2019	0 (0%)	0 (0%)	
2020	0 (0%)	0 (0%)	
2021	0 (0%)	0 (0%)	
<small>*Analytic Reports are those that have been submitted with class of case 00-22. Non-Analytic Reports are those that have been submitted with blank or unknown (99) class of case, or with class of case 30-49. **Diagnosis Year is the year of initial diagnosis by a recognized medical practitioner. It does NOT correspond to either accession year or submission year.</small>			

Delete an Uploaded File

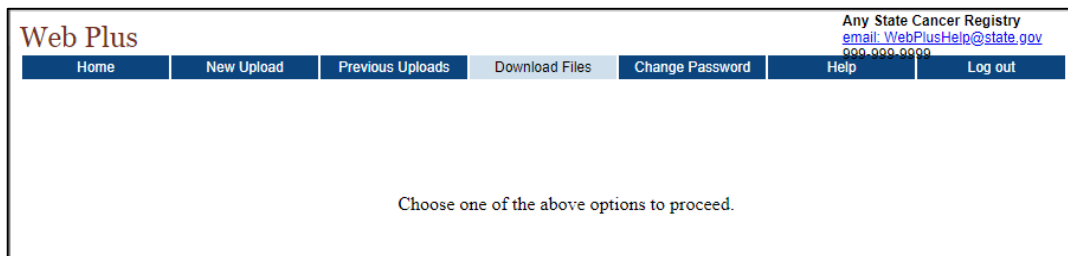
To delete an uploaded file, click the Delete action for the file upload of interest. When deleting a file upload, the uploaded file, as well as all information regarding the file will be deleted from Web Plus. Please use the Delete action with caution. Files that have been exported already cannot be deleted by the facility, and current NAACCR version files that have no errors also cannot be deleted by the facility (the central registry can delete these).

If a facility uploads a file with edit errors, the file may be left in Web Plus while the errors are corrected in the users' system, and then the file can be deleted before the corrected version is uploaded.

Downloading Files

NCCR can post files in Web Plus for facility users (file uploaders) to download. These can be files of any type.

As a File Uploader, select Download Files from the menu.



The Download File page will open.

The screenshot shows the "Download File" page in Web Plus. It features the same navigation menu as the previous screenshot, with "Download Files" selected. Below the menu, the text "Download File" is displayed. A table lists the following files:

File ID	File	Date uploaded	Comment	Action
210	Web Plus reports by user type.docx	11/4/2019 12:35:35 PM	This is a document of all of the reports available in Web Plus by user type, there are many throughout the system	Download
215	NPCR_CSS_2018_SSFs.xlsx	11/22/2019 7:54:05 AM	Call for data information	Download

In the Action column, click on Download next to the file, and the file will download. Once downloaded, it can be saved where appropriate and opened.

APPENDICES

2023 Reporting Calendar

Nevada Central Cancer Registry

2023 Reporting Calendar

*Patient encounter in:	Report no later than:
January 2023	July 2023
February 2023	August 2023
March 2023	September 2023
April 2023	October 2023
May 2023	November 2023
June 2023	December 2023
July 2023	January 2024
August 2023	February 2024
September 2023	March 2024
October 2023	April 2024
November 2023	May 2024
December 2023	*June 2024

*Includes all cases (analytic and non-analytic) diagnosed and/or treated for cancer, having a cancer-related health visit while undergoing cancer treatment, or having any evidence of disease at the time of the encounter. All cases must be abstracted and transmitted to NCCR within 6 months of the date of the first encounter.

*All cases from 2023 must be reported to NCCR on or before the June 30th Annual Reporting Deadline.

The June 30th deadline is the annual call for data (CFD) milestone for cancer reporting in Nevada. All cases must be reported to NCCR on or before June 30, 2024, as required by Nevada law.

Facilities not in compliance with the six-month reporting rule will be notified of the delinquency. Each facility will be asked to develop a remedial correction plan to bring the facility back into compliance with Nevada statutes. The plan must include a statement indicating how the facility plans to stay in compliance once the current reporting year has been completed and compliance has been reached for the year in question.

2023 REQUIRED References for Abstracting

Resource	Web Address for Source
2023 NCCR Reporting Manual	Available for download in FLccSC
2023 Solid Tumor MPH Rules, 2023 Update	https://seer.cancer.gov/tools/solidtumor/
2021 Heme/Lymph Neoplasm MPH Rules with Interactive Online Heme/Lymph Database	https://seer.cancer.gov/seertools/hemelymph/
ICD-O-3.2 Updates & Coding Materials	https://seer.cancer.gov/icd-o-3/
IACR/WHO Histology/Behavior ICD-O-3.2	http://www.iacr.com.fr/images/Newsflash/ICD-O-3.2_final_update09102020.xls
ICD-O-3 Manual, 3 rd Edition–the “purple” book	https://tinyurl.com/PerpleBook
SSDI Manual, V3.0 (October 2022)	https://tinyurl.com/SSDIManual2023
Grade Coding Instructions & Tables, V3.0 (October 2022)	https://tinyurl.com/GradeManual2023
SSDI Coding Instructions, and SSDI Coding Applications, V3.0	https://apps.naaccr.org/ssdi/list/
SEER Program Coding and Staging Manual 2023, (January 2023 Revision)	https://seer.cancer.gov/manuals/2023/SP_CSM_2023_MainDoc.pdf
SEER Summary Staging Manual 2018, V3.0	https://seer.cancer.gov/tools/ssm/2018-Summary-Stage-Manual.pdf
SEER*Rx Online Interactive Drug Database	https://seer.cancer.gov/seertools/seerrx
SEER*RSA (Registry Staging Assistant)	https://staging.seer.cancer.gov/eod_public/software/3.0/
STORE V23	https://tinyurl.com/CoCSTORE2023
National Comprehensive Cancer Network (NCCN)	https://www.nccn.org/guidelines/category_1

Required Data Items

The following table lists the required data items required by NCCR and NPCR. The column with the data item numbers contains a link to [NAACCRs Data Dictionary](#) for more information for that data item.

Data Item #	Data Item Name
70	Addr at DX--City
2330	Addr at DX--No & Street
100	Addr at DX--Postal Code
80	Addr at DX--State
2335	Addr at DX--Supplementl
230	Age at Diagnosis
523	Behavior Code ICD-O-3
1910	Cause of Death
367	Census Tr Certainty 2010
135	Census Tract 2010
610	Class of Case
2152	CoC Accredited Flag
90	County at DX Reported
2110	Date Case Report Exported
2112	Date Case Report Loaded
2111	Date Case Report Received
240	Date of Birth
390	Date of Diagnosis
1750	Date of Last Contact
2113	Date Tumor Record Availbl
2380	DC State File Number
490	Diagnostic Confirmation
1791	Follow-up Source Central
3843	Grade Clinical
3844	Grade Pathological
522	Histologic Type ICD-O-3
1920	ICD Revision Number
2116	ICD-O-3 Conversion Flag
410	Laterality

Data Item #	Data Item Name
2300	Medical Record Number
470	Morph Coding Sys--Current
50	NAACCR Record Version
2280	Name--Alias
2232	Name--Birth Surname
2240	Name--First
2230	Name--Last
2250	Name--Middle
1990	Over-ride Age/Site/Morph
2040	Over-ride Histology
2060	Over-ride Ill-define Site
2070	Over-ride Leuk, Lymphoma
2078	Over-ride Name/Sex
2050	Over-ride Report Source
2000	Over-ride SeqNo/DxConf
2071	Over-ride Site/Behavior
2074	Over-ride Site/Lat/Morph
2010	Over-ride Site/Lat/SeqNo
2030	Over-ride Site/Type
2020	Over-ride Surg/DxConf
20	Patient ID Number
1506	Phase I Radiation Treatment Modality
1942	Place of Death--State
400	Primary Site
160	Race 1
161	Race 2
162	Race 3
163	Race 4
164	Race 5
193	Race—NAPIIA (derived API)
1430	Reason for No Radiation
1340	Reason for No Surgery
10	Record Type

Data Item #	Data Item Name
830	Regional Nodes Examined
820	Regional Nodes Positive
40	Registry ID
540	Reporting Facility
1460	RX Coding System--Current
1410	RX Summ--BRM
1390	RX Summ--Chemo
1400	RX Summ--Hormone
1420	RX Summ--Other
1292	RX Summ--Scope Reg LN Sur
1294	RX Summ--Surg Oth Reg/Dis
1290	RX Summ--Surg Prim Site 2022 (use prior to 2023)
1291	RX Summ--Surg Prim Site 2023 (1/1/23, forward)
1380	RX Summ--Surg/Rad Seq
1639	RX Summ--Systemic/Sur Seq
3250	RX Summ--Transplnt/Endocr
380	Sequence Number--Central
220	Sex
450	Site Coding Sys--Current
2320	Social Security Number
190	Spanish/Hispanic Origin
764	Summary Stage 2018
756	Tumor Size Summary
500	Type of Reporting Source
1760	Vital Status

List of Paired Organs

Code	Site
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum - use code 0)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina - use code 0)
C34.1	Upper lobe, lung
C34.2	Middle lobe, lung
C34.3	Lower lobe, lung
C34.8	Other parts of lung or bronchus
C34.9	Lung, NOS
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bones of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum - use code 0)
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis - use code 0)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face (if midline, code 5)
C44.4	Skin of scalp and neck
C44.5	Skin of trunk (if midline, code 5)
C44.6	Skin of arm and shoulder
C44.7	Skin of leg and hip

Code	Site
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous, and other soft tissue of upper limb and shoulder
C49.2	Connective, subcutaneous, and other soft tissue of lower limb and hip
C50.0-C50.9	Breast (male and female)
C56.9	Ovary
C57.0	Fallopian tube
C62.0	Undescended testis
C62.1	Descended testis
C62.9	Testis, NOS
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges
C71.0	Cerebrum
C71.1	Frontal lobe
C71.2	Temporal lobe
C71.3	Parietal lobe
C71.4	Occipital lobe
C72.2	Olfactory nerve
C72.3	Optic nerve
C72.4	Acoustic nerve
C72.5	Cranial nerve, NOS
C74.0-C74.9	Suprarenal gland
C75.4	Carotid body

Casefinding Code List for Reportable Tumors

An electronic version of the case-finding list is available on the SEER website.

<https://seer.cancer.gov/tools/casefinding/>

COMPREHENSIVE ICD-10-CM Casefinding Code List for Reportable Tumors (EFFECTIVE DATES: 10/1/2022-9/30/2023)

Please refer to your standard setter(s) for specific reporting requirements
before using the Casefinding List

ICD-10-CCode	Explanation of Code
C00.-- C43.-, C4A.-, C45.-- C48.-, C49.-- C96.-	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.10-, C44.19-	Unspecified/other malignant neoplasm of skin of eyelid
C44.13-	Sebaceous cell carcinoma of skin of eyelid, including canthus
C44.20-, C44.29-	Unspecified/other malignant neoplasm skin of ear and external auricular canal
C44.30-, C44.39-	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.40, C44.49	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50-, C44.59-	Unspecified/other malignant neoplasm of skin of trunk
C44.60-, C44.69-	Unspecified/other malignant neoplasm of skin of upper limb, incl. shoulder
C44.70-, C44.79-	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin
C49.A-	Gastrointestinal Stromal Tumors
D00.-- D05.-, D07.- - D09	In-situ neoplasms <i>Note 1: Excludes carcinoma in situ tumors of the cervix (D06._)</i> <i>Note 2: Excludes prostatic intraepithelial neoplasia (PIN III) (8148/2) of the prostate. Other prostate in situ histologies are reportable</i> <i>Note 3: For D04 (carcinoma in situ of skin), excludes basal and squamous cell in situ lesions</i>
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
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
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, 9993)
D47.02	Systemic mastocytosis
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3) ICD-10-CM Coding instruction note: Excludes the following: Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_) Chronic myeloid leukemia BCR/ABL-positive

ICD-10-CCode	Explanation of Code
	(C92.1_) Myelofibrosis & Secondary myelofibrosis (D75.81) Myelophthisic anemia & Myelophthisis (D61.82)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia
D47.4	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D47.Z-	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3) Note: Effective 1/1/2021, PTLN (9971/3) is no longer reportable (9971/1)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
D72.11-	Hypereosonophilic syndrome [HES] (9964/3)
K31.A22	Gastric intestinal metaplasia with high grade dysplasia
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina
R90.0	Intracranial space-occupying lesion found on diagnostic imaging of central nervous system

Cancer Directed Treatment

It is necessary to distinguish cancer-directed treatment from non-cancer directed treatment, which are recorded differently in cancer data fields.

Cancer-Directed Treatment

Any treatment that is given to modify, control, remove or destroy primary or metastatic cancer tissue is cancer directed treatment. The type of treatment is meant to remove a tumor or minimize the size of tumor or delay the spread of disease.

- Surgery (-ectomy) to remove cancer tissue, organ, or lymph nodes
- Exenteration to remove the contents of a body cavity
- Fulguration to destroy tissue with the use of electric sparks
- Debulking to remove as much tumor as possible to reduce tumor volume

Non-Cancer Directed Treatment

Any treatment designed to prepare the patient for cancer-directed treatment, prolong a patient's life, alleviate pain, or make the patient comfortable. Non-cancer directed treatments are not meant to destroy the tumor, control the tumor, or delay the spread of disease. These treatments include diagnostic tests and supportive care.

- Biopsy to remove a tissue to determine a diagnosis
- Palliative care to relieve symptoms but not to cure patient
- Bypass (-ostomy) to create a path around an area blocked by tumor
- Stent placement to alleviate obstruction

To ensure complete and accurate treatment data, terms such as "first course of treatment" and "treatment for recurrence or progression" should be defined.

First course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. In cancer treatment data registration, the date of the first course treatment is the month, day, and year of the first cancer-directed treatment that is administered.

Treatment of recurrence or progression (also called "subsequent treatment") includes all cancer-directed treatments administered after the first course of treatment is completed, stopped, or changed. For the date of "Subsequent Treatment(s) For Recurrence or Progression," the date(s) of treatment(s) administered for progression or recurrence of disease is(are) recorded. In short, subsequent treatment starts after the first course of treatment has been completed, stopped, or changed.

Text Documentation Requirements

Text validation of codes is required by NCCR. Writing text is required to supplement and support coded information. The codes entered in the abstract should mirror the text fields. Text documentation is used for general quality control, visual editing, re-abstracting studies, special research projects, and consolidation by NCCR. Proper text documentation allows for the review and correction of abstracts without access to the patient's actual medical record. Furthermore, text from the original abstract is used to audit NCCR's consolidation practices by our standard setters.

Each abstract takes a significant amount of time and effort to produce. We are all striving for consistent, accurate data. Your text validates the codes selected in your abstract and is vital to resolving discrepancies between multiple facilities who may have submitted an abstract on the same patient.

General guidelines for recording text information.

- All coded data fields must have text support recorded on the abstract. Record text to validate coded data fields.
- Fields requiring text verification include patient race, age, sex, and other demographics (marital status, insurance at diagnosis, and vital status/death information), primary site, histology, extent of disease, treatment, and any other positive/negative findings that validate the primary site, histology, extent of disease and treatment.
- Data fields that do not need text support include date of birth, social security number, NPI or facility numbers, phone numbers, patient address information, and medical record number.
- Text should be completed by the abstractor. Text generated by the computer is not acceptable.
- Record *pertinent* site-specific cancer information.
- We recommend completing the text fields *before* assigning codes.
- Record text in a concise and organized manner.
- Complete sentences are not required or necessary.
- Key phrases are separated by punctuation, either periods, or semicolons.
- Use standard medical abbreviations. Avoid abbreviations with many different meanings in different contexts.
- Use either lower case or a combination of upper and lower case. Avoid all capital letters (we recommend lower case text with all abbreviations in capital letters).
- Do not repeat the same information in multiple fields.
- Avoid including irrelevant information.
- Dates may be estimated and should be documented as estimated dates.

Suggestions for concise text and successful abbreviations.

- Leave out articles, such as "a," "an," and "the."
- Leave out verbs (complete sentences not necessary).
- Use symbols with distinct meanings, such as (+) for positive and (-) for negative.
- Use standard abbreviations wherever possible.
- When in doubt. Just write it out.

Text-Usual Occupation NAACCR Item # 310	Instructions: Record the patient’s usual occupation (i.e., the kind of work performed during most of the patient’s working life before diagnosis of this tumor). Do not record “retired.” If usual occupation is not available or is unknown, record the patient’s current or most recent occupation, or any available occupation. If no information is available, record “unknown.”
	Rationale: Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies occupational groups in which cancer screening or prevention activities may be beneficial
	Example: “High School Teacher”
Text-Usual Industry NAACCR Item # 320	Instructions: Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the greatest number of years before diagnosis of this tumor. Be sure to distinguish among “manufacturing,” “wholesale,” “retail,” and “service” components of an industry that performs more than one of these components. There should be an entry for Text--Usual Industry if any occupation is recorded. If no information is available regarding the industry in which the reported occupation was carried out, record “unknown.” If the patient was not a student or homemaker and had never worked, record “never worked” as the usual industry.
	Rationale: Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.
	Example: If Usual Occupation is “High School Teacher” than the industry would be “Education Services” or “Education.”

Text-DX Proc-PE (Physical exam) NAACCR Item #2520	Instructions: Document the history, physical examination and clinical presentation information including any symptoms that led to workup and evaluation for cancer. This includes date of exam, age, sex, race/ethnicity, clinical tumor size, tumor location, palpability of lymph nodes, and positive and negative clinical findings.
	Rationale: Validates date of diagnosis, class of case, diagnostic confirmation, clinical staging information, race, sex, Spanish/Hispanic ethnicity, and site-specific factors.
	Example: 52 Y/O, white, Hispanic male; referred to MED ONC for consult for recent DX of cancer in RLL lung; PT originally presented in ER elsewhere PTA for severe cough W/blood in sputum; WU showed nodule RT lung; BX revealed ADENOCA; presents now for TX; PE on 4/4/2021 showed no LN PALP and BILAT crackles

Text-DX Proc-X-Ray/Scan (imaging) NAACCR Item #2530	Instructions: Document date, facility, imaging test performed and any pertinent results, findings, and impressions.
	Rationale: Validates date of diagnosis, clinical stage related fields, tumor size summary, extent of disease related fields, and diagnostic confirmation.
	Example: 6/4/2020 (ABC Hospital) CT ABD/pelvis: two pancreatic masses, one 2.5 CM arising in head of pancreas and second 2.3 CM arising in junction of head and body of pancreas. 7/18/2020 MRI ABD: progressive pancreatic duct dilation, suggesting intraductal mucinous tumor of pancreas, solid component arising in head of pancreas, suspicious for MALIG

Text-DX Proc-Scopes NAACCR Item #2530	Instructions: Document all endoscopic examinations and findings that provide information for staging and treatment. Document the date and location of where the study occurred.
	Rationale: Validates RX Summ-DX/Stg Proc, Surgery Primary Site, staging decisions, Laterality, Primary Site, Diagnostic Confirmation, and Histology.
	Example: 5/13/2023 (office of Dr. John Doe) colonoscopy: fungated ulcerated mass in terminal ileum, 2.0 CM extends to MARG, polyp near mass resected; 6/1/2023 (UNK facility) EUS W/FNA: 3.0 CM colon mass found 42 CM from anal verge

TEXT-DX Proc-Lab Tests NAACCR Item #2550	Instructions: Text area for manual documentation of information from laboratory examinations other than cytology or histopathology. Document cancer-specific tumor markers, serum and urine electrophoresis, special studies, etc. Record both positive and negative findings. Record positive results first.
	Rationale: This field validates the coding for site specific factors, special studies, some staging items, and validates information used to assign more specific histology types. If the diagnosis was made clinically, it is used to confirm clinical diagnosis.
	Example(s): Breast: 1/1/2022 ER (+)/ PR (+), HER-2 (-) on IHC (score 0). 1/10/2022 HER-2 by FISH (-), ratio: 1.7 Or Prostate: 7/2/2022 PSA 10 ng/mL (elevated)

<p>TEXT-DX Proc OP (findings)</p> <p>NAACCR Item #2560</p>	<p><u>Instructions:</u> Document dates, names of procedures, along with abnormal findings, and location of tumor. Document observations of the surgeon (what is seen/felt/palpated) when the patient is opened up/explored. Do not record what surgeon did (step by step procedure). Do not record path findings. If no findings are found, record “technique only.”</p> <p><u>Rationale:</u> Validates RX Summary, Surgery of Primary Site, Reason for no Surgery, and staging decisions.</p> <p><u>Example:</u> 8/15/2022 sigmoid colectomy, RT colectomy, and RT oophorectomy: PALP LSN in LT flank; colon was noted 2B dilated as well as small bowel; a near obstructing LSN found in sigmoid colon; cecal area had large tumor noted involving the RT ovary; ovary was noted 2B enlarged and abnormal</p>
<p>TEXT-DX Proc Path</p> <p>NAACCR Item #2570</p>	<p><u>Instructions:</u> Use this field to pull pertinent information from pathology reports. This includes specimen collection date, pathology report number (specimen number), procedure, tissue specimen and any language that describes primary site, histology, laterality, behavior, grade, extent of disease, tumor size, margins, or status of lymph nodes. Note if pathology report is a slide review or a second opinion from an outside source, i.e., AFIP, Mayo, etc. Record any additional comments from the pathologist, including differential diagnosis considered and any ruled out or favored.</p> <p><u>Rationale:</u> Validates the coding of Primary Site, Date of Diagnosis, Histology, Grade, Behavior, Diagnostic Confirmation, Extent of Disease related fields, values selected for site-specific factors, and surgical procedures and treatment fields. Validates staging information such as Pathologic Size and/or Tumor Size Summary, lymph node involvement and metastasis.</p> <p><u>Example(s):</u> colon 1/1/2020 ABC Hospital (NV-20-01456) ascending colon mass BX: INV MOD DIFF ADENOCA W/mucinous and signet ring cell features. 1/15/2020 ABC Hospital (NV-20-01503) hemicolectomy: sigmoid colon; 8.0 CM; LVI: (-); PNI: (-); MARG (-); 2(+)/5 LNs. Liver BX C/W METS; omentum (-) for MALIG</p> <p>Prostate 8/21/2021 ABC Hospital (NV-21-01245) prostate BX: prostatic ADENOCA; Gleason 4+3=7 (group 3); PNI is identified. 11/13/2021 ABC Hospital (NV-21-02546) radical prostatectomy: ADENOCA; Gleason 3+4=7 (group 2); EPE: (-); urinary bladder neck INV: (-); SV INV: (-); carcinoma focally extends to apex MARG of prostatectomy; 0(+)/8 LNs; pT2 pN0</p>
<p>TEXT-Primary Site Title</p> <p>NAACCR Item #2580</p>	<p><u>Instructions:</u> Document the primary site including applicable subsite along with laterality.</p> <p><u>Rationale:</u> Validates coded values of primary site and laterality</p> <p><u>Example:</u> RT breast @ 10:00 OR RT breast UOQ</p>

TEXT-Histology NAACCR Item #2590	Instructions: Document the histology, grade, and behavior of the tumor.
	Rationale: Validates that text agrees with coded values for Histology, Grade, and Behavior.
	Example(s): SCC, G2 Or ADENOCA, Gleason 6 Or DCIS, HG Or Melanoma in situ
TEXT-Staging NAACCR Item #2600	Instructions: Record highest stage prior to treatment. Document tumor size and extension, lymph node involvement, sites of distant metastasis, and any other information related to staging.
	Rationale: Validate staging fields
	Example(s): Prostate confined to prostate, no REG LNs, no DIST METS Breast: PT received NEOADJ TX; 2 LT breast tumors, largest 4.0 CM confined to breast, large mass in axilla C/W METS to LNs, no DIST METS Skin: Clark level IV, 1(+)/4 LNs, no DIST METS
TEXT-Surgery NAACCR Item #2610	Instructions: Enter dates and text describing each surgical procedure(s) performed as first course treatment. Include other treatment information, e.g., planned procedure aborted, unknown if surgery performed, patient refused.
	Rationale: Validates date first course treatment, date of diagnosis, surgery primary site, date surgery, surgery/radiation sequence, and reason no surgery.
	Example(s) Breast 3/15/2021 ABC Hospital: RT breast lumpectomy W/LN dissection Colon 1/1/2022 ABC Hospital: RT hemicolectomy W/LN dissection Skin 3/27/2021 ABC Hospital: RT punch BX. 4/2/2021 RT wide re-excision
TEXT- Radiation (Beam) NAACCR Item #2620	Instructions: Document dates and detailed information regarding radiation treatment for the tumor being reported. Enter date and type (modality) of radiation. If the sequence of surgery and radiation is not apparent, indicate sequence.
	Rationale: Validates Date of First Course TX, Reason for no Radiation, RX Date of Radiation, RX-Summ Surg/Rad Seq, and Regional RX Modality.
	Example: 2/25/2021 45 GY in 25 FX at 180 CGY per FX using photon modality

TEXT- Radiation (other)	Instructions: Document dates and detailed information regarding radiation treatment that is non-beam, e.g., seed implant, radioisotopes (I-131).
NAACCR Item #2630	Rationale: Validates Date of First Course TX, Reason for no Radiation, RX Date of Radiation, RX-Summ Surg/Rad Seq, and Regional RX Modality
	Example: 2/25/2021single injection of 150 millicuries of radioiodine (I-131)
TEXT – Chemo	Instructions: Document start date and chemotherapy agents or regimen. If treatment was discontinued or not completed, state.
NAACCR Item #2640	Rationale: Validates Date of First Course TX, RX Date Systemic, RX Date Chemo, RX Summ-Systemic/Surg Seq, and/or Date of First Course RX
	Example(s): 1/2/2022 Carboplatin and Taxol 1/4/2021 recommended Carboplatin and Taxol, PT refused 1/31/2022 referred to ABC Oncology, unknown if CHEMO recommended or performed
TEXT- Hormone	Instructions: Document start date and drug used. If treatment was discontinued or not completed, state.
NAACCR Item #2650	Rationale: Validates Date of First Course TX, RX Date Systemic, RX Date Hormone, RX Summ-Systemic/Surg Seq, and/or Date of First Course RX
	Example: 2/1/2022 levothyroxine
TEXT- BRM	Instructions: Document start date and immunotherapy agents. If treatment was discontinued or not completed, state. Examples include bone marrow transplant and stem cell transplant.
NAACCR Item #2660	Rationale: Validates Date of First Course TX, RX Hosp-BRM, RX Date Systemic, RX Summ Tranplnt/Endocr, RX Summ BRM, RX Date BRM, and RX Summ-Systemic/Surg Seq
	Example: 3/26/2021 interferon
TEXT – Other	Instructions: Document date treatment started and type of other treatment.
NAACCR Item #2670	Rationale: Validates Date of First Course TX, RX Summ-Other, RX Date Other, and RX Hosp-Other
	Example: 4/7/2021 blinded clinical trial

TEXT – Remarks NAACCR Item #2680	Instructions: Document pertinent information not indicated in other text fields. Include marital status, race, ethnicity, smoking history, insurance at diagnosis, family and personal history of cancer, birthplace, occupation, industry, date of death, and justification of over-ride flags.
	Rationale: Validates Marital Status, Race/Ethnicity fields, Sequence Number Insurance at Diagnosis, Birthplace, Occupation, Industry, and Date of Death.
	Example: married, white, non-Hispanic; Medicare managed care; former 1 PPD smoker x 20 years (quit 2010); no ETOH HX; no family HX or personal HX of cancer; birthplace: Los Angeles, CA; worked as nurse in healthcare industry

TEXT – Place of Diagnosis NAACCR Item #2690	Instructions: Document the facility, physician office, city, state, or country where the diagnosis was made. If the diagnosis was made at a small clinic or family practice, do not abbreviate the name of the practice (“University of California San Francisco” versus “UCSF”). For out-of-state residents and facilities, include the city and state where the facility is located.
	Example: Smith Family Medical

Resources for Text Documentation

- [A Cancer Registrar’s Guide to Collecting Industry and Occupation](#)
- [NAACCR Recommended Abbreviations for Abstractors](#)
- NCRA has published a series of [Informational Abstracts](#) that provide cancer-site specific guidelines for text to be included in abstracts. Updated 2022. These are available as a set and can be downloaded [here](#). Additional resources are available [here](#).

Resources for Education and Training

[Fundamental Learning Collaborative for the Cancer Surveillance Community](#)

The Fundamental Learning Collaborative for the Cancer Surveillance Community (FLccSC- pronounced as “flossy”) is Nevada’s go-to learning management system. Silver State registrars can access CE-eligible courses from NAACCR’s Cancer Registry and Surveillance Webinar Series, as well as course modules that have been created and shared by other states. The webinar recordings and materials are FREE at no cost to Nevada cancer reporters. To access the trainings, you must have a free FLccSC account.

Click [here](#) to register as new user. You will receive an email from the NCCR Education and Training Coordinator with instructions once your registration has been processed.

[AJCC Curriculum for Registrars](#)

This free self-guided learning designed to provide education in a stepwise learning environment. The curriculum breaks down the content into Introduction, Beginning, Intermediate, and Advanced. After the Introduction, the modules will provide lessons in a consistent order of classifications; categories T, N, and M; stage group; additional resources; and a quiz.

[SEER Training Modules](#)

The SEER training website provides web-based training on cancer registration, including site-specific cancer instructions. This website contains resources that are free and can be used by anyone.

[SEER Educate](#)

This FREE comprehensive training platform is tailored specifically for cancer registry professionals to improve technical skills through applied testing on the latest coding guidelines and concepts.

[NCRA's Center for Cancer Registry Education](#)

The Center for Cancer Registry Education is designed to provide easy access to high-quality educational programming to support both seasoned professionals and those new to the field. This one-stop access site offers a variety of products and services, allowing you to tailor your training and manage continuing education credits.

[NAACCR Cancer Registrar Training Guide](#)

The NAACCR Cancer Registrar Training Guide is intended for use by central cancer registries (CCRs) in training individuals new to the cancer registry profession. It consists of one-on-one mentorship, independent learning, hands-on exercises, and practical experience. The primary goal of the Guide is to prepare new staff to become productive, effective members of the central registry workforce using existing education and training resources. Each student should work with a mentor who is a Certified Tumor Registrar with experience in central cancer registry operations.

[Tour of the Hematopoietic Data Base](#)

Working on the live SEER web site, Jennifer Ruhl, MSHCA, RHIT, CTR will demonstrate how registrars can navigate the Hematopoietic Database successfully. Using case scenarios, she will provide tips to help registrars achieve the best and most accurate outcomes for determining reportability requirements and hematopoietic and lymphoid neoplasm cases. CE credit not available for this activity.

[Hematopoietic Project](#)

This site provides data collection rules for hematopoietic and lymphoid neoplasms for 2010+. There are two tools for use with these rules:

[Hematopoietic & Lymphoid Neoplasm Database \(Heme DB\)](#)

- A tool to assist in screening for reportable cases and determining reportability requirements
- The database contains abstracting and coding information for all hematopoietic and lymphoid neoplasm (9590/3-9992/3)

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