NB-IRDT
New Brunswick Institute for Research, Data and Training

Canadian Cancer Registry

Reference Guide
For Years 2000-2015

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WHAT'S NEW?

Changes in the name, meaning, format, description or characteristics of variables are shown in the revision section for each variable.

Refer to the Statistics Canadian Cancer Registry (CCR) System Guide for more details on the Canadian Cancer Registry.

ABOUT THIS GUIDE

This reference guide is intended for users of the Canadian Cancer Registry. This guide provides an overview of the data, the general methodology used in its creation and important technical information. It contains operational procedures as well as tables and field descriptions. The development of this document is an ongoing process that will be updated with changes that occur in the Canadian Cancer Registry.

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OVERVIEW

The Cancer Registry (CCR) is a database of all Canadian residents, alive or dead, who have been diagnosed with cancer since 1992. This registry was developed from the National Cancer Incidence Reporting System (NCIRS) and is maintained by Statistics Canada. It collects data on type and incidence (number) of primary cancers for each person until death, from Provincial and Territorial Cancer Registries (PTCRs).
The New Brunswick Provincial Cancer Registry (NBPCR), located in Saint John, collects the New Brunswick Data.

Data range

2000-2015 (Calendar Years)

Data source

New Brunswick Department of Health

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This document is based on the Canadian Cancer Registry System Guide-2012.

ABOUT THIS PRODUCT

Purpose of the product

The purpose of the Canadian Cancer Registry is to provide usable and linkable New Brunswick cancer incidence and survival data for each primary type of cancer to researchers for public health and other research as well as for the development of population estimates and projections.
The data that comes into the CCR describes both the individual with the cancer, and the characteristics of the cancer.

Content

This version of the Canadian Cancer Registry reference guide contains three (3) groups of data:

Field	Description
1	Input patient variables
2	Input tumour variables
3	Derived tumour variables

The description of fields in the input patient, input tumour and derived tumour variables are shown as follows:

- **Description** – A general description of the variable content.
- **Effective** – Reference years (for example, based on date of diagnosis, not collection date) when the variables are in effect and collected.
- **Length** – The length of the variable in the record layout.
- **Format** – Provides formatting details such as character specifications.
- **Used by –** Field for derived patient and tumour variables only. Provides details about which process reads and/or writes the derived variable.
- **Codes and descriptions –** Lists acceptable values and defines their meanings.
- **Revision** – Lists changes related to the variable and year in which change was made. See Statistics Canada CCR Systems Guide for more details on the edits.

General methodology

Detailed information on what data is reported to the Canadian Cancer Registry, how data is reported, and the data variables are available in the Canadian Cancer Registry System Guide.

Starting 2008, the New Brunswick Provincial Cancer Registry (NBPCR) has used the Collaborative Staging System to capture cancer stage for selected sites (breast, lung, prostate, and colorectum). The College of American Pathologists (CAP) Cancer Protocols and Checklists have been endorsed as the cancer pathology reporting standard in New Brunswick since 2009.

Refer to the Canadian Cancer Registry Dictionary for more information.

Reference date

2000 - 2015 (Calendar years)

TECHNICAL SPECIFICATIONS: RECORD LAYOUTS AND DATA DESCRIPTIONS

Input patient variables

The input patient variables are variables related to the patient and reported by the Provincial or Territorial cancer registries (PTCR).

Variable Name	Description
P1	Patient reporting province/territory
P4	Patient record type
P5	Type of current surname
P10	Sex
P11	Date of birth
P12	Province/territory or country of birth
P14	Date of death
P15	Province/territory or country of death
P16	Death registration number
P17	Underlying cause of death
P19	Patient date of transmission
P20	Date of birth flag
P21	Date of death flag
scram_res_id	Scrambled individual ID

P1 - Patient reporting province/territory

Description: Standard Geographic Code (SGC) of the province or territory submitting the patient record to the Canadian Cancer Registry.

Effective: 1992 and onwards

Length: 2

Codes and Description

Code	Province/Territory
10	Newfoundland and Labrador
11	Prince Edward Island
12	Nova Scotia
13	New Brunswick
24	Quebec
35	Ontario
46	Manitoba
47	Saskatchewan
48	Alberta
59	British Columbia
60	Yukon
61	Northwest Territories
62	Nunavut

Revision

1999 Addition of Nunavut code (62)

P4 - Patient record type

Description: Code which indicates the type of record submitted to the CCR.

Effective: 1992 and onwards

Length: 1

Codes and Description

Code	Record Type
1	New record
2	Update record
3	Delete record

Revision

2004 Change of ownership record was removed

P5 - Type of current surname

Description: Code which indicates the type of surname currently used by the patient in the field P6 – Current Surname.

Effective: 2000 – 2013

Length: 1

Codes and Description

Code	Current Surname Type
0	Current Surname unknown
1	Birth Surname
2	Other type of surname (for example, married name, legal change-of-name)
9	Type of surname unknown

Revision

Not applicable

P10 - Sex

Description: Code which indicates the sex of the patient.

Effective: 2000 – 2015

Length: 1

Codes and Description

Code	Sex
1	Male
2	Female

Revision

2011 Sex unknown (9) was removed as an option as it does not meet Statistics Canada standards for sex.

P11 - Date of birth

Description: Date (YYYYMMDD) on which patient was born.

Effective: 1992 and onwards

Length: 8

Codes and Description

Code	Date of Birth
(0000-9998)	Year of birth
9999	Year of birth unknown
(01-12)	Month of birth (January – December)
99	Month of birth unknown
(01-31)	Day of birth
99	Day of birth unknown

Revision

Not applicable

P12 - Province/territory or country of birth

Description: Code which indicates patient's province/territory (if in Canada) or country (if outside Canada) of birth.

Effective: 1992 and onwards

Length: 3

Codes and Description

Code	Province/territory or country of birth
999	Province/territory or country of birth unknown
(Others)	See Statistics Canada CCR System Guide for eligible province/territory or country codes

Revision

1996 New province/territory and country codes list added for date of birth in 1996 and onwards

P14 - Date of death

Description: Date (YYYYMMDD) on which the patient died.

Effective: 1992 and onwards

Length: 8

Codes and Description

Code	Year/Month/Day of Death
0000	Patient is not known to have died (YYYY)
(0001-9998)	Year of death
9999	Year of death unknown
00	Patient is not known to have died (MM)
(01-12)	Month of death (January – December)
99	Month of death unknown
00	Patient is not known to have died (DD)
(01-31)	Day of death
99	Day of death unknown

Revision

Not applicable

P15 - Province/territory or country of death

Description: Code created by the International Standards Organization (ISO), which indicates the patient's province/territory or country of death.

Effective: 1992 and onwards

Length: 3

Codes and Description

Code	Province/territory or country of death
000	Patient is not known to have died
999	Province/territory or country of death unknown
(Others)	Valid province/territory or country code (see the CCR Systems Guide)

Revision

1996 New province/territory and country codes list added for 'Date of death' in 1996 and onwards.

P16 - Death registration number

Description: Registration number on the official death certificate issued by the Canadian Province/territory in which the patient died.

Effective: 1992 and onwards

Length: 6

Codes and Description

Code	Death registration number
000000	Patient is not known to have died
999998	Patient died outside of Canada
999999	Patient died; death registration number is unknown
(Others)	Valid registration numbers

Revision

Not applicable

P17 - Underlying cause of death

Description: Code which indicates the underlying cause of death, as determined by the Vital Statistics office from the official death certificate.
The underlying cause of death is defined as: 'the disease or injury which initiated the train of morbid events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury'. It is coded using the International Classification of Diseases, 9th Revision (ICD-9) or International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), depending on the Date of death.

Effective: 1992 and onwards

Length: 4

Codes and Description

Code	Underlying cause of death
0000	Patient is not known to have died
0009	Unknown/unavailable underlying cause of death
(Others)	Refer to the Statistics Canada CCR System Guide for exact meaning

Revision

2012 Eligible ICD-10 underlying cause of death codes from 2000 to 2002 and Eligible ICD-10 underlying cause of death codes from 2003 were merged into one table referred to as the Eligible ICD-10 underlying cause of death codes (UCOD) from 2000 and onwards.

2000 ICD-10 Cause of death codes added.

P19 - Patient date of transmission

Description: Date (YYYYMMDD) on which a copy of the patient record was extracted from the provincial/territorial registry for a submission to the CCR

Effective: 1992 and onwards

Length: 8

Codes and Description

Code	Date of Transmission
0000-9999	Year of transmission
(01-12)	Month of transmission (January to December)
(01-31)	Day of transmission

Revision

Not applicable

P20 - Date of birth flag

Description: Flag which explains why no appropriate value is in the field, Date of birth.

Effective: 2010 and onwards

Length: 2

Codes and Description

Code	Description
[Blank]	A valid date value is provided in item 'Date of Birth', or the date was not expected to have been transmitted.
12	A proper value is applicable but not known (i.e., birth date is unknown)

Revision

2010 New variable, must be reported

P21 - Date of death flag

Description: Code which indicates why no appropriate value is in the corresponding field, Date of Death.

Effective: 2010 and onwards

Length: 2

Codes and Description

Code	Description
[Blank]	A valid date value is provided in item Date of death, or the date was not expected to have been transmitted
10	No information whatsoever can be inferred from this exceptional value (for example, patient is not known to be deceased)
11	No proper value is applicable in this context (for example, patient is alive)
12	A proper value is applicable but not known (for example, date of death is unknown)

Revision

2010 New variable, must be reported

Scrambled individual ID

Description: Scrambled code which uniquely identifies a patient who is/has been registered in the Canadian Cancer Registry.

Available Years: 2000 – 2015

Revision

Not applicable

Input Tumour Variables

The input tumour variables are variables related to the tumour and reported by the PTCRs.

Variable Name	Description
T1	Tumour reporting province/territory
T3	Tumour reference number
T5	Tumour record type
T6	Name of place of residence
T7	Postal code
T8	Standard geographic code
T9	Census tract
T11	Method of diagnosis
T12	Date of diagnosis
T13	ICD-9 Cancer code
T14	Source classification flag
T15	ICD-O-2/3 Topography
T16	ICD-O-2 Histology
T17	ICD-O-2 Behaviour
T19	Laterality
T21	ICD-O-3 Histology
T22	ICD-O-3 Behaviour
T23	Grade, differentiation or cell indicator
T24	Method used to establish the date of diagnosis
T25	Diagnostic confirmation
T26	Tumour date of transmission
T27	CS tumour size
T28	CS extension
T29	CS tumour size/ext eval
T30	CS lymph nodes
T31	CS lymph nodes eval
T32	Regional nodes examined
T33	Regional nodes positive
T34	CS mets at diagnosis
T35	CS mets evaluation
T36	CS site-specific factor 1
T37	CS site-specific factor 2
T38	CS site-specific factor 3
T39	CS site-specific factor 4
T40	CS site-specific factor 5
T41	CS site-specific factor 6

T42	AJCC clinical T
T43	AJCC clinical N
T44	AJCC clinical M
T45	AJCC pathologic T
T46	AJCC pathologic N
T47	AJCC pathologic M
T48	AJCC clinical TNM stage group
T49	AJCC pathologic TNM stage group
T50	AJCC TNM stage group
T51	AJCC TNM edition number
T52	CS version input original
T61	Grade path value
T62	Grade path system
T63	Lymph-vascular invasion
T64	CS version input current
T65	CS site-specific factor 7
T66	CS site-specific factor 8
T67	CS site-specific factor 9
T68	CS site-specific factor 10
T69	CS site-specific factor 11
T70	CS site-specific factor 12
T71	CS site-specific factor 13
T72	CS site-specific factor 14
T73	CS site-specific factor 15
T74	CS site-specific factor 16
T75	CS site-specific factor 17
T76	CS site-specific factor 18
T77	CS site-specific factor 19
T78	CS site-specific factor 20
T79	CS site-specific factor 21
T80	CS site-specific factor 22
T81	CS site-specific factor 23
T82	CS site-specific factor 24
T83	CS site-specific factor 25
T84	CS Mets at Dx – Bone
T85	CS Mets at Dx – Brain
T86	CS Mets at Dx – Liver
T87	CS Mets at Dx – Lung

T1 – Tumour reporting province/territory

Description: Standard Geographic Code (SGC) of the province/territory submitting the Tumour record to the CCR at time of diagnosis. Refer to the CCR System Guide.

Effective: 1992 and onwards.

Length: 2

Codes and Description

Code	Tumour reporting province/territory
10	Newfoundland and Labrador
11	Prince Edward Island
12	Nova Scotia
13	New Brunswick
24	Quebec
35	Ontario
46	Manitoba
47	Saskatchewan
48	Alberta
59	British Columbia
60	Yukon
61	Northwest Territories
62	Nunavut

Revision

1999 Addition of Nunavut code (62).

T3 – Tumour reference number

Description: Unique identification number assigned by the provincial/territorial cancer registry, as a reference, to each new tumour reported to the CCR. This field is part of Statistics Canada Tumour record key. It cannot be updated or reused.

Effective: 1992 and onwards.

Length: 9

Revision

Not applicable

T5 – Tumour record type

Description: Code which indicates the type of record submitted to the CCR.

Effective: 1992 and onwards.

Length: 1

Codes and Description

Code	Tumour Record Type
1	New record
2	Update record
3	Delete record

Revision

Not applicable

T6 – Name of place of residence

Description: Name of the city, town, village, reserve, etc. of the patient's usual permanent place of residence at the time of diagnosis. Refer to the Statistics Canada CCR System Guide for more information.

Effective: 1992 and onwards.

Length: 25

Format: Acceptable characters are limited to:

- Uppercase letters from ACSII-7 bit character set ([A-Z])
- Lowercase letters from ACSII-7 bit character set ([a-z])
- Accented characters (Â À Ç É Ê Ë È Î Ï Ô Û Ü â à ç é ê ë è î ï ô û ü)
- Special characters:
  - Spaces ( )
  - Periods (.)
  - Apostrophes (‘)
  - Hyphens (-)
  - Exclamation mark (!)
  - Ampersand (&)
  - Forward slash (/)
  - Parentheses (“and”)
  - Number sign (#)
  - Comma (,)

Revision

2007 Acceptable characters were specified.

T7 – Postal code

Description: Canadian postal code of the patient's usual permanent place of residence at time of diagnosis.

Effective: Reference year 1992 and onwards.

Length: 6

Codes and Description

Code	Meaning
999999	Postal code unknown
[Others]	Postal code

Revision

Not applicable

T8 – Standard geographic code

Description: Standard Geographic Code of the patient's usual permanent place of residence at time of diagnosis. It is coded using Standard geographic classification (SGC).

Effective: 1992 and onwards.

Length: 7

Format: PRCDCSD where PR is the Province code, CD is the Census division code and CSD is the Census subdivision code.

Codes and Description for PR (Province code)

Province Code	Description
10	Newfoundland and Labrador
11	Prince Edward Island
12	Nova Scotia
13	New Brunswick
24	Quebec
35	Ontario
46	Manitoba
47	Saskatchewan
48	Alberta
59	British Columbia
60	Yukon
61	Northwest Territories
62	Nunavut

Codes and Description for CD (Census Division code)

CD Code	Description
00	Unknown Census division
[Others]	Refer to the CCR Systems Guide

Codes and Description for CSD (Census Sub Division code)

CSD Code	Meaning

999	Unknown Census subdivision
[Others]	Refer to the CCR Systems Guide

Revision

2006 Standard Geographic Code (SGC) – 2006 added

2001 Standard Geographic Code (SGC) – 2001 added

1996 Standard Geographic Code (SGC) – 1996 added

T9 – Census tract

Description: Geostatistical area of the patient's usual permanent place of residence at time of diagnosis.
Census tracts contain populations ranging from 2500 to 8000 (found only in large urban communities). They are planned as being as homogeneous as possible in terms of economic status and social conditions. All Census metropolitan areas (CMA) and Census agglomerations (CA), containing a Census subdivision (that is, a city) having a population of at least 50000, are eligible to have Census tracts. It is coded using Census tract dictionary.

Effective: 1992 to 2005.

Length: 9

Format: This field is left blank for cases diagnosed in 2006 and onwards, for cases diagnosed between 1992 and 2005, a value is entered in the format - CMACCC.TT where CMA is the Census metropolitan area/Census agglomeration and CCC.TT is the Census tract.

Codes and Description

Code	Census Tract
[Blank]	For cases outside the effective date range (for example, cases diagnosed in 2006 and onwards)
000000.00	Place of residence not in a Census tract
999999.99	Census tract unknown/incomplete address
[Others]	Refer to Census tract dictionary

Revision

2006 Field only effective for reference years 1992 to 2005. Cases for year 2006 and onwards to be reported as blank (null). Census tract was removed for all cases diagnosed in 2006. Null (blank) value was added.

2001 Census tract dictionary – 2001 added.

T11 – Method of diagnosis

Description: Code which indicates the most definitive procedure by which the tumour was diagnosed.
The method of diagnosis should be based on the method by which the earliest microscopic date of diagnosis was determined. The method should be based on the status before any treatment other than surgery is given.
It is not linked to the Date of diagnosis.

Effective: 1992 to 2003.

Length: 1

Code and Description

Code	Method of Diagnosis
0	For Date of diagnosis in 2004 and onward. Method of diagnosis is reported in Input tumour variables: • T24 – Method used to establish the date of diagnosis and; • T25 – diagnostic confirmation.
1	Histology
2	Autopsy
3	Cytology
4	Radiology or laboratory diagnosis other than specified above
5	Surgery (without histology), or clinical diagnosis
6	Death certificate only
9	Method of diagnosis unknown

Revision

2004 Code (0) added for Date of Diagnosis in 2004 and onwards.

T12 – Date of diagnosis

Description: Date (YYYYMMDD) of diagnosis of the tumour. It is determined using the following sequence order (effective since 2004 for all data):

1. Date of cytological diagnosis: If suspicious cytology is confirmed by subsequent histological diagnosis (including autopsy) or clinical impression of cancer supports the cytology findings, then the cytological diagnosis date will be used.
2. Date of histological diagnosis, including cases diagnosed only on autopsy
3. Date of non-microscopically confirmed diagnosis, including:

a)Positive laboratory test/marker study;
b)Direct visualization without microscopic confirmation (surgery without histology);
c)Radiography and other imaging techniques without microscopic confirmation;
d)Clinical diagnosis, including: physical findings (without histology);
e)Method of Diagnosis unknown.

4. Date of death, if not reported at any other time, Includes:

a) Death certificate only;
b) Autopsy only.

Refer to the CCR System Guide for exceptions and more information.

Effective: 1992 and onwards.

Length: 8

Code	Description
[0000-9999]	Year of diagnosis (1992 to current reference year)
[01-12]	Month of diagnosis (January – December)
99	Month of diagnosis unknown
[01-31]	Day of diagnosis
99	Day of diagnosis unknown

Revision

2004 New sequence order for determining the date of diagnosis was introduced.

T13 – ICD–9 cancer code

Description: International Classification of Diseases, 9th revision (ICD-9) diagnosis of the neoplasm. The ICD-9 Cancer code describes the site of the tumour. It must be supplemented with an ICD–O–2 Histology (field T16) and an ICD–O–2 Behaviour (field T17).

Effective: 1992 and onwards.

Length: **4**

Format: The value does not contain a period between the 3rd and 4th digits
3 digit long values are followed by a blank space in the 4th digit

Codes and Description

Code	ICD-9 Cancer Code
0000	Topography not reported using ICD-9.
[Others]	Refer to the CCR System Guide for eligible ICD-9 Cancer codes and meaning.

Revision

2004 Name was changed from T13 – ICD-9 to T13-ICD-9 cancer code

T14 – Source classification flag

Description: Code which indicates the classification system in which the topography, histology and behaviour of the tumour were originally coded.

It is assumed that other reported topography, histology and behaviour are the result of a conversion from the original source code.

Effective: 1992 and onwards.

Length: 1

Codes and Description

Code	Tumour Classification System
1	Topography originally coded in ICD–9, Histology and behaviour originally coded in ICD–O–2
2	Topography, histology and behaviour originally coded in ICD–O–2
4	Topography, histology and behaviour originally coded in ICD–O–3

Revision

2004 Code 3 (ICD-10) was removed from the eligible codes.

T15 – ICD–O–2/3 Topography

Description: Site of origin of the neoplasm coded according to the International Classification of diseases for oncology (2nd or 3rd edition) topography section.

Effective: 1992 and onwards.

Length: 4

Format: Does not contain a period (.) between the 3rd and 4th digits.

Codes and Description

Code	ICD–O–2/3 Topography
0000	Topography not reported using ICD-O-2/3. If possible, ICD-O-2/3 Topography will automatically be derived from ICD-9 Cancer code by the CCR system.
[Others]	Refer to the CCR System Guide for eligible ICD–O–2/3 topography codes and meaning.

Revision

Not applicable

T16 – ICD–O–2 Histology

Description: Histological description of the neoplasm coded according to the International Classification of Diseases for Oncology 2nd edition - Morphology Section.

Effective: 1992 and onwards.

Length: 4

Codes and Description

Code	ICD–O–2 Histology
0000	Histology not reported using ICD-O-2.
[Others]	Refer to the CCR System Guide for eligible ICD–O–2 histology codes and meaning.

Revision

2004 Name changed from T16 – ICD-O-2 Morphology. Renamed according to CCR data and quality management Committee recommendation.

T17 – ICD–O–2 Behaviour

Description: Code which indicates behaviour associated with the histological description of the neoplasm, reported in Field T16.

Effective: 1992 and onwards.

Length: 1

Codes and Description

Code	ICD–O–2 Behaviour
0	Benign if ICD-O-2 Histology is reported, or behaviour not reported using ICD–O–2
1	Uncertain whether benign or malignant / borderline malignancy
2	Carcinoma in situ / intraepithelial / non-infiltrating / non-invasive
3	Malignant, primary site

Revision

2004 Name was formerly known as T17 – ICD-O-2 M Behaviour. Was renamed to be consistent with the T16 new name.

T19 – Laterality

Description: Code which indicates site-specific localization of the tumour in paired organs or the side of the body on which the tumour originated. It specifies whether the tumour is on the right, left or bilateral, where applicable.
Refer to the CCR System Guide for more details.

Effective: 1992 and onwards.

Length: 1

Codes and Description

Code	Laterality
0	Not a paired site
1	Right: origin of primary
2	Left: origin of primary
3	Only one side involved, right or left origin unspecified (2007 and onwards)
4	Bilateral involvement, lateral origin unknown: stated to be single primary This code is rarely used except for the following conditions: i. Both ovaries involved simultaneously, single histology ii. Bilateral retinoblastomas iii. Bilateral Wilm's tumours
5	Paired site: midline tumour (new as of 2010 see revision statement)
9	Paired site, but no information concerning laterality.

Revision

2011 Slight changes to wording for some codes.
2010 Code 5 for a paired site with a midline tumour. Code 9 no longer records midline tumor information and is used only when there is no laterality information for a paired site. Code 5 may be used to record a midline tumor of a paired site for any year of diagnosis, but review or recoding of historic cases is not required.
2007 NAACCR (SEER) laterality codes and meaning introduced for this variable. Code'1' now refers to 'Right: origin of primary'. Code '2' now refers to 'Left: origin of primary'. Code '3' added to handle 'Only one side involved, right or left origin unspecified. Data already loaded in the CCR (1992-2006) has been updated to reflect the new code set (note: Code '3' was not implemented for cases diagnosed prior to 2007).

T21 – ICD–O–3 Histology

Description: The histological description of the neoplasm, coded according to the International Classification of Diseases for Oncology 3rd edition - Morphology Section.

Effective: 1992 and onwards.

Although this field was added to the CCR in 2001, historical data back to 1992 has been converted to this classification.

Length: 4

Codes and Description

Code	ICD–O–3 Histology
0000	Histology not reported using ICD-O-3. ICD-O-3 Histology will automatically be derived from ICD-O-2 fields (topography, histology and behaviour) by the CCR system.
[Others]	Refer to the CCR System Guide for meaning.

Revision

2004 Name was changed from T21M – ICD-O-3 Morphology to T21 – ICD–O–3 Histology according to CCR data and quality management committee recommendation. Renumbered to fit in sequence.

T22 – ICD–O–3 Behaviour

Description: Behaviour associated with the histological description of the neoplasm, reported in Field T21.

Effective: 1992 and onwards.

Although this field was added to the CCR in 2001, historical data back to 1992 has been converted to this classification.

Length: 1

Codes and Description

Code	ICD–O–3 Behaviour
0	Benign if ICD-O-3 Histology is reported, or behaviour not reported using ICD–O–3. If not reported, ICD-O-3 Behaviour will automatically be derived from ICD-O-2 fields (topography, histology and behaviour) by the CCR system.
1	Uncertain whether benign or malignant / borderline malignancy
2	Carcinoma in situ / intraepithelial / non-infiltrating / non-invasive
3	Malignant, primary site

Revision

2004 Field formerly known as T22 – Date of transmission was moved to T26 – Date of transmission.
Current field formerly known as T21B – ICD-O-3 M Behaviour was renamed to be consistent with T21 new name. Renumbered to fit in sequence.

T23 – Grade, differentiation or cell indicator

Description: Code that describes the system used to identify the type of grade/differentiation/cell indicator. Grade is used by the CS algorithm to produce CS derived data.
Refer to the CCR System Guide for more details.

Effective: 2004 and onwards.

Length: 1

Codes and Description

Code	Grade, differentiation or cell indicator
0	For Date of diagnosis prior to 2004. Not reported
1	Grade I; grade i; grade 1; well differentiated; differentiated, NOS
2	Grade II; grade ii; grade 2; moderately differentiated; moderately well differentiated; intermediate differentiation
3	Grade III; grade iii, grade 3; poorly differentiated; dedifferentiated
4	Grade IV; grade iv; grade 4; undifferentiated; anaplastic
5	T-cell; T-precursor
6	B-Cell; Pre-B; B-precursor
7	Null cell; Non T-non B
8	NK cell (natural killer cell)
9	Grade/differentiations unknown, not stated, or not applicable

Revision

2006 Application of new guidelines for reporting grade, differentiation or cell indicator

2004 Field formerly known as T23 – Method used to establish date of diagnosis was moved to T24 – Method used to establish the date of diagnosis.

T24 – Method used to establish the date of diagnosis

Description: Code that specifies the method by which the date of diagnosis of the tumour was established. The SEER Program Code Manual, third edition, diagnostic confirmation descriptions were used as a reference when determining the appropriate codes for the CCR.

This field is linked to T12 – Date of diagnosis**.**

Effective: 2004 and onwards.

Length: 2

Code	Description
0	For Date of diagnosis prior to 2004 or not reported (refer to T11 – Method of diagnosis.)
1-3, 10	Microscopically confirmed
1	Positive cytology: Cytological diagnoses based on microscopic examination of cells as contrasted with tissues. Includes smears from sputum, bronchial brushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, and urinary sediment. Cervical and vaginal smears are common examples. Also includes diagnoses based on paraffin block specimens from concentrated spinal, pleural and peritoneal fluid. Fine needle aspiration is included here.
2	Positive histology: Histological diagnoses based upon tissue specimens from biopsy (including wide core and needle biopsy), frozen section, surgery, autopsy or D and C. Positive hematological findings relative to leukemia, including peripheral blood smears, are also included. Bone marrow specimens (including aspiration biopsies) are coded as '2'.
3	Autopsy only: Diagnosis confirmed by autopsy only, (if tissue taken) when no other information available.
10	Positive histology: PLUS Positive immunophenotyping AND/OR positive genetic studies (used only for hematopoietic and lymphoid neoplasms 95903-99923 as of 2010 onwards).
4-9	Non-microscopically confirmed
4	Positive laboratory test/marker study Clinical diagnoses of cancer based on certain laboratory tests or marker studies, which are clinically diagnostic for cancer. This includes alpha-fetoprotein for liver cancer and abnormal electrophoretic spike for

	multiple myeloma. Elevated PSA is non-diagnostic for cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, it should be recorded as code 4.
5	Direct visualization without microscopic confirmation (surgery without histology) Visualization includes diagnosis made at surgical exploration, including autopsy where no tissue is taken, or by use of the various endoscopes (including colposcope, mediastinoscope, and peritoneoscope). However, use only if such visualization is not supplemented by positive histology or positive cytology reports.
6	Radiography and other imaging techniques without microscopic confirmation Cases with diagnostic radiology for which there is neither a positive histology nor a positive cytology report. 'Other imaging techniques' include procedures such as ultrasound, computerized (axial) tomography (CT or CAT) scans, and magnetic resonance imaging (MRI).
7	Clinical diagnosis, including physical findings (without histology) Cases diagnosed by clinical methods not mentioned above and for which there were no positive microscopic findings.
8	Death certificate only Cases diagnosed by Death certificates only, when no other information available.
9	Method used to establish the date of diagnosis unknown.

Revision

2010 Length changed from 1 to 2 to accommodate new code.
Positive histology PLUS added

2004 Field formerly known as T24 – Diagnosis confirmation was moved to T25 – Diagnosis confirmation.
Current field formerly known as T23 – Method used to establish the date of diagnosis was renumbered to fit in sequence.

T25 – Diagnostic confirmation

Description: Method of the most accurate diagnostic confirmation. Refer to The SEER Program Code Manual for codes and descriptions.

This field is not linked with T12 – Date of diagnosis.

Effective: 2004 and onwards.

Length: 2

Categories of diagnostic methods are listed below in order of priority.

Code	Description
0	For Date of diagnosis prior to 2004 or not reported. (Refer to T11 – Method of diagnosis.)
1-3, 10	Microscopically confirmed
1	Positive histology: Histological diagnoses based on tissue specimens from biopsy (including wide core and needle biopsy), frozen section, surgery, autopsy or D and C. Positive hematological findings relative to leukemia, including peripheral blood smears, are also included. Bone marrow specimens (including aspiration biopsies) are coded as '1'.
2	Positive cytology: Cytological diagnoses based on microscopic examination of cells as contrasted with tissues. This includes smears from sputum, bronchial brushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, and urinary sediment. Cervical and vaginal smears are common examples. Also included are diagnoses based on paraffin block specimens from concentrated spinal, pleural and peritoneal fluid. Fine needle aspiration are also included here.
3	Autopsy only: Diagnosis confirmed by autopsy only, (if tissue taken) when no other information is available
10	Positive Histology PLUS: Positive immunophenotyping AND/OR positive genetic studies (used only for hematopoietic and lymphoid neoplasms 95903-99923 as of 2010 onwards)
4-9	Non-microscopically confirmed
4	Positive laboratory test/marker study: Clinical diagnoses of cancer based on certain laboratory tests or marker studies, which are clinically diagnostic for cancer. This includes alpha-fetoprotein for liver cancer and abnormal electrophoretic spike for multiple myeloma. Elevated PSA is non-diagnostic for

	cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, it should be recorded as code 4.
5	Direct visualization without microscopic confirmation (surgery without histology): Visualization includes diagnosis made at surgical exploration including autopsy where no tissue is taken, or by use of the various endoscopes (including colposcope, mediastinoscope, and peritoneoscope). This is used only if visualization is not supplemented by positive histology or positive cytology reports.
6	Radiography and other imaging techniques without microscopic confirmation: Cases with diagnostic radiology for which there is neither a positive histology nor a positive cytology report. 'Other imaging techniques' include procedures such as ultrasound, computerized (axial) tomography (CT or CAT) scans, and magnetic resonance imaging (MRI).
7	Clinical diagnosis, including physical findings (without histology): This includes cases diagnosed by clinical methods not mentioned above and for which there were no positive microscopic findings.
8	Death certificate only: Cases diagnosed by Death certificates only, when no other information available.
9	Diagnostic confirmation unknown

Revision

2012 Wording change for clarification of positive histology (code 1).

2010 Length of variable changed from 1 to 2 to accommodate new code.
Positive histology PLUS added.

2004 Name formerly known as T24 – Diagnostic confirmation, renumbered to fit in sequence.

T26 – Date of transmission

Description: Date (YYYYMMDD) on which a copy of the tumour record was extracted from the provincial/territorial registry for submission to the CCR.

Effective: 1992 and onwards.

Length: 8

Code	Description
[0000-9999]	Year of transmission
[01-12]	Month of transmission (January – December)
[01-31]	Day of transmission

Revision

2004 Name was formerly known as T22 – Date of transmission. Renumbered to fit in sequence.

T27 – CS tumour size

T27 as defined for cases submitted in CSV2 or converted to CSV2 (2004 and onwards)

Description: The largest dimension or the diameter of the primary tumour in millimeters. Tumor size at diagnosis is an independent prognostic indicator for many tumors and it is used by Collaborative Staging to derive some TNM-T codes.

Effective: 2004 and onwards.

Length: 3

Code	Description
[Blank]	Tumour outside the CCR collaborative staging scope (see section 1.1.2.2 CCR Collaborative Scope).
[000-998]	See the recommended version of the Collaborative Staging Manual and Coding Instructions (see section 1.1.2.2) for exact meaning. Some values in the range may be invalid depending on site.
999	Not staged if all other CS fields are '9' filled; otherwise see the recommended version of the Collaborative Staging Manual and Coding Instructions (see section 1.1.2.2) for exact meaning
RRR	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

2007	Meaning of value '999' modified

T28 – CS extension

T28 as defined for cases submitted in CSV2 or converted to CSV2 (2004 and onwards)

Description: Code which identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in CS Extension

Effective: 2004 and onwards (cases staged in/converted to CSV2)

Length: 3

Code	Description
[Blank]	Registry is not staging case. CS version input current (T64) indicates not staged ('999999').
[000]	In situ; non-invasive
[001-998]	See the recommended version of the Collaborative Staging Data Collection System and Coding Instructions for exact meaning. Some values in the range may be invalid depending on site.
999	Unknown; extension not stated. Primary tumor cannot be assessed. Not documented in patient record

Revision

2010 Value modified from 2 to 3 in length. Field is left justified.
Values modified to accept 3 digit values and converted values for CSV2 consistent coding.

2007 Meaning of value '99' modified

T29 – CS tumour size/ext eval

Description: CS tumour size/extension evaluation: Code which indicates how the 'CS tumour size' and 'CS extension' were determined based on the diagnostic methods employed.
This item is used by Collaborative Staging to describe whether the staging basis for the TNM-T code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging. Codes (See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org) for rules and site-specific codes and coding structures.)

Effective: 2004 and onwards.

Length: 1

Code	Description
[Blank]	Registry is not staging case. CS version input current (T64) indicates not staged ('999999').
[0-6, 8]	See the recommended version of the Collaborative Staging Data Collection System and Coding Instructions for exact meaning. Some values in the range may be invalid depending on site.
9	Unknown if surgical resection done Not assessed; cannot be assessed Unknown if assessed Not documented in patient record For sites with no TNM schema; Not applicable.

Revision

2007 Meaning of value '9' modified

T30 – CS lymph nodes

T30 as defined for cases submitted in CSV2 or converted to CSV2 (2004 and onwards)

Description: The site-specific code identifying the regional lymph nodes involved with cancer at time of diagnosis. Criteria for involvement are site-specific and may include the location, laterality, size and/or number of involved regional lymph nodes. In general, involved distant lymph nodes are coded in CS Mets at Dx. The involvement of specific regional lymph nodes is a prognostic indicator used by Collaborative Staging to derive some TNM-N codes and SEER Summary Stage codes.
Codes (See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org) for rules and site-specific codes and coding structures.)

Effective: Reference year 2004 and onwards.

Length: 3

Code	Description
[Blank]	Registry is not staging case. CS version input current (T64) indicates not staged ('999999').
[000]	No regional lymph node involvement
[001-987]	See the recommended version of the Collaborative Staging Data Collection
988	System and Coding Instructions for exact meaning.
989-998	Some values in the range may be invalid depending on site.
999	Unknown; regional lymph nodes not stated Regional lymph node(s) cannot be assessed Not documented in patient record
988	Not applicable; information not collected for this schema

Revision

2010 Variable length modified from 2 to 3 in length to accept 3 digit values and converted values for CSV2 consistent coding.

2007 Meaning of value '99' modified

T31 – CS lymph nodes eval

T31 as defined for cases submitted in CSV2 or converted to CSV2 (2004 and onwards)

Description: Code which indicates how the 'CS Lymph Nodes' code was determined based on the diagnostic methods employed.
This data item is used by Collaborative Staging to describe whether the staging basis for the TNM-N code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org) for rules and site-specific codes and coding structures.)

Effective: Reference year 2004 and onwards (cases staged in/converted to CSV2).

Length: 1

Code	Description
[Blank]	Registry is not staging case. CS version input current (T64) indicates not staged ('999999').
[0-3, 5, 6, 8]	See the recommended version of the Collaborative Staging Manual and Coding Instruction for exact meaning. Some values in the range may be invalid depending on site.
9	Unknown if lymph nodes removed for examination Not assessed; cannot be assessed Unknown if assessed Not documented in patient record For sites that have no TNM staging: Not applicable; staging basis is displayed as a blank

Revision

2010 Variable name changed from CS reg nodes eval. to CS lymph nodes eval

2007 Meaning of value '9' modified

T32 – Regional nodes examined

T32 as defined for cases submitted in CSV2 or converted to CSV2 (2004 and onwards)

Description: Indicates the total number of regional lymph nodes that were removed and examined by the pathologist. It is based on pathologic (microscopic) information only, and serves as a quality measure of the pathologic and surgical evaluation and treatment of a patient.

Effective: Reference year 2004 and onwards.

Length: 2

Code	Description
[Blank]	Tumour outside the CCR collaborative staging scope (see section 1.1.2.2. CCR collaborative staging scope).
[00-98]	See the recommended version of the Collaborative Staging Manual and Coding Instructions (see section 1.1.2.2) for exact meaning. Some values in the range may be invalid depending on site.
99	Not staged if all other CS fields are '9' filled; otherwise see the recommended version of the Collaborative Staging Manual and Coding Instructions (see section 1.1.2.2) for exact meaning.
RR	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

2007 Meaning of value '99' modified

T33 – Regional nodes positive

T33 as defined for cases submitted in CSV2 or converted to CSV2 (2004 and onwards)

Description: The exact number of regional lymph nodes examined by the pathologist and found to contain metastases. Based on pathologic (microscopic) information only.

Effective: 2004 and onwards.

Length: 2

Code	Description
[Blank]	Registry is not staging case. CS version input current (T64) indicates not staged ('999999').
[00]	All nodes examined negative
[01-90. 95. 97-98]	See the recommended version of the Collaborative Staging Data Collection System and Coding Instructions for exact meaning. Some values in the range may be invalid depending on site.
99	Unknown whether nodes are positive, not applicable; not documented in patient record

Revision

2007 Meaning of value '99' modified

T34 – CS mets at dx

T34 as defined for cases submitted in CSV2 or converted to CSV2 (2004 and onwards)

Description: CS metastases at diagnosis: Code which identifies the distant site(s) of metastatic involvement at time of diagnosis. This data item is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes.

Effective: 2004 and onwards.

Length: 2

Code	Description
[Blank]	Tumour outside the CCR collaborative staging scope (see section 1.1.2.2 CCR collaborative staging scope).
00	No distant metastasis
[01-98]	See the recommended version of the Collaborative Staging Data Collection System and Coding Instructions for exact meaning. Some values in the range may be invalid depending on site.
99	Unknown; distant metastasis not stated Distant metastasis cannot be assessed Not documented in patient record.

Note: For some schemas that do not use the CS at mets DX field

Code	Description
98	Not applicable; Information not collected for this schema

Revision

2007 Meaning of value ‘99’ modified

T35 – CS mets eval

T35 as defined for cases submitted in CSV2 or converted to CSV2 (2004 and onwards)

Description: CS metastases evaluation: Code which indicate how 'CS mets at dx' was determined based on the diagnostic methods employed. This data item is used in CS to identify whether the M (of AJCC TNM) was clinically or pathologically diagnosed and by what methods 'CS mets eval' is used to calculate the Derived AJCC M descriptor.

Effective: 2004 and onwards.

Length: 1

Code	Description
[Blank]	Registry is not staging case. CS version input current (T64) indicates not staged ('999999').
[0-3, 5, 6, 8]	See the recommended version of the Collaborative Staging Data Collection System and Coding Instructions for exact meaning. Some values in the range may be invalid depending on site.
9	Not assessed; cannot be assessed Unknown if assessed Not documented in patient record For sites with no TNM staging: Not applicable

Revision

2007 Meaning of value '9' modified

T36 – T41 CS site-specific factors 1-6

Description: Codes which identify additional site-specific information needed to generate stage or to code prognostic factors that have an effect on the survival or stage. See the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures. When the Site-specific factors are not used for a specific schema, the value will be entered as '988' (Not applicable).

Effective: 2004 and onwards (cases staged in/converted to CSV2)

Length: **3**

Code	Description
Blank	Registry is not staging case. CS version input current (T64) indicates not staged ('999999').
000-987, 988, 989-999	See the recommended version of the Collaborative Stage Data Collection System.

For schemas that do not use this site-specific factor:

Code	Meaning
988	Not applicable; Information not collected for this schema

Revision

2011 Site-specific factors 1-6 (T36-T41) added into this definition for cases staged in or converted to CSV2. For historical purposes the old variable definitions remain in T36 – T41 for cases submitted in CSV1 (2004 to 2009) that have not yet been converted. RRR is not a valid code according to the NAACCR standard documentation so has been removed for all site specific factors.

2010 New variable, must be reported

2007 Code 888 specified for schemas that do not use the site-specific factor. Meaning of value '999' was modified.

T42 – AJCC clinical T

Description: Site-specific code which evaluates the primary tumour clinically (T) and reflects the tumour size and/or extension as recorded. Clinical stage is assigned prior to any cancer-directed treatment and should not be changed based on subsequent information.

Effective: 2003 to 2007

Length: 9

Code	Description
[Blank]	Tumour outside the CCR AJCC TNM staging scope (see section 1.1.2.3 CCR AJCC TNM staging scope).
TX	Primary tumour cannot be assessed (all reasonable clinical manoeuvres have been used).
T0 **Tis** **TisDCIS** **TisLCIS** **TisPagets** **T1** **T1mic** **T1a** **T1b** **T1c** **T2** **T2a** **T2b** **T2c** **T3** **T3a** **T3b** **T4** **T4a** **T4b** **T4c** **T4d**	Site-specific meaning See AJCC Cancer staging manual, sixth edition for exact meaning.
99	AJCC clinical T is unknown
RRRRRRRRR	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

2009 Variable no longer reported.

T43 – AJCC clinical N

Description: Site-specific code which identifies the absence or presence of clinical regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis as recorded. Clinical stage is assigned prior to any cancer-directed treatment and should not be changed based on subsequent information.

Effective: 2003 to 2007

Length: 3

Code	Description
[Blank]	Tumour outside the CCR AJCC TNM staging scope (Refer to the CCRAJCC TNM staging scope).
NX	Regional lymph nodes cannot be assessed (all reasonable clinical manoeuvres have been used).
N0	
N1	
N2	
N2a	
N2b	Site-specific meaning
N3	Refer to the AJCC Cancer staging manual, sixth edition for exact meaning.
N3a	
N3b	
N3c	
99	AJCC clinical N is unknown.
RRR	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

2009 Variable no longer reported.

T44 – AJCC clinical M

Description: Site-specific code which identifies the presence or absence of clinical distant metastasis (M) as recorded. Clinical stage is assigned prior to any cancer-directed treatment and should not be changed based on subsequent information.

Effective: 2003 to 2007.

Length: 3

Code	Description
[Blank]	Tumour outside the CCR AJCC TNM staging scope (see section 1.1.2.3 CCRAJCC TNM staging scope).
MX	Distant metastasis cannot be assessed (all reasonable clinical manoeuvres have been used).
M0	
M1	Site-specific meaning
M1a	See AJCC Cancer staging manual, sixth edition for exact meaning.
M1b	
M1c	
99	AJCC clinical M is unknown.
RRR	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

2009 Variable no longer reported.

T45 – AJCC pathologic T

Description: Site-specific code which evaluates the primary tumour pathologically (T) and reflects the tumour size and/or extension as recorded. Pathological stage uses all data for clinical staging; the evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination.

Effective: 2003 to 2007

Length: 9

Code	Description
[Blank]	Tumour outside the CCR AJCC TNM staging scope (see section 1.1.2.3 CCRAJCC TNM staging scope).
TX	Primary tumour cannot be assessed (all reasonable pathologic manoeuvres have been used).
T0	
Tis	
TisDCIS	
TisLCIS	
TisPagets	
T1	
T1mic	
T1a	
T1b	
T1c	
T2	Site-specific meaning
T2a	See AJCC Cancer staging manual, sixth edition for exact meaning.
T2b	
T2c	
T3	
T3a	
T3b	
T4	
T4a	
T4b	
T4c	
T4d	
99	AJCC pathologic T is unknown.

RRRRRRRRR	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

2009 Variable no longer reported.

T46 – AJCC pathologic N

Description: Site-specific code which indicates the absence or presence of pathological regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis as recorded. Pathological stage uses all data for clinical staging; the evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination.

Effective: 2003 to 2007

Length: 6

Code	Description
[Blank]	Tumour outside the CCR AJCC TNM staging scope (Refer to the CCRAJCC TNM staging scope).
NX	Regional lymph nodes cannot be assessed (all reasonable pathologic manoeuvres have been used).
N0 **N0i-** **N0i+** **N0mol-** **N0mol+** **N1** **N1mi** **N1a** **N1b** **N1c** **N2** **N2a** **N2b** **N3** **N3a** **N3b** **N3c**	Site-specific meaning See AJCC Cancer staging manual, sixth edition for exact meaning.
99	AJCC pathologic N is unknown.
RRRRRR	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

2009 Variable no longer reported.

T47 – AJCC pathologic M

Description: Site-specific code which indicates the presence or absence of pathological distant metastasis (M) as recorded. Pathological stage uses all data for clinical staging; the evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination.

Effective: 2003 to 2007

Length: 3

Code	Description
[Blank]	Tumour outside the CCR AJCC TNM staging scope (Refer to the CCRAJCC TNM staging scope).
MX	Distant metastasis cannot be assessed (all reasonable pathologic manoeuvres have been used).
M0	
M1	Site-specific meaning
M1a	Refer to the AJCC Cancer staging manual, sixth edition for exact meaning.
M1b	
M1c	
99	AJCC pathologic M is unknown.
RRR	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

2009 Variable no longer reported.

T48 – AJCC clinical TNM stage group

Description: Site-specific code which indicates the anatomic extent of disease based on the clinical T, N and M elements as recorded in TNM Clinical T, N and M fields.

Effective: 2003 to 2007.

Length: 4

Code	Description
[Blank]	Tumour outside the CCR AJCC TNM staging scope (Refer to the CCRAJCC TNM staging scope).
X	All reasonable clinical manoeuvres have been used, but Clinical TNM values do not lead to a certain, specific stage group.
0 **I** **II** **IIA** **IIB** **III** **IIIA** **IIIB** **IIIC** **IV**	Site-specific meaning Refer to the AJCC Cancer staging manual, sixth edition for exact meaning.
99	AJCC clinical TNM stage group is unknown: no clinical manoeuvres have been used; unknown if clinical manoeuvres have been used.
RRRR	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

2009 Variable no longer reported.

T49 – AJCC pathologic TNM stage group

Description: Site-specific code which indicates the anatomic extent of disease based on the pathologic T, N and M elements as recorded in TNM Pathologic T, N and M fields.

Effective: 2003 to 2007

Length: 4

Code	Description
[Blank]	Tumour outside the CCR AJCC TNM staging scope
X	All reasonable pathologic manoeuvres have been used, but Pathologic TNM values do not lead to a certain, specific stage group.
0	
I	
II	
IIA	
IIB	Site-specific meaning
III	See AJCC Cancer staging manual, sixth edition for exact meaning.
IIIA	
IIIB	
IIIC	
IV	
99	AJCC pathologic TNM stage group is unknown: no pathologic manoeuvres have been used; unknown if pathologic manoeuvres have been used.
RRRR	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

2009 Variable no longer reported.

T50 – AJCC TNM stage group

Description: Site-specific code which indicates the stage group when Clinical / Pathologic T, N, M values are incomplete and do not lead to a Clinical / Pathologic stage group.

Effective: 2003 to 2007

Length: 4

Code	Description
[Blank]	Tumour outside the CCR AJCC TNM staging scope (see section 1.1.2.3 CCRAJCC TNM staging scope).
0 **I** **II** **IIA** **IIB** **III** **IIIA** **IIIB** **IIIC** **IV**	Site-specific meaning See AJCC Cancer staging manual, sixth edition for exact meaning.
99	AJCC TNM stage group is unknown.
RRRR	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

2009 Variable no longer reported.

T51 – AJCC edition number

Description: Code which identifies the edition of the Cancer Staging Manual used to stage the case. As codes have changed over time and conversion is not always possible, a case-specific indicator allows for grouping of cases for comparison.

Effective: 2003 to 2007

Length: 2

Code	Description
[Blank]	Tumour outside the CCR AJCC TNM staging scope (Refer to the CCRAJCC TNM staging scope)
00	Not staged (AJCC/UICC staging scheme applies however site not staged)
01	AJCC sixth edition
02	AJCC seventh edition
11	International union against cancer (UICC) sixth edition
12	International union against cancer (UICC) seventh edition
98	AJCC staged, but the edition is unknown
99	UICC staged, but the edition is unknown
RR	Reported data rejected by CCR system (For Statistics Canada use only)

Revision

2009 Variable no longer reported.

2004 Value '88' (Not applicable: cases that do not have an AJCC/UICC staging scheme) was removed as every tumour included in CCR AJCC TNM staging has an AJCC staging scheme.

T52 – CS Version input original

Description: Code which indicates the number of the version used to initially code the Collaborative staging fields. This data item should be entered at the time the CS fields are first coded and the algorithm first applied. If the calculation algorithm is not called at the time of the initial abstracting, the CS Version input original could also be entered manually by the abstractor.

Effective: Reference year 2004 and onwards.

Length: 6

Code	Description
[Blank]	Tumour outside the CCR collaborative staging scope (see section 1.1.2.2 CCR collaborative staging scope).
[others]	Refer to Appendix A (Part III – CCR System Guide) – Core reference tables – Eligible CS Version input original codes for meaning.
999999	Not staged if all other CS fields are '9' filled; otherwise see the recommended version of the Collaborative Staging Manual and Coding Instructions (see section 1.1.2.2) for exact meaning.
RRRRRR	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

2010 Variable name was changed from CS version 1st.

2007 New field added: Was formerly TD19 – CS Version 1st.

T61 – Grade Path Value

Description: Code which indicates the actual grade according to the grading system in Grade path system. This does not replace grade.

Effective: 2010 and onwards.

Length: 1

Code	Description
[Blank]	For cases diagnosed prior to 2010, leave the field blank, or No Two, Three or Four system grade is available; unknown
1	Recorded as grade I or 1
2	Recorded as grade II or 2
3	Recorded as grade III or 3
4	Recorded as grade IV or 4

Revision

2010 New variable must be reported

T62 – Grade Path Value

Description: Code which indicates whether a two, three or four grade system is used.
This item is used to show whether a two, three or four grade system is used. This is the grade system stated in the path report; it is not converted. This item is used in conjunction with Grade path value and is abstracted in addition to Grade differentiation or cell indicator.

Effective: 2010 and onwards

Length: 1

Code	Description
[Blank]	For cases diagnosed prior to 2010, leave the field blank , or No Two, Three or Four system grade is available; unknown
2	Two-grade system
3	Three-grade system
4	Four-grade system

Revision

2010 New variable, must be reported

T63 – Lymph-vascular invasion

Description: Code which indicates whether lymphatic duct or blood vessel invasion (LVI) is identified in the pathology report. This data item will record the information as stated in the record. Presence or absence of cancer cells in the lymphatic ducts or blood vessels is useful for prognosis.

Effective: With the implementation of CSV2.

Length: 1

Code	Description
[Blank]	For cases diagnosed prior to conversion to CSV2 leave the field blank.
0	Lymph-vascular invasion stated as not present
1	Lymph-vascular invasion present/identified
8	Not applicable
9	Unknown/indeterminate/not mentioned in path report
R	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

2010 New Variable, must be reported once CSV2 has been implemented.

T64 – CS Version input current

Description: Collaborative Stage (CS) Data Collection System code which indicates the version after CS input fields have been updated or recoded. This data item is based on the AJCC Cancer Staging Manual, 6th and 7th editions, and is recorded the first time the CS input fields are entered and updated each time the CS input fields are modified.
CS Version Input Current is set to 020000 (a special version number to reflect its conversion status), for cases originally coded under CSv1, upon conversion from CSv1 to CSv2. This item identifies the correct interpretation of input CS items as the input codes and instructions for CS items may change over time.

Format: CS Version Input Current is a 6-digit code (for example, 020100). The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results.

Effective: With the implementation of CSV2.

Length: 6

Code	Description
[Blank]	Tumour outside the CCR collaborative staging scope or not yet converted to CSV2 (see section 1.1.2.2 CCR collaborative staging scope).
[others]	Refer to Appendix A (Part III – CCR System Guide) – Core reference tables – Eligible CS version input current codes for meaning.
999999	Not staged if all other CS fields are '9' filled; otherwise see the recommended version of the Collaborative Staging Manual and Coding Instructions (see section 1.1.2.2) for exact meaning.
RRRRRR	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

2010 New Variable, must be reported once CSV2 has been implemented.

T65 – T83 CS site-specific factors 7-25

Description: Codes which indicate additional site-specific information needed to generate stage, or to code prognostic factors that have an effect on stage or survival. Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.
Codes (The information recorded in each CS Site-Specific Factor differ for each anatomic site. See the most current version of the Collaborative Stage Data Collection System (http://cancerstaging.org), for rules and site-specific codes and coding structures.)
Many site-specific schemas do not use any of the Site-specific factors; other schemas use from 1 to many of the 25 factors. When the Site-specific factors are not used for a specific schema, the value will be entered as '988' (Not applicable).

Effective: With the implementation of CSV2.

Length: 3

Code	Description
[Blank]	Site Specific factors not reported.
000-999	See the recommended version of the Collaborative Stage Data Collection System.
RRR	Reported data rejected by CCR system. (For Statistics Canada use only)

Revision

Not applicable

T84 – CS Mets at Dx - Bone

Description: Code which indicates the presence of distant metastatic involvement of bone at time of diagnosis. This is an independent prognostic indicator, and is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites – only the bone, not the bone marrow.

Effective: 2010 and onwards.

Length: 1

Code	Description
[Blank]	For cases diagnosed prior to 2010, leave the field blank
0	none, no bone metastases
1	Yes
8	not applicable
9	unknown whether bone is involved metastatic site

Revision

2010 New variable, must be reported

T85 – CS Mets at Dx - Brain

Description: Code which indicates the presence of metastatic brain disease at diagnosis. This is an independent prognostic indicator, and is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites - only the brain, not spinal cord or other parts of the central nervous system.

Effective: Reference year 2010 and onwards.

Length: 1

Code	Description
[Blank]	For cases diagnosed prior to 2010, leave the field blank
0	none, no brain metastases
1	Yes
8	not applicable
9	unknown whether brain is involved metastatic site

Revision

2010 New variable, must be reported

T86 – CS Mets at Dx - Liver

Description: Code which indicates the presence of distant metastatic involvement of the liver at time of diagnosis.
This is an independent prognostic indicator, and is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites - only the liver.

Effective: Reference year 2010 and onwards.

Length: 1

Code	Description
[Blank]	For cases diagnosed prior to 2010, leave the field blank
0	none, no liver metastases
1	Yes
8	not applicable
9	unknown whether liver is involved metastatic site

Revision

2010 New variable, must be reported

T87 – CS Mets at Dx - Lung

Description: Code which indicates the presence of distant metastatic involvement of the lung at time of diagnosis.
This is an independent prognostic indicator, and is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes for some sites -only the lung, not pleura or pleural fluid.

Effective: Reference year 2010 and onwards.

Length: 1

Code	Description
[Blank]	For cases diagnosed prior to 2010, leave the field blank
0	none, no lung metastases
1	Yes
8	not applicable
9	unknown whether lung is involved metastatic site

Revision

2010 New variable, must be reported

Derived Tumour Variables

Variable Name	Description
TD7	Derived AJCC T
TD8	Derived AJCC N
TD9	Derived AJCC M
TD10	Derived AJCC T descriptor
TD11	Derived AJCC N descriptor
TD12	Derived AJCC M descriptor
TD13	Derived AJCC stage group
TD14	Derived AJCC flag
TD15	Derived SS1977
TD16	Derived SS1977 flag
TD17	Derived SS2000
TD18	Derived SS2000 flag
TD19	CS version derived
TD21	Derived AJCC-7 T
TD22	Derived AJCC-7 N
TD23	Derived AJCC-7 M
TD24	Derived AJCC-7 T descriptor
TD25	Derived AJCC-7 N descriptor
TD26	Derived AJCC-7 M descriptor
TD27	Derived AJCC-7 stage group
scram_res_id	scrambled individual ID

TD7 – Derived AJCC T

Description: Code that represents the AJCC 'T' component that is derived from CS coded fields using the CS algorithm. Derived AJCC T can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Effective: 2004 and onwards

Length: 2

Used by:

Process	Read	Write
Data loading – posting	No	No
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See CCR System Guide for calculation details.

Codes and Description

Code	Display string*
99	TX
00	T0
01	Ta
05	Tis
06	Tispu
07	Tispd
10	T1
11	T1mic
12	T1a
13	T1a1
14	T1a2
15	T1b
16	T1b1
17	T1b2
18	T1c
19	T1NOS
20	T2
29	T2NOS
21	T2a
22	T2b

23	T2c
30	T3
39	T3NOS
31	T3a
32	T3b
33	T3c
40	T4
49	T4NOS
41	T4a
42	T4b
43	T4c
44	T4d
88	Not applicable
Blank	CS algorithm was not run

* The meaning of the Display strings is explained for each site in the AJCC Cancer staging manual, sixth edition.

TD8 – Derived AJCC N

Description: Code that represents the AJCC 'N' component that is derived from CS coded fields using the CS algorithm. Derived AJCC N can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Effective: 2004 and onwards

Length: 2

Used by:

Process	Read	Write
Data loading – posting	No	No
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See CCR System Guide for calculation details.

Code	Display string*
99	NX
00	N0
09	N0NOS
01	N0(i-)
02	N0(i+)
03	N0(mol-)
04	N0(mol+)
10	N1
19	N1NOS
11	N1a
12	N1b
13	N1c
18	N1mi
20	N2
29	N2NOS
21	N2a
22	N2b
23	N2c
30	N3
39	N3NOS
31	N3a

32	N3b
33	N3c
88	Not applicable
Blank	CS algorithm was not run

* The meaning of the Display strings is explained for each site in the AJCC Cancer staging manual, sixth edition.

TD9 – Derived AJCC M

Description: Code that indicates the AJCC 'M' component that is derived from CS coded fields using the CS algorithm. Derived AJCC M can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Effective: 2004 and onwards

Length: 2

Used by:

Process	Read	Write
Data loading – posting	No	No
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See CCR System Guide for calculation details.

Codes and Description

Code	Display String*
99	MX
00	M0
10	M1
11	M1a
12	M1b
13	M1c
19	M1NOS
88	Not applicable
Blank	CS algorithm was not run

* The meaning of the Display strings is explained for each site in the AJCC Cancer staging manual, sixth edition.

TD10 – Derived AJCC T descriptor

Description: Code that indicates the AJCC 'T descriptor' component that is derived from CS coded fields using the CS algorithm. Derived AJCC T descriptor can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Effective: 2004 and onwards

Length: 1

Used by:

Process	Read	Write
Data loading – posting	No	No
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See CCR System Guide for calculation details.

Code	Description
c	Clinical stage
p	Pathologic stage
a	Autopsy stage
y	Cases in which staging classification is performed during or following initial multimodality therapy. Surgical resection performed after pre-surgical systemic treatment or radiation; tumour size/extension based on pathologic evidence.
N	Not applicable
Blank	CS algorithm was not run

TD11 – Derived AJCC N descriptor

Description: Code that indicates the AJCC 'N descriptor' component that is derived from CS coded fields using the CS algorithm. Derived AJCC N descriptor can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Effective: 2004 and onwards

Length: 1

Used By:

Process	Read	Write
Data loading – posting	No	No
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See CCR System Guide for calculation details.

Codes and Description

Code	Description
c	Clinical stage
p	Pathologic stage
a	Autopsy stage
y	Cases in which staging classification is performed during or following initial multimodality therapy. Lymph nodes removed for examination **after** pre-surgical systemic treatment or radiation and lymph node evaluation based on pathologic evidence.
N	Not applicable
Blank	CS algorithm was not run

TD12 – Derived AJCC M descriptor

Description: Code that indicates the AJCC 'M descriptor' component that is derived from coded fields using the CS algorithm. Derived AJCC M descriptor is used in analysis to differentiate the timing of staging with respect to the treatment process.

Effective: 2004 and onwards

Length: 1

Used by:

Process	Read	Write
Data loading – posting	No	No
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See CCR System Guide for calculation details.

Code	Description
c	Clinical stage
p	Pathologic stage
a	Autopsy stage
y	Cases in which staging classification is performed during or following initial multimodality therapy. Pathologic examination of metastatic tissue performed **after** pre-surgical systemic treatment or radiation and extension based on pathologic evidence.
N	Not applicable
Blank	CS algorithm was not run

TD13 – Derived AJCC stage group

Description: Code that indicates the AJCC 'stage group' component that is derived from CS coded fields using the CS algorithm. Derived AJCC stage group can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Effective: 2004 and onwards

Length: 2

Used by:

Process	Read	Write
Data loading – posting	No	No
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See CCR System Guide for calculation details.

Codes and Description

Code	Display string*
00	0
01	0a
02	0is
10	I
11	INOS
12	IA
13	IA1
14	IA2
15	IB
16	IB1
17	IB2
18	IC
19	IS
23	ISA
24	ISB
20	IEA
21	IEB
22	IE
30	II

31	IINOS
32	IIA
33	IIB
34	IIC
35	IIEA
36	IIEB
37	IIE
38	IISA
39	IISB
40	IIS
41	IIESA
42	IIESB
43	IIES
50	III
51	IIINOS
52	IIIA
53	IIIB
54	IIIC
55	IIIEA
56	IIIEB
57	IIIE
58	IIISA
59	IIISB
60	IIIS
61	IIIESA
62	IIIESB
63	IIIES
70	IV
71	IVNOS
72	IVA
73	IVB
74	IVC
88	Not applicable
90	OCCULT
99	UNK
Blank	CS algorithm was not run

* The meaning of the Display strings is explained for each site in the AJCC Cancer staging manual, sixth edition.

TD14 – Derived AJCC flag

Description: Code that indicates whether AJCC stage group was coded directly or derived from collaborative staging.

Effective: 2004 and onwards

Length: 1

Used by:

Process	Read	Write
Data loading – posting	No	No
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See CCR System Guide for calculation details.

Code and Description

Code	Description
1	AJCC 6th edition derived from Collaborative Staging Manual and Coding Instructions, version 01.04.01
2	Not valid for CCR
Blank	CS algorithm was not run

TD15 – Derived SS1977

Description: Code that indicates the SEER Summary Stage 1977 component (anatomic extent of disease at diagnosis for cases diagnosed **prior to** January 1st, 2001) that is derived from CS coded fields using the CS algorithm.

Effective: 2004 and onwards

Length: 1

Used by:

Process	Read	Write
Data loading – posting	No	No
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See CCR System Guide for calculation details.

Code	Description
0	IS (In Situ)
1	L (Localized)
2	RE (Regional, direct extension)
3	RN (Regional, lymph nodes only)
4	RE+RN (Regional, extension and nodes)
5	RNOS (Regional, NOS)
7	D (Distant)
8	NA (Not applicable)
9	U (Unknown/Unstaged)
Blank	CS algorithm was not run

TD16 – Derived SS1977 flag

Description: Code that indicates whether Derived SS1977 was derived from collaborative staging.

Effective: 2004 and onwards

Length: 1

Used by:

Process	Read	Write
Data loading – posting	No	No
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See CCR System Guide for calculation details.

Code	Description
1	SS1977 derived from Collaborative Staging Manual and Coding Instructions, version 01.04.01.
2	Not valid for CCR.
Blank	CS algorithm was not run.

TD17 – Derived SS2000

Description: Code that indicates the SEER Summary Stage 2000 component (anatomic extent of disease at diagnosis for cases diagnosed on or after January 1st, 2001) that is derived from CS coded fields using the CS algorithm.

Effective: 2004 and onwards

Length: 1

Used by:

Process	Read	Write
Data loading – posting	No	No
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See CCR System Guide for calculation details.

Code	Description
0	IS (In Situ*)*
1	L (Localized)
2	RE (Regional, direct extension)
3	RN (Regional, lymph nodes only)
4	RE+RN (Regional, extension and nodes)
5	RNOS (Regional, NOS)
7	D (Distant)
8	NA (Not applicable)
9	U (Unknown/Unstaged)
Blank	CS algorithm was not run

TD18 – Derived SS2000 flag

Description: Code that indicates whether Derived SS2000 was derived from collaborative staging.

Effective: 2004 and onwards

Length: 1

Used by:

Process	Read	Write
Data loading – posting	No	No
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See CCR System Guide for calculation details.

Code	Description
1	SS2000 derived from Collaborative Staging Manual and Coding Instructions, version 01.04.01.
2	Not valid for CCR.
Blank	CS algorithm was not run.

TD19 – CS version derived

Description: Most recent version of the collaborative staging used to derive the CS output fields at the CCR. The CS version derived is recorded the first time the CS output fields are derived and updated each time the CS derived items are re-computed. The CS version number is returned as part of the output of the CS algorithm. The returned value from the program should be automatically stored as CS version derived. This item should not be updated manually.

Effective: 2004 and onwards

Length: 6

Used by:

Process	Read	Write
Data loading – posting	No	No
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See CCR System Guide for calculation details.

Code	Description
[000000-999999]	Version number
Blank	CS algorithm was not run or field not implemented

Revision

2010 Name changed from CS version latest to CS version derived.

2007 CS version latest (Formerly known as TD20 – CS version latest) replaced TD19.
Name formerly known as TD19 – CS Version 1st.
Data concerning CS version 1st now collected as a tumour input variable as T52 – CS version input original (CS version 1st).

TD21 – Derived AJCC-7 T (AJCC Cancer staging manual, seventh Edition)

Description: This is the derived AJCC —T staging element from coded fields using the CS algorithm. It can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Effective: 2010 and onwards

Length: 3

NAACCR item number: 3400

Used by:

Process	Read	Write
Data loading – posting	Yes	Yes
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See the CCR System Guide for calculation details.

Codes and Description

Code	Display string
999	**TX**
000	**T0**
010	**Ta**
050	**Tis**
060	**Tispu**
070	**Tispd**
100	**T1**
110	**T1mi**
120	**T1a**
130	**T1a1**
140	**T1a2**
150	**T1b**
160	**T1b1**
170	**T1b2**
180	**T1c**
181	**T1d**
199	**T1NOS**

200	**T2**
299	**T2NOS**
210	**T2a**
211	**T2a1**
212	**T2a2**
213	**T2aNOS**
220	**T2b**
230	**T2c**
240	**T2d**
300	**T3**
399	**T3NOS**
310	**T3a**
320	**T3b**
330	**T3c**
340	**T3d**
400	**T4**
499	**T4NOS**
410	**T4a**
420	**T4b**
430	**T4c**
440	**T4d**
450	**T4e**
800	**T1aNOS**
810	**T1bNOS**
888	**Not applicable**
Blank	**CS algorithm was not run**

Revision

2011 New Variable, must be reported. Variable is received as derived by the PTCR registries and not derived on the CCR.

TD22 – Derived AJCC-7 N (AJCC Cancer staging manual, seventh Edition)

Description: This is the derived AJCC - N staging element from coded fields using the CS algorithm. It can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Effective: 2010 and onwards

Length: 3

NAACCR item number: 3410

Used by:

Process	Read	Write
Data loading – posting	Yes	Yes
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes

* See corresponding section for calculation details.

Codes and Description

Code	Display String*
000	N0
010	N0(i-)
020	N0(i+)
030	N0(mol-)
040	N0(mol+)
100	N1
110	N1a
120	N1b
130	N1c
180	N1mi
199	N1NOS
200	N2
210	N2a
220	N2b
230	N2c
299	N2NOS
300	N3
310	N3a

320	N3b
330	N3c
399	N3NOS
400	N4
888	Not applicable
999	NX
Blank	CS algorithm was not run

* The meaning of the Display strings is explained for each site in the AJCC Cancer staging manual, seventh edition.

Revision

2011 New derived variable, must be reported. Variable is received as derived by the PTCR registries. It is not derived on the CCR.

TD23 – Derived AJCC-7 M (AJCC Cancer staging manual, seventh Edition)

Description: This is the derived AJCC —M staging element from coded fields using the CS algorithm. It can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Effective: 2010 and onwards

Length: 3

NAACCR item number: 3420

Used by:

Process	Read	Write
Data loading – posting	Yes	Yes
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See corresponding section for calculation details.

Codes and Description

Value	Display String*
999	MX
000	M0
010	MO(i+)
100	M1
110	M1a
120	M1b
130	M1c
140	M1d
150	M1e
199	M1NOS
888	Not applicable
Blank	CS algorithm was not run

* The meaning of the Display strings is explained for each site in the AJCC Cancer staging manual, seventh edition.

Revision

2011 New derived variable, must be reported. Variable is received as derived by the PTCR registries. It is not derived on the CCR.

TD24 – Derived AJCC-7 T descriptor (AJCC Cancer staging manual, seventh Edition)

Description: This is the derived AJCC —T Descriptor from coded fields using the CS algorithm. It can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Effective: 2010 and onwards

Length: 1

NAACCR item number: 3402

Used by:

Process	Read	Write
Data loading – posting	Yes	Yes
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See corresponding section for calculation details.

Codes and Description

Value	Meaning
C	Clinical stage
P	Pathologic stage
A	Autopsy stage
Y	Cases in which staging classification is performed during or following initial multimodality therapy. Surgical resection performed after pre-surgical systemic treatment or radiation; tumour size/extension based on pathologic evidence.
N	Not applicable
Blank	CS algorithm was not run

Revision

2011 New derived variable, must be reported. Variable is received as derived by the PTCR registries. It is not be derived on the CCR.

TD25 – Derived AJCC-7 N descriptor (AJCC Cancer staging manual, seventh Edition)

Description: This is the derived AJCC —N Descriptor from coded fields using the CS algorithm. It can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Effective: 2010 and onwards

Length: 1

NAACCR item number: 3412

Used by:

Process	Read	Write
Data loading – posting	Yes	Yes
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See corresponding section for calculation details.

Codes and Description:

Code	Description
C	Clinical stage
P	Pathologic stage
A	Autopsy stage
Y	Cases in which staging classification is performed during or following initial multimodality therapy. Lymph nodes removed for examination after pre-surgical systemic treatment or radiation and lymph node evaluation based on pathologic evidence.
N	Not applicable
Blank	CS algorithm was not run

Revision

2011 New derived variable, must be reported. Variable is received as derived by the PTCR registries. Variable is not derived on the CCR.

TD26 – Derived AJCC-7 M descriptor (AJCC Cancer staging manual, seventh Edition)

Description: This is the derived AJCC —M Descriptor from coded fields using the CS algorithm. Derived AJCC-7 M descriptor is used in analysis to differentiate the timing of staging with respect to the treatment process.

Effective: 2010 and onwards

Length: 1

NAACCR item number: 3422

Used by:

Process	Read	Write
Data loading – posting	Yes	Yes
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See corresponding section for calculation details.

Codes and Description

Code	Description
C	Clinical stage
P	Pathologic stage
A	Autopsy stage
Y	Cases in which staging classification is performed during or following initial multimodality therapy. Pathologic examination of metastatic tissue performed after pre-surgical systemic treatment or radiation and extension based on pathologic evidence.
N	Not applicable
Blank	CS algorithm was not run

Revision

2011 New derived variable, must be reported. Variable is received as derived by the PTCR registries. It is not derived on the CCR.

TD27 – Derived AJCC-7 stage group (AJCC Cancer staging manual, seventh Edition)

Description: This is the derived AJCC —Stage Group from coded fields using the CS algorithm. It can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Effective: 2010 and onwards

Length: 3

NAACCR item number: 3430

Used by:

Process	Read	Write
Data loading – posting	Yes	Yes
Internal record linkage	No	No
Death clearance	No	No
Tabulation master file	Yes	Yes*

* See corresponding section for calculation details.