OncoTraX: Cancer Registry

User Manual

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Health Systems Design & Development

Revision History

Date	Description	Author
May 2007	Initial Publication of OncoTraX: Cancer Registry User Manual	Christine Beynon
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Introduction

OncoTraX: Cancer Registry is an integrated collection of computer programs and routines, which work together in assisting the Cancer Registrars to create and maintain a cancer patient database. The software creates case listings and registry reports for Cancer Boards (Cancer Conferences), special studies, and the Annual Report recommended by the American College of Surgeons (ACoS).

The software allows the Cancer Registrars to:

1. Perform case finding.
2. Identify potential cases to include in your registry, enter the pertinent data directly into the computer system, and maintain patient follow-up information on an annual basis.
3. Enter abstracts.
4. Download and transmit data electronically to the VA Central Cancer Registry, state central registries, the National Cancer Database for the ACoS Call for Data.
5. Produce several reports by using an option in the Utility menu.

   Note: Several reports within the software provide basic information; however, for more specific reports, you need to know basic FileMan functions. Any and all data collected within an abstract can be pulled back into reports.
6. Print out by year the number of cases by site, including sex, race, and stages.
7. Generate follow-up reports as required by the ACoS

   Note: OncoTraX is in complete compliance with all ACoS required data elements, and is updated as changes occur.

OncoTraX is used by cancer registrars and meets all requirements set forth by the American College of Surgeons for approved cancer programs.

Note: OncoTraX makes extensive use of Help screens, **but it does not replace the use of your reference manuals.**

This manual deals with the three most commonly used areas of the software. These are the main functions of registry work used to maintain the cancer registry.

1. **Case Finding/Suspense Module** allows you to perform an automated case finding search of relevant hospital databases (pathology, radiology, and patient treatment files) for cases meeting specific criteria for inclusion in the registry.
2. **Abstracting/Printing** allows you to enter coded data into the database directly or by utilizing auto-coding techniques. The software is site-specific prompt driven; the only data elements presented are those pertinent to the site you are abstracting.
3. **Follow-Up** in OncoTraX assists you in following your patients. The database automatically reminds you when it is time to do a follow-up on a patient. You can update each patient's record with new follow-up information. The software comes with a variety of follow-up letters, which may be customized to fit the needs of individual facilities.

When using the electronic version of the manual to search for information, click Edit on the menu bar and select Find (binoculars icon). Enter the word or words for which you are looking and Microsoft Word searches the document.

Recommended Users

This manual is intended for VA registrars using the OncoTraX: Cancer Registry software.

Related Manuals

Every cancer registry office should have the following reference material.

Note: Use the older editions of the reference materials when entering old cases.

- *Facility Oncology Registry Data Standards* (FORDS), 2011 and after
- *Registry Operations and Data Standards* (ROADS), prior to 2003 cases
- *Facility Oncology Registry Data Standards* (FORDS), 2003 and after
- *Collaborative Staging Manual and Coding Instructions*
  Collaborative Staging was added to OncoTraX in July 2004. Use the *Collaborative Staging Manual and Coding Instructions* for all cases diagnosed in 2004 and after.
- *AJCC Cancer Staging Manual, 7th Edition* on cancer cases diagnosed beginning January 1, 2010
- *AJCC Cancer Staging Manual*, 6th *Edition* on cancer cases diagnosed beginning January 1, 2003
- *AJCC Cancer Staging Manual*, 5th edition, for entering older cases
- *SEER Summary Staging Manual*, 2000
- *Summary Staging Guide*, 1977
- *SEER Extent of Disease*, 1988; *Codes and Coding Instructions*, 2nd edition, 1994
- *SEER Extent of Disease*, 1998; *Codes and Coding Instructions*, 3rd edition, 1998
- *SEER Program Coding and Staging Manual*, 2004 (on CD)
- *SEER*Rx - Interactive Antineoplastic Drugs Database*
  The interactive antineoplastic drugs database (helpful when abstracting) is available from SEER on the following website: http://www.seer.cancer.gov/tools/seerrx/
- *SEER Self Instructional Manuals for Tumor Registrars*
  SEER self instructional manuals are available for download on the following website: http://www.seer.cancer.gov/training/manuals/
- *ICD-O-3*, International Classification of Diseases for Oncology (ICD-O), 3rd edition
- *ICD-O-2*, International Classification of Diseases for Oncology (ICD-O), 2nd edition
- *Cancer Registry Management Principles and Practice*, 3nd edition

Recommended Websites

- http://cancer.gov/
  Website for the National Cancer Institute
- http://www.facs.org/cancer/index.html
  Home page for the Commission on Cancer, American College of Surgeons, Cancer Programs

- http://www.facs.org/cancer/cocflash/
  Highlights for the month from the Commission on Cancer, American College of Surgeons, Cancer Programs
- http://web.facs.org/coc/default.htm
  American College of Surgeons, Commission on Cancer: Inquiry and Response System (I & R)
  Available to all cancer care professionals. It is a repository of thousands of questions and answers related to the Approvals and Accreditation Program, the National Cancer Data Base (NCDB), the American Joint Committee on Cancer (AJCC), and the Facility Oncology Registry Data Standards (FORDS).
- http://www.ncra-usa.org/
  Website for the National Cancer Registrars Association
- http://www.cancerstaging.org/
  Website for the American Joint Committee on Cancer (AJCC)
- http://cancerstaging.org/cstage/manuals.html
  Website for Collaborative Staging
- http://vaww.medicalsurgical.va.gov/cancer/index.asp
  All links for the Veterans Health Administration Cancer Program
- http://www.training.seer.cancer.gov
  SEER's Training Web Site provides web-based training modules for cancer registration and surveillance. When the site is complete, it will comprise about 30 training modules, each covering a particular cancer registration training subject.
- http://www.seer.cancer.gov/tools/seerrx/
  Download the SEER*Rx - Interactive Antineoplastic Drugs Database, version 1.1.1 (replaces Book 8)
- http://www.cancerstaging.org/cstage/csmanualpart1.pdf
  Collaborative Staging Manual and Coding Instructions Part I
- http://cancerstaging.org/cstage/CSPart2Manual.pdf
  Collaborative Staging Manual and Coding Instructions Part II
- http://seer.cancer.gov/manuals/codeman.pdf
  The SEER Program Code Manual, Third Edition, 1998
- http://seer.cancer.gov/manuals/EOD10Dig.pub.pdf
  SEER Extent of Disease - 1988, Codes and Coding Instructions, Third Edition, .January 1998
- http://www.facs.org/cancer/coc/cocprogramstandards.pdf
  Commission on Cancer: Cancer Program Standards 2011 Revised Edition, ACoS required standards for approved cancer programs
- http://www.facs.org/cancer/coc/fordsmanual.html
  Facility Oncology Registry Data Standards (FORDS): Revised for 2011

OncoTraX Conventions

You must have a working knowledge of VistA conventions, in order to maneuver easily in OncoTraX. The table contains frequently used characters and their descriptions with examples.

Character	Description
<ret>	**<ret>** is the symbol for the Return or Enter key. Type **<ret>** after every response, or to bypass a prompt or accept a default. **Note:** Do not press it more than necessary; you do not want to bypass an opportunity to enter valuable information.
?	**?** (one question mark) Type **?** at any prompt to view a message explaining the requested information or how to enter it.
??	**??** (two question marks) Type **??** at any prompt to view detailed instructions and/or a list of choices.

//	**//** (two slash marks)
	Type **//** after text for the default response.
	• If you accept the default answer, press **<ret>** to continue to the next prompt.
	• For a different choice, type the choice and press **<ret>**.
	• Press **Enter** at **//** and the word before the slashes becomes the default response.
	• Type **?** at // and a list of choices displays.
	Example
	`PREVIOUS HISTORY OF CANCER: No// ?`
	`Choose from:`
	`0 No`
	`1 Yes`
	`9 Unknown`

^	^ (caret) is Shift + 6 on the keyboard and is also called the up-caret symbol.
	• Type ^ to exit an option and return to the menu;
	• Type ^ to jump to another field.
	Example
	Type **^ DATE DX** at the field prompt to jump to the **DATE DX** field.
	`DATE DX: 04/05/2005//`
	`DX FACILITY: BUFFALO VA MEDICAL CENTER//`
	`PRIMARY SITE: PROSTATE//`
	`TEXT-PRIMARY SITE TITLE: PROSTATE//`
	`LATERALITY: Not a paired site//`
	`HISTOLOGY (ICD-O-3): ADENOCARCINOMA, NOS//`
	`HISTOLOGY CODE: 8140/3`
	`TEXT-HISTOLOGY TITLE: ADENOCARCINOMA, NOS// ^DATE DX`
	`DATE DX: 04/05/2005//`
	`Type a new date after DATE DX:`
	In the Abstract
	• Go from one field to another in most areas of an abstract **type ^<field name>**
	• Go completely out of the abstract **type ^ without a field name**
	• Edit a field already completed

Character	Description

	type ^<field name> to return to the field and then edit.
	Example
	`CLASS OF CASE: 1  Dx here, 1st tx here`
	`FACILITY REFERRED FROM: NONE/ ^CLASS OF CASE`
	`CLASS OF CASE: Dx here, 1st tx here//`

@	**@** (at symbol) is Shift + 2 on the keyboard. Type **@** to delete data values stored in fields.

…	**…** (three dots)
	Type **…** to *replace* all data in a field.
	Example
	`TX Primary Cancer cannot be assessed Replace … With`
	
	At the **Replace** prompt, type **…** and press **Enter**. When **With** displays, type new data.
	Example
	`CLINICAL T: T3 Chest wall/diaphragm/mediastinal pleura etc`
	`Replace ... With`
	There is a submenu when **...** displays after a menu option.
	Example
	`ANN  *Annual Reports ...`
	
	Select **ANN** and the following displays.
	
	`AAR  Annual ACoS Accession Register (80c)`
	`API  Annual ACoS Patient Index (132c)`
	`ASL  Annual Primary Site/GP Listing (132c)`
	`ACL  Annual Patient List by Class of Case (80c)`
	`SST  Annual Primary Site/Stage/Tx (132c)`
	`TST  Annual ICDO Topography/Stage/Tx (132c)`
	`SDX  Annual Status/Site/Dx-Age (132c)`
	`HIS  Annual Histology/Site/Topography (80c)`
	`ACT  Annual Cross Tabs (80c)`
	`CPR  Print Custom Reports`

Dates	Several date formats are acceptable. **Examples** 010102, 1-1-02, 1/1/02, 01/01/2002, January 1, 2002 If the year is omitted, the computer uses **Current Year**.

Character	Description
Device prompt	To send a report to a printer, type the name of the printer at the **Device** prompt. • If the printer is shared, queue your report by entering **Q** at the **Device** prompt and then the name of the printer at the next prompt. • To view a report on your computer screen, press the **<ret>** key at the **Device** prompt. When *capturing a file*, type 0;269;9999999 at the **Device** prompt. **Note:** When you learn to *capture files* from the software, you can also learn many ways to display data.
Space bar return	Press the **space bar** to re-enter the last selection made at a particular level. (This feature may be limited for some options.) **Example** • At a submenu, the space bar enters the last submenu option accessed. • At a field, the space bar re-enters whatever was last entered, to any other field within the same option. **Note:** Press the space bar, and then press the Return key, not both at the same time.
Report options	Report options with **80c** in the name; require an 80-character line printer. Report options with 80c in the name; look correct when viewed on your monitor. Report options with **132c** in the name; require a 132-character line printer. Reports with 132c in the name do not look correct when viewed on your monitor–the text wraps. **Note:** A printer that can print both **80c** and **132c** is recommended.

OncoTraX Menu

The main OncoTraX menu is the first screen that displays when you sign on to the program. The OncoTraX menu displays the version number of the OncoTraX: Cancer Registry software running on your system.

Example

```
ONCOTRAX CANCER REGISTRY V2.11 PATCH ONC*2.11*54
```

The functions on the OncoTraX Option list also display.

```
SUS   *..Case Finding/Suspense ...
ABS   *..Abstracting/Printing ...
FOL   *..Follow-up Functions ...
LIS   *..Registry Lists ...
ANN   *..Annual Reports ...
STA   *..Statistical Reports ...
UTL   *..Utility Options ...
```

- The `Select OncoTraX Option:` prompt is the starting point for all of the modules within the software.
- At the prompt, type in an option/module three-letter abbreviation. The group of related submenu options displays.

Example

```
Select OncoTraX Option: SUS   *..Case Finding/Suspense

********** Suspense Cases **********
CF Automatic Case Finding-Lab Search
LR Print Case Finding-Lab Report
RA Automatic Case Finding-Radiology Search
PT Automatic Case Finding-PTF Search
SE Add/Edit/Delete 'Suspense' Case
SP Print Suspense List by Suspense Date (132c)
NP Patients in Suspense with no primaries
DI Disease Index
```

Getting Started

Before using OncoTraX for the first time, you must define your registry's parameters.

If OncoTraX is already being used by the registry and you are a new registrar, review the registry's parameters because you may need to update them.

To access the registry's parameters:

1. From the main OncoTraX menu, select `UTL *..Utility Options…`
2. From the Utility Options, select `TR  Define Cancer Registry Parameters`

Example

```
SUS   *..Case Finding/Suspense ...
ABS   *..Abstracting/Printing ...
FOL   *..Follow-up Functions ...
LIS   *..Registry Lists ...
ANN   *..Annual Reports ...
STA   *..Statistical Reports ...
UTL   *..Utility Options ...
Select OncoTraX Option: UTL *..Utility Options…

*************UTILITY OPTIONS*************
DP    Delete OncoTraX Patient
DS    Delete Primary Site/GP Record
EA    Edit Site/AccSeq# Data
LG    List Topographic Site Groups
LT    List Topography Codes by Site Group
AR    Create a report to preview ACoS output
CT    Create ACoS Data Download
SR    Create a report to preview State/VACCR output
CC    Create State/VACCR Data Download
TR    Define Cancer Registry Parameters
AC    Enter/Edit Facility file
CDD1  Print Condensed DD--OncoTraX Patient file
```

```
CDD2  Print Condensed DD--OncoTraX Primary file
PSR   Purge Suspense Records
SP    Purge Patient Records with No Suspense/Primaries
CS    Restage CS cases using latest version
TIME  Timeliness Report
```

Define Cancer Registry Parameters

Use **Define Cancer Registry Parameters** to update/change parameters, such as the name of the Cancer Registrar.

You are required to put in information for the following fields.

`Select ONCOLOGY SITE PARAMETERS HOSPITAL NAME:`

`HOSPITAL NAME:` Type the name of your medical center as you want it to display.

`STREET ADDRESS:` Type the street address of your medical center.

`ZIP CODE:` Type the zip code for your medical center.

`REFERENCE DATE:` Type the year: f*irst* day of the *first* month of the year the registry *first* starts capturing data.

`TUMOR REGISTRAR:` Type the name of the cancer registrar (3 - 30 characters in length) as you want it to display on letters and reports.

`PHONE NUMBER:` Type the phone number of the cancer registrar's office.

`STATE HOSPITAL #:` Type the number assigned by the state to your medical center.

`FACILITY ID #:` Type the registry number assigned by the American College of Surgeons. Use the ID to define the registry in the ACoS Call for Data.

`CENTRAL REGISTRY #:` Type the registry number assigned by the state central registry, where applicable.

Note: This field may be left blank.

`VISN:` Type the Veterans Integrated Service Network number.

`CS URL:` Type the URL address for the Collaborative Staging computer algorithms: http://vaww.va.gov/cstage/cgi-bin/cstage.exe

Note: Copy and paste the address, so as not to make a mistake when typing.

`DIVISION:` Type in your division or site number. It is a required field, even for a single division site.

Note: Case finding does not work when Division is blank; type in the name of the hospital or the division.

`COC ACCREDITATION: Type 00 (Not accredited) or 01 (Coc Accredited)`

`Select AFFILIATED DIVISION:` Type the name of the division that is associated with the primary division for purposes of the cancer registry.

- If you are not an integrated site, bypass the Define Cancer Registry Parameters prompt by pressing <**RET**>.
- If you are an integrated site and each site/division manages its own cancer registry, bypass the Define Cancer Registry Parameters prompt by pressing <**RET**>.

- If you are an integrated site and one or more sites/divisions do not have a cancer registry and you are responsible for tracking patients from one or more of those sites in your cancer registry, type the name of each in **Select AFFILIATED DIVISION.**

```
Select QA USER:      Type the name of the cancer registrar.
```

Example

REFERENCE DATE: ??

1. Record the reference date for the registry. This date is listed as the first day of the first month of the year the registry first starts keeping data.
2. Enter the date in format: 010106.

SUS Case Finding and Suspense Module

The SUS Case Finding and Suspense module provides a way to automatically find eligible cases or manually add the patients to Suspense.

Case finding is a systematic method of locating all eligible cases to enter (accession for abstracting) into your database. One of the unique features of the OncoTraX software is Automatic Case Finding. Enter a range, start date and end date, and the computer searches pathology (CF), radiology (RA) and the Patient Treatment File (PT) for eligible cases in that date range. Each search is run separately according to your input. Cases meeting the defined criteria are captured electronically and added to Suspense.

The **Suspense Date** field, the cases are held in Suspense until they are accessioned for abstracting or manually deleted.

- The suspense date is pulled into the abstract as the DATE DX. The date can be changed, if necessary.
- After reviewing the Suspense cases, you may find some that are not required in the registry. You can manually delete them; refer to Deleting a VA Patient from Suspense, page 14.
- You may find some cases that are recurrences of an already documented primary. Recurrences require a follow up. The recurrences must be updated using RF Recurrence/Sub Tx Follow-up, page 27 in the Follow-up Module. Update the follow-up using PF Post/Edit Follow-up, page 26.
- After you do a follow up for a patient, you must manually delete the patient from the Suspense file; refer to Deleting a VA Patient from Suspense, page 14.
- Cases that are accessioned are automatically deleted from Suspense.

```
Case Finding/Suspense Menu
CF Automatic Case Finding-Lab Search
LR Print Case Finding-Lab Report
RA Automatic Case Finding-Radiology Search
PT Automatic Case Finding-PTF Search
SE Add/Edit/Delete from Suspense
SP Print Suspense List by Suspense Date (132c)
NP Patients in Suspense with no primaries
DI Disease Index
```

Note: For your date range, run CF, RA, and PT only once. If you repeat the search for your date range, cases already reviewed end up in your Suspense file.

CF Automatic Case Finding - Lab Search

Use this option to search the Lab files to build a Suspense list of cases. When the search is complete, you can print the Suspense list on a selected device/printer.

```
Start with Date:.  .
Go to Date: Type the end date of the search, such as 1/31/04
            If the year is omitted, the computer uses Current Year.
```

```
Device:     Type the name of your printer.
************ LAB CASE FINDING ************
This option will search the LAB DATA file
   for cases to add to the Suspense List.
Start Date: Type the begin date of the search.
   If this option was used previously, the previous end date is the begin
   date, such as  JUL 1, 2005
End Date:   JUL 31, 2005
Dates OK?   Y//
   Press Enter.
```

Note: The option searches for ICD-O morphology codes 800-998, excluding Behavior Code /0 (Benign) codes.

```
Exceptions to the search criteria:
   Benign Cancers of the central nervous system will be included.
   Squamous cell neoplasms (805-808) of the skin will be excluded.
   Basal cell neoplasms (809) will be excluded.
DEVICE: HOME//
```

Your report shows the total number of patients identified.

Example

```
CASE FINDING LIST      your hospital VAMC     03/10/2004
Patient Name       PtID#   Lab Test          Organ/Tissue   Morph/Disease-SNOMED
       SUSPENSE DATE: 7-5-2005
ONCOPATIENT1       O9999   07/15/2005-SP     LUNG, UPPER    80703-SQUAMOUS CELL
```

LR Print Case Finding - Lab Report

Use this option to generate a list of patients from Suspense, identified in Pathology with reportable malignancies in the CF Automatic Case Finding - Lab Search. You can print all lab cases in Suspense by entering **<ret>** at the start date prompt or print only those cases within a specified date range.

`Start with Suspense Date: First//:`	Type the begin date for the search or press **Enter** to print all cases.
`Go to Suspense Date Last:`	Type the end date for the search or press the **<ret>** key to accept the last date available.
`Device:`	Type the name of your printer.

Example

```
Select *..Case finding/Suspense Option:   lr Print Case finding-Lab Report
START WITH SUSPENSE DATE: FIRST//
DEVICE:  UCX REMOTE TCPIP
------------------------------------------------------------------------
CASE FINDING LIST       WASHINGTON DC VAMC                    03/10/2004
Patient Name      PtID#    Lab Test       Organ/Tissue   CODE-Morphology
------------------------------------------------------------------------
   SOURCE: CYTOPATHOLOGY
ONCOPATIENT1      L9999    07/08/2005-CY  BRONCHIAL WAS  69760-USPICIOUS
   SOURCE: SURGICAL PATHOLOGY
ONCOPATIENT2      N9999    07/10/2005-SP  SKIN OF UPPER  87203-MELANOMA,NOS
   Last Contact: 04/03/1998
Acc/Sequence   Primary Site      Last Cancer Status   Date DX     Status
------------   ---------------  -------------------  --------    -----
1998-00139/00  SKIN, FACE NOS    Unknown              04/03/1998  Complete
```

Note: Patient N999 has a primary from 1998; so that information also displays. When the patient has a history of malignancy, you must verify whether this new finding is a recurrence or a new primary. If it is a recurrence,

i. Document this recurrence using the FOL Follow-up module.

ii. Manually delete the case from the Suspense, using SE Add/Edit/Delete Suspense Case, page 13 in the SUS Case Finding/Suspense module.

RA Automatic Case Finding - Radiology Search

Use this option to search the Rad/Nuc Med (Radiology/Nuclear Medicine) Patient file for suspicious malignancies and add the cases to your Suspense list in the OncoTraX Patient file.

`Select Start Date:` Type the begin date for the search or use the default date.

`Select Ending Date:` Type the end date for the search.

`Device:` Type the name of your printer.

```
------------------------------------------------------------------------
------------------------------------------------------------------------
RADIOLOGY CASE FINDING LIST      WASHINGTON DC VAMC         07/18/2005
Patient Name         PtID#    Exam Date      Procedure
------------------------------------------------------------------------
ONCOPATIENT1         B1111    07/18/2005     CT THORAX W/O CONTRAST
ONCOPATIENT2         D9999    07/18/2005     ULTRASOUND ABDOMEN LTD
```

Note: This option only yields results if Radiology is entering internal Code 8 or Code 9, not an ICD-9 Code for Radiology. Many patients identified through these options may not actually have cancer and need to be manually deleted from Suspense. To delete, refer to Deleting a VA Patient from Suspense, page 14.

PT Automatic Case Finding - PTF Search

Use this option to search the PTF (Patient Treatment File) and add the cases to your Suspense list in the OncoTraX Patient file. After you enter the dates for your search, the program lists the codes to capture during this search.

Note: Suspense date = Admission day +1.

`Select Start Date:` Type the begin date for the search or use the default date.

`Select Ending Date:` Type the end date for the search.

`Device:` Type the name of your printer.

Example

```
   Start Date:  02-01-2004//   FEB 01, 2004
      Go to Date:  2-10  FEB 10, 2004
         Dates ok? Y// ES
         We will capture codes 140.0 to 239.9
         From: FEB 01, 2004 To: FEB 10, 2004
            Including codes:
   042.2,259.2,273.1,273.2,273.3,273.9,284.9,288.3 & 289.8
      V-Codes: 07.3,07.8,10.0-9,58.0-1,66.1,66.2,67.1-2,76,77.1
```

Note: These are the codes searched for and added to your Suspense file.

```
                (Eliminating BENIGN 209.0-229.9)
   ------------------------------------------------------------------------
   PTF-CASE FINDING LIST      WASHINGTON DC VAMC                 03/10/2004
   Patient Name   PtID# Admit – Disch           Level/ICD9-Description
   ------------------------------------------------------------------------
   ONCOPATIENT1   A9999 02/03/2004-02/04/2004   ICD-6/0-HX-PROSTATIC MALIGNA
   ONCOPATIENT2   G9999 02/06/2004-02/06/2004   ICD-8/0-HX OF BLADDER MALIGN
                  PTF CASE FINDING RESULTS
                  38 Cases found
                  2 New Patients added
                  2 New cases added
```

Note: Although there were 38 cases found during this time period, only 2 of the 38 were not already in Suspense.

SE Add/Edit/Delete from Suspense

Use this option to manually add patients to the Suspense file, to modify patient information in the file, or to manually delete patients from Suspense.

Adding a VA Patient to Suspense

To enter a patient in the Suspense file:

1. Type the patient PID#; refer to the *Glossary* on page 107.
2. The program asks: do you want to add the patient as a New OncoTraX Patient? Response is **YES**.
3. At the Suspense Date: prompt, type the provisional date of the diagnosis. You can edit the date when the abstract is complete.

   Note: You must enter a date; this date becomes the Date of Diagnosis in the abstract.

Editing a VA Patient in Suspense

To modify patient information in the Suspense file:

1. Type the patient PID#; refer to the *Glossary* on page 107.
2. At the Suspense Date: prompt, change the date.

Deleting a VA Patient from Suspense

To remove a patient from the Suspense file:

1. Type the patient PID#; refer to the *Glossary* on page 107.
2. Press **@** (shift + 2) to delete the patient.

Example

```
Select ONCOTRAX PATIENT NAME:     19999
Searching for a VA Patient, (pointed-to by NAME)
ONCOPATIENT1   12-21-99     999999999     NO NSC VETERAN
Enrollment Priority: GROUP 8c Category: ENROLLED      End Date:
          ...OK? Yes//   (Yes)
Patient Name:        ONCOPATIENT
Date of Last Contact or Death:
Vital Status:
Follow-Up Status:
SUSPENSE DATE:    FEB 10,2004// @
   SURE YOU WANT TO DELETE THE ENTIRE SUSPENSE DATE? y  (Yes)
This patient is not on suspense and has no primaries.
   This patient's record has been deleted.
```

SP Print Suspense List by Suspense Date (132c)

Use this option to print a list of patients currently in Suspense by the suspense date. The printout lists patients according to how they are identified; first by the source (through Surgical Pathology, Cytopathology, Electron Microscopy, Autopsy, PTF, Radiology, or manual entry) and then in the order of the suspense date. The printout lists the patient's name, the patient's SSN or identifier, Organ/Tissue, Lab Morphology, and Suspense, Admission and Discharge Dates.

> **Note: 132c** (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

`Start with Suspense Date: FIRST//:`	Press the **<ret>** key to accept FIRST. All the cases with suspense dates display. or type a date for a Go to Suspense Date prompt.
`Go to Suspense Date:`	Type the end date of the range for the printout.

Example

```
START WITH SUSPENSE DATE: FIRST//
Patient Name SSN          Organ/Tissue  Lab Morphology         Suspense Dt Admission Discharge
             SOURCE: SURGICAL PATHOLOGY
ONCOPATIENT1  999-99-9999 LOBE OF LUNG  LIGNANT MELANOMA       JAN 6,2006 JAN 6,2006 JAN 10,2006
ONCOPATIENT2  999-99-9999 SIGMOID COLON ENOCARCINOMA,MODERATEL JAN 6,2006 JAN 6,2006 JAN 10,2006
```

NP Patients in Suspense with No Primaries

This option prints a list of OncoTraX patients that are in Suspense, but do not have a primary.

Example

```
              ONCOTRAX PATIENT ONLY
   Patient Name      SSN         Suspense       Last Admit  Last Disch
   ------------------------------------------------------------------
   ONCOPATIENT1      999-99-9999 FEB  3, 2004   03/07/2004  03/09/2004
   ONCOPATIENT2      999-99-9999 FEB  2, 2004   01/30/2004  02/04/2004
```

ABS Abstract Entry and Printing Module

The Abstract Entry and Printing module is used for abstracting cases. An abstract is a summary of pertinent information about the patient, the cancer, the treatment, and the outcome. Components include patient demographic information, cancer identification, extent of disease, stage at diagnosis, first course of treatment, recurrence, and subsequent therapies or progression and follow-up.

- An abstract must be completed for all cases that meet the criteria for inclusion in the registry. (The standards are set forth by the American College of Surgeons and VACCR reportable lists.)
- If a patient has multiple primary malignancies, an abstract must be prepared for each additional primary.
- An abstract must be completed within **six months** from the date of first contact.

```
Abstract Entry/Print Menu
************** ABSTRACT ENTRY/PRINT **************
AI Complete Abstract
EE Abstract Edit Primary
NC Print Abstract NOT Complete List
IR Patient Summary
QA Print Abstract QA (80c)
EX Print Abstract-Extended (80c)
PA Print Complete Abstract (132c)
MA Print QA/Multiple Abstracts
AS Abstract Screens Menu (80c) ...
```

AI Complete Abstract

Note: To complete an abstract, you need the Facility Oncology Registry Data Standards (FORDS), which describe every field in the abstract and the selections for those fields. Keep a copy of FORDS close at hand for reference.

The Complete Abstract option is the main entry point for abstracting new cases or editing existing abstracted cases.

OncoTraX is prompt driven. Once a specific Topography Code is selected, all successive prompts displayed are specific. Some of the data captured in the case finding and suspense process, as well as demographic data, are automatically transferred and inserted into the appropriate fields within the abstract; however you can edit the data if necessary.

Note: The OncoTrax Conventions on page 3 are helpful in maneuvering around an abstract.

Abstracting a Case

You begin an abstract by searching for the patient to determine if the patient is new to the VA. If you do not enter data in all required fields, you cannot change the status of the abstract to Complete (3).

Adding a New Patient

1. At the prompt, type the patient PID#; refer to the *Glossary* on page 107.
2. Respond **YES** to the prompt: Are you adding 'LAST,FIRST' as a new ONCOTRAX PATIENT (the 24673RD)? No//

Example

```
          Enter patient name: h9999

     Searching for a VA Patient, (pointed-to by NAME)

     Searching for a Non-VA or Ambiguous Patient, (pointed-to by NAME)

     Searching for a VA Patient

   1  H3315 LAST,FIRST  *SENSITIVE* *SENSITIVE* NO    EMPLOYEE
   2  H3315 LAST,FIRST1 7-7-15      095093315   NO    COLLATERAL     SY/
   3  H3315 LAST,FIRST2 11-9-58     118483315   NO    NON-VET(OTHER) SY/
   4  H3315 LAST,FIRST3 10-4-48     069423315   YES   SC VETERAN
   5  H3315 LAST,FIRST4 6-4-22      096123315   NO    NSC VETERAN

ENTER '^' TO STOP, OR
CHOOSE 1-5: 1  LAST,FIRST  *SENSITIVE*    *SENSITIVE* NO  EMPLOYEE
        ...OK? Yes//   (Yes)
  Are you adding 'LAST,FIRST' as
    a new ONCOTRAX PATIENT (the 24673RD)? No// y  (Yes)

      The following information is contained in the Patient file
            NOT editable - See your MAS department IF in error

                    Name: LAST,FIRST

DOB:  DEC 24, 1953             Address: 1111 THIRD AVENUE
SSN:  999-00-9999                       Washingon DC 20422
SEX:  Female
POB:  Not Stated                        888-8888, EXT. 1111

                         NOK:

          ************* OncoTraX Patient file DATA **************

    Place of birth.............: UNKNOWN
    Race 1.....................:
    Race 2.....................:
    Race 3.....................:
```

```
Race 4.....................:
Race 5.....................:
Spanish origin.............:
Sex........................: FEMALE
Agent Orange exposure......:
Ionizing radiation exposure:
Chemical exposure..........:
Asbestos exposure..........:
Vietnam service............:
Lebanon service............:
Grenada service............:
Panama service.............:
Persian Gulf service.......:
Somalia service............:
Yugoslavia service.........:
Afghanistan (OEF) service..:
Iraq (OIF) service.........:

Edit patient data? YES//
Continue with Patient History? Yes// n  NO

Register a Primary for this patient? Yes//   YES
```

Editing an Existing Patient

1. Respond **NO** to the prompt: Are you adding 'LAST,FIRST' as a new ONCOTRAX PATIENT (the 24673RD)? No//
2. At the prompt: Edit patient data? YES// y YES
3. Type in the patient's remaining demographic information.
   Some information is automatically imported from the patient's electronic record; and some information is taken from the patient's chart

   Example

   ```
   Edit patient data? YES// y  YES
   ```

   Note: Answer **No** to Edit patient data?, if you are not going to complete this section now; such as when accessioning a patient to remove from Suspense.

   ```
   PLACE OF BIRTH:      New York//
   RACE 1:              White//
   RACE 2:              NA//
   RACE 3:              NA
   RACE 4:              NA
   RACE 5:              NA
   SPANISH ORIGIN:         Non-Spanish, non-Hispanic
   SEX:              Male//
   ```

   Note: These fields are automatically brought into the abstract from information in the patient's electronic record. **Enter 99 for Unknown**.

   ```
   AGENT ORANGE EXPOSURE   :  No//
   IONIZING RADIATION EXPOSURE:  No//
   ```

```
        CHEMICAL EXPOSURE:
        ASBESTOS EXPOSURE:
```

Note: These two fields are not automatically populated. This information is found in the patient's chart. **Leave no blanks**.

```
   PERSIAN GULF SERVICE:      No//
   MIDDLE EAST SERVICE:    No//
   SOMALIA SERVICE:        No//

   Would you like to see a PROBLEM LIST for this patient to assist
   you in entering the COMORBIDITY/COMPLICATION #1-6 prompts? Yes//   YES
```

Note: All problems from the cover sheet display. Select ICD-9 codes as required by ACoS.

```
   DATE OF ONSET  ICD         DIAGNOSIS
   -------------  ---------   ------------------------------------------
   2003           266.2       B-COMPLEX DEFIC NEC
   2003           110.4       DERMATOPHYTOSIS OF FOOT
   2001           401.9       HYPERTENSION NOS
   UNKNOWN        780.79      OTHER MALAISE AND FATIGUE
   UNKNOWN        110.1       DERMATOPHYTOSIS OF NAIL
   UNKNOWN        414.9       CHR ISCHEMIC HRT DIS NOS
 SOURCE COMORBIDITY: Facility face sheet//
    COMORBIDITY/COMPLICATION #1:
         //
    COMORBIDITY/COMPLICATION #2:
    COMORBIDITY/COMPLICATION #3:
    COMORBIDITY/COMPLICATION #4:
    COMORBIDITY/COMPLICATION #5:
    COMORBIDITY/COMPLICATION #6:
    COMORBIDITY/COMPLICATION #7:
    COMORBIDITY/COMPLICATION #8:
    COMORBIDITY/COMPLICATION #9:
    COMORBIDITY/COMPLICATION #10:

Enter RETURN to continue or '^' to exit: ??


    Patient name:

    Secondary Diagnosis  #1.:
    Secondary Diagnosis  #2.:
    Secondary Diagnosis  #3.:
    Secondary Diagnosis  #4.:
    Secondary Diagnosis  #5.:
    Secondary Diagnosis  #6.:
    Secondary Diagnosis  #7.:
    Secondary Diagnosis  #8.:
    Secondary Diagnosis  #9.:
    Secondary Diagnosis #10.:

 Would you like to edit the SECONDARY DIAGNOSIS #1-10 prompts? No//
  *SECONDARY DIAGNOSIS #1-10 refers to future ICD-10 diagnostic coding.
Record as required by ACoS. LEAVE blank prior to ICD-10 implementation
```

4. A registrar often finds that a patient's occupation is not in the list. When **??** (two question marks) display after the occupation, it means the occupation is not in the list. You can add an occupation.

```
Continue with Patient History? Yes//   YES
Select USUAL OCCUPATION:   DOG TRAINER ??
```

   a. Type an existing occupation.
   b. When it is echoed back, type in the new occupation.
   c. At the prompt: Are you adding DOG TRAINER as a new ……., type **YES** with the suggested **SNOMED** code.

Example

```
Select USUAL OCCUPATION: TEACHER IN EDUCATION (THIRD LEVEL)
USUAL OCCUPATION.....: TEACHER IN AGRICULTURAL SCIENCE (THIRD
   LEVEL) // DOG TRAINER
Are you adding 'DOG TRAINER' as a new OCCUPATION FIELD (the 1750TH)?
   No// Y  (Yes)
   OCCUPATION FIELD SNOMED CODE: 1750
```

Note: This SNOMED code is specific to your facility, however you can enter free text into these fields.

Entering a First Primary for a Patient

1. Press **Enter** at the prompt default.

```
Register a Primary for this patient? Yes//
   Select (first) Primary 'SITE/GP':
```

2. At the prompt, Primary 'SITE/GP': type the site group name or the ICDO Topography code (C code).
   The case is assigned to the appropriate group and all subsequent fields display only the information relating to the selected site.

```
******** CREATE FIRST PRIMARY RECORD FOR THIS PATIENT*******

     PATIENT: LAST,FIRST

     Select first Primary SITE/GP: BREAST

     Ok to ADD:? Yes//   YES
     Creating a new Primary record for LAST,FIRST

     ACCESSION YEAR:  2007//

ACCESSION NUMBER: 200700224//
SEQUENCE NUMBER: 00//

 LAST,FIRST                                                    BREAST
 999-00-
   9999
------------------------------------------------------------------------
                          Primary Menu Options
```

```
-------------------------------------------------------------------------
                      1. Patient Identification
                      2. Cancer Identification
                      3. Stage of Disease at Diagnosis
                         Collaborative Staging (2004+ cases)
                      4. First Course of Treatment
                      5. Performance Measures
                      6. Over-ride Flags
                      7. Case Administration
                      8. EDIT Modifiers

                      A  All - Complete Abstract

                         Enter option: All//

-------------------------------------------------------------------------
 LAST,FIRST          Patient Identification                      BREAST
      999-00-9999
-------------------------------------------------------------------------
 Reporting Hospital...........:
 Marital status at Dx.........: MARRIED/COMMON LAW
 Patient address at Dx........: 1111 FIRST AVENUE
```

3. A new primary record is created for this patient and you are prompted for:

`Accession Year:` Type the year the case was added to the registry.

Note: The current year is the default, but you can type in any year.

`Accession No.:` Press **Enter** to accept the accession number.

Note: The next available accession number for the accession year displays.

`Sequence No.:` If this is the first primary for the patient, press **Enter** to accept the sequence number **00**.
If this is not the first primary for the patient, all the primaries for the patient are listed, and you can edit any of the primaries or add another.
If the sequence number is not correct, such as when a patient had a previous cancer diagnosis and was treated elsewhere, type **02**.

Editing a New or an Existing Primary

1. Type a new primary SITE/GP.
   The program takes you to the body of the abstract.

```
E  EDIT existing Primary
A  ADD another Primary
F  Follow-Up
Q  Quit Patient
EDIT/ADD primary for this patient: Edit//
```

2. Select **A** to edit all the information or select the portion of the abstract you want to edit.

```
-------------------------------------------------------------------------
Primary Sub-menu Options
-------------------------------------------------------------------------
```

```
1. Patient Identification
2. Cancer Identification
3. Stage of Disease at Diagnosis
4. First Course of Treatment
5. Patient Care Evaluation
A  All - Complete Abstract
```

Note: If you only want to edit one section of the abstract, select that number.

Adding a Second Primary

1. Select AI, the Abstract/Printing option.

```
Select *..Abstracting/Printing Option: AI  Complete Abstract
Enter patient name:    LAST, FIRST
      Place of birth.............: NEW YORK
      Race 1.....................: WHITE
      Race 2.....................: NA
      Race 3.....................: NA
      Race 4.....................: NA
      Race 5.....................: NA
      Spanish origin.............: NON-SPANISH, NON-HISPANIC
      Sex........................: MALE
      Agent Orange exposure......: NO
      Ionizing radiation exposure: NO
      Chemical exposure..........: UNKNOWN
      Asbestos exposure..........: UNKNOWN
      Persian Gulf service.......: NO
      Middle East service........: NO
      Somalia service............: NO
      Comorbidity/Complication #1: 401.9  HYPERTENSION NOS
      Comorbidity/Complication #2: 724.2  LUMBAGO
      Comorbidity/Complication #3:
      Comorbidity/complication #4:
      Comorbidity/Complication #5:
      Comorbidity/Complication #6:
```

Note: The personal information entered for the first primary displays and you can edit it or accept it as it is.

```
    Edit patient data? YES// NO
         Continue with Patient History? Yes// NO
 Acc/Sequence  Primary Site      Last Cancer Status   Date DX     Status
------------  ------------     ------------------   ---------   ---------

2004-00898/00  BONE MARROW       Evidence this CA     06/23/2004  Complete

      Select one of the following:
      E  EDIT existing Primary
      A  ADD another Primary
      F  Follow-Up
      Q  Quit Patient
```

2. To add another primary for the patient select `ADD another Primary`.

```
EDIT/ADD primary for this patient: Edit// ADD another Primary
```

```
******************** ADD PRIMARY ********************
                 LAST, FIRST
ACCESSION NUMBER: 2004-00898
SEQUENCE NUMBER: 02//
```

Note: The sequence number is updated. The first sequence number is changed from **00** to **01** and the additional one is **02**.

3. Type the site or topography code and press **Enter**.
   `Select another Primary 'SITE/GP': **LUNG NOS**`
4. Continue following the prompts.

Completing an Abstract

After you finish an abstract, you must change the abstract status to **Complete** (**3**).

OncoTraX reviews all mandatory fields and if any are not filled in, you are unable to code the abstract status as Complete. When an abstract is not complete and you have a large amount of data, you can change the status to partial or minimal.

An incomplete abstract generates a list of empty required fields. Go back into the abstract and fill in the empty required fields–**leave no blanks**.

In Abstract Status, you decide when to call an *incomplete* abstract. You can leave it as *incomplete* and do nothing more. To change the status, type the number, the first letter, or the entire word.

Note: You cannot set the abstract to **Complete**, if any of the required fields are left blank.

Example

```
ABSTRACT STATUS
ABSTRACT STATUS: Incomplete// ?
   Choose from:
      0  Incomplete
      1  Minimal data
      2  Partial
      3  Complete

ABSTRACT STATUS: Incomplete// c  Complete??

   Abstract Status may not be set to COMPLETE unless
ALL REQUIRED DATA FIELDS HAVE BEEN ENTERED.

The following REQUIRED fields have not been entered for this primary:
   ALCOHOL HISTORY
   DATE OF SURGICAL DISCHARGE
   DATE RADIATION STARTED
   DIAGNOSTIC CONFIRMATION
   EXTENSION
```

Note: Alcohol History, Tobacco History, Family History, and Occupation Information are considered patient demographic fields.
You *cannot* ^ from these fields back to the patient .You must exit out of the abstract and go back into AI.

You *can* ^ to any primary field, such as Date of Surgical Discharge, Date Radiation Started, Diagnostic Confirmation, and Extension , and so on. Example: ^Date of Surgical Discharge.

ABSTRACT STATUS = Complete will also perform a checksum of the values and an API call-up to the current EDITS metafile. An EDITS report will generate containing any inter-field edit check errors or warnings. Abstract status will reset to INCOMPLETE. Correct these edits and reset ABSTRACT STATUS to Complete to re-run the current EDITS metafile.

EE Abstract Edit Primary

The Abstract Edit Primary option allows you to edit only information related to the cancer and not to a patient's demographics. Only the primary fields of the abstract are brought up. This option allows you to pull up a patient using only the **Accession/Sequence Number**.

Note: The **Accession/Sequence Number** must be typed exactly as in the example.

```
Select *..Abstracting/Printing Option: EE  Abstract Edit Primary
Select primary or patient name: 2000-00163/00
PROSTATE     Last, First
```

Note: The site and patient's name are echoed back to you.

NC Print Abstract NOT Complete List

The Print Abstract NOT Complete List option allows you to print a list of records with an Abstract Status of Incomplete, Minimal, and Partial. The report shows the accession/sequence number, patient name, SSN, ICDO topography, and the date of diagnosis. Records are sorted according to the Status and Patient Name.

Example

```
                          ACC/SEQ
NAME                SSN   NUMBER              PRIMARY SITE       COC     DATE DX
                    ABSTRACT STATUS: Incomplete
ONCOPatient1        999-99-9999    2005-00537/00      UNKNOWN PRIMAR     1       07/29/2005
                    ABSTRACT STATUS: Minimal data
ONCOPatient2        999-99-9999    1995-00136/01      SKIN, TRUNK        1       03/02/1995
                    ABSTRACT STATUS: Partial
ONCOPatient3        999-99-9999    2005-00752/01      RECTOSIGMOID J     1       10/18/2005
ONCOPatient4        999-99-9999    2005-00763/00      ESOPHAGUS, LOW     1       10/27/2005
```

Note: Only **AI** and **EE** allow you to enter data into an abstract.

IR *Patient Summary*

The Patient Summary option allows you to produce a brief summary of the data found in a patient's abstract.

QA ***Print Abstract QA (80c)***

The Print Abstract QA option allows you to print a user-friendly abstract, which physicians can use when doing the ACoS required QA portion of registry abstracts.

Note: 80c (80 columns) presents an easy-to-read display on the computer screen.

EX ***Print Abstract-Extended (80c)***

The Print Abstract Extended option allows you to print a condensed version of a complete abstract.

Note: 80c (80 columns) presents an easy-to-read display on the computer screen.

PA ***Print Complete Abstract (132c)***

The Print Complete Abstract option allows you to print a complete abstract, which includes capturing the extended data set or to print without personal identifiers (sensitive information), specifically name and SSN.

Note: 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

MA ***Print QA/Multiple Abstracts***

The Print QA/Multiple Abstracts option allows you to print quality assurance/multiple abstracts.

AS Abstract Screens Menu (80c)

The Abstract Screens Menu option allows you to print or view on your screen, various portions of a patient's abstract.

Note: 80c (80 columns) presents an easy-to-read display on the computer screen.

FOL Follow-up Module

The Follow-up module provides follow up information based on the date of last contact. A patient is considered delinquent or lost to follow-up when no contact is made within 15 months after the date of last contact. Lost cases remain delinquent in follow-up until further information is obtained.

```
********** FOLLOW-UP FUNCTIONS **********
PF Post/Edit Follow-up
RF Recurrence/Sub Tx Follow-up
FH Patient Follow-up History
DF Print Due Follow-up List by Month Due
LF Print Delinquent (LTF) List
FP Follow-up Procedures Menu ...
```

Note: The first screen contains the information from the last posted follow-up note. The system prompts you to enter new follow-up information, beginning with Date of Last Contact or Death.

PF Post/Edit Follow-up

The Post Follow-up option allows you to post and edit follow-up information.

`PF Post/Edit Follow-up:`	Type the patient's PID#; refer to the *Glossary* on page 107.
`Date of Last Contact or Death:`	Date of last contact with the patient and not the date you are entering the patient information. To edit the date of contact, select the date and press **Enter**. To add new follow-up information, type a new date.
`DATE ENTERED, REGISTRAR:`	The system automatically enters the date you are entering the follow-up and the registrar's name.
`VITAL STATUS:`	Type **A** for Alive or **D** for Dead.
`FOLLOW-SOURCE:`	From the FORDS manual, select allowable fields.
`COMMENTS:`	Type information from the patient's last contact. **Example** Patient seen in Oncology clinic, no evidence of disease recurrence. or Patient seen in urology clinic, PSA <0.05.

```
CANCER STATUS: Choose from the following:
   1  No evidence of this tumor
   2  Evidence of this tumor
   9  Unknown/not stated if this tumor present
```

Note: Every **Complete** abstract must have follow-up and TYPE OF FIRST RECURRENCE posted.

RF Recurrence/Sub Tx Follow-up

The Recurrence/Sub Tx Follow-up option allows you to document the first recurrence and/or subsequent treatment. Date of first recurrence is the date a medical practitioner diagnoses a recurrence of a cancer after a disease-free period. Recurrence means the return or reappearance of the cancer after a disease-free period.

```
Select Initiation Date:
```

`Recurrence/Sub Tx Follow-up:` Type the patient's or PID#; refer to the *Glossary* on page 107.

`Type of First Recurrence:` Enter the appropriate code for the first recurrence for this primary.

Note: To bring up a list of selections, type **??** at the prompt.

`Select Subsequent Course of Treatment` If the patient did not receive subsequent treatment, press **Enter**.
If the patient did receive subsequent treatment, type the date treatment began.
Treatment fields display:

```
  SURGERY OF PRIMARY SITE:
  SCOPE OF LYMPH NODE SURGERY:
  SCOPE OF LN SURGERY DATE:
  SURGICAL PROC/OTHER SITE:
  SURGICAL PROC/OTHER SITE DATE:
  METS SITE RESECTED:
  METS SITE RESECTED DATE:
  RADIATION:
  RADIATION DATE:
  CHEMOTHERAPY:
  CHEMOTHERAPY DATE:
  HORMONE THERAPY:
  HORMONE THERAPY DATE:
  IMMUNOTHERAPY:
  IMMUNOTHERAPY DATE:
  HEMA TRANS/ENDOCRINE PROC:
  HEMA TRANS/ENDOCRINE PROC DATE:
  OTHER TREATMENT:
  OTHER TREATMENT START DATE:
  PALLIATIVE CARE:
  PLACE:
SUBSEQUENT THERAPY COMMENTS:
   No existing text
                    Edit? NO//
                    To enter a comment, type Y.
   Initiation Date:  For each recurrence for this primary, type the date the
                    course of treatment began.
   ************************** POST/EDIT FOLLOW-UP ************************
```

Update the follow-up now.

Note: The subsequent course of treatment may consist of multiple treatments. If a patient did not receive a particular treatment, be sure to code it **00** for *no treatment*. Do not leave any treatment fields blank.

FH Patient Follow-up History

The Patient Follow-up History allows you to print the patient's follow-up history, including when the next follow-up is due. Type the patient's name and a device, or print to your screen.

DF Print Due Follow-up List by Month Due

The Print Due Follow-up List by Month Due option allows you to print a list of follow-ups that are due for a selected date range. They display by month due, along with the SSN, primary site, last date of contact, and date of diagnosis.

Your previous date range selection displays automatically. You want to be current by doing a patient due for follow-up in the month that the follow-up is scheduled; however, with other duties to perform, you may not be able to do this. In this case, work on the **Lost To Follow-up** list.

Example

```
START WITH DUE FOLLOW-UP: // 12-2005  (DEC 2005)
GO TO DUE FOLLOW-UP: LAST// 12-31-05  (DEC 31 2005)
********************************************************************************
TUMOR REGISTRY - DUE FOLLOW-UP    Washington DC VAMC     DEC 21, 2005   PAGE:  1
Patient Name   Med Rec#       Contact        Primary Site/Gp        Date Dx
********************************************************************************
       DUE FOLLOW-UP: DEC 2005
ONCOPATIENT1   999-99-9999    12/1/2004      TESTIS                 03/13/1986
                                             TESTIS                 07/27/1999
ONCOPATIENT2   999-99-9999    12/31/2004     MELANOMA               11/05/2004
ONCOPATIENT3   999-99-9999    12/14/2004     SOFT TISSUE            04/19/2002
-----------------------------------------
COUNT 3
```

LF Print Delinquent (LTF) List

The Print Delinquent (LTF) List option allows you to print a list of all patients whose Due Follow-up date is over 3 months (are not seen/contacted for over 15 months). These patients are considered lost to follow-up. The report is sorted by the month and year the follow-up was due and prints the SSN, date of last contact, Site/Gp, and date of diagnosis.

> **Note:** You may want to use this option frequently; if you are in a crunch, run only this list and work to reduce these numbers.

Example

```
ONCOLOGY DELINQUENT (LTF) LIST
                                                          DATE
                                                          LAST
NAME              SSN            CONTACT                  SITE/GP              DATE DX
-------------------------------------------------------------------------------------------------
              DUE FOLLOW-UP: MAY 1997
ONCOPATIENT1      999-99-9999    5/03/1996                BLADDER              10/25/1993
DUE FOLLOW-UP: JUN 2005
ONCOPATIENT2      999-99-9999    06/07/2004               PROSTATE             05/14/1998
DUE FOLLOW-UP: AUG 2005
ONCOPATIENT3      999-99-9999    08/19/2004               PROSTATE             02/06/1985
DUE FOLLOW-UP: SEP 2005
ONCOPATIENT4     999-99-9999     09/01/2004               ENDOCRINE, OTHER     06/24/1996
ONCOPATIENT5     999-99-9999     09/13/2004               BREAST               03/22/2000
COUNT 5
```

FP Follow-up Procedures Menu

The Follow-up Procedures Menu option allows you to manage follow-up by providing a list of contacts for the patient, follow-up letters, and a summary report of the patient follow-up.

```
PI Patient Follow-up Inquiry
AC Add Patient Contact
AF Attempt a Follow-up
PL Print Follow-up Letter
EL Add/Edit Follow-up Letter
FR Individual Follow-up Report
UP Update Contact File
```

Type a patient name at the prompt.

- PI Patient Follow-up Inquiry – view the last time a patient had follow-up and the status of the cancer at that time.
- AC Add Patient Contact – view contacts for a specific patient and add other contacts. Additional contacts may be useful when doing follow-up on a patient.
- AF Attempt a Follow-up – document the date for which you want a patient follow-up and the method you used.
- PL Print Follow-up Letter – print a follow-up form letter to send to obtain follow-up.
- EL Add/Edit Follow-up Letter – edit or create other follow-up letters specific to your facility.

Follow-up Letter

To send a letter to a patient, use the **AC**, **AF**, and **PL** options, in this sequence.

To generate a follow up letter:

```
Select OncoTraX Cancer Registry Option: fol  *..Follow-up Functions
************ FOLLOW-UP FUNCTIONS **********
PF Post/Edit Follow-up
RF Recurrence/Sub Tx Follow-up
FH Patient Follow-up History
DF Print Due Follow-up List by Month Due
LF Print Delinquent (LTF) List
SR Follow-up Status Report by Patient (132c)
FP Follow-up Procedures Menu ...
Select *..Follow-up Functions Option: FP

Follow-up Procedures Menu
PI Patient Follow-up Inquiry
AC Add Patient Contact
AF Attempt a Follow-up
PL Print Follow-up Letter
EL Add/Edit Follow-up Letter
FR Individual Follow-up Report
UP Update Contact File
Select Follow-up Procedures Menu Option: AC  Add Patient Contact

      ********* DISPLAY CONTACTS **********
```

```
   Select Patient: T9999    (Type the PID# to bring up patient or
patient's name)

   Searching for a VA Patient, (pointed-to by NAME)
LAST,FIRST  10-23-26 000129999

All of the contacts for this patient are displayed

      AVAILABLE CONTACTS
      ==================
      Patient     LAST,FIRST
            000 999-0000
            1269 STREETNAME ST
            City, ST 00000

      Next of Kin LAST,FIRST1, NEXT OF KIN
            000 999-0000
            0000 STREETNAME ST
            City,ST 00000
   ********** ADD/EDIT CONTACTS **********
      for: Last,First
```

To send a letter to a patient:

```
Select TYPE OF FOLLOW-UP CONTACT: Guardian// PT
```
Type PT.
```
   TYPE OF FOLLOW-UP CONTACT: Patient//
   CONTACT NAME: LAST,FIRST1//
```
Go to the Contact File to edit the contact's name and address.
```
   CONTACT: LAST,FIRST1//
   STREET ADDRESS 1: 0000 STREETNAME ST//
   STREET ADDRESS 2:
   STREET ADDRESS 3:
   ZIP CODE: City,ST 00000
```
Note: Always check the Zip Code field. The first town alphabetically with the zip code is selected. Compare it with the address in CPRS and select the correct town.
```
   PHONE: 000 999-0000//
   TITLE: Mr//    Type a title without a period (Mr Mrs Ms and so on)
   COMMENTS:

      Select one of the following:
      1  Display Contacts
      2  Edit Contact
      3  Attempt a Follow-up
      4  Another Patient
      5  Exit Option
```
Select `3 Attempt a Follow-up`.
```
      Select Action: 3//   Attempt a Follow-up

      ********** ATTEMPT A FOLLOW-UP **********

            for Last,First
```

```
Select FOLLOW-UP ATTEMPT DATE: JUL 5,2005//
   FOLLOW-UP ATTEMPT DATE: JUL 5,2005//
TYPE: ?
      How will you be obtaining follow-up information?
      Choose from:
      1  Chart Review
      2  Phone Contact
      3  Letter Contact          Select 3   Letter Contact
      8  Other

   THE CONTACT: LAST,First1,//              Type the patient's last name.
   RESULT: Pending//
   REMARKS:

      Generate Letter...!!

Specify TYPE Contact letter: ??  ?? (two question marks)
   brings up a list from which to select a type.
      Choose from:
      1  PATIENT *Washington LETTER*
      2  PATIENT *Washington 2* DOT MATRIX
      3  PATIENT *Washington 3 LETTER*
      4  PATIENT *Washington NEW*
      5  PATIENT TESTING LETTER
CHOOSE 1-5: 1  PATIENT *Washington LETTER*

DEVICE:  (ENTER YOUR PRINTER)
```

To edit the follow-up letter:

```
Follow-up Procedures Menu
   PI Patient Follow-up Inquiry
   AC Add Patient Contact
   AF Attempt a Follow-up
   PL Print Follow-up Letter
   EL Add/Edit Follow-up Letter        Select EL  Add/Edit Follow-up Letter.
   FR Individual Follow-up Report
   UP Update Contact File

EL Add/Edit Follow-up Letter
   Select letter to Add/Edit: PAT      Type PAT.
   1  PATIENT *Washington LETTER*
   2  PATIENT *Washington DOT MATRIX
   3  PATIENT *Washington 2 LETTER*
   4  PATIENT *Washington NEW*
   5  PATIENT TESTING LETTER
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5:
1  PATIENT *Washington LETTER*

NAME: PATIENT *Washington LETTER*  Replace   To change the name, type … and
   press Enter. Type the name change for the letter.
```

```
FORM TYPE: PATIENT// ?
DESCRIPTION:
   No existing text
   Edit? NO//
MAIN FORM BODY:. . .
Our hospital has a clinical program engaged in following the progress of
   our former patients. We are interested in knowing how you are doing.
   Edit? NO// YES                Respond YES to edit the letter.
```

This takes you into the text editor (like VistA E-MAIL), where you can make changes to the wording of the letter. *Do not change anything that is between the upright characters*.

Example
|PATIENT NAME|

This information is automatically pulled from other parts in VistA. If you delete an *upright* or alter the text in the *upright*, the information is not placed into your letter.

```
Edit? NO// YES
```

Example of the editing screen

```
DO NOT CHANGE ANYTHING WITHIN THE UPRIGHTS OR DELETE THEM

|INDENT(10)|    DEPARTMENT OF VETERANS AFFAIRS
      |HOSPITAL NAME|
            |HOSPITAL STREET ADDRESS|
            |HOSPITAL CITY,ST ZIP|

|LAST(FOLLOW-UP ATTEMPTS:FOLLOW-UP ATTEMPT DATE)|
                              |SSN|
528/111H

|LOWERCASE(ONCOFIRSTNAME LASTNAME(LAST FOLLOW-UP CONTACT))||TAB|
|LAST FOLLOW-UP CONTACT:STREET ADDRESS 1|
|WRAP|
|LAST FOLLOW-UP CONTACT:STREET ADDRESS 2|
|LAST FOLLOW-UP CONTACT:STREET ADDRESS 3|
|NOWRAP|
|LAST FOLLOW-UP CONTACT:ZIP CODE|

Dear |LAST FOLLOW-UP CONTACT:TITLE|. |LOWERCASE(LAST NAME)|,
         Text below this line may be changed.
```

Example of a follow-up letter to a patient

```
Our hospital has a clinical program engaged in following
the progress of our former patients.  We are interested in
knowing how you are doing.

Would you be kind enough to answer the questions
listed below?  Your assistance will add to the
success of this program and help us achieve better
patient care in our hospital.  A self-addressed
stamped envelope is enclosed for your convenience.

Thank you for your participation.
Sincerely,
```

|Cancer Registrar|
Cancer Registrar
Today's date: _____

What is your present status?
_____ Free of cancer _____ Not free of cancer

Are you able to work or carry on normal activity? ____ YES, Normal
_____ Limited _____ Capable, but limited _____ Incapable _____ Bedridden
Have you seen a doctor outside of the VA Medical Center?
_____ Yes _____ No If "Yes", who and where:
_____
IF THE PATIENT IS DECEASED, Please give date and place of death:
_____
What was the cause of death? _____Cancer _____Not Cancer
_____ Other causes (specify) _____
Please list any other symptoms relating to your condition not covered in the above items on the back of this sheet.

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LIS Registry Lists Module

The Registry Lists module is a menu of registry listings containing various accession registers, and patient and site reports.

Any 132c report requires a printer that prints 132 columns. Any 80c report requires a printer that prints 80 columns. The majority of the reports produce information that includes the entire database. If you have 20 years of data in your registry, the report contains all 20 years of data. For data from a specific year, use the options in the
`ANN  *..Annual Reports ...`module.

```
   ************Cancer Registry Lists************
   AA    Accession Register-ACoS (80c)
   AS    Accession Register-Site (80c)
   AE    Accession Register-EOVA (132c)
   PA    Patient Index-ACoS (132c)
   PS    Patient Index-Site (80c)
   PE    Patient Index-EOVA (132c)
   IN    Primary ICDO Listing (80c)
   SG    Primary Site/GP Listing (80c)
   IW    Primary ICDO Listing (132c)
```

AA Accession Register-ACoS (80c)

The Accession Register-ACoS list allows you to print all records. This contains the ACoS required *Accession Register* data items.

Note: 80c (80 columns) presents an easy-to-read display on the computer screen.

Press **Enter** at the START WITH prompt.

For a complete register:

```
   START WITH ACC/SEQ NUMBER: FIRST// <Enter>
         To get all records beginning with the same year:
            For a single accession year (e.g. 2003):
            START WITH ACC/SEQ NUMBER: FIRST// 2003-00000
            GO TO ACC/SEQ NUMBER: LAST// 2003-99999
         To get a Specific range of records:
         START WITH ACC/SEQ NUMBER: 2004-00400 -00//
         GO TO ACC/SEQ NUMBER: 2004-00500
   ACC/SEQ#       PATIENT NAME   ICDO     TOPOGRAPHY         DATE DX     YEAR
   2004-00400/00  ONCOPATIENT1   C42.0    BLOOD              06/03/2004  2004
   2004-00408/00  ONCOPATIENT2   C02.9    TONGUE NOS         06/24/2004  2004
   2004-00409/00  ONCOPATIENT3   C18.7    COLON, SIGMOID     06/24/2004  2004
```

AS Accession Register-Site (80c)

The Accession Register Site list allows you to select a range of accession years or a range of accession numbers.

Note: 80c (80 columns) presents an easy-to-read display on the computer screen.

You are provided with the following data:

```
ACC/SEQ #      PATIENT NAME   SSN   PRIMARY SITE/GP   DATE DX  YEAR
```

AE Accession Register-EOVA (132c)

The Accession Register-EOVA list is similar to AA Accession Register-ACoS, but displays more fields.

Note: 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

PA Patient Index-ACoS (132c)

The Patient Index-ACoS allows you to print the Patient Index, which contains all elements required by the ACoS Cancer Program, for all the patients in the registry. The list is very long.

Note: 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

Example

```
PATIENT NAME MED RECORD# S DT-BIRTH DT-DEATH ACC/SEQ-NO DATE DX  ICD–TOPOGRAPHY L ICDO–MORPHOLOGY
-------------------------------------------------------------------------------------------
ONCOPATIENT1 000-00-0000 M 07/25/1940 07/25/2000 2000-00371/00 09/25/1992 C18.5–COLON, SPLENIC
```

PS Patient Index-Site (80c)

The Patient Index Site list provides an alphabetical list of the entire registry.

Note: 80c (80 columns) presents an easy-to-read display on the computer screen.

```
PATIENT NAME   SSN   SX ACC/SEQ #      PRIMARY SITE/GP   DATE DX
```

PE Patient Index-EOVA (132c)

The Patient Index-EOVA is similar to PA Patient Index Site, but provides slightly different information.

Note: 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

IN Primary ICDO Listing (80c)

The Primary ICDO Listing provides a list of all cases in the entire registry by the ICDO codes. The list begins with ICDO-SITE: C00-LIP. The list is very long.

Note: 80c (80 columns) presents an easy-to-read display on the computer screen.

```
PATIENT NAME    SSN       YEAR ACC/SEQ #     TOPOGRAPHY      DATE DX
```

SG Primary Site/GP Listing (80c)

The Primary Site/GP Listing provides a list of all cases in the entire registry by requested site/gp. The previous selection displays as the default.

Note: 80c (80 columns) presents an easy-to-read display on the computer screen.

```
   * Previous selection: SITE/GP equals LUNG
START WITH SITE/GP: LUNG// PANCREAS          Type PANCREAS.
   GO TO SITE/GP: LAST// PANCREAS
      Previous selection: ICDO TOPOGRAPHY-CODE from C34.0 to C34.9
START WITH PRIMARY SITE CODE: C34.0// C25    For a specific primary site
                                             use only that code
      GO TO PRIMARY SITE CODE: C34.9// C25.9
```

Example

List for an ICDO Code, sorted alphabetically.

```
   PATIENT NAME   SSN         YEAR  ACC/SEQ #      TOPOGRAPHY     DATE DX
   ------------------------------------------------------------------------
                              ICDO CODE: C25.0
   LAST,FIRST A   000-00-0000 2002  2002-00072/00  PANCREAS HEAD  02/20/2002
                              ICDO CODE: C25.1
   LAST,FIRST B   000-00-0000 1978  1978-00089/00  PANCREAS BODY  05/01/1978
   LAST,FIRST C   000-00-0000 2005  2005-00143/02  PANCREAS BODY  03/23/2005
                              ICDO CODE: C25.2
   LAST,FIRST D   000-00-0000 2006  2006-00001/00  PANCREAS TAIL  01/01/2006
   LAST,FIRST E   000-00-0000 1985  1985-00347/03  PANCREAS TAIL  07/17/1985
                              ICDO CODE: C25.9
   LAST,FIRST F   000-00-0000 2005  2005-00089/00  PANCREAS NOS   05/01/2005
   LAST,FIRST G   000-00-0000 1998  1998-00019/00  PANCREAS NOS   02/01/1998
```

IW Primary ICDO Listing (132c)

The Primary ICDO Listing provides a list of all patients by all primary site codes in the entire registry.

```
   PRIMARY SITE: C00.0-LIP, EXTERNAL UPPER
   PATIENT NAME   SSN     DOB     DOD     YEAR    ACC/SEQ#    DATE DX    TOPOGRAPHY MORPHOLOGY
```

Note: If you have time, experiment with this listing to see all that it can provide.

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ANN Annual Reporting Module

The Annual Reporting module is a menu of annual reports.

```
Annual Reports
AAR   Annual ACoS Accession Register (80c)
API   Annual ACoS Patient Index (132c)
ASL   Annual Primary Site/GP Listing (132c)
ACL   Annual Patient List by Class of Case (80c)
SST   Annual Primary Site/Stage/Tx (132c)
TST   Annual ICDO Topography/Stage/Tx (132c)
SDX   Annual Status/Site/Dx-Age (132c)
HIS   Annual Histology/Site/Topography (80c)
AST   Annual Site/ICDO Topography/Histology (80c)
ACT   Annual Cross Tabs (80c)
CPR   Print Custom Reports
```

- The Annual ACoS Accession Register and Annual ACoS Patient Index are required for ACoS approval.
- Print Custom Reports allows you to retrieve data requested by your staff from your database. It requires knowledge of basic FileMan functions.

AAR Annual ACoS Accession Register (80c)

The ACoS Annual Accession Register is an annual report required by ACoS. The report is sorted by accession /sequence number within a specific accession year and a count of the records prints at the end.

Note: 80c (80 columns) presents an easy-to-read display on the computer screen.

```
Select year: 2005                    Type specific year.
```

Example of the report

```
*****************************************************************************************************************
ACC/SEQ-No     Patient Name      ICDO – Topography       Date Dx     C  L
1975-00334/04  ONCOPATIENT1      C44.1  SKIN, EYELID     01/19/2005  1  1
1987-00118/03  ONCOPATIENT2      C80.9  UNKNOWN PRIMARY  05/10/2005  1  0
2005-00055/00  ONCOPATIENT3      C61.9  PROSTATE         02/08/2005  1  0
```

API Annual ACoS Patient Index (132c)

The Annual ACoS Patient Index is an annual report of the required ACoS items for an accession year. A count of the records prints at the end.

Note: 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

```
Select year:                         Type specific year.
```

Example – fields in this report

```
*************************************************************************************************************************************
PATIENT NAME   MED RECORD#    DT-BIRTH   DT-DEATH   ACC/SEQ-NO ICDO – TOPOGRAPHY  MORPHOLOGY L
```

ASL Annual Primary Site/GP Listing (132c)

Note: 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

The Annual Primary Site/GP Listing is an annual report sorted first by accession year and then by the primary site/group.

Example

```
START WITH ACCESSION YEAR: FIRST// 2003
GO TO ACCESSION YEAR: LAST// 2003
START WITH SITE/GP: FIRST// BLADDER
```

Note: Type the **SITE/GP** in capital letters.

```
GO TO SITE/GP: LAST// BLADDER
```

Example – fields in this report

A list of all patients from the year 2003 with a primary Bladder cancer displays.

```
PATIENT NAME  MED RECORD# S DT-BIRTH  DT-DEATH  ACC/SEQ DATE DX ICDO TOPOGRAPHY ICDO MORPHOLOGY
```

ACL Annual Patient List by Class of Case (80c)

The Annual Patient List by Class of Case is an annual report listing all patients alphabetically, for a specific year for each class of case.

Note: 80c (80 columns) presents an easy-to-read display on the computer screen.

Example – fields in this report

```
Patient Name   Med Rec#    Sx    Acc/Seq#    Site/Group     Date Dx
```

SST Annual Primary Site/Stage/Tx (132c)

The Annual Primary Site/Stage/Tx is an annual report listing patients for a specific year and specific site and stage.

Note: 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

```
START WITH ACCESSION YEAR: 2005//
GO TO ACCESSION YEAR: LAST// 2005
   * Previous selection: SITE/GP equals PHARYNX
   START WITH SITE/GP: PHARYNX//
   GO TO SITE/GP: PHARYNX//
```

Example – fields in this report

```
PT ID TX TREATMENT SURG DATE SURGERY RAD DATE RADIATION CHEMO DT CHEMOTHERAPY HT DATE HORMONE TPY
```

TST Annual ICDO Topography/Stage/Tx (132c)

The Annual ICDO Topography/Stage/Tx is an annual report listing cases by stage and site for a selected accession year and selected ICDO-topography.

Note: 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

```
START WITH ACCESSION YEAR: 2006// 2005
```
Define the year.

```
GO TO ACCESSION YEAR: 2006// 2005
   * Previous selection: ICDO-SITE CODE from C00 to C90
   START WITH PRIMARY SITE CODE PREFIX: C00//
```
Define the ICDO-SITE CODE (S).

```
   GO TO PRIMARY SITE CODE PREFIX: C90// C02
```

Example

```
------------------------------------------------------------------------

                                      ICDO-SITE CODE: C32

                                          STAGE GROUPING-AJCC: I
W5321 C32.0  NONE
             -------
SUBCOUNT     1
R3493 C32.0  XRT     00/00/0000  06/13/2005 Beam radiation   00/00/0000 None  00/00/0000 None
             -------
SUBCOUNT     1
             -------
SUBCOUNT     2

                                          STAGE GROUPING-AJCC: II
B4704 C32.0  XRT    00/00/0000   03/03/2005 Beam radiation   00/00/0000 None   00/00/0000 None
             -------
SUBCOUNT     1
             -------
SUBCOUNT     1

                                          STAGE GROUPING-AJCC: IV
B6985 C32.0  NONE
             -------
SUBCOUNT     1
P7689 C32.1  SUR    09/02/2005
             -------
SUBCOUNT
H7872 C32.1  XRT/CMX 00/00/0000  07/13/2005 Beam radiation  07/18/2005 Multiagent00/00/0000 None
             -------
SUBCOUNT     1
             -------
SUBCOUNT     3
             -------
COUNT        6
```

SDX Annual Status/Site/Dx-Age (132c)

The Annual Status/Site/Dx-Age is an annual report listing patients for a specific accession year.

Note: 132c (132 columns) does not present an easy-to-read display on the computer screen because the text wraps; select a device that can print 132 columns.

```
Annual report - sorted first by Accession year
   Then by Class Category (Non-analytic/Analytic)
   Then by Status, Site/GP, and Diagnosis Age Gp.
```

```
          Enter four digit ACCESSION YEAR,
          For Class category: either 'A'
          for Analytic, or first to last.
```

Example

```
START WITH ACCESSION YEAR: 2005
GO TO ACCESSION YEAR: LAST// 2005                          .
  * Previous selection: CLASS CATEGORY equals 1 (ANALYTIC)
  START WITH CLASS CATEGORY: 1//   ANALYTIC
GO TO CLASS CATEGORY: 1//   ANALYTIC
DEVICE:
PRIMARY LIST
                  DX AGE-GP: 60-69
ONCOPATIENT1 999-99-9999 2005-00054/00 02/02/2005 ANUS NOS SQUAM CELL CARC T1 N0 M0 I     SUR
ONCOPATIENT2 999-99-9999 2005-00272/00 03/22/2005 ANUS NOS SQUAM CELL CARC TX NX MX Unkno UR/CMX
```

HIS Annual Histology/Site/Topography (80c)

The Annual Histology/Stage/Topography is an annual report listing.

Note: 80c (80 columns) presents an easy-to-read display on the computer screen.

```
   START WITH ACCESSION YEAR: 2005//
   GO TO ACCESSION YEAR: LAST// 2005
      START WITH SITE/GP: PHARYNX//
      GO TO SITE/GP: PHARYNX//
```

Example

```
*********************************************************************************************
2005 - ANALYTIC              Washington DC VAMc    DEC 21,2005      PAGE:  1
Patient Name       Med Rec#       Sx  Acc/Seq#       ICDO-Topography        Date Dx
*********************************************************************************************
             ICDO HISTOLOGY-CODE: 8070/3
                SITE/GP: PHARYNX
                   ICDO-SITE CODE: C01
                      PATIENT NAME: ONCOPATIENT1
ONCOPATIENT1       999-99-9999    M   2005-00096/00  TONGUE BASE            03/14/2005
                    ICDO-SITE CODE: C09
                      PATIENT NAME: ONCOPATIENT2
ONCOPATIENT2       999-99-9999    M   2005-00494/00  TONSILLAR FOSSA        07/12/2005
                    ICDO-SITE CODE: C10
                      PATIENT NAME: ONCOPATIENT3
ONCOPATIENT3       999-99-9999    M   2005-00029/00  OROPHARYNX NOS         01/27/2005
COUNT     4  -------------
SUBCOUNT                       3
```

ACT Annual Cross Tabs (80c)

The Annual Cross Tabs is an annual report that is very long. Queue this report after hours.

Note: 80c (80 columns) presents an easy-to-read display on the computer screen.

CPR PRINT Custom Reports

The PRINT Custom Reports option allows you to create custom reports using VA FileMan.

Note: It is very helpful to have some FileMan training from the computer department at your facility. Also, with knowledge of capturing files and opening them in Microsoft Excel, you can create a very usable and professional document.

You can retrieve any data that you enter into an abstract. Create a report by specifying:

- file from which the information is coming, OncoTraX Primary (#165.5), OncoTraX Patient (#160), or OncoTraX Contact (#165);
- fields that contain the data;
- how to separate/sort the data; and
- information to be printed.

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STA Statistical Reporting Module

The Statistical Reporting module allows you to obtain 5-year survival information on your data. You can search for user-defined criteria.

```
**********STATISTICAL REPORTS**********
TS Treatment by Stage - Cross tabs
SP Survival by Site
SS Survival by Stage
TX Survival by Treatment
SU Survival Routines
DS Define Search Criteria
```

DS Define Search Criteria

The Define Search Criteria option allows you to define criteria to obtain 5-year survival information from:

```
SP Survival by Site
SS Survival by Stage
TX Survival by Treatment
```

In order to use SP, SS, TX, or SU (Survival Routines), you must first create a template using DS Define Search Criteria.

Use DS to create search templates for Survival Analysis.

Note: Name templates beginning with ONCOZ for user-defined templates rather than software-distributed names, ONCOS.

```
 Select one of the following:
    1  ONCOTRAX PRIMARY
    2  ONCOTRAX PATIENT
    3  ONCOTRAX CONTACT
Select File: 1  ONCOTRAX PRIMARY
We will search entries in ONCOTRAX PRIMARY file...


-A- SEARCH FOR ONCOTRAX PRIMARY FIELD: SITE/GP
-A- CONDITION: ?                                  Type ? to view choices.
   Answer with CONDITION NUMBER, or NAME          Type a condition.
       Choose from
1  NULL
2  CONTAINS
3  MATCHES
4  LESS THAN
5  EQUALS
6  GREATER THAN
YOU CAN NEGATE ANY OF THESE CONDITIONS BY PRECEDING THEM WITH “’” OR "-"
SO THAT "'NULL'" MEANS "NOT NULL"
-A- CONDITION: CONTAINS
-A- CONTAINS: LUNG NOS

-B- SEARCH FOR ONCOTRAX PRIMARY FIELD: ACCESSION YEAR
-B- CONDITION: GREATER THAN
```

```
-B- GREATER THAN: 1995

-C- SEARCH FOR ONCOTRAX PRIMARY FIELD: ACCESSION YEAR
-C- CONDITION: LESS THAN
-C- LESS THAN: 2001

-D- SEARCH FOR ONCOTRAX PRIMARY FIELD: CLASS CATEGORY
-D- CONDITION: EQUALS
-D- EQUALS: ANALYTIC                    Use only analytic cases for survival data.
-E- SEARCH FOR ONCOTRAX PRIMARY FIELD:
```

Note: If you want to include more data, continue with **E**. If not, press **Enter** and at **IF**, type the letters of your search criteria. The screen echoes back your selections.

```
IF: ABCD    SITE/GP CONTAINS (case-insensitive) "LUNG NOS"
and ACCESSION YEAR GREATER THAN 1995
and ACCESSION YEAR LESS THAN 2001
and CLASS CATEGORY EQUALS "1" (ANALYTIC)
```

or

```
STORE RESULTS OF SEARCH IN TEMPLATE: ONCOZ LUNG NOS SURVIVAL
```

Name the template beginning with ONCOZ. Press **Enter** to start the sort.

Note: You do a sort make sure that data is available. You can sort and print any data you want to view.

```
SORT BY: NUMBER// AJCC STAGE
START WITH AJCC STAGE: FIRST//
   WITHIN AJCC STAGE, SORT BY:
FIRST PRINT FIELD: !PID#
THEN PRINT FIELD: DATE DX
THEN PRINT FIELD: TREATMENT PLAN
THEN PRINT FIELD:
Heading (S/C): ONCOTRAX PRIMARY STATISTICS  Replace
Running Survival Options.
   SP Survival by Site
   SS Survival by Stage
   TX Survival by Treatment
```

SP Survival by Site

Survival by Site produces a 5-year survival by site, from the criteria you set in the DS Define Search Criteria.

SS Survival by Stage

Survival by stage produces a 5-year survival by AJCC Stage, from the criteria you set in the DS Define Search Criteria.

TX Survival by Treatment

Survival by Treatment produces a 5-year survival by the treatment, from the criteria you set in the DS Define Search Criteria.

Each of the three options also generates a list of patients who are dropped from the search and why.

Example including reason

```
Cases dropped:  4

PATIENT                    REASON FOR BEING DROPPED
----------------------     --------------------------------
L9999 ONCOPATIENT1         SURVIVAL MONTHS   0
Y1111 ONCOPATIENT2         SURVIVAL MONTHS   0
```

Example of the survival information for the template

```
ONCOTRAX PRIMARY Template ONCOZ LUNG NOS SURVIVAL 96-99
   Life Table
   Yrs   % Alive  # Left   Deaths   Losses
   ------------------------------------------------------------------------
   0     100.0    416      259      0
   1     37.7     157      73       0
   2     20.2     84       17       0
   3     16.1     67       18       0
   4     11.8     49       6        10
   5     10.2     33       3        5
```

TS Treatment by Stage - Cross Tabs

The Treatment by Stage – Cross tabs option allows you to print cross-tabs for all analytic cases for treatment by stage groups (I, II, III, IV). It is a large report and not user-friendly to view.

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UTL Utility Options Module

The Utility Options module allows you to manage the information in your OncoTraX database. You can correct errors, delete records, and create data disks to send to national and state databases.

```
RS    Registry Summary Reports
DP    Delete OncoTraX Patient
DS    Delete Primary Site/GP Record
SQ    Find Duplicate Acc/Seq Numbers
EA    Edit Site/AccSeq# Data
LG    List Topographic Site Groups
LT    List Topography Codes by Site Group
AR    Create a report to preview ACoS output
CT    Create ACoS Data Download
SR    Create a report to preview State/VACCR output
CC    Create State/VACCR Data Download
TR    Define Cancer Registry Parameters
AC    Enter/Edit Facility file
CDD1  Print Condensed DD--OncoTraX Patient file
CDD2  Print Condensed DD--OncoTraX Primary file
PSR   Purge Suspense Records
SP    Purge Patient Records with No Suspense/Primaries
CS    Restage CS cases using latest version
TNM   Compute percentage of TNM forms completed
TIME  Timeliness Report
CHEM  Enter/Edit Chemotherapeutic Drugs file
RQRS  Create RQRS extract
```

RS Registry Summary Reports

The Registry Summary Reports provide a quick count for:

- T–Today
- A–Annual (132c)
- F–Follow-up

The *Today* report gives you an overview of the entire registry on the day and time you run the report.

```
        Analytical:     10144
        Non-Analytical:  1515
           Total:       11659
           WORKLOAD STATISTICS
Suspense: 4 Incomplete: 68  Minimal: 4 Partial: 35  Complete: 1311
```

The *Annual* report gives you the number of cases for the selected year by site, race, sex, and the AJCC Stage. There are two options to choose from after you select the year.

```
Select year for summary:  (1952-2006): 2005//
   Analytic cases only? YES// m

   Answer 'YES' if you want only analytic cases (CLASS OF CASE 0-2)
   displayed.
```

```
   Answer  'NO' if you want all cases (analytic and non-analytic)
   displayed.
```

The *Follow-up* report offers two options that meet the ACoS requirements.

```
Follow-up rate calculation parameters (select 1 or 2):
1) All analytic patients from the cancer registry reference date
2) All analytic patients diagnosed within the last five years, or from the
   cancer registry reference date, whichever is shorter
```

Example of selection 1

```
FOLLOW-UP RATE FOR ALL PATIENTS (LIVING AND DEAD)  NUMBER   PERCENT

      Total patients from registry reference date  11808    100%
1. Less benign/borderline (behavior code 0/1)   -  183
2. Less Carcinoma in situ CERVIX cases          -    9
3. Less cases of in situ/localized basal and    -  1068
   squamous cell carcinoma of skin
4. Less foreign residents                       -    0
5. Less nonanalytic (includes recurrent cases   -  1234
   class of case 3,4,5, 8 & 9)

      SUBTOTAL CASES = ANALYTIC CASES        (A)   9314     100%
      (class of case 0, 1, 2)

1. Less number dead                          (B)   6881     74%

SUBTOTAL CASES (NUMBER LIVING)               (C)   2433     26%

1. Less number current (known to be alive
   in the last 15 months)                    (D)   2380     26%

TOTAL (LOST TO FOLLOW UP OR NOT CURRENT)     (E)   53 *     1%
   (* should be 20%)
```

Note: Percent should be 20% or less.

```
Successful follow-up currency (all patients) (F)   9261 **  99%
   (** should be 80%)
```

Note: Percent should be 80% or greater.

```
=========================================================================
FOLLOW UP RATE FOR LIVING PATIENTS ONLY            NUMBER   PERCENT

   Enter the total number from Line C              2433     100%
   Subtract the total number from Line D        -  2380 *** 98%
   Total lost/not current of living patients    -  53       2%
***
```

DP Delete OncoTraX Patient

The Delete OncoTraX Patient option allows you to delete an OncoTraX patient from the OncoTraX Patient file. You can also delete any associated records in the OncoTraX Primary file.

Note: Once you delete an abstract, you cannot undelete it. If you delete a patient by mistake, you have to manually re-enter the patient's abstract.

DS Delete Primary Site/Gp Record

The Delete Primary Site/Gp Record option allows you to delete a selected primary record for a specific OncoTraX patient.

SQ Find Duplicate Acc/Seq Numbers

The Find Duplicate Ac/Seq Numbers option will check for any existing duplicates in the system.

EA Edit Site/AccSeq# Data

The Edit Site/AccSeq# Data option allows you to edit/correct accession numbers, sequence numbers, diagnosis dates, and so on.

AR Create a Report to Preview ACoS Output

The Create a Report to Preview ACoS Output option allows the cancer registrar to preview the contents of the specified accessions intended as output for the ACoS.

CT Create ACoS Data Download

The Create ACoS Data Download option allows you to create the file for submission to the American College of Surgeons (ACoS), in response to the annual call for data.

SR Create a Report to Preview State/VACCR Output

The Create a Report to Preview State/VACCR Output option allows you to print the state extract data in a report format.

CC Create State/VACCR Data Download

The Create State /VACCR Data Download option allows you to create a file for the transmission of cancer registry information, including confidential patient identity data to the State collecting agencies. This extraction routine includes/downloads only patients from your state based on ZIPCODE and COUNTY AT DIAGNOSIS. It also blanks out communicable diseases and substance abuse, which are protected by federal law.

TR Define Cancer Registry Parameters

The Define Cancer Registry Parameters option allows you to set up the OncoTraX: Cancer Registry software. You must use this option first, in order to make several of the follow-up options work. For more information, refer to software implementation in the *Oncology Technical Manual and Software Security Guide* at http://www.va.gov/vdl/documents/Clinical/Oncology/onc211_tm.doc.

AC Enter/Edit Facility File

The Enter/Edit Facility File option allows you to enter new facilities in the Facility file or change the data for a facility.

CDD1 Print Condensed DD--OncoTraX Patient file

The Print Condensed DD-OncoTraX Patient file option allows you to view the data dictionary, which lists all patient information files in the abstract. Use this option when doing custom reports.

CDD2 Print Condensed DD--OncoTraX Primary file

The Print Condensed DD-OncoTraX Primary file option allows you to view the data dictionary, which lists all primary information files in the abstract. Use this option when doing custom reports.

PSR Purge Suspense Records

The Purge Suspense Records option allows you to enter multiple dates in the suspense file when deleting. *Use this option with caution.*

SP Purge Patient Records with No Suspense/Primaries

The Purge Patient Records with No Suspense/Primaries option allows you to purge OncoTraX Patient records with no suspense records and no primaries

CS Restage CS Cases

The Restage CS Cases option allows you to correct a problem in Collaborative Staging; use the most current version of collaborative staging. **Run it only once.**

TNM Compute Percentage of TNM Forms Completed

The Compute Percentage of TNM Forms Completed option allows you to compute the percentage of Primary Tumor, Regional Lymph Nodes, and Distant Metastasis forms completed.

TIME Timeliness Report

The Timeliness Report computes the percentage of cases within the selected date range, which have an ELAPSED DAYS TO COMPLETION value less than 180 days.

CHEM Enter/Edit chemotherapeutic Drug File

The Chem module allows user to enter chemotherapeutic drugs for use in CHEMOTHERAPY #1-10 fields. Enter generic chemotherapeutic drug name with its NSC number

RQRS Create RQRS Extract

The RQRS module allows user to create a RQRS file for submission to ACoS- NCDB.

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Reporting to VA Central Cancer Registry

Upon completion of an abstract or when an abstract is updated/changed, the record will auto-export to the ONCSRV. Using the Rocky Mountain Cancer Data system, VACCR staff will perform records consolidation procedures of all submitted data.

If VACCR staff requests data, registrars should utilize the CC Create State/VACCR Data download:

```
Select *..Utility Options Option: cc  Create State/VACCR Data Download
    DISPLAY/PRINT on-line instructions? No//   NO

 Available record layouts:

  1) VACCR Record Layout v11.1 (VA Registry)
  2) NAACCR State Record Layout v11.1
  Exclude PHI COMORBIDITY codes: ? YES//

 Select record layout: 1  VACCR Record Layout v11.1

 Facility Identification Number (FIN): 6211145//
 Select date field to be used for Start/End range: ?

Select the date field you wish to use for this download's Start/End
range prompts.

     Select one of the following:

          1 Date Case Completed <<<<<<<<< USE TO REPORT NEW CASES
          2 Date Case Last Changed<<<<<<<<USE TO REPORT UPDATED CASES
          3 Accession Number
 Select date field to be used for Start/End range: 1  Date Case Completed
 Start, Date Case Completed:  010107
   End, Date Case Completed:  013007

 These are your current settings:

 Record layout.....................: VACCR EXTRACT V11.1
 Facility Identification Number (FIN): 6330250
 Start date........................: 1/1/11
 End date..........................: 1/30/11
Are these settings correct? YES//

      ------------------------------------------------------------
      |Please activate your PC capture program.  The data will be  |
      |sent in 2 minutes or when you press the return key.         |
      ------------------------------------------------------------
```

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Utility Tools

PC Capture Program

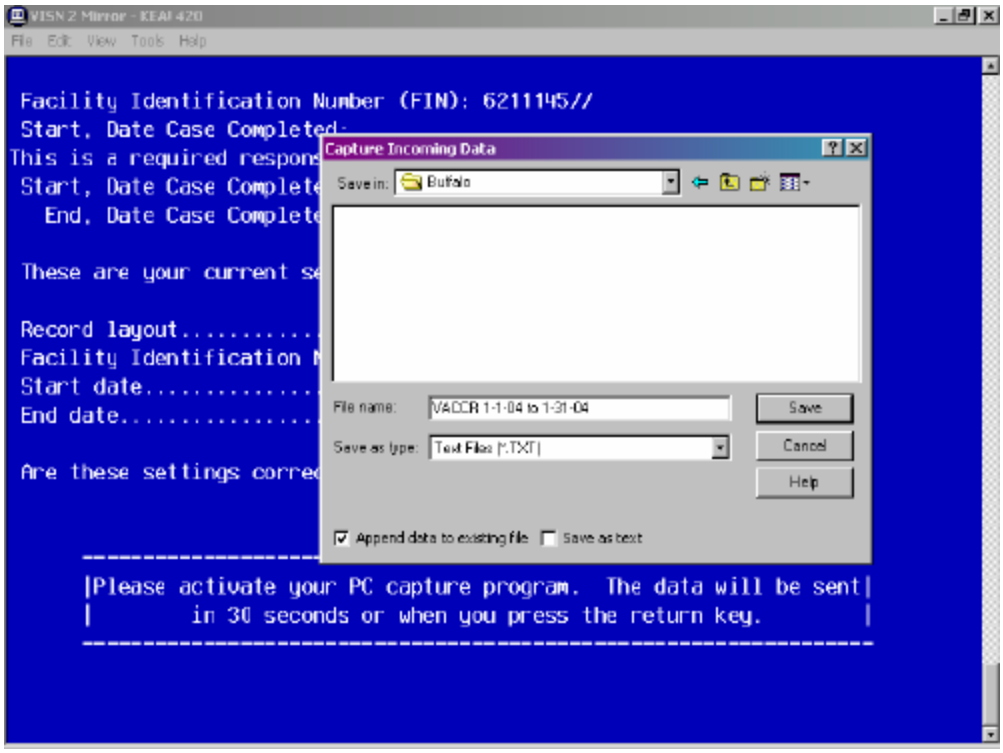
1. Activate your PC capture program.
2. Create a folder on your hard drive or network drive, in which you can save the data for VACCR.
3. Click **Save**. Make sure the **Save as text** is not selected; refer to the KEA Term illustration.
4. Data scrolls across your screen. When the data is done scrolling, a ⸮ (backward question mark).displays.
5. Click the appropriate item on your Toolbar to **End Capture**.
6. Using Microsoft Word, open the file you created.
7. Scroll to the end of the document. A square displays; it was the ⸮.
8. You must delete the square. Place the cursor to the right of it and backspace twice.
9. Use 🖫 (disk icon) on your Toolbar to **Save** your file…. *Do not save the file in Word format.*
10. Close the file.

KEA Term - Illustrated Directions

Note: If your terminal emulation software is not KEA, you may see different options.

Activating your PC capture program

1. Start a capture g File using KEA.
2. Click **Tools** at the top of the VISN 5 Mirror – KEA 420 window.
3. Click **Capture Incoming Data**.
4. Create a folder on your hard drive or network drive and name it so you know what is in the file.



5. Make sure the **Save as text** is not selected.
6. Click **Save**. The dialog box closes and the data scrolls across the screen.
   This can take a long time, depending on how many cases are sent.
7. When the data is done scrolling, a ʕ (backward question mark).displays, click **Tools**.
8. Click **End Capture**.
9. Open the newly created file in Microsoft Word.
   Example illustration: M:\VACCR\Washington\VACCR 1-4-04 to 1-31-04.txt
   Save in: Buffalo
   File name: VACCR 1-4-04 to 1-31-04
   Save as type: .txt

This is the file that you send by email to the VA Central Registry.

Emailing the VACCR file

The file you created must be emailed to the VA Central Registry. There are two methods by which you can do this.

VA PKI (Privacy Key Initiative) in your Microsoft Outlook.
If you do not have VA PKI, request it from the ISO at your facility.

State Reporting

The process for extracting a file to submit to your State Cancer Registry-

1. Start in the Utility Options
2. Select **CC** Create State/VACCR Data Download

```
***************UTILITY OPTIONS***************
```

```
    DISPLAY/PRINT on-line instructions? No//   NO

 Available record layouts:

  1) VACCR Record Layout v11.1 (VA Registry)
  2) NAACCR State Record Layout v11.1

 Select record layout: 2  NAACCR State Record Layout v11.1

 Facility Identification Number (FIN): 6211145//
 Select date field to be used for Start/End range: ?

Select the date field you wish to use for this download's Start/End
range prompts.

     Select one of the following:

          1         Date Case Completed <<<<<<<<< USE TO REPORT NEW CASES
          2         Date Case Last Changed<<<<<<<<USE TO REPORT UPDATED
   CASES

 Select date field to be used for Start/End range: 1  Date Case Completed
 Start, Date Case Completed:  010107
   End, Date Case Completed:  013107
Analytic cases only? YES// NO  <<<<<< If you want to report only Analytic
   cases choose yes, you can ask your state if they want them or not.

 These are your current settings:

 Record layout.....................: STATE EXTRACT V11.1
 Facility Identification Number (FIN): 6211145
 State to be extracted.............: NY
 Start date........................: 1/1/07
 End date..........................: 1/31/07
 Analytic cases only...............: NO
 Are these settings correct? YES//


      ------------------------------------------------------------
      |Please activate your PC capture program.  The data will be  |
      |sent in 2 minutes or when you press the return key.         |
      ------------------------------------------------------------
```

PC Capture Program

1. Activate your PC capture program.
2. Create a folder on your hard drive or network drive, in which you can save the data for VACCR.
3. Click **Save**. Make sure the **Save as text** is not selected; refer to the KEA Term illustration.
4. Data scrolls across your screen. When the data is done scrolling, a ؟ (backward question mark).displays.
5. Click the appropriate item on your Toolbar to **End Capture**.

6. Using Microsoft Word, open the file you created.
7. Scroll to the end of the document. A square displays; it was the ؟.
8. You must delete the square. Place the cursor to the right of it and backspace twice.
9. Use 🖫 (disk icon) on your Toolbar to **Save** your file…. *Do not save the file in Word format.*
10. Close the file.

This is the file that you send to the state. You need instructions from your state, regarding how to transmit the data.

Downloading Your Data from VistA for the ACoS

1. Start in Utility Options.
2. Select CT Create ACoS Data Disk.
3. Activate your PC capture program when you see:

```
------------------------------------------------------------------------
   |Please activate your PC capture program.  The data will be sent|
   in 30 seconds or when you press the return key.
```

4. Name the file, 8 characters or less.
5. Move the file to an accessible place on your hard drive or network drive. The filename in the *path* to the file cannot contain more than 8 characters.

   Note: Do not place the file on your desktop. The path to the file is too complicated for this strictly MS DOS program. (M:\2004BUF.TXT)

6. Data scrolls across your screen. When the data is done scrolling, a ؟ (backward question mark).displays.
7. Click the appropriate item on your Toolbar to **End Capture**.
8. Using Microsoft Word, open the file you created.
9. Scroll to the end of the document. A square displays; it was the ؟.
10. You must delete the square. Place the cursor to the right of it and backspace twice.
11. Use 🖫 (disk icon) on your Toolbar to **Save** your file…. *Do not save the file in Word format.*
12. If a dialog box displays, click **Yes**.
13. Close the file.
14. Make a note of the filename and the path to it.

    Note: Run the data through EDITS, before sending it to the ACoS.

Downloading and Installing Genedits >>NEED LATEST<<<<

Refer to American College of Surgeon's NCDB website for instructions on software needed and submission instructions for current year's Call for data: https://www.facs.org/quality-programs/cancer/ncdb/datasub/edits

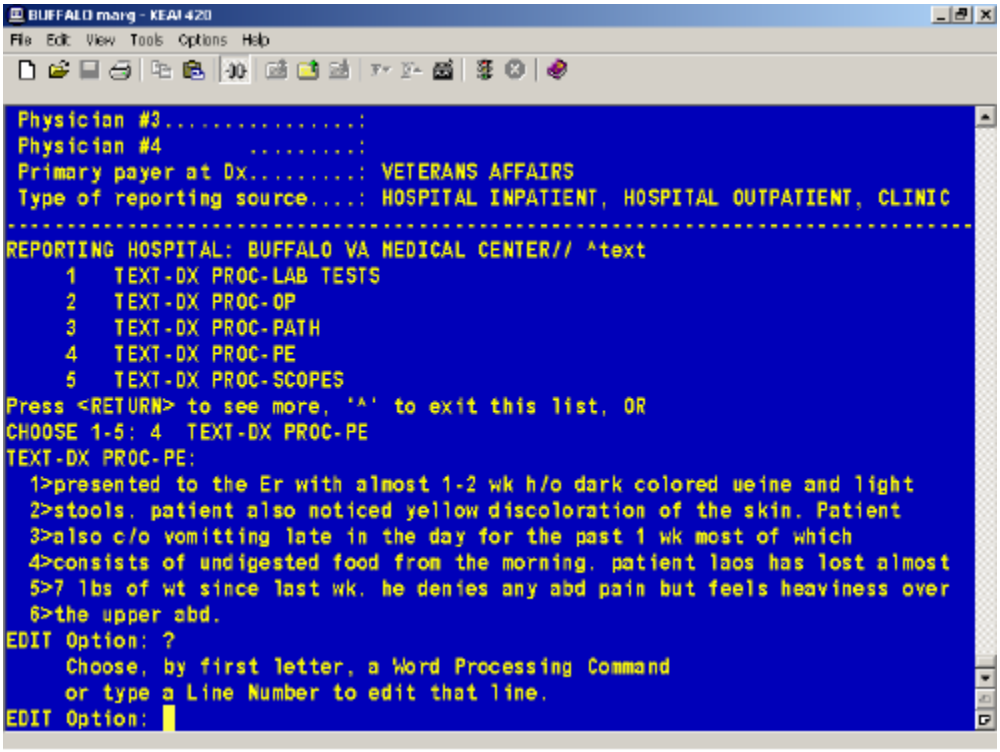
VistA Setup

VistA can be set up in different ways.

Line Editor

If you are set up with **Line Editor** in VistA, your screen for entering text can look like the example, TEXT-DX PROC-PE:. The number lines make editing a little difficult.

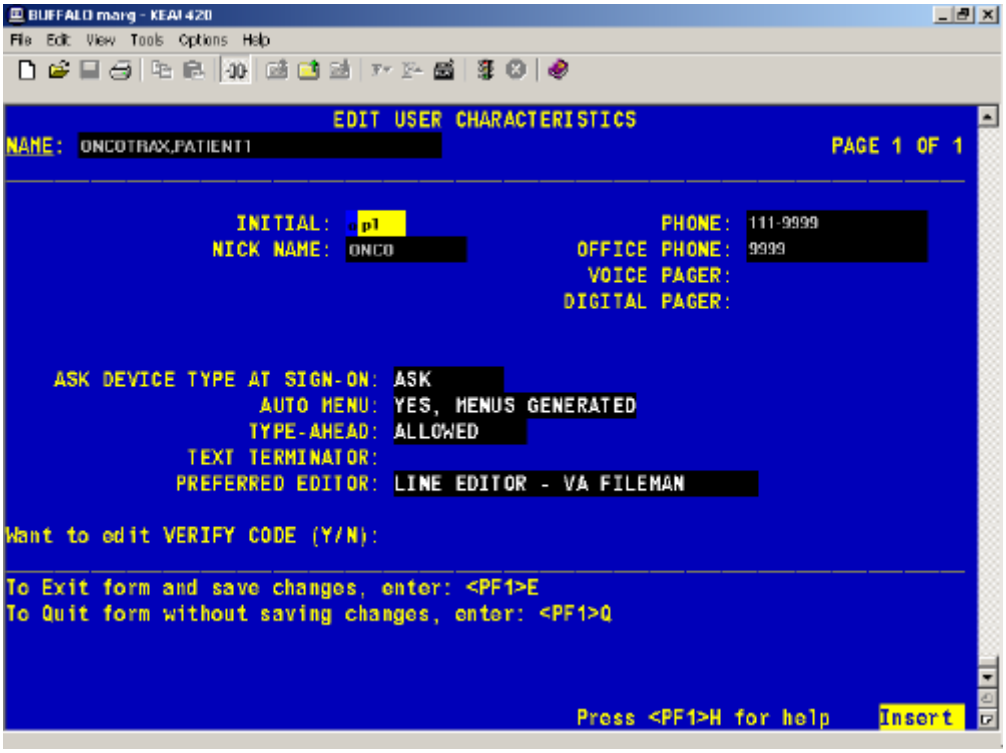
Example of the Line Editor Screen



Screen Editor

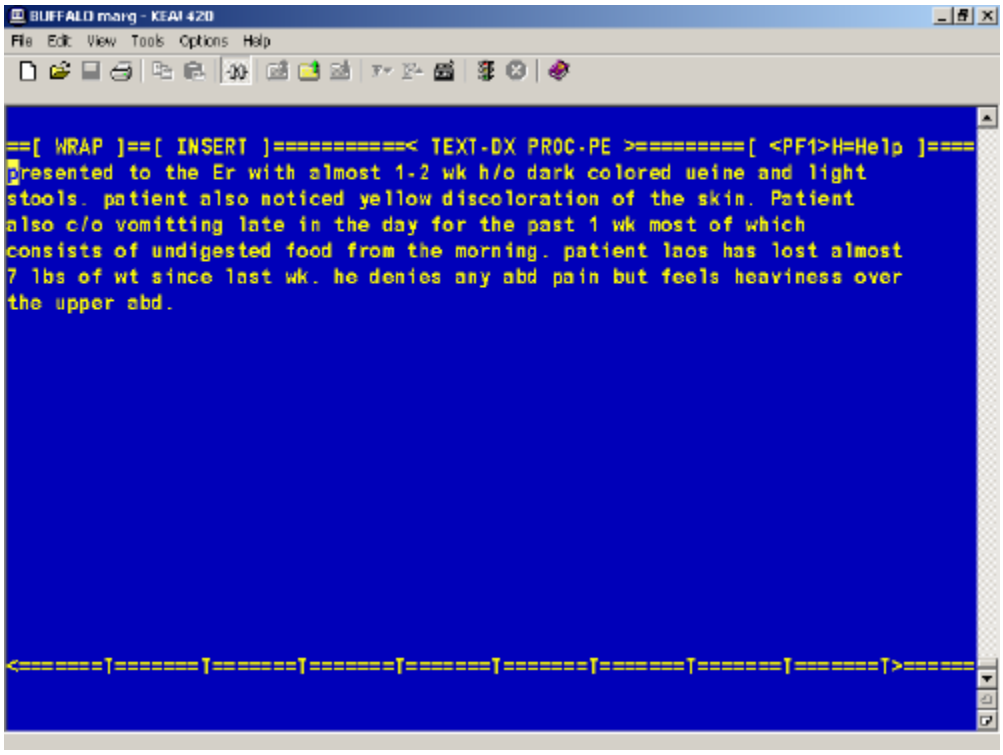
You can change to a more user-friendly word processing screen. Using the **Screen Editor**, you are able to move around easily, format your text, and do many things that are impossible with the line editor.

1. To change to the **Screen Editor**, type **^EDIT USER CHARACTERISTICS**..
2. Tab or arrow down to PREFERRED EDITOR: LINE EDITOR – VA FILEMAN.



3. Change **LINE** to **SCREEN**.

Example of the Screen Editor Screen

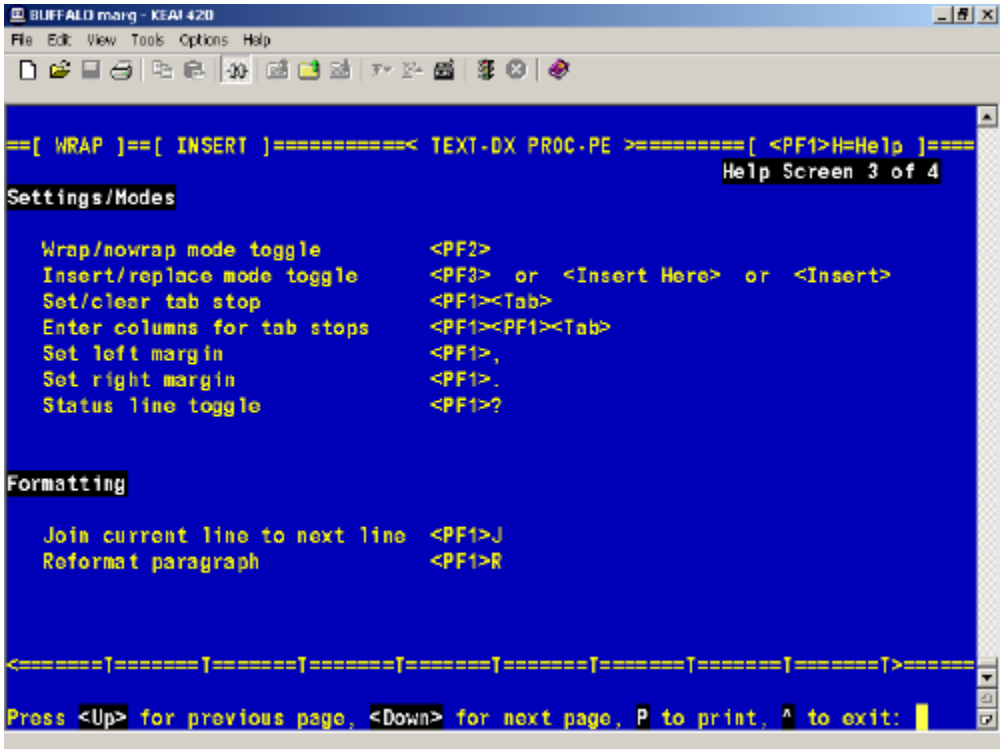


You can type in this screen, just like in Microsoft Word or Word Perfect. You are able to change margins, format text, join lines together, cut and paste text, easily delete text, and so on.

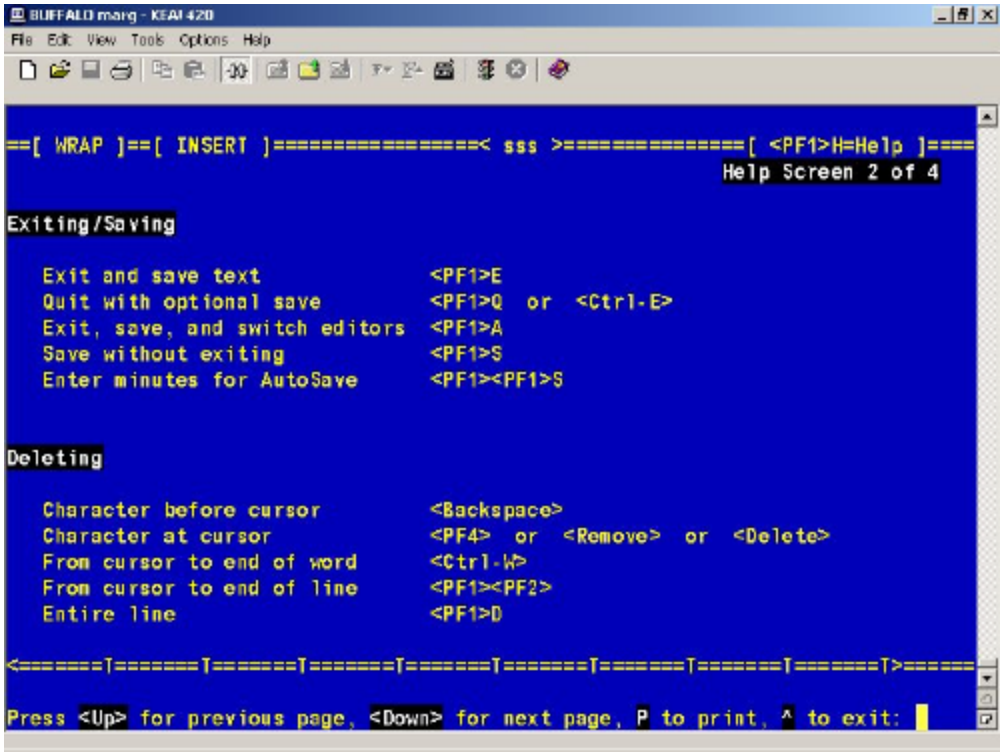
Type **F1H** (H for help) to access word processing Help commands for the Screen Editor.

There are four Help screens to which you can navigate. Use the Arrow keys (to the left of the number pad) to move around the Help screens. Help Screen 3 of 4 is the most useful of the Help screens.

Example of Help Screen 3 of 4

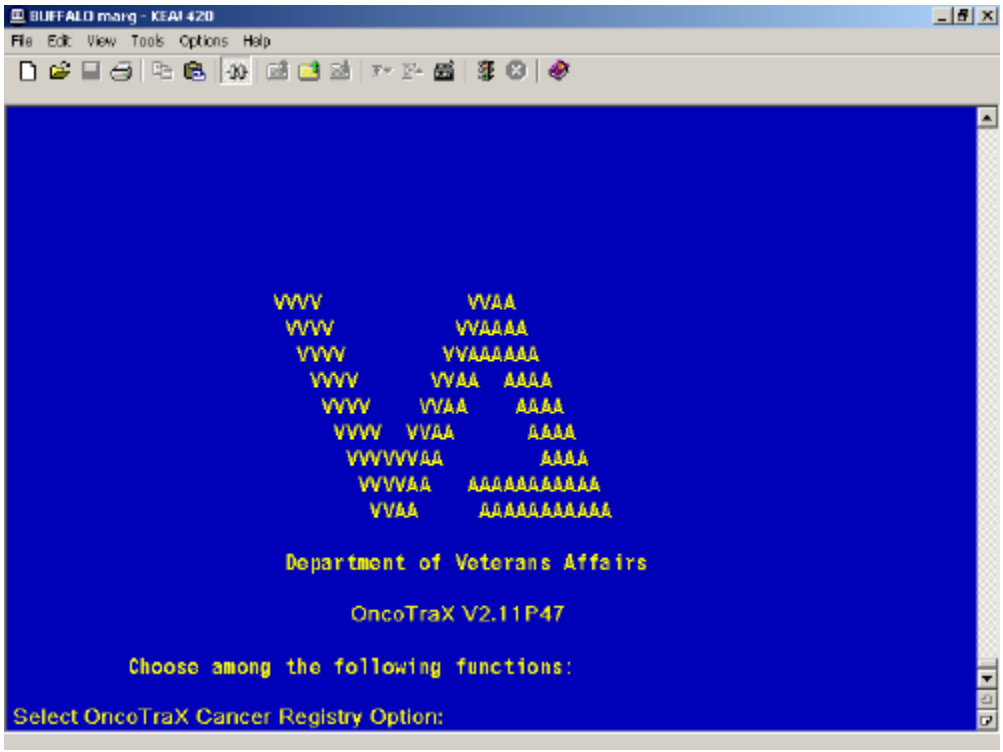


Example of Help Screen 2 of 4

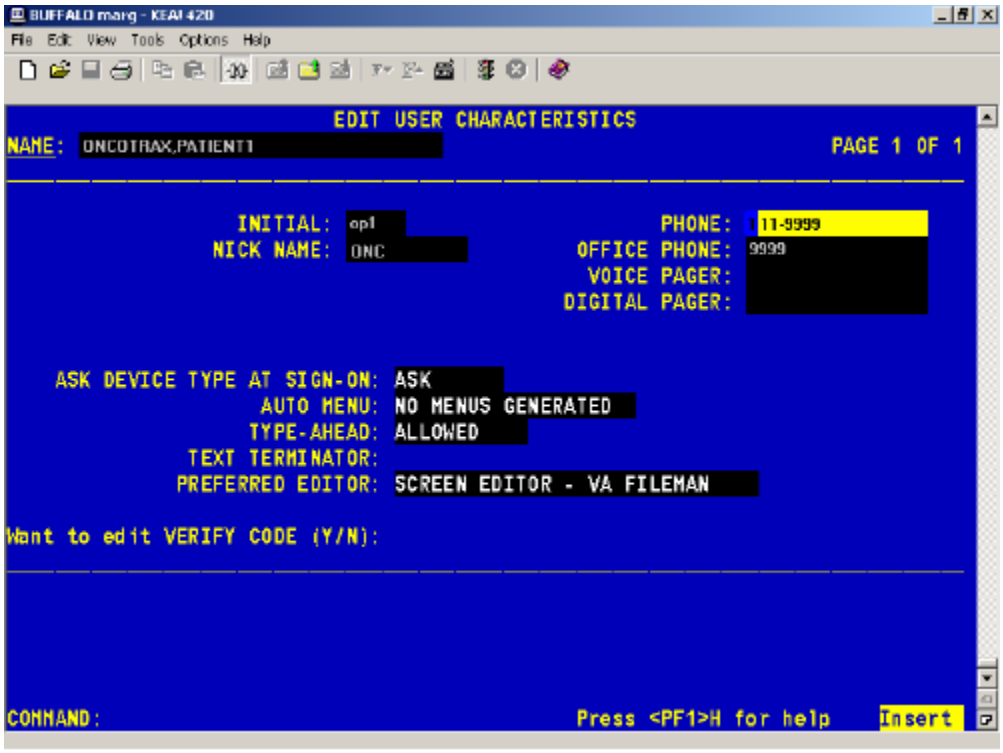


Menu Options

When you sign on to VistA, your screen may be set up not to display menus. You may want to change your set up options, so that you can see your menu choices.

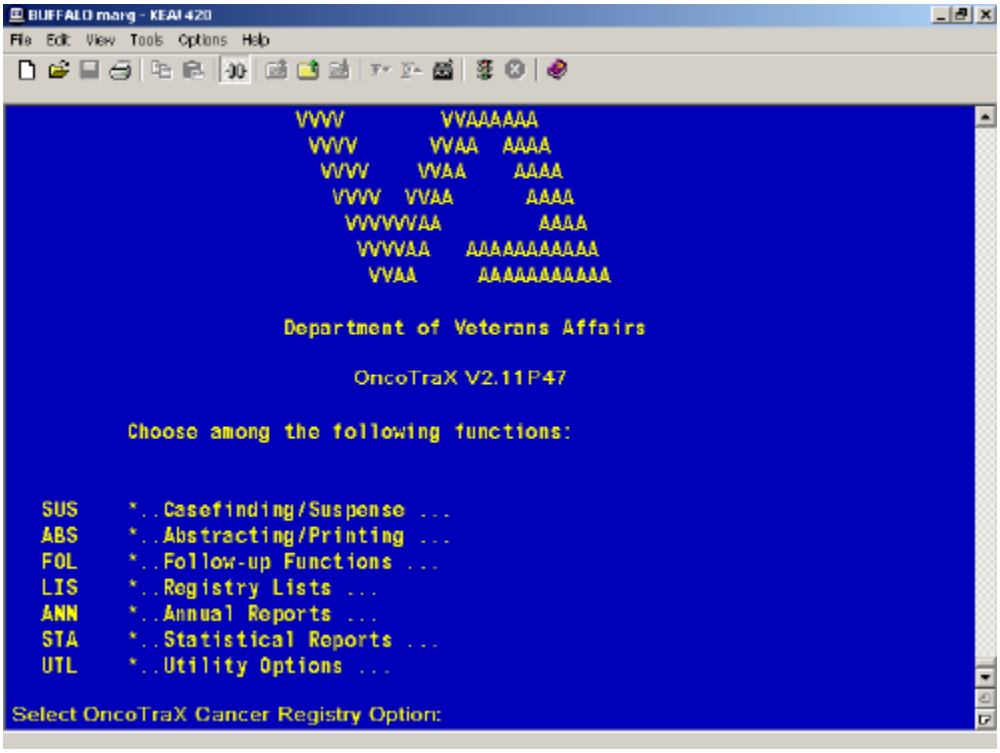


1. At Select OncoTraX: Cancer Registry Option, type **^EDIT USER CHARACTERISTICS**.
2. Arrow down to AUTO MENU: and type ? Your options display.

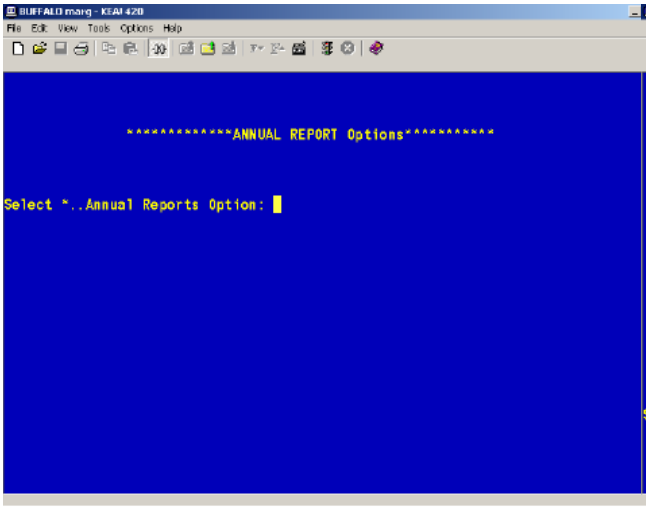


3. Select 1 YES, MENUS GENERATED.

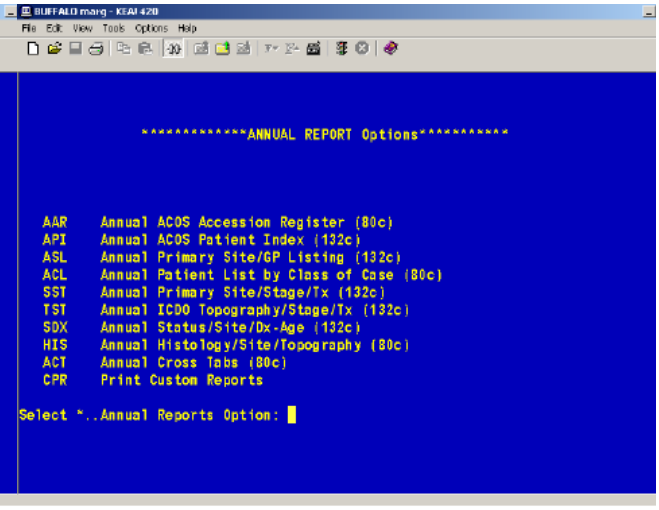
Your menu choices display when you access VistA.



Before



After



Edits within OncoTraX

If there are inter-field problems, warning messages display when you attempt to change the **ABSTRACT STATUS (165.5,91)** to **Complete** These warning messages are the VistA inter-field edit checks. You can override these warnings.

1	WARNING: REPORTING HOSPITAL = REFERRING FACILITY
2	WARNING: REPORTING HOSPITAL = TRANSFER FACILITY
3	WARNING: CLASS OF CASE = 2 (Dx ew, 1st rx here) -REFERRING FACILITY may not be blank
4	WARNING: CLASS OF CASE = 3 (Dx ew, 1st rx ew) REFERRING FACILITY may not be blank
5	WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew)-DATE OF FIRST CONTACT..: later than SURGERY OF PRIMARY SITE DATE.:
6	WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT. later than RADIATION DATE.....:
7	WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT..: later than RADIATION THERAPY TO CNS DATE:
8	WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT..: later than CHEMOTHERAPY DATE.....:
9	WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT..:
10	WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT..: later than IMMUNOTHERAPY DATE.....:
11	WARNING: CLASS OF CASE = 0 (Dx here, 1st rx ew) DATE OF FIRST CONTACT..: later than OTHER TREATMENT DATE.....:
12	WARNING: CLASS OF CASE = 2 (Dx ew, 1st rx here) DATE OF FIRST CONTACT..: earlier than DATE DX.....:
13	WARNING: TYPE OF REPORTING SOURCE = 6 (Autopsy only) CLASS OF CASE must be 5 (Dx at autopsy)
14	WARNING: CLASS OF CASE = 5 (Dx at autopsy) TYPE OF REPORTING SOURCE must be 6 (Autopsy only)
15	WARNING: TYPE OF REPORTING SOURCE = 6 (Autopsy only) DIAGNOSTIC CONFIRMATION must be 1 (Pos histology) or 6 (Direct visualization)
16	WARNING: TYPE OF REPORTING SOURCE = 7 (Death certificate only) DIAGNOSTIC CONFIRMATION must be 9 (Unk if microscopically confirmed)

17	WARNING: XXX is a paired site LATERALITY may not be 0 (Not a paired site)
18	WARNING: XXX is an unpaired site LATERALITY must be 0 (Not a paired site)
19	WARNING: BONES, PELVIS, SACRUM, COCCYX is a paired site
20	WARNING: BEHAVIOR CODE = 2 (In situ) SUMMARY STAGE must be 0 (In situ)
21	WARNING: BEHAVIOR CODE = 3 (Malignant) SUMMARY STAGE may not be 0 (In situ)
22	WARNING: HISTOLOGY = 8331 FOLLICULAR ADENOCA, WELL DIFF GRADE/DIFFERENTIATION must be 1 (Grade I)
23	WARNING: HISTOLOGY = 8851 LIPOSARCOMA, WELL DIFFGRADE/DIFFERENTIATION must be 1 (Grade I)
24	WARNING: HISTOLOGY = 9511 RETINOBLASTOMA, DIFFERENTIATED GRADE/DIFFERENTIATION must be 1 (Grade I)
25	WARNING: HISTOLOGY = 9083 TERATOMA, INTERMEDIATE GRADE/DIFFERENTIATION must be 2 (Grade II)
26	WARNING: HISTOLOGY = 8020 CARCINOMA, UNDIFFERENTIATED GRADE/ DIFFERENTIATION must be 4 (Grade IV)
27	WARNING: HISTOLOGY = 8021 CARCINOMA, ANAPLASTIC NOS GRADE/DIFFERENTIATION must be 4 (Grade IV)
28	WARNING: HISTOLOGY = 9062 SEMINOMA, ANAPLASTIC TYPE GRADE/DIFFERENTIATION must be 4 (Grade IV)
29	WARNING: HISTOLOGY = 9082 TERATOMA, ANAPLASTIC GRADE/DIFFERENTIATION must be 4 (Grade IV)
30	WARNING: HISTOLOGY = 9390 CHOROID PLEXUS PAPILLOMA GRADE/DIFFERENTIATION must be 4 (Grade IV)
31	WARNING: HISTOLOGY = 9401 ASTROCYTOMA, ANAPLASTIC GRADE/DIFFERENTIATION must be 4 (Grade IV)
32	WARNING: HISTOLOGY = 9451 OLIGODENDROGLIOMA, ANAPLASTIC GRADE/DIFFERENTIATION must be 4 (Grade IV)
33	WARNING: HISTOLOGY = 9512 RETINOBLASTOMA, UNDIFFGRADE/DIFFERENTIATION must be 4 (Grade IV)
34	WARNING: HISTOLOGY = 9696 LYMPHOMA, LYMPH. POOR DIFF. NOD GRADE/DIFFERENTIATION must be: 3 (Grade III) or 5 (T-cell) or 6 (B-cell) or 7 (Null cell)
35	WARNING: HISTOLOGY = 9694 LYMPHOMA, LYMPH. INT. DIFF. NOD GRADE/DIFFERENTIATION must be: -2 (Grade II) or 5 (T-cell) or 6 (B-cell) or7 (Null cell) or 9 (Unknown)

36	WARNING: HISTOLOGY = 9683 LYMPHOMA CENTROBLASTIC DIFFGRADE/DIFFERENTIATION must be: 4 (Grade IV) or5 (T-cell) or 6 (B-cell) or7 (Null cell)
37	WARNING: GRADE/DIFFERENTIATION = 5 (T-cell) HISTOLOGY must be leukemia or lymphoma (9590-9941)
38	WARNING: GRADE/DIFFERENTIATION = 6 (B-cell) HISTOLOGY must be leukemia or lymphoma (9590-9941)
39	WARNING: GRADE/DIFFERENTIATION = 7 (Null cell) HISTOLOGY must be leukemia or lymphoma (9590-9941)
40	WARNING: GRADE/DIFFERENTIATION = 8 (Natural killer cell) HISTOLOGY must be leukemia or lymphoma (9590-9941)
41	WARNING: No TNM classification is available for LYMPHOMA SUMMARY STAGE cannot be blank
41	WARNING: No TNM classification is available for KAPOSI'S SARCOMA SUMMARY STAGE cannot be blank
43	WARNING: BEHAVIOR CODE = 3 (Malignant) EXTENSION may not be 00 (In situ)
44	WARNING: ICDO-TOPOGRAPHY = XXX PATHOLOGIC EXTENSION = XXX
45	PATHOLOGIC EXTENSION may only be coded for PROSTATE (C61.9) cases
46	WARNING: NODES POSITIVE (REGIONAL) = 01-97 LYMPH NODES may not be 0 (No lymph nodes)
47	WARNING: ICDO-TOPOGRAPHY = XXX HORMONE THERAPY = 2 (Endocrine surgery and/or radiation) Only BREAST and PROSTATE cases may be coded as receiving endocrine surgery or endocrine radiation
48	WARNING: STATUS = Dead PLACE OF DEATH may not be blank
49	WARNING: STATUS = Dead CAUSE OF DEATH and STATE DEATH CERT may not both be blank
50	WARNING: For race combinations RACE 1 may not be 'White'
51	WARNING: A specific race code may not occur more than once
52	If REGIONAL NODES EXAMINED is 99 (Unknown if nodes examined, NA), REGIONAL NODES POSITIVE must be 99 (Unk if nodes + or -, NA)

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Edits within Genedits

Messages display for the Veterans Administration Edits Metafile (Current version of NAACR – Hospital All metafile). The cross-field edits are skipped when a single-field edit fails.

Refer to the NAACR website for a detail report of these Edit messages:
http://www.naaccr.org/StandardsandRegistryOperations/VolumeIV.aspx

Veterans_Administration_v15 Edits
NAACCR Released February 20, 2015

Abstracted By (COC)
Abstracted By (NAACCR)
Abstracted By, Date of Diagnosis (COC)
Accession Number, Class of Case, Seq Number (COC)
Accession Number--Hosp (COC)
Addr at DX--City (COC)
Addr at DX--City (NAACCR)
Addr at DX--City, Date of Diagnosis (COC)
Addr at DX--Country (COC)
Addr at DX--Country (NAACCR)
Addr at DX--Country, Date of Diagnosis (COC)
Addr at DX--Country, Date of Diagnosis (NAACCR)
Addr at DX--Country, State (NAACCR)
Addr at DX--No/Street (COC)
Addr at DX--No/Street (NAACCR)
Addr at DX--No/Street, Date of Diagnosis (COC)
Addr at DX--Postal Code (NAACCR)
Addr at DX--Postal Code, Addr at DX--State (COC)
Addr at DX--State (COC)
Addr at DX--State (NAACCR)
Addr at DX--State, Date of Diagnosis (COC)
Addr at DX--State, Postal Code Range (NAACCR)
Addr at DX--Supplementl (COC)
Addr Current--City (COC)
Addr Current--City (NAACCR)
Addr Current--City, Date of Diagnosis (COC)
Addr Current--Country (COC)
Addr Current--Country (NAACCR)
Addr Current--Country, Date of Diagnosis (COC)
Addr Current--Country, Date of Diagnosis (NAACCR)
Addr Current--Country, State (NAACCR)
Addr Current--No/Street (COC)
Addr Current--No/Street (NAACCR)
Addr Current--No/Street, Date of Diagnosis (COC)

Addr Current--Postal Code (COC)
Addr Current--Postal Code (NAACCR)
Addr Current--Postal Code, Addr Current-State (COC
Addr Current--Postal Code, Date of Diagnosis (COC)
Addr Current--State (COC)
Addr Current--State (NAACCR)
Addr Current--State, Date of Diagnosis (COC)
Addr Current--Supplementl (COC)
Age at Diagnosis (SEER AGEDX)
Age at Diagnosis, Text--Usual Industry (NAACCR)
Age at Diagnosis, Text--Usual Occupation (NAACCR)
Age, Birth Date, Date of Diagnosis (NAACCR IF13)
Age, Histologic Type, COD, ICDO3 (SEER IF43)
Age, Primary Site, Morph ICDO3--Adult (SEER)
Age, Primary Site, Morph ICDO3--Pediatric (NPCR)
Age, Primary Site, Morphology ICDO2 (SEER IF15)
Age, Primary Site, Morphology ICDO3 (SEER IF15)
Ambig Term DX, Date Conclusive DX (SEER IF162)
Ambiguous Terminology DX (SEER)
Ambiguous Terminology DX, Date of DX (CCCR)
Ambiguous Terminology DX, Date of DX (SEER IF157)
Archive FIN (COC)
Archive FIN, Date of Diagnosis (COC)
Autopsy Only, RX (NPCR)
Behav ICDO2, Date of DX, ICDO2 Conv Flag(SEER IF85
Behav ICDO3, Date of DX, ICDO3 Conv Flag(SEER IF87
Behavior (73-91) ICD-O-1 (SEER)
Behavior Code ICDO2, Sequence Number--Hosp (COC)
Behavior Code ICDO3, Seq Num--Central (SEER IF114)
Behavior Code ICDO3, Sequence Number--Hosp (COC)
Behavior ICDO2 (COC)
Behavior ICDO2, Behavior ICDO3 (SEER IF115)
Behavior ICDO2, Date of Diagnosis (NAACCR)
Behavior ICDO2, Histology ICDO2 (NAACCR)
Behavior ICDO2, Summary Stage 1977 (NAACCR)
Behavior ICDO3 (COC)
Behavior ICDO3 Conversion (NAACCR)
Behavior ICDO3, Date of Diagnosis (NAACCR)
Behavior ICDO3, Site, Histology ICDO3 (NAACCR)
Behavior ICDO3, Summary Stage 1977 (NAACCR)
Behavior ICDO3, Summary Stage 2000 (NAACCR)
Birthplace (SEER POB)
Birthplace, Country, State (NAACCR)
Birthplace--Country (COC)
Birthplace--Country (NAACCR)

Birthplace--Country, Date of Diagnosis (COC)
Birthplace--Country, Date of Diagnosis (NAACCR)
Birthplace--Country, State (NAACCR)
Birthplace--State (COC)
Birthplace--State (NAACCR)
Birthplace--State, Date of Diagnosis (COC)
Birthplace--State, Date of Diagnosis (NAACCR)
Bladder, RX Hosp--Surg Prim Site, BRM (COC)
Bladder, RX Summ--Surg Prim Site, BRM (COC)
Cancer Status (COC)
Cancer Status (NAACCR)
Casefinding Source (NAACCR)
Casefinding Source, Date of DX (SEER IF153)
Cause of Death (NAACCR)
Cause of Death (SEER COD)
Census Block Group 2000 (NAACCR)
Census Block Group 2010 (NAACCR)
Census Block Grp 1970-90 (NAACCR)
Census Cod Sys 1970/80/90 (SEER RESSYST)
Census Cod Sys 1970/80/90, Date of Diag (SEER IF49
Census Ind Code 1970-2000 vs. Coding System (NPCR)
Census Ind Code 2010 (NPCR)
Census Occ Code 1970-2000 vs. Coding System (NPCR)
Census Occ Code 2010 (NPCR)
Census Occ/Ind Sys 70-00 (NPCR)
Census Tr Cert 1970/80/90 (SEER CENSCERT)
Census Tr Certainty 2000 (SEER)
Census Tr Certainty 2000, Date of DX (SEER IF112)
Census Tr Certainty 2010 (SEER)
Census Tr Poverty Indictr (SEER)
Census Tr Poverty Indictr, Date of DX (NPCR)
Census Tr Poverty Indictr, Date of DX (SEER)
Census Tract 1970/80/90 (SEER TRACT)
Census Tract 1970/80/90, Census Cod Sys (SEER IF45
Census Tract 2000 (SEER)
Census Tract 2000, Date of DX (SEER IF111)
Census Tract 2000, State, County at DX (NPCR)
Census Tract 2000, State, County, 2000-2009 (NPCR)
Census Tract 2010 (SEER)
Census Tract 2010, State, County at DX (NPCR)
Census Tract 2010, State, County, 2010-2019 (NPCR)
Cervix In Situ ICDO3 (SEER IF88)
Class of Case (COC)
Class of Case, RX (COC)
Class of Case, Date of 1st Cont, Date of DX (COC)

Class of Case, Type of Reporting Source (NAACCR)
Class of Case,Prim Site,Hist, Beh,DX (COC)
Class, Date Diag, Date Last Cont, Vit Stat (COC)
COC Coding Sys--Curr, COC Coding Sys--Orig (COC)
COC Coding Sys--Current (COC)
COC Coding Sys--Current (NAACCR)
COC Coding Sys--Current, Date of Diagnosis (NAACCR
COC Coding Sys--Original (COC)
COC Coding Sys--Original, Date of Diagnosis (COC)
COC Coding Sys--Original, Date of DX (NAACCR)
Coding System for EOD (SEER EODSYST)
Comorbid/Compl 1, Secondary DX 1, Date DX (COC)
Comorbid/Complication 1 - 10 (COC)
Comorbid/Complication 1, Date DX (COC)
Comorbid/Complication 10, Date DX (COC)
Comorbid/Complication 2, Date DX (COC)
Comorbid/Complication 3, Date DX (COC)
Comorbid/Complication 4, Date DX (COC)
Comorbid/Complication 5, Date DX (COC)
Comorbid/Complication 6, Date DX (COC)
Comorbid/Complication 7, Date DX (COC)
Comorbid/Complication 8, Date DX (COC)
Comorbid/Complication 9, Date DX (COC)
CompEthn, Date of Diag (SEER IF71)
Computed Ethnicity (SEER COMPETHN)
Computed Ethnicity Source (SEER ETHNSRC)
County (SEER IFCOUNTY)
County at DX (COC)
County at DX (NAACCR)
County at DX (NPCR)
County at DX, Addr at DX--State (NAACCR)
County at DX, Date of Diagnosis (COC)
CS Eval Items, Class of Case (CS)
CS Eval Items, Type of Reporting Source (CS)
CS Eval Items, Vital Status (CS)
CS Ext, Histol ICDO3, Breast Schema (CS)
CS Ext, LN, Mets at DX, SSF 1, Retinoblastoma (CS)
CS Ext, LN, Mets at DX, SSF 3, Prostate (CS)
CS Ext, Surg, TS/Ext Eval, Prostate (CS)
CS Ext,TS/Ext Eval, SSF 1, MelanomaConjunc (CS)
CS Extension (CS)
CS Extension, Brain Schema (CS)
CS Extension, CS Lymph Nodes, CS Mets at DX (CS)
CS Extension, CS Tumor Size, Breast Schema (CS)
CS Extension, CS Tumor Size, MycosisFungoides (CS)

CS Extension, CS Tumor Size, Site, Hist ICDO3 (CS)
CS Extension, Hematopoietic (CS)
CS Extension, Hist, Grade, Esophagus Schema (CS)
CS Extension, Hist, Grade, EsophagusGEJunction(CS)
CS Extension, Histology, Grade, Thyroid (CS)
CS Extension, KidneyRenalPelvis Schema (CS)
CS Extension, Lymphoma Schema (CS)
CS Extension, Morphology, Bladder ICDO3 (CS)
CS Extension, Mycosis Fungoides Schema (CS)
CS Extension, MyelomaPlasmaCellDisorder (CS)
CS Extension, Primary Site, Behavior ICDO3 (CS)
CS Extension, Schema (CS)
CS Extension, SSF 1, Conjunctiva Schema (CS)
CS Extension, SSF 1, Head and Neck Schemas (CS)
CS Extension, SSF 1, Lung Schema (CS)
CS Extension, SSF 1, MelanomaConjunctiva (CS)
CS Extension, SSF 1, Thyroid Schema (CS)
CS Extension, SSF 11, MerkelCellVulva Schema (CS)
CS Extension, SSF 11, Vulva Schema (CS)
CS Extension, SSF 16, MerkelCell Schemas (CS)
CS Extension, SSF 16, Scrotum Schema (CS)
CS Extension, SSF 16, Skin Schema (CS)
CS Extension, SSF 17, MerkelCell Schemas (CS)
CS Extension, SSF 17, Penis Schema (CS)
CS Extension, SSF 18, MerkelCell Schemas (CS)
CS Extension, SSF 2, Bladder Schema (CS)
CS Extension, SSF 2, KidneyRenalPelvis (CS)
CS Extension, SSF 2, Lung Schema (CS)
CS Extension, SSF 2, MelanomaChoroid (CS)
CS Extension, SSF 2, MelanomaCiliaryBody (CS)
CS Extension, SSF 2, Vagina Schema (CS)
CS Extension, SSF 24, Breast Schema (CS)
CS Extension, SSF 3, Behavior, Prostate (CS)
CS Extension, SSF 3, Bladder Schema (CS)
CS Extension, SSF 3, Breast Schema (CS)
CS Extension, SSF 3, CorpusCarcinoma Schema (CS)
CS Extension, SSF 3, Head and Neck Schemas (CS)
CS Extension, SSF 3, MelanomaChoroid (CS)
CS Extension, SSF 3, MelanomaCiliaryBody (CS)
CS Extension, SSF 4, FallopianTube Schema (CS)
CS Extension, SSF 4, Head and Neck Schemas (CS)
CS Extension, SSF 4, Vagina Schema (CS)
CS Extension, SSF 5, CorpusCarcinoma Schema (CS)
CS Extension, SSF 5, Head and Neck Schemas (CS)
CS Extension, SSF 5, Testis Schema (CS)

CS Extension, SSF 6, FallopianTube Schema (CS)
CS Extension, SSF 6, Head and Neck Schemas (CS)
CS Extension, SSF 6, Vagina Schema (CS)
CS Extension, SSF 8, KidneyParenchyma (CS)
CS Extension, SSF 9, Head and Neck Schemas (CS)
CS Extension, Surgery, Prostate Schema (CS)
CS Extension, TS/Ext Eval, Prostate Schema (CS)
CS Extension, Tumor Size, Lung Schema (CS)
CS Items - CCCR Required - Non-SSF (CS)
CS Items - CCCR Required - SSF 1 (CS)
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CS Items - CCCR Required - SSF 11 (CS)
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CS Items - SEER Required - SSF 1 (CS)
CS Items - SEER Required - SSF 10 (CS)
CS Items - SEER Required - SSF 11 (CS)
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CS Items - SEER Required - SSF 8 (CS)
CS Items - SEER Required - SSF 9 (CS)
CS Items, DX Pre-2004 (CS)
CS Items, DX Pre-2004 (SEER)
CS Items, Type Reporting Source-DCO (CS)

CS LN, Nodes Eval, SSF 3, MelanomaSkin (CS)
CS LN, Nodes Eval, SSF 3, MerkelCellPenis (CS)
CS LN, Nodes Eval, SSF 3, MerkelCellScrotum (CS)
CS LN, Nodes Eval, SSF 3, MerkelCellSkin (CS)
CS LN, Nodes Eval, SSF 3, MerkelCellVulva (CS)
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CS Lymph Nodes (CS)
CS Lymph Nodes Eval (CS)
CS Lymph Nodes Eval, Lymph Nodes, Breast Schema(CS
CS Lymph Nodes Eval, Nodes Ex (CS)
CS Lymph Nodes Eval, Schema (CS)
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CS Lymph Nodes, Lymph Nodes Eval, RNP (CS)
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CS Lymph Nodes, Nodes Pos, ColoAppRectal (CS)
CS Lymph Nodes, Nodes Pos, MelanomaSkin (CS)
CS Lymph Nodes, Nodes Pos, MerkelCell Schemas(CS)
CS Lymph Nodes, Nodes Pos, SSF3, Breast Schema(CS)
CS Lymph Nodes, Regional Nodes Positive (CS)
CS Lymph Nodes, Schema (CS)
CS Lymph Nodes, SSF 1, Head/Neck Schemas (CS)
CS Lymph Nodes, SSF 17, Penis (CS)
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CS Lymph Nodes, SSF3, Nodes Eval, MelanomaSkin(CS)
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CS Mets at DX, Rectum Schema (CS)
CS Mets at DX, Schema (CS)
CS Mets at DX, SSF 20, Breast Schema (CS)
CS Mets at DX, SSF 4, MelanomaChor/Cil/Iris(CS)
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CS Mets at DX-Bone (CS)
CS Mets at DX-Bone, CS Mets at DX (CS)
CS Mets at DX-Brain (CS)
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CS Mets at DX-Liver (CS)
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CS Mets at DX-Lung, CS Mets at DX (CS)
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CS Mets Eval, Mets at DX, CS Version Inp Orig (CS)

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CS Over-ride CS 20, Rpt Srce, CS Fields (NPCR)
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CS Site-Specific Factor 1, Schema (CS)
CS Site-Specific Factor 2 (CS)
CS Site-Specific Factor 2, Schema (CS)
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CS Site-Specific Factor24, Schema (CS)
CS Site-Specific Factor25 (CS)
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CS SSF 1, Brain, CNSOther, IntracranialGland (CS)
CS SSF 1, CS SSF 3, Lower GI Schemas (CS)
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CS SSF 1, Histol, Urothelial Schemas (CS)
CS SSF 1, Lymph Nodes, CorpusAdenosarcoma (CS)
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CS SSF 1, SSF 2, Prostate Schema (CS)
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CS SSF 1, Surg, DX/Stg, Sarcomas (CS)
CS SSF 1, Surg, DX/Stg, Skin/Scrotum/Merkel(CS)
CS SSF 1, Surg, Sarcomas (CS)
CS SSF 1, Surg, Skin/Scrotum/Merkel (CS)
CS SSF 1, Surg, Urothelial Schemas (CS)
CS SSF 1, Surgery, KidneyParenchyma Schema (CS)
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CS SSF 10, Lymph Nodes, Vulva Schema (CS)
CS SSF 10, SSF 11, Breast (CS)
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CS SSF 11, GISTAppendix, Colon, Rectum (CS)
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CS SSF 11, Surg, DX/Stg Proc, Appendix Schema (CS)
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CS SSF 2, Dx Conf, KidneyRenalPelvis (CS)
CS SSF 2, Ext, KidneyRenalPelvis (CS)
CS SSF 2, Extension, KidneyParenchyma Schema (CS)
CS SSF 2, Extension, Ovary Schema (CS)
CS SSF 2, LN, LN Eval, RNP, SmallIntestine (CS)
CS SSF 2, Lower GI Schemas (CS)
CS SSF 2, Lymph Nodes, Bladder (CS)
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CS SSF 2, Lymph Nodes, PeritoneumFemaleGen (CS)
CS SSF 2, Lymph Nodes, Vagina (CS)
CS SSF 2, Mets at DX, Vagina (CS)
CS SSF 2, MyelomaPlasmaCellDisorder (CS)
CS SSF 2, RX Summ--Surg, DX/Stg, Pleura (CS)
CS SSF 2, RX Summ--Surg, Oth, DX/Stg, Lung (CS)
CS SSF 2, RX Summ--Surg, Pleura (CS)
CS SSF 2, SSF 3, Vagina (CS)
CS SSF 2, Surg, KidneyRenalPelvis (CS)
CS SSF 2, Surgery, KidneyParenchyma Schema (CS)
CS SSF 21, TS/Ext Eval, LN Eval, Breast (CS)
CS SSF 22, SSF 23, Breast (CS)
CS SSF 22, SSF 23, Surgery, DX/Stg, Breast (CS)
CS SSF 25, PeritoneumFemaleGen (CS)
CS SSF 3, RX Summ--SurgMargins, Prost Schema (CS)
CS SSF 3, Breast Schema (CS)
CS SSF 3, Extension, KidneyParenchyma Schema (CS)
CS SSF 3, Lymph Nodes, Bladder (CS)
CS SSF 3, Mets at Dx, KidneyParenchyma Schema (CS)
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CS SSF 3, SSF 4, Prostate Schema (CS)
CS SSF 3, TS/Ext Eval, Prostate Schema (CS)
CS SSF 4, 5, 6, MelanomaSkin (CS)
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CS SSF 4, LymphNodes, NodesPos, ColoRectal (CS)
CS SSF 4, Mets at DX, Vagina (CS)
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CS SSF 4, SSF 5, Vagina (CS)
CS SSF 4, Surg, DX/Stg, KidneyParenchyma (CS)
CS SSF 4, Surgery, KidneyParenchyma Schema (CS)
CS SSF 5, GISTPeritoneum (CS)
CS SSF 5, Lymph Nodes, Testis (CS)
CS SSF 5, RX Summ--Surg, ColoRectal (CS)
CS SSF 5, SSF 7, RX Summ--Surg Other, Vagina (CS)
CS SSF 6, Breast Schema (CS)
CS SSF 6, CS SSF 7, Liver Schema (CS)
CS SSF 6, GISTEsoph, SmallIntest, Stomach (CS)
CS SSF 6, Histology, KidneyParenchyma Schema (CS)
CS SSF 6, Mets at DX, Vagina (CS)
CS SSF 6, RX Summ--Surg, ColoRectal (CS)
CS SSF 6, SSF 12, Testis (CS)
CS SSF 6, SSF 7, Testis (CS)
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CS SSF 6, Tumor Size, Breast Schema (CS)
CS SSF 7, 8, 12, 13, Prostate Schema (CS)
CS SSF 7, MelanomaSkin (CS)
CS SSF 7, SSF 13, Testis (CS)
CS SSF 7, SSF 8, Prostate Schema (CS)
CS SSF 8, CS SSF 9, Breast (CS)
CS SSF 8, CS SSF 9, Surgery, DX/Stg, Breast (CS)
CS SSF 8, Lymph Nodes, KidneyParenchyma (CS)
CS SSF 8, RX Summ--Surg, ColoRectal (CS)
CS SSF 8, RX Summ--Surg, DX/Stg, ColoRectal (CS)
CS SSF 8, SSF 10, Grade, Prostate (SEER)
CS SSF 8, SSF 14, Testis (CS)
CS SSF 8, SSF 9, Testis (CS)
CS SSF 9, Head and Neck Schemas (CS)
CS SSF 9, SSF 10, Prostate Schema (CS)
CS SSF 9, SSF 15, Testis (CS)
CS SSF 9, Surgery, MelanomaChor/Cil/Iris (CS)
CS TS/Ext Eval, Surg/Rad Seq, Prostate (CS)
CS TS/Ext Eval, Sys/Surg Seq, Prostate (CS)
CS TS/Ext Eval, Surgery, Bladder Schema (CS)
CS TS/Ext Eval, Surgery, Prostate Schema (CS)
CS Tumor Size (CS)
CS Tumor Size, Schema (CS)
CS Tumor Size, Site, Histol ICDO3 (CS)
CS Tumor Size, SSF 1, MelanomaConjunctiva (CS)
CS Tumor Size/Ext Eval (CS)

CS Tumor Size/Ext Eval, Schema (CS)
CS Validate Schema (CS)
CS Validate Schema (NPCR)
CS Verify CStage Version 0205xx (CS)
CS Version Derived (CS)
CS Version Input Current (CS)
CS Version Input Current, CS Version Derived (CS)
CS Version Input Original (CS)
CS Version Input Original, CS Version Derived (CS)
CS Version Input Original, Version Input Curr (CS)
Date 1st Crs RX COC (COC)
Date 1st Crs RX COC , Date Flag (COC)
Date 1st Crs RX COC Flag (NAACCR)
Date 1st Crs RX COC, Date Flag (NPCR)
Date 1st Crs RX COC, Date Initial RX SEER (NPCR)
Date 1st Crs RX COC, Date of Diagnosis (COC)
Date 1st Crs RX COC, Date of Last Contact (COC)
Date 1st Crs RX COC, Dates of RX (COC)
Date 1st Crs RX COC, Dates of RX (NAACCR)
Date Case Completed (NAACCR DATEEDIT)
Date Case Completed, Date of Diagnosis (NAACCR)
Date Case Completed-CoC (COC)
Date Case Completed-CoC, Date of Diagnosis (COC)
Date Case Initiated (NAACCR)
Date Case Last Changed (NAACCR)
Date Case Report Exported (NAACCR DATEEDIT)
Date Case Report Loaded (NAACCR DATEEDIT)
Date Case Report Received (NAACCR DATEEDIT)
Date Conclusive DX (SEER)
Date Conclusive DX Flag (NAACCR)
Date Conclusive DX, Date Flag (NAACCR)
Date Conclusive DX, Date of DX (CCCR)
Date Conclusive DX, Date of DX (SEER IF164)
Date Initial RX SEER (NAACCR)
Date Initial RX SEER Flag (NAACCR)
Date Initial RX SEER, Ca Dir RX 2003 (SEER IF180)
Date Initial RX SEER, Ca Dir RX 98-02 (SEER IF179)
Date Initial RX SEER, Ca Dir RX Pre-98 (SEER IF34)
Date Initial RX SEER, Date Flag (NAACCR)
Date Initial RX SEER, Date Flag (NPCR)
Date Initial RX SEER, Date Last Cont(NAACCR IF35)
Date Initial RX SEER, Date of DX (NAACCR IF18)
Date of 1st Contact (COC)
Date of 1st Contact Flag (NAACCR)
Date of 1st Contact, Date Flag(NAACCR)

Date of Birth (NAACCR)
Date of Birth Flag (NAACCR)
Date of Birth, Date Flag (NAACCR)
Date of Birth, Date of Diagnosis (NAACCR IF47)
Date of Death Canada, Date Flag (CCCR)
Date of Death--Canada (CCCR)
Date of Death--Canada, Vital Status (NAACCR)
Date of Death--CanadaFlag (NAACCR)
Date of Diagnosis (NAACCR DATEEDIT)
Date of Diagnosis Flag (NAACCR)
Date of Diagnosis, Date Flag (NAACCR)
Date of Diagnosis, EOD Coding Sys, EOD (SEER IF33)
Date of Inpt Adm (NAACCR)
Date of Inpt Adm Flag (NAACCR)
Date of Inpt Adm, Date Flag (NAACCR)
Date of Inpt Disch (NAACCR)
Date of Inpt Disch Flag (NAACCR)
Date of Inpt Disch, Date Flag (NAACCR)
Date of Last Contact (NAACCR DATEEDIT)
Date of Last Contact Flag (NAACCR)
Date of Last Contact, Cause of Death (SEER IF12)
Date of Last Contact, Date Flag(NAACCR)
Date of Last Contact, Date of Diag. (NAACCR IF19)
Date of Mult Tum, Lymphoma/Leukem/Unk Site(NAACCR)
Date of Mult Tumors (SEER)
Date of Mult Tumors Flag (NAACCR)
Date of Mult Tumors, Date Flag (NAACCR)
Date of Mult Tumors, Date of DX (CCCR)
Date of Mult Tumors, Date of DX (SEER IF165)
Date Tumor Record Availbl (NAACCR DATEEDIT)
DC State File Number, Vital Status (NAACCR)
Death Certificate Only, RX (NPCR)
Derived AJCC-6 M (CS)
Derived AJCC-6 M Descriptor (CS)
Derived AJCC-6 N (CS)
Derived AJCC-6 N Descriptor (CS)
Derived AJCC-6 Stage Group (CS)
Derived AJCC-6 T (CS)
Derived AJCC-6 T Descriptor (CS)
Derived AJCC-7 M (CS)
Derived AJCC-7 M Descriptor (CS)
Derived AJCC-7 N (CS)
Derived AJCC-7 N Descript (CS)
Derived AJCC-7 Stage Group (CS)

Derived AJCC-7 T (CS)
Derived AJCC-7 T Descript (CS)
Derived AJCC--Flag (CS)
Derived AJCC--Flag, Derived AJCC (COC)
Derived AJCC--Flag, Derived AJCC (SEER)
Derived Items, Date of DX (CCCR)
Derived Items, Date of DX (COC)
Derived Items, Date of DX (NPCR)
Derived Items, Date of DX (SEER)
Derived Items, DX Pre-2004 (CS)
Derived SS1977 (CS)
Derived SS1977--Flag (CS)
Derived SS1977--Flag, Derived SS1977 (CS)
Derived SS2000 (CS)
Derived SS2000, Behavior ICDO3 (CS)
Derived SS2000--Flag (CS)
Derived SS2000--Flag, Derived SS2000 (CS)
Diagnostic Confirm, Seq Num--Central (SEER IF23)
Diagnostic Confirm, Seq Num--Hosp (COC)
Diagnostic Confirmation (SEER DXCONF)
Diagnostic Confirmation, Behavior ICDO2(SEER IF31)
Diagnostic Confirmation, Behavior ICDO3(SEER IF31)
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Diagnostic Proc 73-87 (SEER DXINFO)
Edit Over-rides (NAACCR)
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EDP MDE Link (NPCR)
EDP MDE Link Date (NPCR)
EDP MDE Link, Date, Primary Site (NPCR)
EDP MDE Link, EDP MDE Link Date (NPCR)
EOD-4 Extension (SEER)
EOD-4 Lymph Nodes (SEER)
EOD-4 Tumor Size (SEER)
EOD--Ext Prost Path,RX Summ--Surg Prim Site (SEER)
EOD--Ext Prost Path,RX Summ--Surg Sit 98-02 (SEER)
EOD--Extension (SEER)
EOD--Extension Prost Path (SEER)
EOD--Extension Prost Path, Prim Site, ICDO2(NAACCR
EOD--Extension Prost Path, Prim Site, ICDO3(NAACCR
EOD--Extension, Primary Site, ICDO2 (NAACCR)
EOD--Extension, Primary Site, ICDO3 (NAACCR)
EOD--Lymph Node Involv (SEER)
EOD--Lymph Node Involv, Prim Site, ICDO2 (NAACCR)

EOD--Lymph Node Involv, Prim Site, ICDO3 (NAACCR)
EOD--Lymph Node Involv, Reg Nodes
Pos,ICDO2(NAACCR
EOD--Lymph Node Involv, Reg Nodes
Pos,ICDO3(NAACCR
EOD--Old 13 digit (SEER)
EOD--Old 13 digit, Primary Site (SEER IF2613DG)
EOD--Old 13 digit, Primary Site, Hist (SEER IF01)
EOD--Old 2 digit (SEER)
EOD--Old 2 digit, Morphology (SEER IF26NSPC)
EOD--Old 2 digit, Primary Site (SEER IF262DIG)
EOD--Old 4 digit (SEER IF264DIG)
EOD--Reg Nodes Ex,ReNodes Pos, Site, ICDO2 (NAACCR
EOD--Reg Nodes Ex,ReNodes Pos, Site, ICDO3 (NAACCR
EOD--Tumor Size (COC)
EOD--Tumor Size, Date of Diagnosis (COC)
EOD--Tumor Size, Primary Site, ICDO2 (NAACCR)
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EthnSrc, Date of Diag (SEER IF72)
Extent of Disease 10-Digit(SEER IF2610DG)
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Following Registry (COC)
Following Registry (NAACCR)
Following Registry, Date of Diagnosis (COC)
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Follow-Up Contact--Name (SEER)
Follow-Up Contact--No/St (SEER)
Follow-Up Contact--Postal (SEER)
Follow-Up Contact--State (SEER)
Follow-Up Contact--Suppl (SEER)
Follow-Up Source (COC)
Follow-Up Source (NAACCR)
Follow-up Source Central (NAACCR)
Follow-up Source Central, Date of DX (NPCR)
Follow-Up Source Central, Vital Status (NPCR)
Follow-Up Source, Date of Diagnosis (COC)
Follow-Up Source, Vital Status (COC)
GIS Coordinate Quality (NAACCR)
Grade (73-91) ICD-O-1 (SEER)
Grade (CCCR)
Grade (COC)
Grade Path System (COC)
Grade Path System, Grade Path Value, Grade (COC)

Grade Path Value (COC)
Hemato ICDO2, Summ Stg 1977, Class of Case (NAACCR
Hemato ICDO2, Summ Stg 1977, Type Rpt Srce (NAACCR
Hemato ICDO3, Summ Stg 1977 (NAACCR)
Hematopoietic, TNM, ICDO2 (NAACCR)
Hematopoietic, TNM, ICDO3 (COC)
Hematopoietic, TNM, ICDO3 (NAACCR)
Hist ICDO2, Date of DX, ICDO2 Conv Flag(SEER IF84)
Hist ICDO3, Date of DX, ICDO3 Conv Flag(SEER IF86)
Hist/Behav ICDO2, Hist/Behav ICDO3 (SEER IF126)
Histologic Type ICDO2 (COC)
Histologic Type ICDO3 (SEER)
Histologic Type ICDO3 Conversion (NAACCR)
Histologic Type ICD-O-3, Behavior, Grade (SEER)
Histology (73-91) ICD-O-1 (SEER)
Histology ICDO2, Date DX, Date 1st Contact (NAACCR
Histology ICDO2, Date of Diagnosis (NAACCR)
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Histology ICDO3, Date DX, Date 1st Cont (NAACCR)
Histology ICDO3, Date of Diagnosis (NAACCR)
Histology ICDO3, Grade, Date of DX (SEER)
Histology, Primary Site, Tumor Size, ICDO2 (COC)
Histology, Primary Site, Tumor Size, ICDO3 (COC)
ICD Revision Comorbid (COC)
ICD Revision Comorbid, Date of DX (COC)
ICD Revision Number (NPCR)
ICD Revision Number (SEER ICDCODE)
ICD Revision Number, Cause of Death (NAACCR)
ICD Revision Number, Cause of Death (SEER IF37)
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ICD-O-2 Conversion Flag (SEER ICDOREV)
ICD-O-2 Conversion Flag, Hist, Behav (SEER IF70)
ICD-O-3 Conversion Flag (NAACCR)
ICD-O-3 Conversion Flag, Histology ICDO3(SEER IF95
IHS Link (NPCR)
Industry Source (NPCR)
Inpatient Status (NAACCR)
Institution Referred From (COC)
Institution Referred From, Date of Diagnosis (COC)
Institution Referred To (COC)
Institution Referred To, Date of Diagnosis (COC)
Laterality (SEER LATERAL)
Laterality, Primary Site (COC)
Laterality, Primary Site, Date of Diag (SEER IF24)

Laterality, Primary Site, Morph ICDO3 (SEER IF42)
Lymphoma ICDO3, Site, Summ Stg 1977 (NAACCR)
Lymphoma, EOD--Ext, Summ Stg 1977, ICDO2 (NAACCR)
Lymphoma, EOD--Ext, Summ Stg 2000, ICDO3 (NAACCR)
Lymphoma, EOD--Tumor Size, ICDO2 (NAACCR)
Lymphoma, EOD--Tumor Size, ICDO3 (NAACCR)
Lymphoma, Prim Site, Summ Stg 1977, ICDO2 (NAACCR)
Lymphoma, TNM, ICDO2 (NAACCR)
Lymphoma, TNM, ICDO3 (COC)
Lymphoma, TNM, ICDO3 (NAACCR)
Lymph-vascular Invasion (CS)
Lymph-vascular Invasion, Histology, Behav (COC)
Lymph-vascular Invasion, Histology, Behav (CS)
Lymph-vascular Invasion, Penis and Testis (CS)
Marital Status at DX (SEER MARITAL)
Marital Status at DX, Age at Diagnosis (SEER IF14)
Medical Record Number (COC)
Medical Record Number (NAACCR)
Medical Record Number, Date of Diagnosis (COC)
Military Record No Suffix (COC)
Military Record No Suffix, Primary Payer (COC)
Morph (1973-91) ICD-O-1 (SEER OMORPnos)
Morph Coding Sys--Curr, Morph Coding Sys--Orig(COC
Morph Coding Sys--Current (NAACCR)
Morph Coding Sys--Current, Date of DX (NAACCR)
Morph Coding Sys--Originl (NAACCR)
Morph Coding Sys--Originl, Date of Diagnosis (COC)
Morphology--Type/Behavior ICDO2 (SEER MORPH)
Morphology--Type/Behavior ICDO3 (COC)
Morphology--Type/Behavior ICDO3 (SEER MORPH)
Mult Tum Rpt As One Prim (SEER)
Mult Tum Rpt As One Prim, Date of DX (CCCR)
Mult Tum Rpt As One Prim, Date of DX (SEER IF155)
Mult Tum Rpt as One Prim, Date of Mult Tum(NAACCR)
Mult Tum Rpt As One Prim, Primary Site (NAACCR)
Mult Tum Rpt, Lymphoma/Leukemia/Unk Site (NAACCR)
Multiplicity Cntr, Date of Mult Tum (SEER IF163)
Multiplicity Cntr, Mult Tum Rpt as One Prim(NAACCR
Multiplicity Counter (SEER)
Multiplicity Counter, Date of DX (CCCR)
Multiplicity Counter, Date of DX (SEER IF156)
Multiplicity Ctr, Lymphoma/Leukem/Unk Site(NAACCR)
NAACCR Record Version (NAACCR)
Name--Alias (SEER)
Name--First (COC)

Name--First (NPCR)
Name--Last (COC)
Name--Maiden (SEER)
Name--Maiden, Check for Unknown (NAACCR)
Name--Middle (COC)
Next Follow-Up Source (COC)
Next Follow-Up Source, Date of Diagnosis (COC)
NHIA Derived Hisp Origin (NAACCR)
Non-Reportable Skin ICDO2 (SEER IF116)
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NPCR-CER Height
NPCR-CER Height, Date of DX
NPCR-CER Source Comorbidity
NPCR-CER Source Comorbidity, Date of DX
NPCR-CER Tobacco Use Cigarettes
NPCR-CER Tobacco Use Cigarettes, Date of DX
NPCR-CER Tobacco Use NOS
NPCR-CER Tobacco Use NOS, Date of DX
NPCR-CER Tobacco Use Other Smoke
NPCR-CER Tobacco Use Other Smoke, Date of DX
NPCR-CER Tobacco Use Smokeless
NPCR-CER Tobacco Use Smokeless, Date of DX
NPCR-CER Weight
NPCR-CER Weight, Date of DX
NPI--Archive FIN (NAACCR)
NPI--Following Registry (NAACCR)
NPI--Inst Referred From (NAACCR)
NPI--Inst Referred To (NAACCR)
NPI--Physician 3 (NAACCR)
NPI--Physician 4 (NAACCR)
NPI--Physician--Follow-Up (NAACCR)
NPI--Physician--Managing (NAACCR)
NPI--Physician--Prim Surg (NAACCR)
NPI--Registry ID (NAACCR)
NPI--Reporting Facility (NAACCR)
Obsolete Codes - CS Extension (CS)
Obsolete Codes - CS Lymph Nodes (CS)
Obsolete Codes - CS Lymph Nodes Eval (CS)
Obsolete Codes - CS Mets at DX (CS)
Obsolete Codes - CS Mets Eval (CS)
Obsolete Codes - CS Site-Specific Factor 1 (CS)
Obsolete Codes - CS Site-Specific Factor 2 (CS)
Obsolete Codes - CS Site-Specific Factor 3 (CS)
Obsolete Codes - CS Site-Specific Factor 4 (CS)
Obsolete Codes - CS Site-Specific Factor 5 (CS)

Obsolete Codes - CS Site-Specific Factor 6 (CS)
Obsolete Codes - CS Site-Specific Factor 7 (CS)
Obsolete Codes - CS Site-Specific Factor 8 (CS)
Obsolete Codes - CS Site-Specific Factor 9 (CS)
Obsolete Codes - CS Site-Specific Factor10 (CS)
Obsolete Codes - CS Site-Specific Factor11 (CS)
Obsolete Codes - CS Site-Specific Factor12 (CS)
Obsolete Codes - CS Site-Specific Factor13 (CS)
Obsolete Codes - CS Site-Specific Factor15 (CS)
Obsolete Codes - CS Site-Specific Factor19 (CS)
Obsolete Codes - CS Site-Specific Factor21 (CS)
Obsolete Codes - CS Site-Specific Factor22 (CS)
Obsolete Codes - CS Site-Specific Factor23 (CS)
Obsolete Codes - CS Site-Specific Factor25 (CS)
Obsolete Codes - CS Tumor Size (CS)
Obsolete Codes - CS Tumor Size/Ext Eval (CS)
Obsolete Histology ICDO3, Date of DX (SEER)
Occupation Source (NPCR)
Over-ride Misuse (NAACCR)
Path Date Spec Collect 1 (NAACCR)
Path Date Spec Collect 2 (NAACCR)
Path Date Spec Collect 3 (NAACCR)
Path Date Spec Collect 4 (NAACCR)
Path Date Spec Collect 5 (NAACCR)
Path Order Phys Lic No 1 (NAACCR)
Path Order Phys Lic No 2 (NAACCR)
Path Order Phys Lic No 3 (NAACCR)
Path Order Phys Lic No 4 (NAACCR)
Path Order Phys Lic No 5 (NAACCR)
Path Ordering Fac No 1 (NAACCR)
Path Ordering Fac No 2 (NAACCR)
Path Ordering Fac No 3 (NAACCR)
Path Ordering Fac No 4 (NAACCR)
Path Ordering Fac No 5 (NAACCR)
Path Report Number 1 (NAACCR)
Path Report Number 2 (NAACCR)
Path Report Number 3 (NAACCR)
Path Report Number 4 (NAACCR)
Path Report Number 5 (NAACCR)
Path Report Type 1 (NAACCR)
Path Report Type 2 (NAACCR)
Path Report Type 3 (NAACCR)
Path Report Type 4 (NAACCR)
Path Report Type 5 (NAACCR)
Path Reporting Fac ID 1 (NAACCR)

Path Reporting Fac ID 2 (NAACCR)
Path Reporting Fac ID 3 (NAACCR)
Path Reporting Fac ID 4 (NAACCR)
Path Reporting Fac ID 5 (NAACCR)
Patient ID Number (SEER CASENUM)
Patient System ID-Hosp (NAACCR)
Physician 3 (COC)
Physician 4 (COC)
Physician--Follow-Up (COC)
Physician--Follow-Up, Date of Diagnosis (COC)
Physician--Primary Surg (COC)
Physician--Primary Surg, Date of Diagnosis (COC)
PIN III ICDO3, Date of Diagnosis (SEER IF110)
Place of Death (NAACCR)
Place of Death, Country, State (NAACCR)
Place of Death, Vital Status (NAACCR)
Place of Death--Country (NAACCR)
Place of Death--Country, Date of Diagnosis(NAACCR)
Place of Death--Country, State (NAACCR)
Place of Death--Country, Vital Status (NPCR)
Place of Death--State (NAACCR)
Place of Death--State, Date of Diagnosis (NAACCR)
Place of Death--State, Vital Status (NPCR)
Primary Payer at DX (COC)
Primary Payer at DX (NPCR)
Primary Payer at DX, Date of DX (SEER IF181)
Primary Site (SEER SITE)
Primary Site, AJCC M - Ed 7, ICDO3 (COC)
Primary Site, AJCC M - Ed 7, ICDO3 (NPCR)
Primary Site, AJCC M - Ed 7, ICDO3 (SEER)
Primary Site, AJCC N - Ed 7, ICDO3 (COC)
Primary Site, AJCC N - Ed 7, ICDO3 (NPCR)
Primary Site, AJCC N - Ed 7, ICDO3 (SEER)
Primary Site, AJCC Stage Group - Ed 3/4, ICDO2(COC
Primary Site, AJCC Stage Group - Ed 5, ICDO2 (COC)
Primary Site, AJCC Stage Group - Ed 5, ICDO3 (COC)
Primary Site, AJCC Stage Group - Ed 6 (NAACCR)
Primary Site, AJCC Stage Group - Ed 6, ICDO3 (COC)
Primary Site, AJCC Stage Group - Ed 7, ICDO3 (COC)
Primary Site, AJCC Stage Group - Ed 7, ICDO3(NPCR)
Primary Site, AJCC Stage Group - Ed 7, ICDO3(SEER)
Primary Site, AJCC T - Ed 7, ICDO3 (COC)
Primary Site, AJCC T - Ed 7, ICDO3 (NPCR)
Primary Site, AJCC T - Ed 7, ICDO3 (SEER)
Primary Site, Behavior Code ICDO2 (SEER IF39)

Primary Site, Behavior Code ICDO3 (SEER IF39)
Primary Site, CS Extension (SEER IF176)
Primary Site, EOD, ICDO3 (SEER IF40)
Primary Site, Heme Morph, DateDX, NoOverride(SEER)
Primary Site, Heme Morph, DateDX, Override (COC)
Primary Site, Heme Morph, DateDX, Override (SEER)
Primary Site, Laterality (SEER IF82)
Primary Site, Laterality, CS Extension(SEER IF177)
Primary Site, Laterality, EOD, ICDO3 (SEER IF41)
Primary Site, Morphology-Imposs ICDO2 (SEER IF38)
Primary Site, Morphology-Imposs ICDO3 (SEER IF38)
Primary Site, Morphology-Type ICDO2 (COC)
Primary Site, Morphology-Type ICDO2 (SEER IF25)
Primary Site, Morphology-Type ICDO3 (COC)
Primary Site, Morphology-Type,Beh ICDO3 (COC)
Primary Site, Morphology-Type,Beh ICDO3(SEER IF25)
Primary Site, No AJCC Scheme-Ed 5, ICDO2 (NAACCR)
Primary Site, No AJCC Scheme-Ed 5, ICDO3 (NAACCR)
Race 1 (SEER RACE)
Race 1, Race 2, Race 3, Race 4, Race 5 (NAACCR)
Race 1, Race 2, Race 3, Race 4, Race 5 (SEER IF93)
Race 2 (NAACCR)
Race 2, Date of DX (SEER IF89)
Race 3 (NAACCR)
Race 3, Date of DX (SEER IF90)
Race 4 (NAACCR)
Race 4, Date of DX (SEER IF91)
Race 5 (NAACCR)
Race 5, Date of DX (SEER IF92)
Race Coding Sys--Curr, Race Coding Sys--Orig (COC)
Race Coding Sys--Current (NAACCR)
Race Coding Sys--Original (NAACCR)
Race Coding Sys--Original, Date of Diagnosis (COC)
Race--NAPIIA(derived API) (NAACCR)
Rad--Boost Dose cGy (COC)
Rad--Boost Dose cGy, Date of Diagnosis (COC)
Rad--Boost RX Modality (COC)
Rad--Boost RX Modality, Date of Diagnosis (COC)
Rad--Location of RX (COC)
Rad--Location of RX (NAACCR)
Rad--No of Treatments Vol (COC)
Rad--No of Treatments Vol (NAACCR)
Rad--Regional Dose: cGy (COC)
Rad--Regional Dose: cGy (NAACCR)
Rad--Regional RX Modality (COC)

Rad--Regional RX Modality (NPCR)
Rad--Regional RX Modality, Date of Diagnosis (COC)
Rad--Regional RX Modality, Date of Diagnosis(NPCR)
Rad--Regional RX Modality, Reason for No Rad (COC)
Rad--Treatment Volume (COC)
Rad--Treatment Volume (NAACCR)
Readm Same Hosp 30 Days (COC)
Readm Same Hosp 30 Days, Date of Diagnosis (COC)
Reason for No Radiation (COC)
Reason for No Radiation (NAACCR)
Reason for No Radiation, Date of DX (NPCR)
Reason for No Radiation, RX Date Radiation (COC)
Reason for No Radiation, Vital Status (COC)
Reason for No Surgery (NPCR)
Reason for No Surgery (SEER NCDSURG)
Reason for No Surgery, Date of DX (NPCR)
Reason for No Surgery, DateDX, RptSrc (SEER IF57)
Reason for No Surgery, Vital Status (COC)
Record Type (NAACCR)
Recurrence Date--1st (COC)
Recurrence Date--1st Flag (NAACCR)
Recurrence Date--1st, Date 1st Crs RX COC (COC)
Recurrence Date--1st, Date Flag (COC)
Recurrence Date--1st, Date Initial RX SEER(NAACCR)
Recurrence Date--1st, Date Last Contact (COC)
Recurrence Date--1st, Date of Diagnosis (COC)
Recurrence Type--1st (COC)
Recurrence Type--1st (NAACCR)
Recurrence Type--1st, Cancer Status (COC)
Recurrence Type--1st, Recurrence Date--1st (COC)
Reg Nodes Ex,Pos,Site,Hist ICDO3,Rpt (SEER IF130)
Regional Nodes Ex, Reg Nodes Pos (COC)
Regional Nodes Examined (COC)
Regional Nodes Examined (NAACCR)
Regional Nodes Examined (SEER)
Regional Nodes Positive (COC)
Regional Nodes Positive (NAACCR)
Regional Nodes Positive (SEER)
Registry ID (NAACCR)
Registry Type (NAACCR)
Registry Type, Registry ID (NAACCR)
Registry Type, Sequence Number--Central (NAACCR)
Registry Type, Sequence Number--Hospital (NAACCR)
Reporting Facility (COC)
Reporting Facility (NPCR)

RuralUrban Continuum 1993 (NAACCR)
RuralUrban Continuum 2003 (NAACCR)
RX Coding System--Current (COC)
RX Coding System--Current (NAACCR)
RX Date BRM (COC)
RX Date BRM Flag (NAACCR)
RX Date BRM, Date Flag (COC)
RX Date BRM, Date Flag (NAACCR)
RX Date BRM, Date Flag, Date DX (COC)
RX Date BRM, Date Flag, DX Date (NPCR)
RX Date BRM, Date Last Contact (COC)
RX Date BRM, Date of Diagnosis (COC)
RX Date BRM, RX Date Systemic (COC)
RX Date Chemo (COC)
RX Date Chemo Flag (NAACCR)
RX Date Chemo, Date Flag (COC)
RX Date Chemo, Date Flag (NAACCR)
RX Date Chemo, Date Flag, Date DX (COC)
RX Date Chemo, Date Flag, DX Date (NPCR)
RX Date Chemo, Date Last Contact (COC)
RX Date Chemo, Date of Diagnosis (COC)
RX Date Chemo, RX Date Systemic (COC)
RX Date DX/Stg Proc (COC)
RX Date Dx/Stg Proc Flag (NAACCR)
RX Date DX/Stg Proc, Date Flag (COC)
RX Date DX/Stg Proc, Date Last Contact (COC)
RX Date Hormone (COC)
RX Date Hormone Flag (NAACCR)
RX Date Hormone, Date Flag (COC)
RX Date Hormone, Date Flag (NAACCR)
RX Date Hormone, Date Flag, Date DX (COC)
RX Date Hormone, Date Flag, DX Date (NPCR)
RX Date Hormone, Date Last Contact (COC)
RX Date Hormone, Date of Diagnosis (COC)
RX Date Hormone, RX Date Systemic (COC)
RX Date Mst Defn Srg (COC)
RX Date Mst Defn Srg Flag (NAACCR)
RX Date Mst Defn Srg, Date Flag (COC)
RX Date Mst Defn Srg, Date Flag, DX Date (COC)
RX Date Mst Defn Srg, Date Flag, DX Date (NPCR)
RX Date Mst Defn Srg, Date Last Contact (COC)
RX Date Mst Defn Srg, Date Last Contact (NPCR)
RX Date Mst Defn Srg, Date of DX (COC)
RX Date Mst Defn Srg, RX Date Surgery (COC)
RX Date Mst Defn Srg, RX Date Surgery (NPCR)

RX Date Mst Defn Srg, Surg Prim Site (COC)
RX Date Mst Defn Srg, Surg Prim Site (NPCR)
RX Date Other (COC)
RX Date Other Flag (NAACCR)
RX Date Other, Date Flag (NAACCR)
RX Date Other, Date Flag, DX Date (COC)
RX Date Other, Date Flag, DX Date (NPCR)
RX Date Other, Date Last Contact (COC)
RX Date Other, Date of Diagnosis (COC)
RX Date Rad Ended (COC)
RX Date Rad Ended Flag (NAACCR)
RX Date Rad Ended, Date Flag (COC)
RX Date Rad Ended, Date Last Contact (COC)
RX Date Rad Ended, Rad--Location of RX (COC)
RX Date Rad Ended, Rad--No of Treatments Vol (COC)
RX Date Rad Ended, Rad--Regional Dose: cGy (COC)
RX Date Rad Ended, Rad--Regional RX Modality (COC)
RX Date Rad Ended, Rad--Treatment Volume (COC)
RX Date Rad Ended, RX Date Radiation (COC)
RX Date Radiation (COC)
RX Date Radiation Flag (NAACCR)
RX Date Radiation, Date Flag (COC)
RX Date Radiation, Date Flag (NAACCR)
RX Date Radiation, Date Flag, DX Date (NPCR)
RX Date Radiation, Date Last Contact (COC)
RX Date Radiation, Date of Diagnosis (COC)
RX Date Radiation, Rad--Boost Dose cGy (COC)
RX Date Radiation, Rad--Boost RX Modality (COC)
RX Date Radiation, Rad--Location of RX (COC)
RX Date Radiation, Rad--No of Treatments Vol (COC)
RX Date Radiation, Rad--Regional Dose: cGy (COC)
RX Date Radiation, Rad--Regional RX Modality (COC)
RX Date Radiation, Rad--Treatment Volume (COC)
RX Date Surg Disch (COC)
RX Date Surg Disch Flag (NAACCR)
RX Date Surg Disch, Date Flag (COC)
RX Date Surg Disch, Date Flag, DX Date (COC)
RX Date Surg Disch, Date Last Contact (COC)
RX Date Surg Disch, Date Mst Defn Srg (COC)
RX Date Surg Disch, Date of DX (COC)
RX Date Surg Disch, Surg Prim Site (COC)
RX Date Surgery (COC)
RX Date Surgery Flag (NAACCR)
RX Date Surgery, Date Flag (COC)
RX Date Surgery, Date Flag (NAACCR)

RX Date Surgery, Date Flag, DX Date (NPCR)
RX Date Surgery, Date Last Contact (COC)
RX Date Surgery, Date of Diagnosis (COC)
RX Date Surgery, RX Text--Surgery (NAACCR)
RX Date Systemic (COC)
RX Date Systemic Flag (NAACCR)
RX Date Systemic, Date Flag (COC)
RX Date Systemic, Date Last Contact (COC)
RX Date Systemic, Systemic RX (COC)
RX Hosp--BRM (COC)
RX Hosp--BRM (NAACCR)
RX Hosp--BRM, RX Summ--BRM (COC)
RX Hosp--Chemo (COC)
RX Hosp--Chemo (NAACCR)
RX Hosp--Chemo, RX Summ--Chemo (COC)
RX Hosp--DX/Stg Proc (COC)
RX Hosp--DX/Stg Proc (NAACCR)
RX Hosp--DX/Stg Proc, RX Summ--DX/Stg Proc (COC)
RX Hosp--Hormone (COC)
RX Hosp--Hormone (NAACCR)
RX Hosp--Hormone, RX Summ--Hormone (COC)
RX Hosp--Other (COC)
RX Hosp--Other, Date of Diagnosis (COC)
RX Hosp--Other, RX Summ--Other (COC)
RX Hosp--Palliative Proc (COC)
RX Hosp--Palliative Proc (NAACCR)
RX Hosp--Palliative Proc, RX Summ--Pall Proc (COC)
RX Hosp--Reg LN Examined (COC)
RX Hosp--Scope LN Sur, RX Summ--Scope LN Sur(COC)
RX Hosp--Scope Reg 98-02 (COC)
RX Hosp--Scope Reg 98-02, Primary Site, ICDO2(COC)
RX Hosp--Scope Reg 98-02, Primary Site, ICDO3(COC)
RX Hosp--Scope Reg 98-02, RX Hosp--Scope Reg (COC)
RX Hosp--Scope Reg LN Sur (COC)
RX Hosp--Scope Reg LN Sur (NAACCR)
RX Hosp--Scope Reg LN Sur, Primary Site,ICDO2(COC)
RX Hosp--Scope Reg LN Sur, Primary Site,ICDO3(COC)
RX Hosp--Surg App 2010 (COC)
RX Hosp--Surg App 2010, Date of of Diagnosis (COC)
RX Hosp--Surg App 2010, Surg Prim Site (COC)
RX Hosp--Surg Oth 98-02 (COC)
RX Hosp--Surg Oth 98-02, Primary Site (COC)
RX Hosp--Surg Oth 98-02, RX Hosp--Surg Oth (COC)
RX Hosp--Surg Oth Reg, RX Summ--Surg Oth Reg (COC)
RX Hosp--Surg Oth Reg/Dis (COC)

RX Hosp--Surg Oth Reg/Dis (NAACCR)
RX Hosp--Surg Pri Sit, RX Summ--Surg Pri Sit (COC)
RX Hosp--Surg Prim Site (COC)
RX Hosp--Surg Prim Site (NAACCR)
RX Hosp--Surg Prim Site, Primary Site, ICDO2 (COC)
RX Hosp--Surg Prim Site, Primary Site, ICDO3 (COC)
RX Hosp--Surg Site 98-02 (COC)
RX Hosp--Surg Site 98-02, Primary Site (COC)
RX Hosp--Surg Site 98-02, RX Hosp--Surg Site (COC)
RX Summ--BRM (COC)
RX Summ--BRM (NPCR)
RX Summ--BRM, Date of DX (NPCR)
RX Summ--BRM, DateDX, RptSrc (SEER IF63)
RX Summ--BRM, RX Date BRM (COC)
RX Summ--BRM, RX Text--BRM (NAACCR)
RX Summ--BRM, Vital Status (COC)
RX Summ--Chemo (COC)
RX Summ--Chemo (NPCR)
RX Summ--Chemo, Date of DX (NPCR)
RX Summ--Chemo, DateDX, RptSrc (SEER IF61)
RX Summ--Chemo, RX Date Chemo (COC)
RX Summ--Chemo, RX Text--Chemo (NAACCR)
RX Summ--Chemo, Vital Status (COC)
RX Summ--DX/Stg Proc (COC)
RX Summ--DX/Stg Proc (NAACCR)
RX Summ--DX/Stg Proc, RX Date DX/Stg Proc (COC)
RX Summ--Hormone (COC)
RX Summ--Hormone (NPCR)
RX Summ--Hormone, Date of DX (NPCR)
RX Summ--Hormone, DateDX, RptSrc (SEER IF62)
RX Summ--Hormone, RX Date Hormone (COC)
RX Summ--Hormone, RX Text--Hormone (NAACCR)
RX Summ--Hormone, Vital Status (COC)
RX Summ--Other (NPCR)
RX Summ--Other (SEER OTHERRX)
RX Summ--Other, Date of DX (NPCR)
RX Summ--Other, DateDX, RptSrc (SEER IF64)
RX Summ--Other, RX Date Other (COC)
RX Summ--Other, RX Text--Other (NAACCR)
RX Summ--Palliative Proc (COC)
RX Summ--Palliative Proc (NAACCR)
RX Summ--Rad to CNS (SEER RBCNSYS)
RX Summ--Rad to CNS, Prim Site, RptSrc (SEER IF59)
RX Summ--Radiation (NAACCR)
RX Summ--Radiation (SEER RADIATN)

RX Summ--Radiation, DateDX, RptSrc (SEER IF58)
RX Summ--Radiation, RX Text--Radiation (NAACCR)
RX Summ--Reconstruct 1st (NAACCR)
RX Summ--Reconstruct 1st (SEER RECONST)
RX Summ--Reconstruct 1st, Date of DX (COC)
RX Summ--Reconstruct 1st, Primary Site (COC)
RX Summ--Reconstruct 1st,DateDx,RptSrc (SEER IF81)
RX Summ--Reg LN Ex,DateDX,RptSrc,ICDO3 (SEER IF97)
RX Summ--Reg LN Examined (COC)
RX Summ--Reg LN Examined (SEER SURGNODE)
RX Summ--Reg LN Examined, Date of DX (COC)
RX Summ--Scope Reg 98-02 (COC)
RX Summ--Scope Reg 98-02, Date of DX (COC)
RX Summ--Scope Reg 98-02, Date of DX (SEER IF98)
RX Summ--Scope Reg 98-02, Primary Site, ICDO2(COC)
RX Summ--Scope Reg 98-02, Primary Site, ICDO3(COC)
RX Summ--Scope Reg 98-02,Site,Rpt,ICDO3(SEER IF79)
RX Summ--Scope Reg LN Sur (COC)
RX Summ--Scope Reg LN Sur (SEER SCOPE)
RX Summ--Scope Reg LN Sur, Date of DX (NPCR)
RX Summ--Scope Reg LN Sur, Date of DX (SEER IF100)
RX Summ--Scope Reg LN Sur, Site, ICDO2(COC)
RX Summ--Scope Reg LN Sur, Site, ICDO3 (SEER IF109
RX Summ--Surg Approch,RX Summ--Surg Site 98-02(COC
RX Summ--Surg Oth 98-02 (COC)
RX Summ--Surg Oth 98-02, Date of DX (COC)
RX Summ--Surg Oth 98-02, Date of DX (SEER IF99)
RX Summ--Surg Oth 98-02, Primary Site (COC)
RX Summ--Surg Oth 98-02,Site,Rpt,ICDO3 (SEER IF80)
RX Summ--Surg Oth Reg/Dis (COC)
RX Summ--Surg Oth Reg/Dis (SEER SURGOTH)
RX Summ--Surg Oth Reg/Dis, Date of DX (NPCR)
RX Summ--Surg Oth Reg/Dis,DateDX,RptSrc(SEER IF101
RX Summ--Surg Prim Site (COC)
RX Summ--Surg Prim Site (SEER SURGPRIM)
RX Summ--Surg Prim Site, Date of DX (NPCR)
RX Summ--Surg Prim Site, Date of DX (SEER IF102)
RX Summ--Surg Prim Site, Diag Conf (SEER IF76)
RX Summ--Surg Prim Site, Primary Site, ICDO2 (COC)
RX Summ--Surg Prim Site, Primary Site, ICDO3 (COC)
RX Summ--Surg Prim Site, Site, ICDO3 (SEER IF108)
RX Summ--Surg Site 98-02 (COC)
RX Summ--Surg Site 98-02, Date of DX (COC)
RX Summ--Surg Site 98-02, Date of DX (SEER IF103)
RX Summ--Surg Site 98-02, Diag Conf (SEER IF106)

RX Summ--Surg Site 98-02, Primary Site (COC)
RX Summ--Surg Site 98-02, RX Summ--Surg Site (COC)
RX Summ--Surg Site 98-02, Site, RptSrc (SEER IF78)
RX Summ--Surg/Rad Seq (NPCR)
RX Summ--Surg/Rad Seq (SEER RADSEQ)
RX Summ--Surg/Rad Seq, Date of DX (NPCR)
RX Summ--Surg/Rad Seq, DateDX, RptSrc (SEER IF60)
RX Summ--Surgery Type (SEER SURGRX)
RX Summ--Surgery Type, Diag Conf (SEER IF46)
RX Summ--Surgery Type, Radiation (SEER IF44)
RX Summ--Surgery Type, Site, RptSrc (SEER IF29)
RX Summ--Surgery, Reason for No Surgery(SEER IF51)
RX Summ--Surgical Approch (COC)
RX Summ--Surgical Approch, Date of DX (COC)
RX Summ--Surgical Approch, Primary Site (COC)
RX Summ--Surgical Margins (COC)
RX Summ--Surgical Margins (NAACCR)
RX Summ--Surgical Margins, Primary Site,ICDO2 (COC
RX Summ--Surgical Margins, Primary Site,ICDO3 (COC
RX Summ--Systemic/Sur Seq (COC)
RX Summ--Systemic/Sur Seq, Date of DX (COC)
RX Summ--Systemic/Sur Seq, Date of DX (NPCR)
RX Summ--Systemic/Sur Seq, Date of DX (SEER IF154)
RX Summ--Transplnt/Endocr (COC)
RX Summ--Transplnt/Endocr (NPCR)
RX Summ--Transplnt/Endocr, Date of DX (NPCR)
RX Summ--Transplnt/Endocr, DateDX, Rpt (SEER IF104
RX Summ--Transplnt/Endocr, Primary Site (SEER IF28
RX Summ--Transplnt/Endocr, Vital Status (COC)
RX Summ--Treatm Stat, Date 1st Crs RX COC (COC)
RX Summ--Treatm Stat, Treatment (COC)
RX Summ--Treatment Status (COC)
RX Summ--Treatment Status, Date of DX (COC)
RX Summ--Treatment Status, Date of DX (NPCR)
Secondary Diagnosis 1 - 10 (COC)
Secondary Diagnosis 1 (COC)
Secondary Diagnosis 10 (COC)
Secondary Diagnosis 2 (COC)
Secondary Diagnosis 3 (COC)
Secondary Diagnosis 4 (COC)
Secondary Diagnosis 5 (COC)
Secondary Diagnosis 6 (COC)
Secondary Diagnosis 7 (COC)
Secondary Diagnosis 8 (COC)
Secondary Diagnosis 9 (COC)

SEER Coding Sys--Current (NAACCR)
SEER Coding Sys--Current (SEER)
SEER Coding Sys--Current, Date of DX (SEER)
SEER Coding Sys--Original (NAACCR)
SEER Coding Sys--Original (SEER)
SEER Record Number (SEER RECNUM)
SEER Submission Edit 01 (SEER)
SEER Submission Edit 02 (SEER)
SEER Type of Follow-Up (SEER TYPEFUP)
Seq Num--Central, Prim Site, Morph ICDO3(SEER IF22
Seq Num--Hosp, Primary Site, Morph ICDO2 (COC)
Seq Num--Hosp, Primary Site, Morph ICDO3 (COC)
Sequence Number--Central (SEER SEQUENC)
Sequence Number--Hospital (COC)
Sequence Number--Hospital (NAACCR)
Sex (SEER Sex)
Sex, Primary Site (SEER IF17)
Site (1973-91) ICD-O-1 (NAACCR OLDSITE)
Site (1973-91), Date of Diagnosis (SEER IF69)
Site Coding Sys--Curr, Site Coding Sys--Orig (COC)
Site Coding Sys--Current (NAACCR)
Site Coding Sys--Current, Date of DX (NAACCR)
Site Coding Sys--Original (NAACCR)
Site Coding Sys--Original, Date of Diagnosis (COC)
Site Coding Sys--Original, Date of DX (NAACCR)
Social Security Number (COC)
Social Security Number (NAACCR)
Social Security Number, Date of Diagnosis (COC)
Social Security Number-Partial (NAACCR)
Spanish/Hispanic Origin (SEER SPANORIG)
Spanish/Hispanic Origin, NHIA Derived (NAACCR)
Spanish/Hispanic Origin, NHIA Derived (SEER IF183)
Subsq RX 2ndCrs Date Flag (NAACCR)
Subsq RX 3rdCrs Date Flag (NAACCR)
Subsq RX 4thCrs Date Flag (NAACCR)
Summ Stg 1977, Site, Hist ICDO2, Class (NAACCR)
Summ Stg 1977, Site, Hist ICDO2, Rpt Srce (NAACCR)
Summ Stg 2000, Site, Hist ICDO3, Class (NAACCR)
Summ Stg 2000, Site, Hist ICDO3, Rpt Srce (NAACCR)
Summary Stage 1977 (NAACCR)
Summary Stage 1977, Class of Case (COC)
Summary Stage 1977, Date DX, Date 1st Cont (NAACCR
Summary Stage 1977, Date of Diagnosis (NAACCR)
Summary Stage 1977, EOD--LN Involv, ICDO2 (NAACCR)
Summary Stage 1977, Histology ICDO2 (COC)

Summary Stage 1977, Primary Site-Ed 4, ICDO2 (COC)
Summary Stage 1977, Primary Site-Ed 5, ICDO2 (COC)
Summary Stage 1977, Regional Nodes Pos (NAACCR)
Summary Stage 1977, Summary Stage 2000 (NAACCR)
Summary Stage 1977, TNM M (NAACCR)
Summary Stage 1977, TNM N (NAACCR)
Summary Stage 1977, TNM Stage Group (COC)
Summary Stage 1977, Type of Report Source (NAACCR)
Summary Stage 2000 (NAACCR)
Summary Stage 2000, Date DX, Date 1st Cont (NAACCR
Summary Stage 2000, Date of Diagnosis (NAACCR)
Summary Stage 2000, EOD--LN Involv, ICDO3 (NAACCR)
Summary Stage 2000, Over-ride CS 20 (NPCR)
Summary Stage 2000, Primary Site-Ed 5, ICDO3 (COC)
Summary Stage 2000, Primary Site-Ed 6, ICDO3 (COC)
Summary Stage 2000, Regional Nodes Pos (NAACCR)
Summary Stage 2000, TNM M (NAACCR)
Summary Stage 2000, TNM N (NAACCR)
Summary Stage 2000, TNM Stage Group (COC)
Surgery 98-02, Rad, Rad Surg (SEER IF105)
Surgery 98-02, Reason for No Surg (SEER IF107)
Surgery Rad, Rad Surg (SEER IF75)
Surgery, Rad, Surg/Rad Seq (COC)
Surgery, Reason for No Surg (SEER IF77)
Surgery, Reason No Surg (COC)
Surgery, RX Date Surgery, ICDO2 (COC)
Surgery, RX Date Surgery, ICDO3 (COC)
Surv--Cases Dx After Study Cutoff
Surv-Date Active Followup (SEER)
Surv-Date Active Followup, Date Last Cont (SEER)
Surv-Date Active Followup, Mos, Flag (SEER)
Surv-Date DX Recode (SEER)
Surv-Date DX Recode, Date of Diagnosis (SEER)
Surv-Date Presumed Alive (SEER)
Surv-Date Presumed Alive, Date Last Cont, DX(SEER)
Surv-Date Presumed Alive, Mos, Flag (SEER)
Surv-Flag Active Followup (SEER)
Surv-Flag Active Followup, Mos Act Followup (SEER)
Surv-Flag Active Followup,Type Report Src (SEER)
Surv-Flag Presumed Alive (SEER)
Surv-Flag Presumed Alive, Mos Presumed Alive(SEER)
Surv-Flag Presumed Alive, Type Report Src (SEER)
Surv-Mos Active Followup (SEER)
Surv-Mos Presumed Alive (SEER)
Systemic RX, Surgery, Systemic/Sur Seq (COC)

Telephone (COC)
Text--Dx Proc--Path, Diagnostic Confirm (NAACCR)
Text--Histology Title (NAACCR)
Text--Primary Site Title (NAACCR)
TNM Clin Descriptor (COC)
TNM Clin Descriptor, Date of Diagnosis (NPCR)
TNM Clin Descriptor, Date of Diagnosis (SEER)
TNM Clin M (COC)
TNM Clin N (COC)
TNM Clin Stage Group (COC)
TNM Clin Stage Group, TNM Items, ICDO3 (COC)
TNM Clin Stage Group, TNM Path Stage Group (COC)
TNM Clin Stage Group, TNM Path Stage Group (NAACCR
TNM Clin Staged By (COC)
TNM Clin Staged By, Date of Diagnosis (SEER)
TNM Clin T (COC)
TNM Edition Number (COC)
TNM Edition Number, Date of Diagnosis (COC)
TNM Edition Number, Date of Diagnosis (NPCR)
TNM Edition Number, Date of Diagnosis (SEER)
TNM Edition Number, No AJCC Ed 5
Scheme,ICDO3(COC)
TNM Edition Number, No AJCC Ed 6
Scheme,ICDO3(COC)
TNM Edition Number, TNM Fields (NPCR)
TNM Edition Number, TNM Fields (SEER)
TNM Edition, TNM Clin Stage, TNM Path Stage (COC)
TNM Edition, TNM Clin Stage, TNM Path Stg (NAACCR)
TNM Path Descriptor (COC)
TNM Path Descriptor, Date of Diagnosis (NPCR)
TNM Path Descriptor, Date of Diagnosis (SEER)
TNM Path M (COC)
TNM Path N (COC)
TNM Path Stage Group (COC)
TNM Path Stage Group, TNM Items, ICDO3 (COC)
TNM Path Stage Group, TNM Items, ICDO3 (NAACCR)
TNM Path Staged By (COC)
TNM Path Staged By (NAACCR)
TNM Path Staged By, Date of Diagnosis (COC)
TNM Path Staged By, Date of Diagnosis (SEER)
TNM Path T (COC)
Tumor Marker 1 (SEER TUMMARK1)
Tumor Marker 1, Date of Diagnosis (SEER IF65)
Tumor Marker 1, Primary Site, Morph ICDO2 (COC)
Tumor Marker 1, Primary Site, Morph ICDO3 (COC)

Tumor Marker 1, Type of Report Srce (SEER IF67)
Tumor Marker 2 (SEER TUMMARK2)
Tumor Marker 2, Date of Diagnosis (SEER IF66)
Tumor Marker 2, Primary Site (COC)
Tumor Marker 2, Type of Report Srce (SEER IF68)
Tumor Marker 3 (SEER TUMMARK3)
Tumor Marker 3, Date of Diagnosis (SEER IF73)
Tumor Marker 3, Primary Site (COC)
Tumor Marker 3, Type of Report Srce (SEER IF74)
Tumor Record Number (NAACCR)
Type of Rep Srce(DC),Seq Num--Cent,ICDO3(SEER IF04
Type of Report Srce (AO), Date of Dx (SEER IF02)
Type of Report Srce (DC/AO), SEER Fup (SEER IF10)
Type of Report Srce(DC), EOD Coding Sys(SEER IF11)
Type of Report Srce(DC/AO), COD (SEER IF09)
Type of Report Srce(DC/AO), Diag Conf (SEER IF05)
Type of Report Srce(DC/AO), Vit Stat (COC)
Type of Report Srce(DC/AO), Vital Stat (SEER IF08)
Type of Report Srce, Diagnostic Proc (SEER IF20)
Type of Reporting Source (SEER RPRTSRC)
Type of Reporting Source, Date of DX (SEER IF152)
Unknown Site, Hist ICDO3, Summ Stg 1977 (NAACCR)
Unknown Site, Laterality (SEER IF138)
Unknown Site, Summary Stage 1977, ICDO2 (NAACCR)
Verify ICDO2 to ICDO3 Conversion (NAACCR)
Vital Status (COC)
Vital Status (SEER FUPSTAT)
Vital Status, Cause of Death (COC)
Vital Status, Cause of Death (SEER IF36)

Glossary

ACoS	American College of Surgeons
AJCC	American Joint Committee on Cancer
API	Application Program Interface
COC	Commission on Cancer
CS	Collaborative Staging
DOB	Date of Birth
DOD	Date of Death
EOD	Extent of Disease
EOVA	East Orange VA Medical Center
FORDS	Facility Oncology Registry Data Standards
ICD-O	International Classification of Diseases for Oncology
NAACCR	North American Association of Central Cancer Registries
NCDB	National Cancer Data Base
NCI	National Cancer Institute
NCRA	National Cancer Registrars Association
NPCR	National Program of Cancer Registries
PID#	Patient Identification Number First initial of the last name plus the last four digits of the SSN: W9999
PTF	Patient Treatment File
Report 80C	Report contains 80 columns and requires a printer that prints 80 columns
Report 132C	Report contains 132 columns and requires a printer that prints 132 columns; on screen the text wraps.
SEER	Surveillance, Epidemiology and End Results
SNOMED	Systematized Nomenclature of Medicine
SSN	Social Security Number
TNM	Primary Tumor, Regional Lymph Nodes, Distant Metastasis
VACCR	VA Central Cancer Registry
VISN	Veterans Integrated Service Network

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Appendix A: Edits API

Instituted May 2007 with OncoTraX: Cancer Registry V.2.11 - Patch ONC*2.11*47

Subject: EDITS Application Program Interface (API)

Category: INPUT TEMPLATE
ROUTINE
DATA DICTIONARY
ENHANCEMENT
PRINT TEMPLATE

Description:

This patch is available via FTP in a KIDS distribution file. The Host File is named ONC211P47.KID and is located in the [ANONYMOUS.SOFTWARE] directory of the following OI Field Offices.

Preferred Address:

First available ftp server download.vista.med.va.gov

SPECIFIC FIELD OFFICE	FTP ADDRESS
Albany	ftp.fo-albany.med.va.gov
Hines	ftp.fo-hines.med.va.gov
SLC	ftp.fo-slc.med.va.gov

All Data Dictionary modifications and additions have been reviewed and approved by the Data Base Administrator.

This patch will implement the EDITS API.

When the registrar attempts to set the ABSTRACT STATUS (#165.5,91) to 3 (Complete), three things will occur:

1. The program will first check to make sure that all of the "required" data items have been filled in. This is currently being done.
2. Once all of the "required" data items have been filled in, the program will pass the abstract through a series of local inter-field edit checks. This is also currently being done.

3. Once all of the local inter-field edit checks have been resolved (or overridden), the program will invoke the EDITS API and pass the abstract through the EDITS application. This feature is new with this patch.

Example:

```
ABSTRACT STATUS: Incomplete// Complete
All required data fields have been entered.
Beginning inter-field edit checks...
No inter-field edit check warnings.

Calling EDITS API...   <--new with this patch
```

If the EDITS API encounters errors the error messages will be displayed followed by the following message:

```
EDITS errors were encountered. ABSTRACT STATUS is unchanged.
```

Example:

```
Calling EDITS API...

Date of Last Contact, Date of Diag. (NAACCR IF19)
E:Date of Diagnosis and Date of Last Contact conflict
Date of Diagnosis (283)             = 12092004
Date of Last Contact (1294)         = 09052003

RETURN to continue, '^' to exit, or Edit# for help:

Edit Set                          Errors      Warnings
------------------------------------------------------------------------
Veterans Administration              1          0

EDITS errors were encountered. ABSTRACT STATUS is unchanged.
------------------------------------------------------------------------
```

Note: Each error will be numbered sequentially. If the registrar wishes to see additional information about a specific error, he/she may enter the sequential error number after the "RETURN to continue, '^' to exit, or Edit# for help:" prompt for additional error information.

If EDITS errors are encountered, the registrar should then review the error messages and resolve any data conflicts.

If the EDITS API does not encounter any errors the program will do the following:

- ABSTRACT STATUS will be set to 3 (Complete).
- A unique checksum value will be computed for the abstract.
- DATE CASE COMPLETED will be set to the current date.
- ABSTRACTED BY will be set to the registrar who 'completed' the abstract.

The following messages will be displayed:

```
No EDITS errors or warnings.

ABSTRACT STATUS.......: Complete
DATE CASE COMPLETED...: 03/21/2007
ABSTRACTED BY.........: REGISTAR,TEST
DATE CASE LAST CHANGED:
CASE LAST CHANGED BY..:

Computing checksum value for this abstract...
```

Once an abstract has successfully passed through the EDITS API and its ABSTRACT STATUS set to 3 (Complete), if the registrar makes a change which will affect the abstract's NAACCR record, he/she will see the following message:

```
You have made a change to a 'Completed' abstract.
This abstract needs to be re-run through the EDITS API.

Calling EDITS API...
```

If no EDITS errors are encountered the registrar will see the following message:

```
No EDITS errors or warnings.  ABSTRACT STATUS = 3 (Complete).
```

If EDITS errors are encountered the registrar will see the following message:

```
EDITS errors were encountered.

The ABSTRACT STATUS has been changed to 0 (Incomplete).
```

Each time a 'complete' abstract is changed the abstract will be date-stamped with the date of the most recent change and the name of registrar making the change.

Appendix B:

Patch Installation Instructions (Performed by your facility's OIT staff):

1. This patch is being distributed as a KIDS Host File:
   ONC211P47.KID (example)
2. This patch should be installed when the ONCOLOGY users are off the system.
3. The routines included in this patch should be installed in the production UCI.
4. This patch will take approximately 5 minutes to install. Only Oncology users need to be off the system. The ONCOLOGY options do not need to be disabled during the installation of this patch. Your customer support representative will answer any questions regarding this patch.

5. Recommended responses to the following installation questions:

```
Want KIDS to INHIBIT LOGONs during the install? YES// NO
Want to DISABLE Scheduled Options, Menu Options, and Protocols? YES// NO
```

Routine Information:

The checksums below are new checksums, and can be checked with CHECK1^XTSUMBLD.

Routine Name: ONCACD0
Before: B41786309 After: B50497175 **9,12,20,24,25,28,29,30,36,37, 38,40,41,44,45,47**

Routine Name: ONCACD1
Before: B35592372 After: B37943122 **9,12,14,18,20,22,24,25,26,28, 29,31,36,37,41,43,47**

Routine Name: ONCACDU2
Before: B61697601 After: B62930508 **12,18,20,21,22,24,26,27,29, 30,31,32,34,36,37,38,39,41,46, 47**

Routine Name: ONCCS
Before: B25089621 After: B25211155 **40,43,44,47**

Routine Name: ONCEDIT
Before: B41142697 After: B75961355 **27,28,34,36,39,42,43,45,46,47**

Routine Name: ONCEDIT2
Before: B39455814 After: B39277416 **27,28,32,33,44,47**

Routine Name: ONCGENED
Before: n/a After: B17687088 **47**

Routine Name: ONCMPH
Before: n/a After: B1505699 **47**

Routine Name: ONCNTX
Before: B81342152 After: B84335165 **13,15,16,19,22,25,26,27,32, 33,34,36,37,38,39,41,42,43,44, 45,46,47**

Routine Name: ONCOAI
Before: B27854044 After: B26893541 **6,15,17,18,19,25,26,27,28,29,
32,33,34,35,43,45,47**
Routine Name: ONCOAIF
Before: B23300069 After: B41938394 **11,15,16,24,25,26,27,28,37,45,47**
Routine Name: ONCOAIP
Before: B80340597 After: B83328289 **1,5,6,7,11,13,15,16,18,19,22,
24,27,28,32,33,34,35,36,37,38,
39,40,42,43,44,45,46,47**
Routine Name: ONCOCOM
Before: B34787186 After: B38430146 **1,6,11,12,13,14,16,17,19,25,
36,42,43,44,46,47**
Routine Name: ONCOCOS
Before: B16347858 After: B10396818 **5,13,16,17,19,22,24,36,42,45,47**
Routine Name: ONCODEL
Before: B20966808 After: B17087670 **7,15,19,22,27,28,30,36,47**
Routine Name: ONCODIS
Before: B1458506 After: B1400361 **6,7,9,10,11,12,13,14,15,16,
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**
Routine Name: ONCODSR
Before: B76463285 After: B77463937 **1,5,6,7,11,13,15,16,18,27,36,
37,42,46,47**
Routine Name: ONCODXD
Before: B16132012 After: B17370508 **11,13,15,16,18,36,47**
Routine Name: ONCOEDC
Before: B9401955 After: B20416700 **6,7,13,27,36,41,47**
Routine Name: ONCOEDC1
Before: B45858620 After: B50397068 **27,28,29,34,36,39,41,42,47**
Routine Name: ONCOFDP
Before: B14517564 After: B14858104 **1,5,16,22,25,26,47**
Routine Name: ONCOFTS
Before: B11936445 After: B13108300 **24,25,47**
Routine Name: ONCOFUP
Before: B6380858 After: B4130796 **2,22,25,47**
Routine Name: ONCOGEN
Before: B45716953 After: B47169178 **6,7,11,13,16,17,18,22,24,25,
26,29,44,46,47**

Routine Name: ONCOPA1

Before: B64644517 After: B51172298 **13,15,16,18,28,33,34,36,40, 41,42,43,44,45,46,47**

Routine Name: ONCOPA1A

Before: B21375895 After: B35964884 **15,19,27,33,34,36,40,44,45,46,47**

Routine Name: ONCOPA3

Before: B31483342 After: B32549593 **13,15,18,25,26,33,34,36,37, 44,45,46,47**

Routine Name: ONCOPMA

Before: B19369393 After: B20386342 **6,25,44,46,47**

Routine Name: ONCOPMB

Before: B21853476 After: B23097667 **11,23,25,44,46,47**

Routine Name: ONCOPMP

Before: B5147157 After: B5186790 **13,23,25,39,46,47**

Routine Name: ONCOTN

Before: B72159549 After: B74591340 **1,3,6,7,11,15,19,22,25,28,29, 35,36,37,41,42,43,44,46,47**

Routine Name: ONCOTNO

Before: B12536210 After: B13190026 **1,6,7,11,15,27,32,35,47**

Routine Name: ONCOUTC

Before: B15510360 After: B16162194 **5,24,25,47**

Routine Name: ONCPCI

Before: B14621628 After: B17696827 **15,19,24,26,27,28,33,35,36, 42,43,44,45,46,47**

Routine Name: ONCPRE47

Before: n/a After: B1068749 **47**

Routine Name: ONCPSD

Before: B4903225 After: B5294026 **15,19,22,28,34,36,40,45,47**

Routine Name: ONCPST47

Before: n/a After: B1743811 **47**

Routine Name: ONCSAPI

Before: B227298 After: B5208764 **40,47**

Routine Name: ONCSAPI1

Before: B23736526 After: B25134181 **40,41,47**

Routine Name: ONCSAPID

Before: B20217307 After: B21856891 **40,47**

Routine Name: ONCSAPIE

Before: B48334363 After: B50726698 **40,47**

Routine Name: ONCSAPIR

Before: B20113305 After: B26610695 **40,41,44,47**
Routine Name: ONCSAPIT
Before: B63834837 After: B76432501 **40,41,47**
Routine Name: ONCSAPIU
Before: B5721954 After: B7316141 **40,47**
Routine Name: ONCSAPIV
Before: B7451329 After: B11259789 **40,47**
Routine Name: ONCSAPIX
Before: B9724342 After: B9859486 **40,47**
Routine Name: ONCSED01
Before: n/a After: B13507255 **47**
Routine Name: ONCSED02
Before: n/a After: B17490289 **47**
Routine Name: ONCSED03
Before: n/a After: B44378907 **47**
Routine Name: ONCSED04
Before: n/a After: B25577841 **47**
Routine Name: ONCSEDEM
Before: n/a After: B3657858 **47**
Routine Name: ONCSNACR
Before: n/a After: B6005907 **47**
Routine Name: ONCSYMP
Before: B12957496 After: B11984863 **43,47**
Routine Name: ONCTIME
Before: n/a After: B5620212 **47**

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