2019 REPORTABLE CANCERS:

	CoC	NPCR/OSCaR
Reportable Diagnoses	1. Behavior code of 2 or 3 in ICD-O-3; or, for 2010 and later diagnoses, behavior code 3 according to the *WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues* (2008)[39]. 2. Non-malignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in Table 3.	1. Behavior code of 2 or 3 in ICD-O-3 (includes VIN III, VAIN III, AIN III); or, for 2010 and later diagnoses, behavior code 3 according to *the WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues (2008)*[39]. 2. Non-malignant (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3)* for primary sites as defined in Table 3.
Exceptions (not reportable)	1. Skin cancers (C44._) with histology 8000-8110 (after 1/1/2003); prior to that date, AJCC stage groups 2-4 in this group were reportable. 2. CIS of the cervix and CIN III (after 1/1/96). 3. PIN III (after 1/1/96). 4. VIN III (after 1/1/96). 5. VAIN III (after 1/1/96). 6. AIN (after 1/1/96).	1. Skin cancers (C44._) with histologies 8000-8005, 8010-8046, 8050-8084, 8090-8110. 2. CIS of the cervix and CIN III. 3. PIN III (after 1/1/2001).
Multiple Primary Rules	2007 Multiple Primary and Histology Coding Rules (most recent version).	2007 Multiple Primary and Histology Coding Rules (most recent version).

	CoC	NPCR/OSCaR
Ambiguous Terminology Considered as Diagnostic of Cancer**	apparent(ly) appears comparable with compatible with consistent with favors malignant appearing most likely presumed probable suspect(ed) suspicious (for) typical of Exception: if the cytology is reported using any of these ambiguous terms and neither a positive biopsy nor a physician's clinical impression supports the cytology findings, do not consider as diagnostic of cancer.	apparent(ly) appears comparable with compatible with consistent with favors malignant appearing most likely presumed probable suspect(ed) suspicious (for) typical of Exception: if the cytology is reported using any of these ambiguous terms and neither a positive biopsy nor a physician's clinical impression supports the cytology findings, do not consider as diagnostic of cancer.
Ambiguous Terminology NOT Considered as Diagnostic of Cancer**	cannot be ruled out equivocal possible potentially malignant questionable rule out suggests worrisome	cannot be ruled out equivocal possible potentially malignant questionable rule out suggests worrisome

*** Juvenile astrocytomas should be reported as 9421/3.**

**** Do not substitute synonyms such as "supposed" for "presumed" or "equal" for "comparable." Do not substitute "likely" for "most likely." Use only the exact words on the list.**

Table 3. Primary Site Codes for Non-Malignant Primary Intracranial and Central Nervous System Tumors (non-malignant primary intracranial and central nervous system tumors with a behavior code of 0 or 1 [benign/borderline] are reportable regardless of histologic type for these topography codes).

Topography	
Codes	**Description**
C70.0 C70.1 C70.9	Meninges Cerebral Meninges Spinal meninges Meninges, NOS
C71.0 C71.1 C71.2 C71.3 C71.4 C71.5 C71.6 C71.7 C71.8 C71.9	Brain Cerebrum Frontal lobe Temporal lobe Parietal lobe Occipital lobe Ventricle, NOS Cerebellum, NOS Brain stem Overlapping lesion of brain Brain, NOS
C72.0 C72.1 C72.2 C72.3 C72.4 C72.5	Spinal Cord, Cranial Nerves, and Other Parts of the Central Nervous System Spinal cord Cauda equina Olfactory nerve Optic nerve Acoustic nerve Cranial nerve, NOS

Topography	
Codes	**Description**
C72.8 C72.9	Overlapping lesion of brain and central nervous system Nervous system, NOS
C75.1 C75.2 C75.3	Other Endocrine Glands and Related Structures Pituitary gland Craniopharyngeal duct Pineal gland

Source: **Table 2. NAACCR Layout Version 18: Comparison of Reportable Cancers: CoC, SEER, NPCR and CCCR.** http://datadictionary.naaccr.org/?c=3

Multiple Primary Rules

SEER rules have been the *de facto* standard for determining the number of primary cancers in the U.S. for both central and hospital-based registries. See the SEER *Program Coding and Staging Manuals*[3] for details. SEER convened a multi-agency task force (with representation from Canada) to review and revise the multiple primary and histology (MP/H) coding rules in a manner that promotes consistent, standardized determination of multiple primaries and coding of histologies at the data collection level. The revised MP/H rules were implemented January 2007. Additional information is available on the SEER website.[4]

A rule requiring that an invasive tumor diagnosed more than two months after an *in situ* tumor of the same site be reported as a subsequent primary was reviewed by the Uniform Data Standards Committee and adopted on April 26, 1994, effective with tumors diagnosed in 1995 and later. This rule remains in effect and is incorporated into the 2007 MP/H rules as follows:

An invasive tumor following an *in situ* tumor more than 60 days after diagnosis is considered a multiple primary.

Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.

Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.[4]