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Canadian Cancer Registry Manuals

Input data dictionary

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1.0 Introduction

1.1 Content of iInput data dictionary

The purpose of the Input Data Dictionary is to describe the valid content of **patient records** and **tumour records**.

Each record type contains:

a) a *record layout*, showing the name, sequence and size of each field of the record; and
b) a *field definition*, providing a description of each field / data element, and the range of its valid content.

The Input Data Dictionary contains a set of **validation routines** which are common to more than one field and/or common to both *patient* and *tumour records*.

There are six **consistency-input match edits**. These edits ensure that, within any submission, the set of input records for a patient is complete and coherent in terms of the operation to be performed - i.e. posting new records, changing or deleting existing records on the CCR, and/or changing ownership of the *patient record*.

There are five sets of **correlation edits**: the first are intra-record correlations, followed by three sets of inter-record correlations. Intra-record correlations exist for both *patient* and *tumour records*, ensuring that consistent and reasonable relationships exist between different, valid, data elements within each record. The three sets of inter-record correlations - patient record *vs* patient record, tumour record *vs* patient record, and tumour record *vs* tumour record - ensure that all the data relating to one person (one *patient record* and one or more *tumour records*) contain no inconsistencies.

When performing inter-record correlations between the same kind of records (*patient* and *tumour*), the symbol **"(I)"** is used to distinguish data arriving as new input into the CCR, from data already resident on the registry. For comparisons made between two new tumours registered in the same data submission, the first one posted on the CCR becomes **Tumour**, while the second becomes **Tumour(I)**.

The correlation edits sections are followed by the **additional rules for updating the Canadian Cancer Registry**. These three rules complement others within the correlations to ensure that changes made to the CCR respect its logic and structure.

Finally, the Input Data Dictionary contains a series of **appendices** that describe the tables and "coding files" referenced during the edit process, or contain information on the preparation of data for the CCR. In the case of the coding files, there is a record layout, and either a sample of the file's content (larger files), or a copy of the entire file.

1.2 CCR overview

1.2.1 Canadian cancer registry

The patient-oriented Canadian Cancer Registry (CCR) evolved from the event-oriented The National Cancer Incidence Reporting System (NCIRS). Beginning with cases diagnosed in 1992, incidence figures collected by Provincial and Territorial Cancer Registries (PTCRs) have been reported to the CCR, which is maintained by Statistics Canada. Established as a person-oriented database, the CCR includes mechanisms for updating and clearing death records and is linked to provincial databases to help track patients across Canada who have been diagnosed with tumours. Some non-malignant tumours are also included in the CCR[1].

1.2.2 Nature of the data

The CCR, which is person-oriented, has the capacity to identify and eliminate the duplicate reporting of tumours. Thus, the data introduced into the CCR describe both the individual with cancer and the characteristics of that tumour. The PTCRs provide the personal data on a *patient record*, and the details of the cancer, on a *tumour record*.

1.2.3 Adding records to the CCR

A PTCR registers each new tumour diagnosed among its resident population. When this is the person's first cancer, the PTCR creates both a *patient* and *tumour record*, and forwards them to the CCR. Only one *patient record* is maintained for each person on the CCR database. Thus, for any subsequent cancer for that same person, the PTCR submits only the relevant *tumour record*. There are as many *tumour records* as there are distinct cancers diagnosed.

When Statistics Canada receives an initial *patient-tumour record* combination, adding a new person to the CCR, it assigns a **CCR Identification Number (CCRID)** to the individual. This number is first posted onto all relevant records on the CCR, then fed back to the PTCR who originally submitted the data, and henceforward included on all subsequent records for that person.

1. The cancers that are reportable to the CCR are classified according to the *International Classification of Diseases for Oncology - 2nd Edition* or *3rd Edition* (ICD-O-2/ICD-O-3). The CCR will include the following cancers:
   - all primary, malignant tumours (topography codes C00.0-C80.9) with behaviour code of 3, **except** squamous cell skin cancer (morphology codes 805-808) and basal cell skin cancer (morphology codes 809-811) with topographies C44.0-C44.9;
   - in situ/intraepithelial/non-infiltrating/non-invasive carcinomas (all topographies with behaviour code of 2);
   - primary, benign tumours of the brain and central nervous system (topographies C70.0-C72.9 with behaviour code of 0); and,
   - borderline malignancies (all topographies with behaviour code of 1).

1.2.4 Record types (functions)

There are four types of *patient records* and three types of *tumour records*, each of which performs a discrete function in the creation and maintenance of the CCR database: **new** records, **update** records, **delete** records and **change of ownership** *patient records*.

New *patient records* are submitted by PTCRs to register persons for the first time on the CCR. They are characterized by the absence of a CCR Identification Number (CCRID). New *tumour records* add newly diagnosed cancers to the registry. Only the patient's first-reported, new *tumour record* does not have CCR Identification Number (CCRID) when submitted to the registry.

Update records change the content of records already posted to the CCR. Both *patient* and *tumour record* updates require a CCR Identification Number (CCRID), and completely replace existing records with their own content. Therefore, updating involves the replacement of the record and not simply a replacement of fields. Thus, changing the content of one field requires the re-submission of all the unchanged fields as well.

Delete records completely remove entire records from the registry. A number of fields on the delete record must match exactly with a record on the CCR to permit the exercise of the delete function. For both *patient* and *tumour records*, the common match keys are: Reporting Province/Territory, Patient Identification Number (PIN) and CCR Identification Number (CCRID). In addition, *tumour records* have to match by the Tumour Reference Number. Only the above fields, along with Patient / Tumour Record Type and Date of Transmission, are reported on a delete record and subsequently edited; the rest of the record is left blank.

The deletion of a *patient record* does not automatically delete all associated *tumour records*. Therefore, when a *patient record* is removed from the CCR, the PTCR must submit one delete *patient record* and as many delete *tumour records* as there are tumours registered by that PTCR. Failure to do so will nullify the function.

Even when a PTCR correctly deletes a *patient record* from the CCR, it could result in an earlier *tumour record* for that patient from another PTCR left "hanging" on the registry - i.e. it does not have the required *patient record* with it on the database. When such a situation is detected, the *patient record* is not really deleted, but rather it is "inherited" by the PTCR that registered the earlier tumour, and given the identifiers from the "hanging" *tumour record*, namely, Reporting Province/Territory and Patient Identification Number (PIN).

Finally, **Change of ownership** *patient records* permit PTCRs to report new tumours for patients already registered on the CCR, and whose current patient records are "owned" by another PTCR (see below, section 1.2.5 - Ownership of Data and Responsibility for Updates). Use of change of ownership *patient records*, in these cases, avoids the posting onto the CCR of duplicate *patient records* for the same patient by two different reporting provinces/territories.

A change of ownership *patient record* is characterized by the fact that it already has a CCR Identification Number (CCRID), and it must be accompanied, in the same data submission, by at least one new *tumour record* containing the same CCR Identification Number (CCRID). This means that the PTCR must have either obtained the CCR Identification Number (CCRID) from another PTCR, or have registered this patient in the past. In order to minimize risks of errors, the change of ownership *patient record* must also have reported valid data for Sex and Year of Birth, that do not conflict with information already contained in the *patient record* currently on the CCR data base.

The use of this record type presumes close cooperation and sharing of information between PTCRs, and avoids the more cumbersome and time consuming duplicate identification/resolution process using record linkage.

1.2.5 Ownership of data and responsibility for updates

Patient record: it belongs to the PTCR in whose jurisdiction the individual resided at the time of the **most recent/latest** diagnosis of a new tumour. When a new tumour is diagnosed (including by "death certificate only") for a patient residing in a different province/territory, it is the responsibility of the PTCR where the diagnosis was made to pass along the information to the PTCR of residence. This PTCR, in turn, registers the tumour on the CCR, and consequently establishes ownership of the *patient record*.

Tumour record: it belongs to the PTCR in whose jurisdiction the patient resided at the time of the **earliest** diagnosis of the particular tumour being described by the record, regardless of where the diagnosis occurred.

Only the PTCR "owning" the record may submit updates or deletions. Even when other PTCRs have more accurate or recent information, these data can only be submitted via the owner PTCR.

1.2.6 Changing ownership

Ownership of the *patient record* can be transferred to another PTCR under three circumstances. First, when the individual moves to another province/territory and is subsequently diagnosed with a new cancer (including those discovered by "*death certificate only*").

Secondly, if the internal record linkage process discovers that a given tumour was diagnosed earlier and registered by another registry, ownership of the *patient record* could possibly be transferred to another PTCR. This occurs when, following the removal of the duplicate tumour registration, the latest Date of Diagnosis has been reported in a *tumour record* from another PTCR. This registry then becomes the *owner* of that particular *patient record*.

Finally, in rare situations, ownership of a *patient record* can revert to a previous owner. This occurs when the current owner deletes its *patient* and *tumour records* for an individual, leaving a *tumour record* on the CCR previously registered by another PTCR. In order to avoid that this *tumour record* remains on the CCR without an accompanying *patient record*, ownership of the "deleted" *patient record* is returned to the previous owner PTCR.

Ownership of *tumour records* does not change. When the internal record linkage reveals that the same tumour was diagnosed and registered for the same patient by two different PTCRs, one of the duplicate *tumour records* will be deleted (namely, the one with the later Date of Diagnosis). This situation is due to variations in the frequency of the submission of diagnosis information to the CCR, in the completeness of the diagnostic information, and in the effectiveness of the internal record linkage.

Since the concept of ownership is a fundamental aspect of the operation of the CCR, the affected PTCRs are informed about any proposed changes of ownership and involved in the measures undertaken.

1.2.7 Movement between province/territory

When a patient moves to another province/territory, no CCR update is required. Ownership of records and their content remains unchanged.

However, if another cancer is diagnosed in the new province/territory, both a *patient record* and *tumour record* are submitted to the CCR. When the CCR Identification Number (CCRID) is known, it is included on the records; the Patient Record Type is coded as a ***change of ownership*** record, and the Tumour Record Type as a ***new*** record. If the CCR Identification Number (CCRID) is unknown, then both records are submitted as ***new*** records, and the function of the CCR internal record linkage process is to determine if these records refer to a person already registered on the CCR. The new cancers

subsequently reported by the PTCR for the same person will only require the submission of the appropriate *tumour record*. The same process applies for diagnoses made by "death certificate only".

1.2.8 Field characteristics by record type

The *patient* and *tumour record* summaries presented on the next two pages illustrate the differences between the various record types - new, update, delete and change of ownership. They distinguish between the fields that **can never be blank** (V or v), those that **may be blank** (b) and those that **must be blank** (B). Some fields must always have valid codes, and do not include a code for "unknown" (V); while others must always have valid codes, but include a code for "unknown" (v).

Field characteristics by record type: patient record

Field	Position	Description	New	Update	Delete	Change of own.
P1	1-2	Reporting Province/Territory	V	V	V	V
P2	3-14	Patient Identification Number (PIN)	V	V	V	V
P3	15-23	CCR Identification Number (CCRID)	B	V	V	V
P4	24	Patient Record Type	= 1	= 2	= 3	= 4
P5	25	Type of Current Surname	v	v	B	v
P6	26-50	Current Surname	b	b	B	b
P7	51-65	First Given Name	b	b	B	b
P8	66-80	Second Given Name	b	b	B	b
P9	81-87	Third Given Name	b	b	B	b
P10	88	Sex	v	v	B	V
P11	89-96	Date of Birth	v	v	B	V*
P12	97-99	Province/Territory or Country of Birth	v	v	B	v
P13	100-124	Birth Surname	b	b	B	b
P14	125-132	Date of Death	v	v	B	v
P15	133-135	Province/Territory or Country of Death	v	v	B	v
P16	136-141	Death Registration Number	v	v	B	v
P17	142-145	Underlying Cause of Death	v	v	B	v
P18	146	Autopsy Confirming Cause of Death	v	v	B	v
P19	147-154	Date of Transmission	V	V	V	V

* Year of Birth must be reported; Month & Day may be unknown.

Record Type:	
1 = New 2 = Update 3 = Delete 4 = Change of ownership	V = valid codes only; cannot be unknown; cannot be blank v = valid codes only; may have a code for unknown; cannot be blank B = must be all blank b = may be all blank when unknown

Field characteristics by record type: tumour record

Field	Position	Description	New	Update	Delete
T1	1-2	Reporting Province/Territory	V	V	V
T2	3-14	Patient Identification Number (PIN)	V	V	V
T3	15-23	Tumour Reference Number	V	V	V
T4	24-32	CCR Identification Number (CCRID)	B/V*	V	V
T5	33	Tumour Record Type	= 1	= 2	= 3
T6	34-58	Place Name of Residence at Time of Diagnosis	b	b	B
T7	59-64	Postal Code	v	v	B
T8	65-71	Standard Geographic Code (SGC) of Place of Residence at Time of Diagnosis	V	V	B
T9	72-80	Census Tract	v	v	B
T10	81-95	Health Insurance Number	v	v	B
T11	96	Method of Diagnosis (1992 – 2003 data)	v	v	B
T12	97-104	Date of Diagnosis	V	V	B
T13	105-108	ICD-9	V	V	B
T14	109	Source Classification Flag (SCF)	V	V	B
T15	110-113	ICD-O-2/3 – Topography	V	V	B
T16	114-117	ICD-O-2 – Morphology	v	v	B
T17	118	ICD-O-2 - M Behaviour Code	V	V	B
T18	119-122	ICD-10	V	V	B
T19	123	Laterality	v	v	B
T20	124	Filler (Multifocal Tumours) (no longer reported to the CCR)	**	**	B
T21M	125-128	ICD-O-3 – Morphology	v	v	B
T21B	129	ICD-O-3 - M Behaviour Code	V	V	B
T23	130	Method Used to Establish the Date of Diagnosis (effective 2004 data forward)	v	v	B
T24	131	Diagnostic Confirmation (effective 2004 data forward)	v	v	B
	132	Filler			
T22	133-140	Date of Transmission	V	V	V

* This field must be blank (B) when a new *tumour record* is submitted with a new *patient record*; valid codes only (V) when the incoming new *tumour record* has an associated *patient record* already on the base.

** Multifocal Tumours were removed from the CCR and the data dictionary.

Record Type:	
1 = New 2 = Update 3 = Delete	V = valid codes only; cannot be unknown; cannot be blank v = valid codes only; may have a code for unknown; cannot be blank B = must be all blank b = may be all blank when unknown

1.3 How to submit data to the CCR

Provincial and Territorial Cancer Registries (PTCRs) must choose among the four different types of *patient records* and three kinds of *tumour records* when making a data submission to the CCR. To make the choice easier, the following sections describe a number of data-submission scenarios showing the valid record combinations.

The rules

1. All responses in the different data fields must be valid, as defined in the Patient Record and Tumour Record Validation Edits;
2. The relationships between the data fields must be consistent and reasonable, as described in the five sets of Correlation Edits; and,
3. The logical association, as specified in the Input Match Edits and the Additional Rules for Updating the Canadian Cancer Registry, must be maintained among the functions to be performed (i.e. add, change & delete), the records being submitted and the records already residing on the CCR database.

1.3.1 How to submit data for a new patient diagnosed with a first tumour

When a patient is diagnosed with cancer for the first time, the PTCR submits only one *patient record* together with at least one *tumour record* in the same CCR data submission. More than one *tumour record* can be reported at this time if there was more than one new primary cancer diagnosed prior to the initial registration of this patient on the CCR.

Patient record:

- only one;
- no CCR Identification Number (CCRID) (Field P3 = *all blank*);
- new *patient record* Patient Record Type (Field P4) = 1.

Note:

There cannot be updates or deletes in the same CCR data submission as the one that is used to register this new patient.

Tumour record(s):

- at least one;
- Reporting Province/Territory (Field T1) on the new *tumour record(s)* must be identical to the Reporting Province/Territory on the new *patient record* (Field P1);
- Patient Identification Number (PIN) (Field T2) on the new *tumour record(s)* must be identical to the Patient Identification Number (PIN) on the new *patient record* (Field P2);
- no CCR Identification Number (CCRID) (Field T4 = *all blank*);
- new *tumour record* Tumour Record Type (Field T5) = 1.

Important Rule: All *patient record* or *tumour record* within the same data submission can only be subjected to one function (i.e. add, update, change of ownership or delete). A PTCR cannot add a new *tumour record* and update it, or update a record as well as delete it in the same CCR data submission. Any attempt to perform more than one function on a specific *patient* or *tumour record* within the same data submission will result in all records being rejected.

1.3.2 How to submit data for a new 'second' *patient record* for the same patient

Impossible! There can be only one *patient record* per individual on the CCR (i.e. having the same Reporting Province/Territory (Field P1) and Patient Identification Number (PIN) (Field P2), and/or the same CCR Identification Number (CCRID) (Field P3)). Once a patient is registered on the CCR, his *patient record* can only be updated (replaced) or deleted.

1.3.3 How to report a subsequent new *tumour record* for the same patient

There are two ways in which this can be accomplished. (See the section 1.2.5 entitled Ownership of Data and Responsibility for Updates of this document).

i) For the PTCR currently owning the *patient record*:

Patient record:

- none required.

Note:

An update to a *patient record* (for the same patient) may be included in the same CCR data submission

Tumour record:

- one for each new tumour;
- Reporting Province/Territory (Field T1) of the new *tumour record* must be identical to the Reporting Province/Territory of the *patient record* on the CCR;
- Patient Identification Number (PIN) (Field T2) of the new *tumour record* must be identical to the Patient Identification Number (PIN) of the *patient record* on the CCR;
- Tumour Reference Number (Field T3) must be unique, i.e. it cannot be identical to the Tumour Reference Number of any other *tumour record* already on the CCR having the same Reporting Province/Territory and Patient Identification Number (PIN);
- CCR Identification Number (CCRID) (Field T3) of the new *tumour*

Note:

For a given patient, a new *tumour record* may be accompanied by other new *tumour records*, as well as by updates and deletes (for *tumour records* already on the CCR).

record must now be reported and be identical to the CCR Identification Number (CCRID) of the *patient record* on the CCR;
- new *tumour record* Tumour Record Type (Field T5) = 1.

ii) For PTCR NOT currently owning the *patient record*:

The new PTCR wishing to register a patient with a newly diagnosed second/third/etc. tumour, for which the preceding cancer was diagnosed after 1991 while the patient was living in another Canadian province or territory, has two choices: either treat both the *patient* and *tumour record*s as "new", as described in number 1 above; or initiate a change of ownership process.

By reporting both records as new, a duplicate *patient record* for that individual will be created on the CCR. This duplication will be identified and resolved by the internal record linkage phase.

The change of ownership process permits a PTCR, when registering a new tumour, to assume ownership of the relevant *patient record* already on the CCR. In order to be able to accomplish this change, the new PTCR needs the CCR Identification Number (CCRID) assigned to the *patient record*. This number can be obtained from the PTCR of the province/territory of the patient's residence at the time of the diagnosis of the latest tumour.

Patient record:

- only one;
- Reporting Province/Territory (Field P1) of the change of ownership *patient record* must be different from the Reporting Province/Territory of the *patient record* on the CCR;
- CCR Identification Number (CCRID) (Field P3) of the new *patient record* must be reported and by identical to the CCR Identification Number (CCRID) of the *patient record* on the CCR;
- change of ownership *patient record* Patient Record Type (Field P4) = 4.

Tumour record(s):

- at least one;
- Reporting Province/Territory (Field T1) on new *tumour record(s)* must be identical to the Reporting Province/Territory on change of ownership *patient record* (Field P1);
- Patient Identification Number (PIN) (Field T2) on new *tumour record(s)* must be identical to the Patient Identification Number (PIN) on change of ownership *patient record* (Field P2);

Note:

For change of ownership, there can be no accompanying update or delete *of patient* or *tumour records* for the patient in the same CCR data submission.

- Tumour Reference Number (Field T3) must be unique, i.e. it cannot be identical to the Tumour Reference Number of any *tumour record* already on the CCR having the same Reporting Province/Territory and Patient Identification Number (PIN);
- CCR Identification Number (CCRID) (Field T3) of the new *tumour record* must now be reported and identical to the CCR Identification Number (CCRID) of the *patient record* on the CCR;
- new *tumour record* Tumour Record Type (Field T5) = 1.

1.3.4 How to update a *patient record* on the CCR

Patient record:

- only one;
- Reporting Province/Territory (Field P1) of the update *patient record* must be identical to the Reporting Province/Territory of the *patient record* on the CCR;
- Patient Identification Number (PIN) (Field P2) on update *patient record* must be identical to the Patient Identification Number (PIN) on the *patient record* on the CCR;
- CCR Identification Number (CCRID) (Field P3) of the update *patient record* must be identical to the CCR Identification Number (CCRID) of the *patient record* on the CCR;
- update *patient record* Patient Record Type (Field P4) = 2.

Note:

Because the update *patient record* replaces the *patient record* on the CCR, all data fields (P5 - P18) require re-submission.

Tumour record:

- none required.

Note:

The update *patient record* can be accompanied by new, update and delete *tumour records* for the patient in question..

1.3.5 How to update a *tumour record* on the CCR

Patient record:

- none required.

Note:

The same CCR data submission may include an update *patient record* for the patient in question.

Tumour record:

- Reporting Province/Territory (Field T1), Patient Identification Number (PIN) (Field T2), Tumour Reference Number (Field T3) and CCR Identification Number (CCRID) (Field T4) of the update *tumour record* must be identical to the Reporting Province/Territory, Patient Identification Number (PIN), Tumour Reference Number and CCR Identification Number (CCRID) of a *tumour record* on the CCR;
- update *tumour record* Tumour Record Type (Field T5) = 2.

Note:

Because the update tumour record completely replaces the tumour record on the CCR, all data fields (T6 - T20) require re-submission.

Note:

For the same patient, an update *tumour record* may be accompanied by new *tumour records*, as well as update and delete *tumour records* for other tumour records already on the CCR.

1.3.6 How to delete a *patient record* on the CCR

Patient record:

- only one;
- Reporting Province/Territory (Field P1) of the delete *patient record* must be identical to the Reporting Province/Territory of the *patient record* on the CCR;
- Patient Identification Number (PIN) (Field P2) on delete *patient record* must be identical to the Patient Identification Number (PIN) on the *patient record* on the CCR;
- CCR Identification Number (CCRID) (Field P3) of the delete *patient record* must be identical to the CCR Identification Number (CCRID) of the *patient record* on the CCR;
- delete *patient record* Patient Record Type (Field P4) = 3;
- all data fields (P5 - P18) must be left blank;
- Date of transmission (Field P19) must have a valid date.

Tumour record(s):

- at least one;
- Reporting Province/Territory (Field T1), Patient Identification Number (PIN) (Field T2) and CCR Identification Number (CCRID) (Field T4) of the delete *tumour record* must be identical to the Reporting Province/Territory (Field P1), Patient Identification Number (PIN) (Field P2) and CCR Identification Number (CCRID) (Field P3) of the delete *patient record*;
- Reporting Province/Territory (Field T1), Patient Identification Number (PIN) (Field T2), Tumour Reference Number (Field T3) and CCR Identification Number (CCRID) (Field T4) of the delete *tumour record* must be identical to the Reporting Province/Territory, Patient Identification Number (PIN), Tumour Reference Number, and CCR Identification Number (CCRID) of a *tumour record* on the CCR;
- delete *tumour record* Tumour Record Type (Field T5) = 3;
- all data fields (T6 - T21) must be left blank;
- Date of transmission (Field T22) must have a valid date.

Note:

In the same data submission, there must be a delete *tumour record* for every *tumour record* on the CCR having the same Reporting Province/Territory, Patient Identification Number (PIN) and CCR Identification Number (CCRID) as the delete *patient record*.

1.3.7 How to delete a *tumour record* on the CCR

Patient record:

- none required.

Note:

An update *patient record*, for the patient in question, may be included in the same CCR data submission.

Tumour record:

- Reporting Province/Territory (Field T1), Patient Identification Number (PIN) (Field T2), Tumour Reference Number (Field T3) and CCR Identification Number (CCRID) (Field T4) of the delete *tumour record* must be identical to the Reporting Province/Territory, Patient Identification Number (PIN), Tumour Reference Number and CCR Identification Number (CCRID) of a *tumour record* on the CCR;
- delete *tumour record* Tumour Record Type (Field T5) = 3;
- all data fields (T6 - T21) must be left blank;
- Date of transmission (Field T22) must have a valid date.

Note:

the same patient, new *tumour records*, as well as update and delete *tumour records* for other *tumour records* already on the CCR, may accompany a delete *tumour record*.

1.4 Responsibility of the provincial & territorial cancer registries

The CCR is designed to accept only valid data reported by the Provincial/Territorial Cancer Registries. While the CCR is capable of detecting invalid data, there is no error-correction mechanism. Thus, any input records containing invalid data are **not posted** to the CCR database, but are returned to their province/territory of origin for correction and re-submission to the CCR. Therefore, it is the PTCRs' responsibility to implement the specifications contained in the Input Data Dictionary in their entirety. **Only records containing valid data, organized in standard format and using standard codes will be loaded onto the CCR database**.

Since strict adherence to the Input Data Dictionary is imperative, PTCR staff is encouraged to bring forward any questions, and clarify any doubts, by contacting one of the following:

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2.0 Patient record

2.1 Input patient record layout (index of validation edits)

Field	Size	Position	Type	Description	Validation edit no.	Page
P1	2	1-2	N	Reporting Province/Territory	01	19
P2	12	3-14	AN	Patient Identification Number (PIN)	02	20
P3	9	15-23	AN	CCR Identification Number (CCRID)	03	21
P4	1	24	N	Patient Record Type	04	22
P5	1	25	N	Type of Current Surname	05	23
P6	25	26-50	AN	Current Surname	06	24
P7	15	51-65	AN	First Given Name	07	25
P8	15	66-80	AN	Second Given Name	08	26
P9	7	81-87	AN	Third Given Name	09	27
P10	1	88	N	Sex	10	28
P11	8	89-96	N	Date of Birth	11	29
P12	3	97-99	N	Province/Territory or Country of Birth	12	30
P13	25	100-124	AN	Birth Surname	13	31
P14	8	125-132	N	Date of Death	14	32
P15	3	133-135	N	Province/Territory or Country of Death	15	33
P16	6	136-141	N	Death Registration Number	16	34
P17	4	142-145	AN	Underlying Cause of Death	17	35
P18	1	146	N	Autopsy Confirming Cause of Death	18	36
P19	8	147-154	N	Date of Transmission	19	37

2.2 Input patient data dictionary

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 01

Item name: Reporting Province/Territory

Field no.: P1

Length: 2

Type: Numeric

Description: The Standard Geographic Code (SGC) of the province/territory submitting the *patient record* to the CCR. Refer to *Residency Guidelines in Canada* in Appendix Q.

Values & meaning:

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

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 02

Item name: Patient Identification Number (PIN)

Field no.: P2

Length: 12

Type: Alphanumeric

Description: The unique identification number assigned by the provincial/territorial registry to each new patient registered. **It cannot be updated or reused**.

Note: Should be left justified, followed by blanks as required.

Values & meaning: Can be composed of any unique combination of numbers and upper case alphabetic (A to Z). The following special characters are not allowed: accents, embedded blank ( ), period (.), apostrophe (') and hyphen (-).

Cannot be all blank.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 03

Item name: CCR Identification Number (CCRID)

Field no.: P3

Length: 9

Type: Alphanumeric

Description: A unique number assigned by Statistics Canada to each new patient at the time of the initial registration in the CCR.

Note: This field will be blank when the registration is first submitted to the CCR by a provincial/territorial cancer registry. However, any subsequent changes to this registration must contain the CCRID.

Values & meaning: All blank or all numeric.

All blank: New patient registration (no CCRID has been assigned yet).

Cannot be all zeroes (000000000).

Number must be validated (see Routine No. 03).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 04

Item name: Patient Record Type

Field no.: P4

Length: 1

Type: Numeric

Description: The code which identifies whether the record is new to the CCR or is an update of an existing *patient record*, or whether the *patient record* currently on the registry is to be deleted or the ownership of the *patient record* is changed to another province/territory.

Values & meaning:
1: New record
2: Update record
3: Delete record
4: Change of ownership record

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 05

Item name: Type of Current Surname

Field no.: P5

Length: 1

Type: Numeric

Description: A code describing the type of surname currently used by the patient (see Field P6, Current Surname).

Values & meaning:

0: Current Surname unknown
1: Birth Surname
2: Other type of surname (e.g. married name, legal change-of-name, etc.)
9: Type of surname unknown

Blank: Only when Patient Record Type (Field P4) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 06

Item name:	Current Surname
Field no.:	P6
Length:	25
Type:	Alphanumeric
Description:	The surname currently used by the patient. Note: Should be left justified, followed by blanks as required. Can be all blank only if Birth Surname (Field P13) is not blank. Omit all titles such as Dr., Rev., Maj., Sr., M.D., Ph.D., Q.C., M.P.
Values & meaning:	All blank: Unknown or Patient Record Type (Field P4) = 3. Upper and lower case alphabetic (A/a to Z/z), with or without accents, blanks ( ), periods (.), apostrophes (') and hyphens (-) are valid. See Appendix A. If not all blank, must contain at least one alphabetic letter (A/a - Z/z).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 07

Item name:	First Given Name
Field no.:	P7
Length:	15
Type:	Alphanumeric
Description:	The first given name (or initial) currently used by the patient. Note: Should be left-justified, followed by blanks as required.
Values & meaning:	All blank: Unknown or patient has no First Given Name or Patient Record Type (Field P4) = 3. Upper and lower case alphabetic (A/a to Z/z), with or without accents, blanks ( ), periods (.), apostrophes (') and hyphens (-) are valid. See Appendix A. If not all blank, must contain at least one alphabetic letter (A/a - Z/z).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 08

Item name:	Second Given Name
Field no.:	P8
Length:	15
Type:	Alphanumeric
Description:	The second given name (or initial) currently used by the patient. Note: Should be left-justified, followed by blanks as required.
Values & meaning:	All blank: Unknown or patient has no Second Given Name or Patient Record Type (Field P4) = 3. Upper and lower case alphabetic (A/a to Z/z) with or without accents, blanks ( ), periods (.), apostrophes (') and hyphens (-) are valid. See Appendix A. If not all blank, must contain at least one alphabetic letter (A/a - Z/z).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 09

Item name:	Third Given Name
Field no.:	P9
Length:	7
Type:	Alphanumeric
Description:	The third given name (or initial) currently used by the patient. Note: Should be left-justified, followed by blanks as required.
Values & meaning:	All blank: Unknown or patient has no Third Given Name or Patient Record Type (Field P4) = 3. Upper and lower case alphabetic (A/a to Z/z), with or without accents, blanks ( ), periods (.), apostrophes (') and hyphens (-) are valid. See Appendix A. If not all blank, must contain at least one alphabetic letter (A/a - Z/z).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 10

Item name: Sex

Field no.: P10

Length: 1

Type: Numeric

Description: The sex of the patient.

Values & meaning:
1: Male
2: Female
9: Sex unknown

Blank: Only when Patient Record Type (Field P4) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 11

Item name: Date of Birth

Field no.: P11

Length: 8

Type: Numeric

Description: The patient's date of birth, represented by the century, year, month, and day.

Values & meaning:

Format: YYYYMMDD

YYYY:	Four digit numerical year
1875 - xxxx:	Valid years (where xxxx = current reference year)
9999:	Year unknown (then Month and Day of Birth must also be coded as unknown)
MM:	Month
01:	January
.	
.	
12:	December
99:	Month unknown (then Day of Birth must also be coded as unknown)
DD:	Day of the Month
01-31:	Valid days
99:	Day of Birth unknown

Valid dates are subsequently validated according to Routines No. 01 and No. 02.

All blank: Only when Patient Record Type (Field P4) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 12

Item name: Province/Territory or Country of Birth

Field no.: P12

Length: 3

Type: Numeric

Description: The code created by the International Standards' Organization* (I.S.O.) used to represent the patient's province/territory (if in Canada) or country (if outside Canada) of birth. The locations are coded according to current geo-political boundaries.

Values & meaning: To be valid the code must be found on the Province/Territory or Country Code File. See Appendix B.

999: Province/Territory or Country of Birth unknown.

All blank: Only when Patient Record Type (Field P4) = 3.

* The original set of I.S.O. codes has been expanded to include individual Canadian provinces and territories.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 13

Item name: Birth Surname

Field no.: P13

Length: 25

Type: Alphanumeric

Description: The legal surname, or family/last name under which the patient was registered at birth.

Note: Should be left justified, followed by blanks as required.

Can be all blank only if Current Surname (Field P6) is not blank.

Values & meaning: All blank: Unknown or Patient Record Type (Field P4) = 3.

Upper and lower case alphabetic (A/a - Z/z), with or without accents, blanks ( ), periods (.), apostrophes (') and hyphens (-) are valid. See Appendix A.

If not all blank, must contain at least one alphabetic letter (A/a - Z/z).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 14

Item name: Date of Death

Field no.: P14

Length: 8

Type: Numeric

Description: The patient's date of death represented by the century, year, month, and day.

Values & meaning:

Format: YYYYMMDD

YYYY:	Four-digit year
0000:	Patient is not known to have died
1992 - xxxx:	Valid years (where xxxx = current date)
9999:	Year unknown (then Month and Day of Death must also be coded as unknown)
MM:	Month
00:	Patient is not known to have died
01:	January
.	
.	
12:	December
99:	Month unknown (then, Day of Death must also be coded as unknown)
DD:	Day of the Month
00:	Patient is not known to have died
01-31:	Valid days
99:	Day of Death unknown

Valid dates are subsequently edited according to Routine No. 01 or No. 02.

All blank: Only when Patient Record Type (Field P4) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 15

Item name: Province/Territory or Country of Death

Field no.: P15

Length: 3

Type: Numeric

Description: The code created by the International Standards' Organization* (I.S.O.) used to represent the patient's province/territory (if in Canada) or country (if outside Canada) of death. The locations are coded according to current geo-political boundaries.

Values & meaning: To be valid the code must be found on the Province/Territory or Country Code File. See Appendix B.

000: Patient is not known to have died
999: Province/Territory or Country of Death unknown

All blank: Only when Patient Record Type (Field P4) = 3

* The set of original I.S.O. codes has been expanded to include individual Canadian provinces and territories.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 16

Item name: Death Registration Number

Field no.: P16

Length: 6

Type: Numeric

Description: The registration number found on the death certificate issued by the Canadian province/territory in which the patient died (see Field P15, Province/Territory or Country of Death).

Note: Completed only for deaths occurring and registered within Canada.

Values & meaning:

000000:	Patient is not known to have died
000001 - 999997:	Valid registration numbers
999998:	Patient died outside of Canada
999999:	Patient died, but registration number unknown
All blank:	Only when Patient Record Type (Field P4) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 17

Item name: Underlying Cause of Death

Field no.: P17

Length: 4

Type: Alphanumeric

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

- **Prior to 2000 calendar year**: To be valid the code must be found on the ICD-9 Cause of Death Code File. See Appendix C.
- **From 2000 calendar year onwards**: To be valid the code must be found on the ICD-10 Cause of Death Code File. See Appendix D.

Should be left-justified, followed by a blank as necessary. Omit any period/decimal (.).

Values & meaning: Format for ICD-9: NNNN **or** NNNb. See Appendix C.

Format for ICD-10: ANNN **or** ANNb. See Appendix D.

A:	Upper case alphabetic (A to Z)
N:	Any number (0 - 9)
b:	Blank ( )
0000:	Patient is not known to have died
0009:	Unknown/unavailable Cause of Death

All blank: Only when Patient Record Type (Field P4) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 18

Item name: Autopsy Confirming Cause of Death

Field no.: P18

Length: 1

Type: Numeric

Description: The code indicating whether the cause of death from the death certificate takes account of autopsy findings, if applicable.

Values & meaning:

0:	Patient is not known to have died
1:	Autopsy held - results taken into account by the stated cause of death
2:	Autopsy held - results not taken into account by the stated cause of death
9:	No autopsy/unknown autopsy/do not know if autopsy results have been taken into account by the stated cause of death
All blank:	Only when Patient Record Type (Field P4) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Field definition
Validation edit no. 19

Item name: Date of Transmission

Field no.: P19

Length: 8

Type: Numeric

Description: The date on which a copy of the *patient record* was extracted from the provincial/territorial registry for submission to the CCR.

Values & meaning:

Format: YYYYMMDD

YYYY: Four-digit year
MM: Month (01-12)
DD: Day (01-31)

Valid dates are subsequently edited according to Routines No. 01 and No. 02.

Valid dates can be no later than the ***current date**** nor earlier than ten months prior to this date.

* ***Current date*** is the date on the STC computer clock when the data are loaded on the CCR database.

3.0 Tumour record

3.1 Input tumour record layout (index of validation edits)

Field	Size	Position	Type	Description	Validation edit	Page
T1	2	1-2	N	Reporting Province/Territory	01	41
T2	12	3-14	AN	Patient Identification Number (PIN)	02	42
T3	9	15-23	AN	Tumour Reference Number	03	43
T4	9	24-32	AN	CCR Identification Number (CCRID)	04	44
T5	1	33	N	Tumour Record Type	05	45
T6	25	34-58	AN	Place Name of Residence at Time of Diagnosis	06	46
T7	6	59-64	AN	Postal Code	07	47
T8	7	65-71	N	SGC* of Place of Residence at Time of Diagnosis	08	48
T9	9	72-80	AN	Census Tract	09	49
T10	15	81-95	AN	Health Insurance Number	10	50
T11	1	96	N	Method of Diagnosis (1992 – 2003 data)	11	51
T12	8	97-104	N	Date of Diagnosis	12	52
T13	4	105-108	AN	ICD-9	13	54
T14	1	109	N	Source Classification Flag (SCF)	14	55
T15	4	110-113	AN	ICD-O-2/3 - Topography	15	56
T16	4	114-117	N	ICD-O-2 - Morphology	16	57
T17	1	118	N	ICD-O-2 - M Behaviour Code	17	58
T18	4	119-122	AN	ICD-10	18	59
T19	1	123	N	Laterality	19	60
T20	1	124	N	Filler (Multifocal Tumours) (no longer reported to the CCR)	20	61
T21M	4	125-128	N	ICD-O-3 - Morphology	21M	62
T21B	1	129	N	ICD-O-3 - M Behaviour Code	21B	63
T21	3	130-132	AN	Filler	Current	
(T23)	1	(130)	(N)	(Method Used to Establish Date of Diagnosis)		64
(T24)	1	(131)	(N)	(Diagnostic Confirmation)	(Implementation in 2004)	66
(T21)	1	(132)	(AN)	(Filler)		
T22	8	133-140	N	Date of Transmission	22	68

* Standard Geographic Code

3.2 Input tumour data dictionary

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 01

Item name: Reporting Province/Territory

Field no.: T1

Length: 2

Type: Numeric

Description: The Standard Geographic Code (SGC) of the province/territory submitting the *tumour record* to the CCR at time of diagnosis. Refer to *Residency Guidelines in Canada* in Appendix Q.

Values & meaning:

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

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 02

Item name: Patient Identification Number (PIN)

Field no.: T2

Length: 12

Type: Alphanumeric

Description: The unique identification number assigned by the provincial/territorial registry to each new patient registered. **It cannot be updated or reused**.

Values & meaning: Can be composed of any unique combination of numbers and upper case alphabetic (A to Z). The following special characters are not allowed: accents, embedded blank ( ), period (.), apostrophe (') and hyphen (-).

Should be left justified, followed by blanks as required. Cannot be all blank.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 03

Item name: Tumour Reference Number

Field no.: T3

Length: 9

Type: Alphanumeric

Description: A unique identification number assigned by the provincial/territorial cancer registry, as a reference, to each new tumour reported to the CCR. **It cannot be updated or reused**.

For each patient, the tumour reference number must be unique, as its purpose is to distinguish between multiple primary tumours. The tumour reference number is part of the identification key of each *tumour record*.

Values & meaning: Can be composed of any combination, unique to the patient, of numbers, upper case alphabetics (A to Z), without accents, and the following special characters: blank ( ), period (.), apostrophe (') and hyphen (-).

Should be left justified, followed by blanks as required Cannot be all blank.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 04

Item name: CCR Identification Number (CCRID)

Field no.: T4

Length: 9

Type: Alphanumeric

Description: A unique number assigned by Statistics Canada to each new patient at the time of the initial registration in the CCR.

Note: This field will be blank when the registration is first submitted to the CCR by a provincial/territorial cancer registry. However, any subsequent changes to this registration must contain the CCRID.

Values & meaning: All blank or all numeric.

All blank: New patient registration (no CCRID has been assigned yet).

Cannot be all zeroes (000000000).

Number must be validated (see Routine No. 03).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 05

Item name: Tumour Record Type

Field no.: T5

Length: 1

Type: Numeric

Description: The code which identifies whether the tumour is new to the registry or an update to an existing *tumour record* or whether a *tumour record* currently on the registry is to be deleted.

Values & meaning:
1: New record
2: Update record
3: Delete record

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 06

Item name: Place Name of Residence at Time of Diagnosis

Field no.: T6

Length: 25

Type: Alphanumeric

Description: The complete alphabetic name of the city, town or other place of the patient's usual, permanent residence at the time of the diagnosis of this particular tumour. See Appendix Q.

Note: Tumours occurring in patients residing outside of Canada must not be reported.

Values & meaning: All blank: Unknown or Tumour Record Type (Field T5) = 3.

Can be any combination of alphabetic letters, numbers and special characters.

If not all blank, must contain at least two alphabetic letters (A/a - Z/z).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 07

Item name: Postal Code

Field no.: T7

Length: 6

Type: Alphanumeric

Description: The Canadian postal code of the patient's usual, permanent residence at the time of the diagnosis of this particular tumour.

Values & meaning:

999999:	Postal code unknown
	or
1st digit:	Alphabetic (A-Z)
2nd digit:	Number (0-9)
3rd digit:	Alphabetic (A-Z)
4th digit:	Number (0-9)
5th digit:	Alphabetic (A-Z)
6th digit:	Number (0-9)
All blank:	Only when Tumour Record Type (Field T5) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 08

Item name: Standard Geographic Code (SGC) of Place of Residence at Time of Diagnosis

Field no.: T8

Length: 7

Type: Numeric

Description: The SGC of the patient's usual, permanent place of residence at the time of the diagnosis of this tumour (see Field T6, Place Name of Residence at Time of Diagnosis). The code includes the following items: province/territory (PR), 2 digits; census division (CD), 2 digits; and census subdivision (CSD), 3 digits.

Note: Tumours occurring in patients residing outside Canada must not be reported.

Values & meaning:

Format: PRCDCSD

PR: Province/territory (2 digits)
CD: Census Division (2 digits)
CSD: Census Subdivision (3 digits)

To be valid the code must be found on the following files:

1992 – 1995: 1991 SGC File
1996 – 2000: 1996 SGC File
2001 – onwards: 2001 SGC File (not yet available)

See Appendix E for record layout; actual codes available upon request.

PR00999: CD and CSD unknown
PRCD999: CSD unknown
Province/territory cannot be unknown.

All blank: Only when Tumour Record Type (Field T5) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 09

Item name: Census Tract

Field no.: T9

Length: 9

Type: Alphanumeric

Description: A small geostatistical area in which the patient resided at the time this tumour was diagnosed. Census tracts are found only in large urban communities, and contain populations ranging from 2500 to 8000, with an average of 4000.

They are designed as being as homogeneous as possible in terms of economic status and social conditions. All Census Metropolitan Areas (CMA) and Census Agglomerations (CA), containing a Census Subdivision (i.e. a city) having a population of at least 50000, are eligible to have Census Tracts.

Values & meaning:

Format:	NNNNNN.NN **or** NNNNNNbbb
N:	Any number from 0-9
.:	.
b:	Blank

<u>To be valid, the Census Tract code must be found in the following files:</u>

1992 – 1995:	1991 Census Tract Dictionary
1996 – 2000:	1996 Census Tract Dictionary
2001 – onwards:	2001 Census Tract Dictionary (not yet available)

See Appendix F for record layout; actual codes available upon request.

000000.00:	Place of residence not in a Census Tract
999999.99:	Census Tract unknown/incomplete address

All blank: Only when Tumour Record Type (Field T5) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 10

Item name: Health Insurance Number

Field no.: T10

Length: 15

Type: Alphanumeric

Description: The patient's provincial/territorial health insurance number at the time of diagnosis for this particular tumour.

Note: Should be left justified, followed by blanks as required.

Values & meaning: Can be composed of any combination of alphabetic letters and numbers, and cannot contain any special characters. Must have a minimum length of 6 characters (letters/numbers).

999999999999999: Unknown

All blank: Only when Tumour Record Type (Field T5) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 11

Item name: Method of Diagnosis **(1992 – 2003 data)**

Field no.: T11

Length: 1

Type: Numeric

Description: The most definitive procedure by which the tumour was diagnosed.

Note: In general, the method of diagnosis should be based on the method by which the ***earliest*** microscopic date of diagnosis was determined. The method should be based on the status before any treatment other than surgery is given. It is not linked to the date of diagnosis.

Values & meaning: Categories of diagnostic methods are listed below in descending order of priority:

0: Starting with dates of diagnosis in 2004 – Method of Diagnosis reported in Field T23 (Method Used to Establish the Date of Diagnosis) and T24 (Diagnostic Confirmation)
1: Histology
2: Autopsy
3: Cytology
4: Radiology or laboratory diagnosis other than specified above
5: Surgery (without histology), or clinical diagnosis
6: Death certificate only*
9: Method of diagnosis unknown

Blank: Only when Tumour Record Type (Field T5) = 3.

* "Death certificate only" = the only source of information about the case was a death certificate. This category includes deaths where either the Underlying Cause of Death (*patient record*, Field No. 17) is cancer, or there is any mention of cancer on the death certificate. Note: Date of Diagnosis cannot be after the Date of Death.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 12

Item name: Date of Diagnosis

Field no.: T12

Length: 8

Type: Numeric

Description: Date of diagnosis of this tumour is determined using the following sequence order: **(sequence order effective 2004 data and forward)**

Refer to Exceptions and Notes on following page prior to determining the date.

1. Date of **cytological** diagnosis*;
   *If suspicious cytology is confirmed by subsequent histological diagnosis (including autopsy) or clinical impression of cancer supports the cytology findings, then the cytological diagnosis date will be used.

2. Date of **histological** diagnosis, including autopsy;

3. Date of **non microscopically confirmed** diagnosis:

   [includes the following:
   - Positive laboratory test/marker study
   - Direct visualization without microscopic confirmation (surgery {without histology}
   - Radiography and other imaging techniques without microscopic confirmation
   - Clinical diagnosis, including: physical findings (without histology)
   - Method of Diagnosis unknown]

4. **Date of Death** if not reported at any other time.
   - includes Death Certificate Only or Autopsy only

Exceptions:

a) If applicable, the date associated with the method that prompts treatment takes precedence over the above choices and should be chosen.

b) If *autopsy only* case, follow back as per the *Guidelines for Abstracting and determining DCO cases for PTCRs in Canada* (Appendix R of Input Data Dictionary). If previous information is available for this tumour, the initial date takes precedence, including if it is non microscopic information. For example, if an

x-ray result is available prior to the autopsy, the date associated with this initial diagnostic information takes precedence over the autopsy (histological) date.

Notes: For "**Death certificate only**" cases, the date of diagnosis **must equal** the date of death.

For **Autopsy only** cases, the date of diagnosis must equal the date of death.

Please refer to the CCR Guidelines for Ambiguous Terms when determining the date of diagnosis.

The Date of Diagnosis is linked to the Field T23- Method Used to Establish the Date of Diagnosis.

Values & meaning:

Format: YYYYMMDD

YYYY:	Four digit year
1992 - xxxx:	Valid years (where xxxx = processing year)
MM:	Month
01:	January
.	
12:	December
99:	Month unknown (then Day of Diagnosis must also be coded as unknown)
DD:	Day
01-31:	Valid days
99:	Day unknown

Cannot be all 9's.
Valid dates are subsequently edited according to Routines No.01 and No. 02.

All blank: Only when Tumour Record Type (Field T5) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 13

Item name: ICD-9

Field no.: T13

Length: 4

Type: Alphanumeric

Description: The diagnosis of the neoplasm coded according to the International Classification of Diseases, 9th revision. In the CCR, the ICD-9 code is used to describe the site of the tumour, and must be supplemented with an ICD-O-2 - Morphology (Field T16).

Note: Must be left justified, followed by a blank as necessary.

Can be 0000 only if ICD-O-2/3 - Topography (Field T15) or ICD-10 (Field T18) is reported.

Omit any period (.) in the code.

Values & meaning: 0000: Topography reported in Field T15 or Field T18.

To be valid the code must be found on the ICD-9 Tumour Code File as provided by Statistics Canada. See Appendix G.

All blank: Only when Tumour Record Type (Field T5) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 14

Item name: Source Classification Flag (SCF)

Field no.: T14

Length: 1

Type: Numeric

Description: The flag indicates the classification system in which the topography and morphology of the tumour were originally coded.

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

Values & meaning:

1: Topography originally coded in ICD-9, Morphology coded in ICD-O-2
2: Topography/Morphology originally coded in ICD-O-2
3: Topography originally coded in ICD-10 **(Not presently in use in Canada – see Tumour Validation edit no. 18 for details.)**
4: Topography/Morphology originally coded in ICD-O-3

All blank: Only when Tumour Record Type (Field T5) = 3.

Note: For Classification Systems Used in Canada, see Appendix S.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 15

Item name: ICD-O-2/3 - Topography

Field no.: T15

Length: 4

Type: Alphanumeric

Description: The site of origin of the neoplasm coded according to the International Classification of Diseases for Oncology (2nd or 3rd edition) – Topography Section.

Omit any period (.) in the code.

Note: The Canadian Council of Cancer Registries (CCCR) recommended that the following tumours should be reported to the CCR, although not all registries are able to submit:

- All primary, malignant tumours (ICD-O-2/3, topography codes C00.0-C80.9) with behaviour codes of 3 {except squamous cell skin cancer (ICD-O-2/3 morphology codes 805_-808_) and basal cell skin cancer (ICD-O-2/3 morphology codes 809_-811_)} with topographies C44.0-C44.9;
- In situ/intraepithelial/non-infiltrating/non-invasive carcinomas (all topographies in ICD-O-2/3 with behaviour codes of 2);
- Primary, benign tumours of the brain and central nervous system (topographies C70.0-C72.9 with ICD-O-2/3 behaviour codes of 0) and
- Borderline malignancies (all topographies in ICD-O-2/3 with behaviour codes of 1).

Values & meaning: 0000: Topography reported in Field T13, or Field T18.

To be valid, the code must be found on the ICD-O-2/3 Topography Code File. See Appendix H.

All blank: Only when Tumour Record Type (Field T5) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 16

Item name: ICD-O-2 - Morphology

Field no.: T16

Length: 4

Type: Numeric

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

Values & meaning:

0000: Only when morphology reported in Field T21M.

NNNN: Four-digit morphology code

To be valid, the code must be found on the ICD-O-2 Morphology Code File. See Appendix I.

All blank: Only when Tumour Record Type (Field T5) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 17

Item name: ICD-O-2 - M Behaviour Code

Field no.: T17

Length: 1

Type: Numeric

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

Note: The cases with Behaviour Codes "6" and "9" should not be reported to the CCR. Those with Behaviour Code "0" should be reported only with a tumour of the central nervous system, including the brain. (C70.0 – C72.9; Tumour Correlation Edit No. 21).

Omit any slash (/) in the code.

Values & meaning:

0: Benign or behaviour reported in Field T21B
1: Uncertain whether benign or malignant / borderline malignancy
2: Carcinoma in situ / intraepithelial / non-infiltrating / non-invasive
3: Malignant, primary site

All blank: Only when Tumour Record Type (Field T5) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 18

Item name: ICD-10

Field no.: T18

Length: 4

Type: Alphanumeric

Description: The diagnosis of the neoplasm coded according to the International Classification of Diseases, 10th revision. In the CCR, the ICD code is used to describe the site of the tumour, and must be supplemented with an ICD-O-2 - Morphology (Field T16).

Note: Should be left-justified, followed by a blank if necessary.

Omit any period (.) in the code.

Values & meaning: 0000: Topography reported in Field T13 or Field T15.

To be valid the code must be found on the ICD-10 Tumour Code File. See Appendix J for record layout.

Note: Until the official implementation of ICD-10 by the CCR, 0000 will be the only valid content of this field.

All blank: Only when Tumour Record Type (Field T5) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 19

Item name: Laterality

Field no.: T19

Length: 1

Type: Numeric

Description: The site specific localization of the tumour in paired organs or the side of the body on which the tumour originated. It specifies whether the tumour is on the right, left or bilateral, where applicable.

See Correlation Edit No. 22 for the list of sites with their relevant Laterality codes.

Values & meaning:

0:	Not a paired organ
1:	Left
2:	Right
4:	Bilateral (only to be used for kidneys, eyes and ovaries when the side or origin is not known)
9:	Laterality unknown
All blank:	Only when Tumour Record Type (Field T5) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 20

Item name: Filler (Multifocal Tumours) (**no longer reported to the CCR**)

Field no.: T20

Length: 1

Type:

Description:

Values & meaning:

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 21M

Item name: ICD-O-3 - Morphology

Field no.: T21M

Length: 4

Type: Numeric

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

Values & meaning:

0000: Only when morphology reported in Field T16.

NNNN: Four-digit morphology code

To be valid, the code must be found on the ICD-O-3 – Morphology Code File. See Appendix I-O3.

All blank: Only when Tumour Record Type (Field T5) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 21B

Item name: ICD-O-3 - M Behaviour Code

Field no.: T21B

Length: 1

Type: Numeric

Description: The behaviour associated with the histological description of the neoplasm, reported in Field T21M.

Note: The cases with Behaviour Codes "6" and "9" should not be reported to the CCR. Those with Behaviour Code "0" should be reported only with a tumour of the central nervous system, including the brain. (C70.0 – C72.9; Tumour Correlation Edit No. 21).

Omit any slash (/) in the code.

Values & meaning:

0: Benign or behaviour reported in Field T17
1: Uncertain whether benign or malignant
Borderline malignancy
2: Carcinoma in situ
Intraepithelial
Non-infiltrating
Non-invasive
3: Malignant, primary site

All blank: Only when Tumour Record Type (Field T5) = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 23

Item name: Method Used to Establish the Date of Diagnosis

Field no.: T23

Length: 1

Type: Numeric

Description: Method by which the date of diagnosis of this tumour was established. **(effective 2004 data forward)**

Values & meaning: Categories of diagnostic methods are listed below ***in order of priority*** **(see exceptions on Tumour Validation edit no. 12):**

0: Method of diagnosis reported in Field T11 prior to 2004

Microscopically Confirmed

1: Positive cytology
2: Positive histology
3: Autopsy ***only***

Non- Microscopically Confirmed

4: Positive laboratory test/marker study
5: Direct visualization without microscopic confirmation (surgery {without histology})
6: Radiography and other imaging techniques without microscopic confirmation
7: Clinical diagnosis, including: physical findings (without histology)
8: Death certificate only
9: Method of diagnosis unknown

Blank: Only when Tumour Record Type (Field T5) = 3.

See next page for descriptions.

Notes: **This method is linked to the Date of Diagnosis (Field T12).**

Method used to establish the date of diagnosis code descriptions:

Code 1: Cytological diagnoses based on microscopic examination of cells as contrasted with tissues. Included are smears from sputum, bronchial brushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, and urinary sediment. Cervical and vaginal smears are common examples. Also included are diagnoses based upon paraffin block specimens from concentrated spinal, pleural and peritoneal fluid. Fine needle aspiration is included here.

Code 2: **Histological** diagnoses based upon tissue specimens from biopsy (including wide core and needle biopsy), frozen section, surgery, autopsy or D and C. Positive hematological findings relative to leukemia, including peripheral blood smears, are also included. Bone marrow specimens (including aspiration biopsies) are coded as '2'.

Code 3: Diagnosis confirmed by autopsy only, (if tissue taken) when no other information available.

Code 4: Clinical diagnoses of cancer based on certain laboratory tests or marker studies, which are clinically diagnostic for cancer. This includes alpha-fetoprotein for liver cancer and abnormal electrophoretic spike for multiple myeloma. Elevated PSA is non-diagnostic for cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, it should be recorded as code 4.

Code 5: Visualization includes diagnosis made at surgical exploration, including autopsy where no tissue is taken, or by use of the various endoscopes (including colposcope, mediastinoscope, and peritoneoscope). However, use only if such visualization is not supplemented by positive histology or positive cytology reports.

Code 6: Cases with diagnostic radiology for which there is neither a positive histology nor a positive cytology report. "Other imaging techniques" include procedures such as ultrasound, computerized (axial) tomography (CT or CAT) scans, and magnetic resonance imaging (MRI).

Code 7: Cases diagnosed by clinical methods not mentioned above and for which there were no positive microscopic findings.

Code 8: Cases diagnosed by Death Certificates Only, when no other information available.

Code 9: Cases for which the method of diagnosis is unknown.

Note:

The SEER Program Code Manual, 3rd Edition, Diagnostic Confirmation descriptions were used as a reference when determining the appropriate codes for the CCR.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 24

Item name: Diagnostic Confirmation

Field no.: T24

Length: 1

Type: Numeric

Description: Method of the ***most accurate diagnostic confirmation***. **(effective 2004 data forward)**

Determine whether this tumour was microscopically confirmed *at any time* during the patient's medical history.

Values & meaning: Categories of diagnostic methods are listed below in ***order of priority:***

0: Method of diagnosis reported in Field T11 prior to 2004

Microscopically Confirmed

1: Positive histology
2: Positive cytology
3: Autopsy ***only***

Non- Microscopically Confirmed

4: Positive laboratory test/marker study
5: Direct visualization without microscopic confirmation (surgery {without histology})
6: Radiography and other imaging techniques without microscopic confirmation
7: Clinical diagnosis, including: physical findings (without histology)
8: Death certificate only
9: Method of diagnosis unknown

Blank: Only when Tumour Record Type (Field T5) = 3.

See next page for descriptions.

Notes: **This field is not linked with the Date of Diagnosis (Field T12).**

Diagnostic confirmation code descriptions:

Code 1: Histological diagnoses based upon tissue specimens from biopsy (including wide core and needle biopsy), frozen section, surgery, autopsy or D and C. Positive hematological findings relative to leukemia, including peripheral blood smears, are also included. Bone marrow specimens (including aspiration biopsies) are coded as '1'.

Code 2: Cytological diagnoses based on microscopic examination of cells as contrasted with tissues. Included are smears from sputum, bronchial brushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, and urinary sediment. Cervical and vaginal smears are common examples. Also included are diagnoses based upon paraffin block specimens from concentrated spinal, pleural and peritoneal fluid. Fine needle aspiration included here.

Code 3: Diagnosis confirmed by autopsy only, (if tissue taken) when no other information available.

Code 4: Clinical diagnoses of cancer based on certain laboratory tests or marker studies, which are clinically diagnostic for cancer. This includes alpha-fetoprotein for liver cancer and abnormal electrophoretic spike for multiple myeloma. Elevated PSA is non-diagnostic for cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, it should be recorded as code 4.

Code 5: Visualization includes diagnosis made at surgical exploration including autopsy where no tissue is taken, or by use of the various endoscopes (including colposcope, mediastinoscope, and peritoneoscope). However, use only if such visualization is not supplemented by positive histology or positive cytology reports.

Code 6: Cases with diagnostic radiology for which there is neither a positive histology nor a positive cytology report. "Other imaging techniques" include procedures such as ultrasound, computerized (axial) tomography (CT or CAT) scans, and magnetic resonance imaging (MRI).

Code 7: Cases diagnosed by clinical methods not mentioned above and for which there were no positive microscopic findings.

Code 8: Cases diagnosed by Death Certificates Only, when no other information available.

Code 9: Cases for which the method of diagnosis is unknown.

Note:

The SEER Program Code Manual, 3rd Edition, Diagnostic Confirmation descriptions were used as a reference when determining the appropriate codes for the CCR.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Field definition
Validation edit no. 22

Item name: Date of Transmission

Field no.: T22

Length: 8

Type: Numeric

Description: The date on which a copy of the *tumour record* was extracted from the provincial/territorial registry for submission to the CCR.

Values & meaning:

Format: YYYYMMDD

YYYY: Four-digit year
MM: Month (01-12)
DD: Day (01-31)

Valid dates are subsequently edited according to Routines No. 01 and No. 02.

Valid dates can be no later than the ***current date**** nor earlier than ten months prior to this date.

* ***Current date*** is the date on the STC computer clock when the data are loaded on the CCR database.

4.0 Routines

Validation routines are edit procedures common to more than one field and/or to both *patient* and *tumour records*.

Routine No. 01: Used in edits P11, P14, P19, T12 & T22.
Routine No. 02: Used in edits P11, P14, P19, T12 & T22.
Routine No. 03: Used in edits P3 & T4.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Routine no. 01

Purpose: To ensure that there isn't a stated day without a month, nor a stated month without a year, and to ensure that the exceptions are applied only to the entire date - year, month and day.

Procedure: Decision Logic Table

Conditions:

Year = 0000	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	N	N	N	N
Year = 9999	N	N	N	N	N	Y	Y	Y	Y	Y	N	N	N	N	N	N
Month = 00	Y	Y	Y	N	N	Y	N	N	N	N	Y	N	N	N	N	N
Month = 99	N	N	N	Y	N	N	Y	Y	Y	N	N	Y	Y	Y	N	N
Day = 00	Y	N	N	-	-	-	Y	N	N	-	-	Y	N	N	Y	N
Day = 99	N	Y	N	-	-	-	N	Y	N	-	-	N	Y	N	N	Y
Actions:	0	1	1	1	1	1	1	0	1	1	1	1	0	1	1	0	2

Messages:

0: No error - return
1: Error - exceptions
2: No error - go to Routine No. 02

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Routine no. 02

Purpose: To ensure that the day does not exceed the valid maximum for any given month, when applicable.

Procedure: Decision Logic Table

Conditions:

Month = 02	Y	Y	Y	Y	Y	N	N	N	N	N
Month = 04, 06, 09, or 11	N	N	N	N	N	Y	Y	Y	Y	N
Day = 29	Y	Y	N	N	N	Y	N	N	N	-
Day = 30	N	N	Y	N	N	N	Y	N	N	-
Day = 31	N	N	N	Y	N	N	N	Y	N	-
Year = Multiple of "4"	Y	N	-	-	-	-	-	-	-	-
Actions:	0	1	2	2	0	0	0	2	0	0

Messages:

0: No error
1: Error with February 29
2: Error - the day exceeds valid maximum

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Routine no. 03

Purpose: To validate the check digit on the CCR Identification Number (CCRID).

Format: $N_1N_2N_3N_4N_5N_6N_7N_8C$

N_1 to N_8: First 8 digits of the CCR Identification Number (CCRID)
C: Check digit

Procedure:

Step 1: Transform the values of N_2, N_4, N_6, N_8 in the following manner:

$1 \rightarrow 2$
$2 \rightarrow 4$
$3 \rightarrow 6$
$4 \rightarrow 8$
$5 \rightarrow 1$
$6 \rightarrow 3$
$7 \rightarrow 5$
$8 \rightarrow 7$
$9 \rightarrow 9$
$0 \rightarrow 0$

Step 2: Add the original values of N_1, N_3, N_5 and N_7 to the transformed N_2, N_4, N_6 and N_8.

Step 3: Check digit (C) = 0, when the last digit of the sum calculated in step 2 is 0.

Else

Check digit (C) = [10 - (last digit of the sum calculated in step 2)].

If the check digit calculated above is different from the reported check digit, then the reported check digit is invalid. CCR Identification Numbers (CCRID) with invalid check digits are invalid numbers.

5.0 Input consistency - Input match edits

The Input Match Edits ensure that the information in the *patient* and *tumour records* submitted by a province/territory for each patient is complete and coherent in terms of the operations to be performed (i.e. add, update, delete, change of ownership).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Input consistency

Input Match Edit No. 01

Fields involved:	Reporting Province/Territory (Field P1) Patient Identification Number (PIN) (Field P2)
Description:	Only one operation affecting a specific *patient record* can be performed (i.e. add, delete, update or change of ownership) within a data submission.
Edit specification:	Within any data submission, there cannot be more than one *patient record* having identical Reporting Province/Territory and Patient Identification Number (PIN).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Input consistency

Input Match Edit No. 02

Fields involved:	Reporting Province/Territory (Field T1) Patient Identification Number (PIN) (Field T2) Tumour Reference Number (Field T3)
Description:	Only one operation affecting a specific *tumour record* can be performed (i.e. add, delete, update) within a data submission.
Edit specification:	Within any data submission, there cannot be more than one *tumour record* having identical Reporting Province/Territory, Patient Identification Number (PIN) and Tumour Reference Number.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Input consistency

Input Match Edit No. 03

Fields involved:

Reporting Province/Territory (Field P1)
Patient Identification Number (PIN) (Field P2)
Patient Record Type (Field P4)

Reporting Province/Territory (Field T1)
Patient Identification Number (PIN) (Field T2)
CCR Identification Number (CCRID) (Field T4)
Tumour Record Type (Field T5)

Description:

When a patient is registered in the CCR database for the first time by a province/territory, only new *tumour records* may accompany the new *patient record*.

Edit specification:

For every new *patient record* (Patient Record Type = 1):

1) there must be at least one new *tumour record* (Tumour Record Type = 1) with an identical Reporting Province/Territory and Patient Identification Number (PIN), but with no reported CCR Identification Number (CCRID) (all blank);

2) there cannot be a new *tumour record* having an identical Reporting Province/Territory, Patient Identification Number (PIN) as well as a reported CCR Identification Number (CCRID); and,

3) there cannot be an update or delete *tumour record* (Tumour Record Type = 2 or 3) with an identical Reporting Province/Territory and Patient Identification Number (PIN).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Input consistency

Input Match Edit No. 04

Fields involved:

Reporting Province/Territory (Field P1)
Patient Identification Number (PIN) (Field P2)
Patient Record Type (Field P4)

Reporting Province/Territory (Field T1)
Patient Identification Number (PIN) (Field T2)
Tumour Record Type (Field T5)

Description:

A *tumour record* cannot reside on the CCR without an accompanying *patient record*. Thus, when a *patient record* is deleted from the CCR, its *tumour record(s)* must be deleted at the same time. No new *tumour records* can be submitted or existing ones updated.

It is not possible to know the number of *tumour records* attached to any particular *patient record* at the time of data submission, therefore only the removal of at least one *tumour record* can be verified.

Edit specification:

For every delete *patient record* (Patient Record Type = 3):

1) there must be at least one delete *tumour record* (Tumour Record Type = 3) with an identical Reporting Province/Territory, Patient Identification Number (PIN) and CCR Identification Number (CCRID);

2) there cannot be a delete *tumour record* with an identical Reporting Province/Territory and Patient Identification Number (PIN), but having a different CCR Identification Number (CCRID); and,

3) there cannot be a new or update *tumour record* (Tumour Record Type = 1 or 2) with an identical Reporting Province/Territory and Patient Identification Number (PIN).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Input consistency

Input Match Edit No. 05

Fields involved:

Reporting Province/Territory (Field P1)
Patient Identification Number (PIN) (Field P2)
CCR Identification Number (CCRID) (Field P3)
Patient Record Type (Field P4)

Reporting Province/Territory (Field T1)
Patient Identification Number (PIN) (Field T2)
CCR Identification Number (CCRID) (Field T4)
Tumour Record Type (Field T5)

Description:

A change of ownership takes place only when a province/territory wishes to register a new tumour for a patient already on the CCR, but whose *patient record* belongs to another province. The CCR Identification Number (CCRID) must be known and used in order to submit a change of ownership (see Correlation Edit No. 1).

Edit specification:

For every change of ownership *patient record* (Patient Record Type = 4):

1) there must be at least one new *tumour record* (Tumour Record Type = 1) with an identical Reporting Province/Territory, Patient Identification Number (PIN) and CCR Identification Number (CCRID);

2) there cannot be a new *tumour record* with an identical Reporting Province/Territory and Patient Identification Number (PIN), but having a different or unreported CCR Identification Number (CCRID).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Input consistency

Input Match Edit No. 06

Fields involved:	Reporting Province/Territory (Field P1) Patient Identification Number (PIN) (Field P2) CCR Identification Number (CCRID) (Field P3) Patient Record Type (Field P4) Reporting Province/Territory (Field T1) Patient Identification Number (PIN) (Field T2) CCR Identification Number (CCRID) (Field T4) Tumour Record Type (Field T5)
Description:	New *tumour records* must have a CCR Identification Number (CCRID) when the patient is already registered on the CCR database.
Edit specification:	For every new *tumour record* (Tumour Record Type = 1) with a blank CCR Identification Number (CCRID), there must be a new *patient record* (Patient Record Type = 1) with a blank CCR Identification Number (CCRID), and having an identical Reporting Province/Territory and Patient Identification Number (PIN).

6.0 Correlation edits

The Correlation Edits are divided into 5 groups: Patient, Tumour, Patient(I) vs Patient, Tumour vs Patient, and lastly, Tumour(I) vs Tumour. The first two types verify the internal consistency among the various fields comprising each of the two kinds of input records for the CCR. The remaining three involve inter-record comparisons, which not only ensure that the data on the *patient* and *tumour records* do not conflict, but they also examine if the input relative to what already exists on the CCR is reasonable. Finally, the Tumour(I) vs Tumour Correlations make extensive comparisons to avoid the posting of duplicate tumours onto the CCR.

In order for the inter-record correlations to function correctly, the following sequence is assumed: Patient(I) vs Patient, Tumour vs Patient, and Tumour(I) vs Tumour.

6.1 Index of correlation edits

6.1.1 Index of correlation edits (Patient records)

Correlation Number	Fields Involved	Field Number	Page Number
01	• CCR Identification Number (CCRID) • Patient Record Type • Patient Record, positions 25-146	P3 P4	94
02	• Patient Record Type • Sex • Year of Birth	P4 P10 P11	95
03	• First Given Name • Second Given Name • Third Given Name	P7 P8 P9	96
04	• Type of Current Surname • Current Surname	P5 P6	97
05	• Type of Current Surname • Current Surname • Birth Surname	P5 P6 P13	98
06	• Current Surname • Birth Surname	P6 P13	99
07	• Date of Birth • Date of Death	P11 P14	100
08	• Date of Birth • Date of Transmission	P11 P19	101
09	• Date of Death • Date of Transmission	P14 P19	102
10	• Date of Death • Province/Territory or Country of Death • Death Registration Number • Underlying Cause of Death • Autopsy Confirming Cause of Death	P14 P15 P16 P17 P18	103
11	• Province/Territory or Country of Death • Death Registration Number	P15 P16	104

6.1.2 Index of correlation edits (tumour records)

Correlation Number	Fields Involved	Field Number	Page Number
12	• CCR Identification Number (CCRID) • Tumour Record Type • Tumour Record, positions 34-132	T4 T5	106
13	• ICD-9 • Source Classification Flag (SCF) • ICD-O-2/3 – Topography • ICD-O-2 – Morphology • ICD-O-3 – Morphology • ICD-10	T13 T14 T15 T16 T21M T18	107
14	• Postal Code • SGC: Code of Place of Residence at Time of Diagnosis	T7 T8	108
15	• SGC: Code of Place of Residence at Time of Diagnosis • Census Tract	T8 T9	109
16	• Reporting Province/Territory • SGC: Code of Place of Residence at Time of Diagnosis	T1 T8	110
17	• Date of Diagnosis • Date of Transmission	T12 T22	111
18	• ICD-9 • Source Classification Flag (SCF) • ICD-O-2/3 – Topography • ICD-10	T13 T14 T15 T18	112
19	*** DELETED ***	-	113
20	• Source Classification Flag (SCF) • ICD-9 **or** ICD-10 • ICD-O-2 – M Behaviour Code	T14 T13 T18 T17	114
21	• Source Classification Flag (SCF) • ICD-O-2/3 – Topography • ICD-O-2 – M Behaviour Code • ICD-O-3 – M Behaviour Code	T14 T15 T17 T21B	116
22	• Source Classification Flag (SCF) • ICD-9 ICD-O-2/3 – Topography **or** ICD-10 • Laterality	T14 T13 T15 T18 T19	117

6.1.2 Index of correlation edits (tumour records)

Correlation Number	Fields Involved	Field Number	Page Number
23	• Source Classification Flag (SCF) • ICD-9 **or** ICD-O-2/3 – Topography ICD-10 • ICD-O-2 – Morphology • ICD-O-3 – Morphology	T14 T13 T15 T18 T16 T21M	120
24	• ICD-O-2 – Morphology • ICD-O-3 – Morphology • ICD-O-2 – M Behaviour Code • ICD-O-3 – M Behaviour Code	T16 T21M T17 T21B	121

6.1.3 Index of correlation edits (patient(i) vs patient)

Correlation Number	Fields Involved	Field Number	Page Number
25	• Reporting Province/Territory • Patient Identification Number (PIN) • Patient(I) Record Type	P1 P2 P4	123
26	• Reporting Province/Territory • Patient Identification Number (PIN) • CCR Identification Number (CCRID) • Patient(I) Record Type	P1 P2 P3 P4	124
27	• Reporting Province/Territory • CCR Identification Number (CCRID) • Patient Record Type • Sex • Date of Birth	P1 P3 P4 P10 P11	125

6.1.4 Index of correlation edits (tumour vs patient)

Correlation Number	Fields Involved	Field Number	Page Number
28	• Date of Birth • Date of Diagnosis	P11 T12	127
29	• Date of Death • Date of Diagnosis	P14 T12	128
30	• Date of Death • Method of Diagnosis • Date of Diagnosis	P14 T11 T12	129
31	• Sex • Site: ICD-9 **or** ICD-O-2/3 – Topography ICD-10	P10 T13 T15 T18	130

6.1.5 Index of correlation edits (tumour(i) vs tumour)

Correlation Number	Fields Involved	Field Number	Page Number
32	• Reporting Province/Territory • Patient Identification Number (PIN) • Tumour Reference Number • Tumour(I) Record Type	T1 T2 T3 T5	132
33	• Reporting Province/Territory • Patient Identification Number (PIN) • Tumour Reference Number • CCR Identification Number (CCRID) • Tumour(I) Record Type	T1 T2 T3 T4 T5	133
34-A	• ICD-O-3 – Morphology	T21M	134
34-B	• ICD-O-3 – Morphology	T21M	135
34-C	• ICD-O-2/3 – Topography	T15	136
34-D	• Site: ICD-O-2/3 – Topography – First 3 characters • Subsite: ICD-O-2/3 – Topography – 4th digit	T15 T15	137
34-E	• ICD-O-3 – Morphology	T21M	138
34-F	• Laterality	T19	139

6.2 Correlation edits
-
Patient record data

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Data Consistency
Correlation Edit No. 01

Fields involved: CCR Identification Number (CCRID) (Field P3);
Patient Record Type (Field P4), positions 25 to 146

Description: This edit ensures that the content of the *patient record* is consistent with the action described in the Patient Record Type.

Edit specification: If Patient Record Type = 1 (new record), then CCR Identification Number (CCRID) must be all blank, and positions 25 to 146 cannot be all blank.

If Patient Record Type = 2 or 4 (update or change of ownership record), then CCR Identification Number (CCRID), and positions 25 to 146 cannot be all blank.

If Patient Record Type = 3 (delete record), then CCR Identification Number (CCRID) cannot be all blank, and positions 25 to 146 must be all blank.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Data Consistency
Correlation Edit No. 02

Fields involved:	Patient Record Type (Field P4) Sex (Field P10) Year of Birth: Date of Birth (Field P11) - first 4 digits
Description:	In order to perform a change of ownership, a *patient record* must have a stated CCR Identification Number (CCRID) (see Correlation Edit No. 01), Sex and Year of Birth.
Edit specification:	If Patient Record Type = 4 (change of ownership), then Sex must be stated (not= 9), and Year of Birth must be stated (not= 9999).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Data Consistency
Correlation Edit No. 03

Fields involved: First Given Name (Field P7)
Second Given Name (Field P8)
Third Given Name (Field P9)

Description: This edit ensures that there is no stated Second or Third Given Name when there is no stated First Given Name; and that there is no stated Third Given Name when the Second Given Name is blank.

Edit specification: When the Second or Third Given Name is stated, the First Given Name must be stated; and when the Third Given Name is stated, then the Second Given Name must also be stated.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Data Consistency
Correlation Edit No. 04

Fields involved:	Type of Current Surname (Field P5) Current Surname (Field P6)
Description:	This edit ensures that the Type of Current Surname code accurately reflects the contents of the Current Surname field.
Edit specification:	If Current Surname is all blank, then Type of Current Surname must be 0 (Current Surname unknown). If there is a response in the Current Surname field, then the Type of Current Surname must = 1, 2 or 9.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Data Consistency
Correlation Edit No. 05

Fields involved:	Type of Current Surname (Field P5) Current Surname (Field P6) Birth Surname (Field P13)
Description:	In the situation where the Current Surname is described as the Birth Surname in Field P5, this edit checks the consistency between the Birth Surname and the Current Surname.
Edit specification:	If Type of Current Surname = 1 (Birth Surname), then the Current Surname must be the same as the Birth Surname.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Data Consistency
Correlation Edit No. 06

Fields involved:	Current Surname (Field P6) Birth Surname (Field P13)
Description:	A surname must be reported on the *patient record*, either as a Current Surname or as a Birth Surname.
Edit specification:	Current Surname and Birth Surname cannot both be blank.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Data Consistency
Correlation Edit No. 07

Fields involved: Date of Birth (Field P11)
Date of Death (Field P14)

Description: This edit ensures that the Date of Birth and the Date of Death respect a logical chronological sequence.

Edit specification: Decision Logic Table

Conditions:

Yr of Death = 0000	Y	N	N	N	N	N	N	N	N	N	N	N	N
Yr of Death = 9999	-	Y	N	N	N	N	N	N	N	N	N	N	N
Yr of Birth = 9999	-	-	Y	N	N	N	N	N	N	N	N	N	N
Yr of Death > Yr of Birth	-	-	-	Y	N	N	N	N	N	N	N	N	N
Yr of Death = Yr of Birth	-	-	-	N	Y	Y	Y	Y	Y	Y	Y	Y	N
Mth of Death = 99	-	-	-	-	Y	N	N	N	N	N	N	N	-
Mth of Birth = 99	-	-	-	-	-	Y	N	N	N	N	N	N	-
Mth of Death > Mth of Birth	-	-	-	-	-	-	Y	N	N	N	N	N	-
Mth of Death = Mth of Birth	-	-	-	-	-	-	N	Y	Y	Y	Y	N	-
Day of Death = 99	-	-	-	-	-	-	-	Y	N	N	N	-	-
Day of Birth = 99	-	-	-	-	-	-	-	-	Y	N	N	-	-
Day of Death ≥ Day of Birth	-	-	-	-	-	-	-	-	-	Y	N	-	-
Actions:	0	0	0	0	0	0	0	0	0	0	1	1	1

Messages:
0: No error
1: Error - birth occurred after Date of Death

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Data Consistency
Correlation Edit No. 08

Fields involved: Date of Birth (Field P11)
Date of Transmission (Field P19)

Description: The Date of Birth cannot occur later than the Date of Transmission.

Edit specification: Decision Logic Table

Conditions:

Yr of Birth = 9999	Y	N	N	N	N	N	N	N	N
Yr of Birth > Yr of Trans.	-	Y	N	N	N	N	N	N	N
Yr of Birth < Yr of Trans.	-	N	Y	N	N	N	N	N	N
Mth of Birth = 99	-	-	-	Y	N	N	N	N	N
Mth of Birth > Mth of Trans.	-	-	-	-	Y	N	N	N	N
Mth of Birth < Mth of Trans.	-	-	-	-	N	Y	N	N	N
Day of Birth = 99	-	-	-	-	-	-	Y	N	N
Day of Birth > Day of Trans.	-	-	-	-	-	-	-	Y	N
Actions:	0	1	0	0	1	0	0	1	0

Messages:
0: No error
1: Error - birth occurred after Date of Transmission

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Data Consistency
Correlation Edit No. 09

Fields involved: Date of Death (Field P14)
Date of Transmission (Field P19)

Description: This edit ensures that the Date of Death and the Date of Transmission respect a logical chronological sequence.

Edit specification: Decision Logic Table

Conditions:

Yr of Death = 0000	Y	N	N	N	N	N	N	N	N	N
Yr of Death = 9999	-	Y	N	N	N	N	N	N	N	N
Yr of Trans. > Yr of Death	-	-	Y	N	N	N	N	N	N	N
Yr of Trans. = Yr of Death	-	-	-	Y	Y	Y	Y	Y	Y	N
Mth of Death = 99	-	-	-	Y	N	N	N	N	N	-
Mth of Trans. > Mth of Dth	-	-	-	-	Y	N	N	N	N	-
Mth of Trans. = Mth of Dth	-	-	-	-	-	Y	Y	Y	N	-
Day of Death = 99	-	-	-	-	-	Y	N	N	-	-
Day of Trans. ≥ Day of Dth	-	-	-	-	-	-	Y	N	-	-
Actions:	0	0	0	0	0	0	0	1	1	1

Messages:
0: No error
1: Error - death occurred on or after Date of Transmission

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Data Consistency
Correlation Edit No. 10

Fields involved:	Date of Death (Field P14) Province/Territory or Country of Death (Field P15) Death Registration Number (Field P16) Underlying Cause of Death (Field P17) Autopsy Confirming Cause of Death (Field P18)
Description:	This edit ensures that the set of items mentioned above represents a valid combination of values, i.e. a consistent indication that the patient is alive or dead.
Edit specification:	If any one of the fields in the set mentioned above is filled with all zeroes, then the remaining fields in the set should all be, as well.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient record
Data Consistency
Correlation Edit No.11

Fields involved: Province/Territory or Country of Death (Field P15)
Death Registration Number (Field P16)

Description: This edit ensures that there is no specific Death Registration Number reported when there is no specific Province/Territory or Country of Death reported.

Edit specification: Decision Logic Table

Conditions:

Province/Territory or Country of Death = 909	Y	Y	N	N	N
Province/Territory or Country of Death = 999	N	N	Y	Y	N
Death Registration Number = 999999	Y	N	Y	N	-
Actions:	0	1	0	1	0

Messages:
0: No Error
1: Error - Unknown Province/Territory or Country of Death with a reported Death Registration Number

6.3 Correlation edits
-
tumour record data

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 12

Fields involved: CCR Identification Number (CCRID) (Field T4)
Tumour Record Type (Field T5) positions 34 to 132

Description: This edit ensures that the content of the *tumour record* is consistent with the action described in the Tumour Record Type.

Edit specification: If Tumour Record Type = 1 (new record), then positions 34 to 132 cannot be all blank.

If Tumour Record Type = 2 (update record), then CCR Identification Number (CCRID) and positions 34 to 132 cannot be all blank.

If Tumour Record Type = 3 (delete record), then CCR Identification Number (CCRID) cannot be all blank, and positions 34 to 132 must be all blank. **Go to Correlation Edit No. 33**.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 13

Fields involved:

Source Classification Flag (SCF) (Field T14)
Site: ICD-9 (Field T13)
or
ICD-O-2/3 - Topography (Field T15)
or
ICD-10 (Field T18)

Histological Group: First 3 digits of:
ICD-O-2-Morphology (Field T16) or
ICD-O-3-Morphology (Field T21M)

Description:

This edit rejects basal and squamous cell skin cancers from the coverage of the CCR.

Edit specification:

<u>If ICD-9 does not equal 0000</u>

If the site equals 173._, 232._ or 238.2, then the first three digits of ICD-O-2 - Morphology cannot be in the range of 805 to 808 or 809 to 811.

<u>If ICD-O-2/3 - Topography and/or ICD-10 does not equal 0000</u>

If the site equals C44._, D04._ or D48.5, then the first three digits of ICD-O-2 - Morphology or ICD-O-3 – Morphology cannot be in the range of 805 to 808 or 809 to 811.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 14

Fields involved: Postal Code (Field T7) – First digit
Standard Geographic Code (SGC) of Place of Residence at Time of Diagnosis (Field T8) – First 2 digits

Description: This edit checks to ensure that the Postal Code corresponds to the reported province/territory of residence.

Edit specification: The first digit of the Postal Code must be one of the upper case alphabetic letters corresponding to the province/territory of residence, coded in the first two digits of the SGC of Place of Residence at Time of Diagnosis.

Province/Territory	Code	Allowable First Digit of the Postal Code
Newfoundland and Labrador	10	A or 9
Prince Edward Island	11	C or 9
Nova Scotia	12	B or 9
New Brunswick	13	E or 9
Québec	24	G, H, J, K or 9
Ontario	35	K, L, M, N, P or 9
Manitoba	46	R or 9
Saskatchewan	47	R, S or 9
Alberta	48	S, T or 9
British Columbia	59	V or 9
Yukon Territory	60	Y or 9
Northwest Territories	61	X or 9
Nunavut	62	X or 9

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 15

Fields involved: Standard Geographic Code (SGC) of Place of Residence at Time of Diagnosis (Field T8)
Census Tract (Field T9)

Description: It is impossible to have a Census Tract Code without knowing the province/territory and municipality in which the patient lived at the time of diagnosis. This edit ensures that if the former code is found, the latter must also be completely reported. Furthermore, it validates that the coded Census Tract is indeed found within the reported Place of Residence.

Note: The valid codes for the Census Tract are found in the Census Tract Dictionary, which excludes the codes for "not applicable" or "census tract unknown".

Edit specification: If Census Tract NNN000.00 or NNN999.99 (where N is any number from 0 to 9), then the coded Place of Residence at Time of Diagnosis must be identical to the seven digit Standard Geographic Code found on the matching record on the Census Tract Dictionary.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 16

Fields involved:	Reporting Province/Territory (Field T1) Standard Geographic Code (SGC) of Place of Residence at Time of Diagnosis (Field T8) – First 2 digits
Description:	The provinces/territories are to register only the cancers for patients who were part of their resident population at the time of diagnosis. This edit rejects data for patients who were living outside of the reporting province/territory at the time of diagnosis.
Edit specification:	The code of the Reporting Province/Territory must be equal to the first two digits of the coded Place of Residence at Time of Diagnosis (i.e. province/territory of residence).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 17

Fields involved: Date of Diagnosis (Field T12)
Date of Transmission (Field T22)

Description: This edit ensures that the Date of Diagnosis and the Date of Transmission respect a logical chronological sequence.

Edit specification: Decision Logic Table

Conditions:

Yr of Trans. > Yr of Diag.	Y	N	N	N	N	N	N	N
Yr of Trans. = Yr of Diag.	N	Y	Y	Y	Y	Y	Y	N
Mth of Diagnosis = 99-	Y	N	N	N	N	N	-	
Mth of Trans. > Mth of Diag.	-	-	Y	N	N	N	N	-
Mth of Trans. = Mth of Diag.	-	-	N	Y	Y	Y	N	-
Day of Diagnosis = 99-	-	-	Y	N	N	-	-	
Day of Trans. Day of Diag.	-	-	-	-	Y	N	-	-
Actions:	0	0	0	0	0	1	1	1

Messages:
0: No error
1: Error - diagnosis occurred after Date of Transmission

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 18

Fields involved:
ICD-9 (Field T13)
Source Classification Flag (SCF) (Field T14)
ICD-O-2/3 - Topography (Field T15)
ICD-10 (Field T18)

Description:
This edit ensures that one originally coded topography is reported in a correct manner. Furthermore, ICD-9 and ICD-10 codes cannot both be reported.

Edit specification:
Decision Logic Table

Conditions:

ICD-9 = 0000	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	N
ICD-O-2/3 - Topo. = 0000	Y	Y	Y	Y	N	N	N	N	N	N	Y	Y	Y	Y	N	N	N	N
ICD-10 = 0000	Y	N	N	N	Y	Y	Y	N	N	N	Y	Y	Y	N	Y	Y	Y	N
SCF = 1	-	Y	N	N	Y	N	N	Y	N	N	Y	N	N	-	Y	N	N	-
SCF = 2 or 4	-	N	Y	N	N	Y	N	N	Y	N	N	Y	N	-	N	Y	N	-
Actions:	1	2	3	0	2	0	4	2	0	0	0	3	4	5	0	0	4	5

Messages:
0: No error
1: Error - no topography reported
2: Error - flag reported for ICD-9
3: Error - flag reported for ICD-O-2/3
4: Error - flag reported for ICD-10
5: Error - ICD-9 & ICD-10 reported

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 19

*** * * D E L E T E D * * ***

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 20

Fields involved:

Source Classification Flag (SCF) (Field T14)
ICD-9 (Field T13)
or
ICD-10 (Field T18)
ICD-O-2 - M Behaviour Code (Field T17)

Description:

Behaviour Code of the ICD-O-2 - Morphology is used to describe the behaviour of the neoplasm. This edit ensures consistency between the Behaviour Code and the relevant ICD-9 or ICD-10 code, where both are reported. Only tumours of the central nervous system, including brain, are allowed to have a Behaviour Code /0 (benign).

Edit specification:

When SCF = 1 (topography originally coded in ICD-9, morphology coded in ICD-O-2).

If Behaviour Code = 0, then ICD-9 must be in the range 225.0 - 225.9; as well, if the ICD-9 is in the range 225.0 - 225.9, the Behaviour Code must = 0.

If Behaviour Code = 1, then ICD-9 must be in the range 235.0 - 239.9; as well, if the ICD-9 is in the range 235.0 - 239.9, the Behaviour Code must = 1.

If Behaviour Code = 2, then ICD-9 must be in the range 230.0 - 234.9; as well, if the ICD-9 is in the range 230.0 - 234.9, the Behaviour Code must = 2.

If Behaviour Code = 3, then ICD-9 must be found in one of the following ranges:

140.0 - 195.8
199.0 - 199.1
200.0 - 208.9

If the ICD-9 is in one of the above ranges, then the Behaviour Code must = 3.
(Reference: ICD-9, 1975 Revision, Volume I, p. 667)

continued...

Edit specification (cont'd):

When SCF = 3 (topography originally coded in ICD-10).

If Behaviour Code = 0, then ICD-10 must be in the range D32.0 - D33.9; as well, if the ICD-10 is in the range D32.0 - D33.9, then the Behaviour Code must = 0.

If Behaviour Code = 1, then ICD-10 must be in the range D37.0 - D48.9; as well, if the ICD-10 is in the range D37.0 - D48.9, then the Behaviour Code must = 1.

If the Behaviour Code = 2, then the ICD-10 must be in the range D00.0 - D09.9; as well, if the ICD-10 is in the range D00.0 - D09.9, then the Behaviour Code must = 2.

If the Behaviour Code = 3, then the ICD-10 must be found in one of the following ranges:

C00.0 - C76.8
C80 - C96

If the ICD-10 is in one of the above ranges, then the Behaviour Code must = 3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 21

Fields involved:

Source Classification Flag (SCF) (Field T14)
ICD-O-2/3 - Topography (Field T15)
ICD-O-2 - M Behaviour Code (Field T17)
ICD-O-3 - M Behaviour Code (Field T21B)

Description:

A Behaviour Code representing "benign" is only acceptable when it is a tumour of the central nervous system, including the brain.

Edit specification:

When SCF = 2 (topography/morphology originally coded in ICD-O-2), and the ICD-O-2 – M Behaviour Code = 0, then the ICD-O-2/3 - Topography must be in the range C70.0 - C72.9.

When SCF = 4 (topography/morphology originally coded in ICD-O-3), and the ICD-O-3 – M Behaviour Code = 0, then the ICD-O-2/3 - Topography must be in the range C70.0 - C72.9.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 22

Fields involved:

Source Classification Flag (SCF) (Field T14)
Laterality (Field T19)
ICD-9 (Field T13)
or
ICD-O-2/3 - Topography (Field T15)
or
ICD-10 (Field T18)

Description:

This edit ensures that the stated laterality of the tumour is consistent with the cancer site involved.

Edit specification:

If an ICD-9 code (SCF = 1), an ICD-O-2/3 - Topography code (SCF = 2 or 4) or an ICD-10 code (SCF = 3) corresponds to a paired site, then the Laterality code must refer to a paired organ (codes 1, 2, 4 or 9).

In the other case, where the topography does not correspond to a paired site, then the laterality code must equal "0": not a paired organ.

continued...

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 22 (cont'd)

Sites considered paired

Note: *Sites shown in italics were added July 1993.*
Sites shown in bold were added October 1993.
Sites shown in regular font were listed in the original version of the Data Dictionary (October 1992).
Sites Nasal Cavity and Bronchus were deleted October 1993.

	ICD-O-2/3	ICD-9	Correct Laterality Codes
Parotid gland	**C07.9**	**142.0**	**1,2,9**
Submandibular gland	**C08.0**	**142.1**	**1,2,9**
Sublingual gland	**C08.1**	**142.2**	**1,2,9**
Tonsillar fossa	**C09.0**	**146.1**	**1,2,9**
Tonsillar pillar	**C09.1**	**146.2**	**1,2,9**
Overlapping lesion of tonsil	**C09.8**	**---**	**1,2,9**
Tonsil, NOS	**C09.9**	**---**	**1,2,9**
Pyriform sinus	**C12.9**	**148.1**	**1,2,9**
Middle ear	C30.1	160.1	1,2,9
Maxillary sinus	**C31.0**	**160.2**	**1,2,9**
Frontal sinus	**C31.2**	**160.4**	**1,2,9**
Sphenoid sinus	**C31.3**	**160.5**	**1,2,9**
Overlapping lesion of accessory sinuses	**C31.8**	**160.8**	**1,2,9**
Accessory sinus, NOS	**C31.9**	**160.9**	**1,2,9**
Lung, excluding bronchus	C34.1 - C34.9 (excl. C34.0)	162.3 - 162.9, 231.2	1,2,9
Pleura	C38.4	163._	1,2,9
Respiratory system and intrathoracic organs	*C39.8*	*165.8*	*0,1,2,9*
Bones, joints & articular cartilage of limbs	C40._	170.4, 170.5, 170.7, 170.8	1,2,9
Overlapping lesions of bones, joints and articular cartilage	*C41.8*	---	*0,1,2,9*
Skin of eyelid	**C44.1**	**172.1, 173.1, 232.1**	**1,2,9**
Skin of external ear	C44.2	172.2, 173.2, 232.2	1,2,9
Skin of other & unspecified parts of face	**C44.3**	**172.3, 173.3, 232.3**	**1,2,9**
Skin of scalp and neck	**C44.4**	**172.4, 173.4, 232.4**	**1,2,9**
Skin of trunk	**C44.5**	**172.5, 173.5, 232.5**	**1,2,9**
Skin of upper limb and shoulder	C44.6	172.6, 173.6, 232.6	1,2,9
Skin of lower limb and hip	C44.7	172.7, 173.7, 232.7	1,2,9
Overlapping lesion of skin	**C44.8**	**172.8, 173.8, 232.8**	**1,2,9**
Skin, NOS	**C44.9**	**172.9, 173.9, 232.9**	**1,2,9**
Peripheral nerves & autonomic nervous system of upper limb and shoulder	C47.1	---	1,2,9
Peripheral nerves & autonomic nervous system of lower limb and hip	C47.2	---	1,2,9

continued

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 22 (*cont'd*)

Sites considered paired

Note: Sites shown in italics were added July 1993.
Sites shown in bold were added October 1993.
Sites shown in regular font were listed in the original version of the Data Dictionary (October 1992).
Sites Nasal Cavity and Bronchus were deleted October 1993.
Ovary was added in 1999.

	ICD-O-2/3	ICD-9	Correct Laterality codes
Connective, subcutaneous, & other soft tissues of upper limb and shoulder	49.1	171.2	1,2,9
Connective, subcutaneous, & other soft tissues of lower limb and hip	49.2	171.3	1,2,9
Breast	50._	174._, 175, 233.0,	1,2,9
Ovary	56.9	183.3	1,2,4,9
Testis	62._	186.0	1,2,9
Epididymis	**63.0**	186._, 236.4	**1,2,9**
Spermatic cord	**63.1**	**187.5**	**1,2,9**
Overlapping lesion of male genital organs	*63.8*	**187.6**	*0,1,2,9*
Kidney	64.9	*187.8*	1,2,4[1],9
Renal pelvis	65.9	189.0	1,2,9
Ureter	66.9	189.1	1,2,9
Overlapping lesion of urinary organs	68.8	189.2	*0,1,2,4,9*
Eye	69._	*189.8*	1,2,4[1],9
Brain, excluding brain stem	71._ (excl. C71.7)	190._, 234.0	1,2,9
Overlapping lesion of brain and central nervous system	*72.8*	191._, (excl. 191.7)	*0,1,2,9*
Thyroid gland	73.9	*192.8*	1,2,9
Adrenal gland	74._	193	1,2,9
Other and ill-defined sites of upper limb, NOS	*76.4*	194.0, 237.2	*1,2,9*
Other and ill-defined sites of lower limb, NOS	*76.5*	*195.4*	*1,2,9*
Unknown primary site	*80.9*	*195.5*	*0,1,2,3,4,9*
All other sites	00.0 - C77.9	199._	0
ICD-9 sites of non-malignant tumours not listed above	-	140.0 - 195.8, 200.0 208.9 210.0 - 239.9	0,1,2,3,4,9

[1] Code 4 is used to report bilateral involvement of ovaries (effective 1999 data), of kidneys (Wilm's tumours) and eyes (retinoblastomas) when the side of origin (left or right) is not known.

--- Equivalent code does not exist.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 23

Fields involved:

Source Classification Flag (SCF) (Field T14)
ICD-9 (Field T13)
or
ICD-O-2/3 - Topography (Field T15)
or
ICD-10 (Field T18)
ICD-O-2 - Morphology (Field T16)
ICD-O-3 - Morphology (Field T21M)

Description:

This edit rejects those cancer types (morphologies) that cannot occur in certain specific sites (topographies).

Edit specification:

When the SCF = 1

Site/morphology combinations that are found on the Invalid ICD-9 Site/Morphology Code List are in error. See Appendix K.

When the SCF = 2

Site/morphology combinations that are found on the Invalid ICD-O-2 Site/Morphology Code List are in error. See Appendix L.

When the SCF = 3

Site/morphology combinations that are found on the Invalid ICD-10 Site/Morphology Code List are in error. See Appendix M.

When the SCF = 4

Site/morphology combinations that are found on the Invalid ICD-O-3 Site/Morphology Code List are in error. See Appendix L-O3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour record
Data Consistency
Correlation Edit No. 24

Fields involved:

ICD-O-2 - Morphology (Field T16)
ICD-O-2 - M Behaviour Code (Field T17)
ICD-O-3 - Morphology (Field T21M)
ICD-O-3 - M Behaviour Code (Field T21B)

Description:

This edit ensures a reasonable combination of the type of cancer (morphology) and its behaviour. Firstly, leukemias and lymphomas must be coded as invasive. Secondly, there are a number of cancer types that cannot be classified as "in situ".

Edit specification:

If ICD-O-2 - Morphology is found in the range 9590 to 9734 or in the range 9800 to 9989, then the ICD-O-2 – M Behaviour Code must equal "3".

For cancers with an ICD-O-2 – M Behaviour Code of "2" (in situ), the invalid ICD-O-2 - Morphology codes are found on the Invalid In Situ ICD-O-2 Morphology Code List. See Appendix N.

If ICD-O-3 - Morphology is found in the range 9590 to 9723 or in the range 9800 to 9941, then the ICD-O-3 – M Behaviour Code must equal "3".

For cancers with an ICD-O-3 – M Behaviour Code of "2" (in situ), the invalid ICD-O-3 - Morphology codes are found on the Invalid In Situ ICD-O-3 Morphology Code List. See Appendix N-O3.

6.4 Correlation edits
-
Patient record (input) versus patient record

Input Patient Records (Patient(I)) may be of 4 types: new, update, delete and change of ownership. These three edits validate the reasonableness of Patient(I) Record Type, when compared to the *patient record* already on the database.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient(I) vs patient
Data Consistency
Correlation Edit No. 25

Fields involved: Reporting Province/Territory (Field P1)
Patient Identification Number (PIN) (Field P2)
Patient(I) Record Type (Field P4)

Description: This edit ensures that duplicate patient registrations are not posted to the registry, and that each patient is given a unique identification number.

Edit specification: If Patient(I) Record Type = 1 (new record), then there cannot be a *patient record* already on the registry with an identical Reporting Province/Territory and Patient Identification Number (PIN).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient(I) vs patient
Data Consistency
Correlation Edit No. 26

Fields involved:	Reporting Province/Territory (Field P1) Patient Identification Number (PIN) (Field P2) CCR Identification Number (CCRID) (Field P3) Patient(I) Record Type (Field P4)
Description:	A *patient record* which is either an update or delete record, should match with a *patient record* already on the registry.
Edit specification:	If Patient(I) Record Type = 2 (update record) or 3 (delete record), then there must be a *patient record* already on the registry having an identical Reporting Province/Territory, Patient Identification Number (PIN) and CCR Identification Number (CCRID).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Patient(I) vs patient
Data Consistency
Correlation Edit No. 27

Fields involved:	Reporting Province/Territory (Field P1) CCR Identification Number (CCRID) (Field P3) Patient Record Type (Field P4) Sex (Field P10) Year of Birth: Date of Birth (Field P11) – First 4 digits
Description:	For every change of ownership record, there must be a *patient record* already on the registry with the same CCR Identification Number (CCRID), but from a different province. In order to ensure that it is in fact the same patient, reported Year of Birth and Sex cannot be different.
Edit specification:	If Patient(I) Record Type = 4 (change of ownership), then there must be a *patient record* on the CCR with an identical CCR Identification Number (CCRID), a different Reporting Province/Territory and an identical Sex and Year of Birth when known.

6.5 Correlation edits
-
Tumour record versus patient record

Each *patient record*, with its associated *tumour records*, refers to an individual patient. When a patient is first registered on the CCR, the new *tumour records* are compared to the *patient record*. Any subsequent new or update *tumour record* will also be compared to the *patient record* already on the CCR. Any change in the *patient record*, arising from an update or change of ownership, will cause all associated *tumour records* already on the CCR to be once again compared to the *patient record*.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour vs patient
Data Consistency
Correlation Edit No. 28

Fields involved: Date of Birth (Field P11)
Date of Diagnosis (Field T12)

Description: The Date of Birth cannot occur later than the Date of Diagnosis, nor earlier than 117 years prior to the Date of Diagnosis.

Edit specification: Decision Logic Table

Conditions:

Yr of Birth = 9999	Y	N	N	N	N	N	N	N	N	N	N	N
Yr of Birth > Yr of Diag.	-	Y	N	N	N	N	N	N	N	N	N	N
Yr of Birth < Yr of Diag.	-	N	Y	Y	N	N	N	N	N	N	N	N
(Yr Diag. - Yr Birth) > 117	-	-	Y	N	-	-	-	-	-	-	-	-
Mth of Birth = 99	-	-	-	-	Y	N	N	N	N	N	N	N
Mth of Diag. = 99	-	-	-	-	-	Y	N	N	N	N	N	N
Mth of Birth >Mth of Diag.	-	-	-	-	-	-	Y	N	N	N	N	N
Mth of Birth < Mth of Diag.	-	-	-	-	-	-	N	Y	N	N	N	N
Day of Birth = 99	-	-	-	-	-	-	-	-	Y	N	N	N
Day of Diagnosis = 99	-	-	-	-	-	-	-	-	-	Y	N	N
Day of Birth > Day of Diag.	-	-	-	-	-	-	-	-	-	-	Y	N
Actions:	0	1	2	0	0	0	1	0	0	0	1	0

Messages:

0: No error
1: Error - diagnosis occurred before Date of Birth
2: Error - patient was more than 117 years old at the time of diagnosis

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour vs patient
Data Consistency
Correlation Edit No. 29

Correlation Edit No. 29 included with Correlation Edit No. 30

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour vs patient
Data Consistency
Correlation Edit No. 30

Fields involved:

Date of Death (Field P14)
Method of Diagnosis (Field T11)
Date of Diagnosis (Field T12)

Description:

This edit assures that:

1) If the patient is alive that the method of diagnosis is not death certificate only (DCO) or autopsy
2) The Date of Diagnosis does not precede the Date of Death (i.e. positive survival) when the diagnosis was established through DCO (pertinent to cases diagnosed from 1992 to 2003)
3) The Date of Diagnosis does not precede the Date of Death (i.e. positive survival) when the diagnosis was established through DCO or autopsy (pertinent to cases diagnosed from 2004 onward)
4) The Date of Death does not precede the Date of Diagnosis (i.e. negative survival)

Edit specification:

Decision Logic Table

Conditions:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Yr of Death = 0000		Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Yr of Death = 9999		-	-	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Yr Death > Yr of Diag.		-	-	-	Y	Y	N	N	N	N	N	N	N	N	N	N	N
Yr Death = Yr of Diag.		-	-	-	-	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Yr Death < Yr of Diag.		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Y
Mth of Death = 99		-	-	-	-	-	Y	N	N	N	N	N	N	N	N	N	-
Mth of Diag. = 99		-	-	-	-	-	-	Y	N	N	N	N	N	N	N	N	-
Mth Death > Mth Diag.		-	-	-	-	-	-	-	Y	Y	N	N	N	N	N	N	-
Mth Death = Mth Diag.		-	-	-	-	-	-	-	-	-	Y	Y	Y	Y	Y	N	-
Mth Death < Mth Diag.		-	-	-	-	-	-	-	-	-	-	-	-	-	-	Y	-
Day of Death = 99		-	-	-	-	-	-	-	-	-	Y	N	N	N	N	-	-
Day of Diag. = 99		-	-	-	-	-	-	-	-	-	-	Y	N	N	N	-	-
Day Death > Day Diag.		-	-	-	-	-	-	-	-	-	-	-	Y	Y	N	-	-
Day Death < Day Diag.		-	-	-	-	-	-	-	-	-	-	-	-	-	Y	-	-
Yr of Diag. < 2004		Y	N	-	Y	N	-	-	Y	N	-	-	Y	N	-	-	-
Meth. of Diag. = 2 or = 6		Y	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Meth. Used to Establish Date of Diag. = 3 or = 8		-	Y	-	-	**Y**	-	-	-	**Y**	-	-	-	**Y**	-	-	-
Method of Diag. = 6		-	-	-	Y	-	-	-	Y	-	-	-	Y	-	-	-	-
Actions:	1	1	0	2	3	0	0	2	3	0	0	2	3	4	4	4	

Messages:

0: No error

1: Error - Year of Death variable indicates the patient is Alive, but Method of Diagnosis is either "Death Certificate Only" or "Autopsy"
2: Error - Method of Diagnosis is "Death Certificate Only" but Date of Diagnosis precedes Date of Death
3: Error - Method of Diagnosis is "Death Certificate Only" or "Autopsy" and Year of Diagnosis is not less than 2003 but Date of Diagnosis precedes Date of Death
4: Error - Date of Death precedes Date of Diagnosis

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour vs patient
Data Consistency
Correlation Edit No. 31

Fields involved:

Sex (Field P10)
Site: ICD-9 (Field T13)
or
ICD-O-2/3 - Topography (Field T15)
or
ICD-10 (Field T18)

Description:

This edit ensures that sex restrictions on the Topography of the tumour are respected. In addition, if the Sex is not stated and the site of the primary tumour is sex-specific, then an error message is generated.

Edit specification:

When Sex = 1 (male), the following sex-specific site codes are invalid:

ICD-9:	1740-1749, 179-1849, 2331-2333, 2360-2363
ICD-O-2/3:	C510-C589
ICD-10:	C510-C589, C796, D060-D073, D390-D399

When Sex = 2 (female), the following sex-specific site codes are invalid:

ICD-9:	175, 185-1879, 2334-2336, 2364-2366
ICD-O-2/3:	C600-C639
ICD-10:	C600-C639, D074-D076, D400-D409

If a sex-specific site is given, the Sex must be stated - i.e. code "1" or "2".

6.6 Correlation edits
-
Tumour record (input) versus tumour record

Input Tumour Records (Tumour(I)) may be of 3 types: new, update or delete. The full range of Tumour(I) vs Tumour correlations are performed only when Tumour(I) is either a new or an update record. Delete records, Tumour Record Type = 3, only pass through Correlation Edit No. 33.

Every Tumour(I) must be compared to all other *tumour records* on the registry for that same patient.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour(I) vs tumour
Data Consistency
Correlation Edit No. 32

Fields involved:

Reporting Province/Territory (Field T1)
Patient Identification Number (PIN) (Field T2)
Tumour Reference Number (Field T3)
CCR Identification Number (CCRID) (Field T4)
Tumour(I) Record Type (Field T5)

Description:

This edit ensures that:

1) duplicate tumour registrations are not posted to the registry and that each distinct tumour is given a unique identification number;

2) when the CCR Identification Number (CCRID) is reported on a new *tumour record* (thus indicating that there has been a tumour already registered for this patient),

i) there is at least one previous *tumour record*, for the same patient, already on the registry; and,

ii) the new *tumour record* has the same Patient Identification Number (PIN) as any previous *tumour record*, for the same patient, from the same Reporting Province/Territory.

Edit specification:

If Tumour(I) Record Type = 1 (new record):

1) then there cannot be a *tumour record* already on the registry with an identical Reporting Province/Territory, Patient Identification Number (PIN) and Tumour Reference Number; and,

2) in addition, if the CCR Identification Number (CCRID) is also reported, then:

i) there must be a *tumour record* already on the registry with the identical CCR Identification Number (CCRID); and

ii) there cannot be a *tumour record* already on the registry with an identical CCR Identification Number (CCRID) and Reporting Province/Territory, but with a different Patient Identification Number (PIN).

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour(I) vs tumour
Data Consistency
Correlation Edit No. 33

Fields involved:	Reporting Province/Territory (Field T1) Patient Identification Number (PIN) (Field T2) Tumour Reference Number (Field T3) CCR Identification Number (CCRID) (Field T4) Tumour(I) Record Type (Field T5)
Description:	This edit ensures that the *tumour records* already on the registry permit the action described in the Tumour(I) Record Type field.
Edit specification:	If Tumour(I) Record Type = 2 (update record) or 3 (delete record), then there must be a *tumour record* already on the registry with an identical Reporting Province/Territory, Patient Identification Number (PIN), CCR Identification Number (CCRID) and Tumour Reference Number.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour(I) vs tumour
Data Consistency
Correlation Edit No. 34-A

Fields involved: ICD-O-3 - Morphology (Field T21M)

Description: This is the first of 6 correlation edits that identify the reporting of duplicate tumours by comparing their topography, morphology, and laterality, in that order. However, no topographic comparisons are pertinent to cancers of the lymphatic and circulatory systems, and thus, this edit directs such tumours straight to the morphologic comparisons.

Edit specification: If both Tumour(I) and Tumour ICD-O-3 - Morphology are in the code range 9590 to 9989, or if only one of the tumours has a Morphology in this range while the other's Morphology **is not equal** to 800_, then go to Correlation Edit No. 34-B.

Otherwise, proceed to Correlation Edit No. 34-C.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour(I) vs tumour
Data Consistency
Correlation Edit No. 34-B

Fields involved: ICD-O-3 - Morphology (Field T21M)

Description: This is the second of 6 correlation edits designed to identify the duplicate reporting of a specific tumour based upon its characteristics. This edit examines a new tumour of the lymphatic or circulatory system, and confirms that it is indeed distinct because of its different histological description.

Edit specification: If the Tumour(I) 4-digit Morphology Code is not found in the same morphology grouping as the Tumour 4-digit Morphology Code, then Tumour(I) is a distinct tumour.

If the Tumour(I) 4-digit Morphology Code is found in the same morphology grouping, then it is a duplicate tumour. The groupings of the 4-digit Morphology Codes are listed in Appendix P-O3.

Note: The *tumour records* containing a duplicate primary tumour are rejected.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour(I) vs tumour
Data Consistency
Correlation Edit No. 34-C

Fields involved: ICD-O-2/3 - Topography (Field T15)

Description: This is the third of 6 correlation edits designed to identify the duplicate reporting of a specific tumour based upon its characteristics. This edit identifies "same" topographies, when at least one of the reported tumours is an overlapping or unspecified site.

Edit specification: If the Tumour(I) and the Tumour ICD-O-2/3 - Topography codes are found among the code pairs listed in Appendix O, then proceed to Correlation Edit No. 34-E.

If no match is found, then proceed to Correlation Edit No. 34-D.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour(I) vs tumour
Data Consistency
Correlation Edit No. 34-D

Fields involved: Site: ICD-O-2/3 - Topography (Field T15) – First 3 characters
Subsite: ICD-O-2/3 - Topography (Field T15) - 4th digit

Description: This is the fourth of 6 correlation edits designed to identify the duplicate reporting of a specific tumour based upon its characteristics. This edit confirms that the tumour is indeed distinct because of its different topography.

Edit specification: Decision Logic Table

Conditions:

Tumour(I) Site = Site	Y	Y	Y	Y	Y	N
Tumour(I) Subsite = Subsite	Y	N	N	N	N	-
Tumour(I) Subsite = 0 to 7	-	Y	Y	N	N	-
Tumour(I) Subsite = 8 or 9	-	N	N	Y	Y	-
Subsite = 0 to 7	-	Y	N	Y	N	-
Subsite = 8 or 9	-	N	Y	N	Y	-
Actions:	0	1	0	0	0	2

Messages:
0: Same topography - go to Correlation Edit No. 34-E
1: Different subsite - distinct tumour
2: Different site - distinct tumour

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour(I) vs tumour
Data Consistency
Correlation Edit No. 34-E

Fields involved: ICD-O-3 - Morphology (Field T21M)

Description: This is the fifth of 6 correlation edits designed to identify the duplicate reporting of a specific tumour based upon its characteristics. This edit confirms that the new tumour is indeed distinct because of its different histological description.

Edit specification: If the Tumour(I) 4-digit Morphology Code is not found in the same morphology grouping as the Tumour 4-digit Morphology Code, then Tumour(I) is a distinct tumour.

If Tumour(I) 4-digit Morphology Code is found in the same morphology grouping, then proceed to Correlation Edit No. 34-F.

The groupings of the 4-digit Morphology Code are listed in Appendix P-O3.

Statistics Canada
Canadian Cancer Registry
Input Data Dictionary

Tumour(I) vs tumour
Data Consistency
Correlation Edit No. 34-F

Fields involved: Laterality (Field T19)

Description: This is the last of 6 correlation edits designed to identify the duplicate reporting of a specific tumour based upon its characteristics. This edit confirms either that the tumour is indeed **distinct** because of its different laterality, or that it is indeed a **duplicate** registration of a tumour already on the registry.

Edit specification: Decision Logic Table

Conditions:

Tumour(I) Laterality = Lat.	N	Y	N	N	N	N	N	N	N	N	N	N	N	N
Tumour(I) Laterality = 0	N	-	Y	Y	Y	N	N	N	N	N	N	N	N	N
Tumour(I) Laterality = 4	N	-	N	N	N	Y	Y	Y	N	N	N	N	N	N
Tumour(I) Laterality = 9	N	-	N	N	N	N	N	N	Y	Y	Y	N	N	N
Laterality = 0	N	-	-	-	-	Y	N	N	Y	N	N	Y	N	N
Laterality = 4	N	-	Y	N	N	-	-	-	N	Y	N	N	Y	N
Laterality = 9	N	-	N	Y	N	N	Y	N	-	-	-	N	N	Y
Actions:	0	4	1	1	1	1	2	3	1	2	2	1	3	2

Messages:

0: Different laterality - distinct tumour
1: Error - n/a laterality with paired organ
2: Warning - known laterality with unknown - potential duplicate - distinct tumour assumed
3: Warning - lateral and bilateral tumours - potential duplicate - distinct tumour assumed
4: Identical laterality - duplicate tumour

Note: The *tumour records* registering duplicate tumours are rejected.

7.0 Additional rules for updating the CCR

Certain Correlation Edits (particularly No. 25, 26, 27, 32 & 33) exist to ensure that any changes to the CCR are consistent, and that the final result respects the internal logic of the CCR and its structure. The additional rules for updating or changing the CCR, that are displayed hereafter, do not really fall into the five preceding categories of Correlation Edits. Any violation of these rules will also cause the responsible input records to be rejected.

1) If a *patient record* is to be deleted from the CCR, all *tumour records* associated with it (i.e. sharing the same CCR Identification Number (CCRID)) must be deleted simultaneously.

2) If all the *tumour records* associated with a *patient record* (i.e. sharing the same CCR Identification Number (CCRID)) are to be deleted, then that *patient record* must also be deleted simultaneously.

3) A new *tumour record* not accompanied by a new or change of ownership *patient record* can only be posted to the CCR when the *patient record,* already on the CCR, is owned by the same provincial registry submitting the new *tumour record*.

Appendices

Appendix A

Reporting of alphabetic name fields

The name fields on the *patient record* are collected on the CCR to facilitate the elimination of duplicate registration of patients and tumours. In addition, they are used to match with mortality records to facilitate death clearance. Therefore, the following standard reporting of names is recommended:

a) the use of only upper case alphabetic letters, without accents;

b) the removal of any special characters within the name, except hyphens (apostrophes and embedded blanks);

c) the consistent use of the abbreviations "STE" and "ST" respectively, for names starting with "SAINTE" or "SAINT", without any hyphens; and,

d) the removal of all suffixes and titles from the name.

Examples:	Marra-Cortez	→	MARRA-CORTEZ
	St. John	→	STJOHN
	O'Neil	→	ONEIL
	Dr. Patel	→	PATEL
	Cheung, Ph. D	→	CHEUNG
	Sr. Mary-Catherine	→	MARY-CATHERINE
	P.-E.	→	P-E
	Van der Bijl	→	VANDERBIJL
	Côté	→	COTE
	MacDonald	→	MACDONALD

Appendix B

Province/Territory or country code file

Field	Size	Position	Type	Title
1	3	1 - 3	N	ISO Province/Territory and Country Codes
2	3	4 - 6	A	Blank
3	39	7 - 45	A	Description (English)
4	35	46 - 80	A	Description (French)

List of valid province/territory and country codes

Code	Province/Territory and country (English)	Province/Territory and country (French)
004	Afghanistan	Afghanistan
008	Albania	Albanie
010	Antarctica	Antarctique
012	Algeria	Algerie
016	American Samoa	Samoa Americaines
020	Andorra	Principaute D'Andorre
024	Angola	Angola
028	Antigua and Barbuda	Antigua-et-Barbuda
031	Azerbaijan	Azerbaidjan
032	Argentina	Argentine
036	Australia	Australie
040	Austria	Autriche
044	Bahama	Bahamas
048	Bahrain	Bahrein
050	Bangladesh	Bangladesh
051	Armenia	Armenie
052	Barbados	Barbade
056	Belgium	Belgique
060	Bermuda	Bermudes
064	Bhutan	Bhoutan
068	Bolivia	Bolivie

Code	Province/Territory and country (English)	Province/Territory and country (French)
070	Bosnia and Herzegovina	Bosnie-Herzegovine
072	Botswana	Botswana
074	Bouvet Island	Bouvet, Ile
076	Brazil	Bresil
084	Belize	Belize
086	British Indian Ocean Territory	Ocean Indien, Terr. Britanique L'
090	Solomon Islands	Salomon, Iles
092	British Virgin Islands	Vierges Britanniques, Iles
096	Brunei	Brunei
100	Bulgaria	Bulgarie
104	Myanmar	Myanmar
108	Burundi	Burundi
112	Belarus	Belarus
116	Cambodia	Royaume du Cambodge
120	Cameroon	Cameroun
132	Cape Verde	Cap-Vert
136	Cayman Islands	Caimanes, Iles
140	Central African Republic	Centrafricaine, Republique
144	Sri Lanka	Sri Lanka
148	Chad	Tchad
152	Chile	Chili
156	China, People's Republic of	Chine
158	Taiwan, Province of China	Taiwan, Province de Chine
162	Christmas Island	Christmas, Ile
166	Cocos (Keeling) Islands	Cocos (Keeling),Iles des
170	Colombia	Colombie
174	Comoros	Comores
175	Mayotte	Mayotte
178	Congo	Congo
180	Zaire	Zaire
184	Cook Islands	Cook, Iles

Code	Province/Territory and country (English)	Province/Territory and country (French)
188	Costa Rica	Costa Rica
191	Croatia	Croatie
192	Cuba	Cuba
196	Cyprus	Chypre
203	Czech Republic	Tcheque, Republique
204	Benin	Benin
208	Denmark	Danemark
212	Dominica	Dominique
214	Dominican Republic	Dominicaine, Republique
218	Ecuador	Equateur
222	El Salvador	El Salvador
226	Equatorial Guinea	Guinee-Equatoriale
230	Ethiopia	Ethiopie
231	Ethiopia (1997 ISO Country code)	Ethiopie (Codes pays OIN de 1997)
232	Eritrea	Erythree
233	Estonia	Estonie
234	Faeroe Islands	Feroe, Iles
238	Falkland Islands (Malvinas)	Falkland, Iles (Malvinas)
239	South Georgia & South Sandwich Islands	Georgie Sud et Iles Sandwich du Sud
242	Fiji	Fidji
246	Finland	Finlande
250	France	France
254	French Guiana	Guyane Francaise
258	French Polynesia	Polynesie Francaise
260	French Southern Territories	Terres Australes Francaises
262	Djibouti	Djibouti
266	Gabon	Gabon
268	Georgia	Georgie
270	Gambia	Gambie
276	Germany	Allemagne
288	Ghana	Ghana

Code	Province/Territory and country (English)	Province/Territory and country (French)
292	Gibraltar	Gibraltar
296	Kiribati	Kiribati
300	Greece	Grece
304	Greenland	Groenland
308	Grenada	Grenade
312	Guadeloupe	Guadeloupe
316	Guam	Guam
320	Guatemala	Guatemala
324	Guinea	Guinee
328	Guyana	Guyana
332	Haiti	Haiti
334	Heard and Mc Donald Islands	Heard et Mc Donald, Iles
336	Vatican City State (Holy See)	Vatican, État de la Cite du
340	Honduras	Honduras
344	Hong Kong	Hong-Kong
348	Hungary	Hongrie
352	Iceland	Islande
356	India	Inde
360	Indonesia	Indonesie
364	Iran	Iran
368	Iraq	Iraq
372	Ireland	Irlande
376	Israel	Israel
380	Italy	Italie
384	Ivory Coast	Cote D'Ivoire
388	Jamaica	Jamaique
392	Japan	Japon
398	Kasakhstan	Kazakhstan
400	Jordan	Jordanie
404	Kenya	Kenya
408	Korea, Democratic Peoples Repub. of	Coree, Republique Populaire de

Code	Province/Territory and country (English)	Province/Territory and country (French)
410	Korea, Republic of	Coree, Republique de
414	Kuwait	Koweit
417	Kyrgystan	Kirghizistan
418	Lao People's Democratic Republic	Lao, Rep. Democratique Populaire
422	Lebanon	Liban
426	Lesotho	Lesotho
428	Latvia	Lettonie
430	Liberia	Liberia
434	Libyan Arab Jamahiriya	Libyenne, Jamahiriya Arabe
438	Liechtenstein	Liechtenstein
440	Lithuania	Lituanie
442	Luxembourg	Luxembourg
446	Macau	Macao
450	Madagascar	Madagascar
454	Malawi	Malawi
458	Malaysia	Malaisie
462	Maldives	Maldives
466	Mali	Mali
470	Malta	Malte
474	Martinique	Martinique
478	Mauritana	Mauritanie
480	Mauritius	Maurice
484	Mexico	Mexique
492	Monaco	Monaco
496	Mongolia	Mongolie
498	Moldova, Republic of	Moldova, Republique de
500	Montserrat	Montserrat
504	Morocco	Maroc
508	Mozambique	Mozambique
512	Oman	Oman
516	Namibia	Namibie

Code	Province/Territory and country (English)	Province/Territory and country (French)
520	Nauru	Nauru
524	Nepal	Nepal
528	Netherlands	Pays-Bas
530	Netherlands Antilles	Antilles Neerlandaises
533	Aruba	Aruba
540	New Caledonia	Nouvelle-Caledonie
548	Vanuatu	Vanuatu
554	New Zealand	Nouvelle-Zelande
558	Nicaragua	Nicaragua
562	Niger	Niger
566	Nigeria	Nigeria
570	Niue	Nioue
574	Norfolk Island	Norfolk, Ile
578	Norway	Norvege
580	Northern Mariana Islands	Mariannes du Nord, Iles
581	United States Minor Outlying Islands	Iles Mineures Eloignees des E-U
583	Micronesia	Micronesie
584	Marshall Islands	Marshall, Iles
585	Palau	Palau
586	Pakistan	Pakistan
591	Panama	Panama
598	Papua New Guinea	Papouasie-Nouvelle-Guinee
600	Paraguay	Paraguay
604	Peru	Perou
608	Philippines	Philippines
612	Pitcairn	Pitcairn
616	Poland	Pologne
620	Portugal	Portugal
624	Guinea-Bissau	Guinee-Bissau
626	East Timor	Timor Oriental
630	Puerto Rico	Porto Rico

Code	Province/Territory and country (English)	Province/Territory and country (French)
634	Qatar	Qatar
638	Reunion	Reunion
642	Romania	Roumanie
643	Russian Federation	Russie, Federation de
646	Rwanda	Rwanda
654	St. Helena	Sainte-Helene
659	Saint Kitts and Nevis	Saint-Christophe-et-Nevis
660	Anguilla	Anguilla
662	Saint Lucia	Sainte-Lucie
666	St. Pierre and Miquelon	Saint-Pierre-et-Miquelon
670	Saint Vincent and the Grenadines	Saint-Vincent-et-Grenadines
674	San Marino	Saint-Marin
678	Sao Tome and Principe	Sao Tome-et-Principe
682	Saudi Arabia	Arabie Saoudite
686	Senegal	Senegal
690	Seychelles	Seychelles
694	Sierra Leone	Sierra Leone
702	Singapore	Singapour
703	Slovakia	Slovaquie
704	Viet Nam	Viet Nam
705	Slovenia	Slovenie
706	Somalia	Somalie
710	South Africa	Afrique du Sud
716	Zimbabwe	Zimbabwe
724	Spain	Espagne
732	Western Sahara	Sahara Occidental
736	Sudan	Soudan
740	Suriname	Suriname
744	Svalbard and Jan Mayen	Svalbard et Ile Jan Mayen
748	Swaziland	Swaziland
752	Sweden	Suede

Code	Province/Territory and country (English)	Province/Territory and country (French)
756	Switzerland	Suisse
760	Syrian Arab Republic	Syrienne, Republique Arabe
762	Tajikistan	Tadjikistan
764	Thailand	Thailande
768	Togo	Togo
772	Tokelau	Tokelaou
776	Tonga	Tonga
780	Trinidad and Tobago	Trinite-et-Tobago
784	United Arab Emirates	Emirats Arabes Unis
788	Tunisia	Tunisie
792	Turkey	Turquie
795	Turkmenistan	Turkmenistan
796	Turks and Caicos Islands	Turks et Caiques, Iles
798	Tuvalu	Tuvalu
800	Uganda	Ouganda
804	Ukrainia	Ukraine
807	Macedonia, Former Yugoslav Republic of	Macedoine, L'Ex-Rep. Yougoslave de
818	Egypt	Egypte
826	United Kingdom	Royaume-Uni
834	Tanzania,United Republic of	Tanzanie, Republique-Unie de
840	United States	États-Unis
850	United States Virgin Islands	Vierges Americaines, Iles
854	Burkina Faso	Burkina Faso
858	Uruguay	Uruguay
860	Uzbekistan	Ouzbekistan
862	Venezuela	Venezuela
876	Wallis and Futuna Islands	Wallis et Futuna, Iles
882	Samoa	Samoa
887	Yemen Republic of	Yemen
891	Yugoslavia	Yougoslavie
894	Zambia	Zambie

Code	Province/Territory and country (English)	Province/Territory and country (French)
899	At Sea	En Mer
909	Canada Province/Territory Unknown	Canada, Province/Territoire Inconnu
910	Newfoundland and Labrador	Terre-Neuve et Labrador
911	Prince Edward Island	Ile-Du-Prince-Edouard
912	Nova Scotia	Nouvelle Ecosse
913	New Brunswick	Nouveau Brunswick
924	Quebec	Québec
935	Ontario	Ontario
946	Manitoba	Manitoba
947	Saskatchewan	Saskatchewan
948	Alberta	Alberta
959	British Columbia	Colombie-Britannique
960	Yukon	Yukon
961	Northwest Territories	Territoires du Nord-Ouest
962	Nunavut	Nunavut
970	Former USSR (STC Code)	Ex-URSS (Code de STC)
971	Former Czechoslovakia (STC Code)	Ex-Tchecoslovaquie (Code de STC)
999	Unknown	Inconnu

Note: This file is referenced in Patient Validation Edits P12 & P15.

Appendix C

ICD-9 underlying cause of death code file

Field	Size	Position	Type	Title
1	4	1 - 4	AN	ICD-9 Codes
2	85	5 - 89	A	Description (English)
3	75	90 - 164	A	Description (French)

Note: This file is referenced in Patient Validation Edit P17.
List available upon request.

Appendix D

ICD-10 underlying cause of death code file

Field	Size	Position	Type	Title
1	4	1 - 4	AN	ICD-10 Codes
2	85	5 - 89	A	Description (English)
3	75	90 - 164	A	Description (French)

Note: This file is referenced in Patient Validation Edit P17.
List available upon request.

Appendix E

Standard Geographic Code (SGC) file

Field	Size	Position	Type	Title
1	7	1 - 7	N	SGC Code
1.1	2	1 - 2	N	Province Code
1.2	2	3 - 4	N	Census Division Code
1.3	3	5 - 7	N	Census Subdivision Code
2	40	8 - 47	AN	Description (English)

Note: This file is referenced in Tumour Validation Edit T8.
List available upon request.

Appendix F

Census tract (CT) dictionary

Field	Size	Position	Type	Title
1	9	1 - 9	N	CT Code
2	7	10 - 16	N	Standard Geographic Code
3	40	17 - 56	A	Municipality Name

Note: This file is referenced in Tumour Validation Edit T9, and in Correlation Edit No. 15.
List available upon request.

Appendix G

ICD-9 tumour code file

Field	Size	Position	Type	Title
1	4	1 - 4	AN	ICD-9 Codes
2	85	5 - 89	A	Description (English)
3	75	90 - 164	A	Description (French)

Note: This file is referenced in Tumour Validation Edit T13.
List available upon request.

Appendix H

ICD-O-2/3 topography code file

Field	Size	Position	Type	Title
1	4	1 - 4	AN	ICD-O-2/3 Topography Codes
2	80	5 - 84	A	Description (English)

List of valid ICD-O-2/3 topography codes

Code	ICD-O-2/3 topography
C000	External upper lip
C001	External lower lip
C002	External lip, NOS
C003	Mucosa of upper lip
C004	Mucosa of lower lip
C005	Mucosa of lip, NOS
C006	Commissure of lip
C008	Overlapping lesion of lip
C009	Lip, NOS (excludes skin of lip C440)
C019	Base of tongue, NOS
C020	Dorsal surface of tongue, NOS
C021	Border of tongue
C022	Ventral surface of tongue, NOS
C023	Anterior 2/3 of tongue, NOS
C024	Lingual tonsil
C028	Overlapping lesion of tongue
C029	Tongue, NOS
C030	Upper gum
C031	Lower gum
C039	Gum, NOS
C040	Anterior floor of mouth
C041	Lateral floor of mouth
C048	Overlapping lesion of floor of mouth
C049	Floor of mouth, NOS
C050	Hard palate
C051	Soft palate, NOS (excludes C113)
C052	Uvula
C058	Overlapping lesion of palate
C059	Palate, NOS
C060	Cheek mucosa
C061	Vestibule of mouth
C062	Retromolar area
C068	Overlapping lesion of other and unspecified parts of mouth

Code	ICD-O-2/3 topography
C069	Mouth, NOS
C079	Parotid gland
C080	Submandibular gland
C081	Sublingual gland
C088	Overlapping lesion of major salivary glands
C089	Major salivary gland, NOS
C090	Tonsillar fossa
C091	Tonsillar pillar
C098	Overlapping lesion of tonsil
C099	Tonsil, NOS (excludes C024 and C111)
C100	Vallecula
C101	Anterior surface of epiglottis
C102	Lateral wall of oropharynx
C103	Posterior wall of oropharynx
C104	Branchial cleft (site of neoplasm)
C108	Overlapping lesion of oropharynx
C109	Oropharynx, NOS
C110	Superior wall of nasopharynx
C111	Posterior wall of nasopharynx
C112	Lateral wall of nasopharynx
C113	Anterior wall of nasopharynx
C118	Overlapping lesion of nasopharynx
C119	Nasopharynx, NOS
C129	Pyriform sinus
C130	Postcricoid region
C131	Hypopharyngeal aspect of aryepiglottic fold (excludes C321)
C132	Posterior wall of hypopharynx
C138	Overlapping lesion of hypopharynx
C139	Hypopharynx, NOS
C140	Pharynx, NOS
C141	Laryngopharynx
C142	Waldeyer's ring
C148	Overlapping lesion of lip, oral cavity and pharynx
C150	Cervical esophagus
C151	Thoracic esophagus
C152	Abdominal esophagus
C153	Upper third of esophagus
C154	Middle third of esophagus
C155	Lower third of esophagus
C158	Overlapping lesion of esophagus
C159	Esophagus, NOS
C160	Cardia, NOS
C161	Fundus of stomach
C162	Body of stomach

Code	ICD-O-2/3 topography
C163	Gastric antrum
C164	Pylorus
C165	Lesser curvature of stomach,NOS (not classifiable C161-C164)
C166	Greater curvature of stomach,NOS (not classifiable C160-C164)
C168	Overlapping lesion of stomach
C169	Stomach, NOS
C170	Duodenum
C171	Jejunum
C172	Ileum (excludes ileocecal valve C180)
C173	Meckel's diverticulum (site of neoplasm)
C178	Overlapping lesion of small intestine
C179	Small intestine, NOS
C180	Cecum
C181	Appendix
C182	Ascending colon
C183	Hepatic flexure of colon
C184	Transverse colon
C185	Splenic flexure of colon
C186	Descending colon
C187	Sigmoid colon
C188	Overlapping lesion of colon
C189	Colon, NOS
C199	Rectosigmoid junction
C209	Rectum, NOS
C210	Anus, NOS (excludes skin of anus and perianal skin C445)
C211	Anal canal
C212	Cloacogenic zone
C218	Overlapping lesion of rectum, anus and anal canal
C220	Liver
C221	Intrahepatic bile duct
C239	Gallbladder
C240	Extrahepatic bile duct
C241	Ampulla of vater
C248	Overlapping lesion of biliary tract
C249	Biliary tract, NOS
C250	Head of pancreas
C251	Body of pancreas
C252	Tail of pancreas
C253	Pancreatic duct
C254	Islets of langerhans
C257	Other specified parts of pancreas
C258	Overlapping lesion of pancreas
C259	Pancreas, NOS
C260	Intestinal tract, NOS

Code	ICD-O-2/3 topography
C268	Overlapping lesion of digestive system
C269	Gastrointestinal tract, NOS
C300	Nasal cavity (excludes nose, NOS C760)
C301	Middle ear
C310	Maxillary sinus
C311	Ethmoid sinus
C312	Frontal sinus
C313	Sphenoid sinus
C318	Overlapping lesion of accessory sinuses
C319	Accessory sinus, NOS
C320	Glottis
C321	Supraglottis
C322	Subglottis
C323	Laryngeal cartilage
C328	Overlapping lesion of larynx
C329	Larynx, NOS
C339	Trachea
C340	Main bronchus
C341	Upper lobe, lung
C342	Middle lobe, lung
C343	Lower lobe, lung
C348	Overlapping lesion of lung
C349	Lung, NOS
C379	Thymus
C380	Heart
C381	Anterior mediastinum
C382	Posterior mediastinum
C383	Mediastinum, NOS
C384	Pleura, NOS
C388	Overlapping lesion of heart, mediastinum and pleura
C390	Upper respiratory tract, NOS
C398	Overlapping lesion of respiratory system & intrathoracic organs
C399	Ill-defined sites within respiratory system
C400	Long bones of upper limb, scapula and associated joints
C401	Short bones of upper limb and associated joints
C402	Long bones of lower limb and associated joints
C403	Short bones of lower limb and associated joints
C408	Overlapping lesion of bones, joints and articular cartilage of limbs
C409	Bone of limb, NOS
C410	Bones of skull and face and associated joints (excl. C411)
C411	Mandible
C412	Vertebral column (excludes sacrum and coccyx C414)
C413	Rib, sternum, clavicle and associated joints
C414	Pelvic bones, sacrum, coccyx and associated joints

Code	ICD-O-2/3 topography
C418	Overlapping lesion of bones, joints and articular cartilage
C419	Bone, NOS
C420	Blood
C421	Bone marrow
C422	Spleen
C423	Reticuloendothelial system, NOS
C424	Hematopoietic system, NOS
C440	Skin of lip, NOS
C441	Eyelid
C442	External ear
C443	Skin of other and unspecified parts of face
C444	Skin of scalp and neck
C445	Skin of trunk
C446	Skin of upper limb and shoulder
C447	Skin of lower limb and hip
C448	Overlapping lesion of skin
C449	Skin, NOS
C470	Peripheral nerves and autonomic nervous system head-neck
C471	Peripheral nerves and autonomic nervous system of upper limb
C472	Peripheral nerves and autonomic nervous system of lower limb
C473	Peripheral nerves and autonomic nervous system of thorax
C474	Peripheral nerves and autonomic nervous system of abdomen
C475	Peripheral nerves and autonomic nervous system of pelvis
C476	Peripheral nerves and autonomic nervous system of trunk, NOS
C478	Overlapping lesion of peripheral nerves & autonomic nerv-sys.
C479	Autonomic nervous system, NOS
C480	Retroperitoneum
C481	Specified parts of peritoneum
C482	Peritoneum, NOS
C488	Overlapping lesion of retroperitoneum and peritoneum
C490	Connective, subcutaneous and other soft tissues head-neck
C491	Connective, subcutaneous and other soft tissues of upper limb
C492	Connective, subcutaneous and other soft tissues of lower limb
C493	Connective, subcutaneous and other soft tissues of thorax
C494	Connective, subcutaneous and other soft tissues of abdomen
C495	Connective, subcutaneous and other soft tissues of pelvis
C496	Connective, subcutaneous and other soft tissues of trunk, NOS
C498	Overlapping lesion of connective, subcutaneous and other soft tissues
C499	Connective, subcutaneous and other soft tissues, NOS
C500	Nipple
C501	Central portion of breast
C502	Upper-inner quadrant of breast
C503	Lower-inner quadrant of breast
C504	Upper-outer quadrant of breast

Code	ICD-O-2/3 topography
C505	Lower-outer quadrant of breast
C506	Axillary tail of breast
C508	Overlapping lesion of breast
C509	Breast, NOS (excludes skin of breast C445)
C510	Labium majus
C511	Labium minus
C512	Clitoris
C518	Overlapping lesion of vulva
C519	Vulva, NOS
C529	Vagina, NOS
C530	Endocervix
C531	Exocervix
C538	Overlapping lesion of cervix uteri
C539	Cervix uteri
C540	Isthmus uteri
C541	Endometrium
C542	Myometrium
C543	Fundus uteri
C548	Overlapping lesion of corpus uteri
C549	Corpus uteri
C559	Uterus, NOS
C569	Ovary
C570	Fallopian tube
C571	Broad ligament
C572	Round ligament
C573	Parametrium
C574	Uterine adnexa
C577	Other specified parts of female genital organs
C578	Overlapping lesion of female genital organs
C579	Female genital tract, NOS
C589	Placenta
C600	Prepuce
C601	Glans penis
C602	Body of penis
C608	Overlapping lesion of penis
C609	Penis, NOS
C619	Prostate gland
C620	Undescended testis (site of neoplasm)
C621	Descended testis
C629	Testis, NOS
C630	Epididymis
C631	Spermatic cord
C632	Scrotum, NOS
C637	Other specified parts of male genital organs

Code	ICD-O-2/3 topography
C638	Overlapping lesion of male genital organs
C639	Male genital organs, NOS
C649	Kidney, NOS
C659	Renal pelvis
C669	Ureter
C670	Trigone of bladder
C671	Dome of bladder
C672	Lateral wall of bladder
C673	Anterior wall of bladder
C674	Posterior wall of bladder
C675	Bladder neck
C676	Ureteric orifice
C677	Urachus
C678	Overlapping lesion of bladder
C679	Bladder, NOS
C680	Urethra
C681	Paraurethral gland
C688	Overlapping lesion of urinary organs
C689	Urinary system, NOS
C690	Conjunctiva
C691	Cornea, NOS
C692	Retina
C693	Choroid
C694	Ciliary body
C695	Lacrimal gland
C696	Orbit, NOS
C698	Overlapping lesion of eye and adnexa
C699	Eye, NOS
C700	Cerebral meninges
C701	Spinal meninges
C709	Meninges, NOS
C710	Cerebrum
C711	Frontal lobe
C712	Temporal lobe
C713	Parietal lobe
C714	Occipital lobe
C715	Ventricle, NOS
C716	Cerebellum, NOS
C717	Brain stem
C718	Overlapping lesion of brain
C719	Brain, NOS
C720	Spinal cord
C721	Cauda equina
C722	Olfactory nerve

Code	ICD-O-2/3 topography
C723	Optic nerve
C724	Acoustic nerve
C725	Cranial nerve, NOS
C728	Overlapping lesion of brain and central nervous system
C729	Nervous system, NOS
C739	Thyroid gland
C740	Cortex of adrenal gland
C741	Medulla of adrenal gland
C749	Adrenal gland, NOS
C750	Parathyroid gland
C751	Pituitary gland
C752	Craniopharyngeal duct
C753	Pineal gland
C754	Carotid body
C755	Aortic body and other paraganglia
C758	Overlapping lesion of endocrine glands and related structures
C759	Endocrine gland, NOS
C760	Head, face or neck, NOS
C761	Thorax, NOS
C762	Abdomen, NOS
C763	Pelvis, NOS
C764	Upper limb, NOS
C765	Lower limb, NOS
C767	Other ill-defined sites
C768	Overlapping lesion of ill-defined sites
C770	Lymph nodes of head, face and neck
C771	Intrathoracic lymph nodes
C772	Intra-abdominal lymph nodes
C773	Lymph nodes of axilla or arm
C774	Lymph nodes of inguinal region or leg
C775	Pelvic lymph nodes
C778	Lymph nodes of multiple regions
C779	Lymph node, NOS
C809	Unknown primary site
0000	Not applicable (topography reported in Field T13, or Field T18)

Note: This file is referenced in Tumour Validation Edit T15.

Appendix I

ICD-O-2 morphology code file

Field	Size	Position	Type	Title
1	4	1 - 4	N	ICD-O-2 Morphology Codes
2	21	5 - 25	AN	Blank

Note: This file is referenced in Tumour Validation Edit T16.
List available upon request.

Appendix I-O3

ICD-O-3 morphology code file

Field	Size	Position	Type	Title
1	4	1 - 4	N	ICD-O-3 Morphology codes
2	76	5 - 80	AN	Morphology Code description

List of valid ICD-O-3 morphology codes

Code	ICD-O-3 morphology
8000	Neoplasm
8001	Tumor cells
8002	Malignant tumor, small cell type
8003	Malignant tumor, giant cell type
8004	Malignant tumor, spindle cell type
8005	Clear cell tumor
8010	Epithelial tumor
8010	Carcinoma
8011	Epithelioma
8012	Large cell carcinoma, NOS
8013	Large cell neuroendocrine carcinoma
8014	Large cell carcinoma with rhabdoid phenotype
8015	Glassy cell carcinoma
8020	Carcinoma, undifferentiated, NOS
8021	Carcinoma, anaplastic, NOS
8022	Pleomorphic carcinoma
8030	Giant cell and spindle cell carcinoma
8031	Giant cell carcinoma
8032	Spindle cell carcinoma, NOS
8033	Pseudosarcomatous carcinoma
8034	Polygonal cell carcinoma
8035	Carcinoma with osteoclast-like giant cells
8040	Tumorlet
8041	Small cell carcinoma, NOS
8042	Oat cell carcinoma (C34._)
8043	Small cell carcinoma, fusiform cell
8044	Small cell carcinoma, intermediate cell
8045	Combined small cell carcinoma
8046	Non-small cell carcinoma (C34._)
8050	Papilloma, NOS (except papilloma of bladder)
8050	Papillary carcinoma
8051	Verrucous papilloma or carcinoma
8052	Squamous cell papilloma, NOS

Code	ICD-O-3 morphology
8052	Papillary squamous cell carcinoma,
8053	Squamous cell papilloma, inverted
8060	Squamous papillomatosis
8070	Squamous cell carcinoma
8071	Squamous cell carcinoma, keratinizing, NOS
8072	Squamous cell carcinoma, large cell, nonkeratinizing, NOS
8073	Squamous cell carcinoma, small cell, nonkeratinizing
8074	Squamous cell carcinoma, spindle cell
8075	Squamous cell carcinoma, adenoid
8076	Squamous cell carcinoma
8077	Squamous intraepithelial neoplasia, grade III
8078	Squamous cell carcinoma with horn formation
8080	Queyrat erythroplasia (C60._)
8081	Bowen disease (C44._)
8082	Lymphoepithelial carcinoma
8083	Basaloid squamous cell carcinoma
8084	Squamous cell carcinoma, clear cell type
8090	Basal cell carcinoma (C44._)
8091	Multifocal superficial basal cell carcinoma
8092	Infiltrating basal cell carcinoma, NOS (C44._)
8093	Basal cell carcinoma, fibroepithelial (C44._)
8094	Basosquamous carcinoma (C44._)
8095	Metatypical carcinoma (C44._)
8096	Intraepidermal epithelioma of Jadassohn
8097	Basal cell carcinoma, nodular (C44._)
8098	Adenoid basal carcinoma (C53._)
8100	Trichoepithelioma (C44._)
8101	Trichofolliculoma (C44._)
8102	Trichilemmocarcinoma (C44._)
8103	Pilar tumor (C44._)
8110	Pilomatrix carcinoma (C44._)
8120	Transitional cell papilloma
8120	Transitional cell carcinoma
8121	Schneiderian carcinoma or papilloma (C30.0, C31._)
8122	Transitional cell carcinoma, spindle cell
8123	Basaloid carcinoma
8124	Cloacogenic carcinoma (C21.2)
8130	Papillary transitional cell carcinoma (C67._)
8131	Transitional cell carcinoma, micropapillary
8140	Adenocarcinoma
8141	Scirrhous adenocarcinoma
8142	Linitis plastica (C16._)
8143	Superficial spreading adenocarcinoma
8144	Adenocarcinoma, intestinal type (C16._)

Code	ICD-O-3 morphology
8145	Carcinoma, diffuse type (C16._)
8146	Monomorphic adenoma
8147	Basal cell adenocarcinoma
8148	Glandular intraepithelial neoplasia, grade III
8149	Canalicular adenoma
8150	Islet cell carcinoma or adenoma(C25._)
8151	Insulinoma (C25._)
8152	Glucagonoma (C25._)
8153	Gastrinoma
8154	Mixed islet cell and exocrine adenocarcinoma
8155	Vipoma
8156	Somatostatinoma
8157	Enteroglucagonoma
8160	Cholangiocarcinoma (C22.1, C24.0)
8161	Bile duct cystadenocarcinoma (C22.1, C24.0)
8162	Klatskin tumor (C22.1, C24.0)
8170	Hepatocellular carcinoma (C22.0)
8171	Hepatocellular carcinoma, fibrolamellar
8172	Hepatocellular carcinoma, scirrhous (C22.0)
8173	Hepatocellular carcinoma, spindle cell
8174	Hepatocellular carcinoma, clear cell type
8175	Hepatocellular carcinoma, pleomorphic type
8180	Combined hepatocellular carcinoma and
8190	Trabecular adenocarcinoma
8191	Embryonal adenoma
8200	Adenoid cystic carcinoma
8201	Cribriform carcinoma (C50._)
8202	Microcystic adenoma (C25._)
8204	Lactating adenoma (C50._)
8210	Adenocarcinoma (in situ or malignant)in adenomatous polyp
8211	Tubular adenocarcinoma
8212	Flat adenoma
8213	Serrated adenoma (C18._)
8214	Parietal cell carcinoma (C16._)
8215	Adenocarcinoma of anal glands (C21.1)
8220	Adenocarcinoma in adenomatous polyposis
8221	Adenocarcinoma in multiple adenomatous
8230	Solid carcinoma, NOS
8231	Carcinoma simplex
8240	Carcinoid tumor
8241	Enterochromaffin cell carcinoid
8242	Enterochromaffin-like cell tumor
8243	Goblet cell carcinoid
8244	Composite carcinoid

Code	ICD-O-3 morphology
8245	Adenocarcinoid tumor
8246	Neuroendocrine carcinoma, NOS
8247	Merkel cell carcinoma (C44._)
8248	Apudoma
8249	Atypical carcinoid tumor
8250	Bronchiolo-alveolar adenocarcinoma
8251	Alveolar adenocarcinoma (C34._)
8252	Bronchiolo-alveolar carcinoma, non-mucinous
8253	Bronchiolo-alveolar carcinoma, mucinous
8254	Bronchiolo-alveolar carcinoma, mixed
8255	Adenocarcinoma with mixed subtypes
8260	Papillary adenocarcinoma
8261	Adenocarcinoma in villous adenoma
8262	Villous adenocarcinoma
8263	Adenocarcinoma in tubulovillous adenoma
8264	Papillomatosis, glandular
8270	Chromophobe (C75.1)
8271	Prolactinoma (C75.1)
8272	Pituitary carcinoma (C75.1)
8280	Acidophil carcinoma (C75.1)
8281	Mixed acidophil-basophil carcinoma(C75.1)
8290	Oxyphilic adenocarcinoma
8300	Basophil carcinoma (C75.1)
8310	Clear cell adenocarcinoma, NOS
8311	Hypernephroid tumor [obs]
8312	Renal cell carcinoma, NOS (C64.9)
8313	Clear cell adenocarcinofibroma (C56.9)
8314	Lipid-rich carcinoma (C50._)
8315	Glycogen-rich carcinoma
8316	Cyst-associated renal cell carcinoma (C64.9)
8317	Renal cell carcinoma, chromophobe type
8318	Renal cell carcinoma, sarcomatoid (C64.9)
8319	Collecting duct carcinoma (C64.9)
8320	Granular cell carcinoma
8321	Chief cell adenoma (C75.0)
8322	Water-clear cell adenocarcinoma (C75.0)
8323	Mixed cell adenocarcinoma
8324	Lipoadenoma
8325	Metanephric adenoma (C64.9)
8330	Follicular adenocarcinoma (C73.9)
8331	Follicular adenocarcinoma, well
8332	Follicular adenocarcinoma, trabecular
8333	Fetal adenocarcinoma
8334	Macrofollicular adenoma (C73.9)

Code	ICD-O-3 morphology
8335	Follicular carcinoma, minimally invasive
8336	Hyalinizing trabecular adenoma (C73.9)
8337	Insular carcinoma (C73.9)
8340	Papillary carcinoma, follicular variant (C73.9)
8341	Papillary microcarcinoma (C73.9)
8342	Papillary carcinoma, oxyphilic cell (C73.9)
8343	Papillary carcinoma, encapsulated (C73.9)
8344	Papillary carcinoma, columnar cell (C73.9)
8345	Medullary carcinoma with amyloid stroma
8346	Mixed medullary-follicular carcinoma (C73.9)
8347	Mixed medullary-papillary carcinoma (C73.9)
8350	Nonencapsulated sclerosing carcinoma (C73.9)
8360	Multiple endocrine adenomas
8361	Juxtaglomerular tumor (C64.9)
8370	Adrenal cortical carcinoma (C74.0)
8371	Adrenal cortical adenoma, compact cell
8372	Adrenal cortical adenoma, pigmented (C74.0)
8373	Adrenal cortical adenoma, clear cell (C74.0)
8374	Adrenal cortical adenoma, glomerulosa cell
8375	Adrenal cortical adenoma, mixed cell (C74.0)
8380	Endometrioid adenocarcinoma
8381	Endometrioid adenofibroma
8382	Endometrioid adenocarcinoma, secretory
8383	Endometrioid adenocarcinoma, ciliated cell
8384	Adenocarcinoma, endocervical type
8390	Skin appendage carcinoma (C44._)
8391	Follicular fibroma (C44._)
8392	Syringofibroadenoma (C44._)
8400	Sweat gland adenocarcinoma (C44._)
8401	Apocrine adenocarcinoma
8402	Nodular hidradenoma (C44._)
8403	Eccrine spiradenoma (C44._)
8404	Hidrocystoma (C44._)
8405	Papillary hidradenoma
8406	Papillary syringadenoma (C44._)
8407	Sclerosing sweat duct carcinoma (C44._)
8408	Eccrine papillary adenocarcinoma (C44._)
8409	Eccrine poroma, malignant
8410	Sebaceous adenocarcinoma (C44._)
8413	Eccrine adenocarcinoma (C44._)
8420	Ceruminous adenocarcinoma (C44.2)
8430	Mucoepidermoid carcinoma
8440	Cystadenocarcinoma
8441	Serous cystadenocarcinoma (C56.9)

Code	ICD-O-3 morphology
8442	Serous cystadenoma, borderline malignancy
8443	Clear cell cystadenoma (C56.9)
8444	Clear cell cystic tumor of borderline malignancy
8450	Papillary cystadenocarcinoma (C56.9)
8451	Papillary cystadenoma, borderline malignancy
8452	Solid pseudopapillary carcinoma (C25._)
8453	Intraductal papillary-mucinous carcinoma
8454	Cystic tumor of atrio-ventricular node (C38.0)
8460	Papillary serous cystadenocarcinoma (C56.9)
8461	Serous surface papillary carcinoma (C56.9)
8462	Serous papillary cystic tumor of borderline
8463	Serous surface papillary tumor of borderline
8470	Mucinous cystadenocarcinoma
8471	Papillary mucinous cystadenocarcinoma
8472	Mucinous cystic tumor of borderline
8473	Papillary mucinous cystadenoma, borderline
8480	Mucinous adenocarcinoma
8481	Mucin-producing adenocarcinoma
8482	Mucinous adenocarcinoma, endocervical type
8490	Signet ring cell carcinoma
8500	Infiltrating duct carcinoma, NOS (C50._)
8501	Comedocarcinoma (C50._)
8502	Secretory carcinoma of breast (C50._)
8503	Intraductal papillary adenocarcinoma
8504	Intracystic carcinoma
8505	Intraductal papillomatosis, NOS
8506	Adenoma of nipple (C50.0)
8507	Intraductal micropapillary carcinoma (C50._)
8508	Cystic hypersecretory carcinoma (C50._)
8510	Medullary carcinoma, NOS
8512	Medullary carcinoma with lymphoid stroma
8513	Atypical medullary carcinoma (C50._)
8514	Duct carcinoma, desmoplastic type
8520	Lobular carcinoma (C50._)
8521	Infiltrating ductular carcinoma (C50._)
8522	Infiltrating duct and lobular carcinoma (C50._)
8523	Infiltrating duct mixed with other types of carcinoma (C50._)
8524	Infiltrating lobular mixed with other types of carcinoma (C50._)
8525	Polymorphous low grade adenocarcinoma
8530	Inflammatory carcinoma (C50._)
8540	Paget disease, mammary (C50._)
8541	Paget disease and infiltrating duct carcinoma
8542	Paget disease, extramammary (except Paget disease of bone)
8543	Paget disease and intraductal carcinoma of breast (C50._)

Code	ICD-O-3 morphology
8550	Acinar cell carcinoma
8551	Acinar cell cystadenocarcinoma
8560	Adenosquamous carcinoma
8561	Adenolymphoma (C07._, C08._)
8562	Epithelial-myoepithelial carcinoma
8570	Adenocarcinoma with squamous metaplasia
8571	Adenocarcinoma with cartilaginous and
8572	Adenocarcinoma with spindle cell metaplasia
8573	Adenocarcinoma with apocrine metaplasia
8574	Adenocarcinoma with neuroendocrine
8575	Metaplastic carcinoma, NOS
8576	Hepatoid adenocarcinoma
8580	Thymoma (C37.9)
8581	Thymoma, type A (C37.9)
8582	Thymoma, type AB (C37.9)
8583	Thymoma, type B1 (C37.9)
8584	Thymoma, type B2 (C37.9)
8585	Thymoma, type B3 (C37.9)
8586	Thymic carcinoma, NOS (C37.9)
8587	Ectopic hamartomatous thymoma
8588	Spindle epithelial tumor with thymus-like
8589	Carcinoma showing thymus-like element
8590	Sex cord-gonadal stromal tumor, NOS
8591	Sex cord-gonadal stromal tumor,
8592	Sex cord-gonadal stromal tumor, mixed
8593	Stromal tumor with minor sex cord elements
8600	Thecoma (C56.9)
8601	Thecoma, luteinized (C56.9)
8602	Sclerosing stromal tumor (C56.9)
8610	Luteoma, NOS (C56.9)
8620	Granulosa cell tumor (C56.9)
8621	Granulosa cell-theca cell tumor (C56.9)
8622	Granulosa cell tumor, juvenile (C56.9)
8623	Sex cord tumor with annular tubules (C56.9)
8630	Androblastoma
8631	Sertoli-Leydig cell tumor
8632	Gynandroblastoma (C56.9)
8633	Sertoli-Leydig cell tumor, retiform
8634	Sertoli-Leydig cell tumor
8640	Sertoli cell carcinoma (C62._)
8641	Sertoli cell tumor with lipid storage
8642	Large cell calcifying Sertoli cell tumor
8650	Leydig cell tumor (C62._)
8660	Hilus cell tumor (C56.9)

Code	ICD-O-3 morphology
8670	Steroid cell tumor
8671	Adrenal rest tumor
8680	Paraganglioma
8681	Sympathetic paraganglioma
8682	Parasympathetic paraganglioma
8683	Gangliocytic paraganglioma (C17.0)
8690	Glomus jugulare tumor, NOS (C75.5)
8691	Aortic body tumor (C75.5)
8692	Carotid body tumor (C75.4)
8693	Extra-adrenal paraganglioma
8700	Pheochromocytoma (C74.1)
8710	Glomangiosarcoma
8711	Glomus tumor
8712	Glomangioma
8713	Glomangiomyoma
8720	Malignant melanoma (except juvenile melanoma)
8721	Nodular melanoma (C44._)
8722	Balloon cell melanoma (C44._)
8723	Malignant melanoma, regressing (C44._)
8725	Neuronevus (C44._)
8726	Magnocellular nevus (C69.4)
8727	Dysplastic nevus (C44._)
8728	Meningeal melanomatosis (C70.9)
8730	Amelanotic melanoma (C44._)
8740	Melanoma in junctional nevus
8741	Melanoma in precancerous melanosis
8742	Lentigo maligna melanoma (C44._)
8743	Superficial spreading melanoma (C44._)
8744	Acral lentiginous melanoma, malignant (C44._)
8745	Desmoplastic melanoma, malignant (C44._)
8746	Mucosal lentiginous melanoma
8750	Intradermal nevus (C44._)
8760	Compound nevus (C44._)
8761	Melanoma in giant pigmented nevus
8762	Proliferative dermal lesion in congenital
8770	Mixed epithelioid and spindle cell melanoma
8771	Epithelioid cell melanoma
8772	Spindle cell melanoma, NOS
8773	Spindle cell melanoma, type A (C69._)
8774	Spindle cell melanoma, type B (C69._)
8780	Blue nevus (C44._)
8790	Cellular blue nevus (C44._)
8800	Sarcoma
8801	Spindle cell sarcoma

Code	ICD-O-3 morphology
8802	Giant cell sarcoma (except of bone M-9250/3)
8803	Small cell sarcoma
8804	Epithelioid sarcoma
8805	Undifferentiated sarcoma
8806	Desmoplastic small round cell tumor
8810	Fibrosarcoma
8811	Fibromyxosarcoma
8812	Periosteal fibrosarcoma (C40._, C41._)
8813	Fascial fibrosarcoma
8814	Infantile fibrosarcoma
8815	Solitary fibrous tumor
8820	Elastofibroma
8821	Aggressive fibromatosis
8822	Abdominal fibromatosis
8823	Desmoplastic fibroma
8824	Myofibromatosis
8825	Myofibroblastic tumor
8826	Angiomyofibroblastoma
8827	Myofibroblastic tumor, peribronchial (C34._)
8830	Fibrous histiocytoma
8831	Histiocytoma
8832	Dermatofibrosarcoma (C44._)
8833	Pigmented dermatofibrosarcoma
8834	Giant cell fibroblastoma
8835	Plexiform fibrohistiocytic tumor
8836	Angiomatoid fibrous histiocytoma
8840	Myxosarcoma
8841	Angiomyxoma
8842	Ossifying fibromyxoid tumor
8850	Liposarcoma
8851	Liposarcoma, well differentiated
8852	Myxoid liposarcoma
8853	Round cell liposarcoma
8854	Pleomorphic liposarcoma
8855	Mixed liposarcoma
8856	Intramuscular lipoma
8857	Fibroblastic liposarcoma
8858	Dedifferentiated liposarcoma
8860	Angiomyolipoma
8861	Angiolipoma, NOS
8862	Chondroid lipoma
8870	Myelolipoma
8880	Hibernoma
8881	Lipoblastomatosis

Code	ICD-O-3 morphology
8890	Leiomyosarcoma
8891	Epithelioid leiomyosarcoma
8892	Cellular leiomyoma
8893	Bizarre leiomyoma
8894	Angiomyosarcoma
8895	Myosarcoma
8896	Myxoid leiomyosarcoma
8897	Smooth muscle tumor of uncertain malignant
8898	Metastasizing leiomyoma
8900	Rhabdomyosarcoma
8901	Pleomorphic rhabdomyosarcoma, adult type
8902	Mixed type rhabdomyosarcoma
8903	Fetal rhabdomyoma
8904	Adult rhabdomyoma
8905	Genital rhabdomyoma (C51._, C52.9)
8910	Embryonal rhabdomyosarcoma, NOS
8912	Spindle cell rhabdomyosarcoma
8920	Alveolar rhabdomyosarcoma
8921	Rhabdomyosarcoma with ganglionic differentiation
8930	Endometrial stromal sarcoma (C54.1)
8931	Endometrial stromal sarcoma, low grade
8932	Adenomyoma
8933	Adenosarcoma
8934	Carcinofibroma
8935	Stromal sarcoma
8936	Gastrointestinal stromal sarcoma
8940	Mixed tumor
8941	Carcinoma in pleomorphic adenoma (C07._,
8950	Mullerian mixed tumor (C54._)
8951	Mesodermal mixed tumor
8959	Malignant cystic nephroma (C64.9)
8960	Nephroblastoma (C64.9)
8963	Malignant rhabdoid tumor
8964	Clear cell sarcoma of kidney (C64.9)
8965	Nephrogenic adenofibroma (C64.9)
8966	Renomedullary interstitial cell tumor (C64.9)
8967	Ossifying renal tumor (C64.9)
8970	Hepatoblastoma (C22.0)
8971	Pancreatoblastoma (C25._)
8972	Pulmonary blastoma (C34._)
8973	Pleuropulmonary blastoma
8974	Sialoblastoma
8980	Carcinosarcoma, NOS
8981	Carcinosarcoma, embryonal

Code	ICD-O-3 morphology
8982	Myoepithelioma
8983	Adenomyoepithelioma (C50._)
8990	Mesenchymoma
8991	Embryonal sarcoma
9000	Brenner tumor (C56.9)
9010	Fibroadenoma, NOS (C50._)
9011	Intracanalicular fibroadenoma (C50._)
9012	Pericanalicular fibroadenoma (C50._)
9013	Adenofibroma, NOS
9014	Serous adenocarcinofibroma
9015	Mucinous adenocarcinofibroma
9016	Giant fibroadenoma (C50._)
9020	Phyllodes tumor (C50._)
9030	Juvenile fibroadenoma (C50._)
9040	Synovial sarcoma
9041	Synovial sarcoma, spindle cell
9042	Synovial sarcoma, epithelioid cell
9043	Synovial sarcoma, biphasic
9044	Clear cell sarcoma, NOS (except of kidney
9050	Mesothelioma
9051	Fibrous mesothelioma
9052	Epithelioid mesothelioma
9053	Mesothelioma, biphasic
9054	Adenomatoid tumor, NOS
9055	Cystic mesothelioma (C48._)
9060	Dysgerminoma
9061	Seminoma, NOS (C62._)
9062	Seminoma, anaplastic (C62._)
9063	Spermatocytic seminoma (C62._)
9064	Germinoma
9065	Germ cell tumor, nonseminomatous (C62._)
9070	Embryonal carcinoma, NOS
9071	Yolk sac tumor
9072	Polyembryoma
9073	Gonadoblastoma
9080	Teratoma
9081	Teratocarcinoma
9082	Malignant teratoma, undifferentiated
9083	Malignant teratoma, intermediate
9084	Teratoma
9085	Mixed germ cell tumor
9090	Struma ovarii (C56.9)
9091	Strumal carcinoid (C56.9)
9100	Choriocarcinoma

Code	ICD-O-3 morphology
9101	Choriocarcinoma combined with other germ cell elements
9102	Malignant teratoma, trophoblastic
9103	Partial hydatidiform mole (C58.9)
9104	Placental site trophoblastic tumor (C58.9)
9105	Trophoblastic tumor, epithelioid
9110	Mesonephroma
9120	Hemangiosarcoma
9121	Cavernous hemangioma
9122	Venous hemangioma
9123	Racemose hemangioma
9124	Kupffer cell sarcoma (C22.0)
9125	Epithelioid hemangioma
9130	Hemangioendothelioma
9131	Capillary hemangioma
9132	Intramuscular hemangioma
9133	Epithelioid hemangioendothelioma
9135	Endovascular papillary angioendothelioma
9136	Spindle cell hemangioendothelioma
9140	Kaposi sarcoma
9141	Angiokeratoma
9142	Verrucous keratotic hemangioma
9150	Hemangiopericytoma
9160	Angiofibroma
9161	Hemangioblastoma
9170	Lymphangiosarcoma
9171	Capillary lymphangioma
9172	Cavernous lymphangioma
9173	Cystic lymphangioma
9174	Lymphangiomyomatosis
9175	Hemolymphangioma
9180	Osteosarcoma (C40._, C41._)
9181	Chondroblastic osteosarcoma (C40._, C41._)
9182	Fibroblastic osteosarcoma (C40._, C41._)
9183	Telangiectatic osteosarcoma (C40._, C41._)
9184	Osteosarcoma in Paget disease of bone
9185	Small cell osteosarcoma (C40._, C41._)
9186	Central osteosarcoma (C40._, C41._)
9187	Intraosseous well differentiated osteosarcoma
9191	Osteoid osteoma, NOS (C40._, C41._)
9192	Parosteal osteosarcoma (C40._, C41._)
9193	Periosteal osteosarcoma (C40._, C41._)
9194	High grade surface osteosarcoma (C40._, C41._)
9195	Intracortical osteosarcoma (C40._, C41._)
9200	Osteoblastoma (C40._, C41._)

Code	ICD-O-3 morphology
9210	Osteochondromatosis, NOS (C40._, C41._)
9220	Chondrosarcoma (C40._, C41._)
9221	Juxtacortical chondrosarcoma (C40._, C41._)
9230	Chondroblastoma (C40._, C41._)
9231	Myxoid chondrosarcoma
9240	Mesenchymal chondrosarcoma
9241	Chondromyxoid fibroma (C40._, C41._)
9242	Clear cell chondrosarcoma (C40._, C41._)
9243	Dedifferentiated chondrosarcoma (C40._, C41._)
9250	Giant cell tumor of bone (C40._,
9251	Giant cell tumor of soft parts
9252	Tenosynovial giant cell tumor (C49._)
9260	Ewing sarcoma
9261	Adamantinoma of long bones (C40._)
9262	Ossifying fibroma
9270	Odontogenic tumor, malignant
9271	Ameloblastic fibrodentinoma
9272	Cementoma, NOS
9273	Cementoblastoma, benign
9274	Cementifying fibroma
9275	Gigantiform cementoma
9280	Odontoma, NOS
9281	Compound odontoma
9282	Complex odontoma
9290	Ameloblastic odontosarcoma
9300	Adenomatoid odontogenic tumor
9301	Calcifying odontogenic cyst
9302	Odontogenic ghost cell tumor
9310	Ameloblastoma
9311	Odontoameloblastoma
9312	Squamous odontogenic tumor
9320	Odontogenic myxoma
9321	Central odontogenic fibroma
9322	Peripheral odontogenic fibroma
9330	Ameloblastic fibrosarcoma
9340	Calcifying epithelial odontogenic tumor
9341	Clear cell odontogenic tumor
9342	Odontogenic carcinosarcoma
9350	Craniopharyngioma (C75.2)
9351	Craniopharyngioma, adamantinomatous
9352	Craniopharyngioma, papillary (C75.2)
9360	Pinealoma (C75.3)
9361	Pineocytoma (C75.3)
9362	Pineoblastoma (C75.3)

Code	ICD-O-3 morphology
9363	Melanotic neuroectodermal tumor
9364	Peripheral neuroectodermal tumor
9365	Askin tumor
9370	Chordoma, NOS
9371	Chondroid chordoma
9372	Dedifferentiated chordoma
9373	Parachordoma
9380	Glioma, malignant (C71._)
9381	Gliomatosis cerebri (C71._)
9382	Mixed glioma (C71._)
9383	Subependymoma (C71._)
9384	Subependymal giant cell astrocytoma (C71._)
9390	Choroid plexus carcinoma (C71.5)
9391	Ependymoma, NOS (C71._)
9392	Ependymoma, anaplastic (C71._)
9393	Papillary ependymoma (C71._)
9394	Myxopapillary ependymoma (C72.0)
9400	Astrocytoma, NOS (C71._)
9401	Astrocytoma, anaplastic (C71._)
9410	Protoplasmic astrocytoma (C71._)
9411	Gemistocytic astrocytoma (C71._)
9412	Desmoplastic infantile astrocytoma (C71._)
9413	Dysembryoplastic neuroepithelial tumor
9420	Fibrillary astrocytoma (C71._)
9421	Pilocytic astrocytoma (C71._) ??B from 1 to 3 ??
9423	Polar spongioblastoma (C71._)
9424	Pleomorphic xanthoastrocytoma (C71._)
9430	Astroblastoma (C71._)
9440	Glioblastoma, NOS (C71._)
9441	Giant cell glioblastoma (C71._)
9442	Gliosarcoma (C71._)
9444	Chordoid glioma (C71._)
9450	Oligodendroglioma, NOS (C71._)
9451	Oligodendroglioma, anaplastic (C71._)
9460	Oligodendroblastoma (C71._) [obs]
9470	Medulloblastoma, NOS (C71.6)
9471	Desmoplastic nodular medulloblastoma (C71.6)
9472	Medullomyoblastoma (C71.6)
9473	Primitive neuroectodermal tumor, NOS
9474	Large cell medulloblastoma (C71.6)
9480	Cerebellar sarcoma, NOS (C71.6) [obs]
9490	Ganglioneuroblastoma
9491	Ganglioneuromatosis
9492	Gangliocytoma

Code	ICD-O-3 morphology
9493	Dysplastic gangliocytoma of cerebellum
9500	Neuroblastoma, NOS
9501	Medulloepithelioma
9502	Teratoid medulloepithelioma
9503	Neuroepithelioma, NOS
9504	Spongioneuroblastoma
9505	Ganglioglioma
9506	Central neurocytoma
9507	Pacinian tumor
9508	Atypical teratoid/rhabdoid tumor (C71._)
9510	Retinoblastoma (C69.2)
9511	Retinoblastoma, differentiated (C69.2)
9512	Retinoblastoma, undifferentiated (C69.2)
9513	Retinoblastoma, diffuse (C69.2)
9514	Retinoblastoma, spontaneously regressed
9520	Olfactory neurogenic tumor
9521	Olfactory neurocytoma (C30.0)
9522	Olfactory neuroblastoma (C30.0)
9523	Olfactory neuroepithelioma (C30.0)
9530	Meningioma
9531	Meningothelial meningioma
9532	Fibrous meningioma
9533	Psammomatous meningioma
9534	Angiomatous meningioma
9535	Hemangioblastic meningioma
9537	Transitional meningioma
9538	Papillary meningioma
9539	Meningeal sarcomatosis
9540	Peripheral nerve sheath tumor
9541	Melanotic neurofibroma
9550	Plexiform neurofibroma
9560	Neurilemoma
9561	Malignant peripheral nerve sheath tumor
9562	Neurothekeoma
9570	Neuroma, NOS
9571	Perineurioma
9580	Granular cell tumor
9581	Alveolar soft part sarcoma
9582	Granular cell tumor of the sellar region
9590	Malignant lymphoma, NOS
9591	Malignant lymphoma, non-Hodgkin, NOS
9596	Composite Hodgkin and non-Hodgkin
9650	Hodgkin lymphoma, NOS
9651	Hodgkin lymphoma, lymphocyte-rich

Code	ICD-O-3 morphology
9652	Hodgkin lymphoma, mixed cellularity, NOS
9653	Hodgkin lymphoma, lymphocyte depletion, NOS
9654	Hodgkin lymphoma, lymphocyte depletion, diffuse fibrosis
9655	Hodgkin lymphoma, lymphocyte depletion, reticular
9659	Hodgkin lymphoma, nodular lymphocyte predominance
9661	Hodgkin granuloma [obs]
9662	Hodgkin sarcoma [obs]
9663	Hodgkin lymphoma, nodular sclerosis, NOS
9664	Hodgkin lymphoma, nodular sclerosis, cellular phase
9665	Hodgkin lymphoma, nodular sclerosis, grade 1
9667	Hodgkin lymphoma, nodular sclerosis, grade 2
9670	Malignant lymphoma, small B lymphocytic, NOS
9671	Malignant lymphoma, lymphoplasmacytic
9673	Mantle cell lymphoma
9675	Malignant lymphoma, mixed small and large cell, diffuse
9678	Primary effusion lymphoma
9679	Mediastinal large B-cell lymphoma (C38.3)
9680	Malignant lymphoma, large B-cell, diffuse, NOS
9684	Malignant lymphoma, large B-cell, diffuse, immunoblastic, NOS
9687	Burkitt lymphoma, NOS (see also M-9826/3)
9689	Splenic marginal zone B-cell lymphoma
9690	Follicular lymphoma, NOS (see also M-9675/3)
9691	Follicular lymphoma, grade 2
9695	Follicular lymphoma, grade 1
9698	Follicular lymphoma, grade 3
9699	Marginal zone B-cell lymphoma, NOS
9700	Mycosis fungoides (C44._)
9701	Sezary syndrome
9702	Mature T-cell lymphoma, NOS
9705	Angioimmunoblastic T-cell lymphoma
9708	Subcutaneous panniculitis-like T-cell lymphoma
9709	Cutaneous T-cell lymphoma, NOS(C44._)
9714	Anaplastic large cell lymphoma, T cell and Null cell type
9716	Hepatosplenic (gamma-delta) cell lymphoma
9717	Intestinal T-cell lymphoma
9718	Primary cutaneous CD30+ T-cell lymphoproliferative disorder (C44._)
9719	NK/T-cell lymphoma, nasal and nasal-type
9727	Precursor cell lymphoblastic lymphoma, NOS (see also M-9835/3)
9728	Precursor B-cell lymphoblastic lymphoma
9729	Precursor T-cell lymphoblastic lymphoma
9731	Plasmacytoma, NOS
9732	Multiple myeloma (C42.1)
9733	Plasma cell leukemia (C42.1)
9734	Plasmacytoma, extramedullary (not occurring in bone)

Code	ICD-O-3 morphology
9740	Mast cell sarcoma
9741	Malignant mastocytosis
9742	Mast cell leukemia (C42.1)
9750	Malignant histiocytosis
9751	Langerhans cell histiocytosis, NOS
9752	Langerhans cell histiocytosis, unifocal
9753	Langerhans cell histiocytosis, multifocal
9754	Langerhans cell histiocytosis, disseminated
9755	Histiocytic sarcoma
9756	Langerhans cell sarcoma
9757	Interdigitating dendritic cell sarcoma
9758	Follicular dendritic cell sarcoma
9760	Immunoproliferative disease, NOS
9761	Waldenstrom macroglobulinemia (C42.0)
9762	Heavy chain disease, NOS
9764	Immunoproliferative small intestinaldisease
9765	Monoclonal gammopathy of undetermined significance
9766	Angiocentric immunoproliferative lesion
9767	Angioimmunoblastic lymphadenopathy
9768	T-gamma lymphoproliferative disease
9769	Immunoglobulin deposition disease
9800	Leukemia, NOS
9801	Acute leukemia, NOS
9805	Acute biphenotypic leukemia
9820	Lymphoid leukemia, NOS
9823	B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma
9826	Burkitt cell leukemia (see also M-9687/3)
9827	Adult T-cell leukemia/lymphoma (HTLV-1 positive)
9831	T-cell large granular lymphocytic leukemia
9832	Prolymphocytic leukemia, NOS
9833	Prolymphocytic leukemia, B-cell type
9834	Prolymphocytic leukemia, T-cell type
9835	Precursor cell lymphoblastic leukemia, NOS
9836	Precursor B-cell lymphoblastic leukemia (see also M-9728/3)
9837	Precursor T-cell lymphoblastic leukemia (see also M-9729/3)
9840	Acute myeloid leukemia, M6 type
9860	Myeloid leukemia, NOS
9861	Acute myeloid leukemia, NOS (FAB or WHO
9863	Chronic myeloid leukemia, NOS
9866	Acute promyelocytic leukemia, t(15;17)(q22;q11-12)
9867	Acute myelomonocytic leukemia
9870	Acute basophilic leukemia
9871	Acute myeloid leukemia with abnormal
9872	Acute myeloid leukemia, minimal

Code	ICD-O-3 morphology
9873	Acute myeloid leukemia without maturation
9874	Acute myeloid leukemia with maturation
9875	Chronic myelogenous leukemia, BCR/ABL positive
9876	Atypical chronic myeloid leukemia, BCR/ABL negative
9891	Acute monocytic leukemia
9895	Acute myeloid leukemia with multilineage dysplasia
9896	Acute myeloid leukemia, t(8;21)(q22;q22)
9897	Acute myeloid leukemia, 11q23 abnormalities
9910	Acute megakaryoblastic leukemia
9920	Therapy-related acute myeloid leukemia,NOS
9930	Myeloid sarcoma (see also M-9861/3)
9931	Acute panmyelosis with myelofibrosis (C42.1)
9940	Hairy cell leukemia (C42.1)
9945	Chronic myelomonocytic leukemia, NOS
9946	Juvenile myelomonocytic leukemia
9948	Aggressive NK-cell leukemia
9950	Polycythemia vera
9960	Chronic myeloproliferative disease, NOS
9961	Myelosclerosis with myeloid metaplasia
9962	Essential thrombocythemia
9963	Chronic neutrophilic leukemia
9964	Hypereosinophilic syndrome
9970	Lymphoproliferative disorder, NOS
9975	Myeloproliferative disease, NOS
9980	Refractory anemia
9982	Refractory anemia with sideroblasts
9983	Refractory anemia with excess blasts
9984	Refractory anemia with excess blasts in transformation
9985	Refractory cytopenia with multilineage dysplasia
9986	Myelodysplastic syndrome with 5q deletion (5q-) syndrome
9987	Therapy-related myelodysplastic syndrome, NOS
9989	Myelodysplastic syndrome, NOS

Note: This file is referenced in Tumour Validation Edit T16.

Appendix J

ICD-10 tumour code file

(not available ICD-10 not implemented)

Field	Size	Position	Type	Title
1	4	1 - 4	AN	ICD-10 Codes
2	85	5 - 89	A	Description (English)
3	75	90 - 164	A	Description (French)

Note: This file is not referenced at present time. It will be used in Tumour Validation Edit T18.

Appendix K

Invalid ICD-9 site / ICD-O-2 morphology code list

ICD-9	Site	ICD-O-2 Morphology	Histology
1540	Rectosigmoid junction	8090 - 8096	Basal cell carcinoma
1541, 2304	Rectum		
1542 - 1548, 2305, 2306	Anus and anal canal		
1580 - 1589, 2354	Retroperitoneum and peritoneum	8720 - 8790	Melanomas
1600 - 1609	Nasal cavities, accessory sinuses, middle ear and inner ear	9250 - 9340	Osteosarcomas (Giant cell, Ewing's Odontogenic)
1630 - 1639, 1642, 1643, 1649	Pleura and mediastinum	8010 - 8671, 8940 - 8941	Carcinomas
1700 - 1709, 2380	Bone	8720 - 8790	Melanomas
1921, 1923, 2376	Meninges	8010 - 8671, 8940 - 8941	Carcinomas

Note: This list is referenced in Correlation Edit No. 23.

Appendix L

invalid ICD-O-2/3 site / ICD-O-2 morphology code list

ICD-O-2/3 Topography	**Site**	**ICD-O-2 Morphology**	**Histology**
C199 C209 C210 - C218	Rectosigmoid junction Rectum Anus and anal canal	8090 - 8096	Basal cell carcinoma
C480 - C488	Retroperitoneum and peritoneum	8720 - 8790	Melanomas
C300 C301 C310 - C319	Nasal cavity Middle ear Accessory sinuses	9250 - 9340	Osteosarcomas (Giant cell, Ewing's, Odontogenic)
C381 - C388 C400 - C419	Pleura and mediastinum Bone	8010 - 8671, 8940 - 8941 8720 - 8790	Carcinomas Melanomas
C470 - C479	Peripheral nerves	8010 - 8671, 8940 - 8941	Carcinomas
C700 - C709	Meninges	8010 - 8671, 8940 - 8941	Carcinomas

Note: This list is referenced in Correlation Edit No. 23.

Appendix L-O3

invalid ICD-O-2/3 site / ICD-O-3 morphology code list

ICD-O-2/3 Topography	**Site**	**ICD-O-3 Morphology**	**Histology**
C199 C209 C210 - C218	Rectosigmoid junction Rectum Anus and anal canal	8090 - 8096	Basal cell carcinoma
C480 - C488	Retroperitoneum and peritoneum	8720 - 8790	Melanomas
C300 C301 C310 - C319	Nasal cavity Middle ear Accessory sinuses	9250 - 9341	Osteosarcomas (Giant cell, Ewing's, Odontogenic)
C381 - C388 C400 - C419	Pleura and mediastinum Bone	8010 - 8671, 8940 - 8941 8720 - 8790	Carcinomas Melanomas
C470 - C479	Peripheral nerves	8010 - 8671, 8940 - 8941	Carcinomas
C700 - C709	Meninges	8010 - 8671, 8940 - 8941	Carcinomas

Note: This list is referenced in Correlation Edit No. 23.

Appendix M

invalid ICD-10 site / morphology code list

Not available - ICD-10 Not implemented yet

Note: This list is not referenced at present. It will be used in Correlation Edit No. 23.

Appendix N

Invalid in situ ICD-O-2 morphology code list

8020	Carcinoma, undifferentiated
8021	Carcinoma, anaplastic
8331	Follicular adenocarcinoma, well differentiated
8332	Follicular adenocarcinoma, trabecular
8543	Paget's disease and intraductal carcinoma of breast (C50._)
8800 – 8804	Soft tissue tumours and sarcomas
8810 – 8833	Fibromatous neoplasms
8840 – 8841	Myxomatous neoplasms
8850 – 8881	Lipomatous neoplasms
8890 – 8920	Myomatous neoplasms
8930 – 8991	Complex mixed and stromal neoplasms
9000 – 9030	Fibroepithelial neoplasms
9040 – 9044	Synovial-like neoplasms
9062	Seminoma, anaplastic
9082	Malignant teratoma, undifferentiated
9083	Malignant teratoma, intermediate
9110	Mesonephromas
9120 – 9161	Blood vessel tumours
9170 – 9175	Lymphatic vessel tumours
9180 – 9243	Osseous and chondromatous neoplasms
9250 – 9252	Giant cell tumours
9260 – 9262	Miscellaneous bone tumours
9270 – 9342	Odontogenic tumours
9350 – 9373	Miscellaneous tumours
9380 – 9480	Gliomas
9490 – 9523	Neuroepitheliomatous neoplasms
9530 – 9539	Meningiomas
9540 – 9571	Nerve sheath tumours
9580 – 9582	Granular cell tumours and alveolar soft part sarcoma
9590 – 9710	Malignant lymphoma, NOS or diffuse
9711 – 9719	Other specified non-Hodgkin's lymphomas
9727 – 9729	Precursor cell lymphoblastic lymphoma
9731 – 9734	Plasma cell tumours
9740 – 9742	Mast cell tumours
9750 – 9758	Neoplasms of histiocytes and accessory lymphoid cells
9760 – 9769	Immunoproliferative Diseases
9800 – 9948	Leukemias
9950 – 9964	Chronic Myeloproliferative Disorders (C42.1)
9970 – 9975	Other Hematologic Disorders
9980 – 9989	Myelodysplastic syndrome (C42.1)

Note: This list is referenced in Correlation Edit No. 24.

Appendix N-O3

Invalid in situ ICD-O-3 morphology code list

8020	Carcinoma, undifferentiated
8021	Carcinoma, anaplastic
8331	Follicular adenocarcinoma, well differentiated
8332	Follicular adenocarcinoma, trabecular
8543	Paget's disease and intraductal carcinoma of breast (C50._)
8800 – 8804	Soft tissue tumours and sarcomas
8810 – 8833	Fibromatous neoplasms
8840 – 8841	Myxomatous neoplasms
8850 – 8881	Lipomatous neoplasms
8890 – 8920	Myomatous neoplasms
8930 – 8991	Complex mixed and stromal neoplasms
9000 – 9030	Fibroepithelial neoplasms
9040 – 9044	Synovial-like neoplasms
9062	Seminoma, anaplastic
9082	Malignant teratoma, undifferentiated
9083	Malignant teratoma, intermediate
9110	Mesonephromas
9120 – 9161	Blood vessel tumours
9170 – 9175	Lymphatic vessel tumours
9180 – 9243	Osseous and chondromatous neoplasms
9250 – 9252	Giant cell tumours
9260 – 9262	Miscellaneous bone tumours
9270 – 9342	Odontogenic tumours
9350 – 9373	Miscellaneous tumours
9380 – 9480	Gliomas
9490 – 9523	Neuroepitheliomatous neoplasms
9530 – 9539	Meningiomas
9540 – 9571	Nerve sheath tumours
9580 – 9582	Granular cell tumours and alveolar soft part sarcoma
9590 – 9710	Malignant lymphoma, NOS or diffuse
9711 – 9719	Other specified non-Hodgkin's lymphomas
9727 – 9729	Precursor cell lymphoblastic lymphoma
9731 – 9734	Plasma cell tumours
9740 – 9742	Mast cell tumours
9750 – 9758	Neoplasms of histiocytes and accessory lymphoid cells
9760 – 9769	Immunoproliferative Diseases
9800 – 9948	Leukemias
9950 – 9964	Chronic Myeloproliferative Disorders (C42.1)
9970 – 9975	Other Hematologic Disorders
9980 – 9989	Myelodysplastic syndrome (C42.1)

Note: This list is referenced in Correlation Edit No. 24.

Appendix O

Equivalent topographies list for overlapping and unspecified sites

Tumour(I) ICD-O-2/3 - Topography	Tumour ICD-O-2/3 - Topography
C02.8 & C02.9	C01.9
C08.8	C07.9
C13.8	C12.9
C14.8	C00.0 to C13.9
C21.8	C19.9 to C20.9
C24.8	C22.0 to C23.9
C26.8	C15.0 to C25.9
C39.8	C30.0 to C38.8
C41.8	C40.0 to C40.9
C57.8	C51.0 to C56.9
C57.8	C58.9
C63.8	C60.0 to C62.9
C68.8	C64.9 to C67.9
C72.8	C70.0 to C71.9
C01.9	C02.8 & C02.9
C07.9	C08.8
C12.9	C13.8
C00.0 to C13.9	C14.8
C19.9 to C20.9	C21.8
C22.0 to C23.9	C24.8
C15.0 to C25.9	C26.8
C30.0 to C38.8	C39.8
C40.0 to C40.9	C41.8
C51.0 to C56.9	C57.8
C58.9	C57.8
C60.0 to C62.9	C63.8
C64.9 to C67.9	C68.8
C70.0 to C71.9	C72.8

Note: This list is referenced in Correlation Edit No. 34-C.

Appendix P-O3

"Same ICD-O-3 morphology" work table

The use of the "Same ICD-O-3 Morphology" Work Table requires some explanation. In order to be able to decide whether the reported morphology codes in the Tumour(I) and Tumour records should be considered the same, the lower of the two morphology codes must first be found in the left column. If the other morphology code (the higher one) can be found on the same line in the right column, then the two morphologies can be considered as the same. If both morphology codes are identical, the morphologies are the same, and reference to this "Same ICD-O-3 Morphology" Work Table is not necessary.

"Same ICD-O-3 morphology" work table
(for determining multiple primary neoplasms)

ICD-O-3 morphology code	Considered same as
(Note: An underscore (_) used in the fourth digit position indicates any valid fourth digit).	
8000 to 8005	8000 to 9989
8010 to 8035	8000 to 8790
804_	8000 to 8046
8050 to 8060	8050 to 8060
807_	807_
808_	808_
8090 to 8110	8090 to 8110
8120 to 8131	8120 to 8131
814_	8140 to 8576
8150	815_
816_	816_
8170 to 8180	8170 to 8180
819_	819_
820_	820_
8210 to 8221	821_, 822_
823_	823_
8240 to 8245	8240 to 8245
825_	825_
826_	826_
827_	827_
828_	828_
831_	831_
832_	832_
833_	833_
834_	834_
837_	837_
838_	838_
8390 to 8420	8390 to 8420

ICD-O-3 morphology code	Considered same as
(Note: An underscore (_) used in the fourth digit position indicates any valid fourth digit).	
844_	844_
845_	845_
846_	846_
847_	847_
848_	848_
8500	850_, 851_, 8522, 8523, 8530
8501 to 8508	850_
851_	851_
8520	8522, 8524, 8525
8523	8525
8524	8525
854_	854_
855_	855_
857_	857
858_	858_
859_	859_
8600 to 8601	8600 to 8601
862_	862_
863_	863_
864_	864_
867_	867_
8680 to 8693	8680 to 8693
871_	871_
8720 to 8790	8720 to 8790
880_	8800 to 8933, 904_, 9180 to 9241
8810 to 8836	8810 to 8836
884_	884_
8850 to 8881	8850 to 8881
889_	889_
8900 to 8921	8900 to 8921
8930 to 8931	8930 to 8931
8932 to 8934	8932 to 8934
8935	8935
8936	8936
894_	894_
895_	895_
896_	896_
897_	897_
898_	898_
899_	899_
901_	901_
904_	904_

ICD-O-3 morphology code	Considered same as
(Note: An underscore (_) used in the fourth digit position indicates any valid fourth digit).	
905_	905_
9060 to 9105	9060 to 9105
9120 to 9175	9120 to 9175
9180 to 9195	9180 to 9195
9220 to 9243	9220 to 9243
925_	925_
9270 to 9352	9270 to 9352
9360 to 9362	9360 to 9362
9363 to 9364	9363 to 9364
9365	9365
938_	938_
939_	939_
9400 to 9443	9400 to 9443
945_	945_
947_	947_
948_	948_
949_	949_
950_	950_
951_	951_
952_	952_
953_	953_
9540 to 9571	9540 to 9571
958_	958_
9590	800_, 959_, 9650 to 9729
9591 to 9596	800_, 959_, 9670 to 9729
9650 to 9667	800_, 9590, 9650 to 9667
9670 to 9729	800_, 9590, 9670 to 9729
973_	973_
974_	974_
9800 to 9948	9800 to 9948
996_	996_
998_	998_

Note: This table is referenced in Correlation Edits No. 34-B & 34-E.

A more detailed three column table listing all histologies is available from the Nosology Reference Centre.

Appendix Q

Residency guidelines in Canada

To ensure comparability of definitions of cases and the population at risk (numerator and denominator), the Canadian Cancer Registry (CCR) rules for determining **residency at time of diagnosis** are to be identical or comparable to rules used by the Canadian Census Bureau, whenever possible.

The residence at diagnosis is generally the place of usual residence, as stated by the patient or, as stated by the Census Bureau, "the dwelling in Canada where a person lives most of the time". Residency is their usual place of residence, regardless of where they are when diagnosed. For patients with multiple tumours, the address may be different for each primary tumour.

There are a number of situations for which the process of determining residency is not intuitive, and special guidelines have been created in order to define an individual's usual place of residence. The Data Quality Committee (DQC) for the Canadian Council of Cancer Registries (CCCR) recognizes that some Provincial/Territorial Cancer Registries (PTCRs) are removed from the direct patient contact relationship, and may not have access to the patient or the information to confirm residency. Using the provincial health insurance number (HIN) as a determining factor of residency during initial case abstraction is appropriate. When permanently relocating, the HIN from previous province of residence is valid for three months. However, if the case is identified as a potential duplicate during a Record Linkage cycle, additional information should be obtained before confirming residency, as it may not be appropriate to default to using province of HIN, as the primary residence.

PTCRs are encouraged to use these guidelines to determine residency for categories of persons for whom residence is not immediately apparent.

1. Residence (one residence)

The dwelling in Canada where a person lives most of the time.

2. Persons with more than one residence

Usual residence rule applies; however, if the time spent at each residence is equal or the abstractor is not sure which one to choose, the residence where the patient was staying on the day cancer was diagnosed should be considered the usual place of residence. (See examples below.)

Exception: *Consider the residence shared with their family as their usual place of residence, even if they spend most of the year elsewhere.*

a) Commuter workers living away part of the week while working: Consider the residence shared with their family as the usual place of residence, even if they spend most of the year elsewhere. (I.e., parents, husbands, wives or common-law partners)

b) Snowbirds: People who live at another residence (city, province or country) with a warmer climate. Residence should be documented as where they live most of the time.

c) Children in joint custody: Residence should be documented as where they live most of the time. If time is equally divided, their residence is documented as where they were staying on the day cancer was diagnosed.

3. Patients with rural addresses

If the information provides a rural address only, which may be the post office box, record the address as stated, but make every attempt, within your resources, to identify the actual physical place of residence at time of diagnosis.

4. Patients with no usual place of residence (i.e. homeless, transient people)

Residents who do not have a usual place of residence should be documented as where they were staying on the day cancer was diagnosed.

5. Institutional collective dwellings (Collective dwellings that provide care or assistance services). Persons in institutions with no other usual place of residence elsewhere in Canada, or persons who have been in one or more institutions for a continuous period of six months or longer, are to be considered as usual residents of the institution.

Institutional collective dwellings include:

i. Residents of a long-term care facility, a hospital, or a home for the aged.
ii. In homes, schools, hospitals, or wards for the physically handicapped, mentally challenged, or mentally ill or in drug/alcohol recovery facilities.
iii. Inmates of correctional institutions, including prisons, jails, detention centers, or halfway houses.
iv. Children in juvenile institutions, such as residential care facilities for neglected or abused children or orphanages.

For abused women, or for runaway or neglected youth please see section 6 - Non-institutional collective dwellings.

6. Non-institutional collective dwellings (Collective dwellings that do not provide care or assistance services). Residence should be documented as their usual residence, if they report one (the place where they live most of the time) or otherwise at the inn, hotel, etc.

Non-institutional collective dwellings include:

i. Inns, hotels, motels and hostels.
ii. YMCAs/YWCAs, or public or commercial campgrounds.
iii. Military bases.
iv. Migrant workers (lumber / mining camps & farms).
v. Members of religious orders in monasteries or convents.

a) Shelters with sleeping facilities for people without housing, for abused women, or for runaway or neglected youth.

Residence should be documented as the shelter.

7. Students

Students who live away from home while attending school, but who return to live with their parents part of the year should consider their place of residence as their parents home, even if they spend most of the year elsewhere.

8. Live-ins

a) Live-in nannies
Residence should be documented as where they live most of the week.

b) Foster children, boarders or housemates
Residence should be documented as where they are living at time of diagnosis.

9. Merchant and coast guard vessels
Merchant vessels, coast guard vessels and oil rigs at sea should be documented as their usual onshore residence, if they report one (the place where they live most of the time when they are onshore) or otherwise, at their vessel's homeport.

Naval vessels
Canadian Forces Naval Vessel residence should be documented as their usual onshore residence, if they report one (the place where they live most of the time when they are onshore) or otherwise, at their vessel's homeport.

Armed forces
Canadian Armed Forces residence should be documented as their usual place of residence, if they report one, or otherwise, where they are stationed at time of diagnosis.

10. Non-permanent residents (foreign citizens)
Persons who hold a student or employment authorization, Minister's permit or who were refugee claimants at time of diagnosis, for a continuous period of six months or more.

a) Citizens of foreign countries who have established a household or are part of an established household in Canada while working or studying, including family members with them.
Residence should be documented as their household in Canada.

b) Citizens of foreign countries who are living in Canadian embassies, ministries, legations or consulates.
Residence should be documented as the embassy.

c) Citizens of foreign countries temporarily traveling or visiting Canada.
These cases are not reportable to the Canadian Cancer Registry.

Appendix R

Sites based on seer groups[1] for primary site of ICD-O-2

Primary Site	Site / Type	Excluding Type
All Sites	All invasive sites listed below, incl. *in situ* for bladder	
Buccal cavity and pharynx		
Lip	C000:C009	M-9590:9989
Tongue	C019:C029	M-9590:9989
Major salivary gland	C079:C089	M-9590:9989
Floor of mouth	C040:C049	M-9590:9989
Gum and other mouth	C030:C039, C050:C059, C060:C069	M-9590:9989
Nasopharynx	C110:C119	M-9590:9989
Oropharynx	C100:C109	M-9590:9989
Hypopharynx	C129, C130:C139	M-9590:9989
Other buccal cavity and pharynx	C090:C099, C140, C142:C148	M-9590:9989
Digestive system		
Esophagus	C150:C159	M-9590:9989
Stomach	C160:C169	M-9590:9989
Small intestine	C170:C179	M-9590:9989
Colon excluding rectum	C180:C189, C260	M-9590:9989
Rectum and rectosigmoid	C199, C209	M-9590:9989
Anus	C210:C212, C218	M-9590:9989
Liver	C220	M-9590:9989
Gallbladder	C239	M-9590:9989
Pancreas	C250:C259	M-9590:9989
Other digestive system	C240:C249, C221, C480, C481:C482, C268:C269, C488	M-9590:9989
Respiratory system		
Larynx	C320:C329	M-9590:9989
Lung and bronchus	C340:C349	M-9590:9989
Other respiratory system	C300:C301, C310:C319, C384, C339, C381:C383, C388, C390, C398, C399	M-9590:9989
Bones and joints	C400:C419	M-9590:9989
Soft tissue (including heart)	C380, C470:C479, C490:C499	M-9590:9989
Skin (excluding basal and squamous)		
Melanomas of the skin	C440:C449 (types 8720:8799)	
Other skin	C440:C449	8050:8082, 8090:8110, 8720:8799, 9590:9989
Breast	C500:C509	M-9590:9989
Female genital system		
Cervix uteri	C530:C539	M-9590:9989
Corpus uteri	C540:C549	M-9590:9989
Uterus, NOS	C559	M-9590:9989
Ovary	C569	M-9590:9989 M-8442, M-8462, M-8472, M-8473
Other female genital system	C529, C510:C519, C570:C589	M-9590:9989
Male genital system		
Prostate	C619	M-9590:9989
Testis	C620:C629	M-9590:9989

Sites based on seer groups[1] for primary site of ICD-O-2

Primary Site	Site / Type	Excluding Type
Penis	C600:C609	M-9590:9989
Other male genital system	C630:C639	M-9590:9989
Urinary system		
Bladder (incl. *in situ*)	C670:C679	M-9590:9989
Kidney and renal pelvis	C649, C659	M-9590:9989
Ureter	C669	M-9590:9989
Other urinary system	C680:C689	M-9590:9989
Eye	C690:C699	M-9590:9989
Brain and other nervous system		
Brain	C710:C719	M-953, 9590:9989
Other nervous system	C710:C719 (type 953),	
	C700:C709,	M-9590:9989
	C720:C729	M-9590:9989
Endocrine		
Thyroid	C739	M-9590:9989
Other endocrine	C379, C740:C749, C750:C759	M-9590:9989
Lymphomas		
Hodgkin's disease	types 9650:9667	
Non-Hodgkin's lymphomas	types 9590:9595, 9670:9717,	
	type 9823, all sites except C420, C421, C424	
	type 9827, all sites except C420, C421, C424	
Multiple myeloma	types 9731:9732	
Leukemias		
Acute lymphocytic	types 9821, 9828	
Chronic lymphocytic	C420 (type 9823), C421 (type 9823), C424 (type 9823)	
Acute myeloid	types 9840, 9861, 9866, 9867, 9871:9874	
Chronic myeloid	types 9863, 9868	
Other	types 9820, 9822, 9824, 9825, 9826, 9860, 9862, 9864, 9891, 9893, 9890, 9892, 9894, 9801, 9841, 9803, 9842, 9800, 9802, 9804, 9830, 9850, 9870, 9880, 9900, 9910, 9930, 9931, 9932, 9940:9941	
	C420 (type 9827),	
	C421 (type 9827),	
	C424 (type 9827)	
Other, ill-defined, and unknown	types 9720:9723, 9740, 9741, 9760:9764, 9950:9989	
	C760:C768, (types 8000:9589)	
	C809 (types 8000:9589)	
	C420:C424 (types 8000:9589)	
	C770:C779 (types 8000:9589)	

1. The Data Quality Committee has requested a change for 'Ovary' that will allow the CCR Shelf Tables to be consistent with the data published last year in ICD-9 (code 183) and those to be released next year in ICD-O-3 (see exclusion of M-8442, 8462, 8472 and 8473 in the SEER conversion table). The Data Quality Committee has also requested that M-8000:8004 and M-8010:8045 be included in 'Other skin' (C440:C449).

Appendix S

Sites based on seer groups[1,2] for primary site of ICD-O-3

Primary Site	Site / Type	Excluding Type
All Sites	All invasive sites listed below, incl. *in situ* for bladder	
Buccal cavity and pharynx		
Lip	C000:C009	M-9590:9989
Tongue	C019:C029	M-9590:9989
Major salivary gland	C079:C089	M-9590:9989
Floor of mouth	C040:C049	M-9590:9989
Gum and other mouth	C030:C039, C050:C059, C060:C069	M-9590:9989
Nasopharynx	C110:C119	M-9590:9989
Oropharynx	C100:C109	M-9590:9989
Hypopharynx	C129, C130:C139	M-9590:9989
Other buccal cavity and pharynx	C090:C099, C140, C142:C148	M-9590:9989
Digestive system		
Esophagus	C150:C159	M-9590:9989
Stomach	C160:C169	M-9590:9989
Small intestine	C170:C179	M-9590:9989
Colon excluding rectum	C180:C189, C260	M-9590:9989
Rectum and rectosigmoid	C199, C209	M-9590:9989
Anus	C210:C212, C218	M-9590:9989
Liver	C220	M-9590:9989
Gallbladder	C239	M-9590:9989
Pancreas	C250:C259	M-9590:9989
Other digestive system	C240:C249, C221, C480, C481:C482, C268:C269, C488	M-9590:9989
Respiratory system		
Larynx	C320:C329	M-9590:9989
Lung and bronchus	C340:C349	M-9590:9989
Other respiratory system	C300:C301, C310:C319, C384, C339, C381:C383, C388, C390, C398, C399	M-9590:9989
Bones and joints	C400:C419	M-9590:9989
Soft tissue (including heart)	C380, C470:C479, C490:C499	M-9590:9989
Skin (excluding basal and squamous)		
Melanomas of the skin	C440:C449 (types 8720:8790	
Other skin	C440:C449	8050:8084, 8090:8110, 8720:8790, 9590:9989
Breast	C500:C509	M-9590:9989
Female genital system		
Cervix uteri	C530:C539	M-9590:9989
Corpus uteri	C540:C549	M-9590:9989
Uterus, NOS	C559	M-9590:9989
Ovary	C569	M-9590:9989
Other female genital system	C529, C510:C519, C570:C589	M-9590:9989
Male genital system		
Prostate	C619	M-9590:9989
Testis	C620:C629	M-9590:9989
Penis	C600:C609	M-9590:9989
Other male genital system	C630:C639	M-9590:9989

Appendix S

Sites based on seer groups[1,2] for primary site of ICD-O-3

Primary Site	Site / Type	Excluding Type
Urinary system		
Bladder (incl. *in situ*)	C670:C679	M-9590:9989
Kidney and renal pelvis	C649, C659	M-9590:9989
Ureter	C669	M-9590:9989
Other urinary system	C680:C689	M-9590:9989
Eye	C690:C699	M-9590:9989
Brain and other nervous system		
Brain	C710:C719	M-953, 9590:9989
Other nervous system	C710:C719 (type 953),	
	C700:C709,	M-9590:9989
	C720:C729	M-9590:9989
Endocrine		
Thyroid	C739	M-9590:9989
Other endocrine	C379, C740:C749, C750:C759	M-9590:9989
Lymphomas		
Hodgkin's disease	types 9650:9667	
Non-Hodgkin's lymphomas	types 9590:9596, 9670:9719, 9727:9729	
	type 9823, all sites except C420, C421, C424	
	type 9827, all sites except C420, C421, C424	
Multiple myeloma	types 9731:9732, 9734	
Leukemias		
Acute lymphocytic	types 9826, 9835:9837	
Chronic lymphocytic	C420 (type 9823), C421 (type 9823), C424 (type 9823)	
Acute myeloid	types 9840, 9861, 9866, 9867, 9871:9874, 9895-9897, 9910, 9920	
Chronic myeloid	types 9863, 9875, 9876, 9945, 9946	
Other	types 9733, 9742, 9800, 9801, 9805, 9820, 9831, 9832:9834, 9860, 9870, 9891, 9930, 9931, 9940, 9948, 9963, 9964	
	C420 (type 9827),	
	C421 (type 9827),	
	C424 (type 9827)	
Other, ill-defined, and unknown	types 9740, 9741, 9750:9758, 9760:9769, 9950:9962, 9970-9989	
	C760:C768, (types 8000:9589)	
	C809 (types 8000:9589)	
	C420:C424 (types 8000:9589)	
	C770:C779 (types 8000:9589)	

1. The Data Quality Committee has requested that M-8000:8004 and M-8010:8045 be included in 'Other skin' (C440:C449).
2. The SEER Program table is more detailed and separates some groups into subgroups. For details, see www.seer.cancer.gov/siterecode/.