ALL LICENSED HEALTHCARE PROVIDERS IN CONNECTICUT ARE REQUIRED TO REPORT MALIGNANT CASES DIAGNOSED OR TREATED AT THEIR FACILITY TO THE CONNECTICUT TUMOR REGISTRY (CTR). THIS INCLUDES ALL CONDITIONS LISTED IN THE INTERNATIONAL DISEASES FOR ONCOLOGY, THIRD EDITION (ICD-0-3) WITH A BEHAVIOR CODE OF “2” OR “3”.

InSitu and Malignant/Invasive Histologies:

Skin NOS of the genital sites only (C52.9, C51.0-C51.9, C60.0, C60.9 and C63.2) vagina, clitoris, vulva, prepuce, penis, and scrotum.

If a “0” or “1” behavior code item in (ICD-0) is verified by a pathologist as in-situ or malignancy

Behavior code changes from borderline/1 to a malignant/3 (for cases diagnosed 1/1/01 or later)

Bronchial adenoma “carcinoid type” or “cylindroid type” are malignant conditions (8240/3 and 8200/3)

Report only malignant cystosarcoma phyllodes (9020/3) (borderline phyllodes tumors also referred to as “low grade malignant PT’s are not-reportable).

Argentaffin tumors (8241/3)

Any “benign” tumor which states “malignant changes” or “malignant degeneration”

Any “pre-1935” diagnosis of a malignancy only if a new primary tumor is diagnosed in 1935 or later

Benign brain tumors noted in past history

Non-resident cases diagnosed after January 1979

All cases considered to be malignant clinically

Breast LCIS “Lobular Carcinoma In Situ” code to insitu malignancy (8520/2)

Carcinoid Tumors “Appendix” specifically stated as “Well-differentiated neuroendocrine tumor” (8240/3)

IPMN (Intraductal Papillary Mucinous Neoplasm) of the Pancreas is reportable when stated as “IPMN with high-grade dysplasia” or “IPMN with associated invasive carcinoma”.

Early Melanoma InSitu or Evolving Melanoma InSitu must specifically state INSITU
AIN III of the “anus or anus canal” (C210-C211), VIN III and VAIN III “vulva and vagina” (C519-C529)

LIN III “laryngeal intraepithelial neoplasia” (C320-C329) and SIN III “squamous intraepithelial neoplasia” excluding cervix.

Lymphangioma, any site (Note: Includes Lymphangiomas of Brain, Other parts of nervous system and endocrine glands)

Osteomyelofibrosis (9961/3)

Pancreatic endocrine tumor, malignant (C25.) (8150/3)

Mixed pancreatic endocrine and exocrine tumor, malignant (C25.) (8154/3)

Mixed adenoneuroendocrine carcinoma (8244/3)

GIST (Gastrointestinal Stromal Tumors) and Thymomas are only reportable when (multiple foci, lymph node involvement or metastasis are stated)

Borderline Cystadenomas M-8442, 8451,8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-0-3. SEER registries are not required to collect these cases for diagnosis made 1/1/2000 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted and reported to SEER.

NOTE: FOR 2013 DIAGNOSIS and FORWARD:
Urine cytology positive for malignancy is reportable
Code the primary site to C689 in the absence of any other information
Exception: when a subsequent biopsy of a urinary site is negative, do not report the case

Exceptions: InSitu and Malignant/Invasive histologies not required

Skin primary (C440-C449) with any of the following histologies:
- Malignant neoplasm (8000-8005)
- Epithelial carcinoma (8010-8046)
- Papillary and squamous cell carcinoma (8050-8084)
- AIN III (8077) arising in perianal skin (C445)
- Basal cell carcinoma (8090-8110)

NOTE: If the registry collects basal or squamous carcinoma of the skin sites C440-C449, sequence them in the 60-99 range not reportable to SEER.

- Carcinoma insitu of cervix (/2), cervical intraepithelial neoplasia (CIN III) or (SIN III) of the cervix (C530-C539)

- Prostatic intraepithelial carcinoma (PIN III) of the Prostate (C619)

NOTE: (Collection stopped effective with cases diagnosed 1/1/2001).

Reportable Benign Tumors:

- All neoplasms of the brain and central nervous system (C70.0 - C72.9)
- Pancreatic endocrine tumor, benign (C25.) (8150/0)
- Pancreatic endocrine tumor, NOS (C25.) (8150/1)
Non Reportable Benign Tumors:

- Mixed tumors, salivary gland type
- Papillary adenomas or mixed papillary and follicular adenomas of the thyroid
- Benign Kaposi's Sarcoma
- Bronchial adenomas
- Cystosarcoma phyllodes of the breast
- AIN III (8077) arising in perianal skin, VAIN II/III and VIN II/III, only report (III's)
- Carcinoid tumorlets
- Carcinoid tumors of the appendix (8240/1)
- Early Melanoma or Evolving Melanoma (*must specifically state InSitu*)
- IPMN (Intraductal Papillary Mucinous Neoplasm) with “low grade dysplasia” also called “IPMN adenomas”
- Bladder Papillomas (8120/1) or PUNLMPs (8130/1) *non-reportable* (effective 1/1/2015 and forward)

Benign and Borderline Intracranial and CNS tumors:

Required Sites for **“BENIGN”** and **“BORDERLINE”** Intracranial and CNS tumors with a behavior code of /0 or /1 in ICD-0-3 are collected for the following sites, effective with cases diagnosed 1/1/2004 and later.

<table>
<thead>
<tr>
<th>General Term</th>
<th>Specific Sites</th>
<th>ICD-0-3 Topography Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meninges</strong></td>
<td>Cerebral meninges</td>
<td>C700</td>
</tr>
<tr>
<td></td>
<td>Spinal meninges</td>
<td>C701</td>
</tr>
<tr>
<td></td>
<td>Meninges, NOS</td>
<td>C709</td>
</tr>
<tr>
<td><strong>Brain</strong></td>
<td>Cerebrum</td>
<td>C710</td>
</tr>
<tr>
<td></td>
<td>Frontal lobe</td>
<td>C711</td>
</tr>
<tr>
<td></td>
<td>Temporal lobe</td>
<td>C712</td>
</tr>
<tr>
<td></td>
<td>Parietal lobe</td>
<td>C713</td>
</tr>
<tr>
<td></td>
<td>Occipital lobe</td>
<td>C714</td>
</tr>
<tr>
<td></td>
<td>Ventricle, NOS</td>
<td>C715</td>
</tr>
<tr>
<td></td>
<td>Cerebellum, NOS</td>
<td>C716</td>
</tr>
<tr>
<td></td>
<td>Brain stem</td>
<td>C717</td>
</tr>
<tr>
<td></td>
<td>Overlapping lesion of brain</td>
<td>C718</td>
</tr>
<tr>
<td></td>
<td>Brain, NOS</td>
<td>C719</td>
</tr>
<tr>
<td><strong>Spinal cord, cranial nerves, and other parts of the central nervous system</strong></td>
<td>Spinal Cord</td>
<td>C720</td>
</tr>
<tr>
<td></td>
<td>Cauda equine</td>
<td>C721</td>
</tr>
<tr>
<td></td>
<td>Olfactory nerve</td>
<td>C722</td>
</tr>
<tr>
<td></td>
<td>Optic nerve</td>
<td>C723</td>
</tr>
<tr>
<td></td>
<td>Acoustic nerve</td>
<td>C724</td>
</tr>
<tr>
<td></td>
<td>Cranial nerve, NOS</td>
<td>C725</td>
</tr>
<tr>
<td></td>
<td>Overlapping lesion of the brain</td>
<td>C728</td>
</tr>
<tr>
<td></td>
<td>And central nervous system</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nervous system, NOS</td>
<td>C729</td>
</tr>
<tr>
<td><strong>Pituitary, craniopharyngeal duct and pineal gland</strong></td>
<td>Pituitary gland</td>
<td>C751</td>
</tr>
<tr>
<td></td>
<td>Craniopharyngeal duct</td>
<td>C752</td>
</tr>
<tr>
<td></td>
<td>Pineal gland</td>
<td>C753</td>
</tr>
</tbody>
</table>
NOTE: Pilocytic Juvenile ASTROCYTOMA M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-0-3. However, SEER REGISTRIES will continue to report these cases and code behavior as /3 (malignant).

NOTE: Benign and Borderline tumors of the CRANIAL BONES (C410) not reportable.

Reportable Terminology for CNS Tumors
The terms “tumor” and “neoplasm” are diagnostic and reportable for non-malignant brain and CNS primaries.

Non-Reportable Terminology for CNS Tumors
The terms “mass” and “lesion” are not reportable, but may be used for initial casefinding purposes. The terms “hypodense mass” or “cystic neoplasm” are not reportable.

NOTE: The term “neoplasm” alone, for Brain or a CNS, indentified only by diagnostic imaging are reportable.

HEMATOPOIETIC AND LYMPHOID NEOPLASMS
Refer to reportability instructions in the Hematopoietic and Lymphoid Database. The 2010 and 2012 databases have been combined into one database, which also has changes for 2014.

NON REPORTABLE HEMATOPOIETIC CONDITIONS – QUICK REFERENCE (not an inclusive list)

<table>
<thead>
<tr>
<th>NON-REPORTABLE TERMS</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaplastic Anemia</td>
<td></td>
</tr>
<tr>
<td>Castleman’s disease</td>
<td>Must be Castleman’s Disease associated with a Lymphoma to be reportable.</td>
</tr>
<tr>
<td>Chronic Thrombocytosis</td>
<td></td>
</tr>
<tr>
<td>Erythrocytosis</td>
<td>Must state “Erythrocytosis Megalosplenica” to be reportable.</td>
</tr>
<tr>
<td>Hemophagocytic Lymphohistiocytosis</td>
<td>Must state “Fulminant Hemophagocytic Syndrome to be reportable.”</td>
</tr>
<tr>
<td>Idiopathic Polycythemia</td>
<td>is not alternate name for Polycythemia Vera.</td>
</tr>
<tr>
<td>Idiopathic Refractory Anemia</td>
<td></td>
</tr>
<tr>
<td>Idiopathic Thrombocytemia Purpura</td>
<td>Must state “Idiopathic Thrombocytemia” to be reportable.</td>
</tr>
<tr>
<td>Lymphocytosis</td>
<td>Increase of lymphocytosis, may occur for several reasons.</td>
</tr>
<tr>
<td>Mast Cell Activation Syndrome (MCAS)</td>
<td>Group of disorders based on complex of symptoms with no increase in mast cells. Not part of the systemic Mastocytosis/Mast Cell Leukemia/Mast Cell Sarcoma spectrum, not reportable.</td>
</tr>
<tr>
<td>Mild Thrombocytosis</td>
<td></td>
</tr>
<tr>
<td>Myelofibrosis</td>
<td>Must state “Primary Myelofibrosis” to be reportable.</td>
</tr>
<tr>
<td>Monoclonal Gammapathy of Undetermined Significance (MGUS)</td>
<td>Non reportable condition listed in ICD-0-3 with code 9765/1.</td>
</tr>
<tr>
<td>Plasma Cell Dyscrasia</td>
<td>Alternate name for MGUS, may indicate presence of Multiple Myeloma, but do not report unless Myeloma is diagnosed.</td>
</tr>
<tr>
<td>POEMS (Polyneuropathy, Organomegaly, Endocrinopathy,Monoclonal Gammapathy&amp;skin)</td>
<td>May present with a reportable disease, such as Multiple Myeloma.</td>
</tr>
<tr>
<td>Reactive Plasmacytosis</td>
<td>Not alternate name for Plasmacytoma, occurs in a variety of situations, including infections, diabetes and neoplasia.</td>
</tr>
</tbody>
</table>
Reactive Thromocytosis
Refractory Iron Deficiency Anemia
Secondary Polycythemia
Thrombocythemia
Thrombocytosis, NOS
Thrombocytopenia

**Ambiguous Terminology**

Please refer to pages 6-8 of the SEER Program Coding and Staging Manual 2014 for instructions on reporting cases diagnosed using ambiguous terminology.

Although the American College of Surgeons’ Commission on Cancer does not require hospital registries to collect non-analytic cases, they must be abstracted and submitted to the CTR. This includes (Class of Case 30-99). Cases diagnosed at a facility on a slide consultation for another facility only do not need to be reported by the consulting facility.

Cases may be reported electronically, using the latest NAACCR standard record format (Currently NAACCR 14) which is preferred, or submitted as paper abstracts. The CTR requires that hospitals submit copies of pathology reports, as documentation. Facilities that do not submit their cases without adequate documentation will be sent follow-back requests for further information and clarification.

These *ambiguous terms* are *reportable* when they are used with a term such as *cancer, carcinoma, sarcoma, etc.*

- Apparent(ly)
- Appears to
- Comparable with
- Comparable with a malignancy
- Consistent with
- Favor (s)
- Malignant appearing

- Most likely
- Presumed
- Probable
- Suspect or Suspected
- Suspicious (for)
- Typical (of)

*Do not substitute synonyms such as “supposed” for “presumed” or “equal” for comparable.*

*Do not substitute “likely” for “most likely”.*

*If any of the ambiguous terms precede either the word “tumor” or the word “neoplasm” case is *REPORTABLE.*

*Do not use ambiguous terminology* when reporting cytology cases.

**Non-Reportable Ambiguous Terms**

- Approaching
- Cannot be ruled out
- Equivocal
- Possible
- Potentially

- Questionable
- Rule Out
- Suggests
- Very Close to
- Worrisome