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NATIONAL CANCER INSTITUTE

DATA DICTIONARY

CANADIAN CANCER REGISTRY

Health Statistics Division
Statistics Canada

June 17, 1994

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OPERATIONAL OVERVIEW

Canadian Cancer Registry

The Canadian Cancer Registry (CCR) is a central data base, located at Statistics Canada, containing information about cancer in Canada, and about the persons having this disease. The data, loaded onto this base are derived mainly from the eleven* provincial/territorial cancer registries (PTCR's), and for the most part describe the primary, malignant tumours diagnosed among the residents of their respective jurisdictions. Some non-malignant tumours are also included in the CCR.

Nature of the Data

Unlike the National Cancer Incidence Reporting System, the CCR is person-oriented, having the capacity to identify and eliminate the duplicate reporting of tumours. Thus, the data feeding into the CCR describe both the individual with cancer, and the characteristics of that cancer. The PTCR's provide the personal data on a **patient record**, and the details of the cancer on a **tumour record.**

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 data base. Thus, for any subsequent cancer for that person, the PTCR submits only the relevant tumour record. There are as many tumour records as there were distinct cancers diagnosed.

When Statistics Canada receives an initial patient-tumour record combination, adding a new person to the CCR, it assigns a **CCR ID Number** to the individual. This number then is posted onto all relevant records on the CCR, fed back to the PTCR originally submitting the data, and used on all subsequent records for that person.

Record Types (functions)

There are three types of patient and tumour records, each of which performs a discrete function with respect to the creation and maintenance of the CCR data base: **new** records, **update** records, and **delete** records. *There is also an additional patient record type called* **change-of-ownership** *record.*

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* Yukon cases are currently reported by British Columbia

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

Update records change the content of records already posted to the CCR. Both patient and tumour updates require a CCR ID Number, and completely replace existing records with their own content. Updating occurs, therefore, on a record-replacement and not field-replacement basis. Thus, changing the content of one field will require 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, Patient Identification Number and CCR ID Number; 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, would be reported on a delete record and subsequently edited; the rest of the record would be left blank.

The deletion of a patient record does not automatically delete all associated tumour records. Therefore, when a patient is to be 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 effects the deletion of a patient from the CCR, a previously registered tumour, for that person from another PTCR, could be left "hanging" on the Registry. When such a situation is detected, the deleted patient record will be "inherited" by the previous PTCR, and given the identifiers from the "hanging" tumour record - viz. Reporting Province and Patient Identification Number.

Finally, change-of-ownership patient records permit a PTCR to register a new tumour for a patient who already has had a previous tumour registered by another PTCR, and which therefore currently "owns" the patient record (see below: Ownership of Data and Responsibility for Updates).

A change-of-ownership patient record is characterized by having a CCR Identification Number, and must be accompanied by at least one new tumour record also having the same CCR Identification Number. This means that the PTCR must either have obtained the CCR Identification Number from another PTCR, or have registered this patient in the past. In order to minimize error, the change-of-ownership patient record must also have a reported, valid Sex and Year of Birth which do not conflict with that already contained in the patient record currently on the CCR database. The use of this record type presumes close cooperation and sharing of information between PTCR's, and avoids the more cumbersome and time consuming duplicate identification/resolution process using record linkage.

Ownership of Data and Responsibility for Updates

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

Tumour Record: it belongs to the PTCR in whose jurisdiction the patient lived 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's "owning" the records may submit updates or deletions. Even when other PTCR's have more accurate or recent information, these data can only be submitted via the proprietary PTCR.

Changing Ownership

Ownership of the **patient record** can transfer to another PTCR in three circumstances. In the first place, it will most likely occur 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 it is discovered in the record linkage process that the tumour, having the most recent Date of Diagnosis, in fact had been diagnosed earlier and registered by another registry, ownership of the patient record could possibly move to another PTCR. This happens when the removal of the duplicate tumour registration results in the latest Date of Diagnosis now being on a tumour record from a different PTCR; the ownership of the patient record will then shift to this registry.

Finally, ownership of a patient record can, in rare situations, revert to a previous owner. This occurs when the current owner deletes its patient and tumour record(s) for an individual, leaving a tumour record on the CCR previously registered by another PTCR. So as to avoid leaving this tumour record without an accompanying patient record, ownership of the "deleted" patient record is passed on to the previous PTCR.

Ownership of a **tumour record** will not change. Upon discovery, through record linkage, that the identical cancer was in fact diagnosed and registered for the same patient in another PTCR, one of the duplicate tumour records will be deleted (the one with the later Date of Diagnosis). This situation could occur because of differences in the speed in reporting, the completeness of the diagnostic information, and the effectiveness of record linkage.

Since ownership is so fundamental a concept to the operation of the CCR, the affected PTCR's are informed about, and involved in, any proposed changes.

Movement Between Provinces/Territories

When a patient moves to another province/territory, no action is required with respect to the CCR. 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 forwarded to the CCR. When the CCR ID Number is known, it is included on the records and the patient record type is coded as a ***change-of-ownership*** record, and the tumour as a ***new*** record. If the CCR ID Number is unknown, then both records are submitted as ***new*** records, and it will be the responsibility of the CCR linkage procedures to identify these records as belonging to a person already registered on the CCR. Subsequent new cancers reported by this PTCR for the same person would require only the appropriate tumour record. The above applies equally to "death certificate only" diagnoses.

Field Characteristics by Record Type

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

FIELD CHARACTERISTICS BY RECORD TYPE: PATIENT RECORD

FIELD	POSITION	DESCRIPTION	NEW	UPDATE	DELETE	CH of O
1	1-2	Reporting Province	V	V	V	V
2	3-14	Patient Identification Number	V	V	V	V
3	15-23	CCR Identification	B	V	V	V
4	24	Patient Record Type	= 1	= 2	= 3	= 4
5	25	Type of Current Surname	v	v	B	v
6	26-50	Current Surname	b	b	B	b
7	51-65	First Given Name	b	b	B	b
8	66-80	Second Given Name	b	b	B	b
9	81-87	Third Given Name	b	b	B	b
10	88	Sex	v	v	B	V
11	89-96	Date of Birth	v	v	B	V*
12	97-99	Province/Country of Birth	v	v	B	v
13	100-124	Birth/Maiden Name	b	b	B	b
14	125-132	Date of Death	v	v	B	v
15	133-135	Province/Country of Death	v	v	B	v
16	136-141	Death Registration Number	v	v	B	v
17	142-145	Underlying Cause of Death	v	v	B	v
18	146	Autopsy Confirming Cause of Death	v	v	B	v
19	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
1	1-2	Reporting Province	V	V	V
2	3-14	Patient Identification Number	V	V	V
3	15-23	Tumour Reference Number	V	V	V
4	24-32	CCR Identification Number	B/V*	V	V
5	33	Tumour Record Type	= 1	= 2	= 3
6	34-58	Place of Residence of Time of Diagnosis	b	b	B
7	59-64	Postal Code	v	v	B
8	65-71	Coded Place of Residence at Diagnosis	V	V	B
9	72-80	Census Tract	v	v	B
10	81-95	Health Insurance Number	v	v	B
11	96	Method of Diagnosis	v	v	B
12	97-104	Date of Diagnosis	V	V	B
13	105-108	ICD-9	V	V	B
14	109	Source Classification Flag - (S C F)	V	V	B
15	110-113	ICD-O-2 Topography	V	V	B
16	114-117	ICD-O-2 Morphology	v	v	B
17	118	ICD-O-2 M Behaviour Code	V	V	B
18	119-122	ICD-10	V	V	B
19	123	Laterality	v	v	B
20	124	Multifocal Tumour	v	v	B
21	125-132	filler	B	B	B
22	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.

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.

INTRODUCTION TO THE DATA DICTIONARY

Content

The purpose of this manual is to describe the valid content of the patient and tumour records. For each record type, it contains:

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

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

Following the routines, there are six **input match edits.** These edits ensure that, within any submission, the set of input records for a patient is complete and makes sense 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.

Next, are five sets of correlation edits, the first two being **intra-record correlations**, while the remaining three are **inter-record correlations.** There are intra-record correlations for both patient and tumour records, and within each record, they ensure that reasonable relationships exist between different, valid, data elements. 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 or tumour), the symbol **"(I)"** is used to distinguish data arriving as new input into the CCR, from data already resident on the Registry. When two new tumours are registered coincidentally, in any comparisons made between them, the first one posted to the CCR becomes **Tumour**, while the second becomes **Tumour(I).**

After the correlation edits, there are 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 Data Dictionary contains a series of **appendices** which either contain extra information on the preparation of data for the CCR, or describe the "coding files" referenced during the edit process. For 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.

PTCR Responsibility

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 data base, and returned to their province of origin for correction and re-submission to the CCR. It is the PTCR's responsibility, therefore, to implement the specifications contained in the Data Dictionary in their entirety. **Only records containing valid data, organized in standard formats and using standard codes will be loaded onto the CCR data base.**

Because strict adherence to the data dictionary is imperative, PTCR's are encouraged to bring forward any questions, and clarify any doubts, by contacting one of the following:

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PATIENT RECORD

STATISTICS CANADA
Canadian Cancer Registry

INPUT PATIENT RECORD LAYOUT (P)

FIELD	SIZE	POSITION	TYPE	DESCRIPTION
1	2	1-2	N	Reporting Province
2	12	3-14	AN	Patient Identification Number
3	9	15-23	AN	CCR Identification Number
4	1	24	N	Patient Record Type
5	1	25	N	Type of Current Surname
6	25	26-50	AN	Current Surname
7	15	51-65	AN	First Given Name
8	15	66-80	AN	Second Given Name
9	7	81-87	AN	Third Given Name
10	1	88	N	Sex
11	8	89-96	N	Date of Birth
12	3	97-99	N	Province/Country of Birth
13	25	100-124	AN	Birth/Maiden Surname
14	8	125-132	N	Date of Death
15	3	133-135	N	Province/Country of Death
16	6	136-141	N	Death Registration Number
17	4	142-145	AN	Underlying Cause of Death
18	1	146	N	Autopsy Confirming Cause of Death
19	8	147-154	N	Date of Transmission

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Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
25	• Patient Identification Number	P2
	• Patient(I) Record Type	P4
26	• Patient Identification Number	P2
	• CCR Identification Number	P3
	• Patient(I) Record Type	P4
27	• CCR Identification Number	P3
	• Patient Record Type	P4
	• Sex	P10
	• Date of Birth	P11

ITEM NAME: Reporting Province

FIELD NO.: P1

LENGTH: 2

TYPE: Numeric

DESCRIPTION: The standard geographic code (SGC) of the province/territory submitting the initial registration/update of the patient record to the CCR.

VALUES & MEANING:

10: Newfoundland
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

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
25	• Reporting Province	P1
	• Patient(I) Record Type	P4
26	• Reporting Province	P1
	• CCR Identification Number	P3
	• Patient(I) Record Type	P4

ITEM NAME: Patient Identification Number

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.**

Note: Should be left justified followed by blanks as required. The CCR will replace any blanks to the left of the Patient Identification Number with zeroes, however any blanks to the right will remain.

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

Cannot be all blank.

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
01	• Patient Record Type	P4
	• Patient Record, positions 25-146	n/a
26	• Reporting Province	P1
	• Patient Identification Number	P2
	• Patient(I) Record Type	P4
27	• Reporting Province	P1
	• Patient Record Type	P4
	• Sex	P10
	• Date of Birth	P11

ITEM NAME: CCR I.D. Number

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 of the patient in the CCR.

Note: The CCR I.D. Number 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 would contain the CCR I.D. Number.

VALUES & MEANING: All blank or all numeric.

All blank: New registration (no CCR I.D. Number has been assigned yet).

Cannot be all zeroes (000000000).

Number must be validated according to Modulus 10 (see routine 03).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
01	• CCR Identification Number	P3
	• Patient Record, positions 25-146	n/a
02	• Sex	P10
	• Date of Birth	P11
25	• Reporting Province	P1
	• Patient Identification Number	P2
26	• Reporting Province	P1
	• Patient Identification Number	P2
	• CCR Identification Number	P3
27	• Reporting Province	P1
	• CCR Identification Number	P3
	• Sex	P10
	• Date of Birth	P11

ITEM NAME: Patient Record Type

FIELD NO.: P4

LENGTH: 1

TYPE: Numeric

DESCRIPTION: The code which identifies whether the record is new to the Registry or an update to an existing Patient Record; whether the Patient Record, currently on the Registry, is to be deleted; or whether the Patient Record currently on the Registry is to be replaced by one from another province.

VALUES & MEANING:
1: New record
2: Update record
3: Delete record
4: Change-of-ownership record

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
04	• Current Surname	P6
05	• Current Surname	P6
	• Birth/Maiden Surname	P13

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/maiden surname.
2: Other type of surname (e.g. married name, legal change-of-name, etc.).
9: Type of surname unknown.
Blank: Not applicable (Patient Record Type (Field No. P4) = 3).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
04	• Type of Current Surname	P5
05	• Type of Current Surname	P5
	• Birth/Maiden Surname	P13
06	• Birth/Maiden Surname	P13

ITEM NAME: Current Surname

FIELD NO.: P6

LENGTH: 25

TYPE: Alphanumeric

DESCRIPTION: The surname, or family/last name currently used by the patient.

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

Can be all blank only if Birth/Maiden Name (Field No. 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/not applicable (Patient Record Type (Field No. P4) = 3).

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

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

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
03	• Second Given Name	P8
	• Third Given Name	P9

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/not applicable (patient has no First Given Name **or** Patient Record Type (Field No. P4) = 3).

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

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

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
03	• First Given Name	P7
	• Third Given Name	P9

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/not applicable (patient has no Second Given Name **or** Patient Record Type (Field No. P4) = 3).

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

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

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
03	First Given Name	P7
	Second Given Name	P8

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/not applicable (patient has no Third Given Name **or** Patient Record Type (Field No. P4) = 3).

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

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

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
02	• Patient Record Type	P4
	• Date of Birth	P11
27	• Reporting Province	P1
	• CCR Identification Number	P3
	• Patient Record Type	P4
	• Date of Birth	P11
31	• ICD-9	T13
	or	
	ICD-O-2 - Topography	T15
	or	
	ICD-10	T18

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: Not applicable (Patient Record Type (Field No. P4) = 3).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
02	• Patient Record Type	P4
	• Sex	P10
07	• Date of Death	P14
08	• Date of Transmission	P19
27	• Reporting Province	P1
	• CCR Identification Number	P3
	• Patient Record Type	P4
	• Sex	P10
28	• Date of Diagnosis	T12

ITEM NAME: Date of Birth

FIELD NO.: P11

LENGTH: 8

TYPE: Numeric

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

VALUES & MEANING: Format: YYYYMMDD

YYYY: Four digit numerical year.
1875 - 2000: Valid years.
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 edited according to Routine 01.

All Blank: Not applicable (Patient Record Type (Field No. P4) = 3).

ITEM NAME: Province/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/Country Code File (Appendix B).

999: Province/country of birth unknown.

All blank: Not applicable (Patient Record Type (Field No. P4) = 3).

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

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
05	• Type of Current Surname • Current Surname	P5 P6
06	• Current Surname	P6

ITEM NAME: Birth/Maiden Surname

FIELD NO.: P13

LENGTH: 25

TYPE: Alphanumeric

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

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

Can be all blank only if Current Surname (Field No. P6) is not blank.

VALUES & MEANING: All blank: Unknown/not applicable (Patient Record Type (Field No. P4) = 3).

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

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

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
07	• Date of Birth	P11
09	• Date of Transmission	P19
10	• Province/Country of Death	P15
	• Death Registration Number	P16
	• Underlying Cause of Death	P17
	• Autopsy	P18
29	• Date of Diagnosis	T12
30	• Method of Diagnosis	T11
	• Date of Diagnosis	T12

ITEM NAME: Date of Death

FIELD NO.: P14

LENGTH: 8

TYPE: Numeric

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

VALUES & MEANING: Format: YYYYMMDD

YYYY: Four-digit year.
0000: Patient is not known to have died.
1969 - 2000: Valid years.
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 01.

All blank: Not applicable (Patient Record Type (Field No. P4) = 3).

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Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
10	• Date of Death	P14
	• Death Registration Number	P16
	• Underlying Cause of Death	P17
	• Autopsy	P18
11	• Death Registration Number	P16

ITEM NAME: Province/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/Country Code File (Appendix B).

000: Patient is not known to have died.
999: Province/country of death unknown.

All blank: Not applicable (Patient Record Type (Field No. P4) = 3).

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

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Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
10	• Date of Death	P14
	• Province/Country of Death	P15
	• Underlying Cause of Death	P17
	• Autopsy	P18
11	• Province/Country of Death	P15

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/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: Not applicable (Patient Record Type (Field No. P4) = 3).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
10	• Date of Death	P14
	• Province/Country of Death	P15
	• Death Registration Number	P16
	• Autopsy	P18

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 events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury".* It is coded using the ICD-9 codes according to international rules.

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

Omit any period/decimal (.).

VALUES & MEANING: Format: NNNN
or
NNNb

N: Any number (0 - 9)
b: blank ( )

Only numbers (0-9) or blank ( ) are valid. To be valid the code must be found on the ICD-9 Cause-of-Death Code File (Appendix C).

0000: Patient is not known to have died.
0009: The official Underlying Cause of Death is unknown.
7999: Underlying Cause of Death is coded as "unknown" on the death certificate.
All blank: Not applicable (Patient Record Type (Field No. P4) = 3).

* International Classification of Diseases, 9th Revision.

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Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
10	• Death of Death	P14
	• Province/Country of Death	P15
	• Death Registration Number	P16
	• Underlying Cause of Death	P17

ITEM NAME: Autopsy Confirming Cause of Death

FIELD NO.: P18

LENGTH: 1

TYPE: Numeric

DESCRIPTION: A 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/unknown if autopsy result taken into account by the stated cause of death.

All blank: Not applicable (Patient Record Type (Field No. P4) = 3).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
08	• Date of Birth	P11
09	• Date of Death	P14

ITEM NAME: Date of Transmission

FIELD NO.: P19

LENGTH: 8

TYPE: Numeric

DESCRIPTION: The date on which this copy of the patient record was extracted from the provincial registry for initial input, or subsequent update, into the CCR. This date would consist of the century, year, month and day.

VALUES & MEANING: The complete date on the computer at the time the patient record was extracted for transmission to Statistics Canada.

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

Valid dates are subsequently edited according to Routine 02.

Valid dates can be no later than the **CURRENT DATE*** nor earlier than 10 months prior to **CURRENT DATE.**

***CURRENT DATE** is the date on the computer clock when this edit is performed at the CCR.

TUMOUR RECORD

INPUT TUMOUR RECORD LAYOUT (T)

FIELD	SIZE	POSITION	TYPE	DESCRIPTION
1	2	1-2	N	Reporting Province
2	12	3-14	AN	Patient Identification Number
3	9	15-23	AN	Tumour Reference Number
4	9	24-32	AN	CCR Identification Number
5	1	33	N	Tumour Record Type
6	25	34-58	AN	Place Name of Residence at Time of Diagnosis
7	6	59-64	AN	Postal Code
8	7	65-71	N	Coded Place of Residence at Diagnosis
9	9	72-80	AN	Census Tract
10	15	81-95	AN	Health Insurance Number
11	1	96	N	Method of Diagnosis
12	8	97-104	N	Date of Diagnosis
13	4	105-108	AN	ICD-9
14	1	109	N	Source Classification Flag - (S.C.F.)
15	4	110-113	AN	ICD-O-2 - Topography
16	4	114-117	N	ICD-O-2 - Morphology
17	1	118	N	ICD-O-2 - M Behaviour Code
18	4	119-122	AN	ICD-10
19	1	123	N	Laterality
20	1	124	N	Multifocal Tumours
21	8	125-132	AN	filler
22	8	133-140	N	Date of Transmission

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
16	• Coded Place of Residence at Time of Diagnosis	T8
32	• Patient Identification Number	T2
	• Tumour Reference Number	T3
	• Tumour(I) Record Type	T5
33	• Patient Identification Number	T2
	• Tumour Reference Number	T3
	• CCR Identification Number	T4
	• Tumour(I) Record Type	T5

ITEM NAME: Reporting Province

FIELD NO.: T1

LENGTH: 2

TYPE: Numeric

DESCRIPTION: The standard geographic code (SGC) of the province/territory submitting the registration/update of the tumour record to the CCR.

VALUES & MEANING:

10: Newfoundland
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

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
32	• Reporting Province	T1
	• Tumour Reference Number	T3
	• Tumour(I) Record Type	T5
33	• Reporting Province	T1
	• Tumour Reference Number	T3
	• CCR Identification Number	T4
	• Tumour(I) Record Type	T5

ITEM NAME: Patient Identification Number

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.**

Note: Should be left justified followed by blanks as required. The CCR will replace any blanks to the left of the Patient Identification Number with zeroes, however, any blanks to the right will remain.

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

Cannot be all blank.

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
32	• Reporting Province	T1
	• Patient Identification Number	T2
	• Tumour(I) Record Type	T5
33	• Reporting Province	T1
	• Patient Identification Number	T2
	• CCR Identification Number	T4
	• Tumour(I) Record Type	T5

ITEM NAME: Tumour Reference Number

FIELD NO.: T3

LENGTH: 9

TYPE: Alphanumeric

DESCRIPTION: An identification number assigned, by the provincial/territorial cancer registry, as a reference to each new tumour reported to the CCR.

For each patient, the number must be unique, as its purpose is to distinguish between multiple primary tumours. It functions as part of the identification key of each tumour record, and can be created in any number of ways - e.g. sequentially for the patient, or sequentially for all tumours registered within a particular year.

Note: Should be left justified followed by blanks as required; if not, the CCR will left justify the Tumour Reference Number.

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 (-).

Cannot be all blank.

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
12	• Tumour Record Type	T5
	• Tumour Record, positions 34-132	n/a
33	• Reporting Province	T1
	• Patient Identification Number	T2
	• Tumour Reference Number	T3
	• Tumour(I) Record Type	T5

ITEM NAME: CCR I.D. Number

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 of the patient in the CCR.

Note: The CCR I.D. Number 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 would contain the CCR I.D. Number.

VALUES & MEANING: All blank or all numeric

All blank: new registration, no CCR I.D. Number has yet been assigned.

Cannot be all zeroes (000000000).

Number must be validated according to Modulus 10 (see Routine 03).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
12	• CCR Identification Number	T4
	• Tumour Record, positions 34-132	n/a
32	• Reporting Province	T1
	• Patient Identification Number	T2
	• Tumour Reference Number	T3
33	• Reporting Province	T1
	• Patient Identification Number	T2
	• Tumour Reference Number	T3
	• CCR Identification Number	T4

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

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 this particular tumour was diagnosed.

Note: tumours occurring in patients residing outside of Canada should not be reported.

VALUES & MEANING: All blank: Unknown/not applicable (Tumour Record Type (Field No. T5) = 3).

Upper and lower case alphabetics (A/a - Z/z), with or without accents, numbers (0 - 9), blanks ( ), periods (.), apostrophes ('), and hyphens (-) are valid.

If not all blank, must contain at least 2 alphabetic letters (A/a - Z/z).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
14	• Coded Place of Residence at Time of Diagnosis - 1st 2 digits	T8

ITEM NAME: Postal Code

FIELD NO.: T7

LENGTH: 6

TYPE: Alphanumeric

DESCRIPTION: The postal code of the patient's Canadian residence address at the time this tumour was diagnosed.

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: Not applicable (Tumour Record Type (Field No. T5) = 3).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
14	• Postal Code	T7
15	• Census Tract	T9
16	• Reporting Province	T1

ITEM NAME: Coded Place of Residence at Time of Diagnosis

FIELD NO.: T8

LENGTH: 7

TYPE: Numeric

DESCRIPTION: The standard geographic code (SGC) of the patient's Canadian residence at the time this tumour was diagnosed (see Field T6, Place of Residence at Time of Diagnosis). The code includes: province/territory (PR), 2 digits; census division (CD), 2 digits; and census subdivision (CSD), 3 digits.

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

For more details on the Standard Geographic Classification refer to Statistics Canada Catalogue No. 12-571, 12-572, 12-573.

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 current SGC Code File, (Appendix E).

PR00999: CD and CSD unknown.
PRCD999: CSD unknown.

Province/territory cannot be unknown.

All blank: Not applicable (Tumour Record Type (Field No. T5) = 3).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
15	• Coded Place of Residence at Time of Diagnosis	T8

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 2,500 to 8,000, with an average of 4,000.

They are designed as being as homogeneous as possible in terms of economic status and social conditions. All Census Metropolitain Areas (CMA's) and Census Agglomerations (CA's), containing a Census Subdivision (i.e. city) having a population of at least 50,000, are eligible to have Census Tracts.

Note: For more information on Census Tracts, refer to Statistics Canada Catalogue No. 99-121. Details on how to code or extract census tracts will be described in the CCR Policy and Procedures Manual.

VALUES & MEANING: Format: NNNNNN.NN
or
NNNNNNbbb

N = any number from 0-9.
. = .
b = blank

To be valid, the Census Tract code must be found on the Census Tract Dictionary (Appendix F).

000000.00: Not applicable - residence not in a Census Tract.
999999.99: Census Tract unknown/incomplete address.

All blank: Not applicable (Tumour Record Type (Field No. T5) = 3).

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ITEM NAME: Health Insurance Number

FIELD NO.: T10

LENGTH: 15

TYPE: Alphanumeric

DESCRIPTION: The patient's provincial health insurance number, and should be that of the province/ territory of the reporting cancer registry.

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

VALUES & MEANING: Can be composed of any combination of letters, numbers and special characters.

All (15) "9's": Unknown but resident in reporting province.

All blank: Not applicable (Tumour Record Type (Field No. T5) = 3).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
30	• Date of Death	P14
	• Date of Diagnosis	T12

ITEM NAME: Method of Diagnosis

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 status before any treatment, other than surgery, is given.

VALUES & MEANING: Categories of diagnostic methods are listed below in descending order of priority:

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: Not applicable (Tumour Record Type (Field No. T5) = 3).

* Histology should be recorded as the method of diagnosis whether the tissue was taken from the primary or a secondary site.

** "Death certificate only" means that 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.

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
17	• Date of Transmission	T22
28	• Date of Birth	P11
29	• Date of Death	P14
30	• Date of Death	P14
	• Method of Diagnosis	T11

ITEM NAME: Date of Diagnosis

FIELD NO.: T12

LENGTH: 8

TYPE: Numeric

DESCRIPTION: The date attached to the earliest known encounter with the health care system for that tumour.

This may refer to: (a) the date of first admission (inpatient or outpatient) to a hospital, clinic or other institution for the tumour in question; **or** (b) the date of first diagnosis of the tumour by a physician, or the date of the first pathology report; **or** (c) the date of death for cases diagnosed by death certificate only.

The Date of Diagnosis should not be later than 3 months after the earliest encounter with the health care system for that tumour. It includes century, year, month and day.

VALUES & MEANING: Format: YYYYMMDD

YYYY: Four digit year.
1992 - 2000: Valid years.
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 Routine 01.

All blank: Not applicable (Tumour Record Type (Field No. T5) = 3).

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Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
13	• S.C. Flag	T14
	• ICD-O-2 - Topography	T15
	• ICD-O-2 - Morphology	T16
	• ICD-10	T18
18	• S.C. Flag	T14
	• ICD-O-2 - Topography	T15
	• ICD-10	T18
20	• S.C. Flag	T14
	• ICD-O-2 - M Behaviour Code	T17
22	• S.C. Flag	T14
	• Laterality	T19
23	• S.C. Flag	T14
	• ICD-O-2 - Morphology	T16
31	• Sex	P10

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 No. T16.).

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

Can be 0000 only if ICD-O-2 - Topography (Field No. T15), or ICD-10 (Field No. T18) is reported.

Omit any period (.) in the code.

VALUES & MEANING: 0000: Not applicable (topography reported in Field No. T15, or Field No. T18).

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

All blank: Not applicable (Tumour Record Type (Field No. T5) = 3).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
13	• ICD-9	T13
	or	
	ICD-O-2 - Topography	T15
	or	
	ICD-10	T18
	• ICD-O-2 - Morphology	T16
18	• ICD-9	T13
	• ICD-O-2 - Topography	T15
	• ICD-10	T18
20	• ICD-9	T13
	or	
	ICD-10	T18
	• ICD-O-2 - M Behaviour Code	T17
21	• ICD-O-2 - Topography	T15
	• ICD-O-2 - M Behaviour Code	T17
22	• ICD-9	T13
	or	
	ICD-O-2 - Topography	T15
	or	
	ICD-10	T18
	• Laterality	T19
23	• ICD-9	T13
	or	
	ICD-O-2 - Topography	T15
	or	
	ICD-10	T18
	• ICD-O-2 - Morphology	T16

ITEM NAME: Source Classification Flag (S.C. Flag)

FIELD NO.: T14

LENGTH: 1

TYPE: Numeric

DESCRIPTION: The flag indicates the classification system in which the topography of the tumour was originally coded.

It is assumed that any other reported topography (i.e. - in addition to the classification system in which the topography was originally coded) is the result of a conversion from the source code.

For correlations 13, 20, 21, 22 and 23, the S.C. Flag precisely identifies which one of the 3 topography fields (ICD-9, ICD-O-2 - T, or ICD-10) will be edited.

VALUES & MEANING:
1: Topography originally coded in ICD-9.
2: Topography originally coded in ICD-O-2.
3: Topography originally coded in ICD-10.

All blank: Not applicable (Tumour Record Type (Field No. T5) = 3).

Note: The year 1992 is an exception, in that in some Registries, a number of topographies will be coded originally in ICD-O-1. These codes will be converted by the Registries into ICD-O-2 before submission to the CCR. The Source Classification Code in these cases will nevertheless be "2".

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
13	• ICD-9	T13
	• S.C. Flag	T14
	• ICD-O-2 - Morphology	T16
	• ICD-10	T18
18	• ICD-9	T13
	• Source Classification Flag	T14
	• ICD-10	T18
21	• S.C. Flag	T14
	• ICD-O-2 - M Behaviour Code	T17
22	• S.C. Flag	T14
	• Laterality	T19
23	• S.C. Flag	T14
	• ICD-O-2 - Morphology	T16
31	• Sex	P10
34-C	• ICD-O-2 - Topography(I)	T15
34-D	• ICD-O-2 - Topography(I)	T15

ITEM NAME: ICD-O-2 - Topography

FIELD NO.: T15

LENGTH: 4

TYPE: Alphanumeric

DESCRIPTION: The site of the neoplasm coded according to the International Classi-fication of Diseases for Oncology (2nd edition) - Topography Section.

Can be 0000 only if ICD-9 (Field No. T13), or ICD-10 (Field No. T18) is reported.

Omit any period (.) in the code.

VALUES & MEANING: 0000: Not applicable (topography reported in Field No. T13, or Field No. T18).

To be valid the code must be found on the ICD-O(2nd edition) - T Code File (Appendix H) as provided by Statistics Canada.

All blank: Not applicable (Tumour Record Type (Field No. T5) = 3).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
20	• S.C. Flag	T14
	• ICD-9	T13
	or	
	ICD-10	T18
21	• S.C. Flag	T14
	• ICD-O-2 - Topography	T15
24	• ICD-O-2 - Morphology	T16

ITEM NAME: ICD-O-2 - M Behaviour Code

FIELD NO.: T17

LENGTH: 1

TYPE: Numeric

DESCRIPTION: The behaviour associated with the histologic description of the neoplasm, reported in Field T16.

Note: Behaviour Codes "6" and "9" should not be reported to the CCR, whereas, Behaviour Code "0" should be reported only with a tumour of the central nervous system, including the brain.

Omit any slash (/) in the code

VALUES & MEANING:
0: Benign.
1: Uncertain whether benign or malignant/ Borderline malignancy.
2: Carcinoma in situ/Intraepithelial/ Noninfiltrating/Noninvasive.
3: Malignant, primary site.

All blank: Not applicable (Tumour Record Type (Field No. T5) = 3).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
13	• ICD-9	T13
	• S.C. Flag	T14
	• ICD-O-2 - Topography	T15
	• ICD-O-2 - Morphology	T16
18	• ICD-9	T13
	• Source Classification Flag	T14
	• ICD-O-2 - Topography	T15
20	• S.C. Flag	T14
	• ICD-O-2 - M Behaviour Code	T17
22	• S.C. Flag	T14
	• Laterality	T19
23	• S.C. Flag	T14
	• ICD-O-2 - Morphology	T16
31	• Sex	P10

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 No. T16).

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

Can be 0000 only if ICD-9 (Field No. T13), or ICD-O-2 - Topography (Field No. T15) is reported.

Omit any period (.) in the code.

VALUES & MEANING: 0000: Not applicable (topography reported in Field No. T13, or Field No. T15).

To be valid the code must be found on the ICD-10 Tumour Code File (Appendix J) as provided by Statistics Canada.

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

All blank: Not applicable (Tumour Record Type (Field No. T5) = 3).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
22	• S.C. Flag	T14
	• ICD-9	T13
	or	
	ICD-O-2 - Topography	T15
	or	
	ICD-10	T18
34-F	• Laterality(I)	T19

ITEM NAME: Laterality

FIELD NO.: T19

LENGTH: 1

TYPE: Numeric

DESCRIPTION: The site specific localization of the tumour in paired organs. It specifies whether the tumour is on the right, left, central 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
3: Central
4: Bilateral
9: Laterality unknown.

All blank: Not applicable (Tumour Record Type (Field No. T5) = 3).

ITEM NAME: Multifocal Tumours

FIELD NO.: T20

LENGTH: 1

TYPE: Numeric

DESCRIPTION: The existence of more than one focus of the tumour, each focus being of the same histological type and occurring in the same subsite.

VALUES & MEANING:
1: Yes, this is multifocal tumour.
2: No, this is not a multifocal tumour.
9: Unknown.

All blank: Not applicable (Tumour Record Type (Field No. T5) = 3).

Relevant Correlation Edits

Correlation Number	Correlated Fields	Field Number
17	• Date of Diagnosis	T12

ITEM NAME: Date of Transmission

FIELD NO.: T22

LENGTH: 8

TYPE: Numeric

DESCRIPTION: The date on which this copy of the tumour record was extracted from the provincial registry for input into the CCR. This date would consist of the century, year, month and day.

VALUES & MEANING: The complete date on the computer at the time the tumour record was extracted for transmission to Statistics Canada.

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

Valid dates are subsequently edited according to Routine 02.

Valid dates can be no later than the **CURRENT DATE***, nor earlier than 10 months prior to **CURRENT DATE**.

***CURRENT DATE** is the date on the computer clock when this edit is performed at the CCR.

ROUTINES

PURPOSE: To ensure that, for dates, there is no stated day with a not stated month, nor a stated month with a not stated year, and to ensure that the "not applicable" codes are applied only to the entire date - year, month and day together.

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 with the "not applicable" codes and/or with the "not stated" codes.
2: No error - go to Routine 02.

PURPOSE: To ensure that Day does not exceed the valid maximum for any given Month, when a completed date (ie. year, month, day) is important

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 - Day exceeds valid maximum.

PURPOSE: To validate the check digit on the CCR Identification Number.

FORMAT: $N_1N_2N_3N_4N_5N_6N_7N_8C$

N_1 to N_8 : first 8 digits of the CCR Identification Number.
C : Check digit.

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

1 → 2
2 → 4
3 → 6
4 → 8
5 → 1
6 → 3
7 → 5
8 → 7
9 → 9
0 → 0

Step 2 : Add the original the values of N_1, N_3, N_5, N_7, to the transformed N_2, N_4, N_6, 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 with invalid check digits are invalid numbers.

INPUT CONSISTENCY

INPUT MATCH EDITS

Within a province's data submission, comprised of Patient Records and Tumour Records, the Input Match Edits ensure that each person's set of records is complete and makes sense in terms of the operations to be performed (i.e. add, change, delete, change-of-ownership).

FIELDS INVOLVED: Reporting Province (Field P1)
Patient Identification Number (Field P2)

DESCRIPTION: Within any data submission, there can be only one operation (i.e. add, delete, change, or change ownership) affecting a specific Patient Record. Also, there cannot be duplicate operations.

EDIT SPECIFICATION: Within any data submission, there cannot be more than one Patient Record having identical Reporting Province and Patient Identification Number.

FIELDS INVOLVED: Reporting Province (Field T1)
Patient Identification Number (Field T2)
Tumour Reference Number (Field T3)

DESCRIPTION: Within any data submission, there can be only one operation (i.e. add, delete, change) affecting a specific Tumour Record. Also, there cannot be duplicate operations.

EDIT SPECIFICATION: Within any data submission, there cannot be more than one Tumour Record having identical Reporting Province, Patient Identification Number and Tumour Reference Number.

FIELDS INVOLVED: Reporting Province (Field P1)
Patient Identification Number (Field P2)
Patient Record Type (Field P4)

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

DESCRIPTION: When a person is registered onto the Canadian Cancer Registry for the first time by a province, there should be only new Tumour Records accompanying 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 and Patient Identification Number, but with no reported CCR Identification Number (all blank);

(2) there cannot be a new Tumour Record having an identical Reporting Province, Patient Identification Number as well as a reported CCR Identification Number;

(3) and, there cannot be an update or delete Tumour Record (Tumour Record Type = 2 or 3) with an identical Reporting Province and Patient Identification Number.

FIELDS INVOLVED: Reporting Province (Field P1)
Patient Identification Number (Field P2)
Patient Record Type (Field P4)

Reporting Province (Field T1)
Patient Identification Number (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.

Because it is not possible to know the number of Tumour Records attached to any particular Patient Record at the time of data submission, 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, Patient Identification Number and CCR Identification Number;

(2) there cannot be a delete Tumour Record with an identical Reporting Province and Patient Identification Number, but having a different CCR Identification Number;

(3) and, there cannot be a new or update Tumour Record (Tumour Record Type = 1 or 2) with an identical Reporting Province and Patient Identification Number.

FIELDS INVOLVED: Reporting Province (Field P1)
Patient Identification Number (Field P2)
CCR Identification Number (Field P3)
Patient Record Type (Field P4)

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

DESCRIPTION: A change of ownership takes place only when a province wishes to register a new tumour for a person already on the registry, but whose PATIENT RECORD belongs to another province. In order to effect this change, the CCR Identification Number must be known and used (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, Patient Identification Number and CCR Identification Number;

(2) there cannot be a new Tumour Record with an identical Reporting Province and Patient Identification Number, but having a different or unreported CCR Identification Number;

FIELDS INVOLVED: Reporting Province (Field P1)
Patient Identification Number (Field P2)
CCR Identification Number (Field P3)
Patient Record Type (Field P4)

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

DESCRIPTION: New Tumour Records not having a CCR Identification Number should only occur when it is the first tumour which the province is registering for that person, and therefore should be accompanied by a new Patient Record in the same data submission.

EDIT SPECIFICATION: For every new Tumour Record (Tumour Record Type = 1) with a blank CCR Identification Number, there must be a new Patient Record (Patient Record Type = 1) with a blank CCR Identification Number, having an identical Reporting Province and Patient Identification Number.

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 the reasonableness of the input relative to what already exists on the CCR. 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.

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Correlation Number	Fields Involved	Field Number	Page Number
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	• Tumour Record - positions 34-132		
13	• ICD-9	T13	114
	• S.C. Flag	T14	
	• ICD-0-2 - Topography	T15	
	• ICD-0-2 - Morphology	T16	
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14	• Postal Code	T7	115
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15	• Coded Place of Residence at Diagnosis	T8	116
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17	• Date of Diagnosis	T12	118
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Correlation Number	Fields Involved	Field Number	Page Number
TUMOUR RECORD - continued			
21	• S.C. Flag	T14	
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22	• S.C. Flag	T14	
	• ICD-9	T13	124
	or		
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	• Laterality	T19	
23	• S.C. Flag	T14	
	• ICD-9	T13	126
	or		
	ICD-O-2 - Topography	T15	
	or		
	ICD-10	T18	
	• ICD-O-2 - Morphology	T16	
24	• ICD-O-2 - Morphology	T16	127
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PATIENT(I) vs PATIENT			
25	• Reporting Province	P1	129
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27	• Reporting Province	P1	131
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Correlation Number	Fields Involved	Field Number	Page Number
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	• Method of Diagnosis	T11	
	• Date of Diagnosis	T12	
31	• Sex	P10	136
	• Site:		
	ICD-9	T13	
	or		
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TUMOUR(I) vs TUMOUR			
32	• Reporting Province	T1	137
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33	• Reporting Province	T1	138
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	• CCR Identification Number	T4	
	• Tumour(I) Record Type	T5	

Correlation Number	Fields Involved	Field Number	Page Number
TUMOUR(I) vs TUMOUR - continued			
34-A	• ICD-O-2 - Morphology	T16	139
34-B	• ICD-O-2 - Morphology	T16	140
34-C	• ICD-O-2 - Topography	T15	141
34-D	• Site: ICD-O-2 - Topography - 1st 3 char.	T15	142
	• Subsite: ICD-O-2 - Topography - 4th digit	T15	
34-E	• ICD-O-2 - Morphology	T16	143
34-F	• Laterality	T19	144

CORRELATION EDITS

PATIENT RECORD

FIELDS INVOLVED: CCR Identification Number (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 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 cannot be all blank, and positions 25 to 146 cannot be all blank.

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

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 effect a change-of-ownership, a Patient Record must have a stated CCR Identification Number (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 (≠9), and Year of Birth must be stated (≠9999).

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.

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 = 0 (not applicable). If there is a response in Current Surname, then the Type of Current Surname must = 1, 2 or 9.

FIELDS INVOLVED: Type of Current Surname (Field P5)
Current Surname (Field P6)
Birth/Maiden Surname (Field P13)

DESCRIPTION: In the situation where the Current Surname is described as the Birth/Maiden Surname in Field P5, this edit checks the consistency between the Birth/Maiden Surname and the Current Surname.

EDIT SPECIFICATION: If Type of Current Surname = 1 (Birth/ Maiden Surname), then the Current Surname must be the same as the Birth/Maiden Surname.

FIELDS INVOLVED: Current Surname (Field No. 6)
Birth/Maiden Surname (Field No. 13)

DESCRIPTION: A surname must be reported on the patient record, either as a Current Surname or as A Birth/Maiden Surname.

EDIT SPECIFICATION: Current Surname and Birth/Maiden Surname cannot both be blank.

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
Yr of Death = 9999	-	Y	N	N	N	N	N	N	N	N	N	N
Yr of Birth = 9999	-	-	Y	N	N	N	N	N	N	N	N	N
Yr of Death > Yr of Birth	-	-	-	Y	N	N	N	N	N	N	N	N
Yr of Death = Yr of Birth	-	-	-	N	Y	Y	Y	Y	Y	Y	Y	N
Mth of Death = 99	-	-	-	-	Y	N	N	N	N	N	N	-
Mth of Birth = 99	-	-	-	-	-	Y	N	N	N	N	N	-
Mth of Death > Mth of Birth	-	-	-	-	-	-	Y	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

Messages:

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

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

Messages:

0: No error.

1: Error - birth occurred after Date of Transmission.

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

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

FIELDS INVOLVED: Date of Death (Field P14)
Province/Country of Death (Field P15)
Death Registration Number (Field P16)
Underlying Cause of Death (Field P17)
Autopsy (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 all the remaining fields in the set should be equal to all zeroes.

FIELDS INVOLVED: Province/Country of Death (Field P15)
Death Registration Number (Field P16)

DESCRIPTION: This edit ensures that the death Registration Number is accurately reported when the Province/Country of Death is reported as being outside Canada.

EDIT SPECIFICATION: Decision Logic Table

Conditions:

Prov./Country of Death	= 000	Y	N	N	N	N	N	N	N	N	N	N
Prov./Country of Death	= 909	N	Y	Y	Y	N	N	N	N	N	N	N
909 < Prov./Country of Death	< 999	N	N	N	N	Y	Y	Y	N	N	N	N
Prov./Country of Death	= 999	N	N	N	N	N	N	N	Y	Y	Y	N
Death Reg. Number	= 999998	-	Y	N	N	Y	N	N	Y	N	N	Y
Death Reg. Number	= 999999	-	N	Y	N	N	Y	N	N	Y	N	N
Actions:		0	1	0	2	1	0	0	0	3	0	4

Messages:

0: No error.
1: Error - died in Canada but the Death Registration Number indicates died abroad.
2: Error - unknown Province of Death with a known Death Registration Number.
3: Error - unknown Province/Country of Death with a Canadian Death Registration Number.
4: Error - died abroad but Death Registration Number is not equal to 999998 (Patient died outside of Canada).

CORRELATION EDITS

TUMOUR RECORD

FIELDS INVOLVED: CCR Identification Number (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 cannot be all blank, and positions 34 to 132 cannot be all blank.

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

FIELDS INVOLVED: S.C. Flag (Field T14)
Site: ICD-9 (Field T13)
or
ICD-O-2 - Topography (Field T15) -
or
ICD-10 (Field T18)

Histological
Group: ICD-O-2 - Morphology
(Field T16) - 1st 3 digits

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 3 digits of ICD-O-2 - Morphology cannot be in the range of 805 to 808 or 809 to 811.

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

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

FIELDS INVOLVED: Postal Code (Field T7) - 1st digit
Coded Place of Residence at Time of Diagnosis (Field T8) - 1st 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 Coded Place of Residence at Time of Diagnosis.

Province/Territory	Code	Allowable First Digit of the Postal Code
Newfoundland	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

FIELDS INVOLVED: Coded 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 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: A valid code for the Census Tract is one that must be found on 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 7-digit Standard Geographic Code found on the matching record on the Census Tract Dictionary.

FIELDS INVOLVED: Reporting Province (Field T1)
Coded Place of Residence at Time of Diagnosis (Field T8) - 1st 2 digits

DESCRIPTION: Provinces/Territories are to register only those cancers for patients who were their residents at the time of diagnosis. This edit rejects those who were living outside of the reporting province when the diagnosis took place.

EDIT SPECIFICATION: Reporting Province must be equal to the first 2 digits of the Coded Place of Residence at Time of Diagnosis (i.e. province/territory of residence).

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 Transmission	>	Yr of Diagnosis	Y	N	N	N	N	N	N	N
Yr of Transmission	=	Yr of Diagnosis	N	Y	Y	Y	Y	Y	Y	N
Mth of Diagnosis	=	99	-	Y	N	N	N	N	N	-
Mth of Transmission	>	Mth of Diagnosis	-	-	Y	N	N	N	N	-
Mth of Transmission	=	Mth of Diagnosis	-	-	N	Y	Y	Y	N	-
Day of Diagnosis	=	99	-	-	-	Y	N	N	-	-
Day of transmission	≥	Day of Diagnosis	-	-	-	-	Y	N	-	-
Actions:			0	0	0	0	0	1	1	1

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

FIELDS INVOLVED: ICD-9 (Field T13)
Source Classification Flag - (S.C.F.) (Field T14)
ICD-O-2 - 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 be both reported.

EDIT SPECIFICATION: Decision Logic Table

Conditions:

ICD-9 = 0000	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	N
ICD-O-2 - Topography = 0000	Y	Y	Y	Y	N	N	N	N	N	Y	Y	Y	Y	N	N	N
ICD-10 = 0000	Y	N	N	N	Y	Y	Y	N	N	N	Y	Y	Y	N	Y	Y
S.C.F. = 1	-	Y	N	N	Y	N	N	Y	N	N	Y	N	N	-	Y	N
S.C.F. = 2	-	N	Y	N	N	Y	N	N	Y	N	N	Y	N	-	N	Y
Actions:	1	2	3	0	2	0	4	2	0	0	0	3	4	5	0	0

Messages:

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

D E L E T E D

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FIELDS INVOLVED:

S.C. Flag (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 - 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; and it allows only tumours of the central nervous system, including brain, to have a Behaviour Code, /0 (benign).

EDIT SPECIFICATION:

When S.C. Flag = 1 (topography originally coded in ICD-9).

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

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

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

continued ...

EDIT SPECIFICATION: (cont'd)

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)

When S.C. Flag = 3 (topography originally coded in ICD-10).

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

FIELDS INVOLVED: S.C. Flag (Field T14)
ICD-O-2 - Topography (Field T15)
ICD-O-2 - M Behaviour Code (Field T17)

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 S.C. Flag = 2 (topography originally coded in ICD-O-2),** and the Behaviour Code = 0, then the ICD-O-2 - Topography must be in the range C70.0 - C72.9

FIELDS INVOLVED:

S.C. Flag (Field T14)
Laterality (Field T19)
ICD-9 (Field T13)
or
ICD-O-2 - Topography (Field T15)
or
ICD-10 (Field T18)

DESCRIPTION:

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

EDIT SPECIFICATION:

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

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

continued ...

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-0-2	ICD-9	ICD-10	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**
Accesssory 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

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-0-2**	**ICD-9**	**ICD-10**	**Correct Laterality Codes**
Connective, subcutaneous, & other soft tissues of upper limb and shoulder	C49.1	171.2	**	1,2,9
Connective, subcutaneous, & other soft tissues of lower limb and hip	C49.2	171.3	**	1,2,9
Breast	C50.-	174.-, 175, 233.0, 238.3	**	1,2,9
Testis	C62.-	186.-, 236.4	**	1,2,9
Epididymis	**C63.0**	**187.5**	**	**1,2,9**
Spermatic cord	**C63.1**	**187.6**	**	**1,2,9**
Overlapping lesion of male genital organs	*C63.8*	*187.8*	**	*0,1,2,9*
Kidney	C64.9	189.0	**	1,2,4[1],9
Renal pelvis	C65.9	189.1	**	1,2,9
Ureter	C66.9	189.2	**	1,2,9
Overlapping lesion of urinary organs	C68.8	*189.8*	**	*0,1,2,4,9*
Eye	C69.-	190.-, 234.0	**	1,2,4[1],9
Brain, excluding brain stem	C71.- (excl. C71.7)	191.-, (excl. 191.7)	**	1,2,9
Overlapping lesion of brain and central nervous system	*C72.8*	*192.8*	**	*0,1,2,9*
Thyroid gland	C73.9	193	**	1,2,9
Adrenal gland	C74.-	194.0, 237.2	**	1,2,9
Other and ill-defined sites of upper limb, NOS	*C76.4*	*195.4*	**	*1,2,9*
Other and ill-defined sites of lower limb, NOS	*C76.5*	*195.5*	**	*1,2,9*
Unknown primary site	*C80.9*	*199.-*	**	*0,1,2,3,4,9*
ALL OTHER SITES	C00.0 - C77.9	140.0 - 195.8, 200.0 - 208.9	**	*0*
ICD-9 SITES OF NON-MALIGNANT TUMOURS NOT LISTED ABOVE	---	210.0 - 239.9	**	*0,1,2,3,4,9*

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

--- Equivalent code does not exist

** Not now available - awaiting ICD-10 documentation.

FIELDS INVOLVED:

S.C. Flag (Field T14)
ICD-9 (Field T13)
or
ICD-O-2 - Topography (Field T15)
or
ICD-10 (Field T18)
ICD-O-2 - Morphology (Field T16)

DESCRIPTION:

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

EDIT SPECIFICATION:

When the S.C. Flag = 1

Site/morphology combinations that are found on the Invalid ICD-9 S/M Code List (Appendix K) are in error.

When the S.C. Flag = 2

Site/morphology combinations that are found on the Invalid ICD-O-2 S/M Code List (Appendix L) are in error.

When the S.C. Flag = 3

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

FIELDS INVOLVED: ICD-O-2 - Morphology (Field T16)
ICD-O-2 - M Behaviour Code (Field T17)

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 9723, or in the range 9800 to 9941, then the Behaviour Code must equal "3".

For cancers with a Behaviour Code = "2" (in situ), the invalid ICD-O-2 - Morphology codes are found on the Invalid In Situ Morphologies List (Appendix N).

CORRELATION EDITS

PATIENT RECORD(I) 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 data base.

FIELDS INVOLVED: Reporting Province (Field P1)
Patient Identification Number (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 person 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 and Patient Identification Number.

FIELDS INVOLVED: Reporting Province (Field P1)
Patient Identification Number (Field P2)
CCR Identification Number (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, Patient Identification Number and CCR Identification Number.

FIELDS INVOLVED: Reporting Province (Field P1)
CCR Identification Number (Field P3)
Patient Record Type (Field P4)
Sex (Field P10)
Year of Birth: Date of Birth (Field P11) - 1st 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, but from a different province. In order to ensure that it is in fact the same person, 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 already on the Registry with an identical CCR Identification Number, a different Reporting Province, and an identical Sex (when reported) and Year of Birth (when reported).

CORRELATION EDITS

TUMOUR RECORD versus PATIENT RECORD

Each Patient Record, with its associated Tumour Record(s), refers to an individual patient. When a patient is first registered on the CCR, the new Tumour Record(s) is compared to the Patient Record. Any subsequent new or update Tumour Record will also be compared to that 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.

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
Yr of Birth > Yr of Diagnosis	-	Y	N	N	N	N	N	N	N	N	N
Yr of Birth < Yr of Diagnosis	-	N	Y	Y	N	N	N	N	N	N	N
(Yr of Diagnosis - Yr of Birth) > 117	-	-	Y	N	-	-	-	-	-	-	-
Mth of Birth = 99	-	-	-	-	Y	N	N	N	N	N	N
Mth of Diagnosis = 99	-	-	-	-	-	Y	N	N	N	N	N
Mth of Birth > Mth of Diagnosis	-	-	-	-	-	-	Y	N	N	N	N
Mth of Birth < Mth of Diagnosis	-	-	-	-	-	-	N	Y	N	N	N
Day of Birth = 99	-	-	-	-	-	-	-	-	Y	N	N
Day of Diagnosis = 99	-	-	-	-	-	-	-	-	-	Y	N
Day of Birth > Day of Diagnosis	-	-	-	-	-	-	-	-	-	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.

FIELDS INVOLVED: Date of Death (Field P14)
Date of Diagnosis (Field T12)

DESCRIPTION: When both the years and months of the Dates of Diagnosis and Death are reported, and diagnosis takes place after death, this edit ensures that the Date of Diagnosis is no later than in the third month after death.

EDIT SPECIFICATION: Decision Logic Table

Conditions:

Yr of Death = 0000	Y	N	N	N	N	N	N	N	N	N	N
Yr of Death = 9999	-	Y	N	N	N	N	N	N	N	N	N
Yr of Diagnosis > Yr of Death	-	-	Y	Y	Y	Y	Y	N	N	N	N
Yr of Diagnosis = Yr of Death	-	-	N	N	N	N	N	Y	Y	Y	Y	N
(Yr of Diagnosis - Yr of Death) > 1	-	-	Y	N	N	N	N	-	-	-	-	-
Mth of Death = 99	-	-	-	Y	N	N	N	Y	N	N	N	-
Mth of Diagnosis = 99	-	-	-	-	-	Y	N	N	-	Y	N	N	-
((Mth of Diagnosis + 12) - Mth of Death) > 3	-	-	-	-	-	-	Y	N	-	-	-	-	-
(Mth of Diagnosis - Mth of Death) > 3	-	-	-	-	-	-	-	-	-	-	Y	N	-
Actions:	0	0	1	0	0	1	0	0	0	1	0	0

Messages:

0: No error.
1: Error - diagnosis occurred more than 3 months after Date of Death.

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FIELDS INVOLVED: Date of Death (Field P14)
Method of Diagnosis (Field T11)
Date of Diagnosis (Field T12)

DESCRIPTION: This edit assures that the Method of Diagnosis accurately reflects the relationship between the Date of Diagnosis and the Date of Death.

EDIT SPECIFICATION: Decision Logic Table

Conditions

Yr of Death = 0000	Y	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Yr of Death = 9999	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Yr of Death > Yr of Diag.	-	-	-	-	Y	Y	Y	N	N	N	N	N	N	N	N	N	N	N
Yr of Death = Yr of Diag.	-	-	-	-	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
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	N	-
Mth of Death > Mth of Diag.	-	-	-	-	-	-	-	-	Y	Y	Y	N	N	N	N	N	N	-
Mth of Death = Mth of Diag.	-	-	-	-	-	-	-	-	N	N	N	Y	Y	Y	Y	Y	Y	N	-
Day of Death = 99	-	-	-	-	-	-	-	-	-	-	-	-	Y	N	N	N	N	-	-
Day of Diag. = 99	-	-	-	-	-	-	-	-	-	-	-	-	Y	N	N	N	N	-	-
Day of Death > Day of Diag.	-	-	-	-	-	-	-	-	-	-	-	-	Y	Y	Y	N	-	-
Method of Diag. = 2	Y	N	N	-	Y	N	N	-	-	Y	N	N	-	-	Y	N	N	-	-	-
Method of Diag. = 6	N	Y	N	-	N	Y	N	-	-	N	Y	N	-	-	N	Y	N	-	-	-

Actions:	1	1	0	0	0	2	0	0	0	0	2	0	0	0	0	2	0	0	0	0

Messages:

0: No error.
1: Error - Year of Death shows the patient alive, but Method of Diagnosis is either "death certificate only", or "autopsy".
2: Error - Method of Diagnosis of "death certificate only" made before patient died.

FIELDS INVOLVED: Sex (Field P10)
Site: ICD-9 (Field T13)
or
ICD-O-2 - 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 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: 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: 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".

CORRELATION EDITS

TUMOUR RECORD(I) 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 - i.e. when its Tumour Record Type (Field T15) = 1 or 2 respectively. "Delete" records, Tumour Record Type = 3, only pass through correlation no. 33.

Every Tumour(I) must be compared to all other Tumour Records on the Registry for that same person - i.e. sharing the same Patient Record and having identical CCR Identification Numbers.

FIELDS INVOLVED: Reporting Province (Field T1)
Patient Identification Number (Field T2)
Tumour Reference Number (Field T3)
CCR Identification Number (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 Number is reported on a new tumour record (thus indicating that there has been a tumour already registered for this patient),

(i) the new tumour record finds 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 as any previous tumour record, for the same patient, from the same Reporting Province.

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, Patient Identification and Tumour Reference Number;

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

(i) there must be a Tumour Record already on the Registry with the identical CCR Identification Number; and

(ii) there cannot be a Tumour Record already on the Registry with an identical CCR Identification Number and Reporting Province, but with a different Patient Identification Number.

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FIELDS INVOLVED: Reporting Province (Field T1)
Patient Identification Number (Field T2)
Tumour Reference Number (Field T3)
CCR Identification Number (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 identical Reporting Province, Patient Identification Number, CCR Identification and Tumour Reference Numbers.

FIELDS INVOLVED: ICD-O-2 - Morphology (Field T16)

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-2 - 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 No. 34-B.

Otherwise, proceed to Correlation No. 34-C.

FIELDS INVOLVED: ICD-O-2 - Morphology (Field T16)

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 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.

Note: Tumour records containing a duplicate primary tumour are rejected.

FIELDS INVOLVED: ICD-O-2 - 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) ICD-O-2 - Topography and the Tumour ICD-O-2 - Topography Codes are found among the code pairs listed in Appendix O, then proceed to Correlation No. 34-E.

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

FIELDS INVOLVED: Site: ICD-O-2 - Topography (Field T15) - 1st 3 char.

Subsite: ICD-O-2 - 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 34-E.
1: Different subsite - distinct tumour.
2: Different site - distinct tumour.

FIELDS INVOLVED: ICD-O-2 - Morphology (Field T16)

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 No. 34-F.

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

FIELDS INVOLVED: Laterality (Field T19)

DESCRIPTION: This is the last of 3 correlations 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 = Laterality	N	Y	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
Tumour(I) Laterality = 4	N	-	N	N	N	Y	Y	Y	N	N	N	N	N
Tumour(I) Laterality = 9	N	-	N	N	N	N	N	N	Y	Y	Y	N	N
Laterality = 0	N	-	-	-	-	Y	N	N	Y	N	N	Y	N
Laterality = 4	N	-	Y	N	N	-	-	-	N	Y	N	N	Y
Laterality = 9	N	-	N	Y	N	N	Y	N	-	-	-	N	N
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: Tumour records containing a duplicate tumour are rejected.

ADDITIONAL RULES

FOR UPDATING

THE CANADIAN CANCER REGISTRY

ADDITIONAL RULES

FOR

UPDATING THE CANADIAN CANCER REGISTRY

Certain correlation edits (viz. 25, 26, 27, 32 & 33) exist to ensure that any changes to the CCR make sense, and that the final result respects the internal logic of the CCR and the manner in which it is structured. The following are some additional rules for updating or changing the CCR, which do not fall easily into the five preceding categories of correlations. Any violation of these rules will also cause the responsible input record(s) to be rejected.

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

(2) If all the tumour records associated with a patient record (i.e. sharing the same CCR Identification Number) 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

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 persons and tumours. In addition, they are used to match with mortality records to facilitate death clearance.

To increase the likelihood of effectively performing these activities, the standard reporting of names is strongly encouraged. The edits themselves accept any alphabetic letter in addition to blanks, apostrophes (') and hyphens (-). These requirements should be considered the minimum.

It would be better if the following restrictions were also actively applied:

(a) the use of only upper case alphabetic letters with no accents;

(b) the removal of all special characters within the name except hyphens; this would mean the removal of apostrophes and embedded blanks;

(c) for names starting with "SAINTE" or "SAINT", the consistent use of the abbreviations "STE" and "ST" respectively, and dropping 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
	St-Jacques	→	STJACQUES
	Saint	→	SAINT
	Dr. Patel	→	PATEL
	Cheung, Ph. D	→	CHEUNG
	Sr. Mary-Catherine	→	MARY-CATHERINE
	P.-E.	→	P-E
	Van der Bijl	→	VANDERBIJL
	Côté	→	COTE
	MacDonald	→	MACDONALD

31/10/91

APPENDIX B

Province/Country Code File

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

APPENDIX B: PROVINCE / COUNTRY CODES

Field	Size	Position	Type	Title
1	3	1 - 3	N	ISO province / country codes
2	3	4 - 6	A	Blank
3	39	7 - 45	A	Description (English)
4	35	46 - 80	A	Description (Français)

APPENDIX C

ICD-9 Cause of Death Code File

Note: This file is referenced in Patient Validation Edit P17.

APPENDIX C: ICD - 9 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 (Français)

APPENDIX D

ICD-10 Cause of Death Code File

NOT
NOW
AVAILABLE
-
AWAITING
ICD-10
DOCUMENTATION

Note: This file is not referenced at present. It will be used in Patient Validation Edit P17 in 1996.

APPENDIX D: ICD - 10 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 (Français)

APPENDIX E

SGC Code File

Note: This file is referenced in Tumour Validation Edit T8.

APPENDIX E: STANDARD GEOGRAPHIC CODE (SGC) FILE

Field	Size	Position	Type	Title
1	7	1 - 7	N	S G 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)

APPENDIX F

Census Tract Dictionary

Note: This file is referenced in Tumour Validation Edit T9, and Correlation Edit 15.

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

APPENDIX G

ICD-9 Tumour Code File

Note: This file is referenced in Tumour Validation Edit T13. It contains only those valid Chapter 2 codes that are reportable to the Canadian Cancer Registry.

STATISTICS CANADA
Canadian Cancer Registry

APPENDIX G: ICD - 9 TUMOUR CODE FILE

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

APPENDIX H

ICD-O(2nd edition) - T Code File

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

STATISTICS CANADA
Canadian Cancer Registry

APPENDIX H: ICD-0 - 2 TOPOGRAPHY CODE FILE

Field	Size	Position	Type	Title
1	4	1 - 4	AN	ICD-0 - 2 Topography codes
2	80	5 - 84	A	Description (English)

APPENDIX I

ICD-O(2nd edition) - M Code File

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

APPENDIX I: ICD-O - 2 MORPHOLOGY CODE FILE

Field	Size	Position	Type	Title
1	4	1 - 4	N	ICD-0 - 2 Morphology codes
2	21	5 - 25	AN	Blank

APPENDIX J

ICD-10 Tumour Code File

NOT
NOW
AVAILABLE
-
AWAITING
ICD-10
DOCUMENTATION

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

STATISTICS CANADA
Canadian Cancer Registry

APPENDIX J: ICD - 10 TUMOUR CODE FILE

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

APPENDIX K

INVALID ICD-9 S/M CODE LIST

Note: This list is referenced in Correlation Edit 23.

INVALID ICD-9 SITE/MORPHOLOGY CODE LIST

ICD-9	Site	ICD-O-2 Morphology	Histology
1400-1409	Lip	8090-8096	Basal cell carcinoma
1540 1541,2304 1542-1548, 2305,2306	Rectosigmoid junction Rectum Anus and anal canal	8090-8096	Basal cell carcinoma
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 1700-1709, 2380	Pleura and mediastinum Bone	8010-8671, 8940-8941 8720-8790	Carcinomas Melanomas
1921,1923, 2376	Meninges	8010-8671, 8940-8941	Carcinomas

APPENDIX L

INVALID ICD-O-2 S/M CODE LIST

Note: This list is referenced in Correlation Edit 23.

INVALID ICD-O-2 SITE/MORPHOLOGY CODE LIST

ICD-O-2 Topography	Site	ICD-O-2 Morphology	Histology
C000-C009	Lip	8090-8096	Basal cell carcinoma
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

APPENDIX M

INVALID ICD-10 S/M CODE LIST

**NOT
NOW
AVAILABLE
-
AWAITING
ICD-10
DOCUMENTATION**

Note: This list is not referenced at present. It will be used in Correlation Edit 23.

APPENDIX N

INVALID IN SITU MORPHOLOGIES CODE LIST

Note: This list is referenced in Correlation Edit 24.

INVALID IN SITU MORPHOLOGIES 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 - 9241	Osseous and chondromatous neoplasms
9250 - 9251	Giant cell tumours
9260 - 9262	Miscellaneous bone tumours
9270 - 9340	Odontogenic tumours
9350 - 9370	Miscellaneous tumours
9380 - 9481	Gliomas
9490 - 9523	Neuroepitheliomatous neoplasms
9530 - 9539	Meningiomas
9540 - 9570	Nerve sheath tumours
9580 - 9581	Granular cell tumours and alveolar soft part sarcoma
9590 - 9709	Malignant lymphoma, NOS or diffuse
9711 - 9714	Other specified non-Hodgkin's lymphomas
9720 - 9723	Other lymphoreticular neoplasms
9731 - 9732	Plasma cell tumours
9740 - 9741	Mast cell tumours
9760 - 9768	T-gamma lymphoproliferative disease
9800 - 9941	Leukemias
9950 - 9970	Miscellaneous myeloproliferative and lymphoproliferative disorders (C42.1)
9980 - 9989	Myelodysplastic syndrome (C42.1)

APPENDIX O

EQUIVALENT TOPOGRAPHIES LIST

FOR

OVERLAPPING

AND

UNSPECIFIED SITES

Note: This list is referenced in Correlation Edit 34-C.

EQUIVALENT TOPOGRAPHIES LIST
FOR OVERLAPPING AND UNSPECIFIED SITES

Tumour(I) ICD-O-2 - Topography	Tumour ICD-O-2 - Topography
C02.8 & C02.9 C08.8 C13.8 C14.8 C21.8 C24.8 C26.8 C39.8 C41.8 C57.8 C57.8 C63.8 C68.8 C72.8 C80.9	C01.9 C07.9 C12.9 C00.0 to C13.9 C19.9 to C20.9 C22.0 to C23.9 C15.0 to C25.9 C30.0 to C38.8 C40.0 to C40.9 C51.0 to C56.9 C58.9 C60.0 to C62.9 C64.9 to C67.9 C70.0 to C71.9 C00.0 to C77.9
C01.9 C07.9 C12.9 C00.0 to C13.9 C19.9 to C20.9 C22.0 to C23.9 C15.0 to C25.9 C30.0 to C38.8 C40.0 to C40.9 C51.0 to C56.9 C58.9 C60.0 to C62.9 C64.9 to C67.9 C70.0 to C71.9 C00.0 to C77.9	C02.8 & C02.9 C08.8 C13.8 C14.8 C21.8 C24.8 C26.8 C39.8 C41.8 C57.8 C57.8 C63.8 C68.8 C72.8 C80.9

APPENDIX P

"SAME MORPHOLOGY" WORK TABLE

The use of the "Same 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, first the lower of the 2 morphology code numbers must 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 2 morphologies can be considered as the same. If both morphology codes are identical, the morphologies are the same, and reference to this "Same Morphology" Work Table is not necessary.

Note: This table is referenced in Correlation Edits 34-B & 34-E.

"SAME MORPHOLOGY" WORK TABLE
(for determining multiple primary neoplasms)

MORPHOLOGY CODE	CONSIDERED SAME AS
(Note: A dash (-) used in the fourth digit position indicates any valid fourth digit).	
8000 to 8004	8000 to 9989
8010 to 8034	8000 to 8790
804_	8000 to 8045
8050 to 8060	8050 to 8060
807_	807_
808_	808_
8090 to 8110	8090 to 8110
8120 to 8130	8120 to 8130
814_	8140 to 8573
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_
837_	837_
838_	838_
8390 to 8420	8390 to 8420
844_	844_
845_	845_

"SAME MORPHOLOGY" WORK TABLE
(for determining multiple primary neoplasms)

MORPHOLOGY CODE	CONSIDERED SAME AS
(Note: A dash (-) used in the fourth digit position indicates any valid fourth digit).	
846_	846_
847_	847_
848_	848_
8500	850_, 851_, 8522, 8530
8501 to 8506	850_
851_	851_
8520	8522
854_	854_
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 8833	8810 to 8833
884_	884_
8850 to 8881	8850 to 8881
889_	889_
8900 to 8920	8900 to 8920
8930 to 8931	8930 to 8931
8932 to 8933	8932 to 8933
894_	894_
895_	895_
896_	896_
897_	897_
898_	898_

"SAME MORPHOLOGY" WORK TABLE
(for determining multiple primary neoplasms)

MORPHOLOGY CODE	CONSIDERED SAME AS
(Note: A dash (-) used in the fourth digit position indicates any valid fourth digit).	
899_	899_
901_	901_
904_	904_
905_	905_
9060 to 9104	9060 to 9104
9120 to 9175	9120 to 9175
9180 to 9191	9180 to 9191
9220 to 9241	9220 to 9241
925_	925_
9270 to 9340	9270 to 9340
9360 to 9362	9360 to 9362
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 9570	9540 to 9570
958_	958_
9590	800_, 959_, 9650 to 9714
9591 to 9595	800_, 959_, 9670 to 9714
9650 to 9667	800_, 9590, 9650 to 9667
9670 to 9714	800_, 9590, 9670 to 9714
972_	972_

"SAME MORPHOLOGY" WORK TABLE
(for determining multiple primary neoplasms)

MORPHOLOGY CODE	CONSIDERED SAME AS
(Note: A dash (-) used in the fourth digit position indicates any valid fourth digit).	
973_	973_
974_	974_
9800 to 9941	9800 to 9941
996_	996_
998_	998_

Note:

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