



Vermont Cancer Registry Hospital Procedure Manual

2026

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Reportable Neoplasms

This manual contains information necessary for the successful submission of cancer data to the Vermont Cancer Registry.

If you need help accessing or understanding this information, contact AHS.VDHHSICancerRegistry@vermont.gov.

Effective Date

For all cases diagnosed on or after January 1, 2026, the instructions and codes in this manual take precedence over all previous instructions and codes.

Who Reports

All health care facilities and health care providers that diagnose or treat cancer in the State of Vermont are required by the [Cancer Registry Law \(Appendix A\), Title 18, Chapter 4](#) of the Vermont Statutes Annotated (VSA), to report cancer cases to the Vermont Cancer Registry.

When to Report

According to the VCR Law, cases must be reported to the VCR within 180 days after the date of first contact with the patient.

For quality monitoring purposes, the VCR uses a performance standard of at least 90% of cases must be reported within 180 days after the date of first contact.

Reporting facilities must submit data to the VCR monthly. If no data are available for submission, notify the Vermont Cancer Registry by email.

How to Report

See section *Transmission of Case Information*, for policies and procedures relating to submitting data to the VCR.

Reference Date

All reportable cancers diagnosed or treated in the State of Vermont on or after November 1, 1993, must be reported to the VCR.

Vermont and Non-Vermont Residents

All cases of cancer diagnosed in Vermont or receiving the first course of treatment in Vermont health care facilities or by Vermont health care practitioners are reportable to the VCR, regardless of a patient's state of residence.

U.S. and Non-U.S. Residents

Only residents of the United States, its commonwealths, and its territories are reportable to the VCR.

Supplemental Data Collection Standards

The reference materials listed in Table 1-1 are necessary to abstract cancer cases in 2026.

Table 1-1. References Needed to Supplement VCR HPM 2026

Title	Purpose
SEER Program Coding and Staging Manual 2026	Use this reference as a back up to other references. Released in September 2025.
International Classification of Diseases for Oncology (ICD-O-3.2)	Site/histology tables and errata used to assign histology and behavior. Updated in April 2025.
Solid Tumor Rules 2026.1	The purpose of the Solid Tumor Rules is to determine the number of primaries to abstract and the histology to code. The most recent Solid Tumor Rules update should be used as soon as it is released and can be applied to cases diagnosed 2018 and forward. If a specific code or instruction has an effective year later than 2018, it will be noted in the text. Released in July 2026.

**Table 1-1. References Needed to Supplement VCR HPM 2026
(Cont.)**

Title	Purpose
Hematopoietic and Lymphoid Neoplasm Coding Manual	Contains reportability instructions and data collection rules for hematopoietic and lymphoid neoplasms. Updated in October 2025.
Hematopoietic & Lymphoid Neoplasm Database	The database contains abstracting and coding information for all hematopoietic and lymphoid neoplasms. Updated in October 2025.
STORE 2026 (Standards for Oncology Registry Entry)	Contains definitions and coding instructions for most data items required by VCR. Explains how to determine case eligibility and interpret ambiguous terminology. Released in December 2025.
SEER Summary Staging Manual 2018	Used for directly coded SEER Summary Stage 2018. Updated November 2025.
Site-Specific Data Item (SSDI) Manual Version 3.3	Manual used to code Site-Specific Data Items. Released December 2025.
Grade Coding Instructions and Tables Version 3.3	Manual used to code Grade fields. Released October 2025.

Table 1-1. References Needed to Supplement VCR HPM 2026 (Cont.)

Title	Purpose
SEER*Rx – Interactive Drug Database	The information in this database is effective for cancer diagnoses made on January 1, 2005 and after.

Reportable Diagnosis List

Reportable cases are those that a registry is required to collect and report. Reporting requirements for Vermont registries are established by the National Program of Cancer Registries (NPCR). The *Reportable List* includes all diagnoses to be reported to the VCR.

1. Malignant Histologies (In Situ and Invasive)

- a. Report all histologies with a behavior code of /2 or /3 in the ICD-O-Third Edition, Second Revision Morphology (ICD-O-3.2), except as noted in section 1.b. below. **The following are reportable diagnoses that are either new or are frequently questioned.**
 - i. Post Transplant Lymphoproliferative Disorder (PTLD) 9971/1 is reportable as 9971/3 as of 01/01/2025.
 - ii. High-grade astrocytoma with piloid features (HGAP) (9421/3) as of 01/01/2023.
 - iii. Lymphangioliomyomatosis (9174/3) is reportable as of 01/01/2023; behavior changed from /1 to /3.
 - iv. Mesothelioma in situ (9050/2) is reportable as of 01/01/2023.
 - v. Diffuse leptomeningeal glioneuronal tumor (9509/3) is reportable as of 01/01/2023.
 - vi. The following diagnoses are reportable. This is not a complete list. See [ICD-O-3.2](#) for a complete list.
 1. Lobular carcinoma in situ (LCIS) of breast.
 2. Intraepithelial neoplasia, high grade, grade II, grade III.
 - a. Anal intraepithelial neoplasia II (AIN II) of the anus or anal canal (C210-C211).
 - b. Anal intraepithelial neoplasia III (AIN III) of the anus or anal canal (C210-C211).
 - c. Biliary intraepithelial neoplasia, high grade.
 - d. Conjunctival intraepithelial neoplasia with severe dysplasia, Grade III; squamous intraepithelial neoplasia

- Grade II of conjunctiva, or conjunctival intraepithelial lesion (C-MIL).
- e. Differentiated vulvar intraepithelial neoplasia (VIN) or differentiated exophytic vulvar intraepithelial lesion (DEVIL).
 - f. Endometrioid intraepithelial neoplasia (atypical hyperplasia, EIN).
 - g. Esophageal intraepithelial neoplasia (dysplasia), high grade or Grade III.
 - h. Glandular intraepithelial neoplasia, high grade.
 - i. High grade dysplasia of esophagus, stomach, small intestine.
 - j. High grade squamous dysplasia of larynx.
 - k. High grade squamous intraepithelial lesion (HGSIL) of the anus.
 - l. High grade vulvar intraepithelial neoplasia.
 - m. Intraductal papillary neoplasm with high grade intraepithelial neoplasia.
 - n. Intraepithelial neoplasia, grade III.
 - o. Laryngeal intraepithelial neoplasia II (LIN II) (C320-C329)
 - p. Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)
 - q. Lobular neoplasia grade II (LN II)/lobular intraepithelial neoplasia grade II (LIN II) breast (C500-C509).
 - r. Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509).
 - s. Pancreatic intraepithelial neoplasia (PanIN III) (C250-C259).
 - t. Penile intraepithelial neoplasia, grade III or high-grade dysplasia (PeIN III) (C600-C609).
 - u. Squamous intraepithelial neoplasia, grade II excluding cervix (C53_) and skin sites coded to C44_.
 - v. Vaginal intraepithelial neoplasia II (VAIN II) (C529).
 - w. Vaginal intraepithelial neoplasia III (VAIN III) (C529).
 - x. Vulvar intraepithelial neoplasia II (VIN II) (C510-C519).
 - y. Vulvar intraepithelial neoplasia III (VIN III) (C510-C519).
- vii. Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive.

- viii. Mature teratoma of the testes in adults is malignant and reportable as 9080/3.
- ix. Urine cytology positive for malignancy is reportable for diagnoses in 2013, and forward. When a subsequent biopsy of a urinary site is negative, do not report. Code the primary site to C689 in the absence of any other information. Do not implement new or additional casefinding methods to capture these cases.
- b. Do not report (exceptions to reporting requirements).
 - i. Skin primary (C440-C449) with any of the following histologies.
 - 1. Malignant neoplasm (8000-8005).
 - 2. Epithelial carcinoma (8010-8046).
 - 3. Papillary and squamous cell carcinoma (SCC) (8050-8086).
 - 4. Squamous intraepithelial neoplasia III (SIN III) (8077) of skin sites coded to C44_.
 - 5. Basal cell carcinoma (8090-8110).
 - ii. In situ carcinoma of cervix (/2), and histology, cervical intraepithelial neoplasia (CIN III), or SIN III of cervix (C530-C539).
 - iii. Prostatic intraepithelial neoplasia (PIN II and PIN III) (C619).
 - iv. Colon atypical hyperplasia.
 - v. High grade dysplasia in colorectal sites (C180-C189, C199, and C209).
 - vi. Adenocarcinoma in situ, HPV-associated (8483/2) (C53).
- c. “Carcinomatosis” (8010/9) and “metastatic” tumor or neoplasm (8000/6) indicate malignancy and could be indicative of a reportable neoplasm. Review all available information to determine the origin of carcinomatosis or the origin of metastases.

2. Benign/Non-Malignant Histologies

- a. Report benign and borderline primary intracranial and central nervous system (CNS) tumors with a behavior code of /0 or /1 in ICD-O-3 (effective with cases diagnosed 01/01/2004 to 12/31/2020) or ICD-O-3.2 (effective with cases diagnosed 01/01/2021 and later). Benign and borderline tumors of the cranial bones (C410) and peripheral nerves (C47_) are not reportable.
- b. Report pilocytic astrocytoma/juvenile pilocytic astrocytoma as 9421/1 for all CNS sites as of 01/01/2023.
- c. Report diffuse astrocytoma, MYB- or MYBL1-altered and diffuse low-grade glioma, MAPK pathway-altered (9421/1) as of 01/01/2023.
- d. Report multinodular and vacuolating neuronal tumor (9509/0) as of 01/01/2023.
- e. Report juvenile xanthogranuloma (9749/1) as of 01/01/2023 (C715 is the most common site).
- f. Neoplasm and tumor are reportable terms for intracranial and CNS because they are listed in ICD-O-3.2 with behavior codes of /0 and /1.

- g. Mass and lesion and not reportable terms for intracranial and CNS because they are not listed in ICD-O-3.2 with behavior codes of /0 or /1.

Table 1-2. Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors

General Term	Specific Sites	ICD-O-3 Topography Codes
Meninges	Cerebral Meninges	C700
	Spinal meninges	C701
	Meninges, NOS	C709
Brain	Cerebrum	C710
	Frontal lobe	C711
	Temporal lobe	C712
	Parietal lobe	C713
	Occipital lobe	C714
	Ventricle, NOS	C715
	Cerebellum, NOS	C716
	Brain stem	C717
	Overlapping lesion of brain	C718
	Brain, NOS	C719
Spinal cord, cranial nerves, and other parts of the central nervous system	Spinal cord	C720
	Cauda equina	C721
	Olfactory nerve	C722
	Optic nerve	C723
	Acoustic nerve	C724
	Cranial nerve, NOS	C725
	Overlapping lesion of brain and central nervous system	C728

Table 1-2. Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors (Cont.)

General Term	Specific Sites	ICD-O-3 Topography Codes
	Nervous system, NOS	C729
Pituitary, craniopharyngeal duct, and pineal gland	Pituitary gland	C751
	Craniopharyngeal duct	C752
	Pineal gland	C753

Ambiguous Terminology

Ambiguous terminology may originate in any source document, such as a pathology report, radiology report, or clinical report. The terms listed below are reportable when they are used with diagnostic terms such as cancer, carcinoma, or sarcoma. Ambiguous terms not listed below are not reportable.

Do not accession a case based only on suspicious cytology. Follow-back on cytology diagnoses that use ambiguous terminology is strongly recommended. Accession the case when a reportable diagnosis is subsequently confirmed. When a definitive diagnosis follows suspicious cytology, use the date of the suspicious cytology as the date of diagnosis.

“Suspicious cytology” means any cytology diagnosis that uses an ambiguous term, including terms listed as reportable in this manual. The date of a suspicious cytology may be used as the date of diagnosis when a definitive diagnosis follows the suspicious cytology.

Urine cytology positive for malignancy is reportable. In the absence of any other information, code the primary site to C689.

Ambiguous Terms that Constitute a Diagnosis

- Apparent(ly)
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Malignant appearing

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

Report cases that use one of the terms listed above or an equivalent form of the same term, such as “favored” for “favor(s).” Do not substitute synonyms such as “supposed” for “presumed,” “equal” for “comparable” or “likely” for “most likely.”

Use all available information first and seek clarification from clinicians whenever possible.

The following terms are equivalent to a diagnosis of malignancy or other reportable diagnosis. These phrases are reportable when no other information is available or there is no information to the contrary.

- Considered to be [malignancy or reportable diagnosis]
- Characteristic of [malignancy or reportable diagnosis]
- Appears to be a [malignancy or reportable diagnosis]
- Most compatible with [malignancy or reportable diagnosis]
- Most certainly [malignancy or reportable diagnosis]
- In keeping with [malignancy or reportable diagnosis]

Ambiguous Terms that DO NOT Constitute a Diagnosis Without Additional Information

- Cannot be ruled out
- Equivocal
- Possible
- Potentially malignant
- Questionable
- Rule out
- Suggests
- Worrisome

The following phrases are equivalent to “not diagnostic for” malignancy or another reportable diagnosis. These phrases are not reportable when no other information is available:

- Highly suspicious for, but not diagnostic of, [malignancy or reportable diagnosis]
- Most compatible with a [non-reportable diagnosis], such as a [reportable diagnosis]

- High probability for [malignancy or reportable diagnosis]

The following phrase is equivalent to a differential diagnoses:

- Differential considerations

Ambiguous terms may be preceded by a modifier, such as “mildly suspicious”. In general, ignore modifiers or other adjectives and apply the reportability rule associated with the ambiguous term.

If there is no information to the contrary, report a case described as "malignant until proven otherwise." The patient should undergo further work-up to prove or disprove the finding. When additional information becomes available, update, as necessary. Use text fields to document the relevant details.

The ambiguous terms listed below can **only** be applied to nonmalignant primary intracranial and central nervous system tumors (C70.0-C72.9, C75.1-C75.3) beginning with 2004 diagnoses.

- Neoplasm
- Tumor

Reportability and Class of Case

Cancers diagnosed or treated at the reporting facility **must** be reported to the VCR. Other classes of case **may** be reported to the VCR.

Table 1-3. Classes of Case^a Required to Be Reported

Class of Case	Description
00	Initial diagnosis at the reporting facility AND all treatment (or a decision not to treat) was done elsewhere.
10, 11, 12, 13, 14	Initial diagnosis at the reporting facility or in a staff physician's office AND part or all of first course of treatment (or a decision not to treat) was at the reporting facility.
20, 21, 22	Initial diagnosis elsewhere AND all or part of first course of treatment was done at the reporting facility.
34	Type of case not required by CoC to be accessioned AND initial diagnosis AND part or all of first course treatment by reporting facility.

Table 1-3. Classes of Case^a Required to Be Reported (Cont.)

Class of Case	Description
36	Type of case not required by CoC to be accessioned AND initial diagnosis elsewhere AND part or all of first course treatment by reporting facility.
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death.
40, 41, 42 ^b	Diagnosis at a staff physician's office AND all of first course of treatment was at a staff physician's office or other facility.
43 ^c	Pathology or other lab specimens only.

- a. Refer to the STORE Manual 2026, pages 71-74, for instructions on determining the class of case.
- b. Responsibility for reporting staff physician-only cases vary by facility. The registrar must ensure that responsibility is clearly assigned to either the facility or the staff physician's office so that these cases are reported to the VCR.
- c. Pathology-only cases, formerly referred to as "consult" cases, may be reported in any format. Electronic reporting is preferred.

Registry Operations

Each reporting facility is responsible for establishing a cancer registry or contracting with a cancer registry service to meet its legal obligation for cancer reporting.

Cancer registry operations include casefinding, abstracting, coding, staging, and quality assurance. Each hospital cancer registry, or its contractor, must follow nationally recognized standards for these activities.

Cancer registrars should maintain current knowledge of national coding and reporting standards. The following training resources are available to support continuing education and professional development.

Table 2-1 Cancer Registrar Education and Training Websites

Course Title	Description
<u>North American Association of Central Cancer Registries (NAACCR) Cancer Registry and Surveillance Webinar Series</u>	The NAACCR Cancer Registry and Surveillance Webinar Series includes recorded presentations, quizzes, case scenarios, and question-and-answer content from live sessions. Webinars are uploaded to Web Plus for Vermont cancer registrars as they are released. Each three-hour webinar is self-paced and eligible for three continuing education (CE) hours; some webinars also qualify for Category A CE hours.
<u>Surveillance Epidemiology and End Results (SEER) Training Website</u>	The SEER Training Website provides free training for cancer registry professionals on coding guidelines, concepts, and other technical aspects of cancer registration. Training includes opportunities to apply and assess knowledge of current standards. The training is funded by the National Cancer Institute.
<u>National Cancer Registrars Association (NCRA) Center for Cancer Registry Education</u>	The NCRA Center for Cancer Registry Education provides educational resources and training for cancer registry professionals at all experience levels. Programs support continuing education and the development and maintenance of cancer registry knowledge and skills.

Recommended Qualifications for Cancer Registrars

Cancer registrars should have the knowledge, skills, and abilities necessary to accurately collect, interpret, and report cancer data. The following qualifications are recommended for individuals performing cancer registry functions.

Required

- Experience with medical terminology, anatomy and physiology.
- Ability to work independently.
- Attention to detail and documentation.
- Ability to seek guidance or clarification when necessary.
- Ability to follow step-by-step procedures.
- Ability to communicate effectively orally and in writing.
- Ability to establish and maintain effective working relationships.

Preferred

- Bachelor's degree.
- Ability to aggregate data for analysis and presentation.
- Ability to perform statistical analysis.
- Oncology Data Specialist (ODS) credential.

New Registrar Procedure

When a reporting institution designates a new cancer registrar, the VCR **must** be notified immediately. The VCR can provide state-specific training to supplement formal training. To report a staffing change or inquire about training, contact the VCR Quality and Education Coordinator at AHS.VDHHSICancerRegistry@vermont.gov.

- All new abstractors working in Vermont must submit a file containing at least five cases for visual review. This requirement applies regardless of prior experience or ODS credential.
- The Quality and Education Coordinator will review the cases and provide feedback to the new registrar. Particular attention will be given to VCR reporting requirements for coding, documentation, and data item definitions.
- If requested by the Quality and Education Coordinator, the new registrar must provide additional information and make the necessary corrections to previously submitted cases. Corrected cases must be resubmitted and reviewed and must meet VCR quality assurance standards before additional cases are accepted from the new registrar.
- Once the review process is complete, the new registrar may submit additional cases, which will follow the standard VCR review and feedback procedure.

- If the cancer registrar is not responsible for casefinding at the reporting facility, the registry manager must provide the name and contact information for the individual responsible for casefinding.

Consultant Procedure

Before a reporting facility plans to hire a cancer registry contractor, the facility must provide the contractor's contact information to the VCR before the contractor begins abstracting. The VCR will contact the contractor and provide a copy of the VCR HPM.

Contact the VCR Quality and Education Coordinator at

AHS.VDHHSICancerRegistry@vermont.gov.

- The reporting institution is responsible for the completeness and accuracy of the data reported by the contractor.
- All VCR reporting requirements must be met. Data that do not meet these requirements may be rejected.
- Any time a consultant is newly hired in the state of Vermont, they must follow the **A contractor who is new to reporting in Vermont must complete the New Registrar Procedure described above.**

Required Data Items

Definitions and coding conventions for required data items may be found in the [SEER Program Coding and Staging Manual 2026](#). For data items not addressed in the SEER Manual, refer to the corresponding HPM 2026 page reference for definitions and coding instructions.

Table 3-1 Patient Identification

NAACCR Item Name	STORE Manual 2026	STORE Manual 2018	HPM 2026
Accession Number - Hosp	38		
Sequence Number - Hospital	39		
Medical Record Number		51	
Social Security Number		52	
Medicare Beneficiary Identifier			31
Last Name	41		
Birth Surname	42		
First Name	43		
Middle Name (Middle Initial)	44		
Alias	45		
Addr at DX - No & Street		56	32
Addr at DX - Supplementl		58	33
Addr at DX - City	46		33
Addr at DX - State	47		
Addr at DX - Postal Code	49		
County at DX Reported	51		
Birthplace - State	52		
Birthplace - Country	53		
Date of Birth	54		
Age at Diagnosis	55		
Race 1	56		

Table 3-1 Patient Identification (Cont.)

NAACCR Item Name	STORE Manual 2026	STORE Manual 2018	HPM 2026
Race 2		81	
Race 3		83	
Race 4		85	
Race 5		87	
Spanish/Hispanic Origin	58		
Sex Assigned at Birth	59		
Sex_VT			30
Primary Payer at DX	60		
Text - Usual Occupation			31
Text - Usual Industry			31
Tobacco Use Smoking Status	63		

Table 3-2 Cancer Identification

NAACCR Item Name	STORE Manual 2026	STORE Manual 2018	HPM 2026
Class of Case	71		
Date of 1st Contact	77		
Date of Initial Diagnosis	79		
Primary Site	81		
Laterality	85		
Histology	87		
Behavior Code	88		
Grade Clinical	90		
Grade Post Therapy Clinical (yc)	149		
Grade Pathological	91		
Grade Post Therapy (yp)	162		
Diagnostic Confirmation	92		
Type of Reporting Source			33
Casefinding Source			34
Text - Primary Site Title			35
Text - Histology Title			35

Table 3-3 Stage of Disease at Diagnosis

NAACCR Item Name	STORE Manual 2026	STORE Manual 2018	HPM 2026
Lymphovascular Invasion	102		
Regional Nodes Examined	116		
Regional Nodes Positive	118		
Tumor Size Summary	121		
Summary Stage 2018			35

Table 3-4 Site-Specific Data Items (SSDIs)

NAACCR Item Name	Schema ID	Schema Description
Brain Molecular Markers	00721	Brain
Brain Primary Tumor Location for Brain	00721	Brain
Estrogen Receptor Summary	00480	Breast
HER2 Overall Summary	00480	Breast
Progesterone Receptor Summary	00480	Breast
Microsatellite Instability (MSI)	00200 00530	Colon and Rectum Corpus Carcinoma and Carcinosarcoma
Esophagus and EGJ Tumor Epicenter	00161	Esophagus (including GE junction) Squamous
Post Transplant Lymphoproliferative Disorder-PTLD	00710 00790 00795 00812 00821 00822	Hematopoietic Lymphoproliferative Disease
Fibrosis Score	00220 00230	Liver Bile Ducts Intrahepatic
PD-L1	09361	Lung (NSCLC)
Breslow Tumor Thickness	00470	Melanoma Skin
LDH Lab Value	00470	Melanoma Skin
Gleason Patters Clinical	00580	Prostate
Gleason Patterns Pathological	00580	Prostate
Gleason Score Clinical	00580	Prostate
Gleason Score Pathological	00580	Prostate
PSA (Prostate Specific Antigen) Lab Value	00580	Prostate
Gleason Tertiary Pattern	00580	Prostate
p16	09210 09520 09500	Anus (2023+) Cervix Vulva (2024+)

Table 3-4 Site-Specific Data Items (SSDIs) (Cont.)

NAACCR Item Name	Schema ID	Schema Description
Histologic Subtype	09190	Appendix (2023+)
Schema Discriminator 1	00242	Cystic Duct
	00250	Bile Ducts Perihilar
	00260	Bile Ducts Distal
	00161	Esophagus (including GE Junction) Squamous
	00169	Esophagus (including GE Junction)(excl. Squamous)
	00170	Stomach
	00790	Lymphoma
	00830	HemeRetic
	00690	Lacrimal Gland
	00698	Lacrimal Duct
	00671	Melanoma Iris
	00672	Melanoma Choroid and Ciliary Body
	00090	Nasopharynx
	00100	Oropharynx HPV-Mediated (p16+)
	00111	Oropharynx (p16-)
	00060	Cervical Lymph Nodes and Unknown Primary
	00459	Soft Tissue Other
	99999	Ill-Defined Other
	00821	Plasma Cell Myeloma
	00430	GIST
	00730	Thyroid
	00740	Thyroid Medullary
	00631	Urethra
	00633	Urethra-Prostatic
Schema Discriminator 2	00161	Esophagus (including GE Junction) Squamous
	00169	Esophagus (including GE Junction)(excluding Squamous)
	00100	Oropharynx HPV-Mediated (p16+)
	00111	Oropharynx (p16-)
	00410	Soft Tissue Trunk and Extremities
	00421	Soft Tissues Abdomen and Thoracic (excluding Heart, Mediastinum, Pleura)
	00459	Soft Tissue Other

Table 3-5 First Course of Treatment

NAACCR Item Name	STORE Manual 2026	STORE Manual 2018	HPM 2026
Date 1st Crs RX CoC	166		
RX Summ - Treatment Status	167		
Date of First Surgical Procedure	170		
Date of Most Definitive Surgical Resection of the Primary Site	171		
RX Summ - Surg Prim Site 03-2022			35
Scope of Regional Lymph Node Surgery	184		
Surgical Procedure/Other Site	195		
Reason for No Surgery of Primary Site	202		
Date Radiation Started	205		
Phase I Radiation Treatment Modality	216		
Radiation/Surgery Sequence	233		
Reason for No Radiation	236		
Systemic/Surgery Sequence	261		
Date Chemotherapy Started	241		
Chemotherapy	242		
Date Hormone Therapy Started	248		
Hormone Therapy	249		
Date Immunotherapy Started	254		
Immunotherapy	255		
Hematologic Transplant and Endocrine Procedures	259		
Date Other Treatment Started	264		
Other Treatment	263		

Table 3-6 Outcomes

NAACCR Item Name	STORE Manual 2026	STORE Manual 2018	HPM 2026
Date of Last Contact of Death	280		
Vital Status	281		
Follow-Up Source	282		

Table 3-7 Case Administration

NAACCR Item Name	STORE Manual 2026	STORE Manual 2018	HPM 2026
Record Type			36
Registry ID			36
NAACCR Record Version			36
Site Coding Sys - Current		430	
Morph Coding Sys - Current		432	
Facility Identification Number (FIN)	286		
NPI- -Reporting Facility	287		
Abstracted By	285		
RX Coding System - Current		437	
Cause of Death			36
ICD Revision Number			36
Place of Death- -State			37
Place of Death- -Country			37
Over-ride Age/Site/Morph		415	
Over-ride Surg/DxConf		416	
Over-ride Site/Type	292		
Over-ride Histology		418	
Over-ride Leuk Lymphoma		420	

Table 3-7 Case Administration (Cont.)

NAACCR Item Name	STORE Manual 2026	STORE Manual 2018	HPM 2026
Over-ride Site/Behavior		421	
Over-ride Site/Lat/Morph		423	
Date Case Report Exported			37
ICD-O-3 Conversion Flag		435	
CoC Accredited Flag			37

Table 3-8 Text

NAACCR Item Name	SEER Program Coding and Staging Manual 2026	HPM 2026
Text - Physical Exam		40
Text - X-ray/Scan		40
Text - Scopes		41
Text - Lab Tests		42
Text - Operative Report		42
Text - Pathology Report		43
Text - Staging		44
Text - Remarks		44
Text - Place of Diagnosis		44
Text - Surgery		45
Text - Beam Radiation		45
Text - Radiation Other		45
Text - Chemotherapy		46
Text - Hormone Therapy		46
Text - Biological Response Modifier (BRM)		47
Text - Other Treatment		47

Vermont Specific Data Items

This section contains definitions and coding instructions for required data items that are not documented in the STORE Manual, as well as supplemental VCR coding instructions for selected data items.

Data Items Included in This Section

Patient Identification

Sex_VT
Medicare Beneficiary Identifier
Text–Usual Occupation
Text–Usual Industry
Address at DX–No & Street
Address at DX–Supplemental
Address at DX–City

The address fields above include additional VCR guidance to support accurate geocoding.

Cancer Identification

Type of Reporting Source
Casefinding Source
Text–Primary Site Title
Text–Histology Title

Stage of Disease at Diagnosis

Summary Stage 2018

Treatment

RX Summ–Surg Prim Site 03-2022

Case Administration

Record Type
Registry ID
NAACCR Record Version
Cause of Death
ICD Revision Number
Place of Death–State
Place of Death–Country
Date Case Report Exported
CoC Accredited Flag
Text–Remarks
Text–Place of Diagnosis

Patient Identification

Sex_VT

Effective with NAACCR Data Standards & Data Dictionary v26, beginning with the 2026 diagnoses, Data Item **Sex [220]** will be retired and replaced by Data Item **Sex Assigned at Birth [225]**. Under NAACCR guidance, existing values in Sex [220] will be converted to populate Sex Assigned at Birth [225] for historical cases.

To maintain continuity with historical and preserve information previously collected in Sex [220], VCR has created a Vermont-specific data item, **Sex_VT**. Sex_VT is required for cases diagnosed in 2026 and later.

Coding instructions for Sex_VT are the same as those for the retired Sex [220] data item and can be found in historical reference materials, including the *SEER Program Coding and Staging Manual 2025* and *STORE Manual 2025*.

Coding Instructions for Sex_VT:

- Record the patient's sex as indicated in the medical record.
- Natality for transsexuals was added for use in 2015 but may be applied for earlier diagnoses.
- The definition of code 3 was updated in 2016 to "Other (intersex, disorders of sexual development/DSD)."

Table 4-1 Sex_VT Codes

Code	Label
1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not stated/Unknown

Medicare Beneficiary Identifier

The Medicare Beneficiary Identifier (MBI) is a randomly generated 11-character identifier that does not include an SSN or any personal identifiable information. An electronic edit will fail if the format of the MBI is not entered in a valid format. Refer to the document titled [Understanding the Medicare Beneficiary Identifier \(MBI\) Format](#) for instructions on identifying the correct format.

Leave this field blank if the MBI is unavailable or not applicable.

Text - Usual Occupation

Record the patient's usual occupation, meaning the type of work performed during most of the patient's working life before diagnosis of this tumor. **Do not record "retired."** If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or another available occupation.

Special Cases:

- **Child:** Patient is under 14 years of age code child
- **Homemaker:** Patient worked only at home
- **Student:** Patient was a student at time of diagnosis and had never held a job
- **Military:** Patient was part of the military for most of their working life
- **Never worked:** Patient was not a student or homemaker and had never worked

If no occupation information is available, record "unknown." This data item is generally collected only for patients age 14 years or older at the time of diagnosis.

Text - Usual Industry

Record the primary type of business or industry in which the patient worked for the greatest number of years before diagnosis of this tumor. When an industry includes more than one type of activity, distinguish among components such as manufacturing, wholesale, retail, and service.

If the primary activity of the employer is unknown, facility registrars may record the name of the company and the city or town where the patient worked. If resources permit a central or regional registry may use this information to determine the type of activity conducted at that location.

Industry information should correspond to the occupation recorded in **Text - Usual Occupation**. The industry recorded should correspond to the occupation recorded. If a

current or most recent occupation is used, record the industry associated with that occupation.

An entry for Text–Usual Industry should be provided whenever an occupation is recorded. If no information is available about the industry associated with the reported occupation, record “unknown.” If the patient was not a student or homemaker and had never worked, record “never worked” as the usual industry.

This data item is generally collected only for patients age 14 years or older at the time of diagnosis.

Address at Diagnosis and Geocoding

Accurate address information at diagnosis is important for geocoding. Geocoding assigns a geographic location to a patient’s residential address and supports analysis of cancer patterns, geographic disparities, referral patterns, and social and economic characteristics of the area where the patient lives that may affect cancer risk, access to care, or outcomes.

VCR reviews address information as part of the submission process because these fields are not evaluated through electronic edits. **Registrars should enter the patient’s physical residential address at diagnosis as completely and consistently as possible to support accurate geocoding.**

Address at DX – No & Street

Record the physical street address of the patient’s residence at the time of diagnosis whenever it is available. This field should contain the street number and street name and should be kept as standardized and free of supplemental information as possible to support accurate geocoding.

Do not include apartment numbers, facility names, PO Boxes, or other mailing or supplemental address information in this field when the physical street address is available. Enter that information in [Address at DX – Supplemental](#).

For patients residing in a facility, such as a long term care facility, record the facility’s physical street address in [Address at DX – No & Street](#) and the name of the facility in Address at DX – Supplemental.

Address at DX – Supplemental

Use this field to record additional information associated with the patient's address at diagnosis that should not be included in the street address field.

Examples include:

- PO Box, including town or city and postal code if different from physical address.
- Apartment, unit, or other secondary address information.
- Name of a long-term care facility, nursing home, apartment complex, group home, or other residential facility.
- Other relevant address information that may assist with identifying or geocoding the patient's residence.

Whenever a physical street address is available, enter it in Address at DX – No & Street and use this field only for supplemental information. Retaining facility information may also assist with geocoding and record consolidation.

Address at DX – City

Record the city or town of the patient's **physical residence at the time of diagnosis**.

If the patient's mailing address uses a different city or town from the physical residence, record the city or town associated with the physical address in [Address at DX – City](#). The mailing city or town may be included in Address at DX – Supplemental when needed to preserve relevant address information.

In Vermont, some municipalities share a common place name but are separate geographic areas, such as **Barre City and Barre Town, Rutland City and Rutland Town, and St. Albans City and St. Albans Town**. When the specific municipality is known, record the full municipality name rather than the shared place name alone.

Accurately distinguishing these municipalities is important for geocoding and geographic analysis. If the specific municipality is not identified, a case may be assigned to the wrong community, may be geocoded only to a broader area, or may not be geocoded at all. This can affect community level cancer rates and other geographic analyses.

Cancer Identification

Type of Reporting Source

This data item identifies the source documents used to abstract the majority of information about the tumor being reported. It may differ from the original casefinding source. For example, if a case is identified through review of a pathology laboratory

report but the information used to abstract the case comes from the physician's office, code this item 4.

Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7.

Table 4-2 Type of Reporting Source Codes

Code	Description
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records
2	Radiation treatment centers or medical oncology centers (hospital-affiliated or independent)
3	Laboratory only (hospital-affiliated or independent)
4	Physician's office/private medical practitioner (LMD)
5	Nursing/convalescent home/hospice
6	Autopsy only
7	Death certificate only
8	Other hospital outpatient units/surgery centers

Casefinding Source

Code the source that first identified the tumor as a reportable case.

Table 4-3 Casefinding Source Codes

Code	Description
10	Reporting Hospital, NOS
20	Pathology Department Review (surgical pathology reports, autopsies, or cytology reports)
21	Daily Discharge Review (daily screening of charts of discharged patients in the medical records department)
22	Disease Index Review (review of disease index in the medical records department)
23	Radiation Therapy Department/Center
24	Laboratory Reports (other than pathology reports, code 20)
25	Outpatient Chemotherapy
26	Diagnostic Imaging/Radiology (other than radiation therapy, code 23; includes nuclear medicine)

Table 4-3 Casefinding Source Codes (Cont.)

27	Tumor Board
28	Hospital Rehabilitation Service or Clinic
29	Other Hospital Source (including clinic, NOS or outpatient department, NOS)
30	Physician-Initiated Case
40	Consultation-only or Pathology-only Report (not abstracted by reporting hospital)
50	Independent (non-hospital) Pathology-Laboratory Report
60	Nursing Home-Initiated Case
70	Coroner's Office Records Review
75	Managed Care Organization (MCO) or Insurance Records
80	Death Certificate (case identified through death clearance)
85	Out-of-State Case Sharing
90	Other Non-Reporting Hospital Source
95	Quality Control Review (case initially identified through quality control activities such as casefinding audit of a regional or central registry)
99	Unknown

Text - Primary Site Title

Document the primary site of the tumor being reported, including laterality when applicable.

Text - Histology Title

Document the histologic type of the tumor being reported, including behavior and grade when available. Include clinical, pathologic, and post-therapy grade, as applicable.

Stage of Disease at Diagnosis

Summary Stage 2018

Summary Stage 2018 is the only staging system required by VCR. Refer to the [SEER Summary Stage 2018 Manual](#) for coding instructions.

Treatment

RX Summ - Surg Prim Site 03-2022

This data item records surgery of the primary site for cases diagnosed before 2023 using the former two-digit surgery codes. Refer to Appendix A of the [STORE Manual 2022](#) or

Appendix C of the [SEER Program Coding and Staging Manual 2022](#) for coding instructions.

Case Administration

Record Type

This data item identifies the NAACCR data exchange record type used in the submitted file. Code **A** indicates a full case abstract, including incidence data, confidential data, and text summaries, and is used for reporting cases to central registries.

Registry ID

This data item identifies the source of the data transmission using a unique registry code. The value is assigned by the software vendor and should not require manual entry.

NAACCR Record Version

This data item identifies the version of North American Association of Central Cancer Registries (NAACCR) standards used for data exchange. For 2026 submissions, use NAACCR XML Data Exchange Standard Version 26.

Cause of Death

Record the official underlying cause of death using a valid ICD-10 code. If an ICD-10 code is not available, use one of the codes listed below.

Table 4-4 Cause of Death Codes

Code	Description
0000	Patient alive at last contact
7777	State death certificate not available
7797	State death certificate available but underlying cause of death is not coded

ICD Revision Number

This data item identifies the coding system used to code the cause of death.

Table 4-5 ICD Revision Number Codes

Code	Description
0	Patient alive at last follow-up
1	ICD-10
7	ICD-7
8	ICDA-8
9	ICD-9

Place of Death - State

This data item identifies the state or province where the patient died and where the death certificate is filed.

Place of Death - Country

This data item identifies the country where the patient died and where the death certificate is filed.

Date Case Report Exported

This data item records the date the reporting facility exports the electronic abstract for transmission to the central registry.

CoC Accredited Flag

This data item indicates whether the abstract represents an analytic case from a facility accredited by the Commission on Cancer (CoC). The code may be entered manually or assigned automatically by the registry software.

Required Text Fields

Text is an essential component of cancer abstracts and is used for quality control and special studies. Text should support coded values and to document supplemental information not transmitted through coded data. High-quality documentation facilitates consolidation of records from multiple reporting sources for the same patient.

Dates of the diagnostic and treatment procedures should be included in the appropriate text fields to determine the admissibility of information used for diagnosis date, staging, grade, Site Specific Data Items (SSDIs), and first course of treatment.

Cases with insufficient text may be rejected.

Do not type text in all caps. This makes quality assurance review more difficult.

Use of standard abbreviations in text fields is strongly encouraged. A list of common medical abbreviations is available on the [SEER](#) site.

Data Items Included in this Section

Diagnostic Text Fields

Text–Physical Exam

Text–X-Ray/Scan

Text–Scopes

Text–Lab Tests

Text–Operative Report

Text–Pathology Report

Text–Staging

Text–Remarks

Text–Place of Diagnosis

Treatment Text Fields

Text–Surgery

Text–Beam Radiation

Text–Other Radiation

Text–Chemotherapy

Text–Hormones

Text–Biological Response Modifiers (BRM)

Text–Other Treatment

General Instructions

Text fields must contain enough information to support coding without including extraneous information.

- Review all information available in the medical record and document the most descriptive and concise text in the abstract. After manual entry of the text field, ensure that it agrees with the coded values and clearly supports the selected codes.
- Use standard abbreviations.
- **Do not include information regarding HIV status.**
- If information is missing from the record, state that it is missing.
- Avoid using all allowable space and simplify information when possible.
- Record positive and negative clinical findings. Record positive findings first.
- Include only information related to this cancer. Do not include information on comorbidity unless it specifically explains why a patient did not receive a particular treatment.
- Progression, recurrence, and follow-up are not required to be reported. Do not abstract text related to these items unless specifically required by the reporting institution.
- Refer to the Quality Assurance section for information on VCR review procedures.
- For more information, refer to the [SEER Training Site](#).

Descriptions to Record

- Date of physical exam.
- Age, sex, and race/ethnicity.
- History related to the cancer diagnosis.
- Primary site.
- Tumor histology, location, and size.
- Palpable lymph nodes.
- Impression, when stated and relevant to the cancer diagnosis.
- Treatment plan.

Diagnostic Text Fields

Text - Physical Exam

Document relevant findings from the patient's history and physical examination that support the diagnosis, staging, or treatment of the cancer.

Examples:

Breast: 3/26/2026 73 yo Asian, NOS female never smoker, no ETOH, presenting for evaluation of nipple discharge and abnormal MAMMO. 2/15/2026 PE: Breast exam symmetric breast w/out skin changes and a protrusion. Rt breast has no discrete palpable abnormalities, w/ compression there is a single duct in central aspect of breast that has clear slightly yellowish fluid. No blood noted. No palpable LNs in the axilla.

Colon: 4/4/2026 55 yo Chinese female never smoker referred for new sigmoid cancer found on colonoscopy after having positive guaiac testing 3/5/2026 PE: Abd soft, nontender, nondistended.

Lung: 2-25-26 @ outside hospital. 53 y/o/w/f single non Hispanic, presenting to the Emergency Department for subacute left upper and lower extremity weakness and diminished sensation with a last known normal of approximately 7 to 8 days. Also reporting increased falls. Has had head strike. No tenderness of the cervical, thoracic, lumbar spine, chest wall, abdomen. Bruising on the upper and lower extremities imaging showed brain mets, pt transferred to Hospital B. Pt was started on palliative XRT followed by palliative chemo.

Hematopoietic: 3-18-26 @ OSH. 37 y/o/w/f married non Hispanic, persistent enlarged right axillary lymph node, pt had excision and path showed Hodgkin lymphoma. Med onc recommend surveillance, no treatment done.

Melanoma: 77yo W/F, Non-Hispanic. 06/04/2026, Face lesion growing x 1 year. PE: 2cm fungating plaque in Lt upper cutaneous lip. Plan: Shave bx. 07/07/2026, Malignant Melanoma at least T4b of Lt upper lip. PE: Large, dry pigmented Lt upper lip lesion, irregular surface, no active bleeding. No invasion inside of mouth. No neck LAD. Plan: Neoadjuvant Ipi/Nivo. Further imaging for staging. 07/16/2026, Melanoma TB: stage: at least pT4b. Plan: Neoadjuvant checkpoint inhibitor. Brain MRI. F/u w/ derm q3 mo.

Prostate: 1/3/26 dx w/ prostate cancer, 76 y/o wm w/ elevated PSA of 9.1 associated with a benign exam and a PR-5 lesion. never smoker, drinks etoh, fam h/o colon cancer in his father, a brother who had kidney cancer and had a nephrectomy. PE: abdomen is soft, nontender, nondistended. He walks with a normal gait. There is no cyanosis or clubbing of extremities. GU exam reveals bilaterally normally descended testicles, normally formed phallus with a patent but small meatus. A digital rectal exam reveals an approximately 60-65 gram gland, which is benign in nature without palpable nodules or pelvic sidewall fixation.

Text - X-Ray/Scan

Document relevant findings from all X-rays, scans, and other imaging examinations that provide information about diagnosis and staging.

Examples:

Breast: 1/15/2026 MAMMO/US: There is no suspicious architectural distortion or mass. There are several calcifications for which magnification views were obtained. These calcifications are segmentally distributed behind the nipple span approximately 1.3 cm, in the lower inner quadrant anteriorly.

Colon: 2/31/2026 CT chest: no evidence of mets in chest. CT ABD/PELV: Mural thickening of the distal sigmoid colon presumably corresponding to known primary tumor. Prominent but not pathologically enlarged LNs w/in sigmoid mesentery could represent regional nodal mets. 5/15/2026 CT ABD/PELV: no signs of local recurrence or mets. CT chest: NO evidence of mets

Lung: 2-25-26 (OSH) Ct Angio Head- Multiple intracranial rim-enhancing masses with extensive edema within the right parietal and temporal lobes resulting in significant mass effect with 0.9 cm shift of the midline structures to the left. The findings are consistent with intracranial mets. CT neck- Large right upper lobe pulmonary mass, incompletely visualized. There are pathologically enlarged LN within the upper mediastinum, supraclavicular fossae and lower neck. The findings are suspicious for lung cancer with mets. 2-26-26 (OSH) Ct Chest- Right upper lobe lobulated enhancing mass measuring up to approximately 8 cm with adjacent interlobular septal thickening, concerning for primary lung cancer with lymphangitic carcinomatosis. A couple of bronchovascular solid nodules in the right upper lobe measuring up to 9 mm could represent metastatic intrapulmonary LNs or satellite lung nodules. Enlarged mediastinal and right hilar lymph nodes, concerning for metastasis.

Melanoma: 07/07/2026, OSH PET CT: Intensely active Lt upper lip soft tissue lesion, compatible w/ primary melanoma. No regional or distant mets. 07/31/2026, OSH, CT Face w/ con: Exophytic mass in Lt upper lip: 2.1 x 1.3 x 2.1cm. Subcutaneous extension appears inseparable from muscle plane, w/o osseous involvement. No additional masses or LAD.

Prostate: 1/3/26 MRI prostate w/wo: PI-RADS 5 lesion measuring 2.4 cm in the left peripheral zone extending from the base to apex. There is suspected extracapsular extension posterolaterally on the left, although motion artifact degrades diagnostic quality. There is a 0.5 cm short axis lymph node adjacent to the left seminal vesicle, felt to be suspicious due to its atypical location. Consider further characterization with PSMA

PET. 2/20/25 Mass General Brigham: PET/CT: Focal intense PSMA uptake in the left peripheral zone of the prostate gland, consistent with biopsy-proven prostate adenocarcinoma. Intensely PSMA avid left internal iliac lymph nodes, likely representing nodal metastases. More mildly PSMA avid subcentimeter retroperitoneal lymph nodes may also represent early metastatic involvement.

Hematopoietic: 4-14-26 OSH Pet/ct- Increased FDG activity at the site of right axillary lymph node with fat stranding and additional smaller mildly FDG avid right axillary lymph nodes cw known lymphoma. Mild FDG activity in nonenlarged left axillary lymph node. Mildly FDG avid bilateral inguinal lymph nodes favored to be reactive even though disease involvement cannot be entirely excluded.

Text - Scopes

Document findings from endoscopic examinations that provide information for staging and treatment.

Examples:

Bladder: 01/08/2026 Cystoscopy: Bladder tumor present, location: 1 cm left wall posterior. Urethra and ureteral orifices without abnormalities.

Colon: 2/23/2026 colonoscopy: 5 mm sessile polyp (outside surgical center)

Renal Pelvis: 01/06/2026, MD: Dx Cystoureteroscopy: Cystoscopy: Neg. Lt Retrograde pyelogram: Faint filling defect in Lt lower pole. Lt ureteroscopy: No ureteral tumor. Nodular/sessile tumor filling lower pole calyx; bx done. Lt renal pelvis washings sent for cytology. No stent placed.

Stomach: 01/20/2026: Upper GI Endoscopy w/bx & EUS: EGD: Esophagus: Normal. At GE Junction, extending into prepyloric antrum: mucosa firm, non-distensible, hard & friable; present circumferentially in cardia & fundus, and antrum spared up to 50% then last 3cm of antrum also circumferential. Had appearance of linitis plastica & multiple bx taken w/ cold forceps. Duodenum normal. EUS: Diffuse wall thickening in entire stomach, primarily w/in intramural wall, but wall layer could not be determined. Extensive malignant-appearing LAD in gastrohepatic ligament, perigastric & celiac; likely mets. IMP: Likely metastatic gastric adenocarcinoma w/ peritoneal carcinomatosis. 01/30/2026, Upper GI endoscopy: Evidence of tumor extension into distal 1-2cm of esophagus w/ tumor involving GEJ. Extensive tumor infiltration throughout stomach, tumor involving cardia & fundus. No bx.

Text - Lab Tests

Document relevant laboratory test results.

Suggestions for text:

- Date(s) of laboratory test(s).
- Type of laboratory test or tissue specimen(s).
- Record both positive and negative findings. Record positive test results first.
- Record reference values.
- Information can include tumor markers, serum and urine electrophoresis, and other special studies.
- Tumor markers may include:
 - Breast Cancer: Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu.
 - Prostate Cancer: Prostatic Specific Antigen (PSA).
 - Testicular Cancer: Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH)

Examples:

Breast: 3/26/2026 Positive for estrogen receptors (in >90% of tumor cells). Nuclear staining intensity: Strong. Positive for progesterone receptors (in >90% of tumor cells). Nuclear staining intensity: Strong.

Colon: 2/23/2026 Retained expression of MLH1, PMS2, MSH2 and MSH6 (outside surgical center) 2/30/2026 CEA 1.7 ng/mL (ref range 0.0 - 2.5 in 98.2% of Nonsmokers and 87.3% of Smokers. 2.6 - 5 in 1.8% of Nonsmokers and 8% of Smokers. 5.1 - 10.1 in 4.7% of Smokers)

Lung: 2-27-26 PD-L1- 11-49% no ALK or EGFR on file

Melanoma: SSDIs: Breslow: at least 2.3cm. Ulceration: (+). Clark: IV. Mitotic: 10/mm². LVI: Not ID-ed. LDH: 276 (ULN: 220). No resection.

Prostate: 9/3/26 PSA, total 9.1 ng/mL

Hematopoietic: 3-18-26 By flow cytometry, there is no immunophenotypic evidence of a clonal cell population. The majority of lymphocytes are T-cells with a subset of CD4+/CD8+ T-cells. Immunohistochemical staining demonstrates the large cells to be positive for OCT-2 (strong), BOB1, CD20, BCL6, CD45 (weak to negative), and PAX-5 while negative for CD30, CD15, ALK1, EBER ISH, and CD3. The immunophenotype of the large cells is consistent with LP cells. The CD30 highlights scattered background immunoblasts. CD21 demonstrates disrupted/expanded follicular dendritic cell meshworks. The CD3 demonstrates rimming of CD3+ T-cells around LP

Text - Operative Report

Document surgical procedures that provide information for staging.

Suggestions for text:

- Dates and descriptions of biopsies and other surgical procedures from which staging information was derived.
- Number of lymph nodes removed.
- Size of tumor removed.
- Documentation of residual tumor.
- Evidence of invasion into surrounding structures or tissues.

Examples:

Breast: 3/26/2026 Right breast, distal duct, excision

Colon: 2/23/2026 sigmoid colon mass BX (outside surgical center) 4/4/2026 Laparoscopic sigmoid colectomy, mobilization of the splenic flexure, ICG angiography, tap blocks, flexible sigmoidoscopy.

Lung: 2-27-26 CT Guided R Lung mass bx

Melanoma: 06/04/2026, Shave Bx Lt Upper Lip Lesion.

Thyroid: 01/04/2026 Right thyroid lobe mass FNA (Hospital A) 03/26/2026 Total thyroidectomy (Hospital B)

Text - Pathology Report

Document relevant findings from cytology and histopathology reports. Histologic term must be documented.

Examples:

Breast: 3/26/2026 R central breast, DCIS, 3 mm, nuclear grade 2, all margins negative w/ closest margin 1 mm, no LNs submitted or found.

Colon: 2/23/2026 Invasive moderately differentiated adenocarcinoma (outside surgical center) 4/4/2026 sigmoid colon, adenocarcinoma, G2, 3.0 cm, invades through muscularis propria into pericolic or perirectal tissue, LVI positive, perineural invasion negative, all margins negative w/ closest radial margins greater than 1 cm, 4/30 regional nodes positive, tumor deposits negative, pT3 pN2a

Lung: 2-27-26 Lung, RUL, Transthoracic CT Guided Needle core bx- Non-small cell carcinoma, favor adenocarcinoma. Comment - The tumor cells are positive for TTF-1 and negative for p40. Lung, RUL, CT Guided FNA- Non small cell ca, favor adenoca.

Melanoma: 06/04/2026, Shave Bx Lt Upper Lip Lesion, Skin of Lt upper lip: Melanoma, NOS. Breslow: at least 2.3cm (transected at deep), Ulceration: (+). Clark: IV. Mitotic: 10/mm². LVI: Not ID-ed. Neurotropism: Not ID-ed. TIL: (+), non-brisk. Regression: Not ID-ed. Invasive melanoma at peripheral & deep margin, All margins neg for MIS. pT3b.

Prostate: 9/5/26 Prostate biopsy: Prostatic adenocarcinoma. Gleason Score 4 + 5 = 9 (grade group 5). 9/13 cores

Hematopoietic: 3-18-26; LN, R Axillary excision- Nodular lymphocyte predominant Hodgkin/B-cell lymphoma. Comment-Immunohistochemical staining demonstrates the large cells to be positive for OCT-2 (strong), BOB1, CD20, BCL6, CD45 (weak to negative), and PAX-5 while negative for CD30, CD15, ALK1, EBER ISH, and CD3. The immunophenotype of the large cells is consistent with LP cells. The CD30 highlights scattered background immunoblasts. CD21 demonstrates disrupted/expanded follicular dendritic cell meshworks. The CD3 demonstrates rimming of CD3+ T-cells around LP cells (rosetting). Overall, the morphology and immunophenotype are most consistent with nodular lymphocyte predominant Hodgkin/B-cell lymphoma.

Text - Staging

Document unresolved discrepancies between physician and registry staging. Include any additional information relevant to physician staging.

Suggestions for text:

- Physician TNM stage.
- Other staging schemes, Dukes, Jewetts, Bloom Richardson.

Examples:

Breast: cTis(DCIS) cN0 cM0 Stage group 0 pTis(DCIS) cN0 cM0 Stage group 0 SEER Stage 0 Staged by ODS

Colon: AJCC clinical: cT blank cN0 cM0 Stage 99; AJCC path: pT1 pN0 cM0 Stage 1; SEER cN0 cM0 stage group 99 pT3 pN2a cM0 stage group 3B SEER stage 3

Lung: cT4(8.0 cm per imaging) cN3 (Metabolically active bilateral cervical, supraclavicular, mediastinal and right hilar, and left axillary lymphadenopathy) cM1b (brain mets) stage IVA. Path stage- 99 no surgery done Seer summary stage- 7 distant.

Melanoma: Clinical: cT4b (at least, per Tumor Board 07/16/2025), cN0, cM0. Stg Grp: 2C. Per MD: Path: None, neoadjuvant tx. Post Therapy Path: n/a (No surgery at this time)

Prostate: per MD: Stage IVB (cT1c, cN1, cM1a, PSA: 22.6, Grade Group: 5) Per CR: PSA 9.1ng/mL before bx: cT1c (DRE benign) cN1 cM1, Stage 4B (Per MD: Pt has node positive

prostate cancer, I understand based on his discussion with Dr. A yesterday that at least one of the PSMA positive lymph nodes is adjacent to the kidneys, clearly out of the pelvis consistent with M1a disease.) Summary Stage (7) Distant LN

Text - Remarks

Document information that is not captured elsewhere in the abstract or that requires additional explanation. Use this field to clarify coding issues when needed.

Suggestions for text:

- Smoking history.
- Family and personal history of cancer.
- Comorbidities.
- Information on sequence numbers if a person was diagnosed with another cancer out-of-state or before the registry's reference date.
- Place of birth.
- Justification of over-ride flags.

Examples:

Breast: Family hx: MGM breast cancer, Mother breast cancer. Ins: Medicare & private 2nd

Lung: Shx- former smoker, quit 2022, non drinker. Fhx- no family hx of ca. Insurance- Medicaid. Occupation- construction.

Melanoma: Ht: 62in. Wt: 258lbs. Divorced. Medicare + Medicaid. Tobacco: Never. ETOH: None. PMhx: no hx of Ca. FamHx: Sister: Breast ca.

Hematopoietic: SHX- non smoker, former chew, occasional drinker. Fhx- MGF/lung, PGM/ovarian. insurance- BCBS VHP. Occupation- clerical.

Text - Place of Diagnosis

Document the facility, physician office, city, state, or county where the diagnosis was made. This information is particularly important when abstracting as a treating facility.

Treatment Text Fields

Text - Surgery

Document surgical procedures performed as part of treatment.

Suggestions for text:

- Date of each procedure.
- Type(s) of surgical procedure, including excisional biopsies and surgery to other or distant sites.
- Lymph nodes removed.
- Regional tissues removed.
- Metastatic sites.
- Facility where each procedure was performed.
- Other treatment information, such as a planned procedure that was aborted or uncertainty whether surgery was performed.

Text - Beam Radiation

Document beam radiation therapy administered as part of treatment for the tumor being reported.

Suggestions for text:

- Date radiation treatment began.
- Facility where treatment was given.
- Type of beam radiation, such as orthovoltage, Cobalt 60, megavoltage (MV) X-rays, electrons, or mixed modalities.
- Other relevant treatment information, such as treatment being discontinued after a specific number of treatments or uncertainty about whether radiation was given.

Text - Other Radiation

Document radiation therapy other than beam radiation administered as part of treatment for the tumor being reported. This includes brachytherapy and systemic radiation therapy.

Suggestions for text:

- Date treatment was started.
- Facility where treatment was given.
- Type of non-beam radiation, such as high-dose-rate brachytherapy, seed implant, or radioisotopes (for example, I-131).

- Other relevant treatment information, such as uncertainty about whether radiation was given or whether the patient refused treatment.

Text - Chemotherapy

Document chemotherapy administered as part of treatment for the tumor being reported.

Suggestions for text:

- Date chemotherapy began.
- Facility where treatment was given.
- Type of chemotherapy, including name of agent(s) or protocol.
- Other relevant treatment information, such as an incomplete cycle or uncertainty about whether chemotherapy was given.

Text - Hormones

Document hormonal therapy administered as part of treatment for the tumor being reported.

Suggestions for text:

- Date treatment began.
- Facility where treatment was given.
- Type of hormone or antihormone, such as tamoxifen.
- Type of endocrine surgery or radiation, such as orchiectomy.
- Other relevant treatment information, such as incomplete treatment cycle or uncertainty about whether hormonal therapy was given.

Text - Biological Response Modifiers (BRM)

Document biological response modifiers or immunotherapy administered as part of treatment for the tumor being reported.

Suggestions for text:

- Date treatment began.
- Facility where treatment was given
- Type of BRM or immunotherapy agent, such as interferon or BCG.
- BRM-related procedures, such as bone marrow transplant or stem cell transplant.
- Other relevant treatment information, such as incomplete treatment cycle or uncertainty about whether BRM or immunotherapy was given.

Text - Other Treatment

Document treatment for the tumor being reported that cannot be classified as surgery, radiation, or systemic therapy. This includes experimental treatments when the mechanism of action for a drug is unknown and treatment received as part of a blinded clinical trial. If the mechanism of action of an experimental drug is known, document it in the appropriate treatment field.

Suggestions for text:

- Date treatment began.
- Facility where treatment was given.
- Type of other treatment, such as blinded clinical trial or hyperthermia.
- Other relevant treatment information, such as an incomplete treatment cycle or uncertainty about whether other treatment was given.

Quality Assurance

VCR quality assurance procedures include electronic edit checks, review of demographic fields, and ongoing quality assurance review of reported data. VCR also conducts reabstracting and casefinding audits and participates in external audits and other quality assurance activities to evaluate the accuracy and completeness of reported data. Quality Indicator Reports are provided to reporting facilities quarterly to support ongoing monitoring and improvement of data quality.

Data Acceptance Policy

All data must be submitted to the VCR in accordance with the requirements described in Transmission [of Case Information](#) in order to be accepted for review and analysis.

At least 90% of submitted cases must pass electronic edits. Cases that fail required electronic edits are rejected and must be corrected before they can be accepted. The percentage of cases passing edits is also reported as a quality indicator on the quarterly Quality Indicator Report (QIRs).

The percentage is calculated follows:

$$(\text{Cases without errors} \div \text{Total cases in the submittal}) \times 100$$

Electronic Edits

All submissions are processed through electronic edits upon receipt. Reporting requirements are updated annually, and the VCR provides hospital cancer registry software vendors with the current Vermont-specific edit set.

Hospital registrars should work directly with their software vendor to that the most recent Vermont-specific electronic edit metafile is installed and in use. Any questions regarding electronic edits should be directed to the Quality and Education Coordinator at AHS.VDHHSICancerRegistry@vermont.gov.

Quality Indicator Reports (QIRs)

Hospitals are evaluated quarterly for timeliness, accuracy and completeness. The Quality Indicator Reports (QIRs) are provided to the registrar, the registrar's supervisor, and hospital leadership. Hospitals should meet the following standards and are also compared to the statewide average:

- **Timeliness:** At least 90% of cases are reported within 180 days of the date of first contact.
- **Accuracy:** At least 90% of cases pass electronic edits.
- **Completeness:** 100% of cases are reported within 6 months of the close of the diagnosis year.

Quality Review

Once a submission has passed electronic edits and been processed, VCR conducts quality assurance review of reported data. Review may include assessment of reportability and verification of coding for primary site, histology, behavior, stage, and other selected data items. Abstracted text may be compared with coded values to evaluate accuracy and identify records that require additional review.

If a discrepancy is identified and additional information is needed to support coding, VCR will contact the reporting facility. Cases with unresolved errors are not accepted into the VCR database and are not eligible for analysis until errors are resolved.

Correction Process

Vermont reporting facilities are responsible for submitting data that meet VCR quality assurance standards. Cases that meet these standards upon initial submission are accepted into the VCR database and are eligible for analysis.

If a case does not meet VCR quality assurance standards, the reporting facility must provide any additional information or corrections requested by VCR. Cases must meet applicable quality assurance requirements before they can be accepted into the VCR database and credited to the reporting facility.

Reabstracting Audits

Reabstracting audits evaluate how accurately cases submitted to the VCR reflect information in a patient's medical record. During a reabstracting audit, VCR quality assurance staff independently abstract selected information from the medical record and compare it with corresponding data in the VCR database.

A standard set of data items, including at least 20 items, is evaluated for each audited case. Differences are reviewed and summarized. Reporting facilities are expected to achieve at least 95% overall accuracy.

If the 95% standard is met, no response to the audit findings is required. If the standard is not met, areas requiring improvement will be identified and a follow-up review may be conducted within two to three months.

Casefinding Audits

Casefinding audits evaluate how effectively a reporting facility identifies and reports all reportable cancer cases. VCR quality assurance staff review selected casefinding sources, such as pathology reports, imaging reports, and disease indices, for a defined time period and compare identified reportable cases with those submitted to VCR.

Completeness is calculated based on the proportion of reportable cases that were submitted. Reporting facilities are expected to achieve at least 95% completeness.

If the standard is met, no response to the audit findings is required. If the standard is not met, areas requiring improvement will be identified and a follow-up review may be conducted within two to three months. The reporting facility must also abstract and submit any reportable cases identified during the audit that were not previously reported.

Other/Special Study/Validation Audits

VCR may request assistance from reporting facilities with additional audits or special studies. These activities may be used to evaluate data completeness, validate selected data items, assess the effectiveness of prior education efforts, address specific quality assurance issues identified by VCR or the National Program of Cancer Registries (NPCR), or assess the availability of information collected after cases have been submitted to the VCR.

These audits may differ in scope and methodology from reabstracting or casefinding audits but are considered formal VCR activities and will count as an audit completed by the reporting facility.

Examples may include comparison of accession lists with VCR records, targeted review of selected data items or coding issues, or review of treatment information documented after the initial case submission.

Death Clearance

Death clearance is conducted annually to identify reportable cancer cases that may not have been previously reported to the VCR. Reporting facilities receive a list of deceased individuals whose death certificates indicate a cancer diagnosis and are asked to determine whether the cancer was documented in the facilities records.

Facilities should review the cancer registry database, patient index, and available medical records to determine if the cancer was diagnosed on or after November 1, 1993. If a reportable cancer diagnosed on or after that date has not previously been submitted to the VCR, an abstract must be completed and submitted.

Transmission of Case Information

VCR uses Web Plus, a secure web-based application, to collect cancer data electronically. Data transmitted through Web Plus is encrypted during transmission. This section describes the required file format and procedures for submitting data to VCR.

Format

The required file format for reporting cases is the current NAACCR standard data exchange format.

The required file naming convention is an abbreviation of the facility name followed by the three-digit ordinal date. A final letter may be added to distinguish multiple files uploaded on the same date. Additional information about the submission should be entered in the Web Plus comment box or provided by email. **Do not include personally identifiable information (PII) or protected health information (PHI) in any email communications.**

Example: VCR034a.xml and VCR034b.xml for two files uploaded on February 3. Additional information, such as “November 2026 diagnoses,” should be entered in the comment box.

Contact your software vendor if assistance is needed to configure this file naming convention.

Transmission of Data File

Transmit data files at least monthly. If there are no cases to submit during a month, notify VCR at AHS.VDHHSICancerRegistry@vermont.gov.

Data files must be transmitted through Web Plus. Contact VCR for instructions or assistance with Web Plus.

Upload all files using the **Non-NAACCR File** option in Web Plus, including NAACCR-formatted data files. Do not select the NAACCR XML File options.

The screenshot shows a web form for uploading data files. At the top, there are three radio button options: "NAACCR V25.x XML File", "NAACCR V24.x XML File", and "Non-NAACCR File". The "Non-NAACCR File" option is selected. Below these options is a label "Select a file to upload:" followed by a "Choose File" button and the text "No file chosen". Underneath is a large text area labeled "Comment" with a small icon in the bottom right corner. At the bottom left of the form is an "Upload" button.

Transmission of Supporting Information

Supporting information, including case specific questions, supporting documentation, accession list comparison documents, and death clearance spreadsheets, may be uploaded as electronic files using the **Non-NAACCR File** option.

Appendix A: Vermont Cancer Registry Law

Title 18: Health

Chapter 4: Cancer Registry

§ 151. Definitions

As used in this chapter:

- (1) "Cancer" means all malignant neoplasms, regardless of the tissue of origin, including malignant lymphoma, Hodgkins disease, and leukemia, but excluding basal cell and squamous cell carcinoma of the skin.
- (2) "Health care facility" shall have the meaning given in section 9432 of this title.
- (3) "Health care provider" shall have the meaning given in section 9432 of this title.
(Added 1993, No. 90, § 2.)

§ 152. Establishment of cancer registry

(a) The Commissioner shall establish a uniform statewide population-based cancer registry system for the collection of information determining the incidence of cancer and related data. The Secretary shall adopt rules necessary to effect the purposes of this chapter, including the data to be reported and the effective date after which reporting by health care facilities and health care providers shall be required.

(b) All cancers diagnosed or treated in the State shall be reported to the representative of the Department of Health authorized by the Commissioner to compile the cancer data, or any individual, agency, or organization designated to cooperate with that representative.

(c) The Commissioner shall establish a training program for the personnel of participating health care facilities and a quality control program for cancer data. The Commissioner shall collaborate in studies with clinicians and epidemiologists and publish reports on the results of such studies. The Commissioner shall cooperate with the National Institutes of Health and the Centers for Disease Control and Prevention in providing cancer incidence data. (Added 1993, No. 90, § 2.)

§ 153. Participation in program

(a) Any health care facility diagnosing or providing treatment to patients with cancer shall report each case of cancer to the Commissioner or his or her authorized representative in a format prescribed by the Commissioner within 180 days of admission or diagnosis. If the facility fails to report in a format prescribed by the Commissioner, the Commissioner's

authorized representative may enter the facility, obtain the information, and report it in the appropriate format. In these cases, the facility shall reimburse the Commissioner or the authorized representative for the cost of obtaining and reporting the information.

(b) Any health care provider diagnosing or providing treatment to patients with cancer shall report each cancer case to the Commissioner or his or her authorized representative within 180 days of diagnosis. Those cases diagnosed or treated at a Vermont facility or previously admitted to a Vermont facility for diagnosis or treatment of that instance of cancer are exceptions and do not need to be reported by the health care provider.

(c) All health care facilities and health care providers who provide diagnostic or treatment services to patients with cancer shall report to the Commissioner any further demographic, diagnostic, or treatment information requested by the Commissioner concerning any person now or formerly receiving services, diagnosed as having or having had a malignant tumor. Additionally, the Commissioner or his or her authorized representative shall have physical access to all records that would identify cases of cancer or would establish characteristics of the cancer, treatment of the cancer, or medical status of any identified patient with cancer. Willful failure to grant access to such records shall be punishable by a fine of up to \$500.00 for each day access is refused. Any fines collected pursuant to this subsection shall be deposited in the General Fund. (Added 1993, No. 90, § 2; amended 2015, No. 37, § 1.)

§ 154. Confidentiality

(a) All information reported pursuant to this chapter shall be confidential and privileged. The Commissioner shall take strict measures to ensure that all identifying information is kept confidential.

(b) All identifying information regarding an individual patient, health care provider, or health care facility contained in records of interviews, written reports, and statements procured by the Commissioner or by any other person, agency, or organization acting jointly with the Commissioner in connection with cancer morbidity and mortality studies shall be confidential and privileged and shall be used solely for the purposes of the study. Nothing in this section shall prevent the Commissioner from publishing statistical compilations relating to morbidity and mortality studies which do not identify individual cases or sources of information. (Added 1993, No. 90, § 2.)

§ 155. Disclosure

(a) The Commissioner may enter into agreements to exchange confidential information with other cancer registries in order to obtain complete reports of Vermont residents diagnosed or treated in other states and to provide information to other states regarding their residents diagnosed or treated in Vermont.

(b) The Commissioner may furnish confidential information to the National Breast and Cervical Cancer Early Detection Program, other states' cancer registries, federal cancer

control agencies, or health researchers in order to collaborate in a national cancer registry or to collaborate in cancer control and prevention research studies. However, before releasing confidential information, the Commissioner shall first obtain from such state registries, agencies, or researchers an agreement in writing to keep the identifying information confidential and privileged. In the case of researchers, the Commissioner shall also first obtain evidence of the approval of their academic committee for the protection of human subjects established in accordance with 45 C.F.R. part 46. (Added 1993, No. 90, § 2; amended 2015, No. 37, § 1.)

§ 156. Liability

(a) No action for damages arising from the disclosure of confidential or privileged information may be maintained against any person, or the employer or employee of any person, who participates in good faith in the reporting of cancer registry data or data for cancer morbidity or mortality studies in accordance with this chapter.

(b) No license of a health care facility or health care provider may be denied, suspended, or revoked for the good faith disclosure of confidential or privileged information in the reporting of cancer registry data or data for cancer morbidity or mortality studies in accordance with this chapter.

(c) Nothing in this section shall be construed to apply to the unauthorized disclosure of confidential or privileged information when such disclosure is due to gross negligence or willful misconduct. (Added 1993, No. 90, § 2.)

§ 157. Vermont Mammography Registry

The confidentiality, disclosure, and liability provisions of sections 154, 155, and 156 of this title shall likewise apply to all mammography and pathology data relating to breast cancer and any associated identifying information acquired by the Vermont Mammography Registry (VMR). In the case of VMR, the rights and obligations of the Commissioner of Health shall be assumed by the appropriate VMR governing body or official. (Added 1993, No. 140 (Adj. Sess.), § 107a, eff. April 15, 1994.)

§ 158. Dense breast notification and education

(a) All health care facilities that perform mammography examinations shall include in the summary of the mammography report to be provided to a patient information that identifies the patient's individual breast tissue classification based on the Breast Imaging Reporting and Data System established by the American College of Radiology. If a facility determines that a patient has heterogeneously dense or extremely dense breasts, the summary of the mammography report shall also include a notice substantially similar to the following:

"Your mammogram indicates that you have dense breast tissue. Dense breast tissue is a normal finding that is present in about 40 percent of women. Dense breast tissue can make it more difficult to detect cancer on a mammogram and may be associated with a

slightly increased risk for breast cancer. This information is provided to raise your awareness of the impact of breast density on cancer detection and to encourage you to discuss this issue, as well as other breast cancer risk factors, with your health care provider as you decide together which screening options may be right for you."

(b) Facilities that perform mammography examinations may update the language in their notices over time to reflect advances in science and technology, as long as they continue to notify patients about the frequency of dense breast tissue and its effect on the accuracy of mammograms and encourage patients to discuss the issue with their health care provider. Facilities shall notify the Department of Health each time they make changes to the notice required by this section and shall provide an updated copy for the Department's information and review.

(c) Nothing in this section shall be construed to create a duty of care or other legal obligation beyond the duty to provide notice as set forth in this section. (Added 2015, No. 139 (Adj. Sess.), § 1.)

Source: <https://legislature.vermont.gov/statutes/fullchapter/18/004>

Cancer Registry Rule

1.0 Authority

- 1.1 This rule is adopted pursuant to 18 V.S.A. § 152(a).

2.0 Purpose

This rule implements the Vermont Cancer Registry (VCR) created by 18 V.S.A. chapter 4 that requires the Commissioner of Health to establish a uniform statewide population-based cancer registry system for the collection of information determining the incidence of cancer and related data.

3.0 Definitions

- 3.1 "Cancer" means all malignant neoplasms, regardless of the tissue of origin, including malignant lymphoma, Hodgkin's disease, and leukemia, but excluding basal cell and squamous cell carcinoma of the skin.
- 3.2 "Health care facility" means all persons or institutions, including mobile facilities, whether public or private, proprietary or not for profit, which offer diagnosis, treatment, inpatient, or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. The term shall not apply to any institution operated by religious groups relying solely on spiritual means through prayer for healing, but shall include but is not limited to:
 - 3.2.1 Hospitals, including general hospitals, mental hospitals, chronic disease facilities, birthing centers, maternity hospitals, and psychiatric facilities including any hospital conducted, maintained, or operated by the state of Vermont, or its subdivisions, or a duly authorized agency thereof; and
 - 3.2.2 Nursing homes, health maintenance organizations, home health agencies, outpatient diagnostic or therapy programs, kidney disease treatment centers, mental health agencies or centers, diagnostic imaging facilities, independent diagnostic laboratories, cardiac catheterization laboratories, radiation therapy facilities, or any inpatient or ambulatory surgical, diagnostic, or treatment center.
- 3.3 "Health care provider" means a person, partnership, corporation, facility, or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment, or confinement.

4.0 Data Reporting Requirements

- 4.1 Reporting Timeliness

- 4.1.1 A health care facility or health care provider diagnosing or providing treatment to cancer patients must report each case of cancer to the VCR within 180 days of admission or diagnosis as prescribed by these regulations if the cancer is diagnosed on or after November 1, 1993.

4.2 Reportable Neoplasms

4.2.1 The following neoplasms are reportable:

- 4.2.1.1 All cancers with a behavior code of "2" (in situ) or "3" (malignant) in the latest edition of the International Classification of Diseases for Oncology (ICD-O); and
- 4.2.1.2 Benign and borderline (behavior codes 0 and 1) primary intracranial and central nervous system tumors, including juvenile astrocytoma (M9421/3).

4.2.2 The following are not reportable to the VCR:

- 4.2.2.1 Skin primary (C440-C449) with any of the following histologies:
- Malignant neoplasm (8000-8005)
 - Epithelial carcinoma (8010-8046)
 - Papillary and squamous cell carcinoma (8050-8084)
 - Basal cell carcinoma (8090-8110).
- 4.2.2.2 Carcinoma in situ of cervix (/2) or cervical intraepithelial neoplasia (CIN III) of the cervix (C530-C539);
- 4.2.2.4 Prostatic intraepithelial neoplasia (PIN III) of the prostate (C619).

4.3 Data Elements

Each health care facility or health care provider shall report cases to VCR in the format defined in the VCR Procedure Manual and shall include all of the data elements detailed in the VCR Procedure Manual. The data elements include information related to:

- Patient Identifiers and Demographics
- Provider and Facility Identifiers
- Cancer Identification
- Extent of Disease at Diagnosis
- First Course of Treatment
- Follow-up

5.0 Data Quality

5.1 Reviews

- 5.1.1 Each health care facility or health care provider shall permit periodic quality control reviews by the VCR, including case finding, abstracting, coding, and data submission processing.
- 5.1.2 Each new abstractor reporting to VCR must complete the New Registrar Procedure, as defined in the VCR Procedure Manual.
- 5.1.3 Health care facilities or health care providers reporting cases to the VCR shall adhere to the data quality standards as outlined in the VCR Procedure Manual.

5.2 Timing

Unless other arrangements are made with a facility or provider, no fewer than 10 working days' notice is established as the minimum notice period applicable whenever the VCR wishes to have access to information on site at a facility.

5.2 Training

The VCR will ensure the provision of data reporting and data quality training and consultation.

5.3 Mortality and Incidence Reconciliation

Health care facilities or health care providers shall assist the VCR in annual reconciliation of cancer mortality and incidence data.

Source: http://www.healthvermont.gov/sites/default/files/documents/pdf/REG_cancer-registry.pdf

Appendix B: Vermont County Codes

County	Code
Addison	001
Bennington	003
Caledonia	005
Chittenden	007
Essex	009
Franklin	011
Grand Isle	013
Lamoille	015
Orange	017
Orleans	019
Rutland	021
Washington	023
Windham	025
Windsor	027

Appendix C: Vermont Cities, Counties and Codes

Acceptable Abbreviations:

St - Saint
 N - North
 S - South
 E - East
 W - West

Even though these words can be abbreviated, if the word is spelled out that is also acceptable. There are no other acceptable abbreviations currently. For example, Junction cannot be abbreviated to Jct.

City/Town/Township	County
Adamant	023 Washington
Addison	001 Addison
Albany	019 Orleans
Alburg/Alburgh	013 Grand Isle
Alburg Center/Alburgh Center	013 Grand Isle
Alburg Springs/Alburgh Springs	013 Grand Isle
Amsden	027 Windsor
Andover	027 Windsor
Arlington	003 Bennington
Ascutney	027 Windsor
Athens	025 Windham
Averill	009 Essex
Avery's Gore	009 Essex
Bakersfield	011 Franklin
Baltimore	027 Windsor
Barnard	027 Windsor
Barnet	005 Caledonia
Barnumtown	001 Addison
Barnumville	003 Bennington
Barre	023 Washington
Barre City	023 Washington
Barre Town	023 Washington
Barton	019 Orleans
Bartonsville	025 Windham
Basin Harbor	001 Addison
Beebe Plain	019 Orleans

City/Town/Township	County
Beecher Falls	009 Essex
Bellows Falls	025 Windham
Belmont	021 Rutland
Belvidere	015 Lamoille
Belvidere Corners	015 Lamoille
Belvidere Center	015 Lamoille
Bennington	003 Bennington
Benson	021 Rutland
Benson Landing	021 Rutland
Berkshire	011 Franklin
Berlin	023 Washington
Berlin Corners	023 Washington
Bethel	027 Windsor
Binghamville	011 Franklin
Blissville	021 Rutland
Bloomfield	009 Essex
Bolton	007 Chittenden
Boltonville	017 Orange
Bomoseen	021 Rutland
Bondville	003 Bennington
Bordoville	011 Franklin
Bowlsville	021 Rutland
Bradford	017 Orange
Braintree	017 Orange
Braintree Center	017 Orange
Brandon	021 Rutland
Brattleboro	025 Windham
Bread Loaf	001 Addison
Bridgewater	027 Windsor
Bridgewater Center	027 Windsor
Bridgewater Corners	027 Windsor
Bridport	001 Addison
Brighton	009 Essex
Bristol	001 Addison
Brockway's Mills	025 Windham
Brookfield	017 Orange
Brookfield Center	017 Orange
Brookline	025 Windham

City/Town/Township	County
Brookside	007 Chittenden
Brooksville	001 Addison
Brownington	019 Orleans
Brownington Center	019 Orleans
Brownsville	027 Windsor
Brunswick	009 Essex
Brunswick Springs	009 Essex
Buck Hollow	011 Franklin
Buells Gore	007 Chittenden
Burke	005 Caledonia
Burke Hollow	005 Caledonia
Burlington	007 Chittenden
Cabot	023 Washington
Cadys Falls	015 Lamoille
Calais	023 Washington
Cambridge	015 Lamoille
Cambridge Junction	015 Lamoille
Cambridgeport	025 Windham
Canaan	009 Essex
Castleton	021 Rutland
Castleton Corners	021 Rutland
Cavendish	027 Windsor
Centerville	015 Lamoille
Central Park	025 Windham
Charleston/Charlestown	019 Orleans
Charlotte	007 Chittenden
Checkerberry Village	007 Chittenden
Chelsea	017 Orange
Chester	027 Windsor
Chester Depot	027 Windsor
Chimney Corner	007 Chittenden
Chimney Point	001 Addison
Chipman's Point	001 Addison
Chippenhook	021 Rutland
Chiselville	003 Bennington
Chittenden	021 Rutland
Clarendon	021 Rutland
Clarendon Springs	021 Rutland

City/Town/Township	County
Colbyville	023 Washington
Colchester	007 Chittenden
Cold River	021 Rutland
Collinsville	019 Orleans
Concord	009 Essex
Concord Corner	009 Essex
Cookville (Corinth P.O.)	017 Orange
Corinth	017 Orange
Corinth Center	017 Orange
Cornwall	001 Addison
Coventry	019 Orleans
Craftsbury	019 Orleans
Craftsbury Common	019 Orleans
Cuttingsville	021 Rutland
Danby	021 Rutland
Danby Four Corners	021 Rutland
Danville	005 Caledonia
Derby	019 Orleans
Derby Center	019 Orleans
Derby Line	019 Orleans
Dewey's Mills	027 Windsor
Dorset	003 Bennington
Dover	025 Windham
Downers	027 Windsor
Downingville	001 Addison
Dummerston	025 Windham
Dummerston Center	025 Windham
Duxbury	023 Washington
East Albany	019 Orleans
East Alburg	013 Grand Isle
East Arlington	003 Bennington
East Barnard	027 Windsor
East Barnet	005 Caledonia
East Barre	023 Washington
East Berkshire	011 Franklin
East Bethel	027 Windsor
East Braintree	017 Orange
East Brighton	009 Essex

City/Town/Township	County
East Brookfield	009 Orange
East Burke	005 Caledonia
East Cabot	023 Washington
East Calais	023 Washington
East Charlestown	019 Orleans
East Charlotte	007 Chittenden
East Clarendon	021 Rutland
East Concord	009 Essex
East Craftsbury	019 Orleans
East Dorset	003 Bennington
East Dover	025 Windham
East Dummerston	025 Windham
East Enosburg	011 Franklin
East Fairfield	011 Franklin
East Fletcher	011 Franklin
East Franklin	011 Franklin
East Georgia	011 Franklin
East Granville	001 Addison
East Hardwick	005 Caledonia
East Haven	009 Essex
East Hubbardton	021 Rutland
East Jamaica	025 Windham
East Johnson	015 Lamoille
East Lyndon	005 Caledonia
East Middlebury	001 Addison
East Monkton	001 Addison
East Montpelier	023 Washington
East Montpelier Center	023 Washington
East Orange	017 Orange
East Peacham	005 Caledonia
East Pittsford	021 Rutland
East Poultney	021 Rutland
East Randolph	017 Orange
East Richford	011 Franklin
East Roxbury	023 Washington
East Rupert	003 Bennington
East Ryegate	005 Caledonia
East Sheldon	011 Franklin

City/Town/Township	County
East Shoreham	001 Addison
East St. Johnsbury	005 Caledonia
East Thetford	017 Orange
East Topsham	017 Orange
East Wallingford	021 Rutland
East Warren	023 Washington
Eden	015 Lamoille
Eden Mills	015 Lamoille
Elmore	015 Lamoille
Ely	017 Orange
Emerson	027 Windsor
Enosburg	011 Franklin
Enosburg Falls	011 Franklin
Essex	007 Chittenden
Essex Center	007 Chittenden
Essex Junction	007 Chittenden
Evansville	019 Orleans
Ewells Mills	005 Caledonia
Fair Haven	021 Rutland
Fairfax	011 Franklin
Fairfax Falls	011 Franklin
Fairfield	011 Franklin
Fairfield Station	011 Franklin
Fairlee	017 Orange
Fairmont	023 Washington
Fays Corner	007 Chittenden
Fayston	023 Washington
Felchville (Reading P.O.)	027 Windsor
Ferdinand	009 Essex
Ferrisburg/Ferrisburgh	001 Addison
Ferrisburg Station/Ferrisburgh Station	001 Addison
Fletcher	011 Franklin
Florence	021 Rutland
Forest Dale	021 Rutland
Foxville	017 Orange
Franklin	011 Franklin
Gageville	025 Windham
Gallup Mills	009 Essex

City/Town/Township	County
Gassetts	027 Windsor
Gaysville	027 Windsor
Georgia	011 Franklin
Georgia Center	011 Franklin
Georgia Plains	011 Franklin
Gilead	027 Windsor
Gilman	009 Essex
Glastenbury	003 Bennington
Glover	019 Orleans
Goose Green	017 Orange
Gordon Landing	013 Grand Isle
Goshen	001 Addison
Goshen Four Corners	001 Addison
Goulds Mills	027 Windsor
Grafton	025 Windham
Granby	009 Essex
Grand Isle	013 Grand Isle
Grand Isle Station	013 Grand Isle
Graniteville	023 Washington
Granville	001 Addison
Green River	025 Windham
Greensboro	019 Orleans
Greensboro Bend	019 Orleans
Groton	005 Caledonia
Guildhall	009 Essex
Guilford	025 Windham
Guilford Center	025 Windham
Halifax	025 Windham
Hancock	001 Addison
Hanksville	007 Chittenden
Hardwick	005 Caledonia
Harmonyville	025 Windham
Hartford	027 Windsor
Hartland	027 Windsor
Hartland Four Corner	027 Windsor
Hartwellville	009 Essex
Harvey	005 Caledonia
Healdville	021 Rutland

City/Town/Township	County
Heartwellville	003 Bennington
Hewetts Corners	027 Windsor
Highgate	011 Franklin
Highgate Center	011 Franklin
Highgate Falls	011 Franklin
Highgate Springs	011 Franklin
Hinesburg	007 Chittenden
Holden	021 Rutland
Holland	019 Orleans
Hortonia	021 Rutland
Hortonville	021 Rutland
Houghtonville	025 Windham
Hubbardton	021 Rutland
Huntington	007 Chittenden
Huntington Center	007 Chittenden
Hyde Park	015 Lamoille
Hydeville	021 Rutland
Ira	021 Rutland
Irasburg	019 Orleans
Irasville	023 Washington
Island Pond	009 Essex
Isle La Motte	013 Grand Isle
Jacksonville	025 Windham
Jamaica	025 Windham
Jay	019 Orleans
Jeffersonville	015 Lamoille
Jericho	007 Chittenden
Jericho Center	007 Chittenden
Jerusalem	001 Addison
Johnson	015 Lamoille
Jonesville	007 Chittenden
Kansas	003 Bennington
Keeler Bay	013 Grand Isle
Kelley Stand	003 Bennington
Kents Corners	023 Washington
Killington	021 Rutland
Kirby	005 Caledonia
Lake Elmore	015 Lamoille

City/Town/Township	County
Lake Dunmore	001 Addison
Landgrove	003 Bennington
Larrabees Point	001 Addison
Leicester	001 Addison
Leicester Junction	001 Addison
Lemington	009 Essex
Lewis	009 Essex
Lewiston	027 Windsor
Lincoln	001 Addison
Londonderry	025 Windham
Lowell	019 Orleans
Lower Cabot	023 Washington
Lower Granville	001 Addison
Lower Plain	017 Orange
Lower Waterford	005 Caledonia
Ludlow	027 Windsor
Lunenburg	009 Essex
Lympus	027 Windsor
Lyndon	005 Caledonia
Lyndon Center	005 Caledonia
Lyndonville	005 Caledonia
Mackville	005 Caledonia
Maidstone	009 Essex
Mallett's Bay	007 Chittenden
Manchester	003 Bennington
Manchester Center	003 Bennington
Manchester Depot	003 Bennington
Maple Corner (Calais P.O.)	023 Washington
Maquam	011 Franklin
Marlboro	025 Windham
Marshfield	023 Washington
Mc Indoe Falls	005 Caledonia
Mechanicsville	007 Chittenden
Melville Landing	011 Franklin
Mendon	021 Rutland
Middlebury	001 Addison
Middlesex	023 Washington
Middlesex Center	023 Washington

City/Town/Township	County
Middletown Springs	021 Rutland
Miles Pond	009 Essex
Mill Village	017 Orange
Milton	007 Chittenden
Monkton	001 Addison
Monkton Boro	001 Addison
Monkton Ridge	001 Addison
Montgomery	011 Franklin
Montgomery Center	011 Franklin
Montpelier	023 Washington
Moretown	023 Washington
Moretown Common	023 Washington
Morgan	019 Orleans
Morgan Center	019 Orleans
Morristown	015 Lamoille
Morrisville	015 Lamoille
Morses Line	011 Franklin
Moscow	015 Lamoille
Mt. Tabor (Mount Tabor)	021 Rutland
Mt. Holly (Mount Holly)	021 Rutland
New Haven Junction	001 Addison
New Boston	027 Windsor
New Haven	001 Addison
New Haven Mills	001 Addison
Newark	005 Caledonia
Newbury	017 Orange
Newfane	025 Windham
Newport	019 Orleans
Newport Center	019 Orleans
Newport City	019 Orleans
Newport Town	019 Orleans
North Bennington	003 Bennington
North Calais	023 Washington
North Cambridge	015 Lamoille
North Clarendon	021 Rutland
North Concord	009 Essex
North Danville	005 Caledonia
North Derby	019 Orleans

City/Town/Township	County
North Dorset	003 Bennington
North Duxbury	023 Washington
North Enosburg	011 Franklin
North Fairfax	011 Franklin
North Fayston	023 Washington
North Ferrisburg/North Ferrisburgh	001 Addison
North Hartland	027 Windsor
North Hero	013 Grand Isle
North Hyde Park	015 Lamoille
North Kirby	005 Caledonia
North Landgrove	003 Bennington
North Montpelier	023 Washington
North Pawlet	021 Rutland
North Pomfret	027 Windsor
North Pownal	003 Bennington
North Randolph	017 Orange
North Rupert	003 Bennington
North Sheldon	011 Franklin
North Shrewsbury	021 Rutland
North Springfield	027 Windsor
North Thetford	017 Orange
North Troy	019 Orleans
North Tunbridge	017 Orange
North Walden	005 Caledonia
North Westminster	025 Windham
North Williston	007 Chittenden
North Windham	025 Windham
North Wolcott	015 Lamoille
Northfield	023 Washington
Northfield Center	023 Washington
Northfield Falls	023 Washington
Norton	009 Essex
Norwich	027 Windsor
Oakland	011 Franklin
Old Bennington	003 Bennington
Orange	017 Orange
Orleans	019 Orleans
Orwell	001 Addison

City/Town/Township	County
Panton	001 Addison
Passumpsic	005 Caledonia
Pawlet	021 Rutland
Peacham	005 Caledonia
Pearl	013 Grand Isle
Peasville	027 Windsor
Pekin	023 Washington
Perkinsville	027 Windsor
Peru	003 Bennington
Pikes Falls	025 Windham
Pittsfield	021 Rutland
Pittsford	021 Rutland
Pittsford Mills	021 Rutland
Plainfield	023 Washington
Pleasant Valley	015 Lamoille
Plymouth	027 Windsor
Plymouth Union	027 Windsor
Pomfret	027 Windsor
Pompanoosuc	027 Windsor
Post Mills	017 Orange
Poultney	021 Rutland
Pownal	003 Bennington
Pownal Center	003 Bennington
Prindle Corners	007 Chittenden
Proctor	021 Rutland
Proctorsville	027 Windsor
Prosper	027 Windsor
Putnamville	023 Washington
Putney	025 Windham
Quechee	027 Windsor
Randolph	017 Orange
Randolph Center	017 Orange
Rawsonville	025 Windham
Reading	027 Windsor
Readsboro	003 Bennington
Readsboro Falls	003 Bennington
Rhode Island Corners	007 Chittenden
Richford	011 Franklin

City/Town/Township	County
Richmond	007 Chittenden
Ricker Mills	005 Caledonia
Ripton	001 Addison
Riverton (West Berlin)	023 Washington
Robinson	027 Windsor
Rochester	027 Windsor
Rockingham	025 Windham
Rockville	001 Addison
Rocky Dale	001 Addison
Roxbury	023 Washington
Royalton	027 Windsor
Rupert	003 Bennington
Rutland	021 Rutland
Rutland City	021 Rutland
Rutland Town	021 Rutland
Ryegate	005 Caledonia
Ryegate Corner	005 Caledonia
Saint Albans	011 Franklin
Saint Albans Bay	011 Franklin
Saint Albans City	011 Franklin
Saint Albans Town	011 Franklin
Saint George	007 Chittenden
Saint Rocks	011 Franklin
Saint Johnsbury	005 Caledonia
Saint Johnsbury Center	005 Caledonia
Salisbury	001 Addison
Salisbury Station	001 Addison
Sandgate	003 Bennington
Saxtons River	025 Windham
Searsburg	003 Bennington
Shady Rill	023 Washington
Shaftsbury	003 Bennington
Shaftsbury Center	003 Bennington
Sharon	027 Windsor
Shawville	011 Franklin
Sheddsville	027 Windsor
Sheffield	005 Caledonia
Shelburne	007 Chittenden

City/Town/Township	County
Shelburne Falls	007 Chittenden
Sheldon Junction	011 Franklin
Sheldon Springs	011 Franklin
Sheldon	011 Franklin
Sherburne	021 Rutland
Sherburne Center (Killington P.O.)	021 Rutland
Shoreham	001 Addison
Shoreham Center	001 Addison
Shrewsbury	021 Rutland
Simonsville	027 Windsor
Simpsonville	025 Windham
Smithville	027 Windsor
Somerset	025 Windham
South Albany	019 Orleans
South Alburg/South Alburgh	013 Grand Isle
South Barre	023 Washington
South Burlington	007 Chittenden
South Cabot	023 Washington
South Cambridge	015 Lamoille
South Corinth	017 Orange
South Dorset	003 Bennington
South Duxbury	023 Washington
South Hero	013 Grand Isle
South Kirby	005 Caledonia
South Lincoln	001 Addison
South Londonderry	025 Windham
South Lunenburg	009 Essex
South Newbury	017 Orange
South Newfane	025 Windham
South Northfield	023 Washington
South Peacham	005 Caledonia
South Pomfret	027 Windsor
South Randolph	017 Orange
South Reading	027 Windsor
South Royalton	027 Windsor
South Ryegate	005 Caledonia
South Shaftsbury	003 Bennington
South Strafford	017 Orange

City/Town/Township	County
South Starksboro	001 Addison
South Tunbridge	017 Orange
South Vernon	025 Windham
South Vershire	017 Orange
South Walden	005 Caledonia
South Wallingford	021 Rutland
South Wardsboro	025 Windham
South Wheelock	005 Caledonia
South Windham	025 Windham
South Woodbury	023 Washington
South Woodstock	027 Windsor
Springfield	027 Windsor
St. Albans	011 Franklin
St. Albans Bay	011 Franklin
St. Albans City	011 Franklin
St. Albans Town	011 Franklin
St. George	007 Chittenden
St. Rocks	011 Franklin
St. Johnsbury	005 Caledonia
St. Johnsbury Center	005 Caledonia
Stamford	003 Bennington
Stannard	005 Caledonia
Starksboro	001 Addison
Stevens Mills	011 Franklin
Stockbridge	027 Windsor
Stowe	015 Lamoille
Strafford	017 Orange
Stratton	025 Windham
Sudbury	021 Rutland
Sunderland	003 Bennington
Sunderland Station	003 Bennington
Sutton	005 Caledonia
Swanton	011 Franklin
Taftsville	027 Windsor
Talcville	027 Windsor
Tarbellville	021 Rutland
Thetford	017 Orange
Thetford Center	017 Orange

City/Town/Township	County
Thetford Hill	017 Orange
Tinmouth	021 Rutland
Topsham	017 Orange
Topsham Four Corners	017 Orange
Townshend	025 Windham
Trow Hill	023 Washington
Troy	019 Orleans
Tunbridge	017 Orange
Tyson	027 Windsor
Underhill	007 Chittenden
Underhill Center	007 Chittenden
Underhill Flats	007 Chittenden
Union Village	017 Orange
Vergennes	001 Addison
Vernon	025 Windham
Vershire	017 Orange
Victory	009 Essex
Waits River	017 Orange
Waitsfield	023 Washington
Walden	005 Caledonia
Walden Station	005 Caledonia
Wallace Pond	009 Essex
Wallingford	021 Rutland
Waltham	001 Addison
Wardsboro	025 Windham
Wardsboro Center	025 Windham
Warners Grant	009 Essex
Warren	023 Washington
Warren Gore	009 Essex
Washington	017 Orange
Waterbury	023 Washington
Waterbury Center	023 Washington
Waterford	005 Caledonia
Waterville	015 Lamoille
Weathersfield	027 Windsor
Weathersfield Bow	027 Windsor
Weathersfield Center	027 Windsor
Websterville	023 Washington

City/Town/Township	County
Wells	021 Rutland
Wells River	017 Orange
West Addison	001 Addison
West Arlington	003 Bennington
West Barnet	005 Caledonia
West Berkshire	011 Franklin
West Berlin (Riverton P.O.)	023 Washington
West Bolton	007 Chittenden
West Braintree	017 Orange
West Brattleboro	025 Windham
West Bridgewater	027 Windsor
West Bridport	001 Addison
West Brookfield	017 Orange
West Burke	005 Caledonia
West Castleton	021 Rutland
West Charlestown/West Charleston	019 Orleans
West Corinth	017 Orange
West Cornwall	001 Addison
West Danville	005 Caledonia
West Dover	025 Windham
West Dummerston	025 Windham
West Enosburg	011 Franklin
West Fairlee	017 Orange
West Fairlee Center	017 Orange
West Glover	019 Orleans
West Groton	005 Caledonia
West Guilford	025 Windham
West Halifax	025 Windham
West Hartford	027 Windsor
West Haven	021 Rutland
West Lincoln	001 Addison
West Milton	007 Chittenden
West Newbury	017 Orange
West Norwich	027 Windsor
West Pawlet	021 Rutland
West Rupert	003 Bennington
West Rutland	021 Rutland
West Salisbury	001 Addison

City/Town/Township	County
West Swanton	011 Franklin
West Topsham	017 Orange
West Townshend	025 Windham
West Wardsboro	025 Windham
West Waterford	005 Caledonia
West Windsor	027 Windsor
West Woodstock	027 Windsor
Westfield	019 Orleans
Westford	007 Chittenden
Westminster	025 Windham
Westminster West	025 Windham
Westmore	019 Orleans
Weston	027 Windsor
Weybridge	001 Addison
Weybridge Hill	001 Addison
Wheelock	005 Caledonia
White River Junction	027 Windsor
Whiting	001 Addison
Whitingham	025 Windham
Wilder	027 Windsor
Williamstown	017 Orange
Williamsville	025 Windham
Williston	007 Chittenden
Wilmington	025 Windham
Windham	025 Windham
Windsor	027 Windsor
Winhall	003 Bennington
Winooski	007 Chittenden
Wolcott	015 Lamoille
Woodbury	023 Washington
Woodford	003 Bennington
Woodstock	027 Windsor
Worcester	023 Washington
Wrightsville	023 Washington

Appendix D: Reference Materials Based on Diagnosis Year

This is a historic list of reference materials necessary to abstract cancer cases based on diagnosis year. **Regardless of diagnosis year, the most recent Solid Tumor Rules should be used to determine histology and multiple primaries.** For assistance in abstracting old cases, contact AHS.VDHHSICancerRegistry@vermont.gov.

Effective Year	Reference Manual
2026	VCR HPM 2026 SEER Program Coding and Staging Manual 2026 STORE 2026 ICD-O-3.2 Solid Tumor Rules 2026.1 Hematopoietic and Lymphoid Neoplasm Coding Manual Hematopoietic & Lymphoid Neoplasm Database SEER Summary Staging Manual 2018 Site-Specific Data Item (SSDI) Manual Version 3.3 Grade Coding Instructions and Tables Version 3.3 SEER*Rx – Interactive Drug Database
2025	VCR HPM 2025 SEER Program Coding and Staging Manual 2025 STORE 2025 ICD-O-3.2 Solid Tumor Rules Hematopoietic and Lymphoid Neoplasm Coding Manual Hematopoietic & Lymphoid Neoplasm Database SEER Summary Staging Manual 2018 Site-Specific Data Item (SSDI) Manual Version Grade Coding Instructions and Tables Version SEER*Rx – Interactive Drug Database
2024	VCR HPM 2024 SEER Program Coding and Staging Manual 2024 STORE 2024 ICD-O-3.2 Solid Tumor Rules Hematopoietic and Lymphoid Neoplasm Coding Manual Hematopoietic & Lymphoid Neoplasm Database SEER Summary Staging Manual 2018 v3.1 Site-Specific Data Item (SSDI) Manual Version Grade Coding Instructions and Tables Version SEER*Rx – Interactive Drug Database

Effective Year	Reference Manual
2023	VCR HPM 2023 SEER Program Coding and Staging Manual 2023 STORE 2023 ICD-O-3.2 Solid Tumor Rules Hematopoietic and Lymphoid Neoplasm Coding Manual Hematopoietic & Lymphoid Neoplasm Database SEER Summary Staging Manual 2018 Site-Specific Data Item (SSDI) Manual Version Grade Coding Instructions and Tables Version SEER*Rx – Interactive Drug Database
2022	VCR HPM 2022 STORE 2022 ICD-O-3.2 SEER Program Coding and Staging Manual 2022 SEER Summary Staging Manual 2018 Solid Tumor Rules Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual Site-Specific Data Item (SSDI) Manual Grade Manual SEER*Rx – Interactive Drug Database
2021	VCR HPM 2021 STORE 2021 ICD-O-3.2 SEER Program Coding and Staging Manual 2021 SEER Summary Staging Manual 2021 Solid Tumor Rules Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual Site-Specific Data Item (SSDI) Manual Grade Manual SEER*Rx – Interactive Drug Database STORE 2018 ICD-O-3, 3 rd ed.

Effective Year	Reference Manual
2018-2020	VCR HPM 2018-2020 SEER Program Coding and Staging Manual 2018 SEER Summary Staging Manual 2018 Solid Tumor Rules Multiple Primary and Histology Coding Rules Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual Site-Specific Data Item (SSDI) Manual
2018-2020	Grade Manual SEER*Rx – Interactive Drug Database
2016-2017	VCR HPM 2016 FORDS Manual 2016 Multiple Primary and Histology Coding Rules SEER Program Coding and Staging Manual 2016 SEER Summary Staging Manual 2000 AJCC Cancer Staging Manual 7 th ed. Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual ICD-O-3, 3 rd ed. SEER*Rx – Interactive Drug Database VCR Required SSF Table
2015	VCR HPM 2015 FORDS Manual 2015 ICD-O-3, 3 rd ed. Collaborative Stage Data Collection System v0205 SEER Summary Staging Manual 2000, updated 12/2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual v3.1.0 Multiple Primary and Histology Coding Rules SEER*Rx – Interactive Drug Database v2.2.0 AJCC Cancer Staging Manual 7 th ed.
2014	VCR HPM v8.1 FORDS Manual 2013 ICD-O-3, 3 rd ed. Collaborative Stage Data Collection System v0205 SEER Summary Staging Manual 2000, updated 12/2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual v2.3.1 Multiple Primary and Histology Coding Rules SEER*Rx – Interactive Drug Database v2.2.0 AJCC Cancer Staging Manual 7 th ed. 2014 VCR Required Site-Specific Table

Effective Year	Reference Manual
2013	VCR HPM v8 FORDS Manual 2013 Collaborative Stage Data Collection System, v0204 AJCC Staging Manual, Seventh Edition, 2010 Multiple Primary and Histology Coding Rules, Revised 2012 NCI Hematopoietic Database v2.2 SEER Program Coding and Staging Manual 2013 NPCR SSF Grid 2011
2012	VCR HPM 7.2 FORDS Manual 2012 Collaborative Stage Data Collection System, v02.04.00 WHO ICD-O-3, 2000 AJCC Staging Manual, Seventh Edition, 2010 Multiple Primary and Histology Coding Rules, Revised 2012 NCI Hematopoietic Database, v2.1 SEER Program Coding and Staging Manual 2011 NPCR SSF Grid 2011
2011	VCR HPM 7.1 FORDS Manual 2011 Collaborative Stage Data Collection System, v02.03.02 WHO ICD-O-3, 2000 AJCC Staging Manual, Seventh Edition, 2010 Multiple Primary and Histology Coding Rules, Revised November 5, 2010 NCI Hematopoietic Database, v1.6.2 SEER Program Coding and Staging Manual 2010 VCR Required SSF for CSv02.03
2010	VCR HPM 7 FORDS Manual 2010 SEER Program Coding and Staging Manual WHO ICD-O-3, 2000 SEER Summary Staging Manual, 2000 AJCC Staging Manual, Seventh Edition, 2010 Collaborative Stage Data Collection System, v02.00.00 VCR Required SSF for CSv2

Effective Year	Reference Manual
2009	VCR HPM 6 FORDS Manual 2007 SEER Program Coding and Staging Manual 2007, Revision 1 WHO ICD-O-3, 2000 SEER Summary Staging Manual, 2000 AJCC Staging Manual, Sixth Edition, 2002 Collaborative Staging Manual and Coding Instruction, v01.04.00
2008	VCR HPM 6 FORDS Manual 2007 Multiple Primary and Histology Coding Rules, 2007 SEER Program Code Manual, 2007 Collaborative Stage Manual and Coding Instructions, v01.04.00 WHO ICD-O-3, 2000 AJCC Staging Manual, 6 th Edition, 2002 Data Collection of Primary Central Nervous System Tumors, 2004 Abstracting and Coding Guide for the Hematopoietic Diseases, 2002
2007	VCR HPM 5 FORDS Manual 2007 Multiple Primary and Histology Coding Rules, 2007 SEER Program Code Manual, 2007 Collaborative Stage Manual and Coding Instructions, v01.03.00 WHO ICD-O-3, 2000 AJCC Staging Manual, 6 th Edition, 2002 Data Collection of Primary Central Nervous System Tumors, 2004 Abstracting and Coding Guide for the Hematopoietic Diseases, 2002
2006	VCR HPM 5 FORDS Manual 2004 SEER Program Code Manual, 1998 Collaborative Stage Manual and Coding Instructions, v01.02.00 WHO ICD-O-3, 2000 AJCC Staging Manual, 6 th Edition, 2002 Data Collection of Primary Central Nervous System Tumors, 2004 Abstracting and Coding Guide for the Hematopoietic Diseases, 2002
2005	Same as 2004

Effective Year	Reference Manual
2004	VCR HPM 5 FORDS Manual 2004 SEER Program Code Manual, 1998 Collaborative Stage Manual and Coding Instructions, v1.0 WHO ICD-O-3, 2000 AJCC Staging Manual, 6 th Edition, 2002 Data Collection of Primary Central Nervous System Tumors, 2004 Abstracting and Coding Guide for the Hematopoietic Diseases, 2002
2003	VCR HPM 5 FORDS Manual 2003 SEER Program Code Manual, 1998 SEER Summary Stage Manual, 2000 WHO ICD-O-3, 2000 AJCC Staging Manual, 6 th Edition, 2002 SEER Extent of Disease Manual, 1998 Abstracting and Coding Guide for the Hematopoietic Diseases, 2002
2001-2002	VCR HPM 4 ROADS Manual 1996 Revised in 1998 SEER Program Code Manual, 1998 WHO ICD-O-3, 2000 SEER Summary Stage Manual, 2000 AJCC Staging Manual, 6 th Edition, 2002 SEER Extent of Disease Manual, 1998 VCR HPM, 3 rd edition, 2000
1999	VCR HPM 2 ROADS Manual 1996 Revised in 1998 SEER Program Code Manual, 1998 WHO ICD-O-2, 1990 SEER Summary Stage Guide, 1977 AJCC Staging Manual, 5 th Edition, 1997 SEER Extent of Disease Manual, 1998
1998	VCR HPM 1 ROADS Manual 1996 SEER Program Code Manual, 1992 WHO ICD-O-2, 1990 SEER Summary Stage Guide, 1977 AJCC Staging Manual, 5 th Edition SEER Extent of Disease Manual, 1992

Effective Year	Reference Manual
1997	Same of 1996
1998	VCR HPM 1 ROADS Manual 1996 SEER Program Code Manual, 1992 WHO ICD-O-2, 1990 SEER Summary Stage Guide, 1977 AJCC Staging Manual, 4 th Edition SEER Extent of Disease Manual, 1992
1994	VCR HPM 1 ACOS Data Acquisition Manual SEER Program Code Manual, 1992 WHO ICD-O-2, 1990 SEER Summary Stage Guide, 1977 AJCC Staging Manual, 4 th Edition SEER Extent of Disease Manual, 1992