South Carolina Department of Public Health

SC Central Cancer Registry Dermatology Reporting Form Instructions

Use the following instructions to complete the form to submit reportable cases to the South Carolina Central Cancer Registry. Fields with a red asterisk (*) are required

Reporting Facility Name

Use the text box to enter the name of your facility. If your practice is a satellite office, add that information to the facility name to ensure accurate identification. *

Date of Completion

Use the calendar icon to select the date the form is being completed. Do not enter the date manually. *

Are you reporting for Dermatology or Urology

Use the drop-down box to select the appropriate specialty. *

Patient First Name

Use the text box to enter the patient's first name. *

Patient Middle Initial

Enter the patient's middle initial or middle name.

Patient Last Name

Use the text box to enter the patient's last name. *

Name Suffix

If applicable, enter any suffix such as Jr, Sr, III, MD, etc.

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Patient Social Security Number

Enter the patient's social security number. If the SSN is unknown, enter **999999999**. Do not use dashes, slashes, or special characters. *

Street Address at Diagnosis

Enter the street address where the patient lived at the time of diagnosis. *

City at Diagnosis

Enter the city where the patient lived at the time of diagnosis. *

State at Diagnosis

Use the drop-down box to select the appropriate state code corresponding to the address and city entered. Do not manually type the state. *

Zip Code at Diagnosis

Enter the zip code corresponding to the address, city, and state entered in the form. *

County at Diagnosis

Use the drop-down box to select the county where the patient lived at the time of diagnosis. This county must match the address information entered in this form. *

Patient Sex at Birth

Use the drop-down box to select the patient's sex at birth. *

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Patient Race

Use the drop-down box to select the appropriate race code for the patient. If race is unknown, choose the "Unknown" option. *

Patient Date of Birth (DOB)

Use the calendar icon to select the patient's date of birth. Do not enter the date manually. *

Date tissue was collected

Use the calendar icon to select the date of the biopsy or other procedure. Do not enter the date manually. *

Date of First Contact

Use the calendar icon to select the date the patient first visited your office or had their initial virtual visit. Do not enter the date manually. *

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ICDO3 Primary Site Code

Use the drop-down box to select the correct anatomical site where the cancer was located. Refer to the tip sheet in this instruction document for additional guidance on selecting the correct ICDO3 Primary Site. *

C440	Skin of lip (lower or upper)	C445	Skin of Trunk
C441	Eyelid (lower or upper)		Abdomen
	Canthus		Anus
	Inner Canthus		Axilla
C442	External Ear		Back
	Auricle		Breast
	Concha		Buttock
	Earlobe		Chest
	External Auditory Canal		Flank
	Helix		groin
	Tragus		Thorax
C443	Skin of other part of the face		Trunk
	Cheek		Umbilicus
	Chin	C446	Skin of Upper limb and shoulder
	Face		Arm
	Forehead		Elbow
	Jaw		Finger
	Nose		Forearm
	Ala nasi		Hand
	Eyebrow		Shoulder
	Brow		Upper limb
C444	Skin of Neck		Fingernail
	Skin of Scalp	C447	Skin of lower limp and hip
			Ankle
			Calf
			Foot

ICDO3 Primary Site Text

Use the text box to enter the anatomical site where the cancer was located. Refer to the tip sheet in this instruction document for additional guidance on selecting the correct ICDO3 Primary Site. Include tumor laterality. *

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ICDO3 Histology Text

Use this text box to describe the type of cancer for the patient. Refer to the tip sheet (Appendix C) in this instruction document for guidance on appropriate terminology. *

Melanoma NOS **8720** ***Note 1***: Sarcomatoid melanoma is a rare subtype of melanoma characterized by almost complete loss of melanocytic differentiation both morphologically and phenotypically, with the bulk of the tumor being replaced by a spindle cell, sarcomatoid component. Use code 8772/3, spindle cell melanoma. ***Note 2***: Early/evolving melanoma in situ and early/evolving melanoma invasive are reportable for cases diagnosed 1/1/2021 forward.	Melanoma in situ **8720/2** Early/Evolving melanoma in situ** **8720/2 (see Note 2)** Nevoid melanoma **8720/3** Early/Evolving invasive melanoma** **8720/3 (see Note 2)**	Acral melanoma*/acral lentiginous melanoma, malignant **8744/3** Amelanotic melanoma **8730/3** Balloon cell melanoma **8722/3** Desmoplastic melanoma/desmoplastic melanoma, amelanotic/neurotropic melanoma, malignant **8745/3*** Epithelioid cell melanoma **8771/3** Lentigo maligna/Hutchinson melanotic freckle **8742/2** / Lentigo maligna melanoma/Melanoma in Hutchinson melanotic freckle **8742/3** Low cumulative sun damage melanoma*/superficial spreading melanoma **8743/3** Melanoma arising in a blue nevus **8780/3*** Malignant melanoma arising in giant congenital nevus*/malignant melanoma in giant pigmented nevus **8761/3** Malignant melanoma in a precancerous melanosis **8741/3** Malignant melanoma, regressing **8723/3** Malignant Spitz tumor*/mixed epithelioid and spindle cell melanoma **8770/3** Nodular melanoma **8721/3** Spindle cell melanoma **8772/3** Spindle cell melanoma, type A **8773/3** Spindle cell melanoma, type B **8774/3**

ICDO3 Behavior

Use the drop-down box to select the appropriate behavior for this cancer. This information can be found in the final diagnosis text of the pathology report. *

Tumor Laterality

Use the drop-down box to select the appropriate description for the location of the cancer. This information can be found in the final diagnosis text of the pathology report. *

Breslow Thickness (Applies only to Invasive Malignancies)

Enter the appropriate Breslow Thickness in the text box. This information can be found in the final diagnosis text of the pathology report.

Mitotic Rate (Applies only to Invasive Malignancies)

Use the text box to enter the appropriate two-digit numeric code, if the cancer is in situ or you do not know the Mitotic Rate enter 00. You should be able to locate this information in the final diagnosis text of the pathology report.

Ulceration

Use the drop-down box to select the appropriate code. This information can be found in the final diagnosis text of the pathology report. *

Treatment Type

Use the drop-down box to select the surgical procedure performed in your office for this cancer. *

Melanoma Surgery Coding

Assigning surgery codes for melanoma cases can be difficult. Here are some tips to help clarify surgery coding.

1. ***ALWAYS*** obtain ***ALL*** pathology reports from ***ALL*** sources along with operative and office notes. These sources of documentation will be helpful in your decision-making process.

2. Review the PE (physical exam) of the skin area and lymph nodes to help determine if the surgeon intended to remove the lesion on the original/initial biopsy. Any surgeon performing a wide excision of a proven melanoma should be document as clinical exam findings and the exams should be documented in their text.

3. Try to determine the intent of the procedure performed. Often, shave, punch or excisional biopsies will be done prior to the patient presenting to your facility.

    a. If a biopsy (shave, punch, excision, etc.) was done simply to establish a diagnosis ***AND DOES NOT*** remove the entire mole/lesion, then the procedure is to be coded as a **non-definitive therapy**.

    b. If a biopsy (shave, punch, excision, etc.) was done ***WITH THE INTENT*** to remove the ***ENTIRE*** mole/lesion (with or without establishing a diagnosis), then the procedure is to be coded as a **definitive surgery**. This is known as an excisional biopsy

4. The biopsy of the primary tumor is normally followed by a wide excision which removes a margin of healthy or normal tissue around the tumor, so look for two procedures.

5. Code the subsequent wide excision based on the surgical margin measurements: Use the margin measurement from the PATHOLOGY report.

Treatment Date

Use the calendar icon to select the date the surgical procedure was performed. Do not enter the date manually.

Date of Last Contact

Use the calendar icon to select the date of the most recent contact or office visit with the patient. Do not enter the date manually. *

Vital Status

Use the drop-down box to select whether the patient is alive or deceased. *

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Reporting NPI

Enter the ten-digit numeric NPI associated with your practice. If your office has a single provider, the provider's NPI may be entered if there is no practice-level NPI assigned to the facility. *

Contact Information (E-mail)

Enter the email address for the point of contact in your office who can respond to questions about the information submitted in the form. Avoid using a generic practice email unless it is the only option. *

Office Mechanics & Filing: Completed forms will be stored on the registry's network drive. This form is maintained by retention schedule 18839, South Carolina Central Cancer Registry Records. Once the 120-year (after reporting) retention period has been met and quality review has been completed, an ARM-11 destruction request should be submitted and approved prior to disposal of the original form