Date of Diagnosis

Total Field Length: 8 (YYYYMMDD Format)

Day (DD): 2 digit

Month (MM): 2 digit

Year (YYYY): 4 digit

The date of diagnosis is the month, day, and year the reportable neoplasm was first identified, clinically or microscopically, by a recognized medical practitioner

Organization	Field Name	ID	Required
KCR	Date of Diagnosis (DiagDate)	30160	yes
NAACCR	Date of Diagnosis	390	yes

Enter the month, day, and year of the initial diagnosis (YYYYMMDD format)

- **Code the date using a zero to precede single digit days, or months, i.e., June is entered as 06**

This field refers to the date of first diagnosis of this cancer by a recognized medical practitioner. This is the date of the first clinical diagnosis, and in some cases, the diagnosis may never be histologically confirmed. Do not change the date of diagnosis when a later biopsy or cytology provides confirmation of a clinical diagnosis. From 2009 forward, for cases which are diagnosed in utero, record the actual date of diagnosis. For pre-2009 cases, the date of diagnosis for in utero cases should be the date of birth.

Codes for Month

Code	Description
01	January
02	February
03	March
04	April
05	May
06	June
07	July
08	August
09	September
10	October
11	November
12	December

Coding Instructions

1. Code the month, day and year the tumor was first diagnosed, clinically or microscopically, by a recognized medical practitioner

a. When the first diagnosis includes reportable ambiguous terminology, record the date of that diagnosis

Example: Area of microcalcifications in breast suspicious for malignancy on 02/13/2024. Biopsy positive for ductal carcinoma on 02/28/2024. The date of diagnosis is 02/13/2024.

2. When the only information available is a positive pathology or cytology report, code the date the procedure was done as the date of diagnosis. Do not code the date the specimen was

received, read as positive by the pathologist, or the date the report was dictated or transcribed.

Example: Biopsy was performed on 05/06/2024. The specimen from the biopsy was received and read by the pathologist as positive for cancer on 05/09/2024. The date of diagnosis is 05/06/2024.

3. The first diagnosis of cancer may be clinical (i.e., based on clinical findings or physician's documentation)

Note: Do not change the date of diagnosis when a clinical diagnosis is subsequently confirmed by positive histology or cytology.

Example 1: On May 15, 2024, physician states that patient has lung cancer based on clinical findings. The patient has a positive biopsy of the lung in June 3, 2024. The date of diagnosis remains May 15, 2024.

Example 2: Radiologist reports Liver Imaging Reporting and Data System (LI-RADS) Category 5 on imaging. Later biopsy confirms hepatocellular carcinoma (HCC). Record date of diagnosis as date of LI-RADS imaging.

Note: Appendix E in the 2024 SEER Program Coding and Staging Manual lists which PI-RADS, BI-RADS, and LI-RADS are reportable versus non-reportable. If reportable, use the date of the imaging procedure as the date

of diagnosis when this is the earliest date and there is no information to dispute the imaging findings.

4. Positive tumor markers alone are not diagnostic of cancer. Use the date of clinical, histologic, or positive cytologic confirmation as the date of diagnosis.

Example 1: The patient has an elevated PSA and the physical examination is negative. The physician documents only that the patient is referred for a needle biopsy of the prostate. The

biopsy is positive for adenocarcinoma. The date of diagnosis is the date of the biopsy (do not code the date of the PSA or the date the procedure was dictated or transcribed).

Example 2: The patient has an elevated PSA and the physical examination is negative. The physician documents that he/she suspects that the patient has prostatic cancer and is referring

the patient for a needle biopsy. The needle biopsy is positive, confirming the physician'ssuspicion of cancer. The date of diagnosis is the date the physician documented that he/she suspects that the patient has prostatic cancer.

Note: Positive tumor markers alone are never used for case ascertainment.

5. Use the date of suspicious cytology when the diagnosis is proven by subsequent biopsy, excision, or other means

Example: Cytology suspicious for malignancy 01/12/2024. Diagnosis of carcinoma per biopsy on 02/06/2024. Record 01/12/2024 as the date of diagnosis.

Note 1: "Suspicious" cytology means that the diagnosis is preceded by an ambiguous term such as apparently, appears, compatible with, etc.

Note 2: Do not use ambiguous cytology alone for case ascertainment.

6. Code the earlier date as the date of diagnosis when

a. A recognized medical practitioner says that, in retrospect, the patient had cancer at an earlier date or

b. The original slides are reviewed and the pathologist documents that cancer was present. Code the date of the original procedure as the diagnosis date.

Example: The patient had an excision of a benign fibrous histiocytoma in January 2024. Six months later, a wide re-excision was positive for malignant fibrous histiocytoma. The physician

documents in the chart that the previous tumor must have been malignant. Code the diagnosis date as January 2024.

Note: Do not back-date the diagnosis when

• The information on the previous tumor is unclear AND/OR

• There is no review of previous slides AND/OR

• There is no physician's statement that, in retrospect, the previous tumor was malignant

Example: The patient had a total hysterectomy and a bilateral salpingo-oophorectomy (BSO) in June 2024 with pathology diagnosis of papillary cystadenoma of the ovaries. In December

2024, the patient is diagnosed with widespread metastatic papillary cystadenocarcinoma. The slides from June 2024 are not reviewed and there is no physician statement saying the previous

tumor was malignant. The date of diagnosis is December 2024.

7. Code the date of death as the date of diagnosis for autopsy only cases

8. Death certificate only (DCO) Cases

a. Use information on the death certificate to estimate the date of diagnosis

b. Record the date of death as the date of diagnosis when there is not enough information available to estimate the date of diagnosis; for example, the time from onset to the date of death is described as 'years'

c. If no information is available, record the date of death as the date of diagnosis

9. Estimate the date of diagnosis if an exact date is not available. Use all information available to calculate the month and year of diagnosis.

a. Estimating the month

i. Code “spring” to April

ii. Code “summer” or “middle of the year” to July

iii. Code “fall” or “autumn” as October

iv. For “winter” try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is

available to calculate the month of diagnosis.

v. Code “early in year” to January

vi. Code “late in year” to December

vii. Use whatever information is available to calculate the month of diagnosis

Example 1: Admitted October 2024. History states that the patient was diagnosed 7 months ago. Subtract 7 from the month of admission and code date of diagnosis to March 2024.

Example 2: Outpatient bone scan done January 2024 that states history of prostate ancer. The physician says the patient was diagnosed in 2024. Assume bone scan was part of initial work-up and code date of diagnosis to January 2024.

viii. Code the month of admission when there is no basis for estimation

ix. Leave month blank (or convert 99 to blank) if there is no basis for approximation

b. Estimating the year

i. Code “a couple of years” to two years earlier

ii. Code “a few years” to three years earlier

iii. Use whatever information is available to calculate the year of diagnosis

iv. Code the year of admission when there is no basis for estimation

10. If no information about the date of diagnosis is available

a. Case transmitted to NCI SEER

i. Use the date of admission as the date of diagnosis

ii. In the absence of an admission date, code the date of first treatment as the date of diagnosis

b. Case NOT transmitted to NCI SEER

i. Code month and year as unknown

Nursing Home and Hospice Residents (Not hospitalized for their cancer; no information other than nursing home or hospice records and/or death certificate)

1. Use the best approximation for the date of diagnosis when the only information available is that the patient had cancer while in the nursing home and it is unknown whether the patient had cancer when admitted

2. Code the date of admission to the nursing home as the date of diagnosis when

a. The only information available is that the patient had cancer when admitted to the nursing home

b. The only information available is that the patient had cancer while in the nursing home, it is unknown whether the patient had cancer when admitted, and there is no basis for approximation

Cases Diagnosed Before Birth

Record the actual date of diagnosis for diagnoses made in utero even though this date will precede the date of birth.

Example: Fetal intrahepatic mass consistent with hepatoblastoma diagnosed via ultrasound at 39 weeks gestation (01/30/2024). Live birth by C-section 02/04/2024. Code the date of diagnosis as 01/30/2024.

Note: Prenatal diagnoses are reportable when there is a live birth.