Abstracting *In Utero* Diagnoses

SEER reportability requirements apply to diagnoses made in utero. **Diagnoses made in utero are reportable *only when the pregnancy results in a live birth***. In the absence of documentation of stillbirth, abortion or fetal death, assume there was a live birth and report the case.

EXCLUDE those that did not result in a live birth as they are not in the population counts.

If the **disease** was diagnosed *in utero* but **has regressed and disappeared** by birth**,** use the ***diagnostic info from the in utero documentation*** to code case.

For cases diagnosed **PRIOR to 01/01/2009:**

- Date of Diagnosis = Birth date
- Treatment Date = Birth date

For cases diagnosed **01/01/2009 and forward**:

- **Date of Diagnosis**--record the **actual date** that the diagnosis was made *(even though this date will precede the date of birth)*

  For example: Teratoma diagnosed via imaging at 37 weeks gestation (1/31/2010). Live birth by C-section 2/9/2010. Code the date of diagnosis as 01/31/2010.

- **Treatment Date—**record the **actual date** that the treatment was performed prior to birth. **REMEMBER to also code the type of treatment performed in the appropriate data item, i.e. Surgery of Primary Site, chemo, radiation, etc.**

  For example: 1-3-2010 fetus diagnosed with malignant teratoma. The teratoma is resected in utero 1-10-2010. Live birth on 4-18-2010. Code the date therapy initiated as January 10, 2010 and record the appropriate surgical resection code under “Surgery of Primary Site.”

Age at Diagnosis for “in utero” cases will be coded to 000

Sources: 2011 SPCSM; 2009-2012 FORDS