TREATMENT INFORMATION

FIRST COURSE OF TREATMENT

Cancer-directed therapy or definitive treatment is limited to procedures that normally affect, control, change, remove, or destroy cancer tissue of the primary or metastatic site, and administered to the patient before disease progression or recurrence. The **first course** of treatment can be defined as cancer-directed treatment that begins **within four months** of initial diagnosis. Any and all types of first course treatment administered at the reporting facility or elsewhere must be coded in the appropriate treatment field and documented in the *Treatment Documentation* field.

ALL MALIGNANCIES EXCEPT LEUKEMIA

The first course of treatment includes all treatment planned and administered by the physician(s) from the initial diagnosis of cancer. Treatment can include multiple methods and may last a year or more. Any treatment delivered after the first course is considered subsequent treatment.

> ***NOTE:*** Should there be a change of therapy due to apparent failure of the originally delivered treatment or because of the progression of the disease, the later therapy is not considered first course.
>
> ***NOTE:*** For patients with a diagnosis of prostate cancer, some physicians use "watchful waiting". This treatment method **is** considered first course. If other treatment is delivered after disease progression, it is considered subsequent treatment.
>
> ***EXCEPTION:*** *The first course of treatment for leukemia includes all therapies planned and delivered by the physician(s) during the first diagnosis of leukemia. Record all treatment that is remission-inducing or remission-maintaining. Treatment can include multiple methods and may last a year or more. Treatment administered after relapse of the first remission is not considered first course.*

DATE OF INITIAL TREATMENT (NAACCR ITEM #1260) (FORDS pg. 129; SEER pg. 121)

Definition

The date the first course of treatment (surgery, radiation, systemic, or other) started at any facility.

Explanation

The earliest date of treatment before disease progression or recurrence of disease.

Coding Instructions

- Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

- Enter the month, day, century and year (MMDDCCYY) of the start of the treatment.

- If the physician decides not to treat the patient, record the date of this decision as the date of initial treatment. The physician may decide not to treat the patient because of co-morbid conditions, advanced disease, or because the accepted management of the cancer is to observe until the disease progresses or until the patient becomes symptomatic.

  EXAMPLE:
  1. On February 12, 2003 the physician states a low-stage prostate cancer patient will be observed until the Prostatic Specific Antigen (PSA) starts to rise. Enter 02122003 as the date of initial treatment.

- If the patient or the patient's family refuses treatment, record the date of this decision as the date of initial treatment.

- If no treatment is delivered, record the date of the decision not to treat, the date treatment refused, or the date the patient expired.

- Record all zeros (00000000) for cases diagnosed at autopsy.

- Record all nines (99999999) when it is unknown if any treatment was delivered, the initial treatment date is unknown, or the case is identified by death certificate only.

- If the patient is diagnosed at the reporting facility and no further information is available, record all nines (99999999).

RX. SUMMARY - SCOPE OF REGIONAL LYMPH NODE SURGERY (NAACCR ITEM #1292) (FORDS pg. 138; SEER pg. 127)

Definition
Indicates the removal, biopsy, or aspiration of regional lymph nodes at the time of surgery of the primary site or during a separate surgical procedure.

Explanation
This information is used to compare and evaluate the extent of the surgical procedure.

Coding Instructions
- The scope of regional lymph node surgery is collected for the most definitive surgical procedure of lymph nodes even if surgery of the primary site is not done. Codes 0-7 are hierarchical. Code the procedure that is numerically higher.

- Document and code the **SCOPE OF REGIONAL LYMPH NODE SURGERY** using the chart on next page.

- Code to 9 for:
  a. Primaries of the meninges, brain, spinal cord, cranial nerves, and other central nervous system C70.0-C70.9, C71.0-C71.9, C72.0-C72.9).

  b. Lymphomas (M-9590-9596, 9650-9719, 9727-9729) with a lymph node primary site (C77.0-C77.9).

  c. Unknown or ill-defined primary (C76.0-C76.8, C80.9), or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4, or M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989).

- Do not code **distant** lymph nodes removed during surgery to the primary site in this field.

- Refer to the SEER Summary Staging Manual 2000 for site-specific identification of regional lymph nodes to assist you in coding this field.

CODE	DESCRIPTION	DEFINITION
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph nodes, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement.
2	Sentinel lymph node biopsy	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel lymph node biopsy.
4	1-3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated	Code 2 was performed in a single surgical procedure with code 3, 4, or 5. Or code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedure by procedures coded as 3, 4, or 5.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

EXAMPLES:

1. Excision of one cervical lymph node followed by a radical neck dissection with the number of nodes removed not stated. The appropriate code would be "3".

2. Sentinel bx positive for infiltrating ductal carcinoma. Modified radical mastectomy with axillary node dissection: Infiltrating ductal carcinoma with 2/12 axillary lymph nodes positive. The appropriate code would be "6".

3. Transverse colon: Grade IV adenocarcinoma with extension into subserosa fat. 3/10 pericolic nodes are positive. The appropriate code would be "5".

RX. SUMMARY – REGIONAL LYMPH NODES EXAMINED (NAACCR ITEM #1296) (SEER pg. 128)

Definition

Indicates the number of regional lymph nodes examined by the pathologist during the most definitive surgical procedure of regional lymph nodes.

Explanation

This information is used to compare and evaluate the extent of the surgical procedure.

Coding Instructions

- Document and code the number of regional lymph nodes removed and identified in the pathology report using the chart below, **for the most definitive surgical procedure only. Do not** add together the number of nodes removed at different surgical events.

- If **no** regional lymph nodes are identified in the pathology report, code 00 even if the surgical procedure includes a lymph node dissection i.e., modified radical mastectomy or if the operative report documents removal of nodes.

  NOTE: This field is not cumulative and does not replace or duplicate the field *Regional Lymph Nodes Examined*. **Do not** copy the values from one field to the other.

- For the *Summary of Regional Lymph Nodes Examined* codes, the following guidelines apply.

  1. If lymph node surgery is done at the same time as surgery, priority is given to the information connected with the most definitive surgery. Use the priority order listed under *Surgery of Primary Site* in *Appendix A* to determine the most definitive surgery of primary site.

  EXAMPLE:
  2-18-03: Rt. breast excisional bx. with one sentinal node removal-pathology states sentinal node is positive. 2-18-03: Modified radical mastectomy with lymph node dissection – pathology states 3 out of 10 axillary lymph nodes positive for duct cell carcinoma. Code to "10."

2. If lymph node surgery is done at a different time from surgery, priority is given to the code connected with the most definitive lymph node surgery. Use the priority order listed under *Scope of Regional Lymph Node Surgery* on page 124 to determine the most definitive lymph node surgery.

   EXAMPLE:
   Patient had lobectomy and lymph node dissection 4/6 for lung cancer on January 12, 2003 and comes back on February 1, 2003 and has mediastinal lymph nodes removed 4/5. Code to "6".

CODE	DESCRIPTION
00	No lymph nodes were examined
01-89	1-89 lymph nodes were examined (Code exact number of regional lymph nodes examined)
90	90 or more lymph nodes were examined
95	No regional lymph nodes were removed, but aspiration of regional lymph nodes was performed
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated
98	Regional lymph nodes were surgically removed, but the number of nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown
99	It is unknown whether regional lymph were examined; not applicable; not stated in medical record

RX DATE – SURGERY (NAACCR ITEM #1200) (FORDS pg. 131; SEER pg. 121)

NOTE: This item was previously **DATE STARTED – SURGERY.**

Description
The earliest date of the first cancer-directed surgical procedure performed at any facility.

Explanation
Documents the date of the first cancer-directed surgical procedure.

Coding Instructions
- Record the month, day, century and year (MMDDCCYY) of the first cancer-directed surgery.
- Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
- If the exact date of cancer-directed surgery is not available, record an approximate date.
- If two or more cancer-directed surgeries are performed, enter the date for the first cancer-directed surgery.

EXAMPLES:

1. A patient was found to have a large polyp during a colonoscopy on September 8, 2003. A polypectomy confirmed adenocarcinoma of the descending colon. On September 23, 2003 the patient underwent a left hemicolectomy. The date of surgery would be recorded as 09082003.

2. An incisional biopsy is performed on March 3, 2003 followed by a resection on March 17, 2003. Record the date of the resection (03172003) as the date of the first surgical procedure. An incisional biopsy is a diagnostic procedure, not a cancer-directed treatment procedure.

3. February 1, 2003 a patient had a fine needle aspiration of a right breast mass, consistent with infiltrating ductal carcinoma. February 15, 2003, the patient underwent a right modified radical mastectomy. The date of surgery would be recorded as 02152003.

SURGICAL PROCEDURE OF PRIMARY SITE (NAACCR ITEM #1290) (FORDS pg. 135; SEER pgs.124-126)

Description

Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of the primary site. Code the surgery of the primary site performed at any facility as part of the first course of treatment.

> ***NOTE:*** This is surgery of primary site only.

Explanation

Identifies the specific cancer-directed surgery of the primary site.

Coding Instructions

- Site-specific surgery codes are in *Appendix A*.

Code the type of surgery the patient received as part of the **first course of treatment** at any facility.

> ***NOTE:*** Surgery performed solely for the purpose of establishing a diagnosis/stage (exploratory surgery), the relief of symptoms (bypass surgery), or reconstruction is **not** considered cancer-directed surgery. Brushings, washings, and aspiration of cells are not surgical procedures.

CODE	TYPE	DEFINITION
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10-19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to *Appendix A* for correct site-specific procedure code.
20-80*	Site-specific codes; resection	Refer to *Appendix A* for correct site-specific procedure code.
90	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Site-specific surgery codes; special	Special codes. Refer to *Appendix A* for correct site-specific procedure code.
99	Unknown	Medical record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

- Codes 00-79 are hierarchical. If more than one code describes the procedure, use the numerically higher code.
- Code 98 takes precedence over code 00.
- Excisional biopsies that remove the entire tumor and/or leave only microscopic margins are coded in this field.
- Surgery to remove regional tissue or organs is coded in this field only if the tissue or organs are removed in continuity with the primary site, except where noted in *Appendix A*.
- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, code the total or final results.

RX SUMM – SURG OTH REG/DIST RX CODE (NAACCR ITEM #1294) (FORDS pg. 142)

NOTE: This item was previously **REG/DIST RX.**

Description

Indicates the surgical removal of other regional site(s), distant site(s), or distant lymph node(s) beyond the primary site. Code the surgical procedure of other sites the patient received, at any facility, as part of the first course of treatment.

Coding Instructions

- Record the highest numbered code that describes the surgical resection of *distant lymph nodes or regional/distant tissues or organs* the patient received as part of the **first course of treatment** at any facility.

CODE	DESCRIPTION	DEFINITION
0	None	No surgical procedure of non-primary site was performed. Diagnosed at autopsy.
1	Non-primary surgical procedure performed	Non-primary surgical procedure to other site(s), unknown if whether the site(s) is regional or distant.
2	Non-primary surgical procedure to other regional sites	Resection of regional site that is not included in combination surgery codes of the primary site.
3	Non-primary surgical procedure to distant lymph node(s)	Resection of distant lymph node(s).
4	Non-primary surgical procedure to distant sites	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a non-primary site was performed. Death certificate only.

EXAMPLES:

1. The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon is coded to 0.
2. Surgical biopsy of metastatic lesion from liver with an unknown primary is coded to 1.
3. Surgical ablation of solitary liver metastasis with a hepatic flexure primary is coded to 2.
4. Excision of distant metastatic lymph nodes with a rectosigmoid primary is coded to 3.
5. Removal of a solitary brain metastasis with a lung primary is coded to 4.
6. Excision of a solitary liver metastasis and hilar lymph node with a recto-sigmoid primary is coded to 5.

DATE RADIATION STARTED (NAACCR ITEM #1210) (FORDS pg. 148)

Description
The date the radiation therapy began at any facility as part of the first course of treatment.

Explanation
Identifies the date radiation therapy was initially started.

Coding Instructions

- Record the month, day, century, and year (MMDDCCYY) of the first cancer-directed radiation therapy.
- Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
- If the exact date of cancer-directed radiation therapy is not available, record an approximate date.

- If two or more types of radiation therapy are delivered i.e., beam and isotopes; beam and implants, enter the date for the **first** type of radiation therapy.

- Record all zeros (00000000) when no radiation therapy is delivered or the cancer was diagnosed at autopsy.

- Record all nines (99999999) when it is unknown whether any radiation therapy was delivered, the date is unknown, or the case was identified by death certificate only.

RADIATION – REGIONAL TREATMENT MODALITY (NAACCR ITEM #1570) (FORDS pgs. 155-156; SEER pg.134)

NOTE: This replaces **TYPE OF RX – RADIATION.**

Description
Records the dominant modality of radiation therapy used to deliver the most clinically significant dose to the primary volume of interest during first course of treatment.

Rational
Radiation treatment is frequently delivered on two or more phases which can be summarized as “regional” and “boost” treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Coding Instructions

- Radiation treatment modality will typically be found in the radiation oncologist’s summary letter for the first course of treatment. Segregation of treatment components into regional and boost, and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.

- In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality.

- Note that in some circumstances the boost treatment may precede the regional treatment of the patient, record only the dominant modality.

- For purposes of this data item, photons and x-rays are equivalent.

CODE	TYPE	DEFINITION
00	No radiation treatment	Radiation therapy was not administered to the patient.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded to 50 or 51.
23	Photons (2-5 MV)	External beam therapy using a photon-producing machine with a beam energy in the range of 2-5 MV.
24	Photons (6-10 MV)	External beam therapy using a photon-producing machine with a beam energy in the range of 6-10 MV.
25	Photons (11-19 MV)	External beam therapy using a photon-producing machine with a beam energy in the range of 11-19 MV.
26	Photons (> 19 MV)	External beam therapy using a photon-producing machine with a beam energy more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in medical record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in medical record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in medical record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma knife	Treatment categorized as using stereotactic technique delivered with a gamma knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, intracavitary, low dose rate (LDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using LDR applicators and isotopes (Cesium-137, Fletcher applicator).

CODE	TYPE	DEFINITION
52	Brachytherapy, intracavitary, high dose rate (HDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using HDR after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using LDR sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using HDR sources.
55	Radium	Infrequently used for LDR interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	Same as above
80*	Combination modality, specified	Combination of external beam radiation and either radioactive implants or radioisotopes.
85*	Combination modality, NOS	Combination of radiation treatment modalities not specified in code 80.
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

* For cases diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation therapy administered to the patient as part or all the first course of treatment. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to *Vol. II, ROADS* rules and **should not** be used to record regional radiation therapy for cases diagnosed on or later than January 1, 2003.

DATE SYSTEMIC THERAPY STARTED (NAACCR ITEM #3230) (FORDS pg. 169)

Definition
Identifies the date systemic therapy began at any facility. Systemic therapy includes the following treatment modalities:

a. Chemotherapy agents
b. Hormonal agents
c. Biological response modifiers
d. Bone marrow transplants
e. Stem cell harvests
f. Surgical and/or radiation endocrine therapy

Explanation
Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment to recurrence.

Coding Instructions
- Record the month, day, century, and year (MMDDCCYY) the **first** systemic therapy was delivered.

- Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

- If the exact date of the first systemic therapy is not available, record an approximate date.

- Record all zeros (00000000) when no systemic therapy was delivered or the cancer was diagnosed at autopsy.

- Record all nines (99999999) when it is unknown if any systemic therapy was delivered, the date is unknown, or the case was identified by death certificate only.

- Record all eights (88888888) if systemic therapy was planned, but not started or unknown if administered.

CHEMOTHERAPY (NAACCR ITEM #1390) (FORDS pg. 171; SEER pg. 137)

Definition
Chemotherapy is a chemical (or group of chemicals) administered to treat cancer. Chemotherapy consists of a group of anti-cancer drugs that inhibit the reproduction of cancer cells. Chemotherapeutic agents may be administered by intravenous infusion or given orally.

Explanation
This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy.

Coding Instructions
- Refer to the *Self Instructional Manual for Tumor Registrars (SEER): Book 8 - Antineoplastic Drugs, Third Edition*, for a list of chemotherapeutic agents.

- Code the type of chemotherapy the patient received as part of the **first course of treatment** at any facility. Chemotherapy may involve the delivery of one or a combination of chemotherapeutic agents.

CODE	DEFINITION
00	None; chemotherapy was not part of the first course of therapy.
01	Chemotherapy administered as first course of therapy, but the type and number of agents is not documented in the patient record.
02	Single-agent chemotherapy administered as first course of therapy.
03	Multi-agent chemotherapy was delivered as first course of therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors i.e., comorbid conditions, advanced age.
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.

CODE	DEFINITION
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87	Chemotherapy was not delivered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

- Code 00 if the chemotherapy was not delivered and it is known that it is not usually delivered for this type and stage of cancer, or if the treatment plan offered multiple options and the patient selected treatment that did not include chemotherapy.

- Code to 82, 85, 86, or 87 if it is known that chemotherapy is usually administered for this type and stage of cancer, but it was not delivered.

- Code to 87 if the patient refused the recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

- If the physician changes one of the agents in a combination regimen and the replacement agent is in a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen is the beginning of subsequent treatment and is **not** recorded as first course treatment.

EXAMPLES:

1. A patient with primary liver cancer is known to have received chemotherapy. The type(s) of agents delivered is not documented in the medical record. **Code 01**.

2. A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the fluorouracil as a single agent and the levamisole as an immunotherapeutic agent. **Code 02**.

3. A patient with early stage breast cancer receives chemotherapy. The medical record indicated a regimen containing doxorubicin is to be administered. **Code 03**.

4. Following surgical resection of an ovarian mass the physician recommends chemotherapy. The medical record states chemotherapy was not delivered and the reason is not documented. **Code 86**.

HORMONE THERAPY (HORMONE/STEROID THERAPY) (NAACCR ITEM #1400) (FORDS pg. 175-176; SEER pg. 138)

Description
Hormone therapy is a drug or group of drugs that is delivered to change the hormone balance. Hormone therapy may affect a long-term control of the cancer growth. It is not usually curative.

> ***NOTE:*** Hormone therapy is administered to treat cancer tissue and is considered to achieve its effect through change of the hormone balance. Some tissues, such as prostate or breast, depend upon hormones to develop. When a malignancy arises in these tissues, it is usually hormone-responsive. Other primaries and histologic types may be hormone-responsive, such as melanoma and hypernephroma.

Explanation
This data item allows for the analysis of hormone treatment as part of the first course of therapy.

Coding Instructions

- Code the type of hormone therapy the patient received as part of the **first course of treatment** at any facility. Hormone therapy may involve the delivery of one or a combination of agents.

- Refer to the *Self Instructional Manual for Tumor Registrars (SEER) Book 8 - Antineoplastic Drugs, Third Edition*, for a list of hormone agents.

CODE	DEFINITION
00	None; hormone therapy was not part of the planned first course of therapy.
01	Hormone therapy was delivered as first course of therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of treatment. No reason was stated in patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

- Code prednisone as hormone therapy when it is administered in a combination chemotherapy regimen, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone), or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

- Code to 00 if hormone therapy was not delivered to the patient and it is known that it is not usually administered for this type and stage of cancer, or if the treatment plan offered multiple options and the patient selected treatment that did not include hormone therapy.

- Code to 01 for thyroid replacement therapy, which inhibits the thyroid stimulating hormone (TSH). TSH is a product of the pituitary gland that stimulates tumor growth.

- Code to 82, 85, 86, or 87 if it is known that hormone therapy is usually delivered for this type and stage of cancer, but it was not delivered.

- Code to 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

  EXAMPLES:
  1. A patient diagnosed with metastatic prostate cancer is administered flutamide (an anti-estrogen agent) as part of the first course of therapy. **Code to 01.**

  2. A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) as part of the first course of therapy and the refusal is documented in the medical record. **Code to 87.**

- Do not code as hormone replacement therapy when it is given because it is necessary to maintain normal metabolism and body function.

- If prednisone or other hormone is delivered for other reasons, **do not** code as hormone therapy.

  EXAMPLES:
  1. A patient with advanced disease is given Prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy. **Code to 00.**

  2. A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormone therapy. **Code to 00.**

  EXCEPTION: *Decadron is coded as hormonal treatment* ***only for leukemias, lymphomas, and multiple myelomas.*** *It is delivered to achieve its effect on cancer tissue through change of the hormone balance.*

IMMUNOTHERAPY (NAACCR ITEM #1410) (FORDS pg. 179; SEER pg. 139)

NOTE: This item was previously **TYPE OF RX – BIOLOGICAL RESPONSE MODIFIER (BRM).**

Description

Immunotherapy consists of biological or chemical agents that alter the immune system or change the

host's response to the tumor cells.

Explanation

This data item allows for the analysis of the administration of Immunotherapy agents as part of the first course of therapy.

Coding Instructions

- Code the type of Immunotherapy the patient received as part of the **first course of treatment** at any facility.

  NOTE: Examples of Immunotherapy agents are: BCG, C-Parvum, Interfoeron, Inerleukin, Levamisole, MVE-2, Pyran copolymer, Rituxan (for Non-Hodgkins Lymphoma) Thymosin, Vaccine therapy, Virus therapy, ASILI (active specific intralymphatic immunotherapy), Blocking factors, I-131 – labeled immunoglobin (also code as radioisotopes under the radiation treatment). Refer to the *Self Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs, Third Edition*, for a complete list of Immunotherapy agents.

CODE	DESCRIPTION
00	None, Immunotherapy was not part of the first course of therapy.
01	Immunotherapy administered as first course of therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of treatment. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether Immunotherapy agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

- Code to 00 if Immunotherapy was not delivered to the patient, and it is known that it is not usually delivered for this type and stage of cancer, or if the treatment plan offered multiple options and the patient selected treatment that did not include immunotherapy.

- Code to 82, 85, 86, or 87 if it is known that immunotherapy is usually delivered for this type and stage of cancer, but it was not.

- Code to 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

RX SUMM – TRANSPLANT/ENDOCRINE (NAACCR ITEM #3250) (FORDS pgs. 182-183)

Description
Systemic therapeutic procedures that include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy received at any facility as first course of treatment.

Explanation
This treatment involves the alteration of the immune system or change the patient's response to tumor cells, but does not involve the delivery of antineoplastic agents.

Coding Instructions

- Code the type of hematologic transplant and/or endocrine procedures the patient received as part of the **first course of treatment** at any facility.

CODE	DEFINITION
00	No transplant procedure or endocrine therapy was administered as part of first course of therapy.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant-autologous.
12	Bone marrow transplant- allogeneic.
20	Stem cell harvest.
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of endocrine surgery and/or radiation with a transplant procedure. Combination of codes 30 and 10, 11, 12, or 20).
82	Hematologic transplant and/or endocrine surgery/radiation were not recommended/ administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age.
85	Hematologic transplant and/or endocrine surgery/radiation were not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of first course therapy. No reason was stated in patient record.
87	Hematologic transplant and/or endocrine surgery/radiation were not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hematologic transplant and/or endocrine surgery/radiation were recommended, but it is unknown if it was administred.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation were recommended or administered because it is not documented in the medical record. Death certificate only.

- Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (bone marrow donated from an identical twin), the item is coded as allogeneic.

- Stem cell harvests involve the collection of immature blood cells from the patient and the re-introduction of a transfusion of the harvested cells following chemotherapy or radiation therapy.

- Endocrine irradiation and/or endocrine surgery are procedures that suppress the naturally occurring hormonal activity of the patient and therefore alter or affect the long-term control of the cancer's growth. These procedures must be **bilateral** to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.

  EXAMPLES:
  a. Bilateral orchiectomy for prostate cancer.
  b. Bilateral ophorectomy for breast cancer.
  c. Bilateral adrenalectomy for microadenoma.
  d. Bilateral hypophysectomy for pituitary cancer.
  e. Bilateral radiation to ovaries for breast cancer, or to testicles for prostate cancer.

- Code to 00 if a transplant or endocrine procedure was not administered to the patient, and it is known that these procedures are not usually administered for this type and stage of cancer.

- Code 86 if the treatment plan offered multiple options which included a transplant , and the patient selected treatment that did include a transplant procedure.

- Code to 82, 85, 86, or 87 if it is known that a transplant or endocrine procedure is usually delivered for this type and stage of cancer, but it was not.

- Code to 87 if the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

DATE OTHER TREATMENT STARTED (NAACCR ITEM #1250) (FORDS pg. 184)

Definition
The date other treatment began as first course of therapy.

Explanation
Records the date **other** treatment is delivered that is not included in surgery, radiation therapy, and systemic treatment.

Coding Instructions
- Record the month, day, century and year (MMDDCCYY) the other treatment was delivered.

- Punctuation marks (slashes, dashes, etc.) are not allowed in any field.

- Record all zeros (00000000) when no other treatment was delivered or the cancer was diagnosed at autopsy.

- Record all nines (99999999) when it is unknown if other treatment was delivered, the date is unknown, or it is a death certificate only case.

OTHER TREATMENT (NAACCR ITEM #1420) (FORDS pg. 186; SEER pg. 140)

Definition
"Other treatment" is designed to modify or control the cancer cells, but is not defined as surgery, radiation, or systemic therapy fields.

Coding Instructions
- Code the type of "other treatment" the patient received as part of the **first course of treatment** at any facility.

- **Do not** code ancillary drugs in this field. There is no coding scheme for ancillary drugs.

NOTE: Examples of experimental/unproven drugs: Laetrile, Krebiozen, Hyperthermai, Arterial block for renal carcinoma.

NOTE: "Other treatment" for reportable hematopoietic diseases can be supportive care, observation, or any treatment that does not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Such treatments include phlebotomy, transfusions, and aspirin (see ***NOTES*** below), and should be coded to 1.

CODES	TYPE	DEFINITION
0	None	All Cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment.
1	Other	Cancer treatment that cannot be appropriately assigned to specific treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases. *see **EXAMPLES** on next page.
2	Other-Experimental	This code is not defined. It may be used to record participation in facility-based clinical trials.
3	Other-Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven	Cancer treatments administered by non-medical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment.

EXAMPLES:
1. Phlebotomy may be called blood removal, blood letting, or venisection.

2. Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.

3. Aspirin (also known as ASA, acetylsalicylic acid, or by a brand name) is used as a treatment for essential thrombocythemia. Record aspirin therapy ONLY to thin the blood for symptomatic control of thrombocythemia. To determine whether aspirin is administered for pain, cardiovascular protection, or thinning of platelets in the blood, use the following general guideline:

   a. Pain control is approximately 325-1000 mg every 3-4 hours.
   b. Cardiovascular protection starts at about 160 mg/day.
   c. Aspirin treatment for essential thrombocythemia is low dose, approximately 70-100 mg/day.

TREATMENT DOCUMENTATION (NAACCR ITEMS #2610, #2620, #2630)

Recording Instructions
- Text information to support cancer diagnosis, stage, and treatment codes **MUST BE PROVIDED BY ALL FACILITIES**. Document any and all types of the **first course** of definitive treatment administered, regardless of where the treatment was received, in date order.

- Also, document in this section if the medical record indicates no treatment was given (0's entered for Type of Treatment) or if there is no information in the medical record that definitive treatment was given (9's entered for Type of Treatment).

- If it cannot be determined whether an intended therapy was actually performed, record that it was recommended but it is not known if the procedure was administered. For example, “radiation, recommended; unknown if given,” (99 entered for Type of Treatment).

DATE OF LAST CONTACT OR DEATH (NAACCR ITEM #1750) (FORDS pg. 199; SEER pg. 144)

Definition
The date of last contact with the patient or the date the patient expired.

Coding Instructions
- Record the month, day, century and year (MMDDCCYY) the patient was last seen at your facility, date of last contact, or date of death.

- Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

- If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the **Other Pertinent Information** text area, document that the patient is deceased and the date of death is not available.

VITAL STATUS (NAACCR ITEM #1760) (FORDS pg. 200; SEER pg. 145)

Definition
Records the vital status of the patient as of the *Date of Last Contact or Death.*

Coding Instructions
- Code the patient's vital status as of the date recorded in the *Date of Last Contact or Death* field. Use the most current and accurate information available.

- If a patient has multiple primaries **simultaneously**, all records should have the same vital status.

CODE	LABEL
0	Dead
1	Alive

DATE ABSTRACTED (NAACCR ITEM #2090)

- Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

- Record the day, month, century and year (MMDDCCYY) the form was completed.

ABSTRACTOR INITIALS (NAACCR ITEM #570) (FORDS pg. 207)

- Record the initials of the abstractor.

NAACCR RECORDVERSION (NAACCR ITEM #50)

- TCR will automatically code this field.